Annamária Töreki and Emőke Hompoth

Perinatal Mood Disorders – an Applied Perspective

DOI: 10.14232/sztep.chpp.2022.9

1. Introduction

In the life of a woman, pregnancy is a period with the prospect of self-fulfillment; however, it also involves numerous emotional, mental, physical and social changes. Becoming a mother and starting a family often evokes unexpected psychological strains that are difficult to cope with. Pregnancy – either planned or not – exerts psychological effects on women that are difficult to handle. That is why pregnancy is considered a state of crisis; from the onset of planning a family throughout all the three trimesters of a pregnancy, various emotional factors occur that might provoke anxiety, depression or, though rarely, even psychosis/psychotic episodes in the clinical sense (Belső, 2006b). In addition, pregnancy also affects the quality of the relationship of a couple and other social relations. As pregnancy might produce symptoms that require full attention and, if necessary, appropriate attendance, pregnant women need the devoted attention and support of their health care professionals. Untreated psychological symptoms may damage the fetus, but also exert an adverse effect throughout all the stages of motherhood, and thus harm the baby's development and may even destroy the couple's relationship. Proper psychological support is therefore vital for the family to function better and support couples in their decision to become parents.

As early as at the stage of planning a family, hurdles can occur resulting from inadequate mental processing of a miscarriage or a failed conception. In the first trimester, even in the case of planned pregnancies, malaise, fatigue, fear of miscarriage might cause anhedonia-provoking symptoms. The second trimester is usually a more peaceful period provided that the first genetic screening tests yield ideal results. Somewhere between the 12th and 24th weeks of gestation, mothers start feeling fetal movements, that is, the existence of the child becomes palpable, more realistic, while the size of the abdomen is not as large yet as to impede the mother in everyday activities. In contrast, the third trimester is strenuous again with the date of delivery approaching, movements becoming more and more difficult and fears and worries may appear relating to giving birth and caring for the baby. In addition, financial and existential questions might emerge further intensifying tension that the couples feel (Martini et al., 2016). These may even reach the extent of pathological anxiety or depression that call for help by a psychologist (Barker, 1995). These could be day-to-day life experiences, such as

disruptions in everyday routine, experiencing stubbornness due to maximalism or perfectionism, concerns regarding proper nurturing of the infant or even the difficulties of mother-infant attachment after birth. These are completely new feelings and in case they are not dealt with and processed adequately, they can even lead to pathological anxiety or depression.

Initially, depression studies were limited to the postpartum period. We distinguish three types of depression: (1) postpartum blues, which occurs in the days after delivery and lasts for about ten days, with a prevalence of 50 to 80%. Postpartum depression develops in the cases of prolonged maternity blues and affects 15% to 25% of mothers, while postpartum psychosis occurs only one to two mothers per one thousand deliveries, and starts mostly in the first postpartum week. (Beck, 2006; Doucet et al., 2011; Henshaw, 2003; Kennerley & Gath, 1989; Pitt, 1973; Ross et al., 2005).

The incidence of either minor or major forms of depression in different trimesters during pregnancy shows different patterns. Gaynes and colleagues (2005) in their meta-analytic study found a pathological rate of 11% in the first trimester, 8,5% in the second, and 9,7% in the third trimester.

Extensive research has investigated whether untreated maternal depression can cause complications that may pose a risk to the fetus and the mother during pregnancy. Untreated depression during pregnancy often leads to opting for epidural analgesia during labor, that is, endurance of the perceived pain might depend on the mental state of the pregnant or the degree of psychological readiness for the delivery (Chung et al., 2001). Untreated prenatal depression is also more common in the cases of caesarean section or even preeclamptic symptoms (Cripe et al., 2011).

According to research, depression during pregnancy also affects fetal development: it can lead to premature delivery (Jesse et al., 2003), intrauterine fetal retardation (Qiao et al., 2012) or low birth weight (Hompoth et al., 2017; Rahman et al., 2007). In the postpartum period, a depressed mother is less able to attach to her child (Righetti-Veltema et al., 2002), performs less verbal interactions and smiles less at her baby. Furthermore, depressed mothers have more difficulties breastfeeding their babies, and this also adversely affects their sleep (Field, 2010).

All the abovementioned studies clearly demonstrate the severity of mother and fetus complications that perinatal depression can induce. Therefore, it is of utmost importance to view pregnancy from a mental health approach and consider expectant mothers' psychological care as crucial for prevention.

2. Case Report

In this chapter we present a fictional case. We have decided on this option because the period examined is quite long: pregnancy itself lasts for 9 months (its different stages evoke different types of problems), the postpartum period lasts one year after delivery,

but patients often seek psychological support in obstetrics departments with pre-pregnancy difficulties as well. For instance, they often need counseling in the cases of problems with conceiving, fear of infertility or coping with a prior perinatal loss. We dealt with clients mostly on a short-term basis focusing on the main problems they brought in. However, our aim is to demonstrate the broad variety of difficulties this period entails, thus we created a fictional client character exhibiting the most common problems (and named her Ann). Texts in italics indicate typical patient language use, and words in quotation marks are quotations from sentences uttered.

Ann is a thirty-five-year-old intellectual. She arrived in an elegant dress and impressed with a tidy look. A kind of fatigue was visible in her posture, yet we could also feel that she still had strength and resources. She told us about a complex problem: she and her husband had been trying to have a child for years. After a year of attempts, they underwent medical examinations and, as a result, they tried timed intercourse. Ann felt that this had a negative effect on their relationship and was afraid of losing intimacy. In addition, she also developed hypochondria due to the several medical visits and *her inability to live up to the evolutionary call.* She feared that she was soon to receive a diagnosis of infertility, so she developed anticipatory grief. She had feelings of guilt and anxiety and wished *she hadn't focused so much on her career and hadn't waited so long, she was afraid that she was too late and she wouldn't be able to become a mother anymore.* We worked on these difficult emotions in a couple of sessions. As a result, she and her husband started spending more quality time together, talked about their fears and were consciously trying to make their sexual intercourses more intimate (despite having it pre-determined). We were also talking about the various psychological reasons contributing to successful conceptions: we explored stressful situations in her life and identified possible coping strategies for her, such as relaxation, stress relief through workouts, communication techniques and improving her ability to say no.

During our work together, she managed to become pregnant; however, her happiness was interspersed with concerns regarding the possibility of an illness and the loss of the fetus. An intense anxiety and fear developed, as *at her age, there is a higher probability of its occurrence*, and *what will happen if they have to start the whole procedure all over again or if she needs treatments again and they will have to miss out on spontaneous intercourses.* These fears overshadowed her joy of being pregnant; she was not able to enjoy her pregnancy. She mentioned further problems, such as being nauseous, depressed, tired and experiencing cognitive dysfunctions. I tried to help her look at these symptoms from a different perspective: they might stem from the hormonal changes of her body as it was preparing to feed and nurture the fetus, which is a highly strenuous process involving a lot of change, therefore her fatigue, cognitive problems and depressed mood were all explicable. Nausea was also logical as her body tried to protect the fetus and that is why she was much more sensitive to odors, so that she could better filter out potential sources of danger that her body signaled to her that way.

Another source of her anxiety was the genetic screening due at 12th weeks of pregnancy. Ann began to worry again that the screening might detect some fetal anomalies that would lead to the loss of the fetus, and, subsequently, to the necessity of starting the demanding process of conception all over. She dreaded the possibility of her fetus having Down Syndrome, because, in this case, she would have to make a decision about whether to choose an abortion or raise a sick child. *'I am terribly ashamed of it, but I have always been scared of people with Down syndrome. I don't know why, as I've never had any bad experiences with them, actually had no experiences with them at all... but the thought of having a sick child scares me.'* During our conversation, it turned out that she had always been afraid of new, unfamiliar things but when she had had the chance to get involved in them, her negative feelings disappeared. She was therefore pondering to volunteer with self-help groups of people affected by Down syndrome, as she thought that way she would have the opportunity to get to know them better, and it could help alleviate her anxiety. I also asked her what would help her reduce her fears of possible other illnesses. She responded that *more specific knowledge about, for example, prevalence rate, consequences and possible solutions.* Therefore, we went on to deal with her relationship with her health care professionals and I advised her to talk to her gynecologist about her concerns as she could receive a lot of information from her doctor. During the following sessions, she was much more relaxed and talked enthusiastically about how she asked her gynecologist to reassure herself. She found it useful as it helped her build trust in him and from that time on, she felt that she could count on him much more than she had previously expected. She also mentioned that talking to her doctor also helped her reduce concerns regarding delivery and that she felt *she would be in safe hands when the time comes.*

In the second trimester, her feelings of discomfort, cognitive impairment and fatigue all decreased. Her relationship with her husband improved and *everything started working out fine between them again,* though certainly, they still had some disagreements and debates over their plans. Although they were able to agree on many issues, Ann felt that sometimes they were not really listening to each other and she could not make her husband understand her feelings; sometimes tension between them increased up to a point when one of them eventually offended the other. We started talking about Ann's problem solution techniques with regard to assertive communication. We found out that her husband might have felt being attacked and accused so his motives were not to 'attack' Ann (as she first put it) but to defend himself and fight back. At first, she listened skeptically and felt that the method was hair-splitting as the point remained the same. However, she slowly began to see the difference and became enthusiastic: she wanted to practice being assertive and role-play situations, as she was eager to apply it properly to her life. She also thought she could teach it to her husband in order to improve their communication. During the following sessions, she pointed out that they were having successful conversations, or, in those when they failed, she asked me how

they should have behaved differently or what expressions would have been more appropriate.

She had some other concerns. First, about her fetus: she could not sense its movements yet, and *her mother said that at that period Ann had already been moving in her womb*. In addition, the approaching date of the genetic test due at week 20 further intensified her anxiety. She assured me that she was going to ask her gynecologist for information about both issues, just as she had done before, but *at that moment she felt her concerns were overwhelming her.* It was possible to alleviate her anxiety with simple statements such as: during the first pregnancy fetal movement only becomes perceptible at a later stage; and every fetus is different, some move less in a given period so it does not necessarily indicate abnormal development. Regarding the genetic screening outcome, she felt it useful to voice her fears without the presence of her spouse who often ignored the topic with phrases (although probably out of a desire to help) like 'oh, don't even bother with it', 'come on, everything's gonna be fine', 'you shouldn't even think about it' 'you're thinking too much about it' and so on. She said she often came across similar reactions when she wanted to talk to her friends, so she always felt that others were closing in, avoiding the topic; no one wanted to listen to her. In our sessions, she had the opportunity to express her thoughts and voice her fears to somebody listening attentively, not avoiding the topic and not interrupting her. She felt it liberating.

During the following weeks, she began to feel fetal movements and the genetic screening was over, so she was much more relaxed. She expressed her relief in several ways: *how much her burdens were eased and she was ready to let herself get emotionally involved in her pregnancy. Up to that point, she hadn't even dared to get too close to her fetus as she was constantly afraid of losing it; she was convinced that something bad would happen. She was still aware that unexpected difficulties might occur any time, but still she started to let the joy sneak in her heart. She 'allowed herself' to caress her belly, immerse in it, and she began to talk to the fetus, about the plans they were making with her husband.* She was even more relieved and happy after the 24th week, the age of viability, i.e. from this time on the fetus is more likely to survive in the event of a preterm birth. On the other hand, her abdominal circumference began to increase noticeably, so it began to become uncomfortable to move and sleep, and her stamina and performance decreased. It wore on her, as she had felt stressed and tired enough before, and her problems with sleeping made it even worse. The situation has improved somewhat when she implemented relaxation exercises in her daily routine and allowed herself to rest and recharge during the day when she felt it necessary. Also, she bought body pillows to support her body during sleep. She was worried because she often felt short of breath which she had not experienced before due to her regular workout in the past years. Consequently, she felt as if her hard workouts had been in vain. I assured her

that it was usual and typical; the growing fetus occupied more and more space in the uterus, thus it compressed her organs and lungs a little.

At around week 30, her worries took a new direction: first, she was troubled by the thought of delivery; secondly, she had doubts whether she was going to be a good mother, *be able to do it well.* We began with exploring the background for her fear of delivery. She was surprised to realize that she merely had some quite general and superficial theoretical knowledge about it. She became interested and began reading a lot on the subject, talked over the details with her gynecologist, and during our sessions, we focused on its mental aspects. One of the topics that she became preoccupied with was the altered state of consciousness during labor and delivery. She imagined it as a situation completely out of her control and that frightened her. We clarified that a narrowed attentional focus is typical when delivering, as it is a difficult and serious challenge that requires full attention. However, she did not need to be afraid since she would be surrounded by her gynecologist, her spouse and the midwife to help her 'maintain control' over factors she would not (or not continuously) be able to pay attention to. I encouraged her to make plans with her husband about what they assumed she would need, what are the tools that might be of help during labor (gymnastic wall bar, gymnastic ball, etc.) and ask her gynecologist which of these were available at the hospital they had chosen, what postures are recommended at childbirth and in case of a caesarean section how she could have some influence on it (for example if she wanted her husband to be present), and so on. Unexpected situations can definitely occur any time, but the more scenarios she was prepared for, the more secure she would feel. Her husband could also be of help if her narrowed focus hindered her to be able to pay proper attention to her environment (questions, information) and she might happen to have difficulties with decision taking. Should it happen, her husband might function as a so-called 'assistant self', that is, he could help her due to his knowledge about their relationship and the pre-agreed plans, for instance, he could paraphrase a question (to make it more clear) or can take certain decisions. I also recommended her to talk to her friends who had already undergone giving birth as she could gain new ideas, aspects and topics that might as well be beneficial. She could even search for videos about delivery if she thought it would help her gain indirect experience about the process. After all, she decided not to watch these videos though she had searched for them as she did not have the courage to watch them thinking it would only scare her off even more. We certainly acknowledged her decision since we always look for the things that can help our clients.

She also had concerns about the pain and the treatment options. She admitted that she could not bear the pain in general, it made her frustrated and she was afraid of it. She was afraid that she would not be able to control it; *it would absorb and 'devour' her mind.* She had already talked to her gynecologist about pain-relieving options which partially calmed her down. In addition, she attended prenatal classes where she learnt

specific breathing techniques. During several sessions, we focused on the topic of pain: what it meant to her and how she could cope with it. *'Whenever I feel pain, I think I am going to lose control, my body betrays me, it takes over control, I adjust everything to it, it rules me.'* We emphasized that pain is there to indicate physical problems so her body does not destroy her; on the contrary, it helps her survive, and takes over control to lead her towards specific activities and make her avoid other activities that would harm her in order to prevent possible injuries, alleviate the pain and help her recover. However, I framed it as natural to perceive it as a difficult situation since deep, instinctive mechanisms come to rule and suppress her conscious self but she must be aware that they were in the same boat, just like teammates fighting for the same goal. During delivery, pain indicates contractions to prepare her body for another push. She seemed to understand this approach and, at her request, we formulated positive autosuggestion affirmations that would help her during delivery. For instance, '*Pain is manageable and it helps in childbirth* ', '*we work together with Janka (her child's chosen name) to help her birth*', *' I trust my doctor, the staff, I am safe* '. We also elaborated on the topic of altered state of consciousness that heightens the level of susceptibility so we also created phrases of affirmation that her husband would use to help Ann during childbirth. After giving birth, Ann told us that during delivery, she remembered barely anything of the phrases we constructed, but when she did, they seemed to help her, and throughout labor, she felt much calmer when she thought of her mantras. Besides, her husband's support helped a lot and her husband felt more confident due to the prearranged phrases and tasks that provided him solid ground to rely on.

In this period, she was looking back on her childhood, scrutinizing her relationship with her mother. She had various memories: pleasant, sad, infuriating. However, she started to look at them from a different, distanced perspective: 'I agree with that', 'I would never do that', 'I still don't understand why she took that decision then'. Meanwhile, she was wondering a lot about the questions 'Am I going to be a good mother?' 'Can I change my parents' bad patterns?' 'Will I be able to do it differently from what I learnt in my childhood?' 'What if I'm not better than them?' 'Will I destroy my child's life with my mistakes?' These are serious problems that concern many people. Therefore, we talked about what 'being a good mother' meant to her, what are the characteristics, behavior, external and internal qualities that she considered important. How does 'a good mother' lead her life? Does she sacrifice everything or does she allow herself to self-care as well? Is it selfish to want some me-time? Can she ask for help or accept it? She was puzzled, as she had seen only extreme cases of motherhood both in movies and in her own life: she had a polarized image of moms either being '*supermoms*' or '*failed moms*'. In her view, supermoms control everything perfectly, beside housekeeping (and work) they still have time for keeping fit, taking their children to various activities, volunteering for school projects, baking cakes for neighborhood parties, etc., and they do all these without complaints. In contrast, we always see the

'failed' mom in her worst moments, for example, when she happens to be worn out, she is quarrelling with her spoiled, peevish kids, or when they are looking helplessly at their toddler throwing a tantrum over chocolate. *We tend to feel sorry for them, or even voice our opinion about them being such failures as parents. I am terrified of experiencing such humiliation one day. … In the movies, this is the 'need-to-be-rescued' type, which is also a worrying thought for her as she preferred solving problems herself rather than 'being saved'.* As a result of our conversation, her image of being a mother became closer to reality and she was able to relate to herself and her role as a mother more effectively. We also talked a lot about the necessity to be open and flexible, and that she needed to re-evaluate many things. Subsequently, some of her standards and values changed and she wanted to follow the new principles. She also told us how preoccupied she was with her childhood sorrows and that she tried to convey her feelings assertively towards her mother. Their conversations resulted in debates, but in the end they could accept each other's points of view (as for Ann, she could understand that at that time her mother had found the solution she had chosen to be the best; and as for her mother, she realized that she had hurt her daughter's feelings, even if not deliberately). Thus, they got closer to each other and some of their wounds began to heal.

We met a few days after her delivery, without a scheduled appointment. She was still in her ward and requested my visit because she evaluated her symptoms as depression, which made her truly scared. She reported on her delivery experience as well: it had started suddenly so the ambulance had taken her to the closest hospital and not to the pre-chosen one. She had been unprepared for that scenario – although its possibility had had crossed her mind briefly, but it had seemed very unlikely, therefore she had not made a plan for it in detail. The most shocking and terrifying thing about the new scenario was that she had to rely on another, unknown gynecologist. She recounted in tears how terrified she had been. Finally, owing to staff kindness and her husband's encouragement, she had managed to calm down and fortunately, delivery had taken place without complication. However, the experience left a mark on her. She was sure that her depression and symptoms stemmed from that. She complained about mood swings, being oversensitive, feeling like crying all the time, being extremely tired but having trouble sleeping well and waking up to every little noise. Although earlier we had discussed the effects of hormonal changes after childbirth, she was afraid that her symptoms indicated a greater problem. Talking it over again helped her ease off and her body posture got visibly more relaxed. In the following two weeks, she planned to stay at home with her husband and her newborn, so we scheduled our session only after that period. Nevertheless, we agreed that she should call me to meet earlier in case anything unpetted her.

After the two-week break, she returned a bit exhausted. She was still having sleep problems: she woke up to little noises during the night and many times to breastfeed

her child. She tried to make up for the lack of sleep during the day but she said '*I keep waking up all the time to Janka's crying'. I'm terribly ashamed but the question 'why on earth is she always crying?' has run through my mind several times. But when she isn't crying, then that bothers me and I worry about what might be happening to her, why she isn't signaling at the usual time. Nothing is good... whatever happens I find something to worry about'.* We talked in detail about the fact that each baby is different, has different needs, moreover, their needs also change over time and sometimes there might be swings in, for example, her sleep cycle, appetite, weight gain and so on. I suggested her to consult a health care professional regarding her concerns, but I also pointed out to her that she should always be aware that infants are not like clockwork and she should trust herself more.

At this point she started crying: *'Well, that's it!' I can't rely on my gut feelings! They aren't telling me anything! I've got no idea why she is crying, I don't understand, I don't know what she wants! I don't know whether she is hungry or is having a stomach-ache, or what other problem she's having... I'm a terrible mother, I don't understand my own child... and ... and ... I don't feel anything for her... I can't love my own daughter... What kind of mother doesn't like her own child?!'* She was extremely upset. I let her cry for a while, quietly encouraging that she could ease the tension there, she was in a safe space and after that we would discuss everything. A few minutes later, she apologized saying that she had just realized how miserable she felt and that surprised even herself. Although these thoughts had already crossed her mind before, she had not cried over them yet, she had always brushed them off and concentrated on her daily tasks instead. We were having a long talk over the fact that at that moment they were experiencing a brand new situation which demanded brand new knowledge and rules without having handy, ready-made patterns to follow; and learning from one's own experiences always requires time. They also needed more time to get to understand Janka's infant communication as it was completely different from ordinary communication so they needed to get used to it. I assured Ann that she would systematically become more and more confident in recognizing the differences in the baby's signals, figuring out her needs and the ways to fulfil them. I also told her that love needs time to develop, it does not happen the way we see it in the movies. She needed to understand that her newborn was evidently a bit of a stranger to her and she was just getting to know her. Obviously, some kind of a relationship had already been formed between the two of them while her baby had been developing in her womb, but it was a completely different situation. When she was born, everything changed. Until that time, she had only been a product of her imagination, but now she was a living human being with feelings, experiencing and reacting to the outside world. I told her to think of a situation when we meet a stranger: we can have an image of them based on stories we have heard about them, our first impression might be a good one, yet we need time to get to know and like them and we need even more time to get to love them. I

encouraged her that love towards her child would obviously develop much faster as they were spending all the time together, but I also reminded her that the situation was somewhat similar. *She felt an immense relief when she realized that it was not her inability to be a good mother that generated the whole issue, as she had the distressing idea that her conception problems arose from her incompetence for motherhood.*

She had insufficient breast milk supply so she had to buy infant formula to feed the baby, which also provoked guilt and shame as she felt *she wasn't able to nourish her child, her body wasn't giving enough from itself to her baby.* In order to reframe her perspective, I explained that her body was not selfish; it just tried to maintain a healthy balance. She was suffering from lack of sleep but, at the same time, she was overwhelmed by her constant worries and by trying to control and manage everything properly. All these were soaking up all her energy. Yet, from the little energy she retained, her body was striving to produce food for Janka. I advised her to be more patient and empathetic with herself and create some me-time to re-fill her energy. I recommended her to ask the grandparents to help with Janka, for instance while she was having a walk, the grandparents could be happy to take care of the baby.

She also mentioned how hard she found it to put up with the mess in the house. Beforehand, she had always been able to manage household chores and keep the house clean and tidy. This had changed, and she was frustrated because house-related responsibilities had become a never-ending task: as soon as she finished one of them, she had to start doing another. *She felt everything turned into chaos, she was going under, she felt excessively overwhelmed as she was not able to do the cleaning at such a pace.* We spoke about how a baby's arrival can turn one's life upside down. In most cases, the changed circumstances and priorities required a total re-organization of daily activities. I advised her not to compare it to her previous lifestyle; rather, she should re-structure her daily routine and create a new system that would tolerate a sink full of dirty dishes – a typical consequence of trying to attend to a baby's needs. As long as she had some clean dishes to use (or she can quickly clean some), there was nothing to worry about, she should be more at ease with herself, as washing the dishes was a much less important a priority than the baby's needs, therefore it was natural of her to ignore them. I also pointed out the possibility of asking the grandparents to help her out for a few hours per week, or to hire a house-cleaning professional, which is also quite common at the first stages.

She was also frustrated by not being able to carry out her other plans related to the household: *since she was at home anyway, she wanted to sort out her things, but she could not even get it started as there she was always hindered by something new to do around Janka.* I asked whether she could deal with that for only five minutes at a time, if she decides only on two things whether she needed them or not. She could proceed bit by bit. She was surprised: *'Well, after all, but ... I haven't even thought about it this way as I prefer to finish sizeable jobs right away, that's the way I like to do things... but, actually,*

I would proceed this way as well, even if at a slower pace…' After her first astonishment, she became enthusiastic about it, and said *she had many 5-minute gaps a day, so she eventually might be able to proceed with it quite quickly.*

In the following session, she reported that she had been able to tackle all kinds of tasks at home, *she was proud of herself.* However, she still had worries about *doing all household chores like a robot, as if she weren't herself while doing them, as if they were happening just automatically.* She explained it further: *this state wasn't a relaxing kind, 'it isn't just a little relaxation of the mind when I can switch it off, but I feel unpleasantly distancing from my own self'*. Therefore, I asked her to try to practice a bit of mindfulness and stay consciously present in such cases. For instance, during washing the dishes she might try to observe temperature differences between the hot water and the cool air, or notice the different odors, the texture, weight of the dishes and the sponge, and so on… As sessions went by, she became more and more enthusiastic about her achievements, mentioning that she was paying attention to everything and her sense of being automatic had lessened a lot.

She reported on her joining a Facebook group for moms with babies where they chatted about their questions and worries. At least that was what she thought when she joined. However, within a few days she experienced hostile attitudes and comments on everyday questions. She witnessed critical and assaulting comments several times even when somebody asked a completely relevant question. Although there were some clever and helpful responses, there was a lot of criticism and rebukes. I was shocked to hear that and tried to find logical explanations for such behaviors to ease our strain, and eventually we concluded that she would not leave the group as she received a lot of useful information from helpful comments, and she should neglect malicious remarks. However, the situation got worse, and after a few sessions, she told me she did not dare to put any questions or reply to others because some members would pick on her whatever she wrote. Instead, she sent private messages to comfort women who had been assaulted but whom she agreed with. She took part in several similar chats, she had a positive opinion about these, and they could help each other a little. Nevertheless, in the end, as she had been unable to ignore negative comments she made the decision to leave the group altogether after a few weeks. I feedbacked her how clever she was to spend time and energy with observing herself, staying in the situation up until she considered it useful, but then she was able to change her mind when she finally got fed up.

Her relationship with her husband had also gone through some changes. During the first few weeks, they got really close to each other; she felt that the connection among the three of them was truly intimate and affectionate. However, gradually, some emotional distancing started to develop between him and her. He worked a lot, went out with friends, which triggered mixed feelings in Ann. On the one hand, she knew that spending time separately might be good, but she also felt betrayed. She was disappoint-

ed that her husband was not rushing home to see them and he started helping less around the house as well, so Ann felt more and more lonely. The lack of sexual intercourse also meant a problem. Ann tried to avoid them, while her husband would have needed them. I encouraged her to refresh what she had learnt about assertive communication and also encouraged to try to talk to each other. Ann should voice her feelings and wishes but must also listen to her husband's point of view. It is quite common that the husband feels he cannot be part of a close relationship with the baby as much as the mother can, so he becomes an outsider in his own family. In many cases, a father's response is to escape to work. It is essential therefore that the father be part of family life, for example, spend time with the child after bath or take on various tasks day by day. There should also be activities which involve all the three of them actively, and so on. It might broaden their experience of parental roles and intensify their sense of forming a family.

As for sexual intercourses, I reassured her that it was quite a typical female reaction of her to avoid sexual encounters at that period as she was focusing intensely on her mother-role. However, her husband missed them so it bothered Ann as well. We picked on the topic how they could get closer to each other again. I encouraged her to spend more quality time together, and that they themselves should determine what quality time means for them: to watch a film at home, or go to the cinema, take a stroll, or anything they found appealing. Although, at that time, both of them concentrated on their parental roles and functions, they did not cease to be man and woman, husband and wife. They should take the time to snuggle, to please each other. It is important to consciously set aside time for this, and they should be patient with themselves and with each other.

After some more sessions, Ann decided that she was prepared to get along on her own. She felt much better. I completely agreed with her, actually, I felt the same so I had already been planning to discuss to finish of her counseling at that session. We agreed that whenever she needed help she should call me. We also reviewed the issues we had dealt with, the progress she had made and highlighted the things she wanted to continue working on.

Considering that she had never had a disorganized or untidy appearance and she had strength and stamina despite her fatigue and complaints, we found her consultation with a psychiatrist unnecessary. We were able to work with her effectively via simple counseling techniques, such as pre- and postnatal education, attentive and active listening, reframing and summarizing. Developing effective communication skills, relaxation and coping strategies were also embedded in her therapy. I judged these methods appropriate and sufficient for her prevailing condition and energy. Sometimes little things helped her move forward, such as being listened to, without getting any particular advice or plans for solutions. To have somebody simply present helped her face and think over her thoughts. That is why, in the last session, I prefer reviewing the

changes clients themselves have noticed, the gains they have made in treatment, the things I was able to help them with and thus they can take it away with them. I always ask them what particular fields they would like to achieve further improvement in. If a client dares to be honest and does not only give me polite answers, I can learn a lot from their responses.

Lessons learnt from this case

Throughout pregnancy, delivery and the whole perinatal period, women face various types of problems. I am often surprised by how effectively even trivial things can help, such as filling an information gap, or just being present to listen to patients so that they can ventilate, ease the tense and have some space and time on their own. With those clients who improve a lot during the counseling process, I often try to identify the things I was able to help them with, although I know that I do nothing earth-shattering. I simply give my clients small bits of help they cannot get from anywhere else. Fortunately, it is often enough to help them move forward. It can even support the development of the fetus, the newborn and the harmony of the entire family.

3. Discussion

The treatment of depression experienced by pregnant and breastfeeding mothers is an important issue in psychiatry today. Using pharmacotherapy in this critical period always requires extreme precaution, mainly in order to protect the health of the fetus and that of the newborn. Monitoring the mental health of mothers in the perinatal period has proven to be useful against depression and anxiety: supportive talks, psychoeducation, developing communication strategies are all methods to reduce mood swings and improve mood. Talking about changes in family roles, preparing for labor, helping parents' adjustment to parenthood are factors that help the entire family. As our case study clearly demonstrates, pregnant women and mothers of newborn babies happen to face various difficulties in the perinatal period and (as it can be seen in item 6 – questionnaire EPDS) the feeling of being overwhelmed is often experienced.

Treatment of perinatal mood disorders might also take its tools from the field of cognitive behavioral therapy that focuses on improving patient social effectiveness and reducing the frequency and strength of negative automatic thoughts. In addition, relaxation techniques are useful to prepare women for labor so that the client can have better chances for vaginal delivery rather than having a caesarean section (Chang et al., 2008; O'Mahen et al., 2012; Saisto et al., 2006).

Perinatal mood disorders and its various complications might induce several adverse effects on the fetus, the pregnant woman, the newborn and the mother. Hence, maternity care with special attention on tracking mood changes throughout pregnancy, labor, birth and the postpartum period is of primary importance. In order to accomplish this goal, screening and monitoring the mental health of childbearing women, before and after childbirth, has been implemented in Hungary, first in the town of Szeged, and subsequently, in several other towns. The screening project is carried out by the Hungarian midwifery service with the help of the abovementioned EPDS questionnaires (Cox et al., 1987). When a midwife – who pays regular visits to families – assumes mood disorder, she can assess the severity of the condition with the EPDS questionnaire, and can refer the patient to the appropriate mental health professionals. This screening program provides a safety net for families by reducing the risk of various perinatal complications; thus, it opens the way for the birth of mentally more and more balanced mothers, infants and families.

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