Maternal Mental Illness & Risk Factors: A Systematic Review

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Abstract

Background: Pregnant women include a vulnerable population due to various changes that affect their mental health. Mental health problems during the antenatal and postnatal periods affect about one-fifth of pregnant women. Mental illness in pregnant and postpartum women has become a public health concern which has gained attention in recent years. Postpartum depression (PPD) occurring within the first year after delivery, affects 10% to 25% of women globally. 

Objective: The purpose of this comprehensive systematic review was to evaluate research evidence on the determinants of inherited mental health disorders among before and after pregnancy in Indian women.

Methods: Using a systematic literature review of observational studies in English, we focused on Indian women who are evaluated for determinants of inherited mental health problems. PubMed, Google Search, Research Gate, Scopus, Medknow/MedLine and various Journal related to mental health during pregnancy were independently searched to identify articles published during 2000–2019.

Results: More than Eighty-Five studies met the inclusion criteria and the results showed a significant relationship between mental health risk and variables among deprivations such as social mental support inside and outside, early marital status, domestic violence, Domestic workload, Frequent unwanted pregnancy, and socio-economic status. The lack of high-quality research evidence has limited appropriate evidence-based planning and production results that are considered necessary to address innate mental health issues for Indian women.

Conclusions: Our results showed that socioeconomic status, Psycho-social support and Frequent and unplanned pregnancy are the most important risk factors for disturbing mental health among Indian women.

Keywords: Depression, risk factors, social support, mental health etc.

Introduction

Pregnancy is a unique maternal experience with significant psychological, physiological and biochemical effects on women. Pregnant women are vulnerable because of changes they experience in the stages of pregnancy that may affect their mental health stated by Alderdice et.al. (2013), Canals et. al. (2002) Antenatal and postnatal mental health (2014), Romans & Seema (2006). Mental illness in pregnant and postpartum women has become a public health concern which has gained attention in recent years. Several risk factors for developing maternal mental illness and various psycho-social stressors that influence its incidence and prevalence are identified in the literature, as well as the potential harmful impact of maternal mental illness on the mother, child and family unit. In recent years, mental illness in pregnant and postpartum women has become a public health concern. Worldwide about 10% of pregnant women and 13% of women who have just given birth experience a mental disorder, primarily depression. In developing countries this is even higher, i.e. 15.6% during pregnancy and 19.8% after child birth. In severe cases mothers’ suffering might be so severe that they may even commit suicide. In addition, the affected mothers cannot function properly. As a result, the children’s growth and development may be negatively affected as well. Maternal mental disorders are treatable. Effective interventions can be delivered even by well-trained non-specialist health providers.

Mental health problems, such as anxiety and depression, are twice as likely to affect women (Parikh, Lam, & CANMAT Depression Work Group, 2006). Depression is one of the greatest causes of worldwide maternal mental illness in women of childbearing age - approximately 15 to 44
years- and the “contribution to the Global Burden of Disease (GBD) is 7% of the total (GBD) for women of all ages” (World Health Organization, 2008).

An international call to action by the World Health Organization (WHO) entitled “No health without mental health” has emphasized the importance of mental health issues and the major burden these have on resource-constrained countries with a limited health care budget conceived by Prince M, Patel V, Saxena S, Maj M, Maselko J, Phillips MR et. al. (2007). Emotional wellbeing during pregnancy an expectant mother experiences several physiological changes during this period as her body tries to accommodate the baby. She may experience nausea and vomiting, weight gain, increase in heart rate, swelling of feet, a possible increase in the size of the kidney and liver, and stretching of the abdominal muscles. During this period, there are also drastic hormonal changes — more than at any other period of her life.

Postpartum depression (PPD) occurring within the first year after delivery, affects 10% to 25% of women globally (Brockington, 2004; Gold, 2002; Marcus, 2009; McCarthy & McMahon, 2008). Although PPD is most often associated with maternal mental illness, other indications of mental illness are important to consider. Prevalence rates for antepartum depression (during pregnancy) in different populations of women, range from 4 to 57% (Bennett, Einarson, Taddio, Koren, & Einsson, 2004; Bowen, Bowen, Butt, Rahman, & Muhajarine, 2012; Marcus, 2009). Further, depression and anxiety, during and after pregnancy, have been found to occur simultaneously (up to 33%) in mothers with mental illness (Austin et al., 2010; Britton, 2005).

Despite the launch of India’s national mental health programme in 1982, maternal mental health is still not a prominent component of the programme. Dedicated maternal mental health services are largely deficient in health-care facilities, and health workers lack mental health training. The availability of mental health specialists is limited or non-existent in peripheral health-care facilities (Baron EC, Hanlon C, Mall S, Honikman S, Breuer E, Kathree T, et al. 2016).

Hence, the importance of considering not only depressive symptoms, but also anxiety symptoms when pregnant and postpartum women seek help from their health care providers. Moreover, pre-existing mental illness increases the risk of developing maternal mental illness during and/or after pregnancy (Austin, Tully, & Parker, 2007; Bandelow et al., 2006; Gold, 2002). This review examines the factors contributing to antenatal mental health issues among Indian women.

**Method**

In this systematic review, all the existing published studies on the determinants for antenatal mental health problems among Indian women were collected following the Preferred Reporting Items for Systematic Reviews. Articles in English from 2000 to February, 2019 were retrieved from the Scientific Information Databases, Various Journal related to mental health, Pubmed, and Elsevier, and PubMed/Medline, Scopus (international databases). Relevant article and report references were found through electronic search and reviewed manually.

**Result**

There have been many systematic reviews about factors affecting mental health problems during pregnancy and afterward throughout the world, but the present study is the first systematic review that has been conducted for maternal mental illness and risk factor for Indian women. According to Young SA, Campbell N, Harper A. (2002) although depression is not gender specific, women experience major depression twice as often as men. This increased incidence occurs mainly during the reproductive years and is universal and unrelated to culture, race or class. Approximately 10% of pregnant women will experience clinically significant depressive symptoms during pregnancy. Previous research indicates that women with prolonged and/or undertreated maternal mental illness are: at an increased risk of complications during pregnancy; more likely to have adverse neonatal outcomes; less likely to breastfeed; may have problems with infant-mother attachment; at risk for chronicity and severity of maternal mental illness; and more likely to have problems with self care, sleep, and substance abuse (Bonari et al., 2004; Bowen et al., 2012; Da Costa et al., 2010; Marcus, 2009; Seto, Cornelius, Goldschmidt, Morimoto, & Day, 2005). In addition, there is an increased likelihood for children of anxious and depressed mothers to have psychopathology, developmental problems, difficulty with feeding and sleeping, and they may have more emotional and behavioural
problems than children of non-depressed mothers (Bellingham-Young & Adamson-Macedo, 2003; Marcus, 2009; Talge, Neal, & Glover, 2007). Hence, there is a growing need for ensuring optimal mental health for women during their reproductive years by providing adequate maternal mental health care to enhance the well-being of mothers and their families, which would further facilitate healthy child development (Muhajarine, 1999). In general, previous studies have also shown that antenatal mental problems were not always directly related to economic status in low- to moderate-income countries, but other risk factors such as cultural practices had reciprocal effects on each other and contributed to severe mental disorders. In 2010, another systematic review indicated that life stresses, history of depression, lack of social support, domestic violence, unintended pregnancy and poor communication were associated with antenatal depression. Fisher J, Cabral de Mello M, Patel V, Rahman A, Tran T, Holton S, Holmes W.(2012); Edwards GD, Shinfuku N, Gittelman M, Ghozali EW, Haniman F, Wibisono S, Rappe P. (2006); Patel V, Rodrigues M, De Souza N. Gender( 2002) ; Lancaster CA, Gold KJ, Flynn HA, Yoo H, Marcus SM, Davis MM. (2010).

Conflicting findings on unwanted pregnancy and mental health indicated that unintentional pregnancy by itself did not affect mental health, but women accepted it for some reason, but when poor socioeconomic status or social support and when pregnancy is combined with lack of acceptance, women exhibit mental problems, they are characterized by anxiety, fear, depression, irritability and lack of adjustment. Other research has emphasized the impact of socioeconomic status on mental health with unintended pregnancy; In contrast, emotional support of the husband during pregnancy is associated with better mental health. The more support from family and husband, the higher is the mental level. Likewise Prolonged or undertreated maternal mental illness has deleterious effects not only on the mother and baby, but also on the spouse placing undue strain on relationships and family functioning. For instance, depression ranged from 24% to 50% among men whose spouse had PPD (Goodman, 2004). Indeed, the lack of detection and treatment of maternal mental illness has devastating and long-lasting ramifications for the mother, the baby and the family unit, and the community-at-large.

We found that after reviewing, the economic burden during pregnancy affected mental health and that more educated and employed women received adequate health services for their mental health status, provided to working women by various countries. The same if seen in reality, more educated and employed women in low-income countries showed lower risk for mental health problems during pregnancy. Therefore, employment and financial independence increased women's participation in social activities and improved their mental health coping skills. But still in many districts of the country, basic facilities are not available during pregnancy, and due to not being educated, every pregnant woman may not necessarily have a husband, due to which their mental and physical health falls from day to day. Talking the same, the treatment of maternal mental illness of pregnant women is mainly based on a biomedical model that focuses on psycho-pharmaceutical interventions. According to Tufano (2000), the biomedical model concerns itself with: ... disease processes and pathologies associated with disorders or disease. The focus of biomedical models is to reduce symptoms and find a cure based on scientific evidence from research. But for that also it is very important to have the support of the family, because many times the family and the husband of the woman do not provide support and support for the treatment. These treatments are given in a medically prescribed manner and the physical components of diseases and disorders is designed to improve. The biomedical model provides an objective and structured way to deliver health care, an essential and effective mission. Therefore, in terms of its very definition and core, the biomedical model focuses on the physical entities of disability rather than on the psychological effects of disability (p. 113). Looking at the nature of this treatment, it can be said that if the family provides support, then this treatment can be successful.

Our review identified marital quality as the strongest antennas anxiety factor, and was directly associated with mental problems during pregnancy, clearly demonstrating a significant role of husbands and family in raising or raising anxiety during pregnancy. At the same time, the positivity of the family improves the mental health. A poor marital relationship was the most consistent variable in
predicting anxiety during pregnancy, the more positive the husband's behaviour is, the better the mental development of the pregnant woman, and emotional turmoil by recruiting the husband's support to reach a desired outcome. Marital discord, mistrust, decreased maternal attachment to the fetus and family unit: pregnant women experienced a high degree of anxiety and anxiety and expressed hatred and negativity toward pregnancy. Research indicates that pregnant and postpartum women with mental health problems often receive inadequate mental health care, and/or do not seek help due to: a lack of personal insight and awareness of symptoms; stigma and a fear of being judged; a lack of knowledge of PPD; denying and minimizing their symptoms; a lack of and/or limited access to mental health care services; and under-diagnosis by health care providers who may minimize or discount women’s symptoms of emotional distress (Dennis & Chung-Lee, 2006; Marcus, 2009; PintoFoltz & Logsdon, 2008).

In a report published by the World Health Organisation, 15.6% of pregnant women in developing countries experience a mental health disorder, depression being the most common. In India, it is estimated that one in five new mothers is estimated to have postpartum depression because of lack of support and poor economic status. India is experiencing a steady decline in maternal mortality, which means that the focus of care in the future will shift towards reducing maternal morbidity, including mental health disorders. Despite the growing number of empirical studies on postpartum depression in India, there is a lack of robust systematic evidence that looks not only at the overall burden of postpartum depression, but also its associated risk factors. In India, estimates of maternal depression among women accessing antenatal care range from 11.9 to 23%" - (Chandran et al., 2002, Patel et al., 2003).

Several risk factors point towards depression during pregnancy. Some of them are poor antenatal and postnatal care; poor nutrition; Stressful life events such as economic deprivation, gender-based violence (distinction between sons and daughters, a conservational thinking) and polygamy (wanting dowry), previous history of psychiatric disorders (hereditary), and complications of previous births; Events during pregnancy such as previous miscarriages; And previous delivery methods such as previous means or operative delivery. In addition to these, other factors include age, marital status, gravity, whether or not a pregnancy was planned, still prenatal history, previous history of prolonged labour, and level of social support Construed by Wissart J, Parshad O, Kulkarni S.(2005); Alder J, Fink N, Bitzer J, Hösl L, Holzgrewe W.(2007); Rich-Edwards JW, Kleinman K, Abrams A, Harlow BL, McLaughlin TJ, Joffe H, et al. (2006); Adewuya AO, Ola BA, Aloha OA, Dada AO, Fasoto OO.(2007); Pereira PK, Lovisi GM, Pilowsky DL, Lima LA, Legay LF.(2009); Lancaster CA, Gold KJ, Flynn HA, Yoo H, Marcus SM, Davis MM, et al. (2010); Benute GR, Nomura RM, Reis JS, Fraguas Junior R, Lucia MC, Zugaib M, et al. (2010); King NM, Chambers J, O'Donnell K, Jayaweera SR.(2010).Therefore, qualitative health researchers stigma To increase awareness, understanding, and sensitivity to the negative effects of (daughter-born) stigma has supported further exploration of women's subjective experience of stigma and that women's disclosure and treatment engagement (Koniak-Griffin et al., 2006 ). A feminist approach is appropriate for women's stigma and maternal mental illness experience in both theory and practice. For example, according to relational – cultural theory (Miller & Stiver, 1997), all disconnects in a growth – fostering relationship occur in specific socio-cultural contexts and are the source of psychological problems. Some feminist researchers have used feminist, social constructionist approaches when trying to better understand women's experience of maternal mental illness and the socio-cultural discourses of reproduction, motherhood, and motherhood (Arendell, 2000; Choi et al, 2005). ; Cosgrove, 2000; Mauthner, 1998). "This paradigm confirms an instrument for observing, and interacting critically, lexical processes, social contexts, and importantly, relationships," (Arendell, 2000, p. 12) when the stigma associated with maternal mental illness Exploring Women's Experience.

A recent meta-analysis showed that about 20 % of mothers in developing countries experience clinical depression after childbirth. This is much higher than the previous figures on prevalence coming mostly from high income countries. Suicide is an important cause of death among pregnant and post- partum women. Psychosis is much less common but may also lead to suicide and in some cases even harming the newborn. Depression causes enormous suffering and disability and reduced
response to child’s need. Evidence indicates that treating the depression of mothers leads to improved growth and development of the newborn and reduces the likelihood of diarrhoea and malnutrition among them. Postpartum depression can predispose to chronic or recurrent depression, which may affect the mother.

Postpartum depression have greater cognitive, behavioural and interpersonal problems compared with the children of non-depressed mothers. A meta-analysis in developing countries showed that the children of mothers with postpartum depression are at greater risk of being underweight and stunted. Moreover, mothers who are depressed are more likely not to breastfeed their babies and not seek health care appropriately. A longitudinal study in a low- and middle-income country documented that maternal postpartum depression is associated with adverse psychological outcomes in children up to 10 years later. While postpartum depression is a considerable health issue for many women, the disorder often remains undiagnosed and hence untreated.

Good social support protects against antenatal depression even after taking demographic variables into consideration. Psychosocial and emotional changes affect interpersonal relationships and play a role of stressors which contribute to depression. Da Costa D, Larouche J, Dritsa M, Brender W. (2000); Westdahl C, Milan S, Magriples U, Kershaw TS, Rising SS, Ickovics JR; Jesse DE, Walcott-McQuigg J, Mariella A, Swanson MS. (2005). A study has highlighted the important role of social support in reducing the negative impact of adverse events in life: they have shown that women who experience stressful life events but have good social support are less likely to suffer from emotional distress compared with women without an available support network (Glazier et al., 2004).

Major Risk Factors After Review Eighty Five Studies/Articles:
Depression and anxiety are the most common psychiatric disorders during pregnancy and the postpartum (Alipour et al., 2012) and the symptoms can range from mild to severe. However, we still do not know why some women are more “at risk” of developing depression or anxiety symptoms while others remain resilient even in the face of adversity. “Risk” is hazard, danger, exposure to mischance or peril. It implies that the probability of adverse consequences is increased by the presence of some characteristics or factor. Though all mothers and children are vulnerable to disease or disability, there are certain mothers and infants who are at increased or special risk of complications of pregnancy/labor or both. A risk factor is defined as any ascertainable characteristic or circumstance of a person (or group of such persons) known to be associated with an abnormal risk of developing, or being adversely affected by a morbid process” -(WHO, 2000). High risk pregnancy is defined as one which is complicated by factor or factors that adversely affects the pregnancy outcome –maternal or perinatal or both. Major risk factors are as follows:

- Postpartum depression refers to a major depressive disorder occurring after giving birth, which affects between 10 to 25% of women worldwide, within the first postpartum year (Brockington, 2004; Gold, 2002; Marcus, 2009; McCarthy & McMahon, 2008).
- Psychological distress, an emotional disturbance that affects day-to-day living and social functioning inside and outside home, is associated with symptoms of anxiety and depression (Drapeau, Marchand, & Beaulieu-Prevost, 2012; Payton, 2009).
- Antepartum depression, depression during pregnancy, impacts up to 20% of women in a primary health care setting, and 29.3% for socially high-risk (i.e., living in poverty) women (Bowen, Stewart, Baetz, & Muhajarine, 2009).
- Researchers have shown that for 50% of patients being seen in primary care settings for mental health issues, anxiety and depression occurred simultaneously (Matthey, Barnett, Howie, & Kavanagh, 2003).
- Several bio-psycho-social risk factors are associated with the development of maternal mental illness: personal or family history of affective disorders; prior history of PPD or postpartum psychosis; lack of social support; single marital status; lower socio-economic status; poor health functioning; unplanned pregnancy; relationships issues; stressful life events during or near the time of delivery; substance abuse; and a difficult pregnancy (Gold, 2002; Kalra & Einarson, 2006; Marcus, 2009).
Together with partner/social support and satisfaction in the marital relationship, other potential protective factors that have been identified in this review are active coping, high self-esteem and high self-efficacy (Edwards et al., 2008, Zeng et al., 2015). This is not surprising, since social support can help the woman to cope with negative emotions and stressors associated with pregnancy and to prepare positively for the birth and the postpartum period (Jeong et al., 2013).

Difficulty in Coping with Changes of Body Image - Pregnancy causes many changes in your body. Some of these changes can be difficult to deal with or very uncomfortable. Also, after giving birth, your body may take a while to get back to the way it was before, or it may never completely return to the way it looked before pregnancy. This is the major risk factor of negative emotions during that period.

Hyperemesis gravidarum (HG) is a pregnancy condition characterised by extreme levels of intractable nausea and vomiting, fatigue, distorted olfaction responses and hypersalivation. Symptoms can lead to dehydration, malnutrition, and secondary complications such as Wernicke's encephalopathy, oesophageal tears, hypocalcaemia and thyroid dysfunction (MacGibbon et al, 2015). A systematic review and meta-analysis in 2016 found a significantly higher rate of depression and anxiety in women with HG compared to controls (Mitchell-Jones et al, 2017).

Unplanned or Unwanted Pregnancy means An unintended pregnancy may be an unwanted pregnancy (did not want to be pregnant at all) or a mistimed pregnancy (pregnancy occurred earlier than wanted), and the term is used interchangeably with unplanned pregnancy. Pregnancy intent is an important determinant of both short- and long-term maternal and child health outcomes. Pregnancy intention may affect attitudes and behaviors in parenting and eventually have an impact on child development. Mosher WD, Jones J, Abma JC. (2012); Gipson JD, Koenig MA, Hindin MJ. (2008)

Depression during pregnancy one of the most prominent risk factor of maternal illness. Cohen et al.(2006) recently demonstrated that women who discontinued antidepressant medication during pregnancy relapsed significantly more frequently during their pregnancy than those who continued their medication. Maternal depression can itself adversely affect the developing fetus: a number of studies have suggested an association between maternal depression and factors that predict poor neonatal outcome. Nonacs R, Cohen LS.(2002).

The physical condition of the mother can also be a major risk factor. Poor attendance for antenatal care, together with poor personal care, diet and decreased weight gain have been associated with negative pregnancy outcomes.

Women who have prior history of depression, sudden drug discontinuation, family history, low social support system, IPV, pregnancy ambition, L&D complications, difficulty in breastfeeding, in the form of mental illness it is more likely to develop anxiety and depression.

Women having Common anxieties related Fear of childbirth, Fear of having a child with handicap or having something wrong with the baby, Worry about being a good parent.

Alcohol exposure, smoking, passive smoking and obesity were maternal risk factors during pregnancy.

Due to hormonal changes, women of child bearing age, particularly pregnant women, are at higher risk for depression. Prevalence of antenatal depression has been reported as high as 20%. (Deligiandis KM; Husain N, Cruickshank K, Husain M, Khan S, Tomenson B, Rahman A.(2012); Parry BL, Newton RP(2001); Bowen A, Muhajarine N.(2006).

The association between social support, psychological stress and pregnancy outcome is undoubtedly complex, when social support is less then psychological stress and pregnancy outcome become worst. It has been proposed that effective psychosocial resources, particularly social stability and social participation providing emotional and instrumental support, are protective by buffering the impact of life stress on emotional well-being of the mother (Glazier et al., 2004).
Studies have examined many socio-demographic and economic risk factors in relation to antenatal anxiety and depression, but the results are equivocal. Many studies have found a significant correlation between young age and depression/anxiety during pregnancy (Bodecs et al., 2013, Fellenzer and Cibula, 2014, Glazier et al., 2004, Hartley et al., 2011, Lee et al., 2007).

Moreover, women can themselves be reluctant to share symptoms of sadness and irritability owing to the stigma associated with depression and to the discrepancy between women's expectation of happiness during pregnancy (and the postpartum period) and their own experience (Marcus, 2009).

Depression and anxiety are highly comorbid during the antenatal period, and indeed high anxiety during pregnancy is one of the strongest risk factors for depression (). Women with feelings of anxiety are at increased risk of suffering from depression during pregnancy for example, a recent study has found that women who had experienced antenatal anxiety were about three times more likely to suffer from depression during pregnancy. (Mohamad Yusuff et al., 2015; Lancaster et al., 2010, Verreault et al., 2014).

Several mechanisms have been proposed to explain this higher vulnerability conferred by stressful experiences. In fact, being exposed to a traumatic event leads to clear psychobiological changes that alter the ability to adjust and cope with subsequent stressful events. In particular, childhood maltreatment is a predisposing factor in the persistent activation of the two main biological systems involved in the stress response, the hypothalamic–pituitary–adrenal (HPA) axis and the inflammatory system (Baumeister et al., 2014, Pariante and Lightman, 2008).

In reality all women can develop a mental disorder during or after pregnancy and in the first year after delivery because sometimes this happy state is also painful for them because of lack of family support, more than one child, pressure to birth a son etc. The main factors, but also poverty, migration, extreme stress, exposure to violence (domestic, sexual and gender-based), emergency and conflict situations, natural disasters, and low social support also typically increase risk for specific disorders.

Conclusion:

In this systematic review, psycho-social, environmental, obstetric and pregnancy-related risk factors for poor maternal mental health have been investigated. The adverse consequences of poor maternal mental health are far-reaching for both mothers and children. Mothers affected by common mental disorders may be less able to care for their own health or have reduced ability to mobilise social support during the perinatal period; in addition, studies have demonstrated that children born to depressed mothers are at increased risk of poor physical growth (Stewart, 2007, Surkan et al., 2011). South Asian studies have also shown that mothers with common mental disorders, in particular depression, are more likely to have infants who are of low birth weight, and become underweight and stunted in early childhood (Black et al., 2009, Gausia et al., 2009, Patel and Prince, 2006, Patel et al., 2004). Commonly identified predictors of maternal common mental disorders in South Asia include low socio-economic status, lack of social support, adverse life events, disappointment with the sex of the baby and a bad relationship with a mother-in-law or partner (Chandran et al., 2002). In India, estimates of maternal depression among women accessing antenatal care range from 11.9 to 23% (Chandran et al., 2002, Patel et al., 2003). Within adverse events in life, exposure to intrusive life events such as domestic violence or emotional, physical or sexual abuse, significantly affects a mother's mental health in the postpartum period. (Akcal et al., 2014, Ali et al., 2012)

Maternal anxiety, life stress, history of depression, lack of support, domestic violence, unintended pregnancy, low income, lower education, single status, and poor relationship with partner were associated with depressive symptoms during pregnancy in bivariate analyses. Life stress, lack of social support and domestic violence continued to be associated with antenatal depression also in multivariate analyses. Inconsistent results were found for smoking, alcohol and drug use, parity, ethnic
group and age, while no significant association was found with employment and obstetric history (Lancaster et al., 2010).

The results of this systemic review demonstrate that mental health in pregnancy is significantly affected by social issues, support systems, and communication within the family dynamic. These contributing factors can be modified from the social perspective through public education and policy changes to improve antenatal mental health. This systemic review lacks the social support that the family and society receives, the type of relationship with the husband (trusting, coexisting, insensitive), marital satisfaction and dissatisfaction, due to unintended pregnancy, stressful life events, and domestic violence, including mental A list of factors contributing to health problems was found. According to Indian published research, similar to the results in high-income countries, relationship quality with husband and marital satisfaction was associated with mental health issues: women whose husbands welcomed their pregnancy received more emotional support and mental better state of health was experienced. On the other side for the women whose husbands did not give any importance to their pregnancy, their mental health seems to have fallen more. The lack of high-quality research evidence has limited appropriate evidence-based planning and production results that are considered necessary to address innate mental health issues for Indian women.

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