

# Background to Maternal Mental Health

This document provides a general background to perinatal mental health, and includes information of local relevance to the South African context. The topics covered are epidemiological issues, the risk factors, the spectrum of disorders, HIV/AIDS, societal impact, women's empowerment and management options.

## 1. Epidemiology

Perinatal<sup>1</sup> mental health problems are epidemic in the low-income and informal settlements surrounding Cape Town. *One in three* women in informal settlements suffers from postnatal depression (1). This is nearly *three times higher* than the prevalence in developed countries (2).

Globally, 30% of primary care attenders suffer mental disorders, with depression, anxiety and substance abuse being the commonest types. Unipolar depressive disorders are the second highest cause of (Disability Adjusted Life Years) DALYs lost in young adults age 15-44 (HIV/AIDS is the highest cause) (3).

Psychiatric disorders leading to suicide contribute as a leading cause of maternal death in developed countries and accounts for 28% of maternal deaths (4).

In developing countries, suicide is among the most important causes of death in young women (5,6). Mental illness is currently not included in the maternal mortality calculations in South Africa.

## 2. Risk factors

Poor people have more mental illness (7). The risk factors associated with perinatal mental health problems are endemic in the setting of socio-economic adversity.

These include recent stressful life events; adolescent pregnancy; domestic violence; rape; lack of emotional and logistical support from a partner; substance abuse and previous mental illness, particularly in the perinatal period (8). In the local setting, these factors are compounded by the high prevalence of HIV within the community.

## 3. Mental disorders

Anxiety disorders include generalised anxiety disorder, panic disorder, obsessive-compulsive disorder and post-traumatic stress disorder. These are thought to be as common as depressive disorders in the perinatal period.

The affective disorders associated with depression range from postnatal "blues", postnatal depression to postnatal psychosis. Although research has shown that the prevalence for depression is similar to the prevalence for non-postnatal women with children, there is an *increased rate of onset* of depression in pregnancy and the postpartum period (9).

Substance abuse and personality disorders commonly co-exist with disorders in the depression and anxiety spectra (10).

Clinically, the features of these disorders present in a similar manner to episodes occurring at other periods in a woman's life. Features that are particular to the perinatal period are a lack of interest or enjoyment in the infant, intrusive or hostile behaviour toward the infant, and thoughts of harming the infant. Anxiety about the wellbeing of the pregnancy or the infant may also predominate. Problems with breastfeeding and reports of a "difficult" or "colicky" baby are extremely common.

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<sup>1</sup> The term "Perinatal" refers here to the period during pregnancy (antenatal), labour and up to one year after the birth (postnatal).

#### 4. HIV/AIDS

It is widely evident that HIV/AIDS has had a significant impact on the emergence of mental disorders.

- Mental health disorders are more frequent in people with HIV infection
- Mental health disorders are risk factors for HIV infection
- Mental health disorders can impair the efficiency and uptake of HIV treatment<sup>2</sup>
- Some HIV treatment may lead to mental health disorders (11)

During pregnancy and the postnatal period, HIV positive women are particularly vulnerable to mental health problems. These may be associated with learning of their HIV status, which for most occurs at the antenatal booking visit. Anxiety, shame and guilt are typical resulting feelings. In addition, relationship difficulties and social isolation occur commonly in this setting. Furthermore, some mental health problems are associated with the illness itself.

Evidence from the pilot phase of the PMHP supports this and suggests that HIV positive women are in particular need of emotional support and mental health care.

#### 5. Societal impact

Mental disorders, during and after pregnancy, are associated with serious negative consequences for mother, infant and the community. These consequences may be evident in the short term and may persist in the long term.

Antenatal anxiety<sup>3</sup> has a significant impact on the developing foetus, and these effects persist into later childhood. They include organ malformation; premature delivery; low birth weight; neurological impacts e.g. hyperactivity, inattention and behavioural problems as well as emotional problems later in life (12).

There is good evidence from five major studies in developing countries to assert that depression during pregnancy is associated with an increased risk of low birth weight infants and that depression postnatally is associated with infant malnutrition and failure to thrive (13,14).

Depression in the mother may have persistent negative consequences for a child's social, emotional and cognitive development. This can negatively affect school performance and contribute to behavioural problems and long-term mental health problems (15). Further, children of depressed mothers are shown to be particularly *vulnerable to abuse* (16).

#### 6. Women's empowerment

Mental distress has a direct and negative impact on women's ability to negotiate choices around all spheres of life – social, economic, political and sexual. In disadvantaged South African communities, mental health problems may thus further entrench existing gender inequalities. Women who are emotionally distressed are also rendered vulnerable to a range of health problems such as frequent or unplanned pregnancies, HIV or to substance abuse. At the same time, those women who face stressful life events like unplanned pregnancies and domestic violence are at greater risk of mental health disorders.

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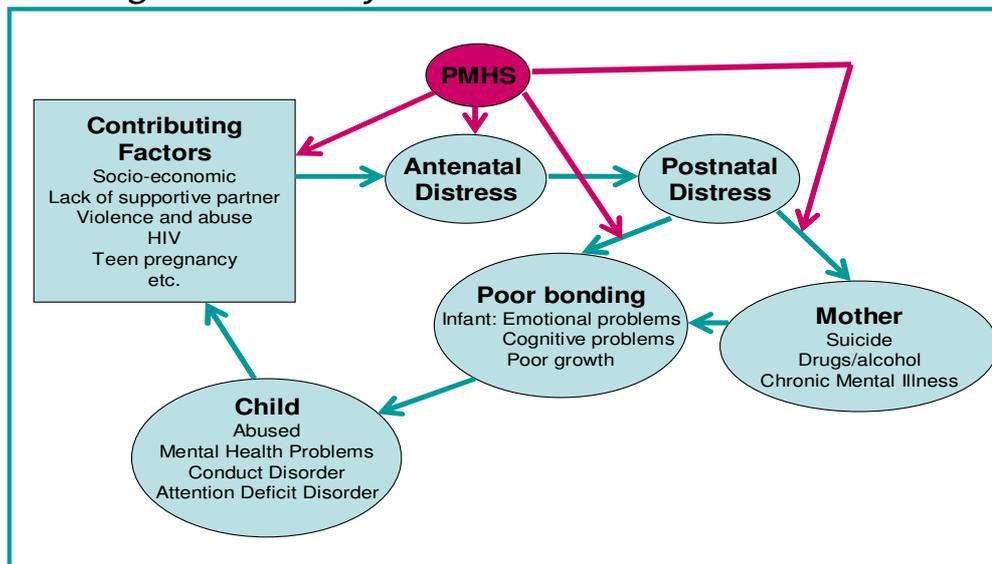
<sup>2</sup> Depression is the single most important factor negatively affecting antiretroviral treatment adherence. Personal communication, Prof James McIntyre, head of Perinatal HIV Research Unit, University of Witwatersrand.

<sup>3</sup> Anxiety disorders are characterized by a state of heightened tension and diffuse uneasiness.

## 7. The Cycle of Perinatal Mental Distress

The cycle of distress in figure 1 below summarises the interaction of contributing factors, the natural history of perinatal mental distress and sequelae for mother, infant, child and community. The possible areas of intervention of the Perinatal Mental Health Project (PMHP) are shown in purple (dark grey).

Figure 1: The Cycle of Perinatal Mental Distress



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## 8. Management of perinatal mental distress

The importance of screening for mental illness *in the antenatal period* was highlighted by a recent Confidential Enquiries into Maternal Deaths in the United Kingdom. The report confirmed that suicide is a leading cause of maternal mortality. Notably, in the vast majority of these deaths, there were signs of the mothers' emotional distress in the antenatal period (17).

When symptoms are untreated, they tend to progress. However, prognosis is improved when management is instituted promptly. For most women, this centres around diagnosis and early detection, counselling using a non-directive, problem-solving approach and antidepressant or anxiolytic medication. Many of the modern antidepressant medications are considered safe during pregnancy and lactation and have shown to be effective in numerous clinical trials (18).

Evidence from randomised controlled trials have shown that antidepressant medication, brief psychotherapeutic therapy and collaborative proactive care are effective in reducing the disability, duration and recurrence rate for those suffering with panic disorder and depressive episodes. These effects are maximised when the therapeutic approaches are used at the same time (11).

The financial savings resulting from treating adult depression have been estimated at US\$ 10,000 to US\$ 35,000 per depressed person per year (19,20). This is confirmed for a developing country setting. In India, a randomised controlled trial of antidepressants for common mental disorders in general healthcare attenders significantly reduced health care costs over a twelve month period (21).

The costs of failing to address perinatal mental health issues may be felt over generations and in the general health sector as well as other areas such as education, crime and employment.

Despite the high prevalence and far-reaching consequences of perinatal depression in impoverished communities, as well as the evidence for the effectiveness of simple treatments, the public health service is currently not addressing the mental health needs of women during and after pregnancy. This constitutes a lack of access to basic healthcare and acts to reinforce the inequities already faced by low-income women.

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