Maternal Mental Health

Maternity Consumer Network supports and promotes the ideas presented in the Indicative Trauma Impact Manual (IITM) written by United Kingdom psychologist Dr Jessica Taylor and promoted through her company Victim Focus.

We support a trauma-informed view of maternal mental health that does not involve pathologizing and positioning pregnant women and mothers as disordered and/or mentally ill.

We believe that 'mental health' problems that many women face during and after pregnancy are not "mental illnesses", but are instead normal reactions to trauma, environmental, and social factors in a woman's life during this time.

We therefore oppose the modern obstetric view that post-partum mental health problems, including post-partum depression and anxiety, are a result of hormone changes due to pregnancy and birth. This view positions women's bodies as deficient and broken, and is a misogynistic idea that comes from the days where women were diagnosed with 'hysteria' by abusive and perverse physicians like Sigmund Freud.

We believe that for the vast majority of women, hormones function perfectly for their bodies. They support pregnancy, trigger labour at the optimal time in the baby's development, enable bonding with the baby, and enable breastfeeding.

'Mental health' problems experienced during pregnancy or after birth can be instead caused by:

- A lack of physical/social/emotional support in pregnancy and post-partum
- Experiencing domestic violence, which is perpetrated more often against pregnant women
- Nutrient deficiencies that interfere with hormone physiology
- Experiencing abuse, mistreatment, disrespect and obstetric violence during pregnancy, birth, and post-partum
- Poor lactation support/judgement for infant feeding choices
- Sleep deprivation due to care requirements for a newborn baby without adequate societal support
- Experiencing a miscarriage/stillbirth/poor neonatal prognosis
- Inappropriate child protection involvement
- Societal disrespect for women's recovery from childbirth, and the expectation to entertain visitors who want to meet their baby
- Poverty
- Blame for birth outcomes that women do not have control over
- Physical birth injuries
- A lack of access/denial of continuity of midwifery care

- Past trauma such as sexual violence or being abused as a child

Having poor mental health after experiencing these things is normal and not pathological.

Women are not disordered, dysfunctional, abnormal, or mentally ill for reacting to these abuses and environmental stressors. Western medical influence on society that pathologizes human suffering and coping mechanisms is harmful and needs to stop.

We strongly advise women to avoid getting labelled with a mental illness during pregnancy and post-partum if possible. Where accessible, we strongly recommend only seeing trauma-informed mental health specialists who specialise in the perinatal period (e.g. perinatal psychologists and birth trauma therapists), as well as utilising counselling and other community support services.

We strongly advise keeping mental health service use separate and private from maternity care, and recommend that women not to disclose previously diagnosed mental health problems to maternity care providers. Midwives and obstetricians do not have specialised training on how give mental health support, and such disclosure are often used against women to restrict birth options, weaponize child protection agencies to coerce women into compliance with problematic care "recommendations" (which is a breach of privacy), and gaslight women during complaint processes.

Below is a table of the problems that cause maternal trauma and the solutions that do not blame women or their bodies for their psychological distress. We have created this tool as many women blame themselves for things that happened in maternity care they had no control over.

Woman-centred care providers can utilise this table to improve their practice and reflect on their attitudes to women with trauma. It can be used to develop trauma-informed strategies and advocacy to support mothers in the medical community and by extension, society.

Causes	**Non-pathologizing Solutions**
A lack of physical/social/emotional support in pregnancy and post-partum	• Provider, community, family support. • Access to continuity of midwifery care • Access to doulas
Experiencing domestic violence	• Support services to leave domestic violence • No inappropriate child protection involvement • Education to women about domestic violence increasing during pregnancy
Inadequate nutrition	• Access to dieticians • Pre and post-natal nutritional counselling • Addressing food insecurity
Obstetric violence	• Culture change to centre women in maternity care • Criminalising Obstetric Violence • Provider training on human rights in childbirth • Reflective medical practice • Empathy and humility from all care providers • Access to continuity of midwifery care
Poor lactation/feeding support	• GP/Midwife/Nurse evidence based lactation training • Nutritional counselling • Respecting and supporting women's decisions to breastfeed or formula feed • Oppose formula industry advertising and funding

	• Promoting donor milk and wet nursing
Sleep deprivation	• Education about biologically normal infant sleep pre-pregnancy and during pregnancy as routine care • Partner/family support • Normalising and access to overnight help/support workers • Community and professional support • Promotion and normalisation of safe co-sleeping and keeping baby close at night • Respect different cultures' norms around infant sleep • Defund "sleep schools" that promote separation of the mother-baby dyad • Regulation of the "infant sleep coaching" industry that promotes harmful "sleep training" techniques
Experiencing miscarriage/stillbirth/Poor neonatal prognosis	• Bereavement services • Women are not placed in maternity wards after a loss • Constant communication between maternity care providers, women, and support services • Community and family support • Women are supported in whatever decisions they make if their baby is predicted to have a disability
Inappropriate Child Protection Involvement	• Child protection policies are changed to remove victim-blaming attitudes • Provide and offer effective support services, including social workers • Education for child protection officers to address victim-blaming attitudes and misogynistic beliefs about how "good mothers" behave • Child protection only involved when there is actual risk of harm to a born child; foetuses do not have legal rights in Australia • Child protection services do not inappropriately collaborate with maternity care providers to coerce vulnerable women into medical procedures
Societal norms that disrespect women's post-partum recovery time	• Educating families about the importance of post-partum rest • Doulas and midwives assisting women create a family post-partum visit plan • School education on post-partum rest, the importance of isolation for a neonate • Family members should only visit when allowed and for the purposes of supporting and serving the mother via cooking, cleaning, childcare for other children, companionship for the woman

	• Providers discussing with women the importance of setting boundaries post-partum and banning problematic family members from visitation on the ward with her permission • Criminalising abusive families as a form of obstetric violence
Poverty	• Community Support • Charity • Helping the woman access support services • Social welfare advocates • School campaigns promoting understanding that social welfare is a human right in Australia • Pregnancy centres for low income women • Campaigns to address society blaming the working poor as ‘stealing their tax money.’ Most tax money is wasted by politicians and tax evasion by the wealthy • Training for Centrelink workers to address classist views
Blame for birth outcomes they do not have control over	• Change the technical language used in maternity care to use terms that do not blame women’s bodies • Evidence-based education for maternity providers on the causes of common poor outcomes • Honest and scientifically accurate open disclosure from care providers when poor outcomes occur • Access to trauma-informed psychological support • Access to continuity of midwifery care
Physical Birth Injuries	• Maternity care policies and environments that promote birth physiology • Access to continuity of midwifery care • Increased competency of instrumental delivery skills • Respecting women’s human right to pain relief • Prompt detection of birth injuries and referral to services • Education about birth injury potential • Reducing caesareans/instrumental birth rates • De-implement CTG as it has been proved ineffective and harmful • Discourage use of the lithotomy position
A lack of access/denial of midwifery	• Midwives are able to work to their full scope of practice • Every woman receives care from a midwife; only women who need specialised care see obstetricians

	• Reciprocal, respectful partnerships and care pathways between maternity care professions • Fully funding midwifery, including Medicare rebates • Support for midwives to retain them in the profession, including increased midwife salaries, appropriate professional indemnity insurance products • Addressing medical misogyny
None of the solutions involve blaming women, band-aid solutions, or positioning women as mentally ill.	

Disclaimer: We are aware perinatal psychologist may need to provide diagnosis as part of job requirements so their patient can receive services. In this case informed consent discussions should take place on what diagnosis would mean such as benefits in terms of receiving social security payments, medicare rebates, access to mental health services etc. As well as the risks e.g. stigma, *potential* losses of medical decision making and legal credibility in court cases.

Psychologists should respect the patient's decision not to be diagnosed and pathologized.