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Maternal postpartum anxiety and depression

Matka z lękiem i depresją w okresie poporodowym

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Abstract

Pregnancy and early motherhood are associated with many difficulties in adapting to the new situation, fulfilling life roles and fears of meeting them, as well as changes taking place in the woman's body, struggling with anxiety, fatigue and general overload. The decision on individualised support should take into account the woman's personality and temperamental predispositions, health history, as well as her social and socioeconomic situation. Prevention of mental disorders, education on self-care during pregnancy, ensuring continuity of treatment in the case of chronic diseases, providing access to psychoeducation and specialists allow to minimise the negative effects of postpartum blues, depression and postpartum psychosis. It is also extremely important to make medical staff (doctors, midwives and nurses) aware of these issues, so that they can support the mother in a professional, empathetic and understanding way, indicating possible sources of help and tailoring them to specific needs taking into account issues such as stigmatisation of individuals with mental health problems. Taking the above into account, the aim of this work was to present the issue of mental disorders affecting postpartum women and their short- and long-term consequences for the well-being of both the mother and the child.

Keywords: anxiety, postpartum depression, postpartum psychosis, postpartum blues

Streszczenie

Okres ciąży i początki macierzyństwa wiążą się z licznymi trudnościami w adaptacji do nowej sytuacji w kontekście odgrywania ról życiowych i obaw przed sprostaniem im, zmian zachodzących w organizmie kobiety oraz borykania się z lękiem, zmęczeniem i przeciążeniem sytuacją. Podejmując decyzję o udzieleniu kobiecie indywidualnego wsparcia za pomocą dostępnych narzędzi, należy uwzględnić jej predyspozycje osobowościowo-temperamentalne, historię zdrowotną oraz sytuacje społeczną i socjoekonomiczną. Profilaktyka zaburzeń psychicznych, edukacja na temat dbania o zdrowie podczas ciąży, zapewnienie ciągłości leczenia w przypadku chorób przewlekłych, psychoedukacja i umożliwienie dostępu do specjalistów pozwalają minimalizować negatywne skutki zarówno smutku poporodowego, jak i depresji lub psychozy poporodowej. Bardzo istotne jest również uświadomienie tych kwestii personelowi medycznemu, w tym lekarzom, położnym i pielęgniarkom środowiskowym, by mógł on wesprzeć matkę w sposób profesjonalny, pełen empatii i zrozumienia, wskazując możliwe sposoby radzenia sobie oraz instytucje udzielające pomocy, dopasowując je do konkretnych potrzeb i uwzględniając przy tym wciąż zdarzające się stygmatyzowanie osób z problemami ze zdrowiem psychicznym. Celem niniejszej pracy jest ukazanie problematyki zaburzeń psychicznych dotykających kobiety w okresie poporodowym oraz ich konsekwencji dla dobrostanu matki i dziecka, zarówno we wczesnych, jak i późniejszych okresach jego życia.

Słowa kluczowe: lęk, depresja poporodowa, psychoza poporodowa, smutek poporodowy

INTRODUCTION

According to the dictionary of the Polish language, motherhood is "a state of being a mother along with the emotions, experiences and duties associated with this state"[1]. This construct functions in people's consciousness regardless of the times and culture they live in. Contemporary non-scientific articles read by women planning to become mothers often emphasise the context of duties without taking into account the feelings and experiences that accompany a pregnant woman[2].

PREGNANCY AS A PERIOD OF ADAPTATION TO A NEW LIFE ROLE

Looking at motherhood from the perspective of psychology, it is impossible to ignore the trend of positive psychology that has been intensely developing in recent years. It shifts the focus of interest from psychopathology, suffering and stress to such aspects of human life as happiness, well-being, expanding one's own resources and creativity, also regarding motherhood as a source of development[3]. However, going back to the 1960s and the research on stress conducted by two American psychiatrists Thomas Holmes and Richard Rahe[4], it should be mentioned that these two researchers proposed a list of stressful life events and ranked them based on the amount of readjustment required from the affected individual. This is how the Social Readjustment Rating Scale (SRRS) was created, in which death of a spouse is rated highest i.e. requires the greatest adjustments, a minor violation of the law is rated lowest (43), and where pregnancy comes 12th, which is relatively high. Although SRRS is sometimes criticised for, among other things, not appreciating the subjective assessment of events, or not taking into account their positive role or the processual nature of the situation, emphasising the effort associated with readjustment is its undoubted advantage[5].

Challenges, referred to as developmental tasks by Robert Havighurst, occur in the life cycle of every person[6]. These are events characteristic of individual periods of life, fulfilling of which brings a sense of satisfaction, contentment and success, and is a prerequisite for effective coping with tasks encountered later in life[7]. Fulfilling life goals and one's own needs contributes to developmental crises, which are classified in psychology as normative and non-normative. The former are related to transitions and turning points in life, while the latter are the result of overload[8].

Pregnancy is a time when a woman needs to adjust to a new situation, experiences changes in her body and lifestyle, perception of her own body and life role. It is also a time of concerns about maintaining the pregnancy, one's own and the child's health, fear of childbirth and the related pain[9], as well as uncertainty about the future in terms of professional career and social relationships. Expecting a child is also a time of stressful choices: hospital, method of delivery, midwife[10].

Expectant mothers experience strong emotions from the very beginning of pregnancy. Emotions play an extremely important role in the life of every human being; they provide orientation, relevant information, judgement, motivation, but also create and strengthen interpersonal bonds[11]. Although emotions are relative, experienced differently by different persons, and may vary in meaning, they are a constant presence[12]. People use different strategies to modify the experienced events, their expression, physiological excitement, but also the triggering situations[13,14]. Awareness of one's own emotions, understanding the context in which they emerge, the purpose of regulation, as well as the adopted strategies are a prerequisite for the adaptive course of this process. Some of them may promote psychopathology, including rumination, typical of anxiety and depressive disorders, as well as negative perception of future events[15].

POSTPARTUM MENTAL DISORDERS AND THEIR CONSEQUENCES

Factors contributing to postpartum depression include difficulties in adjusting to the new life role associated with motherhood, often accompanied by a sense of isolation and exclusion[16,17], problems during previous pregnancies, such as miscarriages, abortion, poor prenatal care, malnutrition, as well as difficulties in relationships with the closest family members, including the father of the child[18]. Maternal medical history, such as the use of medications or their limited use due to possible adverse reactions and effects on the developing foetus, is also extremely important. In the case of pregnant women with mental disorders, failure to start or discontinuation of therapy may lead to serious health consequences for the mother and her child, such as perinatal complications, including preeclampsia, prematurity, low birth weight and an increased risk of diabetes[19–21].

Most women experience some emotional deterioration after childbirth. It occurs shortly after childbirth (between 3 and 5 days) and is referred to as postpartum blues or baby blues. This period is associated with lowered mood, a sense of sadness and depression, emotional lability, tearfulness, and a sense of fatigue or weakness. Importantly, this condition resolves spontaneously and should not persist for longer than about 2 weeks. Therefore, the woman should receive support during this time so that she can take care of her sleep, physical and mental regeneration (focus on rest), but also on caring for her newborn[22], whose well-being should be looked after, which will be further discussed later in the paper.

Baby blues is not the same as postpartum depression, which has its onset between 4 and 6 weeks after delivery and, according to scientific reports, affects about 10–20% of women[23]. Characteristic symptoms of depression include low mood and a pessimistic view of both the existing reality and the future. The affected person experiences a decrease in self-esteem, self-confidence and self-efficacy, as well as an

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increased sense of guilt and worthlessness. Anhedonia and loss of will to act contribute to fatigue, reduce activity and manifest as diminished psychomotor drive. Cognitive functions also deteriorate. Disturbance of circadian rhythms with morning mood worsening, which somewhat improves during the day, allowing for afternoon activities, is also typical. The content of thinking also changes (resignation and/or suicidal ideations). In the case of mothers, the symptoms characteristic of postpartum depression additionally occur, such as a sense of being unable to care for the child, ruminations about the child's health and safety, a sense of being overwhelmed by the situation, tearfulness and intrusive thoughts of harm related to the infant. Postpartum depression is also associated with an increased level of anxiety[24,25]. Anxiety can cause cognitive distortions and affect information processing, which in turn increases alertness for potential threats. As a result, the risk of a threat becomes overestimated and memory is affected. Threatening content becomes easily accessible, promoting psychopathology and its persistence (anxiety or depressive disorders)[26,27].

Postpartum depression is not a temporary physical or mental overload, but a condition requiring pharmacotherapy or psychotherapy, or their combination. Pharmacological treatment is associated with the need to avoid breastfeeding for about 2–3 hours after drug administration, when its plasma concentration is the highest. If hospital stay is considered, it should be decided whether the infant should remain with the mother, which requires considering the possible benefits and risks for maternal health, as well as the child's safety and further development[28].

Postpartum psychosis can develop as early as day 3 postpartum and has an extremely rapid course, with symptoms such as severe anxiety, agitation, lack of sleep, disorientation, irritability, intrusive thoughts of harm related to the infant, suspicious attitude towards the environment, changes in behaviour, hallucinations, delusions, and motor restlessness[9,29].

In addition to psychological, social and cultural aspects, biological factors also play an important role in perinatal mental problems. Hormonal changes and their impact on the woman's body cannot be ignored. Oestrogen, progesterone and cortisol significantly increase during pregnancy to later decrease after delivery[30]. Stuebe et al.[31] showed an inverse relationship between oxytocin levels during breastfeeding and maternal depression. In turn, prolactin increases up to 50-fold during pregnancy and remains elevated during breastfeeding[32]. Similarly, neurosteroids increase during pregnancy and then rapidly drop after delivery. One of them is allopregnanolone, which shows antidepressant and anxiolytic effects[33].

Underestimating postpartum mental disorders is dangerous for both the mother and the child. Depressive symptoms can make it difficult to care for the infant and even lead to rejection. It is extremely important that the mother takes notice of, adjusts to and meets her child's needs[34]. This process may be supressed in mothers with mental disorders due to their reduced responsiveness to signals sent by the newborn, which may make it difficult to bond with the child. This has extremely important consequences, because, as shown by Bowlby[35], a model for creating relationships in later childhood and adulthood is developed based on experiences acquired during infancy and early childhood. Formation of a secure bond is also associated with learning mentalisation transmitted from the mother[36]. This is associated with the ability to regulate one's own emotions, maintain a stable self-image, function in the social world, as well as understand the behaviours and needs of both oneself and others[37]. The latest scientific reports indicate a significant correlation between maternal postpartum depression and mental disorders in the child in later life[38], including conduct disorders, destructive behaviours, affective disorders, substance abuse and anxiety disorders in the form of obsessive-compulsive disorders or phobias[38]. As pointed out by Wasilewska-Pordes[39], maternal depression can compromise the child's proper development. The author lists, among others, increased irritability, nervousness, lower activity or circadian rhythm disorders (sleep, wake) in newborns, as well as delayed motor development, lower body weight, more frequent aggressive, unfriendly or unemphatic behaviours in older children[39]. Jeleniewska et al.[40] pointed to a link between maternal prenatal mental disorders and somatic diseases in their children. These include allergic diseases, atopic dermatitis, recurrent respiratory infections, neurodevelopmental disorders, as well as tachycardia and hypercortisolism in newborns.

PREVENTION OF POSTPARTUM MENTAL DISORDERS

The level of depression can be assessed using a publicly available diagnostic screening tool known as the Beck Depression Inventory (BDI)[41]. Postpartum depression is diagnosed using:

- Edinburgh Postnatal Depression Scale (EPDS)[42];
- Center for Epidemiological Studies Depression (CES-D)[43];
- Patient Health Questionnaire-9 (PHQ-9)[44].

The Regulation of the Minister of Health on Organisational Standard of Perinatal Care[45] entered into force on January 1, 2019 to ensure that women giving birth and their children receive the attention and care of medical personnel during pregnancy, childbirth and the postnatal period, and are placed at the centre of care. These standards indicate the need to respect the general rights of patients and grant them the right to decide on such issues as the possibility of choosing the place of delivery, the scope of medical procedures performed and receiving support from a close person. Additionally, they emphasise the need to inform women about medical procedures and labour progress, as well as to obtain patient consent before performing any tests and procedures. The standards introduce detailed recommendations for mother-child contact and breastfeeding support, as well as suggest providing professional care

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on-site. They also define strict rules for preventive and screening interventions in the newborn.

The document further advocates that mothers should receive psychological care in certain situations, such as:

- diagnosis of a serious condition or foetal defect during pregnancy;
- miscarriage, stillborn child, a child that is unable to live, a sick child or a child with congenital defects;
- a child with very low birth weight, or an extremely premature child.

The regulations clearly point out that psychological care should be accessible in every situation of maternal mental state requiring such interventions, including information about possible forms of support and the institutions providing them. Furthermore, the act requires women entering prenatal care to be assessed for their risk for depression three times: between weeks 11 and 14, between weeks 33 and 37 of pregnancy and after delivery.

For postnatal care to be continuous it should be provided by the same midwife during pregnancy, delivery and the postpartum period. This system has been shown by global studies to be extremely beneficial for the health of both women and their children, to contribute to higher maternal satisfaction with care, less frequent use of pharmacological anaesthesia during labour and lower caesarean-section rates[46]. The model of midwife-led care is recommended by the World Health Organization and is currently implemented in countries such as the Netherlands, Great Britain, Canada, New Zealand and Australia[47].

When addressing mental problems, measures to provide women with support and possible therapeutic interventions, both psychotherapeutic and pharmacological, have been mentioned. Given the impact of maternal mental health on the child's development, the possibilities of therapeutic interventions targeting the child should be mentioned. A child is part of the family system from the earliest moments and therefore all supportive interventions should take into account the child's environment[48].

For newborns and infants, these are their closest caregivers, usually parents, hence systemic therapy is an effective tool for helping all family members, including the youngest ones[49]. Not forgetting the mental health and proper development of infants, also in the context of the relationship with the closest caregiver, it is worth mentioning the psychoanalytic parent-infant therapy[50]. This method is intended to help create bond between the infant and their closest caregivers by encouraging the parents to reflect on the intentions and messages sent by the child. This form of therapy is recommended for problems with feeding, sleeping or soothing an infant who, according to the parents, does not seek closeness, cannot be calmed down, appears sad, whereas parents are overwhelmed by care, feeling helpless or having difficulty reading the child's signals[50].

Every person faces many life situations that may require support and specialist help[51]. Hence, a conversation in which questions about the woman's well-being and how she copes with the new situation, and then patiently listening to her answers, is essential. There is also a need to support activities to reinforce social bonds, among others, by women developing acquaintances established in childbirth classes or support groups for postpartum women[52].

CONCLUSIONS

The above considerations indicate an extremely important issue, which is providing women with proper care during pregnancy and in the postpartum period. The time before pregnancy, during which education on physiology, as well as emotional changes and their adaptive regulation, should take place, is also important. Although knowledge, skills and established management standards are necessary to provide support, empathy, kindness, acceptance, understanding of fatigue, pain, fear and shame remain irreplaceable. It can be concluded in light of the latest reports that appropriate care for maternal mental and physical well-being helps create conditions for the proper development of the child.

Conflict of interest

The authors do not report any financial or personal connections with other persons or organisations which might negatively affect the contents of this publication and/or claim authorship rights to this publication.

Author contributions

Original concept of study; writing of manuscript: JK. Analysis and interpretation of data: JK, AT. Critical review of manuscript; final approval of manuscript: AT.

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