unicef
unite for children

INTERNATIONAL
STEP by STEP
ASSOCIATION

MODULE 7

PARENTAL WELLBEING

DRAFT

CONTENTS

KEY MESSAGES - why is this topic important for you?

- Mild to moderate perinatal mental illness in both fathers and mothers is more common than we think.
- Perinatal mental illness of a caregiver affects the development of the fetus and young child. It can have a lifelong repercussions on the physical and mental health and the achievement of a child exposed in utero and/or during the early years.
- Untreated perinatal mental illness comes at a tremendous financial and social cost to society.
- A high proportion of mental ill health during the perinatal period is never detected and addressed.
- Perinatal mental illness can be found in all cultures and income levels, but is more common in situations of excessive stress and social disadvantage.
- As the trusted professional and friend of the family, you can learn about the mental health needs of a pregnant woman, new mother, or father and provide advice and first-line listening support. You can encourage caregivers to speak openly about their feelings, without fear that they will be stigmatized or labeled as "bad parents" because they feel depressed, anxious, or unhappy before or after the birth of the child.
- In cases where the condition appears to be severe, there may be a risk to the life of the mother or baby. You must keep the best interests of the infant and mother in mind and ensure that the mother receives professional hospital treatment.

LEARNING OUTCOMES

By the end of this module, you will be able to:

- Know why recognising and understanding perinatal illness in both mothers and fathers is so important for your work
- Know about the different types of perinatal mental illness
- Understand about some factors that contribute to perinatal illness and factors that increase resilience
- Understand how perinatal mental illness affects the mother (or father), the developing fetus, the young child, family, and society
- Learn about signs of perinatal mental health you might observe during your home visits and screening tools that you can use
- Know about interventions for mild to moderate perinatal mental illness
- Understand the importance of referring mothers with postnatal psychosis.

INTRODUCTION

While the arrival of a baby is often anticipated with great joy, for some women, men, and families pregnancy and the time after birth can become a period of unparalleled stress and challenges. That women may undergo periods of depression has been well known for several centuries, but only more recently have researchers focused on other mental health conditions during pregnancy, the post-partum period, and beyond. In addition, we are becoming increasingly aware that fathers are also affected.

Between 10-20% of women face mental health conditions during pregnancy and after birth in upper income countries where good sources of data are available. Rates for fathers are somewhat lower (averaging around 10%). Prevalence estimates, as with mothers, depend on the characteristics of the sample and the measures used to assess perinatal conditions.

The problem may be more severe for mothers and fathers in lower and middle income countries: According to WHO, "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" (WHO, Maternal Mental Health).

Perinatal mental health conditions range from mild to severe and encompass disorders other than depression. Because they can be found both before and after the birth and may persist into the second and third years after birth, the term now most commonly used is no longer 'postnatal depression' but perinatal mental health disorders.

Research also provided solid evidence that perinatal disorders can affect the fetus in utero and the infant after birth, causing hormonal changes and toxic stress that impedes brain development and thus affects the domains of child development and wellbeing. As a result, perinatal mental disorders have the potential to influence outcomes across the lifespan.

Given the prevalence of this problem, you will certainly encounter mothers and fathers who are struggling with this issue. In your role as health visitor and professional friend to the family, you are in a unique position to provide first-line listening support and identify those that need professional help and refer them to the appropriate services.

Reflection and discussion

- How would you respond to a co-worker who is telling you that she has a mentally ill mother on her caseload who has just given birth? What is your response to the label "mentally ill"?
- Have you seen among your families (or experienced yourself) the feelings that have been called the "baby blues?" Are some new mothers reluctant to talk about these feelings? What are their fears? Are these parents suffering from perinatal mental illness?

Self-assessment - True/False Statements

Give true/false answers to the following questions:

1. The perinatal period (pregnancy and the post-partum period) is generally a period of good mental health. Women may suffer from "baby blues", but it generally goes away by itself when hormones stabilize in the weeks after birth.

2. A perinatal mental disorder. Give true/false answers to the following questions:

A. Is associated with the post-partum period and related to hormonal changes
B. Only affects women pregnant or giving birth
C. Is a major public health issue that can have a devastating impact on the affected person, children, families and society
D. Is generally a form of depression ranging from mild to severe

SUGGESTED ANSWERS:

1. FALSE: Perinatal mental illness is very common. It occurs in all cultures and income levels. According to a recent global review in a major medical journal "non-psychotic mental disorders are among the commonest morbidities of pregnancy and the postpartum period " (Howard, LM et al. , 2014) In high-income countries, about 10% of pregnant women and 13% of post-partum women experience common non-psychotic perinatal mental disorders. While data are poor, rates for low and middle income countries are generally higher. Severe mental illness is less common, but is estimated to affect 1-2 per 1000 births (Fisher, J et al, 2012)

2. A. FALSE: Perinatal illness is also common during pregnancy (see above).

2. B. FALSE: Fathers can also be affected. According to the Fatherhood Institute UK (Fatherhood Institute UK; Raising Children Australia), a meta-analysis (43 studies) found an average 10.4% of fathers depressed both pre- and post-natally, with the peak time for fathers' depression being between three and six months after the birth. For example, in the reviewed studies, depression in the father was associated with infant sleeping/crying problems; father neuroticism and substance abuse/dependence; mother personality difficulties and her current mental health status; attitudes towards fatherhood and masculinity; a feeling of exclusion from the parenting role, lack of support and a poor quality couple relationship, disagreement about the pregnancy, worries about extra responsibilities; lack of opportunities to care for and bond with the baby; unmet expectations; etc.

2. C. TRUE: The costs to the affected individuals and society are truly staggering in terms of reduced achievement and lifelong poor physical and mental health. A recent costing study in the UK has estimated that costs associated with perinatal mental health (perinatal depression, anxiety and psychosis combined) among women amount to £10'000 for society as a whole for every child born, while better programming would only cost about £400. Nearly three-quarters of the cost are related to adverse impacts on the child (Bauer, A et al., 2014).

2. D. FALSE: While research has focused largely on depressive disorders, particularly post-natal depression, many other mental disorders are common during this period (e.g., anxiety disorders, post-traumatic stress disorder, eating disorders, and personality disorders).

II

WHAT IS PERINATAL MENTAL ILLNESS AND HOW COMMON IS IT?

Mental health problems among women who are pregnant or who have recently given birth, and among expectant and new fathers, are found in all countries and cultures. The condition best known is depression. Perinatal mental health disorders are generally classified into three groups:

Some definitions

- Post-partum "Blues"/baby blues – usually mild and transient (and not found among fathers). This affects 50-80% of all women most often during the first two weeks after delivery and may be very brief (a few days). It may make women feel out of control emotionally, shifting between weepiness, sadness, anxiety, irritability, feelings of dependency and being overwhelmed.

- Perinatal mental illness/disorder - Mental health disorders associated with pregnancy and the immediate postpartum period including depression, anxiety disorders, and puerperal psychosis.

    - Perinatal depression – persistent and pervasive low mood of varying severity and duration. Affects about one in ten women during pregnancy, 10-15% of women (and up to 10% of men) at any point in time after birth, or more that 30% during the year after delivery. Depression can continue into the second and third year after birth.

    - Anxiety disorders – These include phobias, obsessive-compulsive disorders (OCD), post-traumatic stress syndrome, acute stress disorder, and panic and can be found in mothers or fathers.

    - Puerperal Psychosis – Found only among women, this affects about 1-2 mothers per 1000 births; it has a rapid onset (usually just several days), but may take time to detect; childbirth is considered a "powerful trigger of mania and psychosis, and episodes at this time causes substantial morbidity and mortality, with suicide a leading cause of maternal death" (Jones, I. et al., 2014).

Elevated rates of psychosis are not found among new fathers. However, as with mothers, perinatal depression and anxiety disorders is fathers are associated with a reduced responsiveness to the child, specifically greater withdrawal (Sethna, V. et al., 2015). The worst outcomes for the child are when both parents are suffering from mental disorders.

For further information on some of the other conditions, look at the Information card:" Perinatal symptoms and conditions" (i.e. click on the term and find more detailed descriptions).

Self-assessment - Check for Understanding

During the home visit, a father is telling the home visitor that he is very worried because of his wife's changed behaviour over the past week. She is sometimes very agressive towards him, often threatening him and their 3 year old daughter, but then suddenly may be warm and caring, like her old self. She is keeping the baby, a six month old boy, with her all the time, and is right now locked with the baby in the bedroom. The father told you that yesterday she took the baby on a walk, and he was not dressed warmly enough for the cold weather. The father said that he just did not know what to do. It took him several hours to find her. Fortunately, he found her in the entrance of a large apartment building that was heated. When they got home, she was crying, saying that she knows that he wants to hurt

the baby. Based on the father's description and your observations, what do you think about this mother's mental health? What would you do?

ANSWER

This mother seems confused; she is going through mood changes and displaying some strange behaviors. She does not seem to be aware when she is putting her baby at risk. It is possible that she suffers from the most severe form of perinatal illness, i.e., puerperal or postpartum psychosis. Taking the best interest of the baby and sibling into account, you should discuss an immediate referral to your mental health services with the father and proceed according to your standard operating procedures. The father will need additional support for the referral, and you will prioritize this family for enhanced services (additional visits and support) during this critical time.

Remember, there are some important risk factors that make some mothers or fathers more vulnerable – but perinatal mental health conditions can affect any mother or father. More recently, some famous women have shared their own experiences publically and talked about why new motherhood was a very distressing experience for them until they received the help and professional treatment they needed. This is helping to raise public awareness and reduce some of the stigma associated with these conditions.

Watch the video - Jessica Rowe is talking about post-natal depression

Jessica Rowe, an Australian television news presenter suffered post-natal depression after the birth of her first child in January 2007. Here, she talks emotionally about her experience. https://www.youtube.com/watch?v=glC7KcSiC5Y

Famous men are also beginning to speak out about their experiences of depression and anxiety as new fathers: http://www.digitalspy.co.uk/showbiz/news/a202921/laurence-fox-admits-fatherhood-struggle.html#~pdBG7q1xHF3tPH

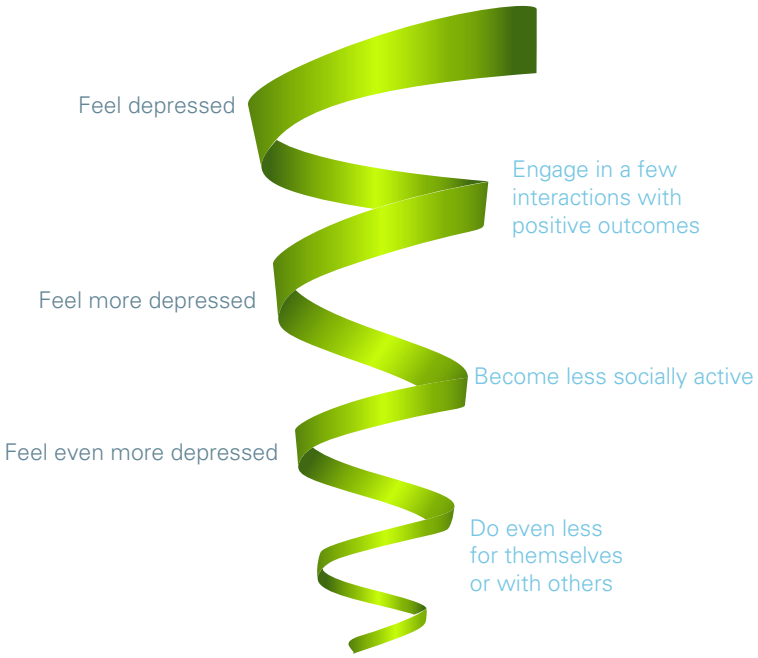
As described by the Institute of Health Visiting (Institute of Health Visiting, 2013, modules 1 – 3), perinatal illness can act like a downward spiral, narrowing life options and choices until the individual is almost paralyzed in her (or his) actions:

There are, however, some factors that make some mothers and fathers more vulnerable.

These are associated with the social determinants, for example, for low education and social disadvantage (for both men and women); living in societies or ethnic groups where the status of women is low and they have low levels of income and education and little participation and say both in society and in their personal lives (for women); age (younger mothers and fathers are more likely to experience poor mental health); adverse or stressful life events, such as stress associated with experiencing maltreatment as a child, living in poverty, without financial means, insecure housing, recent experiences of bereavement or migration; a tenuous or unsupportive relationship with the intimate partner (e.g., substance misuse, violence, the partner's poor mental health, rejection of pregnancy, pregnancy early in the relationship, parents living in

separate households); lack of or a weak family and social support system; the woman's reproductive health history (an unwanted pregnancy, multiple closely spaced pregnancies, multi-partner fertility – i.e. children with different partners and/or living in other households); a traumatic or very stressful birth process or a newborn with serious problems; and, a past history of mental health problems including past perinatal mental health problems (both, for women and men).

The depressive spiral



Watch the video

Depression and Pregnancy: While many women flourish during pregnancy, others may become moody, experience feelings of low self-esteem, become overly negative, have trouble sleeping or want to sleep more than usual, or just feel lonely and depressed.
https://www.youtube.com/watch?v=DtzVIHu9AcA

Watch the video

When Darkness Fell: My True Story of Postpartum Depression. https://www.youtube.com/watch?v=6AwAKk_iwTI&list=PL2pnWK5k5s7Kuvb_IKND7jlurdYqJ3Kio&index=20

You can find out more about paternal depression on a website of The Fatherhood Institute or on http://www.fatherhoodinstitute.org/2010/fatherhood-institute-research-summary-fathers-and-postnatal-depression/

Watch the video

Signs of Male Postpartum depression - Published on 28 Mar 2013
Will Courtenay, PhD Psychotherapist, explains the signs of postpartum depression in men, which can be difficult to recognize due to the fact that men may experience and cope with depression differently from women, for example becoming very angry, staying out of the

house, even engaging in an affair. Since one in 10 new fathers will struggle with depression so it is important to know how to recognize the signs.
https://www.youtube.com/watch?v=dc8rPkaPz5k&list=PL2pnWK5k5s7Kuvb_IKND7jIurdYqJ3Kio&index=13

Coping with a partner's depression is a significant issue. Partners should be involved in prevention and treatment and, on occasion, may need support for their own mental health. Fathers tend to compensate when their partner is depressed (Goodman, S.H. et al, 2014) and can 'buffer' their child against the negative impact of maternal depression (Gere, J.K. et al., 2012 and Mezulis, A.H. et al, 2004).

Watch the video Coping with a partner's depression
https://www.youtube.com/watch?v=zgRkkJ5YpfI

Men in Australia have created their own website to talk about their experiences with their partners and their own feelings:
http://www.howisdadgoing.org.au/why-this-website/stigma

Case studies - Case study 1.

During her first visit to this family, the home visitor noticed high levels of anxiety in mother. She seemed overwhelmed with worries and insecurity, as well as scared and convinced that she would not able to take care of her baby. All her questions were related to dangers that would be faced by her baby. She was meticulously writing down the advice and answers given by the previous home visitor in her notebook.

The home visitor was patient, caring and supportive. She tried to avoid giving answers and proposing solutions. She praised the mother and asked her opinions. She was trying to understand the level of mother's concern as well as her reasons for it.

During the conversation, she discovered that the mother felt very lonely and exhausted, had little help from family members and that her partner worked long hours and was often 'grumpy'. The mother also confided that her partner had not wanted the baby that had come along early in their relationship.

She has mood swings, and most of the time feels tired. She stated that she cannot sleep in the evening and does not want to get up in the morning. She is losing interest in the child and does not have the energy for routine care giving tasks. The mother's tiredness was reinforced by her disappointment that she could not breastfeed. While she was talking about not being able to breastfeed, she started to cry, because she could not provide baby with what she thought is the core element of motherhood.

The home visitor acknowledged the mother's insecurity, feelings of guilt, and need for support from the father and other family members. In her opinion, the baby was "easy", sleeping, eating, and "grateful" for the mother's attention.

The home visitor then set up a visit for the following week and asked the mother if she would be happy for her baby's father to be present. The mother was fine with this suggestion and the visit was scheduled so that both parents could be present.

Answer the following questions:

1. List the symptoms indicating some level of post-partum depression in this mother.

2. List the strengths in this mother-baby dyad, which can empower the mother and prevent a serious mental disorder? List the mother's and the baby's strengths separately.

3. List risk factors that could increase symptoms of depression in the mother. List the risk factors for the mother and baby separately.

SUGGESTED ANSWERS

1. Exhaustion, tearfulness, mood swings, insomnia, nocturnal awakening, difficulty in morning awakening and recently permanent concern, issues with care for the baby, continuous fear and feeling of insecurity and guilt.

2. Mother/strengths: focus on baby; genuine care and commitment; self-awareness and awareness of the problem; asking for help, seeking for support and advice.

Baby/strengths: "easy", responsive to mother's attention; sleeps well.

3. Mother: high level of anxiety, frustration with failure to breastfeed, high level of insecurity; lack of support from wider family and the baby's father; possible depression and/or rejection of the pregnancy in the father.

Baby: "easy", may not demand sufficient attention needed for development

Case studies - Case study 2

During her first visit, the home visitor became aware of the family's chaotic lifestyle. This was the first baby in the family, both the parents were young, and everybody wanted to be involved. Grandmothers and grandfathers were taking over the care for the baby, putting her to sleep, and giving advice on all aspects of baby clothes and care. At the same time, they were often criticizing the mother, making comments about her ways with the baby and her housekeeping. In the home visitor's opinion, the house was buzzing like a hornet's nest. They ignored the father.

As expected, the baby was very irritable, had difficulty falling asleep, and cried a lot. She was only able to fall asleep if an adult was holding her. The moment she was placed in her cradle, she would start crying. During the home visits, the grandparents tried to absorb the home visitor's attention and have her take their side. The father stayed aloof, just making sporadic comments, most of the time critical of the baby and the mother. The mother was either sitting in the armchair or lying on the bed in old unwashed clothes. Her hair was unwashed, and she looked unkempt. When she was not breastfeeding her baby, she was eating chips and watching violent thrillers. She had mood swings and was shifting from shouting to inconsolable crying.

The home visitor decided to focus all her attention on the mother and father. She informed the grandparents that the mother and father should have the say when it came to the baby's wellbeing. She discussed with the young parents how to be supportive to each other, ideas about raising the baby and engaged them in playing with and calming her, pointing out positive interactions, such as smiling. The parents' reactions were very positive. The mother really enjoyed breastfeeding and started to use singing and gentle rocking when calming the baby. The father began to engage in mutual gaze with their baby and vocalize with her. The home visitor helped him to develop skills and self-confidence in caring for her, and to understand

his irreplaceable role as her daddy. Together, the mother and father started to take over the parental role and separation from the primary family (grandparents). Both showed increased appreciation of the other's parenting, as well as pleasure in engaging with their baby, in triadic as well as dyadic interactions.

Answer the following questions:

1. List the symptoms indicating some form of post-partum depression in this mother.

2. List the strengths in the mother, father and baby, which can empower the young parents. List these strengths separately - the mother's, the father's and the baby's.

3. List the strategies the home visitor used to draw the father in as a supportive partner and engaged father.

4. List, separately for each parent and the baby, the risk factors, which could worsen symptoms of post-partum depression in the mother.

5. If you had to advise your colleague, what would you discuss with her?

SUGGESTED ANSWERS

1. Mother was passive (sitting in the armchair), inactive (laying in the bed), she was neglecting her personal hygiene (her hair was dirty, her clothes unwashed), she was passive aggressive (watching violent thrillers), going through some mood swings (crying or shouting)

2. Mother/strengths: She takes care of the baby and she enjoys breastfeeding. She reacts very positively to the support coming from the home visitor. She is very content when she finds out that she can control her baby's behavior. She is able to engage positively with her partner and their baby as a 'triad'.

Father/strengths: He is willing to engage; he reacts very positively to the support coming from the home visitor; he is happy when he understands his role and feels competent in caring for his baby. He is able to engage positively with his partner and their baby as a 'triad'.

Baby/strengths: responsive to mother's and father's attentions; enjoys breastfeeding.

3. She treated him with respect. She validated his role as a father, helped him develop skills and self-confidence in infant care, and supported him as one half of the parenting 'team'.

4. Mother: inactive, immature, not able to confront her parents or her partner and take responsibility for the baby.

Father: detached; critical.

Baby: irritable, having problems with sleeping, only wanting to be held.

5. Provide more visits to support the young parents, inviting the father to be present and scheduling visits to make this more likely; link the mother to a breastfeeding support group outside the home; sustain the father's involvement in care routines and have him ensure that the mother is not disturbed while she breastfeeds; work with the parents to create a calm atmosphere for the baby, with television and other noise kept to a minimum; talk to the grandparents about the importance of giving the new mother and father time and space to bond with their baby and learn to care for her; channel the grandparents' energies into supportive tasks like preparing meals.

III THE IMPACT OF PERINATAL MENTAL ILLNESS ON THE GROWING CHILD

Self-assessment – True/False Statements

Give true/false answers to the following questions:

1. If the mother is depressed or anxious during pregnancy, it does not yet affect the growing fetus, because the fetus is not yet interacting with the mother

2. Mark as True or False the outcomes that are more likely for infants/children that were raised by a mother or father with a perinatal mental disorder. You can mark more than one response:
A. Insecure attachment
B. Increased sleep problems, less advanced language development
C. Difficulty controlling anger, lower self-esteem
D. A. and C. but not B

3. There are few factors that can protect the infant from the negative exposure to a mother with post-partum depression.

4. The development of infants and young children is not affected when fathers suffer from post-natal depression or anxiety.

SUGGESTED ANSWERS

1. FALSE: There are a number of reasons why perinatal disorders can affect development of the fetus before birth: stress-related hormones in the pregnant woman, e.g., cortisol, cross the placenta and affect the brain development of the fetus; a depressed pregnant woman may be less likely to engage in healthy lifestyles, go to her pre-natal health checks, get treatment for medical conditions, and prepare for motherhood; depression may affect the pregnant woman's immune system; the baby may be born pre-term or at a low birth weight.

2. A., B., and C. are correct. As you will see, the both the mother's and the father's mental state are very important from conception through the early years.

3. FALSE - A number of factors can mediate the impact of post-partum depression in a mother or father on the young child. These include the overall situation of the family, including the presence of other nurturing and responsive caregivers (e.g. mother, father, grandmother, grandfather), the child's temperament and overall health status, and the absence of other factors associated with social disadvantage (poverty, poor living conditions, intimate partner conflict, family violence, etc.). The length and severity of the perinatal illness is also of importance.

4. FALSE: Recent reviews have gathered substantial evidence that paternal post-partum depression and/or anxiety does not only affect the father and his partner, but also the comprehensive health, development and wellbeing of the young child.

Pre-natal exposure

The physical and mental health status of the mother and father during pregnancy and even before establishes the first foundations for young children to thrive. Often, the health system is more concerned with medical tests, for example, taking blood pressure and measuring weight gain, than with the mental

health and wellbeing of the mother and her partner, although these can have a significant impact on the fetus. By paying particular attention to the pregnant woman's mental health status and risk, as well as protective factors in her environment, you can contribute to a healthier outcome for the baby in your prenatal home visits.

We now know that anxiety, stress, and depression raise the level of cortisol in the mother's blood stream, and that the filtering capacity of the placenta is reduced and allows increased levels of cortisol to pass through to the growing brain. Research has found that this negatively affects the rapidly developing architecture of the fetus' brain. In addition, a pregnant woman suffering from anxiety, depression or other mental disorders is less likely to engage in the healthy lifestyles needed for a good pregnancy outcome (use of cigarettes, alcohol, and other substances, nutrition, exercise, sleep, etc.) and treatment or management of medical conditions.

Perinatal mental disorders also interfere with many aspects of effective parenting post-delivery. They affect:

- The development of the relationship with the baby (the mother's and father's ability to become engaged emotionally with the baby, to bond, form an attachment, experience joy in the infant's first responses and actions) and the changed relationship with the partner and other family members
- The attunement and responsiveness of the parent (the ability to elicit responses from the infant and respond in kind to the infant's actions and cues – *You can find more in the Module 4: Falling in Love – Promoting Parent Child Attachment)*
- The understanding of what the infant can do based on age, developmental stage, and motivation (the depressed mother or father may for example not be able to understand why the one-month old infant is not letting her/him sleep through the night and may think that the infant is crying on purpose)
- The parent's ability see the infant in a positive light
- The parent's judgment of what the infant may need with respect to health, safety, and nurturing
- The mother or father's tolerance of their surroundings, degree of apathy, and lack of emotional response to the child.

If you have already studied the Module: Falling in love, you will have seen that physical growth, development and behavior in the infant and young child are interlinked in synergistic ways with the behaviour of the caregiver, and that development is best supported in the context of warm, responsive and nurturing relationships. Lack of responsiveness or maladjusted (e.g., unpredictable) responsiveness activates the infant's physiologic stress response. This even happens in short episodes, as you could see in the "non-responsive face experiment" in the module on attachment. When the mother or father is depressed this can seriously affect the infant's brain development, and thus all domains of cognitive and socio-emotional development, including executive function skills.

You may be able to spot some signs of this by observing how the parent handles the infant, how he/she talks about the infant's needs and development, and how attuned parent and infant seem to be in their interactions.

What do we know?

Research has found that both maternal and paternal depression and anxiety disorders are associated with children's developmental problems, affecting socio-emotional, cognitive and executive functioning. Reviews indicate that children of mothers with perinatal illness are more likely to experience the problems listed in

the Table below. While there have been fewer reviews of the impact of paternal depression on children, some of the same negative outcomes are being identified (Ramchandani, P.G, & Stein A., 2008).

Areas of functioning affected by parental depression and anxiety disorders

Socio-emotional	• express negative affect • difficulty controlling their anger • insecure or disorganized attachment • poorer interpersonal skills • elevated stress level
Cognitive	• less advanced language development • lower academic skills • lower self-esteem • vulnerability to depression or other disorders
Behavioral/executive function	• increased sleep problems • less cooperation • attention deficit/hyperactivity disorder • difficulty controlling aggression • increased risk of developing depression and problem behaviors

However, each child experiences and responds to a parent's perinatal mental disorder differently, depending on the severity and length of the condition, the stage of development, other child and family variables (for example, the child's temperament, the presence of another nurturing caregiver, (e. the other parent or grandparent). Conflict between the parents has been found to decrease the child's ability to adjust and can result in disorganized attachment (see module on attachment). Such children may lack coping mechanisms and neurological buffering and are therefore more vulnerable to emotional and mental health problems later on, and can have difficulties in developing relationships with others.

IV

HOW CAN YOU IDENTIFY PERINATAL MENTAL ILLNESS?

It is normal for mothers and fathers to feel very emotional after their child is born. Hormonal changes, lack of sleep, and adjusting to life with a newborn, as well as their own expectations and the expectations of others about their new parenting role can be overwhelming. The vast majority of women go through some mood swings they find difficult to explain during the days after delivery. However, if mothers or fathers feel sad, anxious, moody, guilty, or hopeless for more than a couple of weeks after delivery, this could indicate postpartum depression or another perinatal mental disorder. Some women and men report that they do not feel any joy or excitement about their new baby, and they get no pleasure from things they once enjoyed. Sometimes, they seem to be doing well in adjusting early on, but depression sets in later, frequently between the third and the sixth month postpartum.

There are several screening tools available that have been used widely. Find out what your country is using at various levels of the healthcare system and see if any of these would be useful during your visits. When such tools are routinely integrated into home visiting, it can give you and the mother or father the opportunity to bring up this sensitive issue and discuss it in the same way as any other issue and challenge affecting the family.

A. Whooley Questions. The Whooley uses the following three questions.

1. During the past month have you often been bothered by feeling down, depressed or hopeless?

2. During the past month have you often been bothered by having little interest or pleasure in doing things?

3. Is this something you feel you need or want help with?

The Whooley Questions can be used with little training, but are very limited and have not been validated in research. As a home visitor, you can use the questions to use as an opening to explore the mother's or father's mood and coping with parenthood in more depth and provide the support the family needs.

B. The Edinburgh Postnatal Depression Scale. This is a ten-item scale that was developed for use of professional home visitors and has been validated for the prenatal and postnatal period and for use with fathers, although with a two-point lower cut off suggested (Matthey, S. et al., 2001). It has been used extensively in research globally, and there is no cost attached to using it. With this tool, you can assess the overall mood of the mother or father.

Edinburgh (postnatal) Depression Scale (Institute of Health Visiting (2013), module 2)

1. I have been able to laugh and see the funny side of things
    - As much as I always could
    - Not quite so much now
    - Definitely not so much now
    - Not at all

2. I have looked forward with enjoyment to things
    - As much as I ever did
    - Rather less than I used to
    - Definitely less than I used to
    - Hardly at all

3. I have blamed myself unnecessarily when things went wrong
    - Yes, most of the time
    - Yes, some of the time
    - Not very often
    - No, never

4. I have been anxious or worried for no good reason
    - No, not at all
    - Hardly ever
    - Yes, sometimes
    - Yes, very often

5. I have felt scared or panicky for no very good reason
    - Yes, quite a lot
    - Yes, sometimes
    - No, not much
    - No, not at al

6. Things have been getting on top of me
    - Yes, most of the time I haven't been able to cope at all
    - Yes, sometimes I haven't been coping as well as usual
    - No, most of the time I have coped quite well
    - No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping
    - Yes, most of the time
    - Yes, sometimes
    - Not very often
    - No, not at all

8. I have felt sad or miserable
    - Yes, most of the time
    - Yes, quite often
    - Not very often
    - No, not at all

9. I have been so unhappy that I have been crying
    - Yes, most of the time
    - Yes, quite often
    - Only occasionally
    - No, never

10. The thought of harming myself has occurred to me
    - Yes, quite often
    - Sometimes
    - Hardly ever
    - Never

The scale can either be completed by the mother or father on their own, and then you can go through their responses with them, item by item; or you can go through the questions with them and discuss the issues directly with the parent, question by question. As written, the tool provides you with a good framework to ask questions and learn more about how this father or mother is feeling and coping.

Below find examples how the Institute of Health Visiting (Rahman, A. et al, 2013) proposes that home visitors use the questions of the Edinburgh to explore some of the feelings of the father or mother.

A. You said that *you've ben feeling miserable or depressed lately?*

- can you remember when it started?

- Have these feelings been persisitent?

- When you are miserable does it last for most of the day?

- Has this been nearly everyday?

B. You said that *there have been times over the past few weeks when you've found it hard to be interested in things?*

-what is hard to enjoy e.g. things you do for your baby?

- what about keeping in contact with friends?

The question most difficult to ask is the last one question which asks whether the mother or father has felt like harming himself or herself. Often, if the person is very depressed, he or she will be relieved that this topic has been brought out into the open for discussion . As you know there is huge societal pressure on women and men to be happy after the birth of their baby, so parents may be afraid to mention their unhappiness, lack of feelings for the baby, or fears that they may somehow endanger the safety of their baby. When new mothers or fathers admit how they feel, they are usually blamed for being "bad parents", "abnormal", and less competent. So by discussing this topic openly, you are in a way giving them permission to share their feelings honestly and ask for help. It is important for the wellbeing of the baby, mother or father that in the more serious situations, you make a referral for treatment and ensure that the parent or parents (on occasion, both may be suffering) follow-through and also gets support at home. Sometimes, several additional "listening visits" can be sufficient, as well as connecting the parent with a parenting group.

Limitations. The Edinburgh Postnatal Depression Scale may not help you in identifying women with perinatal psychosis, and you may not be able to identify all women or men that are depressed (false negatives). In addition, you may identify some parents as depressed who are not, but are just responding normally to particular challenges or stress in their environment.

It is important that you never have a mother or father fill out this tool as one of the activities to be completed "for their file", without discussing their response and addressing the specific needs that emerge.

C. The WHO 20-item Self-Reporting Questionnaire (SRQ-20). This WHO screening instrument for psycho-emotional disturbances (20 questions) has also been used for screening perinatal disorders.

The WHO 20-item Self-Reporting Questionnaire (SRQ-20)
WHO/MNH/PSF/94.8

1.	Do you often have headaches?	yes/no
2.	Is your appetite poor?	yes/no
3.	Do you sleep badly?	yes/no
4.	Are you easily frightened?	yes/no

5.	Do your hands shake?	yes/no
6.	Do you feel nervous, tense or worried?	yes/no
7.	Is your digestion poor?	yes/no
8.	Do you have trouble thinking clearly?	yes/no
9.	Do you feel unhappy?	yes/no
10.	Do you cry more than usual?	yes/no
11.	Do you find it difficult to enjoy your daily activities?	yes/no
12.	Do you find it difficult to make decisions?	yes/no
13.	Is your daily work suffering?	yes/no
14.	Are you unable to play a useful part in life?	yes/no
15.	Have you lost interest in things?	yes/no
16.	Do you feel that you are a worthless person?	yes/no
17.	Has the thought of ending your life been on your mind?	yes/no
18.	Do you feel tired all the time?	yes/no
19.	Do you have uncomfortable feelings in your stomach?	yes/no
20.	Are you easily tired?	yes/no

Reflection and discussion

Read the case study below and discuss with your colleagues or reflect on the following questions:

1. What are the risk factors for this mother's mental health?
2. What are the strengths that you can build on with Masha?
3. What actions would you take?

Case study

Masha is university professor who finally became pregnant at age 40. She lives with her husband and his two-year old daughter. You are seeing her for her second appointment during her eighth month of her pregnancy. She is visibly upset when you ring her doorbell. She has just returned from a visit with the pediatrician, who told her that her stepdaughter had lost weight and looked unhappy, and that she should spend some time learning how to feed her better. When, she sees you, Masha begins to sob. She is questioning why she has

ever left her job to go on her maternity leave, how she can contemplate motherhood and a baby, when she is endangering the life of her stepdaughter, how her husband could ever trust her with this coming baby, and that he and his daughter would be better off going back to his ex-wife. After settling the little girl (who had been clinging to her stepmother's neck trying to console her) in her playpen next door, you sit down with Masha and listen to her. One of the first things she brings up are the critical comments her mother-in-law made about her relationship with her stepdaughter. She loves her husband, but she tells you that recently he mentioned that as a professional she should be more than capable of managing a little girl, the house and the coming baby.

SUGGESTED ANSWERS:

1. RISK FACTORS: It is quite likely that Masha is experiencing a moderate level of anxiety about the upcoming birth and her new role. While she is well educated, she is new at parenting, and is lacking support from her mother-in-law in her new role as stepmother. As the husband is not present during the home visit, his role in increasing or reducing risk is not clear; he may not fully appreciate the demands of parenting on Masha, and the difficulty for her in making this major life change.

2. STRENGTHS TO BUILD ON: In the way the little girl is trying to console her stepmother, you can see the development of a relationship that could be nurtured. The husband has a high appreciation of his wife's professional capacities; she is aware of the situation and asks for help from you; she is well educated, has a job….

3. HOW WILL YOU PROCEED? There seems to be some affection between stepmother and stepdaughter. By pointing out to Masha how her step daughter was trying to console her, you can indicate that she is becoming attached to her stepmother; find out where in her parenting Masha feels confident, and what causes her more difficulties. In discussion, you can find out which activities she and her stepdaughter enjoy together and how Masha can help her stepdaughter and herself prepare for the coming baby; you can suggest materials to read about two-year olds and what they like.

Schedule a meeting when you can also meet with the father and find out some more about this family's situation (i.e., why the little girl is not living with her mother, her relationship with her biological mother, the father's role in providing consistent parenting to his little girl, and his expectations with respect to parenting from his new wife). Explain to him the great contributions fathers make as parents in their own right and in providing emotional support to their pregnant wives. Point out the emerging relationship between his new wife and daughter and see how he proposes to nurture it; look at his engagement with his family and ways of strengthening his support.

V

HOW CAN YOU SUPPORT THE FAMILIES YOU WORK WITH?

Remember, if at any point a pregnant woman or post-partum mother appears to be a serious risk to herself, the growing fetus, her infant and/or her family, you must take immediate action following the existing protocol of your health services, notify the appropriate doctor, or make a referral to the hospital. Remember, if in doubt, your first responsibility is to ensure the health and wellbeing of the infant.

Some warning signs include:

- The mother has a past history of mental illness
- The episode seems to have come on suddenly
- The mother seems to be delusional about herself or the infant, not understanding reality
- The mother talks about suicide or harming herself or the baby
- She is using alcohol or drugs
- Her home situation is non-supportive or is causing additional harm (e.g. a family member's drug or alcohol use, mental disorders, actual or potential intra-family violence).

If any of the women or fathers in your caseload is suffering from a mild to moderate perinatal disorders, a number of approaches have been tested and found useful (Rahman, A. et al, 2013). What you will do, will depend on the guidance provided to you by your health service and the training you have received.

Some, but not all approaches may need additional training, and often practice with colleagues, as well as supportive supervision so that you can be provide better help to your families:

1. Psycho-educational approach – During the antenatal period, you can prepare mothers and fathers for parenthood, encourage realistic expectations, explore with them how having this baby will change their lives and family life, if there are other children. You can share positive, but also some more challenging experiences of parenthood, and provide a better understanding about the prevalence and symptoms of depression, anxiety, and obsessive compulsive disorders during the perinatal period. An important point is to let the parents know that it is not only ok to ask for help, but important to do so. And if one of them seems to suffer from depression or another mental disorder, explain that it is as a treatable illness just like any physical illness.

In the post-natal period, your approach can focus on teaching the mother and father about child development, how to engage and stimulate the infant, be responsive to the infant's cues, and show affection. You can show the parents how the infant responds and thus strengthen each of the parent-infant relationships, while also helping them 'co-parent; well – that is, share responsibility, support each other's parenting and develop skills and self-confidence as parenting 'team'. Such approaches have improved maternal and paternal mood and infant health and development.

Research has shown that interventions have better outcomes when they are focused on the parents' mood, co-parenting, and their relationships with their infant. A 'whole family' approach delivers the best outcomes.

Infant massage is sometimes used to help the mother/father become more attuned to the infant's responses and this contributes to the formation of attachment. Seeing the infant's positive responses to massage, helps to build confidence and a feeling of competence.

2. Listening visit. One of the approaches used by health visitors in the UK (Rahman, A. et al, 2013), with women suffering from a mild to moderate perinatal disorder are listening visits, a form of non-directive counselling. Ideally, the health visitor visits 4-8 times for a period of about 45 minutes and helps the mother in a non-directive way to explore her feelings.

By paying attention to the mother, ensuring her that her feelings are valued, she feels more supported in exploring her problems and making decisions and how to deal with them.

4 Phases of listening visits

The health visitor listens to the mothers and uses a number of non-directive techniques, i.e., paraphrasing what the mother has said, reflecting back to her how she seems to feel about this, and summarizing what the mother is feeling.

This can help the mother to gain a new perspective. There is no reason why such an approach would not also work with depressed or anxious fathers.

First find out more about the mother's or father's worries. Are these worries specific and solvable, or do they reflect generalised high levels of anxiety about life and the world, which are outside the parent's control. Help the parent list his or her problems and choose one problem to address in this listening session. What is important to remember that your role is not to give the parent solutions, but to help the parent to take charge and take action or make some changes, i.e., take the first step to regain some control over life. Help the parent plan a realistic course of action. If the problem cannot be solved by the individual e.g., a mother is suffering due to the husband's anger/distress over a loss, perhaps of his job or the child from an earlier relationship, see if she can identify some strategies that may help her to cope with this problem. And of course try to meet with the father and engage with him.

Home visitors may take the following steps with a parent suffering from a mental disorder in the perinatal period:

- Define the problem
- Brainstorm the options
- Explore the pros and cons of each option

- Have the parent choose the desired option
- Together consider the worst case scenario that might result from this option
- Go through the steps needed to carry out this option

At the end of the visit, assure the mother or father that you will discuss how things went for them during the next visit and that you will together look at another problem together.

Other actions you can propose include

- **Increased family support** – While it may be comforting to have the spouse or another relative support a depressed parent by taking on more responsibility, you may want to make sure that this does not increase the affected parent's sense of powerlessness and low self-esteem or create a dependency.

- **Peer and social support structures.** If there are infant parent groups, see if you can have the mother/father join. Sometimes the purpose of these groups is to socialize, to learn about parenting or a specific parenting skill (e.g., infant massage, breastfeeding support), and sometimes they provide therapeutic support. Any of these approaches have been found to be beneficial.

- **Participation in activities organized by an ECD or Parenting Center.** As these, like the infant/parent groups mentioned above, are likely to be mother-dominated, special support may be needed to encourage fathers to attend. Many may do so if the benefits to their infants are pointed out.

- **Exercise**, jogging or walking briskly or taking the infant out alone in a stroller or in an outing with other parents can contribute to counteracting perinatal illness, as well as proper rest and good nutrition.

- **Referral** to the parent's doctor for medical assessment, monitoring, and treatment may be needed.

Sometimes, you may suspect that a Mother or father are suffering from perinatal mental illness, but are doing their best to cover up their problem. Refer to the Information Card and additional resources at the end of this module.

VI

SUMMARY

Final summary

Pregnancy and the post-partum period are particularly challenging times for both parents, when they can experience great joy, but also increased confusion, vulnerability and anxiety.

In your role as health visitor and professional friend to these parents, you will see when they need extra support, ranging from a sympathetic listener to more concrete advice and support.

Occasionally, it will be necessary to refer a woman quickly for treatment. If a father is suffering from a severe mental disorder, this is likely to be a pre-existing condition and links should be made with his doctor or a mental health service that has previously been working with him.

In all situations, the young child will be your priority. Your lack of action might endanger this child's overall health and wellbeing.

Conversely, your support to the mother/father and their relationships with each other and with their infant is likely to contribute to secure attachment and wellbeing.

VII

ANNEX

INFORMATION CARD 1: SYMPTOMS AND CONDITIONS

Condition	Symptoms

Baby Blues/ postpartum blues	• Between 1-3 weeks after delivery, affects up to 80% of postpartum women.
	• Characteristics are:
	  ◦ Lability of mood between euphoria and misery
	  ◦ Heightened sensitivity
	  ◦ Tearfulness, often without associated sadness;
	  ◦ Restlessness
	  ◦ Poor concentration
	  ◦ Anxiety and irritability
	  ◦ Disturbed sleep
	  ◦ Feelings of unreality and detachment from the baby

Perinatal depression	• Affects one in ten or more women (and up to 1 in 10 men), persistently present for at least two weeks • Physical: Tired all the time, sleep problems un related to the baby's sleep patterns, lacks energy, crying, sad, weight loss or gain, • Psychological: self-blame, irritability, feeling overwhelmed physically and emotionally, inability to cope with daily tasks, pessimism, guilt, withdrawal from family and friends, lack of interest and motivation, suicidal ideas, loss of self-confidence and self-esteem • Behavioral: self-neglect or avoidance, irritability, memory difficulties, poor concentration
Anxiety disorder	• Can be acute, episodic or persistent, can include panic disorder, specific phobias, social phobias, obsessive-compulsive disorder, posttraumatic stress disorder, and can coincide with depression • Physical: palpitations, chest pain, accelerated heartbeat, chills or hot flushes, hyperventilation, shortness of breath, dizziness, headache, sweating, tingling and numbness, feeling of choking, nausea, vomiting, diarrhea, aches, pains, restlessness, tremors, shaking • Psychological: Unrealistic or excessive fear or worry, mind racing or going blank, decreased concentration and memory, reduced clarity of thinking, fear of being alone, apprehension or sense of dread, indecisive, confused, feeling on edge, obsessive-compulsive behaviors (obsessive behavior causes anxiety, while the compulsive behaviors reduces anxiety temporarily), loss of self-confidence and self-esteem • Behavioral: avoidance of situations, obsessive /compulsive behavior (excessive cleanliness, rituals…), distress in social situations

Puerperal or postpartum psychosis	• 1-2 women per 1000 births. Serious mental illness that can be life threatening to the mother and/or child. There is an increased risk in subsequent pregnancies. The psychotic symptoms include
	  • Acute onset
	  • Bizarre behaviors
	  • Rapidly changing moods, with mania and elation as well as sadness
	  • Thought disorder
	  • Delusions (thoughts not based on reality);
	  • Hallucinations (involving all the senses)
	  • Disturbed behaviour
	  • Confusion, no insight into her behavior

Bipolar disorder (former manic-depressive disorder)	• Psychosis with extreme highs and lows in mood

INFORMATION CARD 2: WHAT TO DO WHEN A MOTHER IS NOT ACKNOWLEDGING POSTNATAL DEPRESSION

Retrieved from http://raisingchildren.net.au/articles/acknowledging_postnatal_depression_-_panda.html/context/305

Reasons why women might not acknowledge postnatal depression

- Many women and their partners don't know what postnatal depression (PND) is or how to recognise its signs.
- The stigma associated with depression prevents women asking for help. A woman's need to be seen as normal and a good mother is very strong. PND symptoms can be masked with incredible effort, sometimes even from a woman's partner.
- It's hard for a woman with PND to admit she isn't coping and to ask for help. This involves acknowledging that she can't manage her feelings and that something is seriously wrong. But denial is the enemy of recovery.
- Depression itself breaks down a woman's ability to communicate, make decisions and help herself.
- It can be too difficult for a woman to find the words to talk about her painful and negative thoughts. This is because she might feel that no-one will understand or others will be horrified by her thoughts.
- In the early weeks after having a baby, there are many other things happening. A woman might use these to explain how she feels (for example, baby's sleep, her sleep changes, impact on her partner). She assumes things will get better when everything settles down.
- A woman might have tried to communicate her feelings or to ask for help from family or services. But her feelings might have been dismissed or not responded to. This leads to an increased sense of failure, inadequacy and guilt, especially if she's told that she should be happy or that her own mother did it tough and was OK. In this case, the woman might not try again to access help until her depression reduces her capacity to perform everyday tasks.
- A woman might also blame her partner for how she feels, resulting in significant conflict between the new parents.
- Women might not trust workers in services with their dark secrets. A woman might deliberately put on a sunny, capable face when seeing her nurse or doctor. This is because she desperately doesn't want them to know the extent of her bad feelings.
- A woman might fear being put on antidepressants if she talks about her feelings. She might also be worried about what medication might mean if she's pregnant or breastfeeding.
- A woman might fear that the authorities will take her baby away if she has PND and is not coping. She might be worried about being seen to be a bad mother. This fear is reinforced if there's a difficult partnership breakdown, and she fears her ex-partner will take the baby from her.
- Even the most skilled health professional can miss PND, especially if the woman isn't giving clear or honest indications of how she is.
- A woman might not know what services are available to help her or she might feel that no-one can help her anyway.

When a woman doesn't acknowledge postnatal depression

Sometimes a woman's partner, family or friends are the first to pick up that things have changed for her or that she isn't coping with motherhood. It can be very difficult to observe these changes and know how to address them, especially if the woman isn't prepared to talk about these concerns or agree to get help.

When a new mother feels things aren't right, it's ideal for her to talk to her partner, family, friends and health carers to get it checked out.

But there are women who go to great lengths to avoid discussing and dealing with their mental health issues. Over time these mothers can become quite unwell, and relationships with their babies, children, partners and families can become very strained. Their partners, family and friends can become increasingly concerned.

These women can become angry and defensive if the people who care about them bring up concerns. They can stubbornly refuse to get help or stay involved with services.

Effects on partners, family and friends

If a woman continues refusing to acknowledge her postnatal depression (PND), the costs for the woman's partner, family and friends increase. Her partner might need to take time off work to help with the baby and provide support. There might be growing concerns for the wellbeing and safety of the woman, the baby and any older children.

The woman might blame her partner, family or friends for everything. Ultimately, she might break ties with her family and friends or tell her partner to leave the relationship. She might feel that her partner is the source of her distress, and if it wasn't for her partner, she wouldn't be feeling the way she is. She might focus on aspects of the relationship that have been difficult in the past. She thinks that if her partner leaves, she'll get better.

Partners in this situation can become very distressed. They know their partner is unwell but she won't accept any help. This can mean that partners can't do anything to prevent their families from breaking down completely. In this case, partners can be at risk of depression and anxiety. They face a loss of confidence in themselves and their ability to assess the situation accurately.

The breakdown of a couple's relationship and the new family is one of the greatest tragedies of unacknowledged and untreated PND.

Strategies to support women with postnatal depression and their partners

Partners, family and friends can use the following strategies to support and get help for a woman with postnatal depression (PND), as well as to take care of themselves.

- Find out as much as you can about PND. This will help you identify the impact of the illness on your partner's emotions, behaviour and decisions. Try to keep this separate from what you know about your partner before she became depressed.
- Get support for yourself. Talk to someone about how you feel and take care of yourself with rest, exercise and time away from caring for your family member.
- Try to avoid making any significant decisions during this time. You and your partner

might not be thinking clearly. Remember that it's likely that the PND is contributing to her unhappiness in the relationship. If she does seek help and recover, much of the conflict in your relationship is likely to settle.

- Try to be patient with her. She isn't her normal self or thinking clearly. You might have to listen to her concerns and provide support, even though she isn't listening to your concerns or getting help. This is very difficult and frustrating, so sharing this with your family and friends is important.
- Try to avoid conflict. Your partner might say and do some things that are meant to hurt you or start a fight – she is likely to be feeling very angry and guilty. This can feel very unfair and confusing. Try to walk away or not add to conflict. If this doesn't help or the conflict increases or becomes physical towards you or the children, it's time to get help from family and support services.
- Trust your instincts and your concern for her. You might need to risk conflict with her in the short term by getting help for her. This is especially if you're very concerned about her and the baby. You can contact her doctor or child and family health nurse to talk about your concerns and seek their advice. You could also contact mental health crisis services, or go to the local hospital emergency department if you need to.
- In some cases, child protection services might need to be involved. This might be when women refuse to get help and struggle to care for their baby and older children or if children are exposed to a mother's unstable mental health, or alcohol and other drugs. The wellbeing of the baby and older children is very important. In this situation, child protection would try to ensure that the woman gets services that will help her recover and help the family stay together.

Encouraging a woman to talk about her feelings

Make it OK to talk

Start by acknowledging the difficulty of the situation. Make it OK for the woman to talk about her difficult feelings. You can do this by identifying the challenges of motherhood for women in general and the challenges specific to this woman's situation. You could say something like, 'Adjusting to being a mother is one of the largest changes women ever make, yet we often don't speak about how difficult it can be'.

Validate and support her

You might feel that she's not listening to your attempts to support her. Let her know that you understand her feelings are real to her, no matter how bad or unreasonable they sound. Try to avoid telling her how she should feel. Be positive about even the little things she's doing well. You could say something like, 'You're dealing with a lot (for example, lack of sleep, little support, and being away from your family). Anyone in your situation would find it tough'. Or 'You are doing a really good job'.

Encourage her to talk about her feelings

She might be feeling and thinking many different things as she recovers from the birth and manages lack of sleep and the anxieties of motherhood. Ask her open-ended questions that encourage her to give more than yes or no answers. Try the following:

- 'I wouldn't be surprised if you were feeling that way.'
- 'I'm wondering if this might be how you are feeling.'
- 'How are you finding motherhood?'
- 'How are you really feeling?'

Listen to her

Keep trying to listen to her worries without interruptions, ideas or advice. It can be tempting to try to give her advice and tell her what you think she should do. Just try to let her know that you're listening.

Give her the power to make decisions for herself

At the same time, you need to encourage her to seek help. Being heard enables a woman to clarify her issues for herself, which is the first step in deciding what to do to address them. Sometimes she'll benefit from knowing her options. Other times she'll need you to be more involved in decision-making.

Let her know you believe she'll recover

Help her to expect to recover by expecting that she'll come through this (with help). It's generally hard for her to believe that she'll ever feel well again. You can hold the light of hope for her, by telling her she'll recover. In turn, this can support her to make the huge effort to recover.

Look after yourself and your children

Sometimes you might feel like you can't do anything right. You might have to wait for your partner to open up about her need for support. If you're concerned about her wellbeing or that of your baby or older children you'll need to take action and get some help, even if you risk getting into conflict with your partner.

For additional information on this topic, including on postnatal depression in men, see http://raisingchildren.net.au/postnatal_depression/pnd.html

INFORMATION CARD 3: EDINBURGH POSTNATAL DEPRESSION SCALE

(Cox, Holden and Sagovsky, 1987)

1. I have been able to laugh and see the funny side of things
   - As much as I always could
   - Not quite so much now
   - Definitely not so much now
   - Not at all

2. I have looked forward with enjoyment to things
   - As much as I ever did
   - Rather less than I used to
   - Definitely less than I used to
   - Hardly at all

3. I have blamed myself unnecessarily when things went wrong
   - Yes, most of the time
   - Yes, some of the time
   - Not very often
   - No, never

4. I have been anxious or worried for no good reason
   - No, not at all
   - Hardly ever
   - Yes, sometimes
   - Yes, very often

5. I have felt scared or panicky for no very good reason
   - Yes, quite a lot
   - Yes, sometimes
   - No, not much
   - No, not at al

6. Things have been getting on top of me
   - Yes, most of the time I haven't been able to cope at all
   - Yes, sometimes I haven't been coping as well as usual
   - No, most of the time I have coped quite well
   - No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping
   - Yes, most of the time
   - Yes, sometimes
   - Not very often
   - No, not at all

8. I have felt sad or miserable
   - Yes, most of the time
   - Yes, quite often
   - Not very often
   - No, not at all

9. I have been so unhappy that I have been crying
    - Yes, most of the time
    - Yes, quite often
    - Only occasionally
    - No, never

10. The thought of harming myself has occurred to me
    - Yes, quite often
    - Sometimes
    - Hardly ever
    - Never

INFORMATION CARD 4: SRQ – 20

From WHO/MNH/PSF/94.8

1.	Do you often have headaches?	yes/no
2.	Is your appetite poor?	yes/no
3.	Do you sleep badly?	yes/no
4.	Are you easily frightened?	yes/no
5.	Do your hands shake?	yes/no
6.	Do you feel nervous, tense or worried?	yes/no
7.	Is your digestion poor?	yes/no
8.	Do you have trouble thinking clearly?	yes/no
9.	Do you feel unhappy?	yes/no
10.	Do you cry more than usual?	yes/no
11.	Do you find it difficult to enjoy your daily activities?	yes/no
12.	Do you find it difficult to make decisions?	yes/no
13.	Is your daily work suffering?	yes/no
14.	Are you unable to play a useful part in life?	yes/no
15.	Have you lost interest in things?	yes/no
16.	Do you feel that you are a worthless person?	yes/no
17.	Has the thought of ending your life been on your mind?	yes/no
18.	Do you feel tired all the time?	yes/no
19.	Do you have uncomfortable feelings in your stomach?	yes/no
20.	Are you easily tired?	yes/no

VIII

REFERENCES

Barlow J & Coe C. (2013) 'New ways of working: promotional interviewing in health visiting practice', Journal of Health Visiting, 1 (1), (2050-8719).

Bauer A, Parsonage M, Knapp M., Iemmi V, & Adelaja B. (2014). The costs of perinatal mental health problems. London School of Economics. http://eprints.lse.ac.uk/59885/1/__lse.ac.uk_storage_LIBRARY_Secondary_libfile_shared_repository_Content_Bauer,%20M_Bauer_Costs_perinatal_%20mental_2014_Bauer_Costs_perinatal_mental_2014_author.pdf

Burgess A. (2011). Fathers' roles in perinatal mental health: causes, interactions and effects. New Digest 53. The Fatherhood Institute. http://www.nct.org.uk/sites/default/files/related_documents/burgess-fathers-roles-in-perinatal-mental-health-24-9-.pdf

De Mendonça J, Raad Bussab VS, Kiehl Lucci T & Kärtner J. (2015). Father-child interactional synchrony in Brazilian families with maternal depression. The International Society for Human Ethology, 30(1).

Fatherhood Institute UK. Research Summary: Fathers and Postnatal Depression: http://www.fatherhoodinstitute.org/2010/fatherhood-institute-research-summary-fathers-and-postnatal-depression/

Fisher J, de Mello MC, Patel V, Rahman A, Tran T, Holton S, & Holmes W (2012). Prevalence and determinants of common perinatal mental disorders in women in low- and lower-middle-income countries: a systematic review. Bulletin of the World Health Organization, 90 (2). pp. 139-149. ISSN 0042-9686. http://researchonline.lshtm.ac.uk/20658/1/BLT.11.091850.pdf

Goodman SH, Lusby CM, Thompson K, Newport DJ, & Stowe, ZN. (2014). Maternal Depression in Association with Fathers' Involvement with Their Infants: Spillover or Compensation/Buffering? Infant Mental Health Journal, 35(5), 495–508.

Gere MK, Hagen KA, Villabø MA, Arnberg K, Neumer SP, Torgersen S. (2013). Fathers' mental health as a protective factor in the relationship between maternal and child depressive symptoms. Depression and Anxiety, 30(1):31-38.

Howard LM, Molyneaux E, Dennis CL, Rochat T, Stein A, & Milgrom J. (2014). Non-psychotic mental disorders in the perinatal period. Lancet. 384: 1775–1788.

Institute of Health Visiting (2013), modules on perinatal mental health, 1 – 3
http://cs1.e-learningforhealthcare.org.uk/public/BCC/BCC_iHV/module1/index.htm
http://cs1.e-learningforhealthcare.org.uk/public/BCC/BCC_iHV/module2/index.htm
http://cs1.e-learningforhealthcare.org.uk/public/BCC/BCC_iHV/module3/index.htm

Jones I, Dazzan CP, & Howard L. (2014). Bipolar disorder, affective psychosis, and schizophrenia in pregnancy and the post-partum period. The Lancet, 384, 1789-1799.

Matthey S, Barnett B, Kavanagh DJ, & Howie P. (2001). Validation of the Edinburgh Postnatal Depression Scale for men, and comparison of item endorsement with their partners. Journal of Affective Disorder, 64(2-3), 175-84

Mezulis AH, Hyde JS, & Clark R. (2004). Father involvement moderates the effect of maternal depression during a child's infancy on child behaviour problems in kindergarten. Journal of Family Psychology, 18(4), 575–588.

Raising Children: Postnatal depression in men. http://raisingchildren.net.au/articles/men_and_postnatal_depression.html

Ramchandani PG & Stein A. (2008). Depression in men in the postnatal period and later child psychopathology: a population cohort study. Journal of the American Academy of Child Adolescent Psychiatry, 47(4), 390-398.

Rahman A, Fisher J, Bower P, et al (2013). Interventions for common perinatal mental disorders in women in low- and middle-income countries : A systematic review and meta-analysis. WHO Bulletin, 91, 593-601.

Sethna V, Murray L, Netsi E, Psychogiou L, Ramchandani PG. (2015). Paternal depression in the postnatal period and early father-infant interactions. Parenting: Science & Practice. 1(1), 1-8

WHO. Maternal Mental Health: http://www.who.int/mental_health/maternal-child/maternal_mental_health/en/

© UNICEF/Pirozzi