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Reviewing Mental Health in Perinatology, a FOGSI "Manyata" Initiative

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Abstract- Mental illnesses are a serious concern in India where every seventh person suffers from mental health problems[1,5]—with women more affected than men. While the burden of perinatal mental illnesses grows, India lacks exclusive policies to address it. Although postpartum depression or blues are restricted to the period of six weeks post-delivery, the roots of this condition are traced right from pre-pregnancy through the antenatal period to the period of one year post-delivery. We took up a study amongst postpartum mothers about their self-assessment of this condition, their awareness and their strategies to combat postpartum anxiety and reinforce the importance of psychological well-being as a part of routine assessment during antenatal period, fortified in the postpartum phase.

Index Terms- Postpartum period, postpartum depression, anxiety disorder, postpartum blues, mental health

I. INTRODUCTION

Mood disturbances in the postpartum period leading to depression accounts for 20% especially in primiparous women [1], and are traditionally divided into three categories: maternal sadness (postpartum blues), postpartum depression and puerperal psychosis.

Maternal sadness affects approximately 50-80% of women in the puerperal period, with about 20% of those women developing postpartum depression [2]

This is also referred to as "maternity blues", a transient disturbance that usually peaks within 5 days after childbirth [3]. PPI also refers to psychiatric symptoms beyond depression.

Maternal Mortality Review Committees have determined that 11% of pregnancy-related deaths are due to perinatal psychiatric illness (PPI), and these deaths are 100% preventable [2]

PPI is the most common morbidity in pregnancy and the leading cause of mortality during the perinatal period in developed nations [2]

The diagnosis is often masked by normal postpartum behaviors such as the mother's reactions during the adjustment period to the new physiological, social and behavioral conditions, including anxiety and fatigue

We need to be watchful about non-verbal communication, cues from dressing sense, to demeanour reflecting sullen mood level, disinterest and worry. Loss of orientation, incoherent talk and suicidal ideas are red flags and need immediate referral as life-threatening conditions. All these are a part of examination while history taking itself, which should be fortified through a questionnaire pertinent to specific areas like

- **Feelings of Inadequacy:** mild guilt/ coping difficulties…with family/ job/ self-expectations leading to withdrawl
- **Persistent Disinterest in Routine Activities;** leading to altered physical behaviour/activity: sleep, restlessness,
- Persistent sadness/ crying/ lonely/ feeling low in terms of energy/confidence
- **Altered Thinking and Self-Harm:** severe feelings of guilt, worthlessness, suicidal attempts
- **Established Mental Disorder:** seeking medication/ consultation

Aim

To study the incidence of postpartum depression and to develop strategies to manage (prevent as well as treat) the condition through anticipation by scoring tools during antenatal period itself.

II. MATERIAL AND METHODS

A prospective study was conducted amongst 45 postpartum women whose infants were 6 months to 15months old, randomly selected, from those who had delivered in private

nursing home and a corporation hospital in Navi Mumbai in the period 1st. August 2023 till 30th May 2024
After a personal one on one, informed consent about their approval for participation in the study, a questionnaire based on the mental health of women in the postpartum period, their knowledge and impact about the same was recorded. The questionnaire included ten relevant parameters

Physical Consent
I, the undersigned, with a free mind, without any coercion or pressure, hereby permit my participation in the study to answer all questions precisely and honestly.

I also understand that if at any point of time, I feel any question is irrelevant or difficult to comprehend, I am free to skip that question or terminate my interview into.

It is a practical questionnaire which might help paying more attention to mental health in post-delivery period and develop policies that are readily acceptable to ensure a patient friendly future.

I have been informed that to this extent, I shall not receive any financial benefit, as a social initiative.

Questionnaire
After your delivery, were you really happy and excited or felt worries were more than joy?
- No
- Sometimes
- Yes

After delivery, did you feel: you were not able to cope up well, so feeling guilty about your management skills
- Most of the times
- Occasionally
- Never

Were you anxious about thoughts…related to family/baby/work/any other
- Most of the times
- Occasionally
- Never

Did you feel lonely/ crying alone/low energy/confidence/ without reason
- Most of the times
- Occasionally
- Never

Were you able to sleep well when baby is sleeping? Or worries interfered in your sleeping schedule?
- Many times
- Occasionally
- Never

Did you need any medicines for self-confidence or improving emotional health/ for physical symptoms like recurrent acidity/ sleep disturbance and weight loss in the past/ treated for anxiety control?
- Yes, I have been on pills for sometime
- Was advised medication: took for some time/ chose to avoid/ didn't take
- Never required any medication

Did your mind-set/mood swings interfere in the quality of your regular work/ productivity or was a concern for you?
- Yes
- Sometimes
- No

Did you ever try to harm yourself/think about suicide?
- Yes
- No
- Sometimes

Did your talk about/ feel like sharing these ups and downs with your friend/ Dr/ Counselor/ any other
- Yes I tried to seek help from_____
- Wanted to, but didn't know whom to approach
- Myself managed, not needed to share

Did you suffer from significant such emotional setbacks in the past?
- Yes, many times, with pregnancy flare
- Started during my pregnancy only…first time
- Never before

Do you think this 'emotional aspect' post delivery constitutes a problem for many?
- Yes, very much
- Maybe
- Not really

If answer to above question is yes, please go to the next, else skip the next question

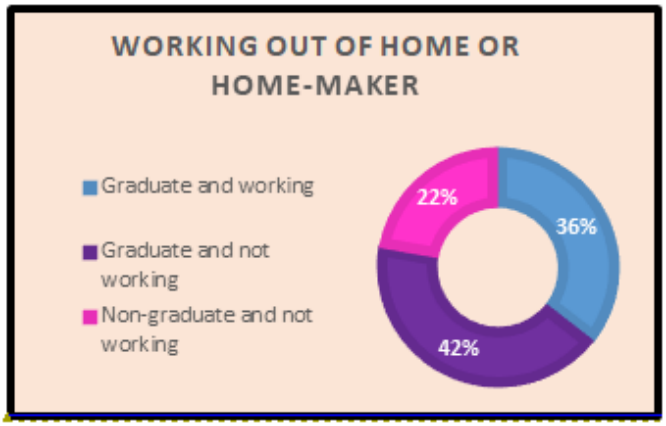
To handle this, I would suggest _____
- Self-help group
- Trained person/ Doctor/Sister to attend from pre-delivery period eg. In OPD itself
- I don't think there is any such need

Based on the questions in the earlier postpartum depression (PPD) assessment scales, we identified risk factors and devised a 10 point questionnaire for evaluation of postnatal depression. Of this, 5 questions are given a score of 2 each, which enables grouping women in whether they were at risk

of PPD. Any person with positive answers to two or more of these relevant questions was considered high risk for postpartum depression. The last question enables in judging the attitude and might have a role in policy making.

Observations

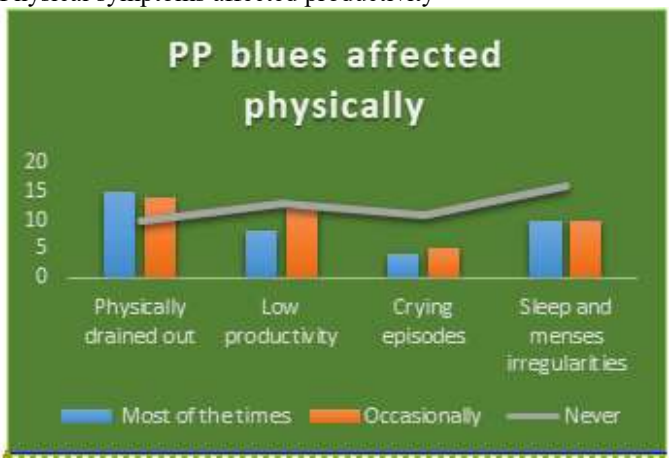
Educational Background



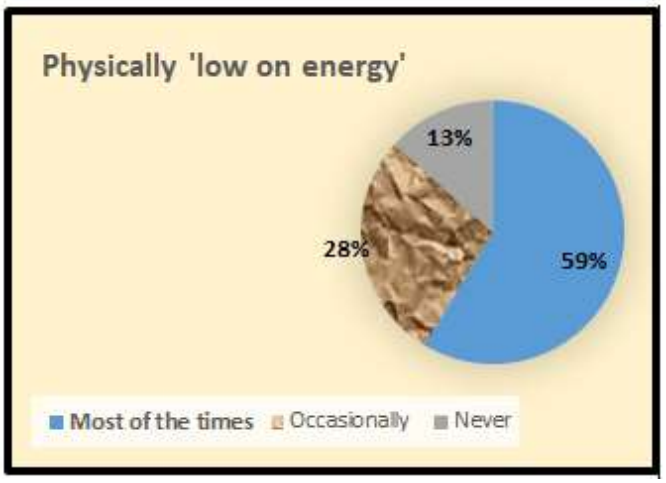
Worries Overweighed Joys

Difficulties encountered with respect to guilt, inadequacy

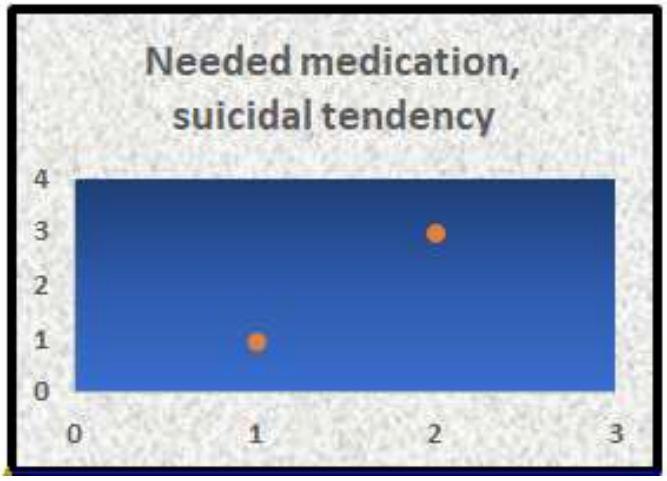
Physical symptoms affected productivity



Persistently low mood/sad/crying



Severity of manifestations: self harm



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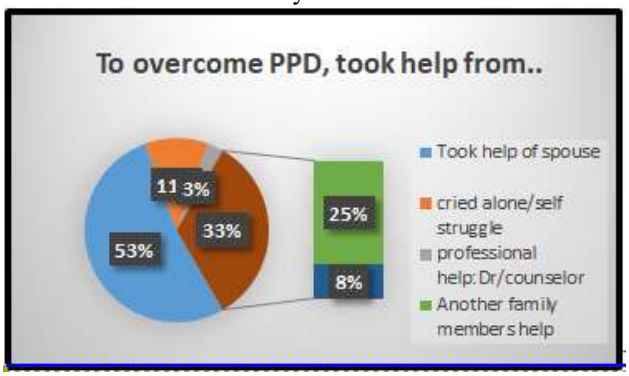
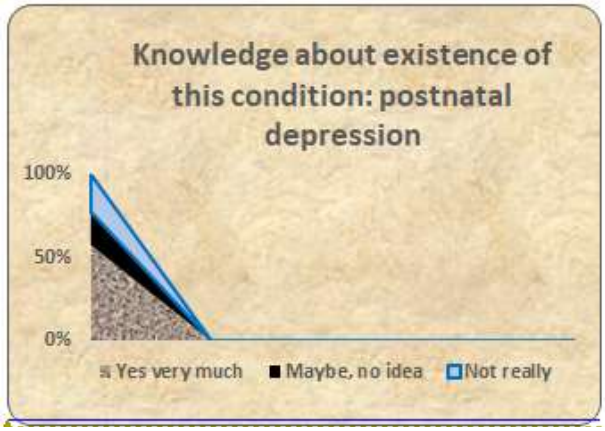
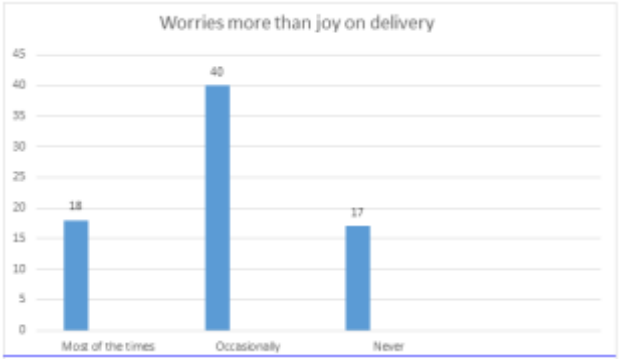
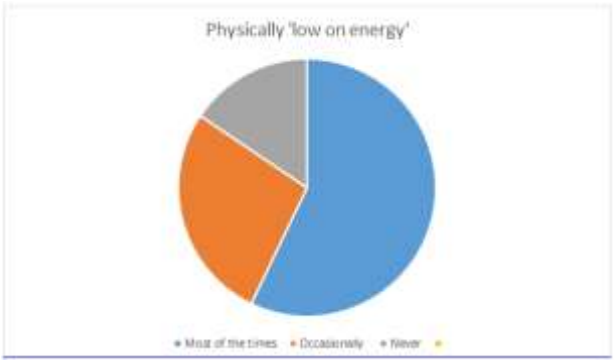
Measures to overcome anxiety

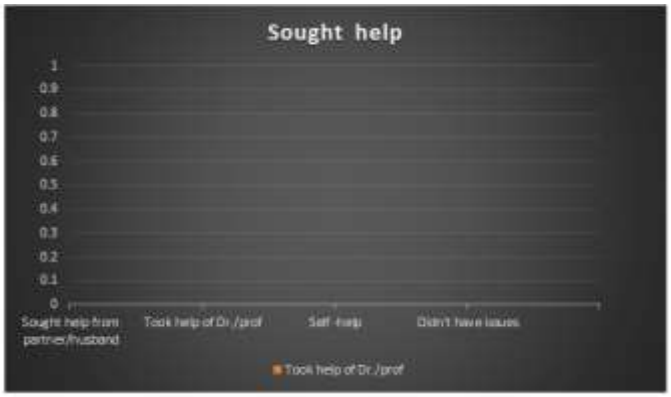


Have you heard of PPD









III. DISCUSSION

WHO estimates that approximately 10% of women who are pregnant and 13% of those who have just given birth will develop a mental health disorder… as per WHO editorial May 2024 [6]

April 29–May 5 marks the Maternal Mental Health Awareness Week 2024

Pregnancy and the postnatal period are psychologically distressing times for women due to physiological changes. Women experiencing familial conflict, abuse, financial constraints, or complications during pregnancy are especially at-risk for developing perinatal depression [6]

Although postpartum depression or blues are restricted to the period of six weeks post-delivery, the roots or this condition are traced right from pre-pregnancy through the antenatal period to the period of one year post-delivery.

It is also known that those women who have been disturbed due to pre-existing traumatic experience like childhood trauma, physical or mental abuse, fertility difficulties, primiparity(itself)[4], unwanted pregnancy, violence with intimates, marital disharmony, family disputes, issues related

to gender discrimination, financial crisis, etc., taking a toll on mental health are more prone to depression[2]

Table 1 Below
Maternal Mortality Review Committees have determined that 11% of pregnancy-related deaths are due to perinatal psychiatric illness (PPI), and these deaths are 100% preventable [3]

An equity-informed model of care that provides universal intervention for pregnant women may be one solution to address the preventable consequences of PPI on child and maternal health, which will emphasize the importance of eliminating known barriers to traditional health care models. Specific challenges must be overcome to fully realize the impact of improved management of PPI [3]

- Like appropriate training at Primary health centre (PHC)
- Training community health workers to sensitise the society, create awareness, facilitate community participation and remove the stigma around mental illness[5]

Table 1

Previous mental trauma A. Having experienced sexual abuse B. Bears a poor attitude regarding previous pregnancies C. Resistance to the baby's gender D. Woman's diminished self-esteem E. Recent stressful life event
Individual factors A. High maternal age B. Current medical illness C. History of psychiatric illness D. Family history of psychiatric illness
Marital relationship status A. Marital conflict B. Polygamy C. First child, with special needs D. Paediatric illnesses E. Domestic violence F. Financial difficulties
Pregnancy-related factors A. Unwanted pregnancy B. History of obstetric complication C. Complicated pregnancy D. High parity E. Caesarean section: Women who wish to deliver by normal vaginal delivery during the perinatal period but who give birth by caesarean section are more prone F. Mismatches between the mothers' expectations and pregnancy events

The reproductive, maternal, new-born, child and adolescent health (RMNCH + A) Program, in effect since 2013, caters to pregnancy and childbirth-related health needs. The mental health needs of the Indian population fall under the national mental health program (NMHP) of the non-communicable disease control program. Despite the National Mental health policy launched in 2014 in India, we have yet not been able to focus on its improvement and have to work upon overcoming the de-stigmatisation. [5]

IV. CONCLUSION

In our study, the average incidence of postpartum mental ill-health was found to be 31% and postpartum overall combined energy drained, physical and mental was 41% which was comparable with the study by Rebecca B, Jacqueline et al "Integrating perinatal mental health screening: Development of an equity-informed model", which showed a prevalence of 31% for any depressive illness.

Evidence from several studies indicate that formal screening for depression is not only feasible in the outpatient setting but also improves rates of detection and treatment of depressive disorders. Being watchful about self-care and physical presentation, as well as abstract features like mood, speech and cognition of to-be-mothers while they come for antenatal check-ups, can help us identify depression and subnormal mental health.

Simple solutions can be offered and redirection of thoughts experimented in cases of early disturbance. Teaching techniques of self-help gives confidence, and may avert fear of visiting psychiatrist and complications like postpartum depression. Cases of compliant families and/or educated expecting mothers can be referred for a formal consultation by psychological counsellor or psychiatrist in a structured manner.

This aspect of acknowledging mental health is also an extension of the respectful maternity care, adopted by Manyata, the FOGSI Government of India initiative; that has now included the same as the golden seventeenth standard after the earlier 16 clinical standards. Including this as a part of the standardised maternity care will certainly sensitise the obstetricians as well as staff nurses identify red flags and prevent untoward mishaps in the postpartum period.

The earlier scales fordiagnosing depression such as the Edinburgh postnatal depression scale (EPDS)and the Generalised anxiety disorder(GAD) are little exhaustive, cumbersome and time-consuming in busy OPD clinics

Therefore, this new questionnaire with limited focus, exclusively on high risk symptoms…is a rational tool for formal screening for depression.

As per Manyata standards, only 2 questions with weighted score >3,viz, persistent disinterest and persistent nervousness and anxiety more than two weeks are at risk of significant depression and need counseling and close monitoring

Few suggestions were offered by our study participants to overcome this challenging phase such as Counseling family members if necessary, by a professional (Doctor or staff nurse during antenatal/pregnancy check-up period itself)

Rather than referring, for simple cases, the Obstetrician herself/himself could offer simple solutions and redirection of thoughts which gives confidence, averts fear of visiting psychiatrist and complications like postpartum depression.

Homb is a postpartum hotel in Melbourne designed to support families during the critical fourth trimester.

Inspired by its founder's experience with postpartum depression, Homb provides a sanctuary for parents and their families to recover, connect, and feel nurtured.

This innovative model, popular in Asia but new to Australia, addresses both physical recovery and mental well-being, aiming to prevent postpartum depression and anxiety. By addressing all issues ranging from lactation and feeding to nutrition and gentle exercise.

With a mission to make perinatal mental health support accessible, Homb empowers mothers to navigate the postpartum period with clarity and confidence deriving support from Nurses, Doula, and Clinicians

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