





Sexual Aspects of Mental Health Disturbances in Pregnancy and Young Parenthood

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17.1 Introduction

Some women with psychiatric diseases would like to have children. Pregnancy and childbirth can aggravate mental health disorders and induce them, while there is little evidence that this period is protective against mental health disorders. Psychiatric disorders usually also have an impact on sexuality and the partner relationship. In addition, the medication used to treat these disorders might have sexual side effects. This chapter will address the various mental health disorders in the period of pregnancy and postpartum and their sexual consequences. It will provide guidelines for diagnosing sexual disorders and for treatment interventions. Cases will illustrate the text.

17.2 Psychiatric Disorders During and After Pregnancy

Psychiatric disorders are among the common morbidities during and after pregnancy. They can have adverse effects on the mother, her child, and the family and influence sexuality and partner relationships. Research in childbirth-related mental disorders mainly focused on postpartum depression. However, it becomes increasingly clear that other psychiatric disorders are also prevalent and relevant in this period. This chapter will review the available evidence on symptoms, epidemiology,

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and treatment options for psychosis, depression, anxiety disorders, and post-traumatic stress disorder (PTSD), as well as the common consequences for sexuality and sexual relationship.

17.2.1 Psychosis

Among peripartum psychiatric disorders, postpartum or puerperal psychosis is the most severe condition. The prevalence of postpartum psychosis is 1–2 in 1000 deliveries, with an increased risk for women with a history of bipolar disorder or a previous postpartum psychosis. Postpartum psychosis nearly always requires admission to a psychiatric ward, as it is associated with an increased risk of suicide and infanticide. Postpartum psychosis usually develops within 2 weeks after birth, with rapidly growing symptoms such as insomnia, irritability, and mood fluctuation, with mania, depression, or a combination of those two ('mixed state'). Core features of psychosis are delusions and hallucinations, often related to the theme of child-birth. Women might also have delirium-like symptoms, such as disorientation, confusion, derealisation, and depersonalisation. As part of a manic episode, women might have increased sexual desire and loss of sexual decorum [1].

Postpartum psychosis is primarily treated with medication. The sequential administration of benzodiazepines, antipsychotics, lithium, and electroconvulsive therapy (ECT) leads to almost 100% recovery [2]. Women with a history of bipolar disorder or a previous postpartum psychosis are treated with prophylactic medication immediately after birth to minimise the risk of relapse [3].

17.2.2 Depression

Depressive disorders are common during and after pregnancy, with a prevalence rate of approximately 10% of women, making it the most common peripartum complication [4]. Whether the incidence of depression is higher after birth is still not clear. Poor identification and diagnosis of depression during pregnancy could lead to many women being misclassified with postpartum onset [5].

A low mood, irritability, or sudden mood changes affect around 50% of the women in the first 2 weeks after birth (so-called baby blues). These symptoms are usually mild and transient and probably related to physiological changes, including abrupt changes in reproductive hormones after birth. When depressive symptoms persist after 2 weeks postpartum, one should be aware of a depressive disorder. The use of a validated screening instrument like the worldwide most used Edinburgh Postnatal Depression Scale (EPDS) is helpful in the detection of peripartum depression [6]. The symptoms of peripartum depression resemble depressive symptoms outside the peripartum. They include at least a depressed mood and loss of interest and pleasure. Other symptoms are weight changes, loss of energy, feelings of worthlessness and guilt, diminished concentration, and recurrent thoughts of death. There is significant overlap in sexual aspects of depression since reduced interest or

pleasure in almost all activities, including sex and loss of sexual desire, is highly prevalent in depression.

Since pharmacological treatment in peripartum depression can affect foetal and infant health, it needs careful evaluation. Therefore, as a general principle, non-pharmacological interventions are the first choice. Most evidence exists for interpersonal and cognitive behavioural therapy. The efficacy of other types of non-pharmacological interventions such as massage, acupuncture, bright light, and omega-3 oils reported inconsistent results [7, 8]. If non-pharmacological treatments are not available or the severity of the depression asks for immediate action, for example, because of suicidal thoughts or actions, antidepressants are indicated.

17.2.3 Anxiety

Anxiety disorders in the peripartum period are more often overlooked and less studied than depression. Nevertheless, they are common, with self-report prevalence rates varying from 18% to 25% during pregnancy and 15% after postpartum. The overall prevalence of a clinical diagnosis of any anxiety disorder is around 15% during pregnancy and 10% after pregnancy [9]. A meta-analysis reported a significantly higher risk of obsessive-compulsive disorder in pregnant women (2,1%) and postpartum women (2,4%) than in non-pregnant women in the general population (1,1%) [10].

Tocophobia is a severe fear of pregnancy and childbirth. There is no exact definition as it is not considered a separate psychiatric diagnosis. However, the overall prevalence is estimated at 14% of pregnant women [11].

Vaginismus, the fear of being penetrated often combined with the fear of giving birth, is another anxiety that interferes with conception or pregnancy. These fears can cause avoidance of becoming pregnant, severe anxiety during pregnancy, and avoidance of natural birth by asking for a caesarean section. These women might also avoid gynaecological or midwife consultations or continue requesting consultations to feel reassured. Biofeedback, hypnosis, Internet-based cognitive behavioural therapy, and antenatal education are promising treatments for fear of childbirth [12].

Cognitive behavioural therapy is the treatment of preference for other anxiety disorders, including obsessive-compulsive disorder. When resources are limited, and the anxiety is disabling, antidepressant medication is a practical option [1].

17.2.4 Post-Traumatic Stress Disorder (PTSD)

PTSD in the peripartum period can result from sexual abuse, abuse in general, or other traumatic experiences before or during pregnancy or childbirth. The prevalence of PTSD during pregnancy is 3.3%, and postpartum PTSD related to birth has a mean prevalence of 4.0% [13]. Typical symptoms of PTSD are intrusions (such as flashbacks and nightmares), hyperarousal, avoidance, and feelings of guilt and

shame. Peripartum PTSD is highly comorbid with depression. HCPs easily miss this diagnosis since, in PTSD, women tend to avoid sharing their traumas due to the disorder. Therefore, it is essential to actively ask about traumatic experiences before, during, or after pregnancy.

Although the efficacy of treatment of PTSD in the peripartum period is scarce, evidence-based trauma-focused psychotherapies for PTSD outside the peripartum period also seem to be effective and safe during pregnancy and after childbirth [14, 15]. The first-choice trauma-focused therapies are trauma-focused cognitive behavioural therapy (TF-CBT) and eye movement desensitisation and reprocessing (EMDR) therapy. Such TF-CBT typically includes 8–12 sessions with a psychotherapist. It includes psychoeducation about reactions to trauma, strategies for managing arousal flashbacks and safety planning; elaboration and processing of the trauma memories and trauma-related emotions (i.e. shame, guilt, loss, and anger); restructuring trauma-related meanings and helps to overcome avoidance; re-establishing adaptive functioning (i.e. example work and social relationships) [16]. EMDR is a highly protocolled therapy in which traumatic memories are recalled while the person simultaneously focuses on an external stimulus (i.e. therapist-directed lateral eye movements or taps and tones) until the memories are no longer distressing (www.emdr.com).

17.3 Psychiatric Disorders, Partner Relationship, and Sexual Function

When, during or after pregnancy, the woman has a psychiatric disorder, the risk increases that the partner will suffer the same fate. It is less studied, but men can also have or develop a psychiatric disorder during or after pregnancy. From pregnancy until 1 year after childbirth, 8% of men suffer from depression [17]. For ‘any’ anxiety disorder, this ranges between 4.1% and 16.0% during pregnancy and 2.4–18.0% after childbirth [18].

Psychiatric disorders are known to impact sexual function in women and men [19]. This is true for all psychiatric disorders, with depression and anxiety disorders probably as the most known. A prospective study among pregnant women with depressive/anxiety symptoms showed that more than 20% of these women perceived a decline in sexual life [20].

In depression, lack of sexual desire is common. In anxiety disorders, avoiding sex because of fear of having a panic attack (panic disorder), fear of being judged by the sexual partner (social phobia), or PTSD symptoms are common.

In some cases, like borderline personality disorders, sexuality can be an important way to establish and maintain a sense of security and attachment, applying pressure on the partner to reciprocate these sexual desires.

In conclusion, when one of the partners has a psychiatric disorder or sexual dysfunction, the partner will suffer also. Relevant factors are the change in partner roles, and the distress and concerns, with a major impact on both partners and the relationship. Relationship problems and sexual problems influence each other. Male

partners of women with sexual dysfunction have a threefold risk of developing sexual dysfunction [21]. Especially when communication between the partners is problematic or stuck in a pattern of blaming, the (sexual) relationship will be under a lot of pressure.

17.4 Sexual Side Effects of Psychiatric Medication

Sexual dysfunction is a common problem in psychiatry and can be related to the psychiatric disorder itself or be a side effect of the prescribed medication. The incidence of sexual side effects can be up to 70–100%, with several drugs reporting a 50–70% incidence [19]. Almost all psychotropic drugs influence overall sexual function and all three phases of the sexual response cycle (i.e. desire, arousal, orgasm/ejaculation). However, there are some distinctions to be made. Antidepressants most of all influence the ability to orgasm or ejaculate. Antipsychotics influence sexual desire more than other functions. Especially, the older generation of antipsychotics can negatively influence fertility. Anxiolytics and mood stabilisers influence all sexual response phases equally. Experiencing sexual side effects can be very distressing and even interfere with treatment compliance. Patients with depression mention decreased desire and orgasmic dysfunction as the most common reasons to stop taking their medication [19].

Depending on the cause of the sexual dysfunction, there are several possible interventions [19]. However, determining the most likely cause of sexual dysfunction can be difficult. As sexuality is a biopsychosocial phenomenon, many factors might influence and interact with each other. The best way to determine if the medication causes the sexual dysfunction is to establish a thorough timeline concerning the development of the psychiatric disorder, the development of the sexual dysfunction, the start of pharmacological treatment, and other potentially influencing factors, like, for example, changes in the partner relationship or general health.

Usually, sexual dysfunctions caused by medication tend to develop very soon after starting and subside very soon after stopping the medication. In general, the influence of physical disease on sexual function usually develops slowly over time, whereas a fast decline usually is a sign of a ‘sudden’ physical change (e.g. medication, surgery) or a psychological change (e.g. psychiatric disorder, relationship issues).

17.5 Diagnosis and Treatment of Sexual Dysfunctions Related to Peripartum Psychiatric Disorders

One needs a thorough evaluation before being able to treat a sexual problem properly [22].

Here are the most relevant questions in diagnosing sexual problems or dysfunctions: when did it start (lifelong or secondary), in what situations is it present (situational or generalised), and in what phase of the sexual response cycle can we put it

(desire, arousal, orgasm, recovery). The answers give much information on what causes the problem and how to deal with it. Besides this, it is also essential to ask about sexual repertoire, sexual behaviour, and sexual stimulation. Limited stimulation or repertoire is often a significant and common cause of sexual dysfunction. It is a professional error not to ask this since it can completely change the choice of intervention. How to diagnose sexual dysfunction will be described in Chap. 29.

The main sexual dysfunctions during pregnancy and postpartum are a lack of sexual desire and dyspareunia [23]. For professionals not trained in sexology, the PLISSIT model (with Permission; Limited Information; Specific Suggestions; and Intensive Therapy) is a useful stepped care model for Treatment [24]. This model (explained in Chap. 3) is helpful in the general population and the psychiatric population of peripartum and young parenthood.

Advising or treating sexual dysfunction in a psychiatric population during the peripartum and young parenthood period is not very different from advising or therapy in other people. Of course, one has to investigate what caused the sexual dysfunction and adjust one's psychoeducation to contain information about the effect of psychiatric illness or medication. Besides this, a lot of interventions could be pretty similar. For midwives, advice and treatment should stay within their own expertise and within the PLISS of the PLISSIT model. We will demonstrate this with some cases with the PLISSIT elements (P, LI, SS, & IT) indicated in brackets.

17.6 Cases

Case 1 Amy

Amy (31, nurse) has had multiple traumatic sexual experiences in her teens and adult years. She has difficulty trusting other people, and she got treatment for PTSD. Amy has also had very exciting sexual experiences, but always with 'bad boys'. By now, she has a loving husband, John (39, account manager), and a very committed relationship, but she doesn't feel like having sex with him.

Because of John's low sperm count, Amy has become pregnant through IVF. During the gynaecological exams, the retrieval of oocytes, and the embryo implantation, Amy was very anxious. Because of her strong wish to become pregnant, she struggled through it all, though she had preferred to have everything done under anaesthesia. She doesn't dare to think about giving birth and avoids discussing the topic.

Amy consults her midwife, who starts with psychoeducation (LI) about the effect of the traumatic experiences on her fears and her pelvic floor. Amy needs to know that it is normal to have these fears since they can remind her of being 'out of control'. Amy finds this very useful, but her fears are still there. She expresses the need for more security during gynaecological examinations and childbirth. The midwife then switches to inquiring about what things are essential for Amy to feel safe during the gynaecological examinations and birth. She marks this information in Amy's file for the professionals who will be on duty during Amy's childbirth. Besides, Amy is allowed the opportunity to bring someone she completely trusts for

emotional support during the examinations and the birth (SS). Amy also gets information about plan B, in case this will not be sufficient. An experienced gynaecologist or sexologist will 'practice' the gynaecological examination with her, during which Amy receives information on how to handle her fears (IT). With this knowledge, Amy starts feeling more in control, and she is less scared. Her birth goes without any additional psychotrauma.

Case 2 Julie

Julie (28, teacher at a primary school) is married to Thomas (30, manager at a big supermarket). Three months ago, their first baby was born. Julie is not very self-assertive and has trouble expressing her wishes. On the other hand, Thomas is a very assertive man, controlling many aspects of their relationship. However, their sexual relationship is not thriving, with a low frequency of sexual contact.

Sexual desire appears to be the only aspect under Julie's control. Since the baby is born, Julie feels down. She is becoming increasingly inactive and unresponsive to the baby. Thomas is very concerned and has contacted their family physician, who diagnosed Julie with depression.

Julie contacts the midwife who supervised her pregnancy and tells her about the depression. The midwife gives Julie some psychoeducation (LI) about possible causes of feeling down when being a young mother and all the changes in her life and the attached new responsibilities. She adds that the depressed feelings could also be related to changing hormones or her low self-assertiveness. Julie realises that with a newborn baby having any control in her life is difficult, combined with the relationship pattern she is in, both influencing her mood and her sexual desire.

To improve her mood, Julie then gets instructions (SS) to establish a daily routine as far as possible. In addition, Julie tries to enjoy some activities without the baby (or at least not as a mother) and share her feelings with people she trusts. Unfortunately, this is not effective enough, after which her family physician refers Julie to a psychologist for cognitive behavioural therapy (IT) combined with medication. There, she also gets sensate focus exercises to improve her sexuality. That turns out to be a good way to re-establish intimate physical contact with Thomas. Julie then starts daring to be more self-assertive and discovering what she herself wants and likes.

Case 3 Fatima

Fatima (25, who finished her master's in psychology at the beginning of her first pregnancy) developed a postpartum psychosis. Her psychiatrist prescribed antipsychotic medication. Soon after starting the medication, Fatima noticed that her sexual desire had 'disappeared'. Sexuality had always been vital for her and her husband Arthur, a 28-year old engineer.

Of course, the pregnancy and giving birth had changed their sexuality, but Fatima still wanted to be close, intimate, and even sexual with Arthur. After starting the medication, she does not feel anything sexual anymore. For Fatima, this is an extraordinary and undesired situation.

The psychiatrist starts with psychoeducation (LI) about the effect of antipsychotic medication on sexual function in general. That already turns out to be a real relief for both Fatima and Arthur. Now they understand that those changes have nothing to do with their relationship. They learn that Fatima should not wait until feeling desire (because it will not come as spontaneous as it used to), but that they have to just start with physical contact and intimacy to ‘awaken’ sexual desire as a reaction to pleasurable touch and experiences (SS). Experiencing this indeed works makes them very happy. They also change their sexual routine and apply more direct stimulation to Fatima’s clitoris (sometimes even with a vibrator), which improves the physical part of her sexual response. Altogether the results are so positive that there is no more need for the eventual next step of changing Fatima’s medication (IT).

17.7 Conclusions and Clinical Recommendations for Midwives

Pregnancy, the postpartum period, psychiatric disorders, and sexual function are interrelated. As we demonstrated, addressing sexuality is important. In this chapter, we have described some topics and guidelines. We conclude with some clinical recommendations.

- It is essential to involve the partner from the start of treatment. As mentioned, a psychiatric or sexual disorder will also influence the partner. The partner could be the one with the disorder. So, actively ask for both partners’ distress, traumatic experiences, or psychiatric symptoms. Additionally, discuss sexuality and its importance for both partners. Since sexual fears or fears of giving birth are common, assess if these are present.
- When confronted with a woman or a couple with a psychiatric disorder and sexual dysfunction, it is essential to address sexuality early. Ask about the effects on the partner relationship, sexual function, and well-being of both partners. Start with educating the couple about common psychiatric symptoms and disorders in the peripartum and young parenthood period. If they are already using medication, inform the couple about possible sexual side effects of medicines and the impact of the psychiatric disorder on sexual function. Check if this affects treatment compliance.
- Interventions and advice for improving sexual function can often be similar to those in other populations. They can be related to medication, mental health, sexuality, or lifestyle. The PLISSIT model is very beneficial for this purpose. For general advice, see Chaps. 3 and 29. Specific advice or interventions for the population in this chapter is related to counselling on sexual side effects of psychiatric problems and psychiatric medication. Advise the couple to discuss this with the prescribing healthcare professional to decide on a strategy to reduce

these side effects (e.g. wait for spontaneous remission, lower the dose, change the medication, change the timing of the medication, or add a drug to counter the side effects).

- Finally, we should not forget that psychiatric disorders can interfere with the postpartum bonding with the child. Be aware of signs of disturbed bonding to the child in both parents. If this is the case, discuss this with the couple and refer them to a healthcare professional, like a psychologist or psychiatrist, with experience in infant mental health.

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