Perinatal Mental Health

A Guide for Health Professionals and Users

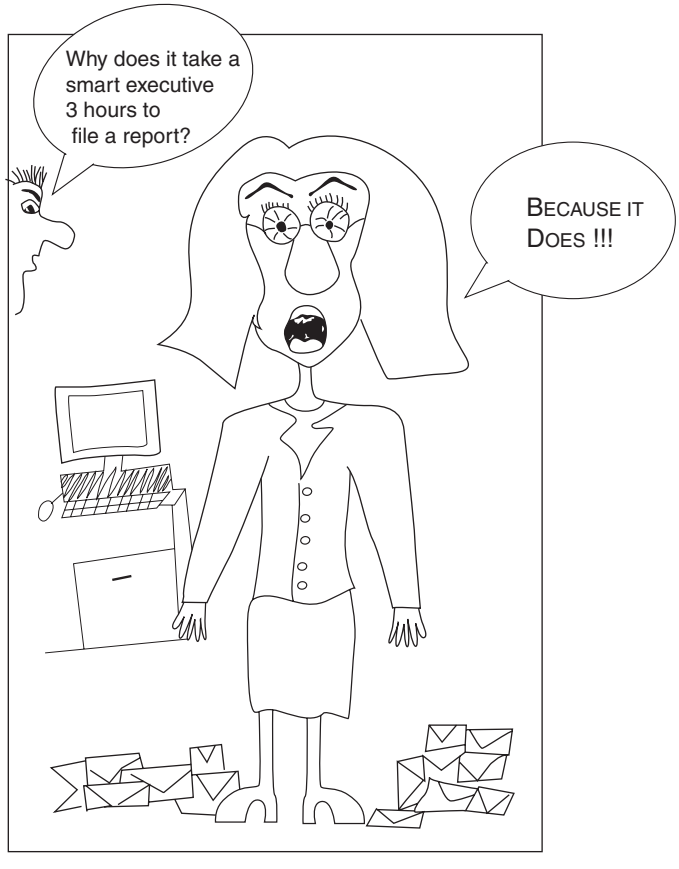
Jane Hanley

School of Health Science
Swansea University
Carmarthen
Wales

WILEY-BLACKWELL

A John Wiley & Sons, Ltd., Publication

Perinatal Mental Health



Postnatal depression

Perinatal Mental Health

A Guide for Health Professionals and Users

Jane Hanley

School of Health Science
Swansea University
Carmarthen
Wales

WILEY-BLACKWELL

A John Wiley & Sons, Ltd., Publication

This edition first published 2009

Wiley-Blackwell is an imprint of John Wiley & Sons, formed by the merger of Wiley's global Scientific, Technical and Medical business with Blackwell Publishing.

Registered office
John Wiley & Sons Ltd, The Atrium, Southern Gate, Chichester, West Sussex, PO19 8SQ, United Kingdom

Editorial office
John Wiley & Sons Ltd, The Atrium, Southern Gate, Chichester, West Sussex, PO19 8SQ, United Kingdom

For details of our global editorial offices, for customer services and for information about how to apply for permission to reuse the copyright material in this book please see our website at www.wiley.com/wiley-blackwell.

Library of Congress Cataloging-in-Publication Data

Hanley, Jane.
Perinatal mental health: a guide for health professionals and users / Jane Hanley.
p. ; cm.
Includes bibliographical references and index.
ISBN 978-0-470-51068-1 (pbk.)
1. Postpartum depression–x Nursing. I. Title.
[DNLM: 1. Postpartum Period–psychology–Nurses' Instruction. 2. Depression, Postpartum–Nurses' Instruction. 3. Mental Disorders–Nurses' Instruction. WQ 500 H514p 2009]
RG852.H36 2009
618.7′60231–dc22

2008044813

A catalogue record for this book is available from the British Library.

Set in 10/12 pt Sabon by Aptara® Inc., New Delhi, India
Printed in Singapore

1 2009

Contents

1	Women's mental health: from Hippocrates to Kumar	1
2	The antenatal period	10
3	Postnatal depression and bipolar disorder	34
4	Puerperal psychosis	50
5	Problems associated with perinatal mental health	67
6	Possible causes of postnatal depression	82
7	Recognition and detection of perinatal mental health disorders	94
8	The effect on the family	100
9	Effects on society	119
10	Management of postnatal depression	132
11	The multidisciplinary team	159
12	Global cultural practices	188
13	An overview of women's perinatal mental health	193

References 203
Appendix 1 230
Appendix 2 235
Index 238

1 Women's mental health: from Hippocrates to Kumar

Blessings on the hand of women!
Fathers, sons, and daughters cry,
And the sacred song is mingled
With the worship in the sky –
Mingles where no tempest darkens,
Rainbows evermore are hurled;
For the hand that rocks the cradle
Is the hand that rules the world.
William Ross Wallace 1819–1881

An overview of perinatal mental health

It is stating the obvious that childbirth is not a new phenomenon, nor has the study of it been neglected over the years. For the most part, and up until recent years, research has focused more on the actual physical side of childbearing, with little regard given to any psychological or emotional factors. There is now a growing body of researchers who suggest that there is overwhelming evidence to recommend that the good mental health of mothers be maintained during the perinatal period. This is because it is now believed that it is crucial to secure a happy outcome for the mother, her infant, and her family, and it is through this research that methods and management strategies may be discovered in order to achieve these outcomes. Despite the evidence of risk to infant development and factors which could harm the mother and her family, the study of maternal and infant mental welfare remains a subject that is often misunderstood and misrepresented.

Criticism has been levied about the weakness and lack of rigour of some pieces of research into perinatal mental health. It seems that few research projects concentrate on producing the results from randomised control trials and there are very few of the type of 'gold standard' research. The reasons for the failure to conduct rigorous research may be many, but not least that it is the overall sensitivity of the condition together with the reluctance of ethics committees to grant permission for such studies. There is apprehension that any enquiries into a mother's mental health may endanger her mental state even further by having the potential to resurrect thoughts and feelings of a mother's previously depressed state of mind. These objections make it difficult to carry out sufficient studies of research into the subject. Many of the studies, particularly of a qualitative nature, have had to be carried out retrospectively, capturing the thoughts and feelings of an event which has passed.

A recent UK Government commissioned report: the Darzi Plan –, *High Quality Care for All* (Darzi, 2008), which is set to revolutionise the vision of the future of health care, highlighted the necessity for services to be focused on individual needs, with the choice for services being centralised. It advocated integrated partnerships, maximising the contribution of the workforce and an intention to prevent policies on health inequalities and diversity. Nowhere, however, did it mention the importance of, or even refer to, perinatal mental health. Even in this enlightened document the mental health needs of mothers were overlooked. Mental health has, historically, been an area of contention when discussing the next priority for government funding. It would appear that those perceived as the more common biological diseases of cancer and the heart override any need for the solution of problems incurred in mental ill-health. The alleviation of mental illness, coupled with the stigma, remains as big a problem in the twenty-first century as it ever was, even though dealing with mental illness and its concomitant dilemmas involves a great deal of the work force and even the finances of the country.

Opinions as to whether postnatal depression is a specific disease have been debated since the time of Hippocrates. From the time of Louis Marcé (1858) the theories of its origin, ranging from hormonal (Dalton, 1985), to social (Guscott & Steiner, 1991; Oakley, 1975) have been considered and disputed. However, it is only in the last thirty years or so that in-depth study of the subject has revealed the high incidence of this distressing complaint (Gerrard *et al.,* 1993). It has been argued that there are still too many women, who, together with their families, are suffering in silence (Kelly, 1994). Recent television and newspaper coverage has stimulated some interest in postnatal depression. However, much remains to be done to educate the public at large, ensuring that a greater awareness of the prevalence of this condition and its damaging symptoms can be recognised and managed.

The debate, however, is not new. It is reputed that the incidence of postnatal depression, as a major mental disorder following childbirth, has been the subject of medical observation since the days of Hippocrates. This ancient Greek philosopher recognised that health and disease are interdependent upon the interplay between human actions and the environment of man. The customs, values, climate, diet, and modes of life and age determined the characteristics of each disease. The additional requirements which determined a person's health status included the whole of the persona and were involved with the examination in detail of a person's innermost thoughts, their speech patterns and the silences contained within them. The reasons for the mannerisms were

thought to be peculiar to that person. There was intricate examination of sleeping habits to establish whether they were fitful, filled with dreams and what those dreams consisted of and when those dreams occurred.

This approach encompassed the person as a whole and recognised the importance and effect of the integration of environmental and socio-economic living conditions as well as individual and collectivist lifestyles on the health of the person. Although this philosophy is still largely advocated in primary care, and health care professionals are urged to apply this approach, this is often marginalised by the more scientific approach that is advocated by the medical profession.

An exploration of the history of the mother's mental health

In 460 BC Hippocrates described 'puerperal fever', also recognised as puerperal sepsis. The name was derived from the Latin *puer* – meaning a boy or child. It was discovered in more recent times that the condition is caused by the Streptococcus A bacterium. Symptoms include a high fever of sudden onset with resulting delirium. Hippocrates, however, credited the cause as the suppressed lochial discharge, which was transported to the brain, where it produced '*agitation, delirium and attacks of mania*'.

Over time, determining health by exploring the body and the environment became compromised as medicine strove to understand the pathology of life. Once it became possible to study cadavers, the expertise on the functioning of particular body parts provided great insight into their operative modes. Anatomical studies performed by Leonardo da Vinci determined an understanding of the locomotion of the human body.

The eleventh-century writings of the gynaecologist Trotula of Salerno noted that '*if the womb is too moist, the brain is filled with water, and the moisture running over to the eyes compels them to involuntary shed tears*'.

Descartes was a mathematician and physicist who is considered the founder of modern philosophy. In 1637 he published *Discourse on the Method* in which he expressed his disillusion with traditional philosophy and the limitations of theology. He respected the certainty of algebra and geometry but as they depended purely on hypothesis he felt it was impossible for the interpretation of reality and to determine what the world was actually like. He recognised the radical difference between the physical and mental aspects of the world and the reality of his own mind. '*I think, therefore I am.*' In 1649 *The Passions of the Soul* further suggested that the human body was split into the biological body and the psychological or spiritual mind and defined the relationship between the body brain and mind:

> *Regard this body as a machine which, having been made by the hand of God, is incomparably better ordered than any machine that can be devised by man, and contains in itself movements more wonderful than those in any machine[e] … it is for all practical purposes impossible for a machine to have enough organs to make it act in all the contingencies of life in the way in which our reason makes us act.*
>
> (Descartes)

Descartes suggested that the human body is purely a vehicle for the mind and it is only able to function because the mind instructs it to do so: '*the mind is not immediately*

affected by all parts of the body, but only by the brain, or perhaps just by one small part of the brain, namely the part which is said to contain the "common sense".' This philosophy gave an entirely different perspective on medicine and the regard for the mind and body working independently of each other.

Louis Marcé

In 1858, Louis Marcé recognised that recently delivered mothers and nursing mothers were prone to disturbances of the mind which, whilst they were similar to the more common forms of mental illness, were, however, different in the organic conditions amidst which they develop. He compared the various descriptions of puerperal psychosis, concentrating on the condition of the blood and its effects on '*those ailments of a special nature that affect recently delivered women*'. He considered that the important period '*is limited to the thirty or forty days in which the uterus is in the condition of a suppurating organ*'.

The functions of maternity are discussed in his *Treatise*; the dangers involved in too frequent pregnancies and repeated miscarriages are recognised and the differences in the physical and mental symptoms are exposed. Whilst discussing the types of psychosis Marcé discovers there are '*present certain differences which it is too good to highlight*'. He differentiates between general paralysis of the insane found in tertiary syphilis, and other types of psychoses. Marcé concludes his treatise by stating that '*our aim is not to study the various mental illnesses for their own sake but rather, with the help of clinical documents, seek out the special modifications which these ailments/affections undergo*'.

Twentieth century opinions and interpretations

Many twentieth-century writers have written about the effects of depression and the torment suffered by women. Sylvia Plath, the twentieth-century American writer and poet is no exception. She speaks of her tormented life, besieged by the wrath and pain of depression and as she plummeted even further into the mire, she describes the pain she experiences as:

> *Look at that ugly dead mask here and do not forget it. It is a chalk mask with dead dry poison behind it, like the death angel. It is what I was this fall, and what I never want to be again. The pouting disconsolate mouth, the flat, bored numb expressionless eyes, symptoms of the decay within. I smile, now, thinking: we all like to think we are important enough to need psychiatrists. But all I need is sleep, a constructive attitude, and a little good luck.*
>
> (Kukil, 2000, p. 155)

Her pain was so intense that she was acquainted with the awfulness of suicidal thoughts which she describes as: '*with the groggy sleepless blood dragging through my veins, and the air thick and gray with rain and the damn little men across the street pounding on the roof with pick and axes and chisels, and the acrid hellish stench of tar*' (Stevenson, 1990, p. 35).

Sylvia Plath describes her own feelings of the struggle to be creative while overwhelmed with depressive thoughts: '*You are frozen mentally – scared to get going, eager to crawl back to the womb. First think: here is your room – here is your life, your mind: don't panic*' (Plath, 2000, p. 186).

RD Laing in his definitive book *The Divided Self* describes his thoughts during his depressive psychosis as being trapped in a deep cave: '*It is getting tighter and tighter in here, I am frightened. If I get out of here, it may be terrible. More of these people would be outside. They would crush me, altogether, for they are even heavier that those in here. I think*' (p. 169).

Spalding (1988) in her book *Stevie Smith* states that Stevie had the symptoms of clinical depression, which were tiredness apathy and irritability, all of which forced her to cut one of her wrists (p. 213).

Depression in women can occur at any age, but it is that which happens at and around the time of childbirth that arouses the most interest today, not only because research is increasing, but also because that same research is uncovering facts about which society was ignorant. Societal changes and attitudes make this a challenging condition. Previously it was postnatal depression that dominated research, but this has been superseded by perinatal mental health, to include all mental health disorders that occur around the time of childbirth, both in the ante and postnatal period and up to one year following the birth of the infant. In some instances it is considered in the pre-conceptual stage.

In the early eighties, Channi Kumar, one of the definitive researchers into perinatal mental health commented that postnatal depression might seem of relatively minor clinical importance when compared with the more florid mental illnesses. However, this insidious and chronic condition that can be responsible for the impairment of both personal and family life could be substantially even more severe and longer lasting. He stressed that as it is over one hundred times greater in terms of breakdown, in purely statistical terms, postnatal depression merits very serious attention.

Depression as a concept in itself is physically inexplicable and appears too complex and difficult to understand – so much so that it is easier to use a 'standard one fits all' diagnosis. Most general practitioners (GPs) will accept the responsibility for front line psychiatry and will make commendable efforts to relieve patients of their problems. What is becoming clearer about depression, however, is not that the cure, if indeed there is one, relies on antidepressant medication, but that it requires time and patience from the GP, as well as from others who are concerned about that person. Time is a precious commodity that medical practitioners rarely have, and in today's rationing of time to patients, it becomes even more crucial that time is given to the depressed patient, and perhaps even more so to the woman who has recently given birth. It is probably reasonable to suggest that only those who have suffered from, or experienced mental illness and depression *per se* are in a position to understand what it means to feel the plethora of negative thoughts and how mental illness can be more painful than any physical pain.

Unfortunately, society demands explanations for every illness and the diagnosis of depressive conditions is not alone. The nomenclature of depression in itself is interesting. Is it a depressive 'illness'? To be ill is defined as being 'out of health', 'sick', 'unsound' or 'harmful' and illness is a state of being ill. Some philosophers have defined physical illness as a condition where organic systems do not function according

to normal standards. In contrast, the problems of mentally ill individuals are located within the minds of the sufferers. Someone who is mentally disordered is simply 'out of his mind'.

Is depression a condition which is seen either as a state of physical fitness or an ailment or abnormality, as in a 'heart condition'? The word 'disease' is rarely used but it is synonymous with distress. 'Dis' implies the reversal of an action or state. Dis-ease literally means someone who is not at ease, distress someone who is overly stressed. 'Mental health disorder' appears to be the latest label. Disorder interpreted as a lack of order, disease or ailment.

Women's health and welfare in general has been taken into account by many researchers. The impact a mother has, both on and in society, is becoming more relevant. It is an interesting concept to question whether depression and in particular postnatal depression is determined by the society in which a woman lives, or whether it is indeed a physiological manifestation.

In order to pursue the notion that social expectations and evaluations influence the conception of the self and behaviour, it is pertinent to consider the various types of theoretical explanations for ill health. It was Parsons (1951) who originally considered the view of illness as a social state and provided a functionalist analysis of the sick role. This theory has been developed by sociologists and philosophers and allows conditions like postnatal depression to be viewed from a theorist's, non-medical perspective, which questions whether depression is the result of a sociological deterioration rather than a purely physical reaction?

Others have postulated that there is a fundamental distinction between physical illness and mental illness. Each type of illness is interpreted with the use of common-sense frameworks. The body is seen as a part of the physical world in which we live, and as such, it is affected by the laws of cause and effect. Things may happen but fundamentally there is no control over when and how they happen. The mind, however, is viewed in more of a cultural framework of actions, meanings and motives (Horowitz, 1982). In this way perinatal mental health may be observed as a manifestation of social difficulties, as well as a malfunction of the mental processes, since the social difficulties encountered by the mother will have an adverse effect on her mental status.

Durkheim (1858–1917) was concerned about the social processes and constraints that integrate individuals into the larger social community. His belief was that when society was strongly integrated, the individuals who were a part of it were held firmly under control, rather than being allowed to dictate the terms and conditions of that society. From this functionalist perspective, illness can be regarded as a form of social deviance, in which an individual adopts the sick role. Unlike the criminal who chooses to violate social norms, sick persons are considered 'deviant' because they have no control over their condition. The sick role is characterised by the exemption of the sick person from normal social responsibilities. Neither blame nor responsibility is attached to being sick, but sick people are expected to seek out medical attention to 'cure' the problem quickly, to enable them to return to their place in society. Postnatal depression and other mental disorders can be construed as a manifestation of an illness in that the 'patient' in this instance, though lacking any physical signs or symptoms of disease is, or appears to be, 'suffering'. This makes it clear in many if not all cases, that the sufferer requires as much sympathy and understanding for her needs as any other sick patient does, although it can be argued that consciously, and perhaps subconsciously,

the woman believes she is 'sick', as do those associated with her. However, it is possible that the woman is subconsciously feigning sickness in order that she may receive that sympathy. The incumbent of a sick role is also expected to comply with the regime prescribed by a competent member of the medical profession (Abercrombie *et al.*, 1984). This obligation of conforming to the sick role ensures this role is not used as an excuse for opting out of normal social responsibilities (Morgan *et al.*, 1991).

Parsons' (1951) earlier work provides a basis for Morgan's assumption, as Parsons' concept of the sick role was based on the premise that a sick person is not in that position because they chose to be, but rather because they had it foisted upon them, either by infection or injury or some other non-deliberate external force. Parsons (1951) argues that being sick is not just experiencing the physical condition of a sick state, but it constitutes a social role, since it involves behaviour based on institutional expectations and is reinforced by the norms of society corresponding to these expectations. In the case of postnatal depression this could mean that women may seek medical permission to vacate the role of 'caring mother'. Women may on the one hand be constrained by common beliefs and facts that belong to a bygone age, that is from a functional perspective they may believe that they should stay at home to care for the child. On the other hand they may feel obliged to agree with modern day feminist thinking regarding their 'rights' to freedom and the need to accept the triple role of wife, mother and worker. Whichever way they turn it appears that women will believe themselves to be disadvantaged.

Whereas many writers have criticised the works of Parsons, some originally offered a viable alternative medical supremacy in controlling role conformity. One exception was Friedson (1970) who reformed the functionalist framework to produce the 'labelling approach' (Morgan *et al.*, 1991). In this interpretation a clear distinction was made between disease, which is regarded as a biophysical phenomenon that exists independently of human evaluation and illness, which depends on the social and medical response to disease. This theory explains illness as a deviance not as a product of individual psychology, physiology or of genetic inheritance, but of social control. In respect of this perspective, women with perinatal mental health disorders might be seen as deviant because they reject or cannot cope with the pressures of motherhood. They must therefore be given a label or diagnosis which places them in a socially acceptable category.

During the 1970s, symbolic interactionism was seen as a major alternative to functionalism. Whereas functionalist theory focuses on the influence of the larger society on the individual, symbolic interaction emphasises interpersonal forms of interaction. The intellectual roots of this paradigm are in the concept of self, as developed by Mead (1934) who argued that reflexivity (referring to self) is crucial to the self as a social phenomenon. The individual is seen as a creative, thinking organism responsible for his or her own behaviour that does not react mechanically to social processes. Social life depends on the individual's ability to imagine how they would react to other people's situations or roles. The ability to achieve this state depends on the individual's capacity for internal conversation. Mead (1934) believed that society was conceived by an exchange of gestures involving the use of symbols. Symbols impose particular meanings on objects and events and, as a result, exclude other possible meanings. Without symbols no human interaction or human society would be possible (Haralambos, 1985). However, the theory has been criticised for failing to give sufficient weight to

the objective restraints on social action. In recent years, Denzin (1992) has sought to resurrect the theory by refining and developing the finer points and argues that interpretive and symbolic interactionists see society as an emergent phenomenon that it is constantly changing and, as a result, cannot be understood through grand theory. Consequently, it is believed that people are constrained by the constructions they build and inherit from the past, and that recurrent meanings and practices are produced when individuals do things together. To understand social behaviour, therefore, the focus should be on the actual, lived emotional experiences of individuals and the assumption that people create the worlds of experience they live in through the meanings gleaned through interaction. From this viewpoint new mothers would be expected to behave in a way that they have internalised. If, for some reason, their 'internalised ideals' conflict with reality, they may wish to 'opt out'.

In work by Waters (1994) it is assumed that the world is subjective and consists of creations, meanings and ideas of thinking and acting subjects. Individuals are competent and communicative agents who actively construct the social world. In order to understand the social world it is important to understand the individual's meaning of the world. The individual is not responsible for the creation of the world they were born into as that world already exists. Whatever the individual learns and absorbs about culture and values during a lifetime is achieved by their own discovery and negotiation. These are usually appropriate to the type of lifestyle familiar to them. Although certain social phenomena are intrinsic, it is argued it is possible to affect change as an ongoing process during a lifetime. Many factors affect that change and it is the decision of the individual to adopt that change. An informed choice is usually made, but those beliefs that are arguably undeniable in one culture, may be rejected or even discredited in another, and there is always the probability that a steadfastly held belief may be altered, or even dismissed, as information about that belief is changed. Hence the observation that knowledge is not value free. This idea therefore presupposes that postnatal depression is only one of the many decisions the mother might take to achieve respite, or that self-knowledge predisposes some women to hide behind a mental condition until they feel ready to resume their role in society.

This approach expands on the theory of medicalisation and regards all medical categories as social constructs, which define and give meaning to certain classes of events. The implication is not that illness is imaginary but that medicine is a form of social practice that observes, treats and tabulates the origin of illness. Foucault (1973) was a forerunner in the concept of social construction of medicine. He termed the concept the 'clinical gaze', whereby the medical approach views the body by clinical observation, physical examinations and bedside teachings. Over a period of time this gave rise to the belief in a solid invariant reality of the body, and as a result, the body was observed in a completely different way. Armstrong (1983) examined how the clinical gaze served to create new specialities and expand the remit of those specialities which had already been developed. This philosophy developed during the 1960s when practitioners started regarding the person as a whole being, not as a segment of illness or disease.

Often, however, the diagnosis of postnatal depression is made only in relation to the manifestation of certain behaviours. Socially structured predisposing factors are therefore likely to be ignored. This means that the issues, which may be causing severe stress for a mother, are ignored. Only when a medically orientated social construction is presented will the women receive attention.

A feminist perspective

Feminism and female emancipation have had a significant impact on the way women view themselves. They have created enormous inroads into the male domain, but many question whether men have accommodated women into the social world. As females have created a niche for themselves so they have exposed themselves and left themselves wide open to abuse and it has been postulated that the function of childbirth itself constitutes such abuse. Ideally, there should be no sexually based differences between men and women.

Paglia (1995) describes a woman as:

> *One who does not dream of transcendental or historical escape from natural cycle. Her sexual maturity means marriage to the moon, waxing and waning in lunar phases. Moon, month, menses mean the same word same world[e] … The female body is a chthonian machine, indifferent to the spirit, which inhabits it. Organically it has one mission, pregnancy, which it may spend a lifetime staving off. Nature cares only for species, never individuals: women, who probably have a greater realism and wisdom than men because of it, most directly experience the humiliating dimensions of this biologic fact.*

Therefore to emulate men in the world of work, or conversely to desire to opt out and be a mother may mean that women are unlikely to conform to everyone's construction of motherhood. This means that women may experience internal conflict between a feminist construction of proper role behaviour and their natural instincts.

These sociological perspectives all serve to determine whether women are subjected to pressures foisted upon them by society as a whole, and if this is the case, the question must be asked whether the pressures are too heavy to bear. Is the result of all these indications the 'breakdown' or manifestation of perinatal mental illness?

In recent years society has seen the disintegration of the supportive mothering role of the extended family, as grandmothers as well as mothers, seek gainful employment. Sometimes the female family members are so removed, geographically, that the support network of families becomes even more fragmented than ever. It is also recognised that this is a complex cultural phenomenon, which cannot be simplified. Another problem is that the nuclear family appears to be less relevant today than it has been in the past. Divorce is increasing and the single parent family is rapidly becoming accepted as a normal status in society. Efforts by the Government to become child friendly and provide good child care echo the sentiments of women who may have been forced to work over the past few decades by the capitalist nature of society and feminist pressures. However, good childcare is essential, and there are mothers who would prefer to care for their own children. Unfortunately, past and present Government policy appears to preclude this, and mothers are not only encouraged to resume paid employment as soon as possible, but are actively persuaded to introduce care workers to look after their children during working hours.

With obligation on women to become – at least in some cases – the sole breadwinner, it is not to be wondered that some of these women succumb to pressures of which previous generations have been unaware.

2 The antenatal period

Pregnancy as a natural phenomenon

Much attention has been given to perinatal mental health disorders and postnatal depression in particular, but until recently there was little research into the effects of the antenatal period on maternal mood. Pitt (1968) was one of the first psychiatrists to recognise the importance of an 'atypical' depression following childbirth, and deemed it as a common and important complication of the puerperium which necessitated a greater understanding. Since then, the focus of research into mothers' mental health has featured primarily on the postnatal period. It had been believed that the condition of pregnancy protected women from feelings of despondency and despair; therefore improving maternal mental health during pregnancy may stand alone as a legitimate goal.

It appears that there has been the commonly held misconception that mothers thrive and positively 'glow with health' whilst they are pregnant. Phrases describe mothers as 'blooming' or having 'fresher complexions' and 'glossy hair'. The whole demeanour of a woman with child is one of serenity and calm. It is interesting, then, to discover in the work by Evans *et al.* (2001) that the symptoms of depression are not more common or severe after childbirth than during pregnancy. The research suggested that antenatal depression affects 15–20% of mothers, which is a higher percentage than women who get postnatal depression. Characteristically, and in line with postnatal depression, it was previously thought that antenatal depression occurred in 10% of mothers (Cox & Holden, 1994), but recent studies have found the prevalence to be over a quarter of pregnant mothers (Bolton *et al.*, 1998).

Authors have acclaimed the pregnant mother as a thing of loveliness, to be admired and coveted. Mansfield (1910) in this poem captured the solicitude of infant *in utero* towards his carer as:

Her beauty fed my common earth.
I cannot see nor breathe nor stir,
but through the death of some of her.

While John Suckling (1646) wrote:

'Tis expectation makes a blessing dear:
Heaven were not heaven, if we knew what it were.

Fraser (2006) asked eleven mothers to describe their final trimester of pregnancy by completing abstract drawings and accounts of their perceptions and feelings; although there were different responses to the positive and negative aspects of their pregnancy, they all reported 'joy' as the common underlying emotion.

Research is continuing to show that many women were distressed during their pregnancy but failed to recognise it as a problem. However, anecdotal evidence from mothers who have shared their experiences on websites state: 'Crying in pregnancy was "perfectly normal" and how could I be depressed when I was so happy to be pregnant?' It is possible that women accept the differing emotions as part of the excitement or foreboding of being pregnant with the baby they either longed for or dreaded. It is also possible they are unable to recognise the source of these emotions and may explain this as being tired, anxious or lonely (Welford, 1998). The plethora of feelings which assail the mother may make it difficult to differentiate between what is normal for her, and what is different from normal because of bearing an infant.

Not only is depression common in pregnancy but it is associated with the high rates of mortality and morbidity for infants as well as mothers (Rondo *et al*., 2003).

It is possible that hormonal changes are responsible but there is insufficient evidence to suggest this is the case. However, the biological changes of increased concentrations of sex steroids during pregnancy are known to have a direct effect on the mother's emotional state.

Pregnancy is a major life-changing event so it is not beyond the realms of possibility that women may become depressed during this period, particularly if this compounds other life stressors. The addition or untimely advent of a pregnancy may cause further stress, which in turn may become unmanageable.

The writer Maureen Lawrence (1972) portrays the feelings of depression during pregnancy, which probably encapsulate some of the commoner emotions felt by women burdened by pregnancy:

She felt lazy. The stirring of the curtains told her it was good drying weather; she must rinse out the stain, but her body felt achingly large to move. It felt like something that would burst open at a touch. She thought of what it said in the paper and in the books from the clinic. It was not just the baby. There was water, and a long chord that sometimes got fast in a knot round the baby's neck. She felt afraid. There was washing, shopping, cleaning. She felt afraid. She has to get out of bed, get down on her knees, get the case quickly, get dressed, get ready.

Perhaps her most succinct description of the trauma of pregnancy was: '*and always it was dark. She could see no end to it, except in darkness*' (p. 175).

Tokophobia

A study by Hofberg & Brockington (2000) uncovered the condition of tokophobia, a morbid fear of childbirth, which in many cases is so profound that it sometimes leads to a complete avoidance of pregnancy, even though many of the mothers admit that they would dearly love children. Such is the fear in some women that in extreme cases they are resigned to the fact that adoption or fostering is the only possible course of action for them to rear children in the future. For other women the only recourse is to remain childless and in some cases women will avoid long-term relationships which could result in childbearing. It is believed that as many as one in seven women suffer from the condition.

This intense anxiety and unreasoning dread of childbirth sometimes culminates in a fear of death, but it is their overwhelming need for a baby that in the main overcomes this. This 'dread' is also associated with anxiety, depression, post-traumatic stress disorder (PTSD) and bonding disorders. Mothers have admitted it is deeply psychologically traumatising for them, which leads to a profound disgust of childbirth. Some mothers may feel disgusted by the fact that something alien is growing inside them.

Tokophobia has been categorised into primary and secondary tokophobia.

Primary tokophobia may begin during adolescence. Girls may have normal sexual relations but this fear may be so powerful that they take extra care with contraceptive methods to avoid becoming pregnant, sometimes using several different methods at the same time. Some women have blamed their first visual images of childbirth on their perception of their own childbirth. One woman remembered watching a video of childbirth in a sex education lesson and described it as '*barbaric, like watching a horror film[e] … I couldn't believe the amount of blood*' (Nicholas, 2007). Another mother said she felt nauseous at images portrayed at the birth. It is also possible to develop tokophobia during the pregnancy and mothers can be concerned that they will die during childbirth.

Avoidance of the act of childbirth itself is also a common symptom and it is most probable the mothers would request and prefer a Caesarean birth because, for them, it would be less gruesome. They would be allowed sedation throughout the procedure to avoid confrontation with the operation. This, too, has its drawbacks, as for some women the thought of having their stomachs cut open is fairly terrifying.

In Hofberg & Brockington's study it was found that the majority of the mothers who had primary tokophobia also suffered with postnatal depression; PTSD was endured by two of the mothers and bonding was delayed in another two cases.

Secondary tokophobia occurs in the second pregnancy following a traumatic or distressing delivery during the previous pregnancy which, understandably, makes mothers fear their forthcoming delivery. These women become pregnant again despite their overwhelming fears. In the Hofberg study some of these mothers suffered from postnatal depression, PTSD and bonding difficulties. All of them suffered from extreme anxiety during their pregnancy.

It is possible to overlook the condition and the symptoms presented because the horror and disgust of giving birth to a child remains one of society's taboo subjects. The general feeling is that all women want to experience the joy of giving birth and that it is the most natural thing in the world. For some mothers it is a pathological problem and they find it very difficult to discuss tokophobia for fear of the reaction they may have from friends, who may accuse them of being insensitive, not to mention heartless. It has been argued that mothers who give voice to their own traumatic deliveries only serve to collude with the view that mothers who have an innate fear of childbirth have no right to feel as they do. This fosters the belief that the mother with tokophobia is unique.

Some organisations (such as Birth Trauma Association) have called for greater recognition of the condition and for the understanding that the increasing prevalence of a genuine and morbid fear of pregnancy and birth is real. Obstetricians and midwives, most importantly, should be more sympathetic to the mothers' needs. There should be a greater emphasis on pain relief and more acceptance of the need for a Caesarean delivery. There is always some anxiety about giving birth, but the intensity of tokophobia means that mothers will overcompensate with their type of contraception in order to prevent pregnancy. It should be recognised as a psychological problem which requires support, not condemnation.

Mother's nutritional status and eating disorders

One survey found that one in fifty pregnant women developed an eating disorder because of the stress they encountered during the pregnancy. The main stressors were the worries about eating the correct type of food. There is no conclusive evidence to suggest that there is an increase in the number of pregnant women experiencing an eating disorder, although the pressure on women to return to their pre-pregnancy weight is increasing and that in itself could add to the risk.

For some women, the stress that surrounds the idea of their bodily state commences early in the pregnancy and reveals a distortion of their body image. Rather than seeing themselves as pregnant and carrying a baby, some mothers avoid or in some instances fail to recognise the natural process of childbearing and complain that their clothes feel tighter and increasingly uncomfortable. The tummy feels generally bloated and they are aware they are becoming fat. Any gain in weight within their social environment is seen as highly undesirable, and some women have been determined to avoid gaining any unnecessary weight during their pregnancy other than that which is recommended by obstetricians and dieticians. As the foetus grows the result is the struggle to maintain the control over weight gain. In order to achieve this, however, it is probable that some women will carefully monitor their diet and restrict their calorie intake, sometimes dangerously compromising their own health and that of their infant. This determination to control her weight is further enhanced as the woman strives to accomplish a strict and sometimes severe daily exercise routine.

For some women, the body image becomes more important than the pregnancy. In some communications women have commented that whereas being pregnant is acceptable, the inevitable weight gain is not. This is particularly so even when then they

are aware of the amount of weight that could be expected to be gained throughout the pregnancy.

In some studies, contrary to any beliefs that the mother might enjoy being pregnant, some women tended to abandon any thoughts of a state of childbearing where they might blossom with health and be blissfully happy. They laboured under more critical thoughts by describing pregnancy as a state that would make them appear like a 'fat blob'. Some of the women demonstrated some insight into their behaviour, but they appeared to be under the illusion that any previous stressful behaviour about their diet and consequent need to exercise would diminish or even cease once they became pregnant. However, despite their best efforts, when they did become pregnant their obsession with body image remained just as strong.

In general, it is the more affluent and educated women who tend to exercise routinely and restrict their calories during pregnancy. They are also more anxious, stressed and not delighted by being pregnant. They rationalise their behaviour by explaining that any weight gain would cause health risks for both themselves and their foetus, but they fail to recognise that by starving themselves they are depriving their infant of essential nutrients. A further problem is that although they may be overly conscious about their weight, they sometimes appear ignorant of how much weight they should gain during the pregnancy and what foods would facilitate that gain.

Whilst some women make a conscious effort to maintain the perfect pregnant figure there are women who are gaining too much weight. Some reports have found that obese mothers were more likely to report being emotional or subjected to traumatic stress during their pregnancy. Some obese women are likely to become depressed because they are unhappy with their appearance and often complain about poor health status. However, there is little evidence to suggest that obesity in these women increases the incidence of their depressive outcomes (Atlantis & Baker, 2008; La Coursiere *et al.*, 2006; Markowitz *et al.*, 2008). Indeed, it is argued that the physiological changes in the hormone and immune systems of depressed women may cause them to become obese in the first place. As an added antithesis, the symptoms of depression often make it difficult to be fully compliant and aware of health issues. Adhering to fitness and diet regimes may be almost impossible to do. It becomes a chicken and egg scenario as it becomes difficult to manage one and the other. Exercise and techniques that help to limit or reduce stress are helpful and can manage both the depressive symptoms and the weight issues, but strict dieting may deepen the depression. The addition of antidepressants may cause a further weight gain. It is estimated that nearly 40% of pregnant women have 'big babies' where they gain more than the recommended amount of weight. The recommended weight gain is based on pre-pregnancy body mass index (BMI), which compares weight to height. It is recommended that women of normal weight should gain between 11–13.5 kg and underweight women should gain 12.5–18 kg. Overweight women should be able to limit their weight increase to 6.5–11 kg and obese women should gain about a stone during the pregnancy.

There is evidence to suggest that eating disorders in mothers affect children's growth. A further study concentrated on the effect of the growth of infants whose mothers suffered from an eating disorder and postnatal depression (Stein *et al.*, 1999). They also looked at the conditions under which growth retardation may occur. It was found that the infants of mothers with eating disorders were smaller, both in weight and length, than either of the comparison groups. There was little evidence that mothers with eating

disorders preferred smaller children or were dissatisfied with their children's shape; rather, these women were highly sensitive to their children's body shape, compared with the other groups.

Several studies have found that the problem with excessive weight during pregnancy is that mothers tend not to lose the excess weight and in effect gain more weight over the ensuing years. There is increasing evidence to show that there is also the added risk of the infant gaining excessive weight during his/her early childhood.

Recent research has suggested that there should be a holistic approach to the treatment and management of depressed and clinically obese women, together with recognition that the two conditions may not be wholly isolated.

Anorexia nervosa

Anorexia nervosa is a severe emotional disorder, which seldom appears before puberty and primarily affects girls: 3% of adolescent girls. In recent years it appears to be affecting boys, too. It rarely occurs in either men or women over the age of forty.

It sometimes follows a traumatic event and is often entangled with emotional or stressful life crises. Some studies have found that dominating and controlling parents have been a factor. There is a lack of emotional attachment and often the parents find it difficult to respond to the emotional needs of their offspring. There are usually great expectations of the child, which are often unfulfilled. Some may argue that by not eating the child regains control as an act of passive revenge.

There is a large body of work that subscribes to the theory that there is a direct relationship between eating disorders and sexual abuse. In one study, 30% of the women with eating disorders reported sexual abuse. This type of abuse was prevalent among bulimics but was rare among those women who were classed as anorexic 'restrictors'. It has been suggested that a history of sexual abuse was just as common in women with psychiatric disorders as in the bulimic or anorexic women (Stieger & Zankor, 1990; Welch & Fairburn, 1994). Likewise, there are sufferers of abuse who have not experienced any bulimic episode. However, sexual abuse should not be discounted as a cause of eating disorders as excessive dieting may help the woman to regain control where sexual abuse has occurred.

There are often tentative conclusions about whether an eating disorder is more a symptom of dysfunctional family life than being strictly related to sexual abuse. This relationship is complex and is probably affected by both individual and family characteristics. It is probable that any traumatic event has the potential to lead to the development of bulimia nervosa, and the home environment may enable such traumatic events to perpetuate.

There are recorded cases of a family history, with one fifth of those suffering from an eating disorder having a relative who also has the condition. It is unclear, however, whether this is in fact hereditary, or whether it is learned behaviour. It is often reported that the adolescent becomes fixated with the populist culture that equates a slim and lean body with success and beauty. It has been argued that there are changes in the serotonin levels and the process of purging the body of the necessary nutrients may deplete the amount of trypophan, which is necessary for the production of serotonin.

There have been some reports of an association between beta-haemolytic streptococcal infection in the form of Epstein Barr virus and the development of anorexia. Other physiological components have been offered but to date the research is sparse and nothing is conclusive.

Anorexia is classified into two main types. The first is associated with extreme dieting, and in some cases a starvation diet where the minimum of food is eaten. This is not because of hunger, but as an appeasement, because they are often under pressure to eat 'something' though this may be contrary to their own belief. Some may resort to excessive exercise in order to loose any extra weight that may have been gained by eating.

The second type is called bulimia, more commonly known as 'binge' eating. This is characterised by eating and then inducing vomiting immediately afterwards or as soon as it is convenient. To expel any eaten food, despite the quantity, as rapidly and effectively as possible, the girl may resort to the use of laxatives, or in the more severe cases, enemas. Diuretics are viewed as a convenient way to loose extra fluid. This is often carried out without the knowledge of the family and often even close friends are unaware of the consequences.

The most notable indicators are severe and often rapid and sustained weight loss. This loss may be accompanied by physical symptoms. The most prominent is the irregularity and sometimes absence of menstrual periods. The hair and skin are dry and thin and the extremities, the hands and feet, are often cold, with a bluish tinge, indicating poor circulation. As the feelings of hunger are often absent, the stomach tends to feel bloated or often irritable.

It is more usual for a girl to prepare an elaborate meal for others than to enjoy the food herself. The excuse not to indulge in the meal with guests is 'when you have been cooking all day you don't really feel hungry'. Mealtimes may be scrupulously planned beforehand. The mealtime itself becomes almost ritualistic, with food being cut into small pieces and eaten slowly and deliberately, chewing each individual piece. The food may be toyed with on the plate and pushed over to one side to give the impression that more has been consumed than actually has. It is not unusual for food which should have been consumed, to be hidden during the meal to be disposed of later.

The most predominant psychological signs are a profound distortion of body image, whereby despite the extreme weight loss the girl has the false belief that she still requires to lose more weight. Other signs may include poor judgement, poor memory and feelings of depression, with a flattening of affect, poor quality sleep and a diminished interest in sex.

Management of the disorder

The condition has several risk factors during pregnancy. There is an increased risk of having a caesarean section, the infant having a low birthweight or being born prematurely. The added risk for these infants is that their prematurity may affect their neurological and physical development.

Other birth complications may also present, though studies have shown that the majority of women carry their babies to term and the infants have good Apgar scores. There is a also a greater risk of the mother having postnatal depression as the mother

becomes increasingly unable to cope with the pressure and stresses of parenthood, particularly if her mental state was fragile prior to the pregnancy.

As the condition is often life threatening it is important to restore the weight that has been lost as quickly as possible and ensure that there is no further weight loss. The most effective form of management is cognitive behavioural therapy combined with antidepressants. Here complementary therapies and herbal remedies have a sound function and can help to promote appetite as well as self-esteem. In these circumstances it is not only the mother who requires help but therapy is recommended for the family. The existing feelings of guilt and anxiety need to be tackled and partners and parents, in particular, need to be aware of the gravity of the condition and understand how they may be contributing to it. The importance of support and encouragement for the mother is vital and will help recovery.

Complementary therapies and herbal remedies have an influence on increasing the appetite as well as promoting self-esteem (LaValle *et al.*, 2000; Wheatland, 2002). Hypnotherapy has been known to have a marginal success rate.

Social influences are important too, including engaging the family in the significance of weight control and not being over critical of any weight gain that might have been achieved. Family therapy is recommended to explore any feelings of guilt and anxiety and the way in which these may inadvertently be contributing to the condition.

Treatment can sometimes be prolonged and there is no completely effective management of the condition. Recovery can often take over five years and long-term studies have found that 50–70% recover, whereas 25% will never fully recover.

Pregnancy itself poses a potential problem and often the mother may find it difficult to become pregnant again primarily because of her fertility situation. Women with an eating disorder have higher rates of spontaneous abortion or find it difficult to carry the foetus to term. Infants are often of low birthweight and there is an increased risk of birth defects. The malnourishment of the foetus is also a concern as there is often a tendency towards calcium deficiency.

There is also the added risk of the mother suffering from a relapse because of the added stress of the pregnancy and in the postnatal period the increased demands made on her by parenthood.

The fourth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (APA, 1994) lists four criteria that an individual must meet in order to be diagnosed as anorexic, generalised as follows:

1) The individual maintains a body weight that is about 15% below normal for age, height and body type.
2) The individual has an intense fear of gaining weight or becoming fat, even though they are underweight. Paradoxically, losing weight can make this fear of gaining even worse.
3) The individual has a distorted body image. Some may feel fat all over, others recognise that they are generally thin, but see specific body parts (particularly the stomach and thighs) as being too fat. Their self-worth is based on their body size and shape. They deny that their low body weight is serious cause for concern.
4) In women, there is an absence of at least three consecutive menstrual cycles. A woman also meets these criteria if her period occurs only while she is taking a hormone pill (including, but not limited to, oral contraceptives).

Bulimia nervosa

The number of women suffering from bulimia is difficult to define, but some statistics have suggested that as many as one in three women have engaged in some sort of bulimic behaviour (Thornton & Russell, 1997).

Researchers are divided about the exact causes of bulimia and as in other eating disorders; it is probable it is the product of a number of factors. It is generally considered to be both a psychological and emotional disorder. It is possible for it to co-exist with obsessive compulsive disorder or depression.

The first cause might be attributed to low self-esteem and dissatisfaction with the body image. It may be felt that trying to lose weight quickly might restore some feelings of self-worth. Once again, cultural pressure may cause an aspiration to mimic the slim bodies of models, portrayed by the media, and fashion may also be a precursor.

It may be caused by the type of emotional stress that is activated during a traumatic experience, but paradoxically bulimia might be seen as a way to manage distress. The intake of food on an eating binge may temporarily distract the mother from her thoughts of distress and focus on the pleasure of taste and fulfilment. The act of purging can help to regain control so that weight gain does not become an additional issue.

Also, while bulimic behaviour may have started as a seemingly innocent way to lose weight, the cycle of bingeing and purging usually becomes an addictive escape from all other types of problems. It is not uncommon for women to become addicted to an illegal substance or adopt behaviours which will help them to avoid painful or distressing situations; for sufferers of bulimia the principles are the same. The bingeing and purging acts as a comfort barrier to life's disturbing events and does not have the negative connotations of alcohol or drug abuse:

> *When life is OK I am OK and so are my eating habits. But sometimes the slightest thing upsets me and I have to go and find something quickly to eat. One Easter I had twelve Easter eggs and ate them all at the same time.*
>
> *I would often avoid going out for meals with friends, if there was a celebration which involved a dinner I would make excuses not to go. If I felt compelled to go I would give loads of reasons why I could not join them at the table. If that failed sit, eat and pick the most opportune moment to go to the ladies to vomit.*

Some women have cited a past history of sexual abuse as one of the main causes of the disorder. The evidence for this is inconsistent when reporting the number of patients with eating disorders that have been sexually abused. The figures for bulimic women with a history of sexual abuse have been reported to range from 7% to 70%; however, the majority report that approximately 60% of bulimics have experienced some form of sexual abuse. Bulimia may be used as a way to dissociate the woman's thoughts from what was a frightening and destructive experience: '*When I was abused by my uncle I was rewarded with ice cream and sweets[e] . . . I hated the thought of food and[e]*' . . ..

There may be a genetic component, as it is believed that those who have a close relative who has, or has had, bulimia are four times more likely to develop it compared to those who do not have a relative who has had the condition. Other studies have linked it to lowered levels of brain serotonin function (Kaye *et al*., 2008).