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Continuous Education for Perinatal Mental Health Among Clinical Midwives: Necessity and a Literature Review

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Abstract

During perinatal period, a variety of mental disorders are often seen among pregnant and child rearing women; psychosis, depression, anxiety disorders including tokophobia (fear of childbirth), panic disorders, and traumatic symptoms due to childbirth. Due to the negative impact on mother's well-being, childrearing, and family relationships, midwives should obtain sufficient knowledge and skills for detecting women with either of these mental disorders and their family and providing proper care. However, education of mental health care for mothers with psychiatric disorders may not be sufficient in the current curriculum of midwifery. Therefore, continuous training for the mental disorders, is essential for improving the quality of midwifery care. This literature review describes clinical symptoms, related factors, pharmacological and non-pharmacological treatments of the mental disorders, suggesting clinical implication for midwives.

Keywords

Continuous Education, Mental Disorders, Midwives, Literature Review

1. Introduction

Perinatal periods are characterized by physical, social and emotional changes. During the transitioning to motherhood, a variety of mental disorders are often witnessed among pregnant and child rearing women; psychosis, depression, bipolar disorder, anxiety disorders including tokophobia (fear of childbirth), panic disorders, social phobia and traumatic symptoms due to childbirth [1] [2]. These mental health problems are associated with adverse process of pregnancy and delivery, low birth weight of child, child maltreatment, increased suicidal ideation of mothers, and poor relationships with family members [3]-[6]. In developing countries, maternal mental problems are related to child's malnourishment, and increased child's mortality [4]. Hence, perinatal mental health of mothers should be taken seriously as an important topic to be prioritised among midwives, psychiatrists, and obstetricians.

However, education of mental health care for mothers with psychiatric disorders may not be sufficient in the current curriculum of midwifery. The basic midwifery curriculum proposed by the International Confederation of Midwives (ICM) in 2012 does not include mental health care for mothers with psychiatric disorders [6]. Midwives and obstetric nurses sometime fail to detect mothers with psychiatric disorders and support them due to lacking of their knowledge and skill for mental health. Therefore, continuous training for the following psychiatric disorders, which can be seen during perinatal period, is essential for improving the quality of midwifery care.

2. Main Mental Health Disorders

2.1. Postpartum Psychosis

Postpartum psychosis displays symptoms of manic and severe depression in the form of delusions, confusion or stupor,

triggered by severe stress [2]. This psychosis is viewed in one birth out of a thousand– It is a type of acute transient psychotic disorders, and not related to schizophrenia [1]. Since the concerned patients can be easily detected, and effective pharmacological treatment such as anti-psychotics has already been established, its prognosis is usually good. Mothers with postpartum psychosis usually recover within several weeks, and resume parenting.

2.2. Depression

Depression comprises continuous depressive moods, a marked diminished interest or pleasure, decreased appetite, psychomotor agitation or retardation, fatigue, feeling of guilt, insomnia, and suicidal ideation [7] – It occurs in around 5－10% of women during pregnancy or postpartum period [8]. The incidence of postnatal depression is reported as 5% in a multicentre epidemiological study in Japan [9]. Perinatal depression has been socially recognised as a major health issue, widely among not only clinical practitioners, but also mothers and family members. Since the report of Pitt [10], a huge amount of research and clinical interventions have already been conducted. Research shows that maternal depression around the perinatal period may have negative impact on children's development [11].

As for pharmacological treatments, antidepressants are administered and they are effective. Besides these pharmacological treatments, several psychological interventions and preventions have been developed in developed countries [12]-[14]. Recent studies show that non-pharmacological therapy such as cognitive behavioural therapy or interpersonal psychotherapy are effective [15]. However, such psychological intervention is not frequently performed by nursing professionals [15]. Midwives should cultivate their counselling skill and used it in their daily care. In addition, because backgrounds of depressed mothers are antenatal distress, negative life events after childbirth [16], disturbed relationships with others, social isolation and lack of social support [17], midwives should also pay attention to these factors related to depression.

2.3. Anxiety Disorders

Compared with depression, less attention has been paid to anxiety disorders in clinical settings and research field. Anxiety disorder is a generic term, covering a wide range of diagnostic categories that share symptoms of anxiety, fear, and physical symptoms such as a racing heart and shakiness [7]. These disorders may be more seen than depression, which is around 10 – 30% of postpartum women. Anxiety disorders include obsessive compulsive disorder, antenatal fear of childbirth and post-traumatic stress disorder (PTSD).

2.3.1. Obsessive Compulsive Disorder

Obsessive compulsive disorder refers to an anxiety disorder characterized by intrusive thoughts that produce uneasiness, apprehension, fear or worry (obsessions), and repetitive behaviours aimed at reducing the associated anxiety (compulsion). The association between childbirth and obsessive-compulsive disorder has been reported [19]. The incidence of panic disorder is 4% [20]. Among anxiety disorders observed perinatal period, fear of childbirth and PTSD due to childbirth are specific to this period and thus need special attention.

2.3.2. Antenatal Fear of Childbirth (Tokophobia)

Pregnant women desire to give birth to their babies, but simultaneously they feel fear the upcoming birth. Antenatal fear of childbirth, also known as tokophobia [21], is defined as a negative expectancy brought by fear towards upcoming childbirth [22]. It concerns the child's health, pain, surgical interventions, a difficult course of labour, loss of control and isolation [23][24]. In the UK and Nordic countries, intense antenatal fear of childbirth has been found in 11–15% of pregnant women [25], some of whom report strong anxiety, fatigue, and sleep problems [26]. Pregnant women who had severe fear of childbirth are more likely to perceive severe pain, and consider their childbirth experiences frightening [27]. Intense fear of childbirth during pregnancy is also related to subsequent emotional maladjustment such as irritation and anxiety, and postnatal traumatic symptoms [28][29]. In Sweden, professional support provided by the 'Aurora team'-counselling via the telephone, education with regard to the process of childbirth, and birth planning has proven to be effective [30]. Some parts of these interventions such as planning the birth, and providing information regarding childbirth by group-education are routine clinical services. However, individual counselling may be more effective because some women conceal or mask their severe fear of childbirth. They hesitate to tell others because they feel that talking about their fears will be unacceptable [24].

2.3.3. Traumatic Stress Symptoms Due to Childbirth

Traumatic stress symptoms due to childbirth (Postnatal traumatic symptoms) are triggered by the experience of childbirth (traumatic event). According to DSM-5[7], traumatic symptoms consist of four domains: (a) re-experiencing of traumatic events, (b) avoidance of situations that remind one of the traumatic events, (c) negative cognitions and moods related to the traumatic experiences, and (d) alterations in arousal and reactivity. Re-experiencing of traumatic events refers to "spontaneous memories of the traumatic event, recurrent related dreams, flashbacks or other intense psychological distress" [7]. Avoidance refers to avoiding behaviours of "distressing memories, thoughts, feelings, or external reminders of the event" [7]. Negative cognitions and moods represent "a variety of feelings from a persistent and distorted sense of blame of self or others to estrangement from others, or markedly diminished interest in activities to an inability to remember key aspects of the event" [7]. Finally, alterations in arousal and reactivity include "aggressive, reckless or self-destructive behaviour, sleep disturbances, hyper vigilance or related problems" [7]. Postnatal traumatic symptoms have drawn more attention to clinical researchers and clinical care providers for the last

decade. It has been often controversial that childbirth can be a traumatic event [31].

Generally, traumatic symptoms are triggered by experiencing or witnessing a life-threatening event [7]. Traumatic events include not only unusual experiences such as war, murder, accident, natural disaster, injury and abuse, but also unexpected experiences that occur in a human's daily life such as being diagnosed with cancer, and surgical operation [7]. Childbirth itself is accompanied with uncertainty that adverse outcomes may occur for the mother and her baby, regardless of the presence of adverse processes such as emergency Caesarean section and instrumental delivery [32]. In Western countries, 24－33% of postpartum women may have one or more traumatic stress symptoms following childbirth [33][34]. Between three and 11 months of postpartum, 1-15 % of women fulfil the criteria [33]. Postnatal traumatic symptoms causes impairment of mother's bonding with her infant, and her overall adjustment to motherhood, as well as, her relationship with her partner, and for multiparas, other children. These women suffering from postnatal traumatic symptoms are emotionally detached to infants, and afraid of caring for the baby [35]. In addition, they tend to become less patient with other children, facing difficulties to deal with others' problems, and reluctant to have any more children because of their childbirth experience(s) [36][37]. Furthermore, they are distressed in having sexual activity with their partner, who, in turn, show irritation with them [36].

Several modes of treatment have been proposed: debriefing [38], cognitive behavioural therapy [39], and group counselling [40]. Debriefing is a more general, unstructured intervention, where women are given the opportunity to discuss their traumatic experience, which has been often used as a treatment for postnatal traumatic symptoms arriving from other traumatic events [41]. However, the effects of these interventions for birth trauma remain unclear because these findings are inconsistent and the number of studies is small [42]. In addition, because debriefing may increase trauma symptoms after other traumatic experiences, more caution is necessary for implication. Furthermore, there are women who cannot be 'detected' because they avoid recalling the event and are reluctant to disclose their negative birth experiences [36]. Therefore, primary prevention to reduce the risk of postnatal traumatic symptoms may be feasible among midwives, have good opportunities to provide women with psychological support in routine care. A variety of factors have been reported as associated with postnatal traumatic symptoms; prolonged labour, emergency Caesarean section, instrumental delivery [43], negative birth experience(s) brought by fear, dissatisfaction with the care provider, and pain during labour [44] [45], younger age, new motherhood, low socioeconomic status, prior psychiatric problems and previous traumatic experience(s) such as history of sexual abuse and poor attachment with partner [34], [43], [45], antenatal fear of childbirth, and perceived lower social support with family and health care providers [45]-[48]. Therefore, both of antenatal care and intra-partum care should be important. Midwives may need to be aware that women having such factors may manifest post-traumatic stress symptoms after delivery. During pregnancy, midwives should give close attention to these women with severe anxiety and fear. The following can reduce the anguish faced during delivery: frequent communication, patiently explain the process of delivery and the baby's condition, and provide an assuring atmosphere so that women can easily express their fear and concern.

3. Conclusion

In conclusion, the potential of midwifery care to enhance the well-being of women, families and the society should be valued and promoted. On considering mental disorders that negatively impact not only childrearing, but also family relationships, and having additional children, it is a fundamental duty for midwives to give ultimate support for women with either of these mental disorders and their family. Midwives may be the first professional to identify mothers with these mental disorders. Having sufficient knowledge and skill to assess mental disorders among mothers at early stage and referring to appropriate treatment would reduce the subsequent impact on mothers, babies and families.

Furthermore, midwifery care promotes the normal healthy process of pregnancy, childbirth, and breastfeeding and supports women's confidence in their abilities [48]. As well as early detection and referring to treatment, midwives should be aware of women at the risk of having mental disorders and emotionally support them to reduce their concern and anxiety so that mothers can transfer to motherhood without any trouble.

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