

Perinatal mental health and recommendations for integral care in gynecologic hospitals

Salud mental perinatal y recomendaciones para su atención integral en hospitales ginecoobstétricos

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Abstract

Mental health is defined as the ability by which individuals recognize their own abilities and cope with the normal stress of life, work productively and fruitfully, contribute to their communities and enjoy the greatest possible well-being. Therefore, it is essential as a part of the health of the individual and its constant evaluation. Recently, special attention has been drawn to the study of the mental health of women, given the greater probability to suffer depression and anxiety disorders during and after pregnancy. The most vulnerable state occurs in adolescence, pregnancy, puerperium and perimenopause; Adequate mental health during pregnancy has shown beneficial effects in the resolution of pregnancy and in the health of the newborn. Regarding this paper, the fundamental aspects in the definition of perinatal mental health were reviewed, its determinants, the main mental disorders in this vital period, its role in perinatal outcomes and the importance of its evaluation. Some basic recommendations for adequate mental health care in gynecologic hospitals are also proposed.

Keywords: Maternal mental health. Mental disorders in pregnancy. Mental health care. Gynecologic hospitals.

Resumen

La salud mental es la aptitud por la cual los individuos reconocen sus habilidades y son capaces de hacer frente al estrés normal de la vida, trabajar de forma productiva y fructífera, contribuir a sus comunidades y gozar del mayor bienestar posible. Por ello, es fundamental para la salud integral del individuo y su evaluación constante. Recientemente se ha prestado especial atención a la salud mental de las mujeres, puesto que se ha observado una mayor propensión a sufrir depresión y trastornos de ansiedad durante y posterior al embarazo. El estado de mayor vulnerabilidad sucede en la adolescencia, el embarazo, el puerperio y la perimenopausia. Una adecuada salud mental durante la gestación ha mostrado efectos benéficos en la resolución del embarazo y en la salud del recién nacido. En este trabajo se revisan aspectos fundamentales en la definición de salud mental perinatal, sus determinantes, los principales trastornos mentales en este periodo vital, su papel en los resultados perinatales y la importancia de su evaluación. Se exponen también algunas recomendaciones básicas para la atención adecuada de la salud mental en los hospitales ginecoobstétricos.

Palabras clave: Salud mental materna. Trastornos mentales perinatales. Atención en salud mental. Hospitales ginecoobstétricos.

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Introduction

Pregnancy is perhaps one of the most transcendent experiences for women. During this period she will face various physiological, psychological and social changes, which makes her a particularly vulnerable being. In Mexico, as in other developing countries, public policies are aimed at reducing maternal and perinatal morbidity and mortality, as well as reducing the incidence of teenage pregnancy. However, just as health professionals take care of women's physical health, multidisciplinary care of their mental health (MS) is essential, since it intervenes greatly in the proper outcome of pregnancy.

Perinatal mental disorders (PMD) are a serious public health problem worldwide and are more prevalent in middle- to low-income countries, such as Mexico, mainly in poorer women with a psychiatric history. With regard to PMT, an international prevalence of perinatal depression is estimated at 10-21%, post-traumatic stress at 3-14%, anxiety disorder at 15%, eating disorders at 3-5% and schizophrenia and bipolar disorder at 0.5%^{1,2}.

The study conducted by De Castro et al.³ in 2016 analyzed the level of national and regional coverage in perinatal depression care, evaluating 211 obstetric units of the second and third level of care of the Ministry of Health, the Institute of Security and Social Services for State Workers (ISSSTE), the Mexican Social Security Institute (IMSS) and IMSS-Oportunidades. It was observed that, although 64% of obstetric hospitals provided some type of care for MS, only 37% of them had PMT screening protocols and 40% provided primary care. This study showed an important gap in SM, mainly between the southern and northern regions of Mexico. Mexico City and the State of Mexico are the entities with the highest coverage of care in SM; however, only 20% of units have protocols in place for the assessment and care of TMPs. This contrasts with access to perinatal MS in other countries, such as the United States of America, France, Germany or Belgium, where coverage is greater than 70%³.

For this reason, the objective of this article is to describe PMTs and emphasize the importance of evaluation and clinical care of MS in pregnant women in obstetric hospitals.

Basic concepts in mental health

In 1954, the World Health Organization (WHO) defined health as a "state of complete physical, mental and social well-being, and not merely the absence of

disease or infirmity"⁴. This definition is based on the concept of the individual as a biopsychosocial being that requires well-being and balance in each of the dimensions that make it up. With regard to MS, it is very complex to propose a definition that satisfies all professionals⁵. Although the WHO states that concepts such as subjective well-being, autonomy, competence, intergenerational dependence and intellectual and emotional fulfillment capacity should be taken into account in the definition of MS, MS is itself a "skill by which individuals recognize their abilities and are able to cope with the normal stresses of life, work productively and fruitfully, and contribute to their communities"^{4,5}. In this way, MS is not only a concept, but it is a possibility to increase the competence of individuals and communities, and enable them to achieve their own goals. Therefore, perinatal mental health (PMS) is more than the mere absence of mental disorders; it is a vital component of people and is intimately linked to physical and social well-being, so that there is no health without SM⁵.

Definition of perinatal mental health

According to what is established by the WHO, it is proposed in this paper that the SMP corresponds to the degree of adaptation of the woman to her condition as pregnant women, to the harmonious functioning of her psychic activity and her corresponding individual and social integration, which leads to a state of personal well-being and qualifies for future motherhood⁵.

SM is a human condition that allows the enjoyment of life in the full psychic faculties of the individual. This must be understood as a right that concerns the State, but it must also be protected by the community, the family and the person himself. This is because it has a direct impact on behavior and coexistence in personal and social harmony. Thus, carrying out structured actions in a targeted manner in SM could prevent situations such as social and intrafamily violence, delinquency, risky sexual behaviors, school dropout, human rights affectation, social stigma and discrimination, among many others. In this regard, factors such as poverty, demographic transition, socioeconomic conflicts, violence in all its areas or the presence of organic pathologies directly impact the psyche of the individual. Therefore, these situations increase the demand and cost of care in MS, which in turn has repercussions on the development and economy of the countries⁶.

Emotional aspects of motherhood

For a woman, becoming a mother is an arduous psychological task, especially if it is the first pregnancy, when she moves from the role of only woman to the task of actively becoming a mother. Therefore, with the birth of the child it could be said that the mother is also born. It is precisely during pregnancy when women undergo a series of psychic and behavioral changes that change their way of thinking and feeling, and their lifestyle. This implies the definitive change from “I” to “we”, which is usually an uneasy process⁷.

Preparation for motherhood starts from the childish games “of being a mother” to the very moment of the news of pregnancy. Gestation entails a revolution of feelings ranging from happiness, fear, uncertainty and rejection to complete ambivalence. According to various statistics, up to 30% of all pregnancies have not been planned, so that, in these circumstances, negative feelings towards pregnancy may be more frequent^{8,9}.

The process towards pregnancy resolution is complicated. During the first trimester, up to 80% of women may have frequent cravings, fatigue, drowsiness, nausea and vomiting that, depending on the intensity of the symptoms, can cause the pregnant woman to a certain degree of dependence and require special care. After this initial reaction, it is common for the woman to present fantasies about her future child and try to communicate with him, talking and sharing the experiences of her day to day. Physically, there is an increase in body weight and a progressive growth of the abdomen and mammary glands⁹.

In the third trimester, the fetus has grown to such a degree that it causes new symptoms. There are changes in women's gait and body posture, and respiratory and gastrointestinal disorders due to abdominal growth, among other alterations. In this period, the woman is visualized as a unit with her future child and begins the process of “preparing the nest”⁹.

Describing the entire emotional dimension during pregnancy is a complex task. This is a period in which people expect the woman to feel fulfilled and in a complete state of happiness; Unfortunately, this is just a myth and an ideal that cannot always be achieved for many women¹⁰.

The various physical, physiological and pathological changes cause some women to experience an abrupt change in their lifestyle, but also a radical change in

their daily routine and social relationships. To this is added the responsibility of the care and provision of the newborn (with greater negative feelings when added to the responsibility of caring for other children or being a single mother), as well as the decrease in effective hours of rest and sleep, leading to a state of irritability with alterations of the circadian cycle, mood disturbance and even profound depressive states and psychosis⁹.

Therefore, pregnancy is considered a “critical” period of high psychological sensitivity that makes women vulnerable and in great need of emotional support^{8,10}. At this time, women process emotions more intensely than before pregnancy, especially at the end of pregnancy, and various situations of tension and anxiety increase vulnerability and affect women's well-being: economic tensions and poor living conditions, domestic and domestic violence, addictions in women or their partners, lack of psychosocial support and support networks, chronic pathologies and pre-existing mental disorders or those that begin during pregnancy^{8,9}.

Several authors describe that excessive and chronic stress in women and babies *in utero* and during life outside the womb can cause spontaneous abortion, prematurity, preeclampsia-eclampsia, low birth weight, fetal programming for stress and anxiety, increased incidence of emotional and behavioral disorders in children, and immune system disorders¹⁰⁻¹³.

Perinatal mental disorders

For your better understanding, TMPs are described below depending on whether they occur during pregnancy or in the puerperium.

Mental disorders during pregnancy

WHO declared the first Wednesday of May each year as World Maternal Mental Health Day in 2016, with the aim of raising awareness of its importance and improving the resources allocated by governments for the prevention, detection and treatment of mental disorders during pregnancy and the first year after birth¹⁴.

Undoubtedly, the SMP could be considered as the great forgotten of the health system, since its evaluation should be as systematic as the realization of obstetric ultrasounds or the screening for the detection of gestational diabetes. In this regard, health personnel rarely ask the mother about whether she has suffered any depressive episode previously or during

the current pregnancy, nor about how she feels at the time of the consultation or if there are concerns about her pregnancy or future maternity¹⁵. This situation makes the problem invisible and, therefore, delays its evaluation, affecting diagnosis, treatment and clinical follow-up.

Because the vast majority of institutions and hospitals that provide gynecobstetric care services do not have a specific area of SMP, in Mexico there are few or no statistics about mental disorders that occur during pregnancy.

Knowing the current panorama of mental disorders during pregnancy is essential for health professionals, since, according to national data, they affect about 30% of the general population at some point in their lives, and the vast majority are mental disorders with an adequate response to treatment, such as anxiety and depression, and that represent a high social cost not only for the costs in health that they represent, but also for unemployment, absenteeism from work and school, and the loss of overall productivity that they represent. For the Organization for Economic Cooperation and Development (OECD), health spending for care of various mental disorders can reach up to 4% of the national gross domestic product¹⁶.

It is considered that up to 21.7% of women suffer from depression during pregnancy, with an average duration of 7 months postpartum^{7,12}. One of the factors associated with depression is the decrease in effective hours of sleep or the quality of it. It has been observed that insomnia occurs in up to 50% of pregnant women and has its highest incidence in the third trimester of pregnancy^{17,18}.

As for anxiety disorders, they occur in up to 10-15% of women at some point during pregnancy and the puerperium. Post-traumatic stress disorder can appear in the postpartum period in up to 3% of women with vaginal delivery, increasing to 6% in those who require emergency cesarean section, with obstetric loss (death) or whose newborn suffers from a serious illness or requires intensive care¹⁷.

Delayed care for various perinatal mental disorders can lead to infanticide or suicide, the latter being the leading cause of maternal death during the first postpartum year. Therefore, mental disorders during pregnancy are a serious public health problem worldwide^{18,19}.

When the expectations of happiness are not met, there is inadaptation to pregnancy or breastfeeding. There may also be an inability to meet current obligations and those expected of it in the immediate future. In addition to the above, if there are pre-existing or

developed mental disorders during pregnancy or after childbirth, deep suffering can occur in women, and affect the mother-child relationship or family dynamics. All these factors are enhanced by the delay in the diagnosis of mental disorders and by inadequate treatment¹⁹.

In the newborn, mental disorders in the mother have been shown to have a negative effect on her physical, emotional, social and cognitive development. In addition, several prospective studies show that children of depressed, anxious or stressed mothers during pregnancy have a higher risk of presenting emotional problems in childhood and adult life, or attention deficit hyperactivity disorder^{10,20}.

Mental disorders during the puerperium

Among these disorders are postpartum sadness, postpartum depression and postpartum psychosis, which can occur in up to 80% of women, with symptoms of varying intensity ranging from mild discomfort to infanticide or suicide^{12,13,21}.

POSTPARTUM SADNESS

Postpartum sadness or *baby blues* has been linked to stressors during the last month of gestation, sleep disorders, history of premenstrual syndrome, depression in previous pregnancies or death. It has a prevalence of 50-80% and appears 2-4 days postpartum. It remits clinically spontaneously after 2-3 weeks and is characterized by emotional lability, irritability, anxiety, despair, sadness or easy crying. The patient and family should be informed that remission may be spontaneous, but that if the intensity of the symptoms increases or if the condition has not subsided after a maximum period of 3 weeks, the help of a professional specialized in MPS should be sought^{21,22}.

POSTPARTUM DEPRESSION

It occurs in 30-56% of postpartum women. The risk factors for postpartum depression are diverse: history of mental disorders (mainly anxiety and depression), depressive symptoms during pregnancy, obstetric complications, unplanned or unwanted pregnancy, lack of family or social support, family or social problems, poor marital relationship, abandonment of the couple (separation or divorce), poor or no emotional support of the couple, stress, hardship or financial

worries, history of abuse (physical, emotional or sexual), unresolved grief, poor relationship with the mother, history of perinatal losses, thyroid disorders, newborn health problems and difficulties in caring for the newborn or other children^{12,13,23,24}.

The clinical picture may begin immediately after delivery or even cases of onset have been reported 1 year after delivery. It appears with any type of birth and with any number of gestation. The disorder is usually minimized by the woman, by the family and even by health personnel, which leads to its underdiagnosis and delay in treatment. Warning signs include psychosomatic complaints, fatigue, various pains, multiple calls for help, sadness, constant worry and fear^{12,13,19,21,22}.

Other symptoms are frequent crying, anhedonia, anxiety and panic attacks, change in eating and sleeping patterns, feeling helpless and inadequate, self-reproach, reluctance to seek help, irritability, difficulty bonding with the newborn, feelings of ambivalence towards the child, difficulty breastfeeding, inability to care for the newborn, obsessive thoughts and compulsive behaviors towards the child and towards herself, negative thoughts towards the child, feelings of guilt, thoughts of harm towards the child and suicidal ideation¹⁶. The literature describes the first 3 months postpartum as the period of greatest vulnerability in women^{21,23,24}.

For its diagnosis there are some instruments developed for this purpose, among which are:

- Structured Clinical Interview (SCID, *Structural Clinical Interview for DSM*)
- Beck Depression Inventory (BDI)
- Depression Scale of the Center for Epidemiological Studies in its 7-item version (CESD 7)
- Patient Health Questionnaire in its 9-item version (PHQ-9)
- Hamilton Depression Rating Scale (HAM-D)
- Hospital Anxiety and Depression Scale (HADS)
- Montgomery-Asberg Depression Scale (MADRS)
- Goldberg's 12-item General Health Questionnaire (GHQ 12)
- Edinburgh Postpartum Depression Scale (EPDS)

Of these, the most widely used and which has been designed specifically for postpartum women, validated in Spanish and for the Latin American population, is the EPDS instrument. However, the observation of mother-child dynamics is the main complementary tool to corroborate the diagnosis^{21,23,25,26}.

There are two main therapeutic axes: 1) individual or group psychotherapy, and 2) pharmacological

treatment. In the first, interpersonal or cognitive-behavioral psychotherapy has been used more frequently, with good results. For the therapeutic plan it is advisable to take into account the following aspects: provide complete, clear and precise information to the woman, her partner and family; focus therapy on the control, reduction and elimination of symptoms; psychoeducation in the role of mother and reduction of fear and anguish that this may generate; protect, improve or strengthen the mother-child bond and with their partner if they have one; promote good family functioning; control, decrease or eliminate current stressors; and seeking, taking advantage of and strengthening family, social and institutional support networks^{25,26}.

With regard to the pharmacological treatment of postpartum depression, the most commonly used medications are tricyclic antidepressants and selective serotonin reuptake inhibitors to treat depressive symptoms, in addition to the use of benzodiazepines for anxiety and insomnia. It is essential to assess the follow-up of breastfeeding in women with psychopharmacological treatment^{21,25,26}.

POSTPARTUM PSYCHOSIS

Postpartum psychosis is an affective episode with psychotic symptoms and has an approximate rate of 2/1000 pregnancies. It usually develops between the second and fourth weeks, even until the sixth month postpartum. It has been observed that women with a history of a previous episode of psychosis at any time in their lives have a 35% higher risk of having a new episode during pregnancy or in the puerperium. Other risk factors include a history of bipolar disorder or schizophrenia, a family history of affective disorders and medical complications during pregnancy, childbirth or the puerperium^{21,25}.

The disorder is characterized by paranoid delirium or grandeur, changes in mood, altered thinking and disorganized behavior. In addition, it may include agitation and stupor, euphoria and anxiety, verbiage or mutism, disturbance in the perception of time, sleep disturbances, loss of contact with reality, delusions or hallucinations, and desires, attempt or culmination of infanticide. Psychopharmacological treatment should be vigorous; Antipsychotics, mood stabilizers, and benzodiazepines are commonly used. It may also require hospitalization and electroconvulsive therapy, and later psychosocial therapy. The consequences of poor postpartum psychosis

care can be disastrous for the woman, the newborn, and the family. Suicidal ideation is also described during the depressive period, mainly between the second and sixth month postpartum^{10,21,25,26}.

Evidence-based intervention strategies

The best way to assess the psychological aspects of pregnant women is through direct observation. However, the evaluation of the psychological factor is objectified and economically feasible through the use of screening instruments. The suitability of the therapeutic strategies to be implemented will depend on an adequate evaluation²⁵.

In this regard, clinical and socio-health research in SMP allows to increase knowledge for its application to the diagnosis, treatment and prevention of diseases. Its ultimate goal is that the knowledge obtained is truly transformative and useful in a massive way for public health²⁷. Mainly in perinatal depression (during pregnancy and postpartum) good results have been obtained with the permanent implementation of the following strategies:

- Creation of specialized areas in perinatal MS (odds ratio [OR]: 0.30)²⁸.
- Home visiting programs (OR: 0.71).
- Counseling services and telephone follow-up (OR: 0.36).
- Interactive coaching programs (OR: 0.41).
- Individual and group psychotherapy services of cognitive-behavioral (OR: 0.51) and interpersonal (OR: 0.71) type.
- Mother-newborn intervention workshops (OR: 0.47).
- Implementation of relaxation therapy services and physical activity programs (OR: 0.49)²⁹⁻³¹.

Recommendations for mental health care in obstetric-gynecology hospitals

In 2015, WHO published a guide for the treatment of perinatal depression entitled Thinking Healthy. A manual for psychosocial management of perinatal depression (mhGAP-IG), in which several evidence-based recommendations are made with emphasis on low-intensity psychological interventions to be implemented throughout the pregnancy process and until the tenth month of the newborn's life. Regardless of the MPR to be addressed, the WHO Plan of Action for Global Mental Health (2013-2020) recommends comprehensive and integrated social and MS care, as well as the

implementation of strategies for promotion and prevention, including maternal, newborn, couple and nuclear family MS³². This guide is useful for the planning and intervention of strategies for the evaluation and management of mental, neurological and substance abuse disorders in future pregnant women, with a focus on primary care and with the purpose of implementing a program based on cognitive-behavioral therapy³².

In summary, the *mhGAP-IG* guide makes the following recommendations³²:

- Psychosocial interventions are the first line of therapy, especially in the case of perinatal depression, which is the most prevalent TMP.
- Psychopharmacological treatment should be avoided as far as possible, and if necessary individualized taking into account the pharmacological, maternal, psychosocial, socioeconomic and cultural factors of the woman, her partner and the family impact.
- Incorporate sensitive, clear and empathetic communication with women and their families into the general principles of care, and do not forget the importance of social support.
- Provide psychoeducation related to the prevention of overmedication and the improvement of therapeutic adherence.
- Cognitive-behavioral therapy should be started as soon as possible, if this resource is available.
- Initiate complementary treatments, such as structured physical activity, relaxation, and problem solving.
- The family, social and institutional network for pregnant women should be reactivated or strengthened.

In Mexico, although there is a guide for the Prevention, Diagnosis and Management of Prenatal and Postpartum Depression in the First and Second Levels of Care, it does not specify the mechanisms for its implementation, so its usefulness for resource planning and the implementation of the necessary strategies is limited. So far, the only global intervention strategy is education at all levels and screening at the first contact with pregnant women and up to 4-6 weeks after delivery^{14,33}.

According to the WHO Mental Health Action Plan 2013-2020, six key actions are proposed to improve SMP care:

- Achieve universal coverage for all pregnant and postpartum women.
- Policies, actions, strategies and interventions for the treatment, prevention and promotion of MS must comply with a gender and human rights approach.

- Choose, adapt and individualize the treatment according to the best scientific evidence.
- Strategic planning in SM must take into account social and health needs at all stages of life.
- Empower users of health services for the development, implementation and monitoring of public policies in SMP^{34,35}.

On the other hand, according to the Specific Action Program on Mental Health 2013-2018 of the Government of Mexico, the following five specific objectives are proposed:

- Modernize obstetric care services to include effective MS services, with a community, comprehensive and multidisciplinary approach.
- Carry out actions to prevent mental disorders and improve MS and well-being at different stages of the life cycle of women.
- Train health professionals in TMP, its diagnosis, therapeutic prevention in primary care and rehabilitation.
- Promote the education and training of researchers and specialists in SMP.
- Promote research into gynecobstetric care models that integrate SMP into their management strategy³⁶.

Conclusions

Very few hospitals usually have well-identified and functional areas of MS for the mental evaluation of women in the pregestational, during and after pregnancy period. Of those that have psychological and psychiatric care services, patients are referred to other institutions for reevaluation and continued treatment, but in rare cases it can be verified that the referral has been effective and the patient is receiving care in a more appropriate institution or with better resources. However, the vast majority of patients do not go to these institutions because of the expenses involved, the remoteness or difficulty of access, or because of the family and socio-cultural stigma infringed by going to an SM institution, which could lead to situations of discrimination.

One of the limitations of this work is the heterogeneity of the studies on the subject, since the metrics depend on the author who reports them and the characteristics of the institution and the population studied. However, a common element is to consider PMDs as a serious public health problem, especially perinatal depression. Although it is not a systematic review, this article presents the main elements to inform and sensitize the health professional about the

importance of SMP, and its beneficial effects for the mother, which, in the case of the newborn, have an impact until adult life.

It is therefore necessary to systematically evaluate whether the strategies implemented at the institutional and public policy levels achieve the objectives and goals set, which is a priority factor to make primary health care more efficient. It is also recommended to strengthen research in the following areas:

- Investigation of the predictive attributes of demographic, psychosocial, clinical, genetic and biological factors in the genesis, development and recurrence of TMPs.
- Evaluation of the actions of MS professionals, especially at the first level of care.
- Efficacy and safety of interventions.
- Quality of care in perinatal MS.
- Strategies for rehabilitation and prevention of chronicity of TMPs.

By way of conclusion, it is emphasized that the knowledge of MS disorders in pregnancy or puerperium, the recognition of alarm signs by health personnel, as well as women and their families, together with the commitment to follow-up and diagnostic evaluation directed in each contact with the patient in this critical period, facilitate timely diagnosis and appropriate and individualised treatment, this in turn will improve the quality of women's care, both outpatient and hospital, to reduce maternal and perinatal morbidity and mortality.

The recommendations presented here are not only useful for improving the service provided by obstetric-gynecology hospitals, but are also applicable to the various institutions in the country that directly or indirectly attend to women who wish to become pregnant, who are pregnant or who are treated during the puerperium.

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