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REVIEW

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The Important Role of Partner Support in Women's Mental Disorders During the Perinatal Period. A Literature Review

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ABSTRACT

The arrival of a newborn is often a happy event in a woman's life. However, many women experience perinatal distress such as anxiety disorders and depression during pregnancy or postpartum period. Although the positive interpersonal relationships of women with their wider environment seem to be a support network, research shows that support provided by partners is a very important protective factor in reducing mental health disorders in both prenatal and postnatal period in a woman's life. for this reason, more research needs to be done in the field of perinatal distress in order to clarify the causes that lead to mental disorders and to strengthen the partner's role in the management of perinatal mental disorders of women.

Keywords: perinatal mental health, perinatal distress, perinatal mental disorders, perinatal anxiety, perinatal depression, perinatal PTSD, perinatal OCD, postpartum psychosis, support from spouse.

BACKGROUND

Preventing perinatal mental health problems is crucial due to the unpropitious effects on women and their family. Support from the partner is considered to be the ideal way, as it is a factor in preventing and treating the mother's mental disorders (1). Perinatal mental disorders include anxiety, depression (2), posttraumatic stress disorder (3), obsessive compulsive disorder (OCD) (4) and psychosis (5) (Table 1).

The *prenatal period* is defined as the period from the start of the pregnancy to the onset of labour, while the *postnatal period* includes the period of six weeks after delivery (6, 7). The *perinatal period* is defined as pregnancy and the first year postpartum and it represents a time in women's lives that involves significant physiological and psychosocial change and adjustment (8). The perinatal mental health period, encompasses the mental health problems which occur either during pregnancy or in the first year following the birth of a child (9).

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Data related to perinatal mental disorders showed a high prevalence during the postpartum period, while 19.8% of women have postnatal mental health disorders compared to 15.6% of women who have the same disorders prenatally (10), indicating that the postpartum period is slightly more sensitive to the development of mental disorders. Since the perinatal period is a very sensitive period for the development of perinatal disorders, social support, and especially support from the partner, is critical in the adverse effects of the perinatal illness (11).

So, the purpose of the present study was to investigate the support from the partner and its impact on maternal perinatal mental disorders. In order to achieve this goal, an international literature searching in Google Scholar, PubMed, Crossref and PsycINFO was carried out. We selected all studies that included the following variables: *partner support or partner lack of support and perinatal outcomes on women mental health*. Languages other than English as well as articles published before 2009 were excluded from the present literature review.

Anxiety and depression are attributed to some extent to the hormonal changes of this period – they are the most commonly observed symptoms in the perinatal period and often extend from the beginning of pregnancy up to two years later in some cases (17). In addition, perinatal depressive and anxiety symptoms may have negative effects on infant and child health as they are associated with premature birth, perinatal complications and cesarean sections (18). More specifically, the prevalence of perinatal anxiety during pregnancy varies between 8.5% and 10.5% and it is higher than in general population (between 1.2% and 10.5%). The disorder appears to evident in women who have a family history of anxiety or other mood disorders (19).

Perinatal mental disorders	Symptoms
Perinatal anxiety (12)	• Feeling nervous, restless or tense • Having a sense of impending danger, panic or doom • Having an increased heart rate • Sweating, hyperventilation • Trouble concentrating • Anxiety about the outcome of pregnancy • Fear of childbirth
Perinatal depression (13)	• Feelings of guilt, hopelessness, or helplessness • Persistent sad, anxious, or "empty" mood • Thoughts of harming herself or the baby • Irritability, loss of interest • Abnormal appetite, weight changes, or both • Trouble bonding with the neonate • Difficulty concentrating, remembering, or making decisions • Suicide ideation
OCD (14)	• Obsessive thoughts of hurting the baby such as dropping or throwing • Concerns about accidentally causing the baby harm through carelessness • Compulsive behaviour • Anxiety or distress emotions
PTSD (15)	• Symptoms of re-experiencing the traumatic birth • Symptoms of avoiding strains reminiscent of traumatic childbirth • Negative cognitions and mood • Hyperarousal
Psychosis (16)	• Hallucinations • Delusions • A manic mood • Depressive symptoms • Sometimes a mixture of both a manic mood and a low mood • Feeling suspicious or fearful • Feeling very confused • Behaving in a way that is out of character

TABLE 1. Perinatal mental disorders and their symptoms

Perinatal anxiety can appear with different conditions such as generalized anxiety. Pregnancy related concerns in the first trimester of primiparous women can make the diagnosis of prenatal anxiety very difficult (20). Another complex diagnostic problem is the comorbidity between anxiety and depression, with many symptoms being similar in anxiety and depression (21). However, perinatal anxiety is more common in the postpartum period than in pregnancy, with a frequency ranging from 6.1% to 27.9% in the postpartum period (22). This high prevalence is due to the emotional deregulation from the function of the hypothalamic–pituitary–adrenal axis and can be mitigated by recent contact with infants (23). On the other hand, perinatal depression is depression that occurs during or after pregnancy. Symptoms vary from rare to severe but can be treated effectively. Perinatal depression is caused by a combination of environmental and genetic factors (13). In addition to personal and family history of depression, some other factors, including maternal anxiety, poor relationship quality, pregnancy complications and history of physical and sexual abuse, can contribute to perinatal depression (24). The prevalence of prenatal depression has averaged 10–25% (25). Postnatal depression most commonly occurs within six weeks after birth and affects about 6.5% to 20% of postpartum women. It occurs more commonly among mothers with premature infants and in adolescents (26).

Obsessive compulsive disorder affects 2% of pregnant women and 2-3% of postpartum women (within the first year) (27). Assessing a pregnant or postpartum woman involves a careful consideration of risks and an attentive communication and the purpose of therapy is to teach women to tolerate their symptoms and to develop the mother-infant bond (28).

Some women can develop posttraumatic stress disorder (PTSD) during pregnancy. Women who re-experienced a past trauma or those who suffered from a new trauma during pregnancy may experience posttraumatic stress that can worsen in the postpartum period (29). The mean prevalence of prenatal PTSD is 3.3% (30). Various conditions seem to affect the development of PTSD in the perinatal period, including pregnancy complications, complications during childbirth, emergency cesarean section, atomic history of psychiatric disorders, fear of childbirth, and previous traumatic life events (31-33). A traumatic birth experience that evolves into PTSD can overshadow the mother-infant relationship, the relationship with the partner and the desire for another pregnancy in the future (34). The prevalence of postpartum PTSD varies between 4.6 to 16.8%, and, in some cases involving emergency surgeries, it may reach up to 30% (35).

Finally, postpartum psychosis is a very serious perinatal mental disorder that can affect women soon after delivery. It affects around 1 in 500 postpartum mothers (16). Women with a family or personal history of bipolar disorder run a higher risk of recurrence in this period. Also, the risk is higher if a pregnant woman with a bipolar disorder discontinued her medication (36). Other risk factors for postpartum psychosis include the extremes of reproductive age, primiparity cesarean section (37), poor socioeconomic status and postpartum maternal and neonatal complications (38).

Intimate partner violence (45)	Physical or sexual violence and/or financial, emotional/psychological, cultural, spiritual, and reproductive abuse as well as other forms of controlling behavior
Infidelity (46)	Infidelity is essentially disloyalty or unfaithfulness to a sexual partner in what was supposed to be a sexually exclusive relationship.
Partner tension (47)	Marital tension includes negative emotions such as feelings of tension, resentment and irritability about the relationship. These feelings come as a result of frustration, disagreement and conflict in the relationship. It is a broader construct than conflict, defined as open arguments. The tension can be expressed by screams or a continuous calm disagreement.
Dissatisfaction from the relationship (48-50)	Includes intimate partner violence, partner tension, infidelity, low educational levels, financial difficulties, psychiatric history and low partner support in unplanned pregnancies.

TABLE 2. Low partner support

1. Support from the partner

By the term "partner support" we mean all supportive mental and behavioral actions that a partner offers to the problems faced by the partner in a relationship (39). The fact that the support from a partner is considered the most important source of help during the perinatal period is not arbitrary. So far, many studies support the role of social support in the prevention and treatment of women's mental health problems during the perinatal period (40), but the mother's relationship with her partner is considered a more stronger protective factor than social support (41-43). It has been shown that intimacy resulting from a balanced relationship can promote mental and physical health. Thus, even in the case of women suffering from a mental illness, the support of a partner can minimize these symptoms (44). Severe perinatal mental health issues were a more frequent sign in women with low partner support. More specifically, intimate partner violence, partner infidelity or partner tension are factors of woman's dissatisfaction with their relationship (Table 2).

1.1. Intimate violence during the perinatal period

Domestic violence is a physical, sexual or emotional abuse by an intimate partner (51). However, it has been shown that the high prevalence of perinatal depression (52), anxiety and PTSD is associated with intimate partner violence experiences (53). Some studies have reported that women who had experienced prenatal stress were more likely to have experienced violence from their partner compared to those without anxiety symptoms (54). Also, in a study conducted in Bangladesh, 7 in 10 pregnant women reported being the victim of at least a single act of physical violence from the partner, while the prevalence of antenatal anxiety and antenatal depression was 29.4% and 18.3%, respectively (50). It is a fact that intimate partner violence is a risk factor for postpartum mental health problems. In a study published in 2014 (55), almost two thirds of postpartum women who showed serious mental health issues reported intimate partner violence during pregnancy. In addition, a systematic review of Paulson, published in 2020, reported that the intimate partner violence was largely associated with perinatal depression and PTSD. Outcomes were more severe for women when the intimate partner violence occurred during the perinatal period (56). Regarding the causes associated with perinatal partner violence, several issues might be responsible for such incidences, including suspicion about the newborn or preference for a male sex of the child, alcohol consumptions, partner infidelity, lower educational level and financial difficulties (57).

1.2. Partner infidelity

Another indicator of the quality stability is the absence of infidelity. Few studies have been conducted on the effect of partner infidelity on maternal depressive symptoms during the perinatal period. One qualitative study published in 2014 (58) highlighted that partner rejection and infidelity were possible causes of maternal perinatal mental disorders, while a study of Fisher *et al* from 2012 (10) had reported that polygamous relationships resulted in more symptoms of perinatal mental disorders in mothers. In addition, jealousy was considered as a major factor of abusive relationships and may be a consequence of partner's infidelity. Similarly, partner infidelity can also lead to intimate partner violence (57).

1.3. Partner tension

Partner tension is considered as a predictor factor of anxiety and depression in women during the perinatal period and poor quality of a relationship, according to the study of Bayrampour *et al* (2015) (59). In the research of postpartum depression and the relationship with a partner, all fathers reported some communication problems and an increase of their tension. Tension sometimes came from differing communication styles, while the role transitions during the perinatal period contributed to the deterioration of the problem (60).

2. Other factors that contribute to dissatisfaction from the relationship

Various studies have correlated the couple's socioeconomic status and symptoms of maternal depression, anxiety and PTSD during the perinatal period (3, 10, 61-63). However, other studies did not find any correlation between the above variables (64, 65). In fact, the balance in a relationship can be upset due to financial difficulties (49), while other factors, including low educational level (49, 66), history of mental health

problems (50, 59), younger age (67) as well as unwanted pregnancies (68), can be contributors to perinatal mental health problems (69). When the partner is not supportive during the perinatal period, the above factors increase the chances of women being dissatisfied with their relationship. ❑

DISCUSSION/ CONCLUSIONS

The aim of this study was to investigate the support from the partner and its impact on maternal perinatal mental health outcomes. As seen above, the relationship with the partner is catalytic in the development and consolidation of perinatal mental disorders. Therefore, a non-supportive partner will not be able to offer support neither to the mother during the prenatal period nor to himself during the postpartum period (70). Severe perinatal mental health problems were a more common sign or may more easily recur in women with low partner support. More specifically, partners of women with postpartum psychosis should be hypervigilance for signs of relapse or positive changes in a woman's attitudes and behavior (71). On the other hand, postpartum PTSD is related to low couple relationship satisfaction, even when controlling for a considerable number of background factors (72). In terms of support for postpartum depression, a significant reduction in symptoms has been observed in women who received support from their partner, in contrast to those who did not have support and experienced a worsening of their depressive symptoms (73). However, a cross-sectional study published by Nasreen in 2011 (50) showed that 18% of women had depressive symptoms and 29% anxiety symptoms during pregnancy, which were associated with low partner support, including intimate partner violence, in combination with other factors such as the interaction between poor household economy and poor partner relationship.

Of course, intimate partner violence, partner infidelity and partner tension are major factors of relationship dissatisfaction. In addition to the above problems in a relationship, the role of other factors, such as financial difficulties, low educational levels, psychiatric history, younger age and unplanned or unwanted pregnancies can be a link between all causes of dissatisfaction with the partner. However, the high quality of perinatal support from the partner can contribute to the improvement of mothers' health but also of the newborn's and, consequently, the child's health (11). Finally, the World Health Organization (74) has recommended that health policies on maternal mental health problems should emphasize the importance of early screening for perinatal mental health problems, perinatal care and implications for training.

Instructions to perinatal care professionals

We believe that the current study will help develop a more thorough understanding of the impact that the support or non-support from a partner can have on women. For this reason, early detection of couples' relationship problems during the perinatal period and the provision of professional help, particularly in high-risk couples, may not only improve the quality of the couple's relationship but also favour positive perinatal experiences, positive perinatal mental health outcomes, development of strong bond mother-child and therefore, positive effects on infant and child health.

Finally, it is imperative to establish health policies on mental health, especially perinatal mental health, which should focus on the importance of early diagnosis of perinatal mental disorders, good midwifery practices and perinatal training. ❑

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