NEW maternal mental health briefing for integrated care systems Take a look

Physical and Mental Health in the Postnatal Period

9TH FEBRUARY 2018 | FIONA.SALTER

Emma Brockwell is a women's health physiotherapist in Surrey, with a particular passion for helping women to recover after birth. Here she writes about the links between physical and mental health in the postnatal period.

Pregnancy and childbirth are life-changing events that affect women both physically and mentally. Whilst their impacts affect women at different levels and in many different ways, it is rare to have a baby and not be affected in some capacity. As a women's health physiotherapist I see that physical and mental health issues often go hand in hand, but as a system we are very poor at seeing and treating these conditions and giving women the holistic care that they need.

A women's health physiotherapist treats obstetric (pregnancy) and gynaecological related issues. We treat a range of conditions including (but not limited to) urinary and/or faecal incontinence, pelvic organ prolapse, and dyspareunia (pain during sex). Women's health physiotherapists can work with women throughout their life cycle, but my particular passion and specialism is helping women to recover as a result of birth.
Shockingly, a lot of women do suffer negative physical outcomes as a result of childbirth:

• 1 in 3 women will experience urinary incontinence after having a baby.
• 50% of women who have had children have some degree of symptomatic or asymptomatic pelvic organ prolapse. (Hagen & Stark 2011).
• 1 in 10 women will have pain during sex after childbirth.

These problems can occur in women who have had simple or traumatic vaginal deliveries or a caesarean section.

These conditions, whilst not life threatening, can significantly affect a woman's quality of life. Incontinence can be embarrassing and can deter women from going out. Pelvic organ prolapse can lead to uncomfortable sensations during activity, leading women to decrease their activity levels, and pain during sex affects women's sex lives and places new pressures on their relationships. Some women change their routines and lifestyles so dramatically to 'cope' with their symptoms that they become isolated and socially compromised.

It is easy to see how the physical effects of birth have significant emotional, social and psychological impacts on women that can lead to a decline in their mental health. We know that exercise and mental health are positively related. For example the NHS website for postnatal depression recommends exercise as a form of self-help, yet many women do not feel able to do this when they leak urine or have a prolapse and subsequently their mental health is negatively affected.

I work closely with women who have suffered 3rd and 4th degree perineal tears – otherwise known as OASI (Obstetric Anal Sphincter Injuries). These women most commonly complain of faecal and wind incontinence and / or faecal urgency. They often report significant mental health issues too. They feel there is no hope, that they cannot return to work as their condition is too debilitating, and that they spend more time worrying about the nearest toilet rather than enjoying life. Many are terrified about the prospect of having another baby for fear of tearing again. A great many of these women suffer PTSD (post traumatic stress disorder) which affects not only them but their families too. Sadly, despite having been through significant trauma, many of these women, do not receive any mental health support, due to a lack of recognition of the impact of their injuries, and a lack of awareness and availability of appropriate help.

In my opinion the system fails postpartum women. In the UK postnatal care is usually concluded by 6-8 weeks. The current timing and content of postnatal care originated in the 20th century in response to the – then – high maternal mortality rate. It has since had minimal revision despite a dramatic fall in maternal mortality, earlier postnatal discharge and widespread persistent maternal morbidity. We know that women are at risk of both physical and mental health problems which may only become apparent in the later perinatal period.

Revisions to the GP contract in 2004 removed an item of service payment for maternity care, which has led to a decline in GP involvement in postnatal care, with consequences for their skills and training. As a result GP postanatal checks – if they occur at all – are often brief

and do not thoroughly address the physical and mental health issues of postpartum women. In a 2010 survey of 1260 first time mothers, 1 in 8 were highly critical of postnatal care (Bhavani et al).

Current postnatal care is not fit for purpose as it now stands (CMO 2014). Physical and mental screening postpartum often does not occur, or is not fit for purpose. Many healthcare professionals are unaware of what a women's health physiotherapist does and therefore they do not refer women who need help. In France, the state offers 10-20 sessions of physiotherapy to all postpartum women addressing the physical conditions of childbirth.

In the UK we could go one better, offering a gold standard of care, whereby every woman receives joined-up care and is thoroughly screened and treated for both physical and mental health problems. I strongly believe that we would see a rapid decline in physical and mental morbidity rates and, as a nation, we would be providing the type of healthcare that every woman in the 21st century should be receiving.

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BIRTH TRAUMA POSTNATAL DEPRESSION PTSD