

# VARIOUS ASPECT OF MATERNAL MENTAL HEALTH ON THE BASIS OF MINI REVIEW

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## ABSTRACT

*Mental health problems such as depression and anxiety are very common during pregnancy and after childbirth in all parts of the world. One in three to one in five women in developing countries, and about one in ten in developed countries, have a significant mental health problem during pregnancy and after childbirth. Social determinants are an important cause of mental health problems in pregnant women and mothers. Women, especially those living in developing countries are more exposed to risk factors, which increase their susceptibility to develop mental health problems. Some of these include poor socioeconomic status, less valued social roles and status, unintended pregnancy and gender-based violence (Prince M et al.,2007).*

**Keywords:** Maternal mental illness, violence, depression.

Mental health relates to a person's emotional, psychological and wellbeing status and can therefore, influence how a pregnant woman and a newly birthed mother feels and functions. The World Health Organization (WHO) define mental health as "...a state of wellbeing in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community".

Worldwide about 10% of pregnant women and 13% of women who have just given birth experience a mental disorder, primarily depression. In developing countries this is even higher, i.e. 15.6% during pregnancy and 19.8% after child birth. In severe cases mothers' suffering might be so severe that they may even commit suicide. In addition, the affected mothers cannot function properly. As a result, the children's growth and development may be negatively affected as well. Maternal mental disorders are treatable. Effective interventions can be delivered even by well-trained non-specialist health providers.

## MOTHERS AND DEPRESSION

Depression is a common, treatable mood disorder. About 6% of women, including up to 10% (one in 10) of women who are pregnant, will experience depression at some time during their lives. Women are more at risk of depression while they are pregnant, and during the weeks and months after having a baby. Depression during these times can be confused with the symptoms of pregnancy or with the 'baby blues' that many women experience right after birth. The good news is that depression can be treated. It's important to talk to your doctor if you think you are depressed. If left untreated, depression can lead to problems for you and your baby or child.

Maternal depression is one of the leading causes of disease burden in women globally, and symptoms of depression impede women's ability to function optimally in a caretaking role (Vos et al., 2012; Prince et al., 2007).

Depressive symptoms in the perinatal period are associated with poor physical health, substance abuse, increased risk of pregnancy complications, and suicidality (Dewing et al., 2013; Alder et al., 2007). In the postnatal period, children of mothers with depressive symptoms are at risk for poor physical growth, as well as behavioral and developmental problems (Surkan et al., 2011; Engle et al., 2007; Black et al., 2007).

The 'baby blues' is a mild form of postpartum depression that many new moms experience. It usually starts one to three days after the birth, and lasts for about 10 days to a few weeks. With baby blues, many women have mood swings – they're happy one minute and crying the next. They may feel anxious, confused, or have trouble eating or sleeping. The baby blues is very common – up to 80% of new moms have it, and it will go away on its own.

About 13% of new mothers experience postpartum depression, which is more serious and lasts longer. It can start up to a few months after childbirth. If you have a family history of depression or have suffered from depression before, you're more at risk. Postpartum depression needs to be treated.

### **MATERNAL AND CHILD UNDERNUTRITION**

Maternal and child undernutrition are estimated to be underlying causes of 3.5 million child deaths annually. Undernutrition is associated with increased risk for morbidity and mortality in children under five years of age, mainly due to its detrimental effects on immunity, which make undernourished children susceptible to common childhood illnesses (Black et al., 2003 (Black et al., 2008).

There are a variety of both direct and underlying causes of child undernutrition. At a macro-level, sociocultural, economic, and political factors impact household access to resources, including financial, human, and social capital (UNICEF, 2013). Lack of access to resources is associated with household food insecurity, inadequate care and feeding practices, and lack of adequate health services. These factors result in inadequate dietary intake and disease, which are direct causes of undernutrition (UNICEF, 2013).

Women may be especially vulnerable to depression in the perinatal period due to the major changes and challenges presented by childbearing (Alipour et al., 2012; Smith et al., 2011; Biaggi et al., 2016). It is estimated that 15.6% of women in low and middle income countries experience symptoms of antenatal mental health problems and 19.8% experience symptoms of postpartum mental health problems (Fisher et al., 2012). Risk factors for perinatal mental health problems include socio-economic disadvantage, low educational attainment, age (younger women being at greater risk), being unmarried, and being of a religious minority (Chandran et al., 2002; Fisher et al., 2010; Rahman et al., 2003; Abiodun, 2006; Faisal-Cury et al., 2004; Ukpong & Owolabi, 2006; Patel et al., 2002; Melo et al., 2012). Poor relationships with intimate partners, intimate partner violence, and low social support are also important risk factors for perinatal mental health problems (Sawyer et al., 2010; Gomez-Beloz et al., 2009).

### **MATERNAL MENTAL HEALTH AND MATERNAL DIET AND NUTRITIONAL STATUS**

Maternal under nutrition has a wide range of detrimental effects on maternal and child health, thus it is important to understand the role that mental health plays in maternal diet and nutritional status. Maternal nutritional status has implications for pregnancy outcomes in low-resource settings, as well as for long-term infant and child health and development outcomes (Mori et al., 2012; Pharoah et al., 2012; Dror, 2011; Christian et al., 2009; Perez et al., 2005; King, 2000). Iron-deficiency anemia (IDA) is associated with increased risk for maternal mortality, as well as low birth weight (LBW) and perinatal mortality, and zinc deficiency is associated with risk of preterm birth (Imdad & Bhutta, 2012; Dibley et al., 2012; Stoltzfus, 2003; Mori et al., 2012). Maternal Vitamin A deficiency can cause night blindness, which has in turn been linked with low birth weight and infant mortality (Tielsch et al., 2008; Christian et al., 2001; Christian et al., 1998). Mental health problems are often associated with overnutrition, there is some evidence for an association between mental health problems and eating disorder psychopathology, potentiating undernutrition (Kaye et al., 2004; Lowe et al., 2001; VazLeal et al., 2014).

Relations between mental health symptoms and the nutritional status of women of reproductive age have not been widely evaluated in developing countries, however relations between food insecurity and mental health problems have been more widely assessed. One study in peri-urban South Africa found that symptoms of postpartum depression, food insecurity, and hazardous drinking were co-occurring in a sample of new mothers (Dewing et al., 2013).

### **MATERNAL MORTALITY**

Maternal death is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes. To facilitate the identification of maternal deaths in circumstances in which cause of death attribution is inadequate, a new category has been introduced: Pregnancy-related death is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the cause of death. Live birth refers to the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life - e.g. beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles - whether or not the umbilical cord has been cut or the placenta is attached. Each product of such a birth is considered live born.

Maternal death or maternal mortality is defined by the World Health Organization (WHO) as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes". With declining rates of maternal mortality worldwide, researchers are recognizing the importance of addressing morbidity as well. The contribution of maternal mental health to maternal morbidity however has not been well ascertained.( Fisher J, deMello MC, Izutsu T. ,2009).

Mental health problems are often undiagnosed, because many of its core features such as fatigue and poor sleep are also commonly associated with motherhood itself and/or part of the gender stereotype of what motherhood should include. These symptoms and signs are not trivial conditions. Pregnant women or mothers with mental health problems often have poor physical health and also have persistent high-risk behaviours including alcohol and substance abuse. They have increased risk of obstetric complications and preterm labour (Alder J et al.,2007)

## **VIOLENCE DURING PREGNANCY**

Family violence (also known as domestic violence) is a serious issue in World, and unfortunately, it can begin or become worse during pregnancy. Violence during pregnancy or intimate partner violence has also received research attention due to its lasting consequences on the mental health and wellbeing of the mother and her child. Further, motherhood is often glorified, which makes the pregnant woman or mother feel guilty about experiencing negative emotions. Family violence is described by the Family Court of Australia as: "Violent, threatening or other behaviour by a person that coerces or controls a member of the person's family or causes the family member to be fearful." A child is exposed to family violence if they see or hear family violence or experience its effects.

It can involve many types of abuse:

- Physical Abuse, including shaking, pushing, hitting, kicking, driving dangerously, trying to choke and physical restraint
- Emotional Abuse, including blaming, undermining, name calling, bad moods, making the victim feel guilty, harassment, stalking yelling, insulting and swearing
- Sexual Abuse, including rape, unwanted touching, sexual jokes, forced sex without contraception, deliberately causing pain during sex and any other type of forced or unwanted sexual activity
- Financial Abuse, including taking control of all money and finances, stopping someone from working, restricting their access to money, credit cards or bank accounts and identity theft to get credit
- Social Abuse, including keeping someone away from family and friends, controlling who they see, monitoring phone calls and emails, undermining their family or friends, and insulting or criticising in front of others.
- Verbal Abuse, including criticism, name-calling, attacks on someone's intelligence or how they look, swearing and yelling.

## **CONCLUSION:**

Literature review in this area clearly indicates that studies from India on the impact of antenatal distress on birth outcomes and antenatal/postnatal distress on infant temperament and child behavior (cognitive, emotional and behavioral) problems are few. Recent meta-analysis showed that about 20 % of mothers in developing countries experience clinical depression after childbirth. This is much higher than the previous figures on prevalence coming mostly from high income countries. Suicide is an important cause of death among pregnant and postpartum women. Psychosis is much less common but may also lead to suicide and in some cases even harming the newborn. Depression causes enormous suffering and disability and reduced response to child's need. Evidence indicates that treating the depression of mothers leads to improved growth and development of the newborn and reduces the likelihood of diarrhoea and malnutrition among them (WHO,2015). Though maternal mortality still lies at the heart of maternal health indicators; for the post 2015 agenda for development goals, WHO is considering Universal Health Coverage (UHC) and proposing Healthy Life Expectancy (HLE) related indicators as well. This implies stronger focus on mental health conditions in the integrated delivery of services for maternal and child health. The need is not just felt in high income countries. In fact, some academic and public health institutions in low and middle income countries have already initiated integrated maternal mental health programmes. These have been low cost interventions with the involvement of non-specialized or

community health providers. Impact has been demonstrated not only on mothers but also on growth and development of children.

#### REFERENCE:

- Alder J et al. Depression and anxiety during pregnancy: a risk factor for obstetric, fetal and neonatal outcome? A critical review of the literature. *J Matern Fetal Neonatal Med* 2007; 20: 189-209.
- Dewing, S., Tomlinson, M., le Roux, I. M., Chopra, M., & Tsai, A. C. (2013). Food insecurity and its association with co-occurring postnatal depression, hazardous drinking, and suicidality among women in peri-urban South Africa. *J Affect Disord*, 150(2), 460-465.
- Fisher J, deMello MC, Izutsu T. Mental health aspects of pregnancy, childbirth and the postpartum period. In: Chandra PS, Herman H, Fisher J, Kastrup M, Niaz U, Rondon MB, et al., editors. *Contemporary Topics in Womens Mental Health-Global Perspectives*. United Kingdom: John Wiley and Sons Ltd; 2009. pp. 197–226.
- [https://www.who.int/mental\\_health/maternal-child/maternal\\_mental\\_health/en/](https://www.who.int/mental_health/maternal-child/maternal_mental_health/en/)
- Maternal mental health and child health and development in low and middle income countries. Report of the WHO meeting. Geneva, World Health Organization, 2008.
- Maternal Mortality Estimates developed by WHO, UNICEF and UNFPA. Geneva, World Health Organization, 2004.
- McNamara, J., Townsend, M. L., & Herbert, J. S. (2019). A systemic review of maternal wellbeing and its relationship with maternal fetal attachment and early postpartum bonding. *PloS one*, 14(7), e0220032.
- Prince M et al. No health without mental health. *Lancet* 2007; 370: 859-77.
- Surkan, P. J., Kennedy, C. E., Hurley, K. M., & Black, M. M. (2011). Maternal depression and early childhood growth in developing countries: systematic review and meta-analysis. *Bull World Health Organ*, 89(8), 608-615
- Vos, T., Flaxman, A. D., Naghavi, M., Lozano, R., Michaud, C., Ezzati, M., et al. (2012). Years lived with disability (YLDs) for 1160 sequelae of 289 diseases and injuries 1990-2010: a systematic analysis for the Global Burden of Disease Study 2010. *Lancet*, 380(9859), 2163-2196
- World Health Organization (WHO). *Mental health: strengthening our response* Genève: WHO; 2016.