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# Maternal Mental Health Promotion: Facilitator's Training Manual for Auxiliary Nurse Midwives in India


**NATIONAL INSTITUTE OF MENTAL HEALTH AND NEURO SCIENCES**

(Institute of National Importance)

Bengaluru - 29




# Maternal Mental Health Promotion: Facilitator's Training Manual for Auxiliary Nurse Midwives in India

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**2018**

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The development of this manual was made possible by a grant from Department of Health Research and Indian Council of Medical Research (ICMR) (Grant no: DHR/11/GIA-2015-16)

NIMHANS Publication No.

Year of Publication: 2018

Number of Pages:



First edition - 2018

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Aditi Enterprises
aditiprints@gmail.com

## TABLE OF CONTENTS

**Sections 3: Annexure**

Annexure 1- Pre and post-test questionnaires

Annexure 2 - Role plays script- role of ANMs in promotion of antenatal and postnatal mental health

Annexure 3 - Role plays script - 'helpful' and unhelpful response

Annexure 4 - Questions for summarizing

Annexure 5- Feedback form

**Section four: Abbreviations**

| | |
|---|---|
| ACMD | Ante partum Common Mental Disorders |
| AIDS | Acquired Immune Deficiency Syndrome |
| ANM | Auxiliary Nurse Midwives |
| ASHA | Accredited Social Health Activist |
| ASMD | Ante partum Severe Mental Disorders |
| AWW | Anganwadi Worker |
| FGD | Focus Group Discussion |
| HIV | Human Immunodeficiency Virus |
| MO | Medical Officer |
| MBB | Mother Baby Bonding |
| MMH | Maternal Mental Health |
| OCD | Obsessive Compulsive Disorder |
| PHC | Primary Health Care Centre |
| PCMD | Post-partum Common Mental Disorders |
| PSMD | Post-partum Severe Mental Disorders |
| PTSD | Post-traumatic stress disorder |
| SHG | Self Help Group |
| WHO | World Health Organization |

# Preface

Optimal maternal mental health is critical not only for the well-being of the mother but also to ensure that every child is safe, healthy, nurtured, and able to thrive. This is vital as children are the future of the nation. In most developed countries, there is an emphasis on psychosocial mental health assessment for all pregnant mothers. Early identification of risk factors can ensure prevention. Maternal mental health is the ability of a mother to assess and respond to her own needs and those of her new-born. Perinatal period is a vulnerable period for women to develop mental illnesses. However, mental health during pregnancy and postpartum is not prioritized in routine antenatal care settings in India. Untreated mental illness during this period has a long-lasting impact both on mothers and their children. Hence, all healthcare professionals who are involved in supporting the women in perinatal period need to be trained to identify and offer treatment of mental health matters. In the Indian health care system, Auxiliary Nurse Midwives (ANMs) are ideally placed to offer mental health promotion, early identification and linkage for the women with mental health issues to the appropriate services. This manual was developed exclusively for Auxiliary Nurse Midwives based on recent evidence related to maternal mental health. Further, this manual incorporated experts' suggestions and qualitative findings from focus group discussions conducted among ANMs. While this manual aimed at ANMs may also be useful for other health care providers who care for women during their pregnancy and the first year after childbirth.

The main aim is to empower the ANMs by imparting knowledge and competencies to identify, refer and manage women with maternal mental health problems. This manual uses case vignettes, illustrations, charts and tables to simplify the complex language of psychiatry. It also attempts to bust myths and misperceptions. The main focus of this manual is to train the ANMs on the concept of maternal mental health and make them understand the importance of their role in maternal mental health issues. We hope that, ANMs and other health workers trained using this manual will be able to provide better services to mother, children, and work towards strengthening mental health care in the community. Integrating mental health into routine mother-infant health should be the ultimate aim. A mother's mental health both during pregnancy and the first year after childbirth has the far-reaching impact on the development of the foetus and the infant. There is evidence to suggest that a mother's mental health during pregnancy can influence the health of the progeny even in adolescence. The focus is not only on maternal mental disorders but also with an emphasis on the role of maternal well-being.

**Prof. Prabha.S.Chandra**
**Dr. Sailaxmi Gandhi**

# Acknowledgement

Completion of this Manual was possible with the support of several wonderful people. We would like to express our sincere gratitude to all of them.

First of all, we are sincerely thankful to **Prof. B N. Gangadhar,** Director/Vice Chancellor of NIMHANS and Registrar **Prof. K. Sekar,** for granting permission and unconditional support.

Our special thanks to **Prof. S.K. Chaturvedi,** Dean of Behavioural Sciences for his exemplary guidance, valuable feedback and constant encouragement in developing this manual.

We express our profound gratitude and deep regards to **Indian Council of Medical Research (ICMR)** and **Department of Health and Research** for generously granting the fund for this project.

It is our privilege to express our sincere regards to our Former Director/Vice Chancellor **Prof. P. Satish Chandra** and Former Registrar **Prof. V. Ravi,** for their kind co-operation and motivation to make this research possible.

We are deeply honoured in expressing our gratitude to **Dr. K.Reddemma,** Former Senior Prof and Dean of Behavioural Sciences, for her valuable guidance, scholarly inputs and consistent encouragement in bringing out this manual from its conception till the end.

We are also immensely grateful to **Prof. B.V. Kathyayani,** Principal, College of Nursing, who gave timely support and creating conducive environment for our research project.

It's our gratitude to express our appreciation to the research assistants **Mrs. Nayana Kumari, Mrs. Tansa** and **Mrs. Sowmya** for their valuable contribution to this manual.

We are thankful to **Mr. Prabhudev**, Assistant Editor, **Ms. Tejaswani,** Department of Publications, for proof reading and editing the manual.

We specially thank **Mr. Dinesha Kumar S, Ms.Ancy, Ms. Anet Maria Jose** for providing meaningful illustrations to this manual.

We are also grateful to **Mr. Mohan** for providing his expertise, and technical support in preparing this manual.

# Maternal Mental Health Promotion: Facilitator's Training Manual for Auxiliary Nurse Midwives in India

## INTRODUCTION

Maternal mental health refers to mental and emotional wellbeing of a woman during pregnancy and postpartum period. Recently maternal mental health is recognized as a public health priority as it not only affects the mothers but also infants, families, and communities. According to World Health Organization (WHO, 2008), one in three to five women in low and middle-income countries have a significant mental health problem during pregnancy and postpartum period. Social determinants are an important cause of mental health problems in pregnant women and new mothers. In India women are more vulnerable to maternal mental disorders due to significant risk factors such as early marriage, poverty, domestic violence, lack of social support etc. Mental health problems in women during their reproductive period may lead to increased maternal mortality, by affecting physical health needs and directly through suicide. Maternal mental health issues such as 'anxiety' and 'depression' are more common during pregnancy and postpartum period. Though depression accounts for the greatest burden of disease within all mental illnesses and is twice common in women than men, depression among women in the perinatal period is often unnoticed and underreported. Hence, there has been increasing recognition to train frontline health care providers to identify and refer women with mental health issues to the mental health services at an early stage. It is also very important to train primary health care workers to adopt simple and reliable tools to assess maternal mental health issues. It is important that their training equips midwives not only with knowledge about perinatal mental illness but also with the skills and confidence to talk to women about their feelings and explore issues about their mental health. Auxiliary Nurse Midwives (ANMs) are the female health workers in India who are mainly involved in providing maternal and child health services. Hence they are in close contact with women throughout pregnancy and after childbirth. Hence training ANMs may help to reduce the impact of maternal mental illness on mothers, children, and families.

## AIM

The overall aim of this training manual is to help the facilitators to build the capacity of ANMs in early detection, referral and coordinated treatment for pregnant and postpartum women with mental health issues.

## OBJECTIVES

At the end of the training program, participants will be able to

1. Update their **knowledge** on maternal mental disorders
2. **Recognize** the women who are at risk for developing mental disorders

3. **Perform** maternal mental health assessment including psychosocial risk factors and screening for mental disorders using standardized questionnaires.
4. **Respond** appropriately to the women with common mental disorders with basic counselling skills.
5. **Refer** women who are experiencing mental health problems during pregnancy and post-partum period, to the mental health services
6. **Support** the women and families with proper guidance in accessing mental health services
7. **Promote** positive mental health among pregnant and post-partum women
8. **Prevent** mental disorders with appropriate interventions at individual, family and community levels.

## WHAT IS THIS MANUAL ABOUT

This manual outlines a three day training program to help ANMs to promote maternal mental health and prevent maternal mental disorders. The training program consists of three components:

1. Updating knowledge and skills on maternal mental disorders including its risk factors, clinical features and management.
2. Assessment skills which helps the ANMs to elicit psychosocial risk factors for maternal mental disorders and screening the women for common mental disorders such as anxiety, depression and for suicidal thoughts if necessary, to refer the women for mental health services.
3. Application of knowledge and skills in their practice soon after the completion of the training program and the participants will be followed up by the supervisor or a facilitator to ensure that the knowledge and skills learnt are utilized in their practice.

## OVERVIEW OF THE MANUAL

This manual is developed for Auxiliary Nurse Midwives (ANMs) who work in the community at gross level to support women with maternal mental health issues.

- The first session of this manual aims to welcome the participants, help them to get familiar with each other, understand the participant's expectations and associate them with objectives of the training program and describe the ground rules for the training session.
- The second session explores participants' understanding of health, mental health, and mental disorders and enables them to differentiate common mental disorders from severe mental disorders.
- The third session describes the concept of maternal mental health, maternal mental disorders and their impact on pregnancy, mother, children and families.
- The fourth session focuses on various risk factors for maternal mental disorders and helps the participants to identify women who are at risk for development of mental disorders during pregnancy and postpartum period.

- The fifth session aims to enhance participant's knowledge on concept of domestic violence and its consequences on mother and foetus/child.
- The sixth session touches upon the aspect of common mental disorders during pregnancy and after childbirth.
- The seventh session helps the participants to understand the various severe mental disorders during the perinatal period.
- The eighth session describes the importance of positive mother baby bonding, effect of maternal mental disorders on mother baby bonding and strategies to improve mother baby bonding.
- The ninth session helps the participants to understand the importance of psychosocial assessment for maternal mental disorders and enable them to build their knowledge and skills in psychosocial assessment and screening for maternal mental disorders.
- The tenth session aims to help the ANMs to understand their role in promotion of maternal mental health and prevention of maternal mental disorders.
- The eleventh session introduces participants to the basic counselling skills and its importance in supporting the women with maternal mental health issues in their daily practice.
- The twelfth session concludes the training program, provides summary of all the topics and receives feedback from participants.

## HOW TO USE THIS MANUAL

This manual is developed and designed as facilitator's guide which can help them to train ANMs in promotion of maternal mental health. It provides information and builds skills of ANMs and other health workers who work in the community to support women with maternal mental health issues. Women are more vulnerable to mental health issues during pregnancy and after childbirth. This manual help the ANMs to understand their primary responsibility in screening a woman with mental health issues at an early stage and support them to reach appropriate services.

This manual use a mix of teaching methodologies, such as brainstorming, small group activity, power point presentation, video presentation, role plays, and it provides an opportunity for discussion, brainstorming, and clarification of doubts.

The manual provides the following information about each session:

**Background:** An overview of each session's aim and a general understanding of what is included in the related topic

**Topic outline:** List of all the individual topics in a session.

**Total session time:** Approximate time required to cover each topic

**Facilitator's note:** This information helps the facilitator to understand the case vignettes.

**Reference:** It guides for further reading about a particular topic by providing links to related website that provides in-depth information on the same topic

**For each topic the following information is provided**

**Aim:** What the facilitator expects to achieve by the end of the session

**Learning outcomes:** Expected changes in the participants by the end of each session

**Description:** How the facilitator achieves the aim through particular activity

**Suggested training methodology:** What training and teaching methods are used in each session

**Material/preparation required:** What materials are required for particular session like blackboard, pen, chart paper, laptop, etc.

**Duration:** Setting an approximate time for the completion of each topic

**Process:** The step by step instructions on how to implement the activities and run the sessions

**Schedule**

This manual has been designed for three days training program. Total participants can be 25-30 in number. Four sessions are scheduled on each day; each session has its own objectives and consists of presentations that are given by the facilitator and activities that involve the entire group. A proposed schedule for the training is provided, but this has to be adjusted if necessary. It is important that the facilitator carefully monitors the timing of each session as it is easy for session to extend beyond the allocated time.

## WHO IS THIS MANUAL FOR

This training manual is designed for Auxiliary Nurse Midwives to learn more about maternal mental disorders and to identify mental health issues of women in perinatal period. It also helps the ANMs to respond appropriately to women with mental health problems and to refer them to appropriate services.

An ANM is defined as someone who assists in the provision of maternal and new born health care, particularly during childbirth and also in the prenatal and postnatal period. They possess some of the basic nursing skills and midwifery competencies but are not fully qualified as midwives.

## WHAT ARE THE TEACHING METHODS INVOLVED IN THIS MANUAL

In this manual different types of training methods which are appropriate to the content are used. The facilitator can adapt any of the training methodology depending on the level of knowledge and experience of the participants

An important training methodology that is often used in the manual is group discussion and role play method by using the given case vignettes. This is done intentionally to explore participant's ideas to the larger group and expose them to the various situations faced by the women with maternal mental disorders. It helps them to have a firsthand experience and empathize with the women with maternal mental disorders.

Suggested teaching methodologies to a trainer are;

- Mini lectures that are given by the facilitators or a resource specialist to convey information, theories or principles.
- Case studies that provide descriptions of real-life situations to be used for group discussions and role play.
- Small group participatory activities in which participants share experiences and ideas or solve problems together, and then make a presentation to the larger group to stimulate further discussion. Small groups of four to five participants are ideal.
- Brainstorming involves encouraging every participant to think and contribute creative ideas through group discussion.
- Participatory role plays wherein participants assume roles to demonstrate and reinforce the learning. It provides first -hand experience to a participant through perceiving the role of a woman with mental health issues or a health worker
- Lecture is a verbal presentation intended to present information or teaches people about a particular subject and it is visually enhanced by using training aids like chalkboard, charts or power points etc.
- Demonstration involves explaining or clarifying with examples, experiments or actual performance in order to provide concrete experience of real life situations. It improves behavioural and cognitive skills and enhances the communication process.

## TRAINING MATERIALS

- Black board/white board/flip chart
- Chalk pieces/ Marker pen
- Chart papers
- Hand outs
- Pictures
- Short video films
- LCD projector
- Computer
- Index cards, stick notes

## WHO ARE THE FACILITATORS

The program will be enhanced if facilitators already have a good understanding of mental health and mental disorders.

## SELECTION CRITERIA FOR A FACILITATOR

Facilitators are the backbone of the training program. Right facilitator will take the training program in the right path. Selecting a facilitator is a critical part in the planning process. When selecting facilitator, it is important to assess the individual's readiness and evaluate their ability to be successful.

These tips guide in finding the right facilitator for the training program and help to achieve pre-determined objectives. The facilitator should have the following characteristics

- Good listening skills
- Non-judgemental
- Ability to adopt different teaching methods
- Sound knowledge on maternal mental disorders including clear understanding of the emotional and physical changes associated with pregnancy and childbirth
- Exhibit a good sense of humour
- Creates a comfortable learning environment
- Shows respect for the ideas and opinions of others
- Able to think quickly, improvise, and adjust to the needs of others
- Encourage open communication
- Punctual and professional at all time.
- Assertive in nature
- Manage and make effective use of time
- Posses core communication skills - Questioning skills, Attentive listening skills, Ability to give information clearly
- Responsive to the needs of the group
- Make effective use of the materials

## TIPS FOR THE FACILITATORS

**Before the training**

- Set some simple ground rules for the training
- Look at the background information for each session to familiarise yourself with it, and prepare materials
- Read the session carefully to see how each topic is related to the next topic
- The facilitators carefully review each session, case studies and other materials and adapt them appropriately to the local setting and cultural background.
- Plan for appropriate translation of the materials like case studies, handout, role plays and script in advance.
- Keep ready all the required materials for the program such as chart paper, marker pens, computer etc.
- Keep participants' kits ready and photocopy of the reading material, if required

**During the training**

- Encourage the participants to express their ideas or views related to a particular topic.
- To stimulate lively discussions:
  - Ask open – ended questions e.g. "Can you tell me more about..."
  - Invite participants to answer the questions by asking "can anyone help me with this question?"
  - Encourage participants who give limited response by asking "can you tell me a bit more about that?"
- Encourage passive participants to speak and provide them with positive reinforcement.
- Paraphrase participant's comments to check that you have understood them properly.
- Summarise the discussion to ensure that everyone understand the main points.
- Gently correct any misinformation communicated by the participants.
- Make sure that all objectives are met.
- Direct the interpersonal and group communication.
- Avoid using abbreviations and acronyms that participants may not be familiar with.
- Try to keep the program running to time (otherwise you will run out of time).
- Encourage the group to engage in brief energising activities that involve movement from time to time e.g. immediately after lunch. Some group members will be familiar with a range of energising activities that they can lead. Standing up and singing a short song together is often effective.
- Be sure to evaluate the training by asking the participants for feedback with suggestions to further improve the program, before they leave at the end of the program.
- The distribution of personalised certificates of attendance at the completion of the training is usually appreciated

**After the training**

Providing training program to the participants is only the primary steps in promotion of maternal mental health. To accomplish the aim of this training program, facilitator has to provide ongoing or continuous support to the participants.

## ADULT LEARNING PRINCIPLES

*Anyone who stops learning is old, whether at twenty or eighty.*
*Anyone who keeps learning stays young.*

***- Henry Ford***

As the training program aims at building the knowledge and skills of an adult learner, it is important for the facilitator to know the adult self concept and needs. Adult learning is

based on the principles of andragogy that means "the art and science of helping adults learn". It is student centered. The facilitator should understand that adults are very different from children in learning aspect.

Malcolm Knowles, a pioneer in adult education suggested the concept of five teaching strategies for adults, which states that they learn best when:

1. Adults understand why something is important to know or do
2. Adults have the freedom to learn in their own way
3. Learning is pragmatic
4. The time is right for them to learn
5. The process is positive and encouraging

**Tips for training adults**

- Content must be relevant to participants
- Use easy understandable language
- Use humour appropriately
- Use activities that encourage adult learners to explore
- Offer immediate feedback to allow adult learners to learn from mistakes
- Remember that practice makes perfect. It enables the adult learners to fully absorb and remember the subject matter.
- Consider participants' own experience and knowledge.
- Training *must* be active.
- Respect the time
- Know the information thoroughly
- Keep the class relevant to the age group
- Encourage them to ask questions
- Make it visually-compelling because 83% of learning occurs visually.
- Using charts, pictures, power point or video presentation
- Using word games, music etc.

**Suggested methods for the training are:**

- Brainstorming
- Group discussion
- Case vignettes
- Panel discussion
- Visual aids like charts, power point, projector, handout etc.
- Ice breakers
- Role plays
- Story telling methods

# Manual at a Glance

# Suggested Schedule

| SESSIONS | | DURATION |
|---|---|---|
| Pre – session process | | 30 minutes |
| **SESSION 1: INTRODUCTION** | | 60 minutes |
| 1.1 | Welcome and self-introduction | 15 minutes |
| 1.2 | Participants' expectations and objectives of the training program | 20 minutes |
| 1.3 | Ground rules | 10 minutes |
| **SESSION 2:UNDERSTANDING MENTAL DISORDERS** | | 120 minutes |
| 2.1 | Concept of health, mental health, and mental disorders | 30 minutes |
| 2.2 | Severe Mental Disorders (SMD)<br>Common Mental Disorders (CMD) | 90 minutes |
| **SESSION 3:MATERNAL MENTAL HEALTH: KEY CONCEPTS** | | 60 minutes |
| 3.1 | Concept of Maternal Mental Health | 30 minutes |
| 3.2 | Impact of Maternal Mental Disorders | 30 minutes |
| **SESSION 4:RISK FACTORS FOR MATERNAL MENTAL DISORDERS** | | 60 minutes |
| 4.1 | Risk factors for maternal mental disorders | 60 minutes |
| **SESSION 5:DOMESTIC VIOLENCE** | | 90 minutes |
| 5.1 | Concept of domestic violence | 30 minutes |
| 5.2 | Domestic violence among women in perinatal period | 30 minutes |
| 5.3 | Domestic violence: Role of ANMs | 30 minutes |
| **SESSION 6:COMMON MATERNAL MENTAL DISORDERS** | | 120 minutes |
| 6.1 | Ante partum Common Mental Disorders (ACMD) | 60 minutes |
| 6.2 | Postpartum Common Mental Disorders (PCMD | 60 minutes |
| **SESSION 7:SEVERE MATERNAL MENTAL DISORDERS** | | 90 minutes |
| 7.1 | Ante partum Severe Mental Disorders (ASMD) | 45 minutes |
| 7.2 | Postpartum Severe Mental disorders (PSMD) | 45 minutes |
| **SESSION 8: MOTHER BABY BONDING (MBB)** | | 60 minutes |
| 8.1 | Concept of mother baby bonding | 15 minutes |
| 8.2 | Common barriers and Impact of maternal mental disorders on Mother-Baby Bonding | 30 minutes |
| 8.3 | ANMs role in promoting mother-baby bonding | 15 minutes |
| **SESSION 9:MATERNAL MENTAL HEALTH ASSESSMENT** | | 90 minutes |
| 9.1 | Significance of maternal mental health assessment | 30 minutes |
| 9.2 | Assessment for psychosocial risk factors and Screening for maternal mental disorders | 60 minutes |
| **SESSION 10: MATERNAL MENTAL HEALTH: ROLE OF AUXILIARY NURSE MIDWIVES** | | 120 minutes |
| 10.1 | Role of ANMs in promotion of maternal mental health | 60 minutes |
| 10.2 | Role of ANMs in prevention of maternal mental disorders | 60 minutes |
| **SESSION 11:COUNSELLING** | | 90 minutes |
| 11.1 | Concept of counselling skills | |
| **SESSION 12: CONCLUDING SESSION** | | 60 minutes |
| 12.1 | Consolidation of the training | 30 minutes |
| 12.2 | Feedback from participants | 30 minutes |
| 12.3 | Closing | 30 minutes |

## SESSION BRIEFS

**Pre- session processes**

**Preparation**

- Plan for the three days training program in advance
- The venue should be comfortable, well ventilated and check for seating arrangements
- Ensure there is enough space for activities
- Ensure arrangements and logistics for drinking water, tea, lunch etc.
- Keep photocopies of the entire necessary materials such as hand-outs, pre-test or post-test questionnaires, feedback forms etc, ready
- Make sure that all the training materials are arranged in sequence
- Ensure that venue is arranged with necessary requirement like mike, computer etc
- Plan for the appropriate icebreaking exercises
- Begin the training program at stipulated time
- Plan for the activities in such a way that all the participants are engaged.
- Request all the participants to fill the registration form with required details
- Distribute kits to all the participants

**Registration**

Before the start of the program instruct all the participants to register themselves by providing information such as name, age, designation, area of work, years of experience, contact details etc.

**Pre /Post test**

Suggested time frame **-** 30 minutes

Training material – Pre- test formats

Pre–test format is a questionnaire provided to participants at the start of program. It encompasses questions based on the content of the manual. At the end of the training program the same set of questions are administered to the participants as post-test. The difference between pre and post-test mean scores help the facilitator to assess the effectiveness of training program in terms of changes in level of knowledge of participants.

**Criteria to fill Pre test**

- Participants are requested not to write their name on questionnaire as their responses will be kept confidential
- Distribute the pre-test format and allow 30 minutes for filling it.
- Participants are asked to respond individually and discussions are not allowed
- Encourage them to answer all the questions according to their understanding.
- Make sure that the participants understand the meaning of the questions. If required, translate to the local language.
- Do not explain too much or give examples
- Collect the questionnaires and keep them aside carefully

# Session 1: Introduction

## BACKGROUND

This session is important for creating a conducive and enabling learning environment for the participants in the training program. This session help the participants to know each other which will enhance their communication and cooperation during the training program. It is also important to encourage the participants for their active participation. This activity further fosters space for setting objectives and ground rules, in determining acceptable behaviour during the training program. This session facilitates the participants to match their expectations with the goals of the training program.

**Topic outline**

1.1 : Welcome and self-introduction
1.2 : Participants' expectations and objectives of the training program
1.3 : Ground rules

**Session duration: 60** minutes

## TOPIC 1.1: WELCOME AND SELF INTRODUCTION

**Aim**

Welcome the participants and help them to get familiar with each other

**Learning outcomes**

At the end of the session, participants will be able to

- Get to know each other by names
- Be comfortable with the facilitators and co-participants.

**Description**
The facilitator welcomes the participants and initiates a small group activity to enable the participants to introduce themselves (*Me and my work*)

**Suggested training methodology**
Small group activity

**Materials:** A small ball or a flower or any nice small soft object

**Duration:** 30 minutes

**Process**
- Facilitator greets the participants and introduces him/herself and gives a brief outline (aims and objectives) of the training programme.
- Ask the participants to walk around the room without saying anything, but can look at each other, nod… and smile…. This should go on for one minute. Then the participants can greet others while walking around saying 'Hi', 'Hello', 'Good morning', pleased to meet you'; etc…
- Ask the participants to sit in a circle, give a small ball to one of them, who has to tell her name to others slowly and loudly and throw the ball to somebody sitting opposite to her. The second participant tells her name and throws the ball again. This continues until everybody tells their names at least twice. If time permits participants can proceed to the second half of the activity. In the second half of the activity participant, 'A' has to call out participant 'B's name before throwing the ball to her. This will continue until every participant has heard her name being called out in two rounds.
- Other participants can help if some names are not remembered immediately.
- If the participants are not comfortable to throw the ball, a small object like flower or doll can be used.

**Note to the facilitators**
- Helps everyone to get involved in the activity.
- Participants who hesitate or do not remember co-participants' names may need extra attention.

## TOPIC.1.2: PARTICIPANTS' EXPECTATIONS AND OBJECTIVES OF THE TRAINING PROGRAM

**Aim**
Explore the participants' expectations from the training program and associate them with objectives of the training.

**Learning outcomes**
By the end of the session, participants will be able to
- Understand the objectives of the training program
- Identify whether their expectations meet with the objectives of the training program

**Description**
Participants share their expectations from the training program, to provide optimal care to women during pregnancy and after child birth. Then the facilitator introduces the objectives of the training program.

**Suggested training methodology**
Brainstorming

**Materials:** Index cards, pens, Marker pens, Black/white board or Flip chart

**Duration: 15** minutes

**Process**

- Give each participant an index card or a sheet of paper.
- Ask each person to write at least two of expectations from the training program
- Collect all the cards shuffle them and re-distribute to them.
- Ask someone to read the card they hold, and record the answers on a flipchart or white/ black board.
- Encourage the person to pick the next reader, who will pick the next reader, and so on.
- In case of duplicate answers, place a checkmark next to the original on the flip chart or white/black board, so that all contributions are acknowledged.

## TOPIC. 1.3: SETTING THE GROUND RULES

**Aim**
Enable the participants to be aware of and agree with acceptable behaviours during the training program.

**Learning outcomes**

- By the end of the session, participants will be able to agree on acceptable behaviours during the training sessions.

**Description**
Facilitator explains the concept of ground rules and encourages the participants to suggest and reach consensus on the ground rules for the training program.

**Suggested training methodology**
Power point presentation (PPT)

**Materials:** Laptop, LCD projector

**Duration:** 15 minutes

**Process**

- Display some common ground rules on PPT and ask the participants which rule is most important and facilitator list out the rules according to the importance.
- Invite the participants for any other comments or suggestions.
- Examples of common ground rules include (but are not limited to)

1. Turn on the mobile phones in silent mode
2. Be punctual
3. Confidentiality of the participants should be respected
4. Include everyone in small group activities
5. One person at a time may speak
6. Respect the fact that others will also want to give their inputs. Hence, everyone has to speak concisely.
7. In the large group discussion, participants should request permission from the trainer before speaking
8. Avoid passing judgment
9. No side talking
10. Give feedback directly and honestly

# Session 2: An Over View of Mental Disorders

## Background

This session aims to impart knowledge about the concept of health, mental health, and mental disorders. It helps the participants to differentiate common mental disorders from severe mental disorders. Thus participants will be able to identify and refer the individuals suffering from mental disorders. This session also provides a basis to enhance participants' awareness of mental disorders.

**Topic outline**

2.1: Concept of health, mental health, and mental disorders
2.2: Severe Mental Disorders (SMD) and Common Mental Disorders (CMD)

**Session duration: 1 hour 30 minutes**

### TOPIC 2.1: HEALTH, MENTAL HEALTH, AND MENTAL DISORDERS

**Aim**

Explore participants' understanding of health, mental health, and mental disorders.

**Learning outcomes**

At the end of the session, participants will be able to

- Understand the concept of health
- Be aware of mental health
- Differentiate between mental health and mental disorders

**Description**

Participants are encouraged to brainstorm and explain the meaning of health and mental health. The facilitator provides presentation on definitions of health and mental health. Then participants are divided into small groups and are provided with chart papers and pens to draw pictures/cartoons of people with mental illness based on their imagination and present their views to the larger group. At the end facilitator clarifies their myths and doubts about mental illness through explanation.

**Suggested training methodology**

Brainstorming followed by small group activity

**Materials:** Laptop/computer, LCD projector, chart papers, markers, pencils and erasers

**Duration:** 30 minutes

**Process**

- Facilitators invite the group to brainstorm about the meaning of health and mental health
- The participants are encouraged to express their views about health and mental health.
- Facilitator describes the definitions of health and mental health through the power point presentation.

- Then participants are divided into small groups and each group is provided with a chart paper and marker pens to draw the picture of the person with mental illness as per their imagination.
- Give 10 minutes to the group complete the task.
- Invite the volunteers to present their understanding of mental disorders to the whole group.
- Based on their presentation, the facilitator summarises about mental disorders.

## BACKGROUND MATERIAL

**Health**

Mahatma Gandhi, father of our nation describes health as "real wealth and not pieces of gold and silver". Health is defined by World Health Organization (1948) as "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity".[1]

**Mental Health**

Mental health refers to our cognitive, behavioural, and emotional wellbeing that includes the way people think, feel, and behave. Mental health can affect daily life, relationships, and even physical health. Mental health also includes a person's ability to enjoy life, to attain a balance between life activities and efforts to achieve psychological resilience. [3]

According to World Health Organization (WHO, 2004) mental health is "a state of well-being in which an individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community"[4]WHO also stresses that there is "*no health without mental health"*

***To be a healthy person one should have both physical and mental health and these are interrelated.***

**Mental disorders**

Mental disorders comprise a broad range of problems, with different symptoms. However, they are generally characterized by combination of abnormal thoughts, emotions, behaviour and relationships with others. Most of these disorders can be successfully treated.[5]

The American Psychiatric Association (APA, 2013) defines mental disorders as "a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning".[6]

## TOPIC. 2.3: SEVERE AND COMMON MENTAL DISORDERS

**Aim**

Helps the participants to recognize individuals suffering from severe mental disorders (SMD) or common Mental Disorders (CMD)

**Learning outcomes**

At the end of the session, participants will be able to

- Identify broader classification of mental disorders
- Understand psychotic symptoms (Hallucinations and Delusions)
- Describe the signs and symptoms of SMD and CMD
- Differentiate severe mental disorders from common mental disorders

**Description**

Participants are divided into small groups and each group is provided with a case vignette. Each group is asked to identify the type of mental disorder (SMD or CMD) and note down the symptoms from the case vignettes. Volunteers from each group are invited to present their case and to discuss the symptoms of the case to the larger group. They are also provided with a handout on *'Types of Mental disorders'*. Based on the small group activity, facilitator adds necessary inputs.

**Suggested training methodology**

Small group activity followed by presentation

**Materials:** Handouts on *'Types of mental disorders'* and case vignettes, pens

**Duration:** 45 minutes

**Process**

- Participants are divided into small groups and provide each group a copy of case vignette.
- Ask one participant in each group to read the case study to the rest while the other group member (from the same group) makes the notes for the feedback to the larger group at the end of the activity.
- Allow 10 minutes for discussion and invite a volunteer from each group to report their findings to the larger group.
- Lead a brief group discussion using the following probes;
  - Identify and list out the symptoms in the given case
  - What type of mental disorder do you think this person is suffering from?
  - Encourage the participants to think of a person in their community who might be suffering from a SMD/CMD (without saying his/ her name or identifying the person in any way), either now or at some time in the past. Invite three or four of the volunteers to share their experiences with others.
- Give a presentation based on small group activity and distribute a copy of hand out on "*Types of Mental disorders* 'to all the participants
- Facilitator concludes the session by informing the participants that mental disorders are treatable.

## Case Vignette 1

*Lakshmi is a 22-year-old married woman. For the last few months, her family members started noticing that she stays away from people, locks herself in the room and does not talk with the family members. Lakshmi used to be a cheerful and friendly woman who would lead all household activities and interact with all the family members. Her husband also says that she is not taking care of herself and sometimes she mutters to herself as if she is talking to someone. Many times, she ran away from home saying that somebody is following her and a group of people are planning to kill her. With these complaints,*

*Lakshmi was forcefully brought to the hospital by her husband. Since Lakshmi was unmanageable, she was admitted and provided necessary treatment.*

**Note to the Facilitator**: Lakshmi is experiencing symptoms of severe mental disorder

- **Behavioural symptoms :** Stays away from people, running away from home
  - Locking herself due to fear
- **Auditory hallucinations:** Muttering to self or talking to self
- **Delusions:** Believes that somebody is following her and group of people are planning to kill her

Lakshmi is experiencing symptoms of severe mental disorder known as '**Paranoid Schizophrenia'**

**Case vignette 2**

*Shruthi is 24 years old working woman who has the history of psychiatric illness before marriage. She married one year back and now she is a mother of two months old girl baby. She was brought to the hospital by her husband with complaints of being violent, aggressive and abusive towards family members. On examination, she was irritable and uncooperative. Following this, suddenly her behaviour has changed and she became irritable, had sleep disturbances, increased speech, purposeless wandering, not responding to her baby's needs. During history collection, Shruthi's mother stated that before marriage "Shruthi had been diagnosed with a psychiatric illness and taken treatment from a psychiatric hospital. After marriage, she seems to be mentally healthy without treatment. Hence we didn't inform her husband and in-laws about her illness".*

**Note to the Facilitators:** Shruthi is experiencing symptoms of severe mental disorder

- **Behavioural symptoms :** aggressive, abusive, violent towards family members, irritability , purposeless wandering, not responding to baby's needs
- **Sleep disturbances:** Decreased sleep

Shruthi is experiencing symptoms of severe mental disorder known as **'Bipolar Affective Disorder-Mania'**

**Case vignette 3**

*Shanti is a 22 years old married woman and a homemaker. She seems generally happy when at home but when asked to go out becomes nervous and gives a number of reasons why she cannot go out and wants to stay at home. She says that she has rapid heartbeat and difficulty in breathing. So she needs to lie down. About half an hour later, she seems to be fine until her mother asks her to go out again. She had her first panic attack 3 years back when she was travelling in a bus. She experienced dizziness, pounding heart, trembling and difficulty in breathing. As a result of her intense fear of having another panic attack, she avoids the following situations: waiting in line, crowded places such as movie theatres, going to park, etc. She worried that she will end up alone because of her symptoms and their interference in her life. Also, she has been unable to visit her family members and friends due to fear of having a panic attack while travelling in the bus.*

**Note to the Facilitators:** Shanti is experiencing symptoms of common mental disorder

- **Biological symptoms :** Dizziness, rapid heartbeat, shortness of breath, trembling, heart pounding
- **Behavioural symptoms:** Fear of going outside, not leaving the house
- **Cognitive symptoms:** Fear of having another panic attack

Shanti is experiencing symptoms of common mental disorder known as ' **Panic Disorder**'

**Case vignette 4**

*Sandhya is 24 years old married female. Her husband had brought her to the hospital as Sandhya was complaining of a severe backache since 3 days. On examination she didn't have any noticeable physical problems when doctor further enquired her husband about her mood, he said Sandhya was complaining of unusual fatigue and difficulty in concentrating in daily activities. His family members have noticed that she is often irritable over small issues and withdrawn. She stays in the bed all the time without sleeping. He also noticed that she had little interest in sex and has had difficulty in falling asleep at night from past few weeks. He has overheard her having frequent tearful phone conversations with her closest friend, which has made him more worried. Although she has never talked about suicide, now a day's she keeps saying that "life is not interesting, why should I live"*

**Note to the Facilitators:** Sandhya is experiencing symptoms of common mental disorder

- **Physical symptoms:** Unusual fatigue
- **Behavioural symptoms :** Irritable and withdrawn, poor sleep, loss of interest in daily activities, reduced concentration, decreased interest in sex, crying spells
- **Cognitive symptoms:** Death wishes, feeling hopeless about self and life

Sandhya is experiencing symptoms of common mental disorder known as "**Depression"**

## BACKGROUND MATERIAL:

Mental disorders comprise two main categories

- **Severe Mental Disorders (SMD):** are often difficult for the general community to understand, for example, hearing of voices or expressing strange or unusual beliefs.
- **Common Mental Disorders (CMD):** includes symptoms that all individuals experience from time to time, for example, feeling of fear, anxiety, tension, worry or sadness.

## SEVERE MENTAL DISORDERS

People with severe mental disorders usually experience a mixture of physical, emotional, thinking and behavioural symptoms. Severe mental disorders are not uncommon and usually involve psychosis that means 'losing touch with reality' or expression of unusually strange beliefs (delusions).

People with severe mental disorders are more easily identified as having a mental health problem than those with common mental disorders because they seem more obviously different from others in the way they think and behave. People with severe mental disorders may require hospital treatment.[7]

### 1. SCHIZOPHRENIA

Schizophrenia is a severe mental illness characterized by fundamental and characteristic distortions of thinking and perception and by inappropriate or blunted affect.[8]

Schizophrenia is one of the most serious mental disorders that affect around 0.3 –0.7% of people at some point in their life.[9] Both men and women are affected equally by schizophrenia, and symptoms may develop rapidly over several weeks or more slowly over several months. People with schizophrenia may seem like they have lost touch with reality. Although schizophrenia is not as common as other mental disorders, the symptoms can be very disabling. [10]

**Signs and symptoms**

The symptoms of schizophrenia fall into three categories: positive, negative, and cognitive.

**Positive symptoms: "**Positive" symptoms are psychotic behaviours not generally seen in healthy people. Symptoms include:

- **Hallucinations:** experiencing things that are not real. For example hearing of voices, smelling strange odours, having a "funny" taste in mouth, and crawling sensations on the skin. Hearing voices is the most common hallucination in people suffering from schizophrenia. The voices may comment on the person's behaviour, insult the person, or give commands.
- **Delusions:** Delusions are false, fixed unshakable beliefs that are not based on reality. For example, hearing his or her own thoughts, believes that he or she is God, people are putting thoughts into his or her head etc.
- **Thought disorders** (unusual or dysfunctional ways of thinking): Talking in sentences that do not make sense or using nonsense words, making it difficult for the person to communicate or engage in conversation, shifting quickly from one topic to the next.

**Negative symptoms:** "Negative" symptoms are associated with a disturbance in normal emotions and behaviours. They often last longer than positive symptoms. Symptoms include

- "Flat affect" (reduced expression of emotions)
- Unable to experience pleasure in day to day activities
- Reduced speaking
- Withdrawal from family, friends, and social activities
- Reduced energy
- Poor personal hygiene
- Lack of motivation

**Cognitive symptoms:** Changes in memory or other aspects of thinking. Symptoms include :

- Inability to understand information and use it to make decisions
- Trouble in focusing attention. [10]

**2. BIPOLAR AFFECTIVE DISORDER(BPAD)**

Bipolar Affective disorder is characterized by repeated (at least two) episodes in which the patient's mood and activity levels are significantly disturbed either mania (an elevation of mood, increased energy, and over activity) or depression (low mood, decreased energy and activity)[4]The first attack occurs most commonly between the ages of 15 and 30 years. To be diagnosed with mania, the episode should last for at least 1 week and should be severe enough to disrupt ordinary work and social activities more or less completely. The manic episodes may occur with or without psychotic symptoms (Hallucinations, Delusions)

The symptoms of the manic episode without psychotic symptoms include

- Elevated mood varying from joviality to uncontrollable excitement
- Increased energy resulting in over activity
- Pressure of speech
- Decreased need for sleep
- Marked distractibility

- Difficulty in concentration
- Inappropriate sexual behaviour
- Excessive optimism
- Increased self-esteem
- Spend money irresponsibly
- Aggressive, amorous, or facetious in inappropriate circumstances
- Irritable mood

The episode of mania with psychotic symptoms is a more severe form of Bipolar Affective disorder characterized by Grandiose delusions for example: Believes that he/she is special or superhuman

- Delusions of persecution that includes false belief that one is being attacked, harassed, or cheated
- Becomes incomprehensible due to flight of ideas and pressure of speech
- Severe and sustained physical activity and excitement may result in aggression or violence,
- Neglect of eating, drinking, and personal hygiene may leads to dehydration and self-neglect. [8]

## COMMON MENTAL DISORDERS (CMD)

People with CMD usually experience physical, emotional, thinking and behavioural symptoms, but not psychotic symptoms. In general, people get treatment for physical problems such as poor sleep or decreased appetite that are commonly associated with underlying common mental disorders (Depression or anxiety). [11]

### 1. DEPRESSION

Depression is an unusually sad mood that does not go away and lasts for at least two weeks and beyond. They affect the person's ability to carry out his/her work or have satisfying personal relationships. Everyone can feel sad at times but occasional sadness is not depression.[12] A recent national survey from India shows the prevalence of depressive disorders to be 0.8%.[13]

According to ICD-10-Diagnostic criteria for depression include
At least two of the typical symptoms from following features must be present for at least two weeks:

1. A depressed mood for most of the day
2. Loss of interest or pleasure in activities that are normally pleasurable
3. Tiredness, decreased energy, and fatigue

Additionally, any four of the following should be present

1. Loss of confidence and self-esteem
2. Feelings of guilt and blaming oneself
3. Recurrent thoughts of suicide or death
4. Difficulty in concentration
5. Agitation or lethargy
6. Sleep disturbance

7. Appetite disturbance

***Not every person who is depressed has all these symptoms, and the severity of depression is different for different people.***[8]

## 2. ANXIETY DISORDERS

Anxiety is a common mental disorder characterized by feelings of worry, nervousness or fear that interfere with one's daily activities. Anxiety is defined as "a state of intense apprehension, uncertainty, and fear resulting from the anticipation of a threatening event or situation, often to a degree that normal physical and psychological functioning is disrupted".[14] According to a national mental health survey, the current prevalence of anxiety disorders is 3.6%.[13]

Anxiety disorders can be classified into six main types. These include

**Generalized Anxiety Disorder (GAD)**

The essential feature of Generalized Anxiety Disorder is excessive anxiety and worry (apprehensive expectation), occurring for a period of at least 6 months, about a number of events or activities.

Symptoms include:

- Difficulty to control the anxiety and worry
- Restlessness
- Being easily fatigued
- Difficulty in concentrating
- Irritability
- Muscle tension and disturbed sleep

Some people with the generalized anxiety disorder (GAD) may become excessively apprehensive about the outcome of routine activities.[15]

**Panic Disorder**

The individual experiences recurrent attacks of severe anxiety (panic) that occurs suddenly in any particular situation or set of circumstances, and which are therefore unpredictable. The frequency and severity of these experiences may vary from person to person. Panic attacks usually last for only few minutes. Triggers can be in the environment such as a particular individual, an examination etc or they may be within the body such as physiological arousal.[15] The important symptoms include:

- Sudden onset of palpitations
- Chest pain
- Choking sensations
- Dizziness
- Feelings of unreality (depersonalization or derealization)
- Fear of dying
- Loss of control, or going mad

If a panic attack occurs in a specific situation, such as on a bus or in a crowd, the person may subsequently avoid that situation. Similarly, frequent and unpredictable panic attacks

produce fear of being alone or going into public places. A panic attack is often followed by a persistent fear of having another attack.

**Obsessive Compulsive Disorder (OCD)**
Obsessive Compulsive Disorder is characterized by the presence of obsessions and compulsions.

**Obsessions –** Unwanted intrusive thoughts, images or urge that repeatedly enters the person's mind. Common obsessions in OCD includes

- Contamination from dirt, germs, viruses, body fluids etc.
- Fear of harm (for example, that door locks are not safe)
- Excessive concern with order or symmetry
- Obsessions with the body or physical symptoms
- Religious, insulting thoughts
- Sexual thoughts (for example, of being a paedophile or a homosexual)
- Thoughts of violence or aggression

**Compulsion –** Compulsions are repetitive behaviours or mental acts that the person feels driven to perform. Common compulsions are;

- Checking (for example, gas, taps, door latch)
- Cleaning
- Washing
- Mental compulsions (for example, repeating special words or prayers in a particular manner)
- Ordering, symmetry or exactness
- Hoarding/collecting and counting[15]

**Post-Traumatic Stress Disorder (PTSD)**
Post-traumatic stress disorder is a delayed and/or prolonged response to a stressful event or situation of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress. e.g. natural or man-made disaster, serious accident, witnessing the violent death of others, or being the victim of torture, terrorism, rape, or other crime
The symptoms of PTSD include:

- Flashbacks
- Re-experiencing past experiences
- Repetitive and upsetting or distressing thoughts or images
- Extra attention and searching for threatening cues
- Exaggerated startle responses
- Irritability
- Difficulty in concentrating
- Sleep problems
- Avoidance of trauma reminders[15]

**Social anxiety disorder**
Social anxiety disorder also referred to as social phobia, is characterized by an intense fear in social situations that results in considerable distress and in turn impacts on a person's ability

to function effectively in aspects of their daily life. Social phobias are usually associated with low self-esteem and fear of criticism central to the disorder is a fear of being judged by others and of being embarrassed or humiliated. This leads to the avoidance of a number of social situations and often impacts significantly on educational and vocational performance.
Symptoms include:

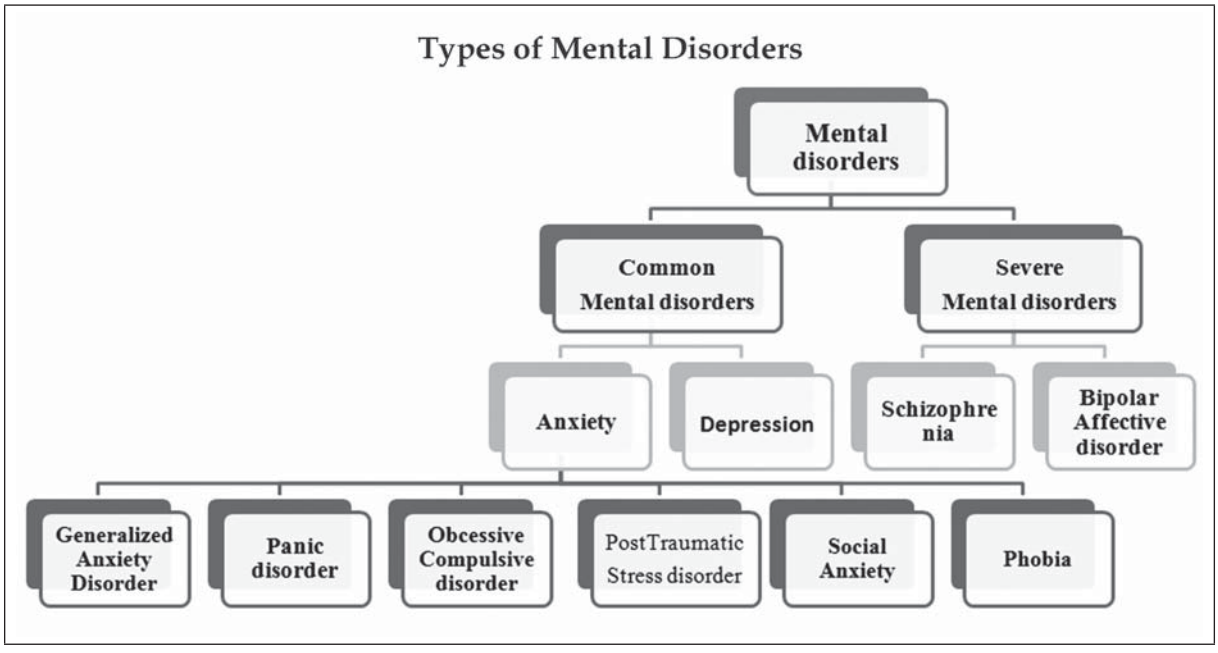
- Excessive blushing
- Sweating
- Trembling or hand tremors
- Urgency of micturition
- Palpitations and nausea[15]

**Phobia**

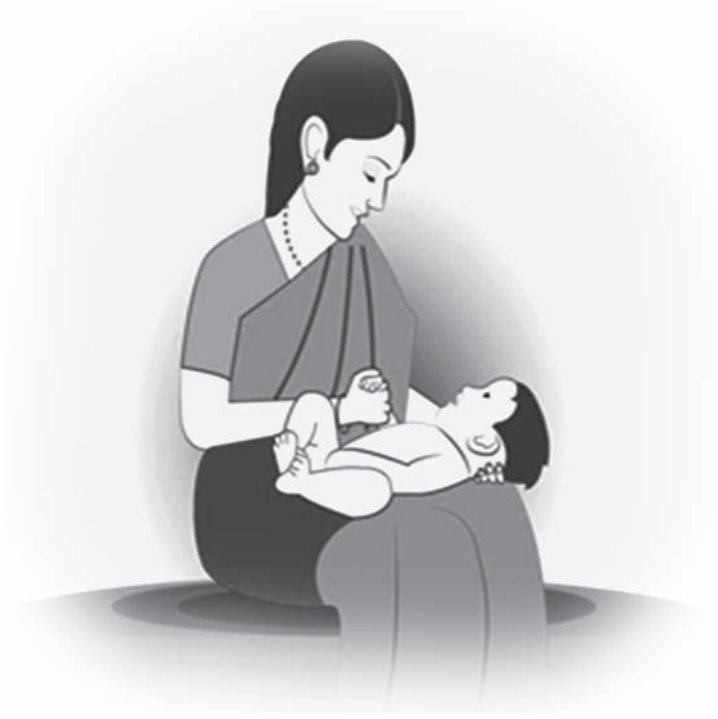
A phobia is an unwarranted, extreme and persistent fear of a specific object. The fear and anxiety occur immediately upon encountering the feared object or situation and may lead to avoidance or extreme discomfort.[15]

Phobias may be related and restricted to highly specific situations such as proximity to particular animals, heights, thunder, darkness, flying, closed spaces, urinating or defecating in public toilets, eating certain foods, dentistry, the sight of blood or injury, and the fear of exposure to specific diseases (such as AIDS).

Specific phobias usually arise in childhood or early adult life and can persist for decades if they remain untreated. [8]



# Session 3: Maternal Mental Health: Key Concepts



## BACKGROUND

This session enables the participants to understand about the concept of maternal mental health and maternal mental disorders. It also helps the participants to be aware of common maternal mental disorders and their impact on pregnancy, mother, baby and their families. Participants might use this information to provide optimal perinatal care to the women in their community.

**Topic outline**

3.1. Concept of Maternal Mental Health
3.2. Impact of Maternal Mental Disorders

**Session duration: 1 hour 30 minutes**

## TOPIC.3.1: CONCEPT OF MATERNAL MENTAL HEALTH

**Aim**

Helps the participants to understand the meaning and importance of mental health in women during pregnancy and after child birth

**Learning outcomes**

At the end of the session participants will be able to

- Understand the meaning of maternal mental health.
- Recognize the importance of maternal mental health

**Description**

A short video on *"Introduction to Maternal Mental health"* in regional language is played and participants are encouraged to observe the video followed by a group activity. Participants are divided into two groups and provided with a case vignette depicting women with common maternal mental disorders for discussion followed by a presentation by the facilitator.

**Suggested training methodology**

Video presentation followed by Small group activity and presentation

**Materials**

Laptop or computer, LCD Projector, Case vignettes, pens, papers

**Duration: 45** minutes

**Process**

- Play a video on *"Introduction to Maternal Mental health"* in regional language and participants are encouraged to express their views on mental health of a woman during pregnancy and postpartum period.
- Divide the participants into two groups and provide a case vignette to each group.
- Ask each group to identify a member of the group who will make notes of all the points during discussion and later to give feed back to the whole group at the end of this activity.
- Allow 5-10 minutes for group discussion.
- Invite a volunteer from each group to share their discussion to the whole group and encourage other group members to participate in the discussion.
- Facilitator uses the following questions to generate the discussion
  - What are the problems that you think, this woman is facing?
  - How does this problem affect her mental status?
  - What are the common mental health issues faced by the mother during her pregnancy and postpartum period in your locality/community?

**Case vignette 5**

*Radha is a19 yrs old woman, married to an auto driver without her parents' consent. Currently, she is six months pregnant. She does not have support from in laws and husband. During her prenatal visit, she was informed that she has a twin pregnancy. She is not happy about this and is constantly worrying about possible financial difficulties to take care of her children. She doesn't have her parents support as she married Ravi against their wish. She feels low, tired and anxious all the time. She is not able to sleep and eat properly.*

**Case vignette 6**

*Anuradha is a 26-years-old married woman who is a homemaker from a low socioeconomic background. Six weeks back she delivered her third child at 31 weeks of gestation and the baby was 1900 grams. She became pregnant when her second child was less than a year and her first child was just 4 yrs old.*

*She was not happy with her third pregnancy and worried constantly about taking care of her children. Moreover, she doesn't have any support from her husband and other family members. During a post-natal visit, Laxmi who is an ANM noticed Anuradha looking dull, inactive, not interested to take care of her children. On inquiry, she also expressed constant suicidal thoughts, inability to cope with her household chores and not able to take care of her children*

**BACKGROUND MATERIAL**

According to World Health Organization, mental health is an essential component of health. Mental health of women during pregnancy and after child birth is very important for healthy development of the child. Maternal mental health refers to a woman's mental health during pregnancy and the first year after birth.[16] It is also about the emotional well-being of pregnant women and their child, partner and families. Maternal mental disorders refers to mental illness during pregnancy and one year after birth.[16]

*The perinatal period is defined as period from conception until the end of the first postnatal year.[17]The terms perinatal and maternal are often used interchangeably.*

**Importance of Maternal Mental Health**

Pregnancy and having a baby is the most beautiful experience for most of the women. Good mental health and wellbeing is as important as physical health during perinatal period. Further the psychological state of a woman during pregnancy and after child birth has direct impact on the health of her foetus/baby. Thus, mental health during pregnancy and after child birth is essential because it helps to

- Maintain and promote emotional wellbeing of mother and child
- Nurture healthier child
- Develop and maintain positive relationships with family members
- Helps to cope with stress and challenges that occur during pregnancy and child birth
- Experience positive pregnancy and satisfying mother baby bonding

## TOPIC 2.3: IMPACT OF MATERNAL MENTAL DISORDERS

**Aim**

Help the participants to understand the impact of maternal mental disorders on women, foetus/baby and families.

**Learning outcomes**

At the end of the session the participants will be able to

- Understand the impact of maternal mental disorders on
  - Pregnancy
  - Postpartum period
  - Children
  - Families

**Description**

Participants are divided into smaller groups and each group is encouraged to brain storm on impact of maternal mental disorders on women during pregnancy, postpartum period, their children and families. Facilitator invites volunteers from each group to present their responses to the larger group and encourages other participants to contribute. At the end facilitator summarizes and adds inputs if required.

**Suggested training methodology**

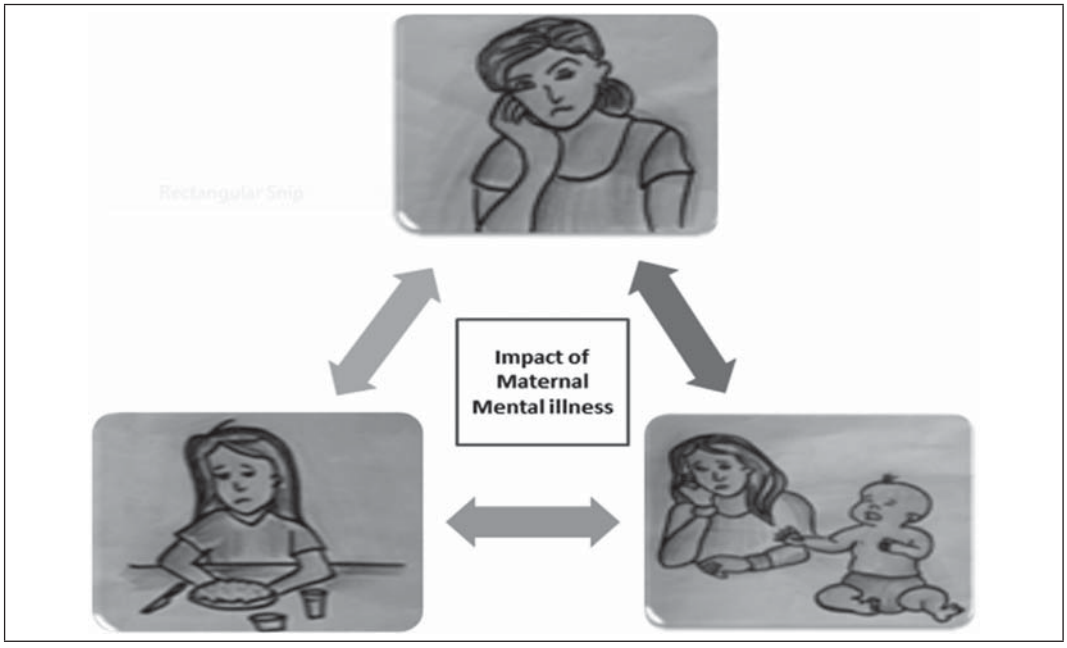
Small group activity followed by discussion and presentation

**Materials:** Chart paper, Marker pens

**Duration:** 45 minutes

**Process**

- Divide the participants in to four (A, B, C, D) smaller groups.
- Give chart papers and marker pens to each group.
- Instruct the participants to brainstorm on below given topics
  - Group A: Impact of mental illness on (during) pregnancy
  - Group B: Impact of mental illness on postnatal mothers
  - Group C: Impact of perinatal mental illness on their children
  - Group D: Impact of perinatal mental illness on their partners/families
- Allow 10 minutes for discussion and list out the points on a chart paper
- Ask the volunteer from each group to readout the points written on the chart paper to the larger group
- Encourage group to come out with as many points as they can. Congratulate them by saying that they have indeed given a comprehensive list.
- Provide additional information to the participants
- Encourage the participants to express their experiences from their practice



## BACKGROUND MATERIAL

Maternal mental disorders presents a major public health challenge, given its contribution to maternal morbidity and indirect mortality.[18] Emerging research shows maternal mental disorders not only affects the mother's well-being but may also have significant effects on fetal and child outcomes. [19]

### Impact of mental illness on pregnancy

- Research has established a strong and consistent relationship between mental illness and obstetric complications such as preterm delivery, low birth weight, stillbirth and children with cardiovascular congenital anomalies.[20, 21]
- Poor perinatal care [22]
- Increased risk for suicide[23]
- Increased maternal mortality rate[24]
- Influences fetal brain development due to maternal cortisol that crosses placenta [25]

### Impact of mental illness on mothers

- Impaired parenting skills and inability to seek support from health care providers.
- After the birth, the mothers with mental illness may fail to eat adequately, and care for self leads, to increased risk of physical illness.
- Increased risk for suicide and infanticide (Killing of her own baby) [26]
- Impaired bonding that may have long term impact on the child's development[27]
- Interfere with care for her baby and may cause the baby to have problems with sleeping, eating, and behaviour as he or she grows.[28]
- Mother may not respond at all to their children's behaviour such as crying or they may respond in a negative way.
- Reduced self esteem, guilt
- Impaired social and occupational functioning
- Problems with breast feeding. Mother may breastfeed for shorter period of time
- Increased risk of future episodes of depression and other mental health issues

### Impact of maternal mental illness on children

Maternal mental disorders can affect the children before they are born. Mental health of the mother may influence healthy development of a child both directly and indirectly. It is well documented that perinatal mental illnesses have lasting effects on children.

- Research found that children of mothers who were anxious or depressed in the perinatal period had lower IQs at 11 and 16 years of age and were more likely to have a diagnosis of depression themselves at age 16.[29]
- Children may be at risk for:
  - Behavioural/emotional problems such as crying louder and longer spend less time in the quiet and alert state, hyperactivity and inattention.[30]
  - Delayed milestones. For example; may walk and talk later than others
  - Social issues such as difficulty in establishing secure relationships, may be socially withdrawn[30]
  - Low birth weight, irritability and sleep problems in infancy, and academic difficulties when they go to school[31]

- Insecure attachment relationships due to impaired patterns of early interaction occurring between mother and infant [32]
- Risk for child abuse and neglect

**Impact of maternal mental illness on their partners/families**

- Relationship disruption (increased risk of separation/divorce)
- Partners depression may have negative impacts on relationships, children and families[30]

# Session 4: Understanding Risk Factors For Maternal Mental Disorders


**BACKGROUND**

This session aims to enable the participants to understand and identify the risk factors for mental disorders during the perinatal period. It also helps them to provide additional support to the women who are at risk for development of mental disorders.

**Topic outline**

Topic: 4.1. Risk factors for maternal mental disorders

**Session duration:** 45 minutes

## TOPIC: 4.1 RISK FACTORS FOR MATERNAL MENTAL DISORDERS

**Aim**

Enhances participants' knowledge on various risk factors for maternal mental disorders and helps them to identify women who are at risk for development of mental disorders during pregnancy and postpartum period.

**Learning outcomes**

At the end of the session, participants will be able to

- Understand the biological, social and psychological risk factors for the development of maternal mental disorders.
- Identify and provide sensitive care to the women who are at risk for development of maternal mental disorders

**Description**
Participants are divided into smaller groups and are provided with case vignettes. Participants are encouraged to discuss and identify the risk factors from the case vignettes given to them. Facilitator invites a volunteer from each group to present their responses to the larger group. Other participants are requested to listen and contribute to the same. Each participant is provided with a handout on *"risk factors for maternal mental disorders"* and the facilitator adds inputs to the session if required.

**Suggested training methodology**
Small group activity followed by discussion and presentation

**Materials:** Case vignettes, handouts, chart papers, marker pens, pens, flipchart or black/white board

**Process**

- Participants are divided into small groups and provide each group a copy of case vignette.
- They get 5-10 minutes to read the case vignette, discuss and note down their answers.
- Each group should choose someone to write up the answers and someone else to present the answers to the larger group.
- Participants are asked to list out the *risk factors* that are identified from the case vignettes given to them.
- Give each group 3 to 5 minutes to share their responses and get feedback from the larger group
- Write each factor on the flipchart or black/whiteboard ignoring repeated factors.
- If the participants suggest factors that are in fact not associated with the risk factors of a maternal mental disorder, write this on the board in a separate place from the main list.
- Distribute the handout on *"Risk factors for maternal mental disorders"*.
- Using the handout on *"Risk factors for maternal mental disorders"* ensure that all factors are adequately listed. If the groups do not mention certain factors then the facilitator can add them to the list.

**Case Vignette 7**
*Manasa 20-year-old woman married since 2 years, and mother of two months old baby is living in a nuclear family. She was working for a small company till her delivery. After the delivery, she lost her job, as she has to take leave for baby care and her company could not afford it. Manasa's husband who is currently in abroad due to official trip has stopped talking to her since she was not able to bring money from her parents. She doesn't want to express her problems to her parents as they stay in another city and are very old. Her neighbours noticed her being inactive, not interacting with them, not maintaining personal hygiene, and not responding to her baby's cry. They had informed to her parents and taken her to a doctor for treatment.*

**Note to the facilitator:** The following risk factors are identified from the below-given case vignette

- Nuclear family
- Loss of job
- Husbands' behaviour and demanding for dowry
- Lack of support from husband and family members

**Case Vignette 8**

*Sahana a 26-year-old woman married since six years and she was on treatment for infertility. After taking treatment for four years, she got conceived and had a miscarriage in the first trimester. Again after one year Sahana got conceived and was so anxious throughout her pregnancy due to the previous history of miscarriage. She had a complication in the third trimester of her pregnancy and undergone preterm delivery. The baby was kept in Neonatal Intensive Care Unit (NICU) for two weeks. She was not able to see her baby properly due to restriction from the hospital staff. After waiting for six years she got conceived and delivered a baby with great difficulty. She was worried about baby's health and had thoughts like whether she will be able to take care of her baby. Even though Sahana had a good support from her husband and family members, she is extremely anxious and expresses low mood, hopelessness, worthlessness and neglected her health. However, she denies suicidal thoughts.*

**Note to the facilitator:** The following risk factors are identified from the below-given case vignette

- Unable to conceive
- History of miscarriage
- Pregnancy complications
- Preterm delivery
- Baby was kept in NICU
- Unable to spend time with her baby

**Case Vignette 9**

*Sugandi 17 year girl, she lost her mother when she was 5 years old. Father married again and Sugandi didn't receive any care and support from her stepmother. So she started feeling the emptiness and got into the relationship with an auto driver. Sugandi used to spend most of the time with him and within a couple of months, she conceived. Since she was unmarried, her stepmother forced her to undergo an abortion. Family members were not willing for her marriage with an auto driver. So Sugandi eloped with him and got married in a temple. After few months, Sugandi conceived again but she had continuous thoughts of aborting her current pregnancy due to lack of family support and she also reported having disturbed sleep, lack of interest in household activities and planning to end her life. She also attempted suicide twice and was saved by her husband.*

**Note to the facilitator:** The following risk factors are identified from the below-given case vignette

- Teenage pregnancy
- Low socio-economic status
- Lack of support from family members

**Case Vignette 10**

*Geetha is a 23 yrs old woman belongs to low socio-economic status. She is a mother of two girl children and now she is 6 months pregnant. She was brought to the hospital by her mother with complaints of sadness, fatigue, decreased appetite, lack of concentration, poor interactions with the family members and attempted suicide twice. Her husband and in-laws wanted a boy baby which did not happen. Now husband threatens her that if this is also going to be a girl child, he would throw her out of the house with her children. He also beats the children very often. He started consuming alcohol and abuses her physically almost every day. She is fearful of police involvement, to take legal actions against him. Since she was feeling helpless she attempted suicide, fortunately, she rescued by her family members and was brought to the hospital.*

**Note to the facilitator:** The following risk factors are identified from the below-given case vignette

- Low socioeconomic status
- Preference for a boy baby
- Lack of support from family members
- Consuming alcohol by husband
- Physical and emotional abuse

## BACKGROUND MATERIAL

According to World Health Organization (WHO), 20% of mothers from developing countries experience depression after child birth.[33, 34]

Virtually every woman can develop a mental disorder during the perinatal period. However, studies from India emphasized certain risk factors that increase the risk of developing maternal mental disorders.

### RISK FACTORS FOR MATERNAL MENTAL DISORDERS

| Biological factors | Psychological factors | Social factors |
|---|---|---|
| • Multi gravida[35]<br>• HIV infection[36]<br>• Obstetric complications [6-8]<br>• History of miscarriage[35]<br>• Premature infant, hospitalization of the child admission, and infant death[37, 38]<br>• Younger maternal age (less than 20 years) [35]<br>• Caesarean section[38],[39] | • History of personal and family mental illness[36, 37, 39, 40]<br>• History of mental illness during pregnancy including depression and anxiety [35, 37, 41]<br>• Child care stress [35]<br>• Low self-esteem [35]<br>• Infant temperament[35]<br>• Thoughts of aborting current pregnancy[35] | • Stressful life events[35, 39, 42]<br>• Poverty [37, 38, 41-45]<br>• Domestic Violence[35, 37, 44]<br>• Lack of social support especially from partner [35, 37-39, 42, 44]<br>• Birth of a girl child when a son was desired[35, 37-42, 44]<br>• Unmarried[35]<br>• Nuclear family[40]<br>• Relationship difficulties with husband mother in law and parents[35, 38, 40-42]<br>• Husband's use of alcohol [35, 36, 39]<br>• Working women[44]<br>• Low education[37, 41] |

**Though there are many risk factors identified, some of the significant risk factors include:**

1. **Poverty**

   Poverty is one the significant risk factor for poor physical and mental health. Women those who live in poverty frequently suffer from anemia, due to improper nutrition. It was reported that 4% of Indian pregnant women are suffering from anemia which is the highest in the world and 20% of maternal deaths are due to anaemia.[46] Women who don't have access to eat food are at high risk for developing anxiety and depression during pregnancy and after childbirth.[46]

   Women who are living in poverty encounter significant challenges that affect mental health during pregnancy and after childbirth including; poor sanitation, unemployment, alcohol and substance abuse, Increased rates of domestic violence, poor access to

health services, obstetric complications due to malnutrition such as low birth weight, stillbirths, poor education, overcrowded housing etc.[47]

ANMs and other health care providers can help the women in accessing health care and supplementary nutrition under Integrated Child Development Services (ICDS) Scheme.

**2. Lack of social support**

Social support is essential for maintaining physical and psychological health. Social support has been described as "support accessible to an individual through social ties to other individuals, groups, and the larger community."[48]

The benefits of social support are essential for the women during pregnancy and after childbirth includes

a) Provides physical and emotional comfort
b) Improves woman's ability to cope with stress as it acts as a buffer against adverse life events.
c) Important for positive pregnancy outcomes. Motherhood requires lots of support in various forms (e.g., financial, appraisal, physical, emotional), and support from family, partners, and peers. [49]
d) Enhances quality of life of women

**3. Gender Preference**

Gender preference is not the uncommon issue in developing countries. In India, son preference is an important concern as it is associated with neglect and death of millions of females through infanticide, sex-selective abortions, improper nutrition, and lack of medical care.[50]

Pregnant women frequently experience prenatal anxiety when there was a strong family preference for sons.[51] Further, the birth of a female child when a male child is desired [51] and if the mother has already had a female child is strongly associated with postnatal depression.[52] It was reported that mothers' education is the single most significant factor in reducing son preference.[53] Hence, it is essential for health care providers to educate mother and family members about the consequences of gender imbalance in a society.

**4. Life stressors**

Negative life events can affect the mental health of women during pregnancy and the postpartum period. Adverse life events which can predispose women to maternal mental disorders include; loss of job or unemployment,[54]childhood abuse, premature birth and low birth weight, death of loved one, past history of miscarriage or stillbirths, marital separation, daily hassles (day-to-day stressors such as losing house keys and missing the bus, lack of sleep etc).

Working mothers are especially vulnerable to workplace stressors because of sleep deprivation, role demands of caring for an infant, and inability to engage in health promotion activities because of competing demands from home and work.[55]

5. **History of mental illness**

Perinatal period is the most vulnerable period for the development or relapse of mental disorders. The woman may be at increased risk for maternal mental illness in case of

- Untreated anxiety and depression during the pregnancy[56]
- Personal history of mental illness
- History of a postnatal depression after a previous birth
- Family history of mental illness

According to World Health Organization, it is important to refer women with history of mental illness for mental health services for preconception care and to reduce the risk of prenatal mental health problems. It is also essential to the ANMs to assess emotional wellbeing of the women at every visit and should provide additional support throughout perinatal period.

6. **Substance abuse**

Substance abuse in women is a growing concern in India. Substance abuse and mental illness often occur at the same time, or as a result of each other.[57]

Substance abuse during pregnancy and postpartum period may cause devastating effects on mothers, infants and their families. The most common substance abuse in Indian women includes tobacco (Smoking, passive smoking and chewing).

As per the National Family Health Survey (NFHS)-4, the prevalence of tobacco consumption among Indian women was 6.8%.[58] According to guidelines prescribed by the government of India for antenatal care suggests that ANMs should ask a pregnant woman about tobacco consumption habit/history during antenatal visits and intervene by advising pregnant women to give up tobacco at least during pregnancy and possibly forever.[59]

7. **Domestic violence** (discussed in detail in session 5)

***To promote maternal mental health, ANMs should recognize the risk factors as early as possible for appropriate interventions.***

# Session 5: Domestic Violence

**BACKGROUND**

This session aims to help the participants to enhance their understanding of domestic violence (DV) during perinatal period and its effects on women and foetus/child. This session also enables the participants to identify and provide emotional support to the women who experience DV.

**Topic outline**

5.1: Concept of domestic violence
5.2: Domestic violence among women in perinatal period
5.3: Domestic violence: Role of ANMs

**Session duration: 1 hour 30 minutes**

## TOPIC 5.1.CONCEPT OF DOMESTIC VIOLENCE

**Aim**

Helps the participants to improve their understanding on concept of domestic violence

**Learning outcomes**

At the end of the session, participants will be able to

- Understand the meaning of domestic violence
- Be aware of types of domestic violence
- Recognize the type of domestic violence that women are experiencing during pregnancy and postpartum period.

**Description**

Each participant is asked to brain storm and share their views on domestic violence in turn. Followed by this activity, participants are divided into small groups and each group is provided

a topic on types of domestic violence. They are asked to list out the various acts related to the topic given to them. Volunteers from each group are requested to present their responses to the larger group followed by facilitator's presentation.

**Suggested training methodology**
Brainstorm and discussion followed by small group activity

**Materials**
Chart papers, Marker pens, Flip chart or Black/whiteboard, pens

**Duration: 30** minutes

**Process**

- Lead a brainstorming session to explore participants' views on domestic violence.
- Invite participants to share their ideas randomly or in turn.
- The ideas are not to be criticized or discussed; participants may build on ideas voiced by others. The questions for brainstorming are
  - What does the phrase "Domestic violence" mean to you?
  - What actions do you feel as "Domestic violence"?
- Write down the response from each participant on the flip chart or black/whiteboard without any comments or questions.
- Followed by this activity, participants are divided into small groups.
- Each group is provided with a chart paper and a topic from topics listed below
  - Physical violence,
  - psychological violence,
  - social violence,
  - sexual violence
  - Financial violence

Participants are requested to list out related behaviours under the concerned headings.

- They have 5-10 minutes to discuss and note down their responses.
- Each group should choose someone to write up the answers and someone else to present the answers to the larger group
- Participants are asked to list out the acts related to concerned topics.
- Ask the volunteers from each group to read aloud and as they read out write down on the blackboard.
- Encourage the participants to express their professional or individual experiences.
- Facilitator may provide additional information to the participants

## BACKGROUND MATERIAL

**Introduction**
Globally, violence against women is a serious public health concern and violation of women's human rights. According to National Crime Records Bureau (2015) in India, domestic violence accounted for 34% of cases rising by 6% over the last four years.[60]

**Definition**

Domestic violence refers to any kind of abusive behaviour by the husband or their relatives including either male or females.

Domestic violence is defined by Domestic violence act (2005) as "any act, omission or commission or conduct of the respondent shall constitute domestic violence in case it:

1. Harms or injures or endangers the health, safety, life, limb or well-being, whether mental or physical, of the aggrieved person or tends to do so and includes causing physical abuse, sexual abuse, verbal and emotional abuse and economic abuse; or
2. Harasses, harms, injures or endangers the aggrieved person with a view to coerce her or any other person related to her to meet any unlawful demand for any dowry or other property or valuable security; or
3. Has the effect of threatening the aggrieved person or any person related to her by any conduct mentioned in clause (a) or clause (b); or
4. Otherwise, injuries or causes harm, whether physical or mental, to the aggrieved person." [61]

**Types of Domestic violence**

1. **Physical violence** - Hitting, punching, kicking, starving, tying up, stabbing, throwing things, using objects as weapons, pulling hair, pushing etc.
2. **Sexual violence** -Forced sex, forced prostitution, refusal to practice safe sex, deliberately transmitting STDs (sexually transmitted diseases), preventing breastfeeding etc.
3. **Psychological violence**- yelling, insulting woman for simple things, isolating a woman from friends and family, criticizing, treating her as an inferior, threatening to harm children or take them away
4. **Financial violence -** Not letting a woman work, refusing to give money, asking for an explanation of how money is spent, making her beg for money, not paying bills.
5. **Social violence-**Preventing a woman from having social contact with friends or family or restricting the woman going out.

## TOPIC.5.2: DOMESTIC VIOLENCE IN WOMEN DURING PERINATAL PERIOD

**Aim**

Explore and enhance the participants' understanding about physical and mental health impact of domestic violence in women during pregnancy and after childbirth

**Learning outcomes**

At the end of the session, participants will be able to

- Identify various risk factors for domestic violence in women during perinatal period
- Explain the impact of DV on physical health of women and foetus/child
- Discuss the impact of DV on mental health of women and foetus/child

**Description**

Participants are divided into small groups and each group is provided with a case vignette. Participants from each group are asked to identify the risk factors and physical/mental health

impact of DV on women and child from the case vignette. Volunteers from each group are invited to present their responses to the larger group. Each participant is provided a handout on "*Physical and mental health effects of domestic violence on women and foetus/child"*. Based on the handout, facilitator leads the discussion by adding necessary inputs.

**Suggested training methodology**
Small group activity followed by discussion and presentation

**Materials:** Case vignettes, Handouts, pens

**Duration:** 45 minutes

**Process**

- Divide participants into smaller groups and each group is provided with a case vignette.
- They have 5-10 minutes to read the case vignette, discuss the questions and note down their answers.
- Each group should choose someone to write up the answers and someone else to present the answers to the larger group
- Participants are asked to identify the type of violence and physical and mental health impact of DV on women and children in the given case vignette.
- Give each group 3 to 5 min to share their responses and get feedback from the larger group.
- Encourage three or four volunteers to share their experiences of a woman (without disclosing her name) in their community who might be experiencing DV during the perinatal period, either now or at some time in the past.
- Distribute a copy of handout on *"Physical and mental health impact of domestic violence"* to all the participants and facilitator leads the discussion based on the handout.
- At the end, facilitator concludes the session by informing the participants that ANMs play a unique role in identifying and supporting women who experience with DV.

**Case Vignette 11**

*Nandini is a 26-year-old lady from middle socioeconomic status brought to the hospital by her husband. She got married two years back and has an eight months old baby. Her husband stated that she has fallen on the floor and had a head injury. On physical examination, it was found that the injury was not compatible with his explanation. She was examined by the female nurse in private. On repeated questioning, she reported that this injury was due to her husband pushed her to the wall .On further inquiry she described repeated episodes of physical abuse, sexual coercion, controlling and threatening behaviour by her husband. She reported that her husband frequently comments on her appearance as she looks ugly. He would abuse her in front of other family members calling her as "mad woman". He repeatedly asks her to leave the home. He does not allow her to talk to her parents. He restricted her to meet her friends. This behaviour of husband made her to have negative thoughts about her life and she started thinking that she is good for nothing, cries whenever she is alone, neglected herself and child care activity. She was unable to involve in household chores.*

**Note to the Facilitator:** Nandini is experiencing domestic violence

- **Physical violence:** Head injury, repeated physical abuse
- **Sexual violence:** Sexual coercion
- **Psychological violence:** threatening behaviour, commenting her as "mad woman", ask her to leave the house
- **Social violence:** not allowing her to talk with her parents and restricted her to meet her friends

**Health impact on women and child**

- Negative thoughts about life
- Sad mood as she cries often
- Neglected care of self and child
- Loss of interest in household chores

**Case vignette 12**

*Ramya 20-year-old married since one year. Recently, Ramya's in-laws started demanding for dowry. When she could not meet their demand they repeatedly abused her physically and threatened her that if she is not getting the dowry they will go for a second marriage for their son and she will be thrown out of the home. Her husband was witnessing these things in silence. When Ramya requested her husband to talk to his parents he chooses to be silent on this issue. She was very much disturbed and she did not have proper food, soon then she got conceived and now she is three months pregnant. During her first visit to a doctor, she was underweight and anemic so the doctor had strictly asked her to follow nutritious food, and take good rest for three months. Even after doctor's prescription, her in-laws did not give her nutritious food, and she was made to do household chores without adequate rest. Her in-laws frequently made comments that "if she needs any food let her bring from her parents, we will not do any expenditures on her " They also threatened her that if she does not give birth to a baby boy, then she and her baby will be sent out of their house. Since her parents were poor and she had one more sister to get married, she didn't ask help from them. One evening during an argument with her in-law about the dowry, her in-law pushed her forcefully leading to undergo an abortion due to abdominal trauma. After all this, her husband was silent on this issue. She felt helpless and started to worry about her future and started neglecting her health. During the home visit, the health worker met Ramya. During the routine examination, health worker observed that Ramya has lost her weight, became anemic, anxious, has disturbed sleep, socially withdrawn and worried about something. When she enquired about her problems, Ramya revealed that she is abused by her in-laws every day. She has a constant worry that they may send her out of the home.*

**Note to the Facilitator:** Ramya is experiencing domestic violence

- **Physical violence:** abdominal trauma
- **Psychological violence:** demanding for dowry, threatening her that she will be thrown out of house, demand for a birth of a boy baby

**Health impact on women and child**

- **Physical health:** Inadequate nutritious food, abortion, loss of weight, anemic
- **Mental health:** Low mood as she feels helplessness, anxious, having disturbed sleep, social withdrawn and persistent worry

**Case vignette 13**

*Narmada 24 years old married woman educated up to 10th standard and belongs to low socioeconomic status. On the very next day after she got married, she found that her husband has an extramarital affair with another lady and had a child. When she inquired about his affair he started beating her physically and threatened her that she will be thrown out of the house if she reveals this to her parents. Her first pregnancy ended in a stillbirth one week back because her husband had forceful, violent sex with her during her last trimester. Following this, he started harassing her saying she is good for nothing and insults her calling with filthy nicknames and restricted her visiting parents and other family members. During the home visit, Roopa a health care provider (ANM) observes the Narmada being tearful, not able to converse freely with Roopa in front of her husband. As Roopa also noted that her husband is not leaving her alone so she requests her husband to leave the room as she wanted to perform a physical examination. On inquiry, she busted out saying that "I was abused both physically and sexually from the time of my marriage. I am good for nothing.. and I don't feel like to live anymore". Roopa provides psychological support to her and gives her contact number for further help.*

**Note to the Facilitator:** Narmada is experiencing domestic violence

- **Physical violence:** Beating
- **Sexual violence:** forceful violent sex during last trimester of pregnancy
- **Psychological violence:** threatening her that she will be thrown out of her house, insulting her as she is good for nothing, calling her filthy nicknames
- **Social violence:** restricted her to meet her parents and other family members

**Health impact on women and child**

- **Physical health:** Still birth
- **Mental health:** Death wishes as she doesn't want to live any more

**Case vignette14**

*Sujatha, 23-year-old graduated woman belongs to middle socioeconomic status. She fell in love with Mahesh and married him two years back. Since it was out of her caste marriage, their parents had a great disapproval to this. Her harassment started after one year of marriage when she could not have a child. Currently, she is three months pregnant and she is ambivalent about her pregnancy as her husband lost his job because of his aggressive behaviour. Following this, he started consuming alcohol every day and abuses her physically and sexually. She has no support from her parents and he started demanding her to go to her parents to get money. Since she doesn't want to do this he started screaming at her for simple things. One evening she was not well and unable to cook dinner because the smell of food made her more nauseous. He started yelling at her as "useless" and pushed her against the wall. He also insults her when she vomits due to morning sickness as she is a dirty female and disturbed him in the night. He doesn't provide any financial support to have a healthy diet and ignored about her prenatal care. Following this, she started worrying about her future, had sleep disturbances, lost her weight and neglected her health. During home visit she ventilates her feeling with Susheela ANM and describes about him with tears as "he would kick me, slap me, push me, throw things at me, and life has become hell for me and I don't want to live anymore". Susheela provides psychological support to her and informed about the maternal services that are available in her community.*

**Note to the Facilitator:** Sujatha is experiencing domestic violence

- **Physical violence:** kicking, slapping, throwing things, pushing
- **Sexual violence:** Sexual coercion
- **Psychological violence:** Demanding to get more money from her parents, screaming her for simple things, yelling her as useless, insulting her as a dirty female
- **Financial violence:** lack of financial support

**Health impact on women and child**

- **Physical health:** loss of weight
- **Mental health:** worrying about her future, sleep disturbances, death wishes as expressed that she doesn't want to live anymore

## BACKGROUND MATERIAL

### Introduction

Domestic violence during perinatal period is a serious concern as it affects not only physical and mental health of the mother but also foetus and child. According to WHO multi-country study, the prevalence of intimate partner violence in pregnancy ranges between 1% to 28%.[62] Unfortunately, India has the second highest domestic violence prevalence rate during pregnancy (28%) in the world.[63]

### Risk factors for domestic violence

Though pregnancy is a protective factor for domestic violence as it retains a privileged position in Indian culture, it is not true in case of all women. Some of the factors that increase the risk for domestic violence in women during perinatal period include

| Individual factors | | Relationship factors | Societal factors |
|---|---|---|---|
| Perpetrators | Victims | | |
| • Substance abuse<br>• Unemployment<br>• Spousal gambling[64] and extramarital affairs[65, 66]<br>• Low education[66]<br>• Witnessing and experiencing violence as child<br>• Personality disorders | • Young woman who is single, separated or divorced<br>• History of mental illness<br>• History of child abuse<br>• Low literacy<br>• Adolescent pregnancy<br>• Love marriage [66]<br>• History of violence both before and during pregnancy [67,68]<br>• Lack of social support , multi parity[69] | • Poverty<br>• Living in urban slums<br>• Marital conflicts<br>• Lower castes[66] | • Son preference [70]<br>• Social acceptance of violence |

### Health effects of domestic violence

In India, one-third of women who experience violence during pregnancy and postpartum period may have various complications.[71] The following are some of the few common physical and mental health effects of domestic violence on mother and child.

| Domestic violence during perinatal period | | | |
|---|---|---|---|
| Effects on Physical Health | | Effects on Mental Health | |
| Mother | Foetus | Mother | Child |
| • Premature birth<br>• Miscarriage<br>• Infection<br>• Poor nutrition<br>• Maternal mortality<br>• Homicide<br>• Low weight gain<br>• Placental abruption<br>• High blood pressure<br>• Ante partum hemorrhage<br>• Caesarean delivery<br>• Frequent hospitalization | • Low birth weight<br>• Breastfeeding difficulties<br>• Stillbirth<br>• Fetal death | • Increased distress<br>• Anxiety<br>• Depression<br>• Somatic complaints (insomnia, headache, pains)<br>• Suicide<br>• PTSD<br>• Relapse of mental illness<br>• Lack of attachment to foetus/child | • Nightmares<br>• Startling easily,<br>• Being bothered by loud noises bright lights<br>• Avoiding physical contact,<br>• Difficult to comfort<br>• Problems with breastfeeding<br>• Developmental problems<br>• Excessive separation anxiety |

## TOPIC. 5.3: DOMESTIC VIOLENCE: ROLE OF ANMS

**Aim**

Explore the participants' views about their role in response to domestic violence among women during the perinatal period

**Learning outcomes**

At the end of the session, participants will be able to

- Identify women who are experiencing domestic violence
- Provide emotional support to the women who are experiencing DV
- Assist the women in safety planning
- Inform women about support services that are available in their community
- Work collaboratively with other healthcare providers and stakeholders in the community to prevent DV

**Description**

Volunteers from the participants are invited and provide them a case vignette to enact a role play. Give them 10 minutes of time to discuss and decide the characters. Facilitator instructs them to focus on ANMs role in addressing the domestic violence. At the end, facilitator provides necessary inputs.

**Suggested training Methodology**

Role play followed by discussion

**Materials:** Case vignette, papers, pens

**Duration: 45** minutes

**Process**

- Display the case vignette to the whole group and invite the volunteers to enact the role play
- Allow 10 minutes for discussion among the volunteers.
- After the discussion ask the volunteers to enact the role play.
- Ask the other participants to watch the role play without any comments and note down their observations
- Encourage the participants to discuss the role of ANMs in identifying, providing immediate interventions and referring the women for appropriate services.
- Encourage the participants to express their professional experiences.
- Facilitator may provide additional information to the participants

**ROLE PLAY – CASE VIGNETTE 15**

*Bhavya is 22 years old seven months pregnant woman from middle socioeconomic status. She is staying with her husband and in-laws who demand her to get money from her parents. Her husband is an alcoholic and abuses her physically almost every day. One evening, Bhavya questioned him about his habit of drinking that lead to a big fight and she had been beaten up very badly. Unfortunately, her in-laws also didn't support. Further, she was blamed for questioning the husband. During a home visit, Aruna, who is the concerned ANM, observe Bhavya being sad, tearful, and not talking to her as usual. During the physical examination, she also notices the bruise marks on hand and legs. Aruna suspects domestic violence.*

**BACKGROUND MATERIAL**

**Role of ANMs**

Domestic violence has been recognized as the public health priority and severe violation of human rights of the women. Being a grass root level worker, ANMs play an important role in addressing this issue.

- **Identify Domestic violence**
  - As part of routine care during home visits, ANMs should ask sensitively about whether the woman is experiencing domestic violence.
  - Look for cues to find out whether a woman is at risk or experiencing Domestic violence
  - Provide more flexible appointments if they need time to disclose.

**Cues to identify Domestic violence**

- Delay in seeking pre and post-natal care
- Continued use of products harmful to pregnancy (betel leaf, tobacco, cigarettes, drugs, alcohol)
- Lack of attendance for prenatal education[72]
- Presence of injuries (bruises on the body, especially around eyes and face, hit marks on ears, lose or broken teeth) that do not match the explanation of how they occurred.
- Vague complaints (unspecified complaints of pain, numbness, or pain in lower abdomen) persisting for a long time with no obvious physical cause
- Unexplained, spontaneous abortion in pregnant women
- Attempted suicide or suicidal thoughts
- Anxiety, fear, depression
- Sleep related problems[73]

- **Access to health services**
  - Provide first aid for minor injuries
  - In case of serious injuries refer her to appropriate health care facilities and escort her if necessary and ensure follow up.
- **Offer emotional support**

  Often, first-line support is the most important care that ANMs can provide to the women who are experiencing DV. First-line support provides practical care and responds to a woman's emotional, physical, safety and support needs, without intruding her privacy.

  First-line support involves **LIVES Module** with five simple tasks. It responds to both emotional and practical needs at the same time.

| | |
|---|---|
| **L**ISTEN | Listen to the woman closely, with empathy, and without judging. |
| **I**NQUIRE | Assess and respond to her various needs and concerns — emotional, physical, social and practical (e.g. childcare) |
| **V**ALIDATE | Understand and believe her. Assure her that she is not to be blamed |
| **E**NHANCE SAFETY | Discuss a plan to protect herself from further harm if violence occurs again |
| **S**UPPORT | Support her by helping her connect with information, services, and social support |

- **Safety planning**
  - A safety plan is a list of ideas that help a woman for the safety of herself and her children if in case violence increases at home.
  - Assist the woman to identify a safe place like parent's home, a friend or relative's house where she can be temporarily located until the situation is resolved
  - Provide information about shelters run by government or NGOs to support the woman and make sure that she carries all the important documents such as identity card, bank passbook, ration card, and the children's birth certificate, marriage

registration or proof, educational certificates, health-related records, assets on her name, etc.

- ANMs can take support from ASHAs, other members of the community such as women's groups and Gram Panchayat to help the woman.

- **Inform the woman about legal recourse**
  - ANMs should explain the woman regarding places or persons to contact in case she decides to report the violence.
  - Most districts in the country have a Women's Police Station.
  - The woman could also contact functionaries of the Women and Child Department (WCD). These persons will forward her complaint to the concerned "Protection Officer" of the WCD. This officer has been authorized by the government to take action on violence against women, and there is a 24-hour toll-free helpline number (1800-425-90900) to reach this officer.
  - The ANM also should provide her with details of Legal Aid Centers existing in court at the district level and provide guidance on seeking legal assistance.
- **Accessing other resources for assistance**

  ANMs should have the telephone numbers of Police such as Vanitha Sahayavani (1098), support organizations and media personnel- such as newspaper/magazine reporters and TV journalists.
- **Prevention of Domestic Violence**

  Gender inequality is the root cause of violence against women. Thus, ANMs have a responsibility to address gender inequality through primary prevention programs such as
  - Build awareness among the public by creating and disseminating materials to improve attitude towards girl child and women.
  - Emphasize the responsibility of men to end violence against women.
  - Focus on abused woman's needs to build self-efficacy and livelihood skills.
  - Work collaboratively with ASHAs, Village leaders, Mahila Mandals, NGOs and voluntary organizations to end violence against women.[74]
  - Organize and participate in awareness programs related to violence against women
  - Sensitize the women about their rights and legal provisions or Acts that prohibit violence against women

## DAY -TWO

Activity : Revision of Day One

Time : 30 minutes

Purpose : To revise the information discussed in the day one

Materials : Quiz questions and some small prizes

Directions : Divide the participants into small groups (about 4-5 people in each group)

Ask the quiz questions below, one at a time.

For each single question, the group decides what the best answer is and one of the group members responds. If it is right answer, one credit point to be given to the group. If the first group answer is incorrect, then the facilitator asks the second group and so on.

Small prizes will be given to the group members who scores high credit points.

**Quiz questions – Revision of day one**

1. What is Mental Health?
   **Answer:** Mental Health is a capacity of an individual to enjoy life and deal with challenges successfully.
2. There is no health without mental health – true /false
   **Answer:** True
3. What are the types of mental disorders?
   **Answer:** Severe and common mental disorders
4. Name two severe mental disorders
   **Answer:** Schizophrenia and BPAD
5. What area the differences between severe and common disorders
   **Answer:** People with SMD suffer with psychotic symptoms (hallucinations and delusions)
6. Name two symptoms of SMD?
   **Answer:** Hearing of voices and talking to self
7. What is hallucination?
   **Answer:** Experiencing things that are not real. Example: hearing of voices, smelling strange odours, crawling sensations
8. What is delusion?
   **Answer:** Delusions are false fixed unshakable beliefs that are not based on reality Example: Believing that he or she is god, superman etc
9. Name two common mental disorders?
   **Answer:** Anxiety, Depression

10. Name two symptoms of depression
    **Answer:** Persistent low mood, lack of energy, sleeping disturbances, feeling of hopelessness, worthlessness and helplessness
11. What is anxiety?
    **Answer:** Fear of unknown
12. Name two symptoms of anxiety
    **Answer:** Difficulty in concentration, irritability, sleeps disturbance, restlessness, trembling
13. What is Maternal Mental Health?
    **Answer:** Maternal Mental Health refers to emotional wellbeing of women during pregnancy and after child birth.
14. What is perinatal period?
    **Answer:** Perinatal period refers to soon after conception to one year after child birth.
15. Name two risk factors for maternal mental illness?
    **Answer:** Younger age, previous history of mental illness, stressful life events, lack of family support and domestic violence

# Session 6: Common Maternal Mental Disorders

## BACKGROUND

This session helps the participants to understand about common maternal mental disorders. It also helps the participants to improve their knowledge about signs and symptoms of anxiety disorders that occur during pregnancy and postpartum period. This information may be useful to identify and support the women with these mental health issues.

**Topic outline**

6.1. Ante partum Common Mental Disorders (ACMD)
6.2. Postpartum Common Mental Disorders (PCMD)

**Session duration :**1 hour 30 minutes

## TOPIC. 6.1: ANTE PARTUM COMMON MENTAL DISORDERS

**Aim**

Enhance the participants' understanding on ante partum mental disorders and learn effective strategies to deal the women who experience anxiety or depression.

**Learning outcomes**

At the end of the session participants will be able to

- Understand the common mental disorders that occur during prenatal period
- Be aware of the common risk factors related to anxiety and depression
- Differentiate the signs and symptoms of various anxiety disorders
- Identify the women with depression to provide optimal care

**Description**

Participants are divided into two groups (A&B) and each group is provided with a case vignette. Group A is asked to discuss about the case vignette given to them and present to

the larger group. Participants from group B are asked to enact a role- play based on the case vignette and followed by video presentation on antepartum mental health assessment. At the end facilitator concludes the session with his/her presentation.

**Suggested training methodology**
Small group activity followed by role-play

**Materials:** Case vignettes, LCD projector, computer, paper and pen

**Duration:** 45 minutes

**Process**

- Divide the participants into 2 groups. Let them read the case vignettes given below amongst themselves
- They have 5-10 minutes to come up with the type of information required to be discussed under each heading. Guide them to write notes on paper given to them.
- Group A should choose someone to write up the answers and someone else to present the answers to the large group. Similarly group B should discuss among them about the case vignette and choose the volunteers to perform the role play.
- It is important to stress that the groups should focus only on symptoms of woman mentioned in the case vignettes.
- Ask group A to present their case vignette to the rest of the participants and share their responses and get feedback from the larger group.
- Invite volunteers from group B to enact the role play based on the case vignette given to them and encourage other participants to observe and write down the points for the discussion.
- At the end, facilitator clarifies the doubts of the participants and provides the information using the power point presentation.

**Case vignette16**

*Shamala is a 20 year old female educated up to 10$^{th}$ standard. She got married 3 years back. . She had a past history of anxiety when she failed in 10$^{th}$ standard and had taken treatment for the same. After that, she used to be cheerful and interactive with family members and friends. However, she used to be very shy in front of the husband. After, one year of marriage couple had planned for pregnancy. Following that, she had a miscarriage. Since then she is scared to get conceive, as she is constantly having fear of another miscarriage. Shamala had thoughts like "if I conceive again, definitely I am going to lose the pregnancy; my husband like kids but I am scared of having another miscarriage; I am really worried after hearing to so many horror stories of pregnancy losses". She missed her period again and urine pregnancy test came positive. She again started worrying about miscarriage. It persisted throughout the pregnancy. Shamala kept having fear of miscarriage throughout her pregnancy. Due to these thoughts, she had fear to travel, even for ANC visits, or attending family functions. She found difficulty in doing household chores, daily routines, difficulty in falling asleep, and was more cautious about diet and medications. She also used to develop dizziness, palpitations, sweating while attending the antenatal clinic. She believes that her worrying makes her be prepared for disappointment and prevents bad things from happening*

**Note to the facilitators:** Shamala is experiencing symptoms of a common mental disorder

- **Risk factors:** she had miscarriage two times, young age, and past history of anxiety
- **Physical symptoms:** difficulty in carrying out household chores and daily routines
- **Autonomic symptoms:** dizziness, palpitation, sweating
- **Cognitive symptoms:** fear of another miscarriage
- **Behavioural symptoms:** difficulty in falling asleep, fear to travel, fear of ANC visits, or attending family functions

Shamala is experiencing symptoms of a common mental disorder known as **"Generalized Anxiety Disorder"**

**Case vignette 17**

*Sushma is a 20 year old, married lady, educated up to third standard, and belongs to low socio-economic status. Her husband is a carpenter who is an alcoholic. He is not a cooperative husband and abuses Sushma physically and sexually very often. She presents with symptoms of sadness of mood, lack of interest in pleasurable activities, sleep disturbances, and loss of appetite since one month. Before the onset of the illness she was found to be cheerful, actively participating in her daily routine activities. She was very happy during her previous pregnancies and delivered two girl babies. But her in laws were not happy of having two girl children and criticized her for not able to give birth to a male baby. They were also blaming her for not bringing any dowry from her parents. Considering their financial status and in laws' demand for a boy baby, she did not think about the third pregnancy but husband and in-laws were insisting for a male child. Her third pregnancy was not planned. When she learnt that she is pregnant, she was unable to accept it. She was constantly worried and had thoughts like 'What would be the gender of the baby?' and how to face the financial difficulties. Gradually she started losing interest in doing household chores, and she lost interest in taking care of her two daughters. She could not enjoy the activities such as watching TV or meeting her friends etc. She started to cry when alone, gradually neglected her health, and stopped talking to others including her husband and children.*

**Note to the Facilitators:** Sushma is experiencing symptoms of a common mental disorder.

- **Risk factors :** young age, financial difficulties, demand for dowry and disappointment with girl children, Physical, sexual and emotional abuse
- **Mood :** Low mood
- **Physical symptoms:** Sleep disturbances, loss of appetite
- **Behavioural symptoms:** Social withdrawal , loss of interest in household chores, lost interest in taking care of children, lack of interest in pleasurable activities crying spells
- **Cognitive symptoms:** worried about gender for the baby and financial difficulties

Sushma is experiencing symptoms of a common mental disorder known as **"Depression"**

**BACKGROUND MATERIAL**

Motherhood represents a milestone in woman's life and is often a period of stress and challenges.[75] A recent systematic review revealed higher rates of common mental disorders among women from low-and-middle-income countries (LAMIC), where the mean prevalence of these disorders was found to be 15.6% in pregnant women and 19.8% in women who had recently given birth.[76] Anxiety and depression often occur together, are often present in pregnancy and persist if not treated These disorders can have a wide range of effects not only

for the mother but on the foetus, the infant, partner and other family members

## 1. ANXIETY DISORDERS

Anxiety is a normal human emotion and it is common for pregnant woman to have some concerns and worries. However, for some mothers' anxiety becomes so severe, distressing and disabling that interferes with their daily life and indicates the need for interventions.

**Risk factors**

Research shows that there are a number of risk factors that may predispose women to anxiety disorders during pregnancy that include

- Family history of anxiety disorders
- Personal history of depression or anxiety[77]
- Thyroid imbalance
- Low socioeconomic status
- Childcare stress
- History of smoking [78]
- Infertility treatment[79]
- Younger age (below 20 yrs)
- Stressful life events[80]
- Obstetric complications such as history of miscarriage, fetal loss, preterm delivery[81]

**Consequences of anxiety disorders**

The most important consequences of anxiety disorders on mother and foetus/child include

**Consequences on mother**

- Poor access to prenatal care[82]
- High risk for antenatal and postnatal depression[83]
- Irritability
- Poor interaction between mother and child
- Fear in dealing with life events is common.

**Consequences on foetus/child**

- Underweight and stunted children[84]
- Preterm birth[54]
- Children may experience impaired cognitive development, emotional problems and concentration difficulties [85]
- Increased risk for development of anxiety and depression at the age of 18.[86]

**Anxiety disorders can have various presentations**

**Generalized Anxiety Disorder (GAD)**

GAD is a persistent and excessive worry about a number of life domains along with various physical symptoms such as tension headaches, muscle aches, irritability and poor concentration

for more than 6 months. Women with past history, low education and support, and child abuse histories were at risk of GAD before and during pregnancy.[87]

During pregnancy women with GAD experience excessive worry about role changes, health concerns for the foetus and bodily changes.[88]

**Panic disorder**

Panic disorder is a type of anxiety disorder characterized by recurring severe panic attacks, for at least one month. Due to the physiological changes of pregnancy, a woman may be at increased risk of onset or recurrence of the panic disorder.

During a panic attack, mothers likely to experience same symptoms as others experience such as palpitation, dizziness (lightheadedness), feeling faint, chest pain or discomfort, shortness of breath or hyperventilation etc. Anticipatory future Panic attacks and consequences of these on the foetus can disable the mother significantly.[88]

**Phobias**

Phobia is an irrational fear of an object or a situation leading to avoidance. Tokophobia is a specific type of phobia related to pregnancy. Tokophobia refers to apathological fear of pregnancy and associated with avoidance of childbirth.[89]The prevalence of Tokophobia was 5.5% in women and the risk factors include

- History of sexual or physical abuse
- A traumatic gynecological examination
- Previous experience of childbirth and related anxiety
- Myths about labour and childbirth.[90]

Tokophobia often associated with avoidance of pregnancy and elective caesarian section in subsequent pregnancies.[91]

**Obsessive–Compulsive Disorder (OCD)**

Obsessive-compulsive disorder is one of the common anxiety disorder characterized by unwanted, irrelevant, repetitive thoughts, images, doubts and ruminations. It is associated with impairment in the quality of life and functional status and disabilities in occupational and social areas. The prevalence of OCD during pregnancy has been reported in the range of 0.2% to 5.2%. [92]

The main risk factors for OCD during pregnancy include; primiparity, miscarriage in previous pregnancies, obstetric complications and positive family history of OCD. [92]

During pregnancy, obsessions mainly include intrusive thoughts or mental images related to the baby and the most common compulsions are cleaning/washing and frequent checking.[88]

**Post–Traumatic Stress Disorder (PTSD)**

The post-traumatic stress disorder (PTSD) refers to a disorder that can occur following the experience or witnessing of life-threatening events such as a real or perceived trauma. Most significant risk factors for PTSD during pregnancy include; domestic violence, history of sexual trauma, previous adverse reproductive events (e.g. ectopic pregnancy, miscarriage, stillbirth), poor social support and previous traumatic events.

**Pregnancy-specific anxiety**

Pregnancy anxiety should be regarded as a relatively distinctive syndrome that includes; 'fear of giving birth', 'fear of bearing a handicapped child' and 'concern about one's appearance'.[93] A recent Indian study reported that young age, nulliparous status and nuclear family nature were the common risk factors for pregnancy-specific anxiety.[94]

Women with pregnancy-specific anxiety are more likely to practice negative health-related behaviours such as smoking, alcohol use and inappropriate weight gain.[95]

**ANTENATAL DEPRESSION**

Antenatal depression is of immense public health importance, as it can adversely affect both the mother and developing foetus. It can easily be misattributed to normal physiological changes that occur during pregnancy, e.g., disturbed sleep and changes in appetite.[96] A recent National mental health survey shows that 20% of depression occurs among Indian pregnant women. [97]

**Risk factors**

Research shows a number of predisposing factors for depression during pregnancy that includes:

- Financial difficulties
- Low educational attainment[98]
- Childhood abuse
- Family history of psychiatric illness
- Past history of anxiety and depression[99]
- History of previous abortions and current obstetric complications [98]
- Lack of social support [100]
- Stressful life events [96]
- Domestic violence
- Pressure to have a male child[98]

**Consequences of Antenatal depression**

- Intrauterine growth retardation
- Failure to thrive [101]
- Developmental delays, including intellectual disability[102]
- Poor mother baby bonding
- Increases the risk of postpartum depression
- Poor prenatal care [82]
- Obstetric complications and adverse pregnancy outcomes like preterm birth[103]

**Symptoms**

Women with depression usually experience some of the following symptoms for 2 weeks or more

- Persistent sadness
- Feeling tired easily, even for doing routine work
- Difficulty in concentration
- Forgetfulness
- Anxiety
- Feelings of guilt or worthlessness
- Feelings of hopelessness
- Thoughts of harming to self
- Sleep disturbances
- Change in eating habits[104]

## TOPIC. 6.2. POSTPARTUM COMMON MENTAL DISORDERS

**Aim**

Helps the participants to gain insight on common postnatal mental disorders to enable them to identify and provide early interventions.

**Learning outcomes**

At the end of the session, participants will be able to

- Understand about common postnatal mental disorders such as anxiety and depression
- Predict various risk factors for postnatal anxiety and depression
- Describe the signs and symptoms of postnatal anxiety and depression
- Be aware of the consequences of postnatal anxiety and depression among women and their children
- Differentiate baby blues from postpartum depression.
- Identify anxiety and depression among postnatal mother and refer them for further interventions
- Explain and provide psychosocial interventions for the women those who are experiencing anxiety or depression during perinatal period

**Description**

Participants are divided into two groups (A&B) and each group is provided with a case vignette. Group A is asked to discuss about the case vignette given to them and present to the larger group. Participants from group B are asked to enact a role- play based on the case vignette and followed by video presentation on post partum mental health assessment. At the end facilitator concludes the session with his/her presentation.

**Suggested training methodology**

Small group activity and role-play followed by video presentation

**Materials:** Case vignettes, LCD projector, computer, paper and pens

**Duration:** 45 minutes

**Process**

- Divide the participants into 2 groups. Let them read the case vignettes given below amongst themselves
- They have 5-10 minutes to come up with the type of information required to be discussed under each heading. Guide them to write notes on paper given to them.
- Group A should choose someone to write up the answers and someone else to present the answers to the large group. Similarly group B should discuss among them about the case vignette and choose the volunteers to perform the role play.
- It is important to stress that the groups should focus only on symptoms of woman mentioned in the case vignettes.
- Ask group A to present their case vignette to the rest of the participants and share their responses and get feedback from the larger group.
- Invite volunteers from group B to enact the role play based on the case vignette given to them and encourage other participants to observe and write down the points for the discussion followed by a small video presentation on *"Post-partum mental health assessment"*
- At the end, facilitator clarifies the doubts of the participants and provides the information using the power point presentation.

**Case Vignette 18**

***Shyla's story – "This too shall pass..."***

*My parents came to stay with me for a week to help me with the baby. Things were going well and then all of a sudden when my parents decided to return to native place, I did not know what to do, I was feeling confused, crying and I couldn't breathe and I was able to listen to my heart beat. It was a horrible experience all of a sudden. I started crying uncontrollably. My husband said that I was stressed out because my parents are leaving' and that it was a normal thing which I am going through. I didn't had proper sleep that night, I woke up suddenly in the middle of the night and couldn't fall asleep again. I was feeling nervous, and I began pacing the living room. I felt butterflies in my stomach every time my child woke up from her nap or during the middle of the night. I used to get nervous when it neared her waking up time; I just wanted her to go away I woke my husband up and told him that something wrong with me… he tried being compassionate but he didn't understand my situation. I finally calmed myself. The next day when my husband left for work again I faced the same situation like that. I didn't want to be alone. I called him repeatedly asking him to come home soon.. I wanted things to be like they were before. I called my mother a few nights later and spilt my heart out to her, as always she responded that "This too shall pass".*

**Note to the Facilitator:** Shyla is experiencing symptoms of a common mental disorder **Postnatal Anxiety**.

- **Physical symptoms:** tremulousness, dryness of mouth, feeling restless, unable to relax
- **Autonomic symptoms:** feeling short of breath, tightening of stomach, racing of heart (palpitation), nervousness
- **Cognitive symptoms:** fear to take care her baby, confusion, fear of being alone with baby
- Sleep disturbances
- Reassurance seeking behaviour: requesting her husband to come back to home

Shyla is experiencing symptoms of a common mental disorder known as "**Postnatal Anxiety"**.

**Case Vignette 19**

***Kavita's story – Am I a Bad Mother…***

*Arun, my first son, after he born, I experienced 'moodiness'. I remember crying a lot but attributed it to physical pain. By the time Arun was 4-6 weeks old, I felt mentally and physically alright. I loved my child, I loved being a mother, and I was very happy. When I was pregnant again for my second daughter-Arathi, I started to experience nervousness in certain situations. I did my best to ignore it. After she was born, I* ***again*** *got through the same moodiness as I went through in my first pregnancy along with nervousness. I thought it was 'normal' as every mother might experience and it would go away. During Arathi's second week I realized something was different. I was feeling extremely low and depressed. I was often gripped by hopelessness and helplessness. I felt on the verge of losing my control and really hurting my baby and ending my life. I remember forgetting to feed her, I didn't feel close to my baby. I didn't love her. She was an easy baby, very different from my demanding first child, so why I couldn't love her? , I had thoughts like ...'am I a horrible and bad mother to Arathi, what sin has she done to be born in my womb, no one helped me to come out from this situation, is it because I am a bad mother..!!!!'*

**Note to the Facilitator**: Kavitha is experiencing symptoms of a common mental disorder.

- **Behavioural symptoms:** Poor mother baby bonding, not feeding the baby, and Lack of sleep
- **Cognitive symptoms:** Forgetfulness, hopelessness and helplessness, feeling discouraged, feeling extreme sadness, harming herself and baby

Kavita is experiencing symptoms of a common mental disorder known as "**Postnatal Depression"**

## BACKGROUND MATERIAL

### POSTPARTUM ANXIETY DISORDERS (PAD)

Anxiety disorders are more prevalent in postnatal period and are often associated with significant impairment and distress among mothers.[105] Though motherhood is a beautiful journey in a woman's life, some women may have excessive worries and experience various levels of anxiety. However, postpartum anxiety disorders (PAD) are often undetected.

**Risk factors**

Common risk factors include:

- Personal history of anxiety before or during pregnancy
- Family history of anxiety or a perinatal mental health issue

- History of endocrine dysfunction (thyroid imbalance, diabetes)
- Teenage pregnancy
- Low socioeconomic status
- Lack of social support (friends, family…)
- Stressful life events such as crisis in job, housing, finances [106]
- Overwhelmed by changing roles
- Lack of sleep or sleep disturbances
- Worrying about personal appearance and postpartum weight gain and health and wellbeing of the infant [107]
- Domestic violence

**Consequences of Postpartum Anxiety Disorders**

Published evidence suggests a possible deleterious impact on mothers and children include

- Lower self-confidence in mother
- Poor mother-infant interactions
- Maternal neglect and failure to thrive to infanticide
- Differences in maternal recognition of infant emotions
- Reduced or delayed infant mental development [108]
- Breastfeeding difficulties[109]
- Risk for conduct disorders among adolescents of mothers those suffered from postnatal anxiety[110]
- Anxiety disorders are likely to be transmitted from mother to child [111]

The most common Postpartum Anxiety Disorders include

**Generalized Anxiety Disorder (GAD)**

GAD is the most common postpartum anxiety disorder among women during the first year after childbirth.[112]

Women with GAD experience excessive worry about their financial needs, physical appearance, domestic duties, sexual adjustment[113] their ability to care (breastfeeding, soothing; etc) and well-being of the child.[112]

Research shows that mothers with GAD are less responsive and less affectionate towards their newborns. [114]

**Obsessive Compulsive Disorder (OCD)**

The postpartum period is a high-risk time for the development of OCD symptoms.[115] About 70% of women with OCD also were suffering from depression. The unique subset of obsessions and compulsions could indicate postpartum OCD to represent a distinct postpartum mental illness.[116]

Women with OCD during postpartum period often experience the following symptoms

- Fear of being left alone with the infant
- Hyper-vigilance in protecting the infant
- Loss of appetite

- Tremendous guilt and shame[117]
- Unique obsessions about harming their baby and avoid their infants due to their fear of acting on such thoughts.

Some examples of postpartum obsessions include; thoughts that the baby could die while sleeping (S.I.D.S), dropping the baby from a high place, an image of the baby dead, baby choking and not being able to save him, drowning the baby during a bath etc.[92, 118]

Contamination obsessions include microorganisms, chemicals or dirt contaminations via her hand or the baby's bottles or foods.[119]

The most common compulsions are: cleaning/washing, checking, not giving bath to the infant, staying physically isolated from the baby, checking the baby's breathing or body etc.[52]

**Post–Traumatic Stress Disorder (PTSD)**

Postpartum Post–Traumatic Stress Disorder **(**PTSD) is another important anxiety disorder among the mothers. The women with PTSD often experience frightening flashbacks of the birth and delivery experience, feelings of numbness and detachment and isolation from motherhood.[105]

The significant risk factors for PTSD include pregnancy complications, emergency caesarean, instrumental delivery, inadequate care during the labour, low socioeconomic status, history of episiotomy, the severe pain experienced during the birth, postpartum complications primiparous, preterm labour, and stressful life events.

The untreated PTSD in women may have the consequences such as depression, suicidal risk, difficulties with bonding and breastfeeding, Tokophobia and over-vigilance and anxiety about baby's health.[120]

**Phobia**

The common type's phobias that occur during postpartum period include social phobia and phobia for the infant

**Social phobia**

Social phobia is characterized by excessive fear of embarrassment or negative evaluation that is associated with significant distress, interference with functioning and avoidance of social situations.[105] Women with social phobia often experience fears of negative evaluation or judgment from others about her parenting skills and they become hesitant to seek support, such as joining to a parenting class.[112]

**Phobia for the infant**

The mother may have severe anxiety with the idea of the baby could die while sleeping (Sudden Infant Death Syndrome (SIDS).

The mothers will not let their infants to sleep with fear that they stop breathing and often waken them to see if they are alive. These mothers experience severe insomnia, because of

the need to lie awake listening to the baby's breathing; they may check the infant 20-30 times every night.[121]

**Panic Disorder**

The postpartum period appears to be a time of increased vulnerability to recurrent panic symptoms.[122]Panic attacks during postpartum period are associated with substantial distress and impairment in mothers.

Women who had never been pregnant, marital disharmony family, health, financial and occupational problems were reported to be the significant risk factors for panic disorders during the postpartum period. During the postpartum period, the woman may interpret panic attacks as something being wrong with her baby.

## POSTPARTUM DEPRESSION DISORDERS

The postpartum period is the period that is associated with intense physical and emotional changes leading to anxiety and mood disturbances.[123]

## POST PARTUM BLUES (PPB)

Postpartum blues (PPB) also known as "baby blues" are the most common feelings of exhaustion and anxiety while adjusting to an infant's arrival coupled with a significant decline in hormone production during the initial postpartum period.[124]

Baby blues, in general, begins 1 to 3 days after the delivery and lasts about 10 -14 days of postpartum period. While the baby blues are considered as "normal," the blues can evolve into full-blown post-partum depression if symptoms last longer than two weeks and 25% of these women develop postpartum depression.

**Risk factors**

The exact cause of PPB is not known, but various factors such as

- Hormonal changes
- Socio-cultural factors such as gender bias of the infants (mothers who had given birth to female child)[42]
- Low socio-economic status
- Lack of support from partner and the family [125]

**Signs and symptoms of postpartum blues**

The symptoms of PPB include

- Mood swings
- Unexplained weeping
- Irritability
- Impatience
- Lack of sleep
- Anxiety
- Loneliness
- A feeling of vulnerability.[126]

***The key differences between the postpartum blues and PPD are***

1. Postpartum blues usually resolves within two weeks and doesn't require any treatment.
2. Postpartum blues do not interfere with maternal role functioning.[127]

(Management of women with baby blues are discussed in detail at the end of the session)

**POST-PARTUM DEPRESSION**


Postpartum depression is an important public health problem, having a significant impact on the mother, the family, her partner, mother-infant interaction and on the long-term emotional and cognitive development of the baby.

Post-Partum Depression (PPD) is usually defined as post birth feelings that include extreme sadness, anxiety, fatigue, and excessive worry (or lack thereof) about one's infant. [128] The onset of symptoms usually occurs during the first four weeks after delivery and women remain at risk for developing depression for several months following delivery.[129] According to a recent systematic review, the prevalence of postpartum depression in Indian mothers was 22%.[130]

**Risk factors**

The reported risk factors from low and middle-income countries for postpartum depression include

1. **Demographic factors**
   - Younger age (below 20 yrs.)
   - Nuclear families [131]
   - Financial difficulties
   - Low maternal education
   - Personal and family history of psychiatric illness
   - PPD higher in mothers residing in urban than in rural areas due to
     - Overcrowding
     - Inadequate housing
     - Increased work pressure
     - High cost of living
     - Increased out-of-pocket expenditure on health care.[132]
2. **Obstetric factors**
   - Complications during pregnancy[18, 19]
   - Multi parity
3. **Psychosocial factors**
   - Domestic violence
   - Marital conflict
   - Lack of support from husband and in-laws[39]

- Birth of a female baby (preference for a boy baby)
- More than one girl child
- Alcohol abuse in partner
- Adverse life events[39]

The signs and symptoms of postpartum depression are generally the same as those associated with major depression occurring at other times, including depressed mood, anhedonia and low energy. Reports of suicidal ideation are also common.

**Consequences of PPD**

***The effects of PPD on mother include***

- Increased risk of future depressive episodes [133]
- Influences negatively her relationships with her baby, partner, elder children and the wider family [134]
- Undermines the mother's confidence
- Impairs her social functioning and quality of life
- In serious cases contributes to infant abuses, infanticides and suicidal behaviour. [134]
- Research shows seven dimensions of the PPD: sleeping and eating disturbances, anxiety and insecurity, emotional instability, mental confusion, loss of self, guilt and shame, and suicidal thoughts.[135]

***The effects of mother-infant interaction***

Early relationships are central to promoting healthy social and emotional child development.[136] The impact of PPD on the children includes

a) P**oor mother-infant relationship**: In a meta-analysis study, mothers with depression were noted to be more irritable, hostile, less engaged and may have lower rates of play (Less vocal behaviour, including the use of longer utterances, less repetition, more negative effect, fewer explanations, less smiling etc) with their 3-month-old infants.[137]

**b) Child care activities**

**Breastfeeding:** Mothers with PPD often experiencebreastfeeding problems and lower levels of breastfeeding self-efficacy[138]

**Sleep routines:** Studies report undesirable sleep practices and sleep problems among women with PPD.[139] Undesirable practices such as placing the infant to sleep in the prone position instead of the recommended supine position. Sleep problems included the infant sleeping in the parents' bed, being nursed to sleep, taking longer to fall asleep and waking more often and for longer periods

**C) Healthcare**

Mothers with depressive symptoms have also been noted to affect children's receiving health care during infancy.[139] Due to this reason they are unable to seek health care support[139] and results in increased use of acute care or emergency department visits, decreased services from well-child visits and up-to-date vaccinations.

## PSYCHOSOCIAL INTERVENTIONS FOR COMMON MATERNAL MENTAL DISORDERS

### 1. Psychoeducation

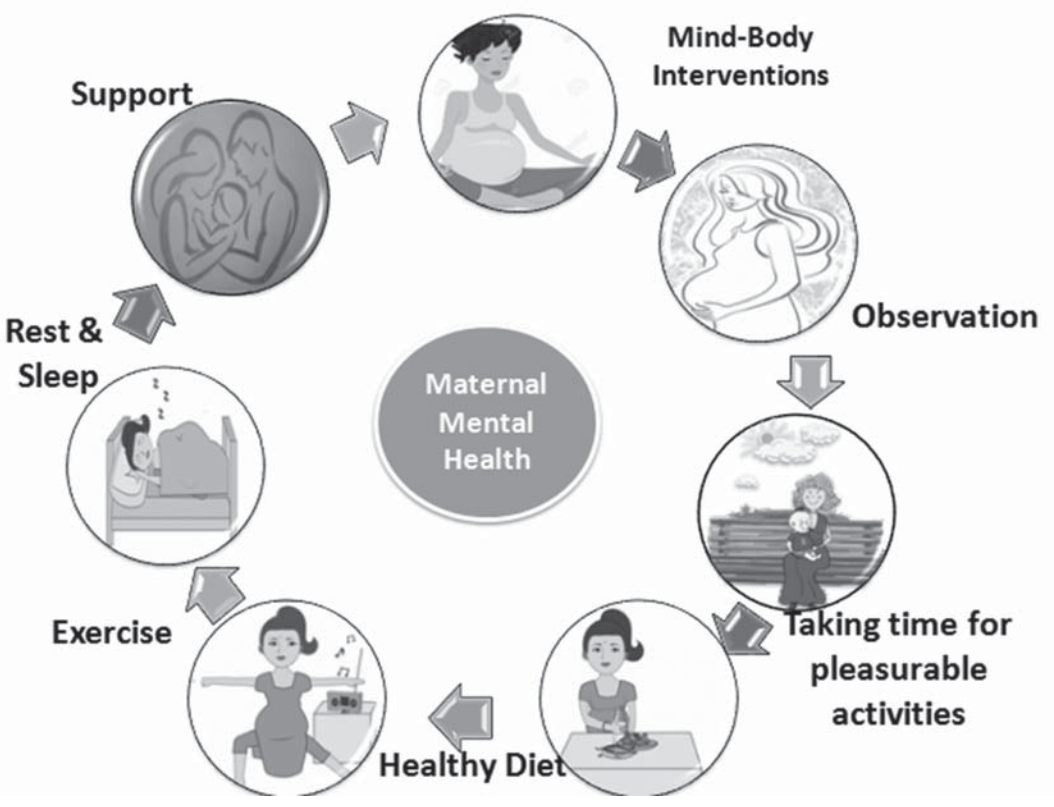
Psychoeducation is to help women and their families understand the mental disorders and include

- Provide information about the disorder to the women and their family members
- Talk about how prevalent these disorders are during pregnancy and postpatrum
- Educate them about the signs and symptoms of common maternal mental disorders.
- Help them to Identify the risk factors of common maternal mental disorders.
- Educate them about the benefits of early identification and treatment of common maternal mental disorders.
- Inform them about available treatments and provide them the contact details of the referal clinics.
- Explain about the expected progress of the disorders
- Do not separte mother- baby , even the mother is on treatment.
- Encourage husband and family members to support and stay calm with the women.
- Assist the women in her baby care needs and household chores.
- Promote Breast feeding even women are under treatment, follow the doctor's advice.

### 2. Selfcare

Self-care is vital for the pregnant women to keep themselves healthy physically and emotionally. The self-care activities include

**'MOTHER-S'**



**Mind-body interventions**

Motivate the mother to practice mind-body interventions to cope with her stress and challenges during pregnancy and postpartum period.

- Mind-body therapies regard as essential an approach that acknowledges each person's capacity for self-knowledge and self-care.
- Mind-body interventions include relaxation, guided imagery, meditation, and yoga. Mind-body interventions might benefit women's anxiety during pregnancy.[140]
- Relaxation during pregnancy reduces stress and anxiety. [141]Women to be encouraged to attend relaxation education sessions during the prenatal period.

**Observation**

- Pregnant women who monitor their babies' movements via fetal movement counting tend to be less anxious about their babies' wellbeing.
- Fetal movement counting may be associated with improvement in maternal-fetal attachment, which in turn, improves pregnancy outcomes and postnatal mother-infant attachment.[142]
- It's common for a woman to have concerns about weight gain during pregnancy and postpartum period. Body image is strongly associated with depression and anxiety symptoms. Hence, the woman needs to be aware of normal weight gain during pregnancy and postpartum period
- Observe for appropriate weight gain of the baby
- Observe for the infant s milestones like smiling, rolling over, sitting or crawling etc.
- Observe how well the mother- baby bonding is developing.

**Taking the time for pleasurable activities**

It is very important for women during pregnancy to take some time for activities which makes her feel good, uplifted or joyful. 'Daily uplifts' can help to protect the women against the negative physical and mental effects of stress. Some of the pleasurable activities include

- **Hobbies:** Reading, cross-stitching, doing crossword puzzles, listening to music, watching a video, gardening, going for walk, warm bath, seeing old photographs etc.
- **Connecting with Others:** Spending time on relationships, emailing a friend, calling a friend, meeting a friend, going out to dinner with partner, reading a magazine on a park bench etc
- **"Self Pampering"** nail painting, buying a gift for self, dressing up neatly etc
- **Spending Time in Nature**: Some women may find relaxation and comfort in places in nature such as a garden, a beach etc.[143]

**Healthy diet**

Balanced diet plays an important role in maintaining physical and mental health of the expectant mother. Eating nutritious foods regularly throughout the day will help the woman to feel better and carry on her daily activities.

- Whole grains, low-fat dairy products and fresh fruits and vegetables
- Small and frequent meals including having snacks every 2 hours from different food groups, eg. grains, protein, vegetables etc

- Reducing intake of stimulants such as coffee, tea (eight ounces (240ml)of coffee/tea per day is recommended) cola and energy drinks as all these can all exacerbate anxiety symptoms.[143]
- Multivitamin supplements as suggested by the healthcare providers
- Take plenty of water including milk, fresh fruit juices.
- Avoid consumption of alcohol and recreational Drugs (Marijuana, Cocaine, Tobacco, etc.) as these substances during pregnancy as use may lead to low birth weight, premature birth, and spontaneous abortion.[143]

**Exercise**

Regular exercise is an important part of self-care for several reasons:
Regular exercise can

- Boost mood and energy levels.
- Promote a good sleep during night
- Help to reduce muscle tension and create feelings of relaxation
- 'Clear the mind' and help to gain a better perspective on depressing or anxious thoughts that can make them easier to challenge.
- Increase self-confidence of the mother
- Gives a chance to meet others, have fun and take some time for themselves.[143]

**Rest and Sleep**

Sleep and rest are very important for both physical and mental health of women during pregnancy. Sleep may significantly help to control anxiety symptoms during pregnancy. As the baby grows, it is difficult for pregnant women to find a comfortable position. Deprived sleep may worsen the depression among women.

Sleep-promoting strategies during pregnancy

- Body pillow to help support the changing body
- Create a routine: Wake up and go to bed at approximately the same time
- Avoid napping during the day if the women have trouble going to sleep at night
- Not to spend a lot of time in bed without sleeping
- Use bed only for sleep and try to avoid other activities such as watching TV
- The pregnant women should have at least 6-8 hrs of sleep during the night and 60 minutes of a nap in the daytime (around lunch) which are essential to improve mental well being.
- Avoid stimulating activities, exercises, heavy meals, and bright light for at least one hour before going to bed. The light emitted from TV and computer screens can also interfere with sleep
- Reduce or cut out caffeine intake and be sure not to have it after 4 pm.
- Manage daily stresses by making a to-do list for the next day.
- Have a light carbohydrate snack like milk and cookies before bed and/or a hot bath.
- Practice breathing exercises or listening music when attempting to get to sleep.
- Create a good sleep environment: comfortable, not too warm or cold, with minimal light and noise.

**Support groups**

Social support plays a very important role in helping the women to cope with stress and challenges during the perinatal period. Healthy relationships are a protective factor against depression. Studies have also shown that social support can reduce depression and anxiety in women.[144]Hence increasing and strengthening healthy supportive relationships are essential for mental well-being the mother. Types of support women can have [143]

| Emotional support | Practical support | Social network support | Information support |
|---|---|---|---|
| To talk to about worries and concerns about her mood and the baby | To help the womenin household tasks, and child-care.For example; someone to take care of the baby so that mother can have a nap. | To build social network with other pregnant women or mothers | To provide accurate information about maternal mental disordersand health care services that can help the women. |
| **Possible sources:** Partner, family members, friends, support groups etc. | **Possible sources**: Partner, family members, friends | **Possible sources:** Mother with similar problems orwomen fromprenatal classes | **Possible sources:** Healthcare professionals including doctors and nurses |

**3. Supportive Psychotherapy**

Supportive psychotherapy involves offering support, reassurance, and psychoeducation to patients and their families.[145]

The benefits of supportive therapy include improving self-esteem, psychological functioning, and adaptive skills among women with common mental disorders.

Supportive psychotherapy may be a useful approach to help the women to cope with depression and anxiety in a low resource setting where mental health professionals seldom exist to provide Cognitive-Behavioural Therapy or Interpersonal Psychotherapy.

Research shows that supportive psychotherapy is a plausible intervention that nurses and other maternity care providers can use with women who experience anxiety and depression in the perinatal period.[146]

4. **Pharmacotherapy**

If the problems are mild, pharmacotherapy is not necessary. Psychological interventions will help women to learn cope with her anxiety, stress and depression with the above-described measures. If the problems are severe, medicines are prescribed by a Psychiatrist. It is adviced to take medications under the supervision of a psychiatrist.

1. Anxiolytics (benzodiazepines)
2. Hypnotics (Non –benzodiazepines)
3. Antidepressants
   - SSRI (Selective serotonin reuptake inhibitors)
   - SNRI (Serotonin-norepinephrine reuptake inhibitors)
   - TCA (tricyclic antidepressants)

# Session 7: Severe Maternal Mental Disorders Background

This session helps the participants to understand about severe mental disorders (SMD) during perinatal period. It also helps the participants to improve their knowledge about signs and symptoms of SMI such as bipolar disorders, schizophrenia, major depression, suicide that occur during pregnancy and postpartum period. This information may be useful to identify and refer the women to appropriate services.

**Topic outline**
7.1. Ante partum Severe Mental Disorders (ASMD)
7.2. Postpartum Severe Mental disorders (PSMD)

**Session duration:** 1 hour 30 minutes

## TOPIC. 7.1: ANTE PARTUM SEVERE MENTAL DISORDERS

**Aim**
Enhance the participants' understanding on ante partum severe mental disorders and learn to identify and refer the women with SMD to the appropriate services.

**Learning outcomes**
At the end of the session participants will be able to

- Understand about severe mental disorders that occur in prenatal period
- Be aware of common risk factors related to severe mental disorders
- Identify the woman with various psychotic features and refer them to the mental health services
- Understand various consequences of severe mental disorders on mother and foetus.
- Describe and identify warning signs of suicide among expectant mother

**Description**
Participants are divided into two groups and each group is provided with a case vignette discuss among themselves and to present to the larger group. The facilitator invites a volunteer from each group to present the case vignette and their observations with the larger group. A few of the participants are requested to share their own experiences followed by facilitator's presentation.

**Suggested training methodology:** Small group activity followed by discussion and presentation

**Materials**
Case vignettes, paper and pen

**Duration: 45** minutes

**Process**

- Divide participants into 2 groups and provide each group with a case vignette.
- Provide 5-10 minutes for discussing the case.
- Each group should nominate one person to note down the answers and another person to present the answers to the large group
- Participants are asked to list out the *symptoms and to identify the type of the severe mental disorder the mother might be suffering from.*
- Give each group 3 to 5 min to share their responses and get feedback from the larger group based on their experiences followed by facilitator's presentation.

**Case vignette 20**

*Arpita 24 year old lady married since two years. She had a history of psychiatric illness and was on antipsychotic medication until her pregnancy was confirmed and discontinued medications thinking that it will affect her baby. She was apparently normal for first three months of her pregnancy. In her second trimester of pregnancy, her husband noticed drastic changes in her behaviours such as wondering unnecessarily, doing many things at a time without completion and spending lot of time in having telephone conversations with her family members or friends to inquire about diet, exercise or baby care. She was highly excited about her pregnancy and doesn't want to visit her obstetrician saying that she can take care of herself. She used to be awake in the nights and was not interested in having a healthy diet. She was brought to the hospital by her family members since it was unmanageable to control her behaviour at home.*

**Note to the Facilitator:** Arpita is experiencing the following symptoms of a severe mental disorder**.**

- **Risk factors:** history of psychiatric illness, discontinuation of medication
- **Behavioural symptoms:** Wandering behaviour, doing many things at a time without completion, spending lot of time in having telephone conversations with her family members or friends to inquire about diet, exercise or baby care.
- **Mood :**Highly excited about her pregnancy,
- **Delusions:** she doesn't want to visit her obstetrician saying that she can take care of herself could be because of delusion of grandiosity
- **Decreased need for sleep and nutrition:** She used to be awake in the nights and not interested in having a healthy diet.

Arpita is suffering from a severe mental disorder known as **Manic episode of Bipolar affective disorder'.**

**Case vignette 21**

*Aruna 27-year-old woman, a homemaker, educated up to 10$^{th}$ standard, married since five years and currently she is five months pregnant. She has a 2-year-old girl child. Aruna was apparently normal one week back and she brought to the emergency department with complaints of talking to self, crying inconsolably and stopped taking food saying that her mother in law wants to kill her baby by adding poison in the food. On inquiry, her husband revealed that she lost her mother who was suffering from schizophrenia and committed suicide three years*

*back. During the mental status examination, Aruna says that some voices are disturbing her and commanding her to kill the baby.*

**Note to the Facilitator:** Aruna is experiencing the following symptoms of severe mental disorder**.**

- **Risk factors :** family history of psychiatric illness, suicide
- **Behavioural symptoms :** Talking to self, Crying inconsolably
- **Delusion of persecution:** she believes that mother-in-law may add poison in her food and stopped taking food
- **Auditory hallucination**s: some voices are disturbing her too much and commanding her to kill the baby and talking to self could be because of she is responding to hearing voices

Aruna is experiencing symptoms of severe mental disorder known as "**Schizophrenia"**

## BACKGROUND MATERIAL

Women experience a wide range of overwhelming emotions such as excitement, happiness as well as anxiety, or sadness/guilt during perinatal period which makes them highly vulnerable to psychiatric disorders.[147]

## ANTE PARTUM SEVERE MENTAL DISODERS

### Bipolar Affective Disorder (BPAD)

Bipolar affective disorders are chronic psychiatric illnesses characterized by alternating episodes of mania and major depression with or without psychotic symptoms. The incidence of bipolar disorders in women peaks in the reproductive period from 12 to 30 years of age.[148] Most women in India experience many life stressors during this period and are highly vulnerable for bipolar illness.[149]

### Risk factors

The significant risk factors for BPAD during pregnancy include

- High risk of relapse for women with a history of bipolar affective disorder (BPAD), if a woman ceases medication when planning to become pregnant or on confirmation of pregnancy. [150]
- Younger age (below 20years)
- Previous perinatal episodes of mania or depression
- Family history of BPAD [151]
- Lower socio-economic status
- Primiparity
- Pregnancy related complications [152]

### Signs and Symptoms

The symptoms of bipolar disorder during pregnancy and postpartum period are the same. Women during pregnancy may focus on her fears and be excessively worried about the pregnancy or whether she will be a good mother. [150, 153]

| Depression | Mania |
|---|---|
| Sad mood | Euphoric or irritable mood |
| Increased irritability and frustration | |
| Spending less time with friends and family | Over familiarity, Over activity |
| Loss of interest in food, sex, exercise or other pleasurable activities | Increased energy, Increased spending |
| Being awake throughout the night | Being reckless or taking unnecessary risks |
| Loss of libido, Increased alcohol and drug use | Increased sex drive |
| Increased physical health complaints like fatigue or pain | Racing thoughts |
| Slowing down of thoughts and actions | Rapid speech |
| Staying home from work | Decreased sleep |
| Hallucinations and/or delusions | Grandiose ideas |
| | Hallucinations and/or delusions |

**Complications**

- Increased hospital admissions due to poor prenatal care
- Poor nutrition
- A rise in alcohol or tobacco use
- Poor maternal-fetal attachment[154]
- Poor maternal self-care
- Poor engagement in obstetric and antenatal care
- Maternal self-harm or suicide [155]
- Risk of having small for gestational age/low birth weight infant
- Preterm births [156]
- Interpersonal conflict and marital difficulties[157]

**a) Major depressive disorders (MDD)**

Major depression is twice as common in women than in men and frequently occur during the reproductive period.[158]

**Risk factors**

- Discontinuation of antidepressant medications [159]
- Past history of mood disorders [160]
- One third of depressed pregnant women represent the first episode of major depression[161]
- Marital discord or dissatisfaction
- Inadequate psychosocial supports
- Recent adverse life events
- Lower socio-economic status,
- Women with recurrent major depression are athigh risk for relapse during pregnancy [162]

**Symptoms**

Clinical features of major depression include:

- Anhedonia (loss of pleasure)

- Feelings of guilt and hopelessness
- Suicidal thoughts (risk of suicidal behaviours appears to be low)[162]
- Agitation or retardation

During a major depressive episode it is very unlikely that the women will be able to continue with her social, work, or domestic activities.[163]

**Consequences**

- Risk for self-injurious or suicidal behaviour,
- Inadequate self-care
- Poor compliance with prenatal care
- Low weight gain in pregnancy due to decreased appetite [20]
- Increased use of harmful substances (smoking, alcohol and illicit drugs) that increase the risk to the foetus[164]
- Poor neonatal outcomes including preterm birth, lower birth weight, and lower apgar scores
- Postpartum depression

**Schizophrenia**

Pregnancy is a period of increased risk for relapse of schizophrenia. The onset for schizophrenia in women is during the reproductive years from ages 25-35 and 50-60% of these women will become pregnant that are unplanned or unwanted. [165]

**Risk factors**

- Discontinuation of medication associated with relapse of illness and poor outcomes of the pregnancy. [166]
- Increased substance use
- Lack of sleep[167]
- Unemployment
- Poor social support[168]
- Pre-existing mental disorder
- Stressful life events

**Symptoms**

The symptoms of schizophrenia are same that occur in non-pregnant women or others .The major psychotic symptoms are delusions (false beliefs) and hallucinations (hearing of voices) during pregnancy may have serious outcomes. For example; delusions that the foetus is evil or dangerous, leads the pregnant woman to stab herself in the abdomen or engage in other self or infant destructive behaviours.[169]

**Consequences**

The consequences that women who suffer from schizophrenia during pregnancy encounter include

- Delayed recognition of pregnancy

- Poor prenatal care,
- Failure to recognize signs of labour
- The most high-risk symptom is psychotic denial of pregnancy (a condition in which the woman denies that she is pregnant despite clear indications,) leads to refusing prenatal care, misinterprets signs of labour, risks precipitous and unassisted delivery, and fails to bond with her unborn baby.
- Increased risk for domestic violence during pregnancy
- A reduced likelihood of having a partner or husband[165]
- Greater incidence of obstetric complications such as placental abruption, low birth weight and cardiovascular congenital anomalies.[170]
- Induced labour and cesarean delivery
- Health complications (women who have schizophrenia are likely to suffer from diabetes and high blood pressure before they become pregnant).[171]

**Suicide**

Suicide can be defined as intentional self-inflicted death.[172] Suicide death rates in India have been found to be among the highest in the world with a significant proportion of suicides occurring among younger women.[173] A recent study found 7.6 % of suicidal ideation among pregnant women in India.[174]

**Risk factors**

Risk factors for suicide during pregnancy include

- Prenatal depression
- Intimate partner violence[175]
- Living alone
- History of mental illness
- Substance abuse [176]
- Past history of suicidal attempt
- Poverty

**Symptoms**

The symptoms of suicide reflect the symptoms of depression that include

- Excessive sadness or moodiness
- Hopelessness
- Sleep disturbances
- Sudden calmness
- Loss of interest in pleasurable activities
- Sudden changes in personality and/or appearance. For example**:** women might suddenly become less or more concerned about her personal appearance.
- Increased use of drugs and/or alcohol
- Talking about suicide or dying
- Giving things away (clothes, expensive gifts)[177]

- Suicidal ideation refers to persistent thoughts of committing suicide. Sometimes these thoughts can escalate to make plans and attempt suicide.[178]

**Management**

- ANMs and other health care providers should routinely assess women for suicidal ideations during their prenatal visits.
- Talking about suicide or dying and other depressive symptoms should not be ignored. Women with any kind of suicidal ideation should be referred immediately to psychiatrists for further appropriate interventions.
- Assessment of suicidal risk is discussed in detail in the next session.

## TOPIC.7.2. POSTPARTUM SEVERE MENTAL DISORDERS

**Aim**

Helps the participants to improve their knowledge on severe postnatal mental illnesses to enable them to their children identify and support the mothers in seeking help from mental health services.

**Learning outcomes**

At the end of the session participants will be able to

- Understand about severe mental disorders that occur in postpartum period.
- Predict various risk factors for severe mental disorders
- Describe the signs and symptoms of severe mental disorders
- Be aware of the consequences of severe mental illnesses among women
- Identify women with severe mental illness and refer them for further interventions
- Explain their role in providing optimal care and support the women with severe mental illness during perinatal period

**Description**

Participants are divided in to two groups and each group to be provided with a case vignette and are encouraged to discuss among themselves. Representatives from each group are requested to enact role play based on the case vignettes. Other participants are asked to observe and write down the key points for discussion. This activity is followed by facilitator's input.

**Suggested training methodology**

Role plays followed by discussion and presentation

**Materials :** Case vignettes, paper, and pens

**Duration :**30 minutes

**Process**

- Divide participants into 2 groups and nominate volunteers to enact the role play.

- Provide 5-10 minutes to read the case vignettes, discuss and practice the role plays.
- It is important to stress that the groups should focus only on symptoms of woman mentioned in the case vignettes.
- Invite volunteers from group to enact the role play based on the case vignette given to them and encourage other participants to observe and write down the points for the discussion.
- Give each group 3 to 5 min to share their responses and get feedback from the larger group followed by facilitator's presentation.

**Case vignette 22**

*Vanaja 25 years old woman working for a Multi National Company has two months old girl child. She brought to the emergency department after attempting suicide. On mental status examination, she expressed that she has intrusive thoughts about harming self. She believes that someone is trying to kill her and following her. She also says that she can hear clearly that some people are discussing to kill her baby. Hence she wants to lock herself with her baby in a room. Her husband reports that she doesn't sleep as she observes her baby frequently. He further says that they both were very happy about their child and doesn't understand why is she behaving this way. The doctor convinces him that her condition is treatable but requires immediate hospitalization.*

**Note to the Facilitator:** Vanaja is experiencing the following symptoms of a severe mental disorder.

- **Auditory hallucinations:** hearing of voices discussing about killing of her baby
- **Delusions:** someone is trying to kill her and her baby
- **Suicidal thoughts:** she attempted suicide

Vanaja is experiencing symptoms of a severe mental disorder known as **"Schizophrenia".**

**Case vignette 23**

*Madhavi 33-year-old woman belongs to low socio-economic status. She is mother of three girl children and younger one is two months old. Madhavi's husband is an alcoholic and he is not helping her financially. Jayanthi who is an ANM meets Madhavi during her routine home visit and observes Madhavi being sad, inactive and not interacting with her baby. On inquiry Madhavi says that she is not interested in taking care of her children, has sleep disturbances and unable to cook and eat. She doesn't have support from husband and other family members. She further stated that "she doesn't deserve to be a good mother as she is not able to cook for her children and she has repeated thoughts of harming herself". Jayanthi convinces her that it is normal to have these feelings but she requires help from mental health services.*

**Note to the Facilitator:** Madhavi is experiencing symptoms of a severe mental disorder

- **Behavioural symptoms:** sadness of mood, unable to cook and eat, not interested in taking care of her other children
- **Mother baby bonding:** Poor mother baby bonding as mother is not interacting with her baby
- Sleep disturbances
- **Suicidal ideation:** repeated thoughts of harming herself

Madhavi is experiencing symptoms of a severe mental disorder known as **"Postpartum major depression".**

## BACKGROUND MATERIAL

### POSTPARTUM SEVERE MENTAL DISORDERS

Postpartum period is the most vulnerable period for relapse of severe mental disorders in women's life.

### BIPOLAR AFFECTIVE DISORDER (BPAD)

Bipolar disorder is profoundly affected by child birth than any other psychiatric disorder.[179] Some women may experience bipolar symptoms (called an episode) for the first time in the postnatal period even without preexisting of this illness.[180]

**Risk factors**

- History of bipolar disorders (relapse) [180]
- Onset of illness at an early age
- Experiencing a episode during the first pregnancy
- Discontinuation of psychotropic drugs while planning to become pregnant or on confirmation of pregnancy. [150]
- Sleep deprivation [181]

**Symptoms**

Woman who is experiencing bipolar disorder may have unusual changes in the way they think and behave.

If a mother is experiencing depression she may have worries about whether she is a good mother or worries about her child's health. She fears that something bad may be happen and consults the doctor frequently for reassurance.[180]

On the other hand, if a mother has symptoms of mania, experience high levels of energy and requires little sleep even with a younger child.[180]

**Consequences**

- Sleep disturbances
- Inability to care for her baby
- Increased risk for or harming self (suicide) or the baby (Infanticide)[180]
- Breastfeeding and bonding difficulties
- Children of mothers with bipolar disorder are at increased risk for intellectual disability[182] and greater risk for developing psychosocial, emotional or behavioural disturbances[183]

### MAJOR DEPRESSIVE DISORDER (MDD)

Major depressive disorder also known as postpartum depression has been discussed in detail in the earlier session.

## SCHIZOPHRENIA

The postpartum period is a time of increased risk for relapse of schizophrenia[147] and is highest in the first 3 months.[184]

### Risk factors

- Past episode of psychotic disorder
- Family history of schizophrenia
- Stressful life events
- Increased use of alcohol and other drugs may trigger symptoms of schizophrenia[185]
- Discontinuation of medication [166]

### Symptoms

The psychotic symptoms of women with schizophrenia during postpartum period reflect the symptoms of their pre-existing illness, including positive, negative and cognitive symptoms.[186] The auditory hallucinations may include command to harm self or the child and delusions (false belief) that the child may be at risk in some way.

Negative (apathy, lack of emotion, poor social functioning) and cognitive (Disorganized thoughts, difficulty concentrating and/or following instructions, difficulty completing tasks, memory problems) symptoms of schizophrenia may impair a woman's ability to adequately care for her child. [187]

### Consequences

The major consequences of an acute episode of schizophrenia include

- Difficulty in parenting due to delusions and hallucinations.[188]
- Under stimulation or neglect of a baby due to negative symptoms of schizophrenia, such as apathy or difficulty in expressing emotions.[165]
- Obstetric complications
- Increased long-term risk of psychiatric problems in the children of women with schizophrenia.[165]
- Infanticide (killing the infant) can be the ultimate tragic consequence of schizophrenia [189]
- Infant avoidance due to lack of maternal sensitivity and responsiveness of the mother leads poor mother baby bonding. [190]

## SUICIDE

Suicide is one of the leading causes of death in postpartum women.[191] Women are at significant risk for severe psychiatric illness after childbirth, particularly during the first three months.[192]

**Risk factors**

Some of the risk factors include

- Preexisting mental illness including major depression, bipolar disorders, alcohol and substance use disorders, schizophrenia, and anxiety disorders
- History of suicide attempts or suicidal thoughts
- Family history of suicide
- Sleep disturbances
- Intimate partner violence
- Postpartum psychiatric admission

**Signs and symptoms**

Signs and symptoms of women with suicidal ideation during pregnancy and postpartum are alike and had been discussed earlier. However, new mothers who are feeling suicidal are also likely to consider thoughts about harming their babies, and could be at risk of filicide or Infanticide (Killing of one's own baby).[193]

**Management**

Suicide has devastating consequences for the woman, her family and her community.[194] Hence ANMs should be proactive in identifying early signs of suicide and assist the woman in seeking support from mental health services.

**Guidelines for ANMs in management of women with severe mental disorders**

Auxiliary Nurse Midwives (ANMs) are the female health workers who provide essential primary care services to the pregnant women, mothers and children. Along with providing as usual care, ANMs should provide extra care to the women with severe mental disorders include;

- **Identify** the women those are suffering from mental illness
- Provide **psycho education** about their illness and importance of continuing medication.
- **Preconception planning:** Advice and support the women who are planning to have children to seek support from psychiatrist and Obstetrician.
- **Antenatal care**
  - Monitoring the expectant mother whether she is following suggestions given by mental health specialists
  - Observe for early signs of relapse and provide assistance to access mental health services
  - Watch for extra weight gain and any other medical complications such as gestational diabetes, hypertension etc in women on antipsychotic medications
- **Postnatal care**: Postpartum period is extremely distressing time for the women with severe mental disorders. Hence it is essential to
  - Help the women to initiate mother baby bonding in early postpartum period.

- Identify and provide support if mother has any breastfeeding difficulties
- Educate the partner and family members to support the women particularly for ensuring that women has adequate sleep and nutrition
- Observe for early signs of relapse and refer the women to the psychiatric services
- Assist the women in receiving postnatal care and child care

- **Psychosocial support**
  - Listen to women about her concerns with empathy
  - Encourage the women and family members to express their concerns
  - Provide psycho education about the illness and assure the women and family members that severe mental disorders are treatable and manageable with additional support from family and health services

# Session 8: Mother Baby Bonding

**BACKGROUND**

This session enhances the participant's understanding about positive mother-baby bonding and importance of mother-baby bonding to maintain the emotional wellbeing of mother and baby. It helps to identify the difficulties to initiate mother-baby bonding. So that ANMs can intervene at an early stage to promote mother-baby bonding. Participants are also aware of the impact of maternal mental illness on mother-baby bonding. This interactive session enables the participants to improve their knowledge on various strategies to promote mother-baby bonding during pregnancy and after childbirth

**Topic outline**

8.1 Concept of mother-baby bonding
8.2. Common barriers and impact of maternal mental disorders on mother-baby bonding (MBB)
8.3. ANMs role in promoting mother-baby bonding

**Session duration:** 1 hour 30 minutes

**TOPIC.8.1: CONCEPT OF MOTHER BABY BONDING (MBB)**

**Aim**

Facilitates the participants to understand the meaning of mother-baby bonding and its importance to promote emotional wellbeing of mothers and children

**Learning outcomes**

At the end of the session, the participants will be able to

- Describe the meaning of mother-baby bonding
- Be aware of maternal-fetal attachment

- Explain the importance of positive mother-baby bonding on mother
- Express the influence of positive mother-baby bonding on healthy development of children

**Description**

Divide the participants into two groups and invite a volunteer from each group. Blindfold the volunteers and distribute a stick note to each participant. Ask Group A to think and write one idea about *"Importance of mother-baby bonding for the mother"* and similarly for the group B to write one idea on the "*Importance of mother-baby bonding for the child".* Play a background soft music and encourage the participants to go around and paste their stick notes on the back of the volunteers. Later ask one more volunteer from each of the group to read the stick notes pasted on the volunteers to the whole group. Participants are encouraged to share their experience from their practice followed by a presentation from the facilitator.

**Suggested training methodology**

Small group activity followed by presentation

**Materials**

Blindfold, stick notes**,** pens, laptop and speakers

**Duration:** 45minutes

**Process**

- Divide the participants into two groups (Group A and B)
- Invite volunteers from each group.
- Blindfold the volunteers and distribute a stick note to each participant.
- Ask group A to think and write one idea about "*Importance of mother-baby bonding for the mother"* and similarly for the group B to write one idea on *"Importance of mother-baby bonding for the child"*
- When they finish writing, play soft music and encourage the participants to go to the volunteers of their group and paste their stick notes on the back of the volunteers.
- At the end, two other volunteers from each group are requested to read out aloud and facilitator would write it on the board.
- The ideas are not criticized or discussed; participants may build on ideas voiced by others.
- Encourage the participants to express their experiences from their practice
- At the end facilitator provides additional information to the participants.

**BACKGROUND MATERIAL**

Bonding refers to the special attachment that forms between a mother and father and their new baby.[195] Mother Baby Bonding refers to the attachment between mother and baby. Actually, mother-baby bonding begins to happen before the delivery. Maternal-fetal attachment (MFA) is defined as the affectionate relationship that the pregnant women develop for their unborn child.[196]The bonding process has tremendous implication for both the mother and the child and is affected by many factors.[197]

**Importance of Mother Baby Bonding**

Mother-baby bonding is essential not only for the healthy development of a child but also for the mother to maintain emotional well being. The benefits of MBB include;

*Mother*

1. Makes mother feel happy through interacting with the unborn child during pregnancy and infant after the delivery. This in turn enhances mothers' emotional well being
2. Necessary for successful adaptation to motherhood
3. Helps the mother to form maternal identity, feel confident and good about themselves
4. Good maternal - foetal attachment reinforces women to have antenatal healthy behaviours and practices such as adherence to healthy diets, regular sleep schedules, increased exercise, utilization of needed medical attention, and abstinence from un-prescribed drug use etc.
5. Decreases risk for anxiety and depression in perinatal period [198]
6. Enhances optimal healthy outcome
7. Helps the mother in understanding her role in caring and supporting the child

*Child*

1. Ensure the child to have the best possible start in life
2. Makes the child to feel secure, understood, and be calm enough to experience the optimal development of his or her nervous system. Developing brain provides the child best foundation for life: a feeling of safety that results in eagerness to learn, healthy self-awareness, trust, and empathy.[199]
3. A strong emotional attachment between the mother and her baby may help prevent diseases, boost immunity, and enhance the child's IQ[200]
4. Serves as a prototype for all future relationships.[201]
5. Has an enormous impact on child's future mental, physical, social, and emotional health
6. Helps the child to develop fulfilling intimate relationships with the family
7. Makes the children feel confident and good about themselves
8. Positive bonding will help the child to cope with disappointments and losses which he/she undergo in a lifetime.
9. Influences the child's social development across the lifespan, beyond infancy.

## TOPIC. 8.2 COMMON BARRIERS AND IMPACT OF MATERNAL MENTAL DISORDERS ON MOTHER-BABY BONDING

**Aim**

Helps participants' to improve their knowledge on common barriers and effect of maternal mental illness to initiate mother-baby bonding.

**Learning outcomes**

At the end of the session, participants will be able to

- Identify the common barriers to initiate mother-baby bonding

- Provide early interventions to help the mother to initiate mother-baby bonding
- Understand the impact of maternal mental disorders on mother-baby bonding on mother and child

**Description**

Participants are divided into four groups and are provided with case vignettes. Ask them to discuss among themselves and list out the common barriers and impact of maternal mental illness on mother-babybonding.A volunteer from each group is asked to present their discussion to the larger group. Following discussion, facilitator adds necessary inputs.

**Suggested training methodology**

Small group activity, discussion followed by presentation

**Materials:** Chart paper, pens and case vignettes

**Duration: 45minutes**

**Process**

- Divide the participants into four groups and give each group a copy of case vignette. Ask one of the participants in each group to read the case vignette to the rest while the other group members (from the same group) identify the difficulty of the mother to initiate the mother-baby bonding andimpact of maternal mental illness on mother-baby bonding.
- Allow 10 minutes for the discussion and invite a representative from each group to report their findings to the larger group.
- Participants are encouraged to express their views and to share their professional experiences.
- At the end, facilitator adds inputs if required.

**Case vignette 24**

*Nisha20-year-old woman married two years back and delivered a boy baby. Since this was Nisha's first pregnancy, everything was a new experience for her. She had added of difficulties to adjust to a new role as a mother. Nisha's mother stated that she didn't enjoy her pregnancy and even motherhood because her pregnancy was unplanned. She wanted to continue her education to become financially independent. Family members noticed that she was irritable for simple things, and wanted to be alone. She was also not interested in taking care of her baby and not responding to her baby's cry. She further insists family members to keep the baby in the cradle and not next to her.*

**Note to the facilitator**

**Barriers for mother baby bonding:** Unwanted pregnancy (she wanted to continue her education and wanted to be financial independent)

**Difficulties of the mother to initiate mother-baby bonding:** Difficulty in adjusting to a new role as a mother, irritable, wanted to be alone

**Impact of maternal mental illness on mother-baby bonding:** Not interested to take care of her baby and not responding to her baby's cry, insists family members to keep the baby in the cradle and not next to her.

**Case vignette 25**

*Seema24-year-oldwoman married three years back and currently, she is a mother of 2 months old girl baby. She had a history of hospitalization for moderate depression before her marriage and currently, she is not on treatment. Seema had undergone cesarean section due to maternal complications. She was expecting normal delivery and a boy baby. When her expectation didn't come true her symptoms worsened and she neglected her health and baby care. Her husband expresses that she is not interacting with her baby and expressing anger towards her unnecessarily.*

**Note to the facilitator**

**Barriers for mother baby bonding:** previous history of psychiatric illness (discontinuation of medication after marriage), maternal complication, expecting normal delivery and boy baby

**Difficulties of the mother to initiate mother-baby bonding:** Her symptoms become worsened when her expectation didn't come true

**Impact of maternal mental illness on mother-baby bonding:** Neglected her health and baby care, Not interacting with her baby and expressing anger towards her baby unnecessarily

**Case vignette 26**

*Jaya 26-year-old woman, married against her parents' decision. Since then she didn't have any support from family members. Currently, she is a mother of two months old baby and her husband also not supportive in taking careof her child. Jaya's husband is an alcoholic and often abuses her physically, even during pregnancy and after the delivery. He even doesn't support her financially. Gradually Jaya failed to cope with these problems and complaints of loss of appetite, difficulty in sleeping and not able to enjoy with her child. Jaya also states that "I am not a good mother; I am not able to feed and take care of my child".*

**Note to the facilitator**

**Barriers for mother baby bonding :** Lack of support from partner and family members, domestic violence, no financial ~~no~~ support from partner

**Difficulties of the mother to initiate mother-baby bonding:** Failed to cope with above problems and complaints of loss of appetite, difficulty in sleeping and having thoughts like "she is not a good mother and not able to feed and take care of her child".

**Impact of maternal mental illness on mother-baby bonding:** Not able to enjoy her motherhood, feeling difficulty in feeding and taking care of child

**Case vignette27**

*Manjula 34 year old woman is a mother of three girl children. She is a homemaker and belongs to middle socioeconomic status. Her husband and family members were very supportive and were expecting for a boy baby. After the birth of third girl child, no one turned to see her baby. With tears she expressed that she and her husband were close to each other, he used to take her for antenatal check-up, and they both used to enjoy movements of their unborn baby. She started worrying too much and developed feelings of sadness, worthlessness, and hopelessness. She also expresses harming of self and baby.*

**Note to the facilitator**
**Barriers for mother baby bonding :** lack of support from husband and family members because of disappointment with gender of the baby
**Difficulties of the mother to initiate mother-baby bonding:** Worrying too much, sadness, worthlessness, hopelessness and expresses harming of self and baby
**Impact of maternal mental illness on mother-baby bonding:** Expresses harming of self and her baby

## BACKGROUND MATERIAL

### Common barriers to the mother-baby bonding process

The following are the common barriers that interfere with mother-baby bonding process

- Preterm newborn requiring prolonged NICU (Neonatal Intensive Care Unit )
- Maternal fatigue
- Caesarean birth
- Emotional stress in mother
- Postpartum depression
- Gender dissatisfaction
- Congenital malformations
- Younger maternal age
- Intellectual disability in the mother
- Lack of family support/partners
- A childhood that lack a positive parental role model
- A history of depression or mental illness
- A past history of pregnancy loss or loss of a child
- Lack of a social network
- Stressful life events such as a difficult job, unemployment, or other financial troubles
- Marital problems or domestic violence [195]

### Impact of maternal mental illness on mother-baby bonding

Maternal mental disorders can negatively impact on children's development. It adversely affects breastfeeding, mother-baby bonding, and parenting quality.[202] However, it must be noted that bonding difficulties are also experienced by mother without mental illness.

Maternal mental illness is a risk factor for impaired mother-baby bonding which may include a spectrum of difficulties: decreased maternal affective involvement, increased irritability, aggressive impulses, or, at worst, outright rejection of the infant [203]

- Mothers with mental illness are less likely to play with their babies, make eye contact, or speak in an engaging voice. As a result, babies can become anxious and fearful[204]
- Mother with mental illness may
  - Be less sensitive to child's needs
  - Have impaired parenting skills
  - Inappropriate expression of anger towards her baby

  - influence lactation
- Due to poor mother-baby bonding, the children may have
  - Behavioural disturbances such as crying louder and longer
  - Delay in expressive language development
  - Risk for child abuse and neglect
  - Emotional problems when they grow old
  - Trouble interacting with their mother (they may not want to be with their mother, or maybe upset when with them);
  - Withdrawn or become passive

**TOPIC: 8.3. ANMS' ROLE IN PROMOTING MOTHER-BABY BONDING**

**Aim**

Helps the participants to learn different strategies to improve mother-baby bonding.

**Learning outcomes**

At the end of the session, the participants will be able to

- Understand their role in initiating and promoting mother-baby bonding
- Be aware of prenatal and postnatal strategies to improve the mother-baby bonding
- Identify the difficulties of a woman with mental disorders in initiating mother-baby bonding
- Educate the women and family members on about various activities that promote mother-baby bonding

**Description**

Participants are divided into two groups and each group is encouraged to brain storm on *"ANMs role in promoting* mother *baby bonding during pregnancy and after child birth"*. One volunteer from each group is nominated to write down and present their responses to the larger group and encourages other participants to contribute. At the end facilitator summarizes and add inputs if required.

**Suggested training methodology**

Small group activity followed by discussion and presentation

**Materials:** Chart paper, Marker pens

**Duration:** 45 minutes

**Process**

- Divide the participants in to two groups.
- Give chart papers and marker pens to each group.
- Instruct the participants to brainstorm on *"ANMs role in promoting mother baby bonding during pregnancy and postpartum period".*

Group A: Strategies to promote maternal-foetal bonding during pregnancy
Group B: Strategies to promote mother baby bonding during postpartum period

- Allow 10 minutes for discussion and list out the points on a chart paper
- Ask the volunteer from each group to readout the points written on the chart paper to the larger group
- Encourage group to come out with as many points as they can. Congratulate them by saying that they have indeed given a comprehensive list.
- Provide additional information to the participants
- Encourage the participants to express their experiences from their practice

**BACKGROUND MATERIAL**

**Role of ANMs to promote Mother-Baby Bonding**

Children are future builders of the nation. Positive mother-baby bonding should be promoted as this is crucial to develop emotional capacity of an infant. [205] ANMs, being frontline health care providers, play a key role in promoting mother-baby bonding. They are responsible for providing care to the women throughout perinatal period and promoting maternal newborn practices.

The mother-baby bonding is essential for healthy development of a child. Hence, ANMs must be able to recognize impaired MMB and provide necessary interventions to improve mother-baby bonding.

**Strategies to promote mother-baby bonding**

Mother-baby bonding is crucial for successful transition into motherhood. Thus ANMs need to be proactive in initiating strategies to promote early maternal-newborn bonding and attachment.[206]

**Prenatal**

ANMs should inform and emphasize all mothers about the importance of mother-baby bonding before they plan to have a child.

ANMs need to prepare the couple physically and emotionally for the arrival of their newborn baby. Partners are the main source of emotional support for women which influence the development of positive maternal feelings towards the baby during pregnancy. Thus, ANMs should encourage both parents to attend prenatal classes.

**ANMs should encourage pregnant women to do the following activities to promote mother-baby bonding**.

- Encourage the mother to visualize positive images of her unborn baby.
- Facilitate bonding by encouraging women to spend time thinking about and talking to her unborn child. [207]

- Encourage parents to communicate and visualize their unborn baby during ultrasound scans, fetal auscultation and self-palpation.[199]
- Inform mothers that singing lullabies could not only improve maternal-foetal bonding but also have positive effects on neonatal behaviour and maternal stress.[208]
- Promote awareness of baby's movements to strengthen the maternal-fetal relationship.[209]
- Support women to cope with stress and encourage women to feel happy. People who are happy release "happiness" hormones including endorphins, dopamine, and serotonin. These hormones are essential for mental wellbeing of both mother and foetus.[210]
- Encourage pregnant women to communicate verbally with their unborn baby about all her daily activities. For example; *shall we have breakfast together, I am going to take a warm bath now, we shall read a book (read it loudly), etc.* It was found that unborn baby will respond to noises he/she hears outside the womb by about 25-26 weeks gestation. Talking or reading to unborn baby is a great way to develop a relationship with him/her before birth because as soon as a baby is born he/she will be attuned to the sound of mothers voice. [210]
- The unborn baby also enjoys hearing of family members voices. Thus it is important for the mother to introduce her partner, siblings, and grandparents and encourage them to have a conversation with the unborn baby to form an affectionate relationship with the child after birth. These conversations also help foetus to adjust to the real environment after birth.
- Educate women that foetus will develop touch receptors at eight weeks of gestation and enjoys belly massage around 20 weeks.
- Instruct women to have warm baths as the foetus feels the sense of relaxation.
- Motivate the mother to play with her unborn child by gently pushing or rubbing the baby part (lump of a heel or hand) and observe for baby's response.
- Encourage the mother to meditate, dance and yoga as these activities strengthen mother-baby relationship.[210]

**Postnatal**

Auxiliary Nurse Midwives have a unique opportunity to provide compassionate care to women during childbirth process and promote positive attachment between mother and baby either in labour room or operating room.

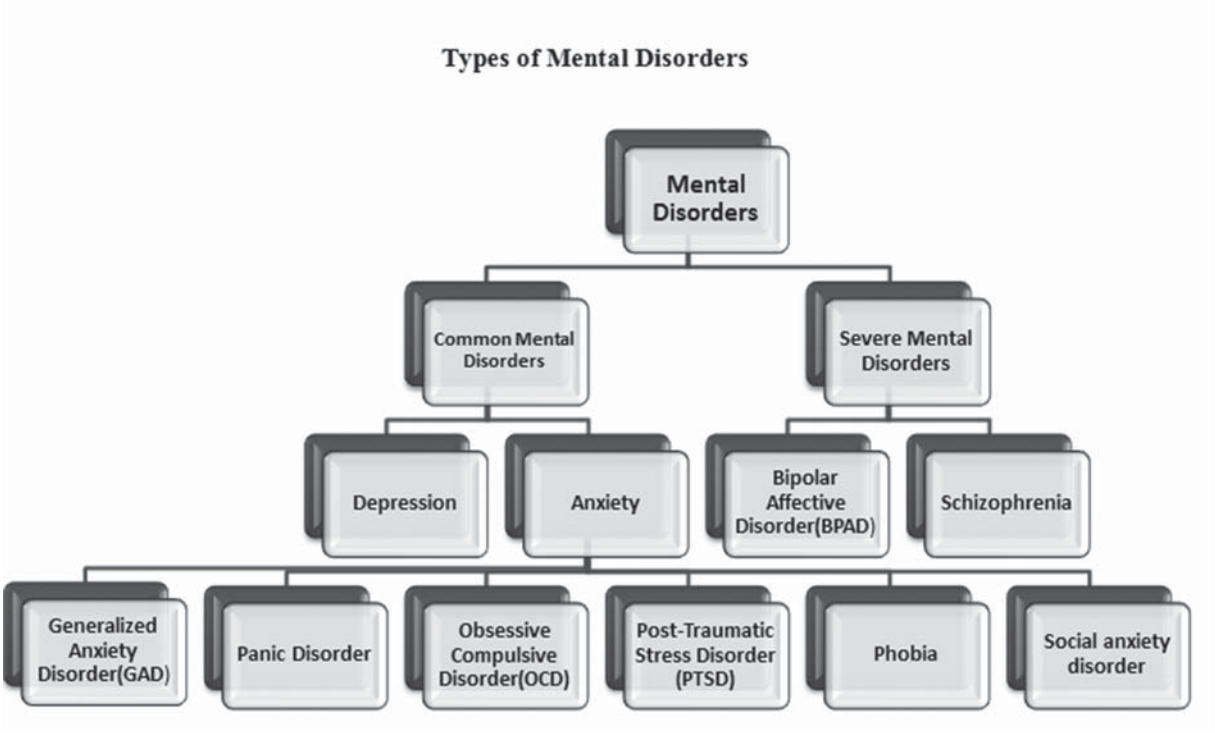
By encouraging maternal-newborn bonding, ANMs support psychosocial well being of mother and baby.[211] The mother-baby bonding that began at conception will be further enhanced at the moment the mother hears her newborns' first cry.[212]

ANMs should

- Be aware that the first hour after birth is the strongest foundation for mother-baby bonding [213] and the emotion and love formed during these early moments may greatly enhance the maternal-newborn bonding.[214]

- Encourage the mothers to have skin to skin contact with their baby immediately after birth (Kangaroo Mother Care, KMC). The benefits of KMC include;
  - Enables a continuous skin-to-skin contact[206]
  - Help mothers to feel close and responsible for the care of their newborn[206]
  - Increases the mother's confidence in her abilities to respond to her newborn's needs.[215]
  - Helps to stabilize newborn temperature and cardio-respiratory status, promote breastfeeding, reduce newborn crying and enhance maternal-newborn attachment.[211]
  - Facilitates a positive emotional mood between mother and newborn
- Support women to initiate breastfeeding as early as possible after the delivery as breastfeeding not only nourishes the baby but it is also a way to strengthen a mother's feeling of "being close to the child" and enhances the experience of "motherhood." [206]
- Recognize and support the role of a partner (husband) and family in developing a secure mother-infant bond and encourage them to touch and cuddle the baby to promote parent-infant bond.[199]
- Provide an environment that encourages quiet, calm interaction between mother and the newborn.
- Encourage the mothers to touch, talk, and sing to her baby.
- Encourage mothers to repeatedly cuddle, hold and stroke their baby and advice that she can't 'spoil' a baby by holding too much.[199]
- Support mother to hold her baby in the en face position to promote direct face-to-face and eye-to-eye contact between the mother and newborn. Encourage the mother to talk to her baby when the newborn's eyes are open to promote active bonding.[199]
- Inform the mother that positive moment of maternal touch-massage during the first postpartum hour improves mother-baby bonding and relaxation.[215]. Postpartum newborn massage also helps the mother to familiarize herself with her newborn through fingertip exploration of the newborn from head to toe.[211]
- Involve the mothers in the care of their newborn to develop confidence. For example, to change nappies, touch, and talk to their newborns etc[206]
- Identify and provide psychosocial support to the women who experience difficulties in initiating breastfeeding and mother-baby bonding.
- Early recognition of postnatal mental disorders and provide appropriate timely support for the women and family.[199]
- Help the mother with postnatal mental disorders to improve her interactions with her baby through step by step suggestions through video feedback. These interventions have been shown to be effective in reducing depressive symptoms in the mother and improving the quality of interactions between the mother and her infant. [216]


Strategies to improve Mother-Baby Bonding


Types of Mental Disorders
Mental Disorders
Common Mental Disorders
Severe Mental Disorders
Depression
Anxiety
Bipolar Affective Disorder(BPAD)
Schizophrenia
Generalized Anxiety Disorder(GAD)
Panic Disorder
Obsessive Compulsive Disorder(OCD)
Post-Traumatic Stress Disorder (PTSD)
Phobia
Social anxiety disorder


Have you often been bothered by little interest or pleasure in doing things
Then, you require to see Doctor for further evaluation
Have you often been botheredby feeling down, depressed or hopeless?
YES!!, Past one month it has increased....

# Session 9: Maternal Mental Healthassessment

**BACKGROUND**

This session helps the participants to understand the importance of psychosocial assessment for maternal mental disorders. It also helps the participants to build their knowledge and skills in psychosocial assessment and screening for maternal mental disorders. This in turn helps the participants to identify, treat and refer the women who are experiencing mental health issues during perinatal period

**TOPIC OUTLINE**

Topic 9.1: Significance of maternal mental health assessment
Topic 9.2: Process of maternal mental health assessment

**Session duration: 1 hour 30 minutes**

**Topic 9.1: SIGNIFICANCE OF MATERNAL MENTAL HEALTH ASSESSMENT**

**Aim**

Help the participants to improve their knowledge and understanding related to the importance of mental health assessment among women during pregnancy and postpartum period.

**Learning outcomes**

At the end of the session, participants will be able to

- Describe the importance of maternal mental health assessment as a part of their routine care
- Appreciate the mother related barriers to maternal mental health assessment
- Understand health workers' related barriers to maternal mental health assessment

**Description**

Participants are divided into two groups and each group is asked to list out either mother (group A) or health worker (group B) related barriers to maternal mental health assessment. After having a discussion among the group members, volunteers from each group present their identified barriers to the larger group. Facilitator encourages the participants to share their professional experiences followed by his/her presentation.

**Suggested training methodology** Small group activity, discussion followed by presentation

**Materials:** Chart paper, marker pen, flip chart, white/black board

**Duration:** 45minutes

**Process**

- Divide participants into 2 groups (group A & B) and each group is provided with a chart paper and marker pens

- Group A is asked to list out the *mother related barriers for maternal mental health assessment* and similarly, group B asked to list out the *health workers related barriers* for the same
- They have 5-10 minutes to discuss the given topic and note down their responses
- Each group should nominate one person from the group to note down the points discussed among the group members and present it to larger group.
- As the nominated person readout discussion points aloud, the facilitator write it on a whiteboard and motivate other group members to contribute to the same.
- Encourage the participants to share their own experiences about mental health assessment during pregnancy and postpartum period.
- Facilitator concludes the session by adding necessary inputs.

**BACKGROUND MATERIAL**

Pregnancy is the happiest period in a woman's life. Yet social and emotional health problems that occur in perinatal period can lead to poorer outcomes for women, infants and families.

ANMs being primary health care providers, they have frequent contact with women in the perinatal period. Thus they are ideally placed to identify the women who are at risk for development maternal mental disorders. World Health Organization also recommends that physiological and psychosocial assessment should begin during the first antennal visit.[217]

*Assessment refers to the broad psychosocial evaluation of the client, including risk factors and current symptoms which may be enhanced by the use of relevant measures.*

**Importance of maternal mental health assessment**

It is very important for midwives to perform a comprehensive mental health assessment of women as early as possible during pregnancy and postpartum period. The benefits of mental health assessment include;

1. This early identification helps to reduce long-term consequences of MMD for women and their children
2. It helps to identify and support women who are experiencing mental health problems.
3. Midwives usually conduct mental health assessment during their home visits which have positive impact
    a. Screening occurs in a familiar and non-threatening environment
    b. Women can avoid the stigma associated with seeking help for mental health problems
    c. Women do not have to spend extra time and money to access mental health care[218]
    d. Provides psychosocial support to the women
    e. To create awareness on maternal mental disorders among women and their families
4. Routine mental health assessment makes it more acceptable for mothers and health care providers.
5. Regular antenatal screening is important since postnatal mood disorders often begin during or before pregnancy.[219]

6. Facilitates a woman's successful transition to motherhood[220]
7. Routine psychological screening as a part of antenatal assessment reduces stigma towards maternal mental illness.[221]
8. Early diagnosis of maternal mental illness has positive impact such as
    a. Healthy development of child
    b. Reduces maternal mortality and morbidity rate
    c. Enhances mother-baby bonding
    d. Reduces suicidal risk
    e. Decreases chances of substance or alcohol misuse
    f. Compliance with pre and postnatal care recommendations

**Common barriers to maternal mental health assessment**

ANMs need to be aware of the most common barriers to screen and help the women in seeking mental health services. The barriers can be related to mother and health care providers

**Barriers related to mother include**

- Lack of awareness about maternal mental disorders
- Fear of stigma i.e. being labeled with mental illness
- Perceptions of motherhood. For example; feeling that "good mothers" do not get depressed or feelings of sadness were part of the motherhood process.
- Afraid that their children will be separated from them.
- Fear of hospitalization
- Poverty
- Lack of transportation

**Barriers related to healthcare providers**

- Lack of knowledge on maternal mental disorders due to inadequate training
- Lack of skills in screening and identifying maternal mental disorders
- Unawareness of referral pathways related to maternal mental illness
- Lack of time due to shortage of staff and work overload
- Lack of universal screening tools and guidelines for psychosocial assessment [222]

## TOPIC 9.2: MATERNAL MENTAL HEALTH ASSESSMENT

**Aim**

Help the participants to develop skills in screening the women for mental health issues during pregnancy and postpartum period.

**Learning outcomes**

At the end of the session, participants will be able to

- Understand the steps in the process of mental health assessment of women during the perinatal period.
- Identify psychosocial risk factors that contribute to the development of maternal mental health issues.

- Describe the tools used to assess anxiety, depression and suicidal ideation
- Demonstrate maternal mental health assessment using standardized questionnaires
- Recognize the women with mental health issues in perinatal period
- Be aware of local referral pathways to help the women with mental health issues during pregnancy and postpartum period

**Description**

The facilitator does the didactic session on assessment of maternal mental disorders. Then participants are divided into three groups. Each group is provided with a case vignette to enact role plays. Encourage the participants to share their experiences related to identification of the maternal mental disorders.

**Suggested training methodology**

Facilitator's presentation followed by role plays

**Materials:** Computer, LCD projector, paper, pens and case vignettes

**Duration:** 45minutes

**Process**

- The facilitator does the didactic session on *"Assessment of maternal mental disorders"*.
- After the presentation, participants are divided into three groups
- Provide each group with copies of case vignette and handout on psychosocial assessment.
- Ask each group to enact a role play based on the case vignettes given below
    - Assessment of anxiety
    - Assessment of depression
    - Assessment of self-harm thoughts
- Allow 10 minutes for discussion
- Encourage the participants to discuss their experiences in assessment of mothers with psychological problems

**Case vignette 28**

*Supriya, 26-year-old well educated, seven months pregnant woman. She is a mother of a three-year-old girl child and wishes to have a son in her second pregnancy. She has a strong support from her husband and family members. Past two weeks she started worrying about potty training for her elder child, and excessive concern for the boy baby. Since she had gestational diabetes in her previous pregnancy She also worried about her diet, exercise. Though her lab reports for blood sugar level and ultrasound reports were normal, her worries were out of control. She feels panic if she eats extra food other than her diet plan. She feels that something might goes out of her plan; it may affect her unborn baby. She was not able to control these constant worries and sometimes she used to get up in the midnight with profuse sweating, shivering and heart pounding. When her husband asked about her problem, she couldn't express anything and* ***says*** *she is normal. During the home visit, Supriya ventilated her feelings with Geetha ANM. Geetha convinces her that these feelings are common as part of pregnancy but requires help from mental health services. So she refers Supriya to Medical officer at PHC for further interventions.*

**Case vignette 29**

*Shylaja 28 year old woman educated up to 8th standard married since 2 yrs. She had episodes of depression during her pervious pregnancy for which she took treatment. Currently, she has three months old boy baby. During a postnatal visit by Seetha ANM, family members reported that since past three weeks, Shylaja is not taking care of herself, not involved in care the baby, not interested to feed the baby and not interacting with others. They also expressed that she is not eating and sleeping well. On inquiry, she says that she doesn't have "normal" feelings towards her child. She also says that she is not a good mother. Seetha convinces the family members that these behaviours are not normal, she requires treatment and refers her to a psychiatry hospital.*

**Case vignette 30**

*Sudha is 24 years old, four months pregnant woman, from middle socioeconomic status. During a home visit, Girija ANM observes Sudha being sad, tearful and with unkempt dressing. On probing, she revealed that her parents died in an accident when she was 12 years old and her uncle was the legal guardian who abused her physically and sexually. Recently she joined a private company and married to one of her colleagues. She says that from past one month, her husband became suspicious about her pregnancy. He started consuming alcohol and abusing her physically almost every day. As she could not expect this behaviour from her husband, she feels that she is good for nothing and wishes to die by consuming rat poisoning. Girija convinced that she needs urgent help from mental health services and refers her to a nearby psychiatrist.*

**BACKGROUND MATERIAL**

Mental health assessment includes evaluation of psychosocial risk factors and screening for mental disorders using GAD-2 and Whooley's questionnaires.

Screening and psychosocial assessment in pregnancy and the postpartum period should be broader and consists of three key elements

1. Focus on women' emotional wellbeing
2. Her relationship with her foetus /baby and
3. Her relationship with her partner and family members [223]

**Process of mental health assessment include**

1. Explain the women and family members about the importance of mental health assessment during pregnancy and postpartum period
2. Assure the women that mental health assessment is voluntary and not compulsory. ANMs also should inform the women that she will be asking few sensitive questions. Though, these questions are purely personal but important to analyze the emotional well being of the mother.
3. Discuss confidentiality of the responses given by the women
4. **Ensure the privacy**: Conduct the assessment privately. If the woman is literate, give her choice of filling the questionnaires. If they are illiterate, ask questions which reflect symptoms of mental illness and known risk factors.
5. **Language**: ANM should communicate in a language which mother is comfortable and understandable
6. **Referral**: Explain the mother about the pathway of the referral

ANMs need to mark the checklist related to psychosocial risk factors after having an informal discussion with the mother.

**Checklist for Psychosocial risk factors**

| S.No | Risk factors | YES | NO |
|---|---|---|---|
| 1 | History of mental illness | | |
| 2 | Younger age (below 20 years ) | | |
| 3 | Low socioeconomic status | | |
| 4 | Domestic violence | | |
| 5 | History of childhood abuse (physical, emotional, sexual abuse) | | |
| 6 | Unhappy about the current pregnancy | | |
| 7 | Disappointment with gender of the baby | | |
| 8 | Poor social support (domestic, financial and emotional) | | |
| 9 | Stressful life events (Example; death of a loved one, loss of job, marital discord etc.) | | |
| 10 | History of miscarriage, abortion, stillbirth, or the death of a child any time after birth. | | |

***Note:*** *If in case the presence of one or more risks factors, they are at risk for mental disorders. Hence ANMs need to provide extra support and sensitive care to these women.*

**SCREENING FOR ANXIETY, DEPRESSION AND SUICIDAL IDEATION**

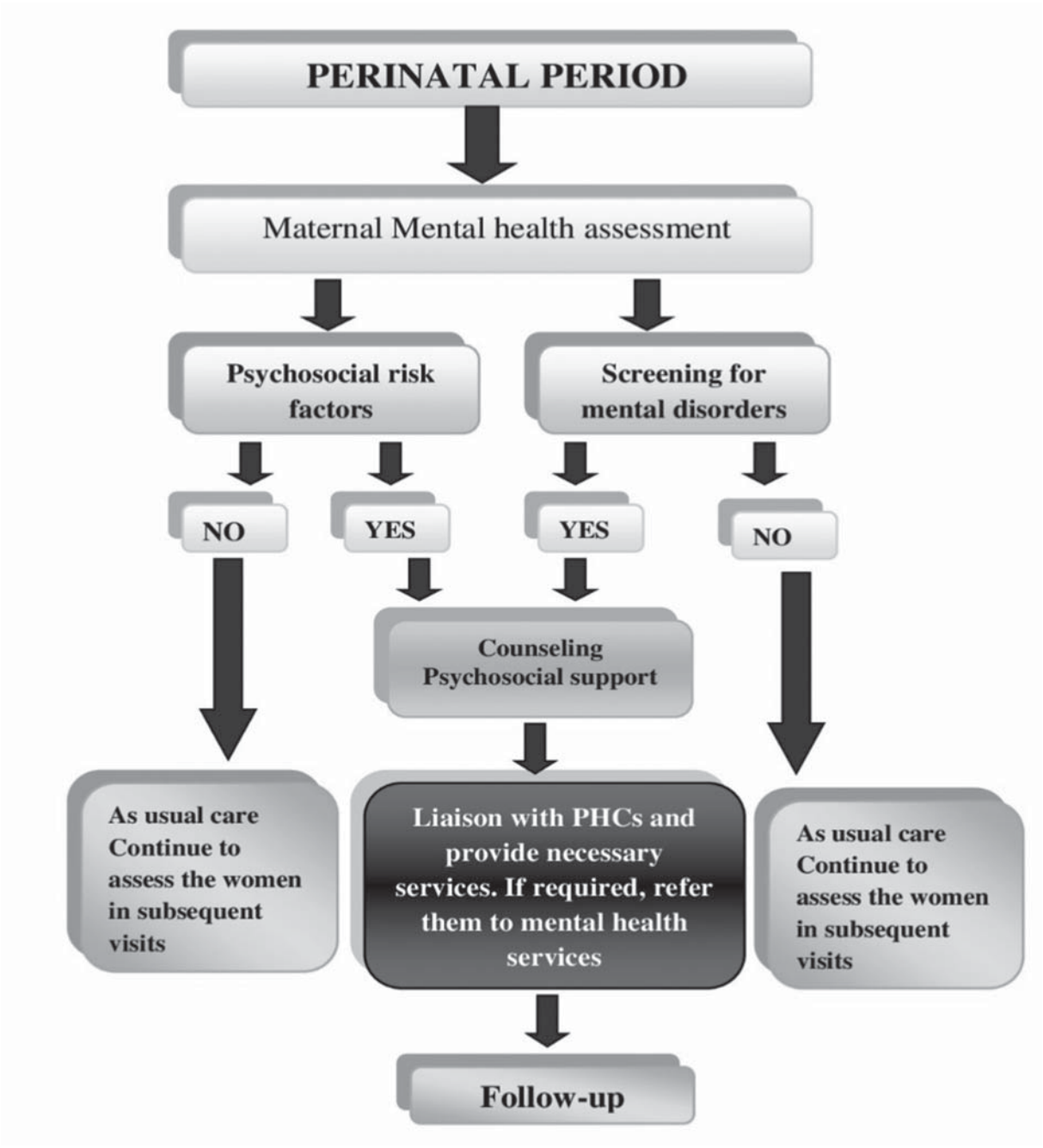
| Generalized Anxiety Disorder ( GAD-2, questionnaire) | Yes | No |
|---|---|---|
| **Over the last 2 weeks, are you**<br>Feeling nervous, anxious or on edge | | |
| Not being able to stop or control worrying | | |
| **Depression (Whooley's questionnaire)** | **Yes** | **No** |
| **During the past month,**<br>have you often been bothered by feeling down, depressed or hopeless? | | |
| have you often been bothered by little interest or pleasure in doing things | | |

***If "YES" for any question, women require further assessment for suicidal ideas and help***

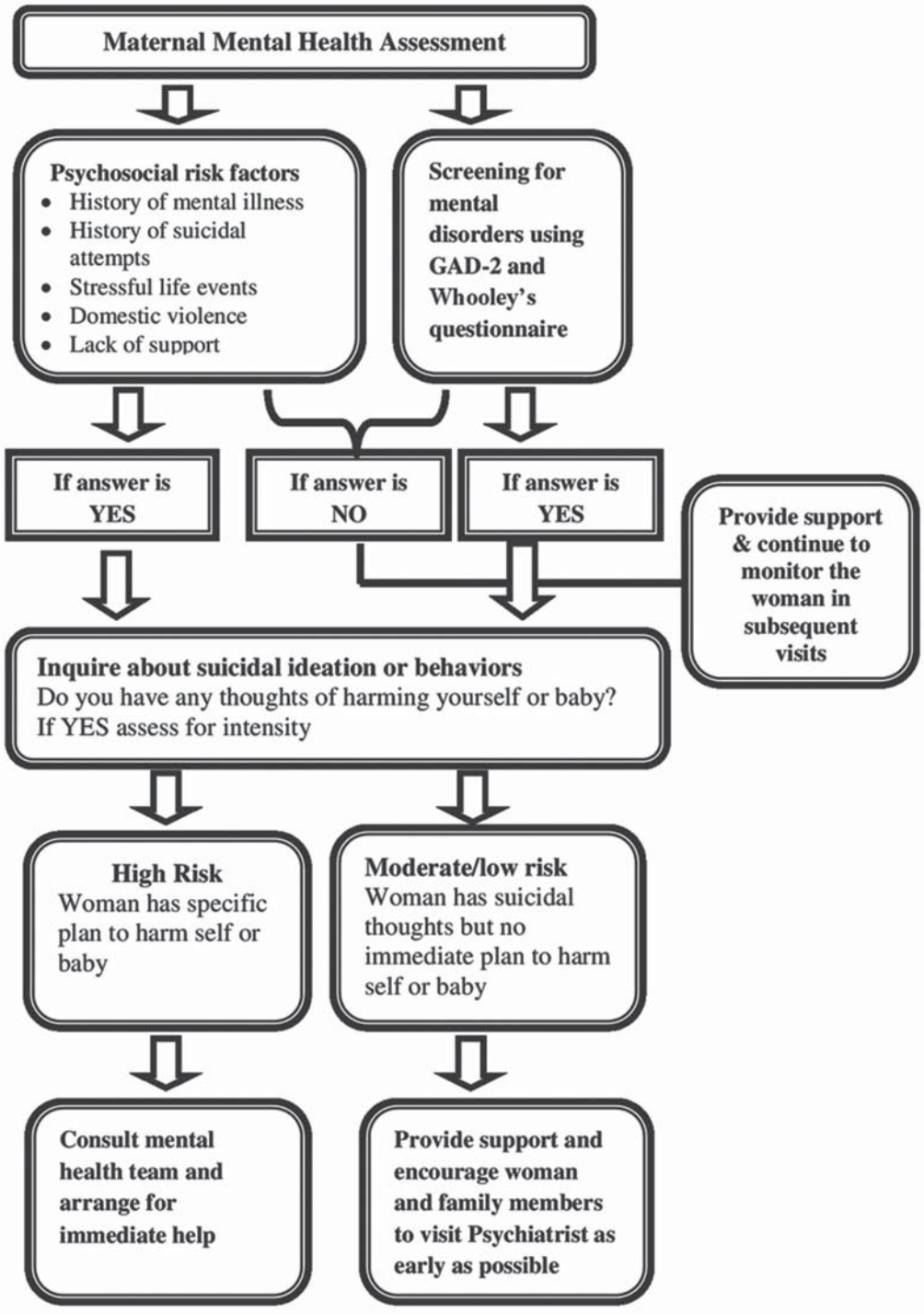
| Suicide | Yes | No |
|---|---|---|
| Currently, do you have any thoughts of harming yourself?<br>If yes, describe your plan | | |
| Have you attempted to harm yourself in the past? | | |
| Do you have any thoughts of harming your baby?<br>If yes describe your plan | | |

***Suicidal thoughts among women should not be ignored. Refer women immediately for psychiatric services.***

***Note:*** *it is important to remember that psychosocial risk assessment and screening doesn't confirm the presence of mental disorders. Yet indicates further evaluation and referral.*


PERINATAL PERIOD
Maternal Mental health assessment
Psychosocial risk factors
Screening for mental disorders
NO
YES
YES
NO
Counseling Psychosocial support
As usual care Continue to assess the women in subsequent visits
Liaison with PHCs and provide necessary services. If required, refer them to mental health services
As usual care Continue to assess the women in subsequent visits
Follow-up

**Flowchart for suicidal risk assessment of women in Perinatal period**



## DAY 3

**Activity** : **Revision of Day Two**

**Time** : 30 minutes

**Purpose** : To revise the information discussed on the day two clarify their doubts.

**Materials** : Quiz questions and some small prizes

**Directions** : Divide the participants into small groups (about 4-5 people in each group)
Ask the quiz questions below, one at a time.

For each single question, the group decides what the best answer is and one of the group members responds. If it is right answer, one credit point to be given to the group. If the first group answer is incorrect, then the facilitator asks the second group and so on.

Small prizes will be given to the group members who scores high credit points.

**Quiz questions**

1. Name any two common maternal mental disorders?
   **Answer:** Anxiety, Depression
2. What are the common types of anxiety disorders that occur during perinatal period?
   **Answer:** Generalized anxiety disorders, Obsessive compulsion disorders, panic disorders, post traumatic stress disorder and phobia
3. What is Tokophobia?
   **Answer:** Tokophobia refers to pathological fear of pregnancy.
4. Anxiety and depression often occur together in women during pregnancy and after childbirth. True /false
   **Answer:** True
5. Name two important consequences of anxiety disorders in women during pregnancy.
   **Answer:** Poor prenatal care, high risk for antenatal and postnatal depression, poor mother baby bonding
6. Pregnancy specific anxiety includes------
   **Answer:** Fear of giving birth, fear of bearing a handicap child, concern about one's appearance
7. What are the most important risk factors for postpartum depression?
   **Answer:** History of mental illness, gender preference, lack of social support, poverty, domestic violence, stressful life events
8. Common obsessions in women during postpartum period -
   **Answer:** Thought that the baby could die while sleeping, dropping the baby from the high place, drowning the baby during bath.

9. When does the baby blues occur?
   **Answer:** Begins one to three days after the delivery and lasts about 10-14 days of postnatal period
10. What is the prevalence of postpartum depression in Indian mothers?
    **Answer:** 22%
11. MOTHER –S stands for
    **Answer:** Motivation, observation, taking time for pleasurable activities, healthy diet, exercise, rest and sleep
12. Name two important risk factors for relapse of severe mental disorders in perinatal period
    **Answer:** History of mental illness and discontinuation of antipsychotic medications
13. What is the role of ANM if she comes across women with severe mental disorders?
    **Answer:** Identify and refer to mental health services
14. What is mother baby bonding?
    **Answer:** Special attachment between mother and baby.
15. Name few Strategies that promote positive mother baby bonding –
    **Answer:** Encouraging the mother to - visualize the image of unborn baby, breast feeding, singing lullabies and skin to skin contact, involving in baby care activities etc.

# Session 10: Maternal Mental Health: Role of Auxiliary Nurse Midwives


**BACKGROUND**

This session helps Auxiliary Nurse Midwives (ANMs) to understand about their role in promotion of maternal mental health. It also aims to develop various skills required to provide optimal care to the women with maternal mental health issues. It encourages the participants to work collaboratively with ASHAs, medical officers, women self-help groups, panchayat members, and anganwadi workers to promote maternal mental health and to prevent maternal mental disorders

**Topic outline**

10.1 Role of ANMs in *promotion of maternal mental health*
10.2 Role of ANMs in *prevention of maternal mental disorders*

**Session duration: 1 hour 30 minutes**

## 10.1 ROLE OF ANMS IN PROMOTION OF MATERNAL MENTAL HEALTH

**Aim**

Helps the participants to aware of their role in promotion of maternal mental health of women in their community

**Learning outcomes**

At the end of the session, ANMs will be able to

- Understand their role in promoting physical and emotional well being of the women during perinatal period
- Create awareness among partners/family members about importance of their support

to promote and maintain health (physical and mental health ) of women and babies
- Explain about the importance of early identification and interventions for maternal mental disorders
- Discuss with and motivate the mothers to have good maternal diet to promote physical and emotional well being of the mother and foetus/child
- Encourage and teach the mother about stress management techniques to cope with her stress during perinatal period
- Work collaboratively with other health workers and stakeholders to promote the maternal mental health of women.

**Description**
Participants are divided into two groups and are provided with a case vignette with role play script to enact role play depicting the role of ANM in the promotion of maternal mental health. Other participants are encouraged to observe the role play and share their views.

**Suggested training methodology**
Role plays followed by presentation

**Materials:** Case vignette, role play script (Annexure 2), papers and pens

**Duration:** 45 minutes

**Process**
- Participants are divided into two groups
- Invite the volunteers to perform role play to depict the role of ANMs in the promotion of maternal mental health
- Provide the volunteers with case vignette and role play script (Annexure 2).
- Ask the group (Volunteers) to read the case vignette and discuss within a group to perform role play.
- Instruct the group that the role play should end in 15 minutes
- Allow 10 minutes for discussion
- Ask rest of the participants to observe the role play and note down their own observations
- Ask participants to share their suggestions and comments to whole group.
- The facilitator will conclude the role play by presentation

**Case Vignette 31**
*Chaitra 22 years old woman, studied up to PUC, married one year back. Gayathri, an ANM met Chaitra for the first time, (as a part of prenatal visit) when she was two months pregnant.. She educated Chaitra and her family members about the importance of having a healthy diet to maintain good physical and mental health. She further insisted Chaitra and her husband to attend prenatal classes which are held at primary health care centre. Gayathri followed up Chaitra every month and when she was seven months pregnant, she found that Chaitra is extremely worried about labour pains and complains of low mood. Gayathri provides consistent and sensitive care to Chaitra throughout her pregnancy.*

**Case vignette 32**

*Kalpana is a 23 year's old graduated woman working for a corporate company and married since two years. She delivered a boy baby one week back. Anusuya who is an ANM, as part of her home visit, met Kalpana and observed Kalpana being inactive, looking dull, not interested to converse with her and above all, she was not responding to her baby's cry. Kalpana's mother complains that from past 2-3 days, she is not eating properly, not interested to feed and talk to her baby. On inquiry, she also expressed that her sister also had the same issue during her postpartum period and had taken treatment from a psychiatric hospital. Anusuya counsels her that these feelings are common after the delivery and she might feel good as days goes, advice her to keep the baby next to her, feed the baby according to her need, sing a lullaby to her, and cuddle her. Anusuya advices her family members to provide her adequate rest, sleep and nutritious diet as well emotional support to come out of this problem. Further, she had insisted them to observe her behaviours if it is persisting more than two weeks, advice them, to take her to the psychiatric hospital. Anusuya visits Kalpana after one month. Kalpana s condition got worsened and she referred Kalpana to a psychiatrist at the district hospital.*

**BACKGROUND MATERIAL**

Auxiliary Nurse Midwives being frontline healthcare providers in India plays a significant role in promoting mental health and prevention of mental disorders in women during the perinatal period. ANMs work closely with women during pregnancy and postpartum period. Hence, they have a unique opportunity to support and guide women to have positive pregnancy experience and cope with challenges associated with motherhood.

> A positive pregnancy experience is defined as 'maintaining physical and socio-cultural normality, maintaining a healthy pregnancy for mother and baby, having an effective transition to positive labour and birth, and achieving positive motherhood.
>
> **World Health Organization-2017[2]**

The role of ANM includes

**1. Knowledge and development**

Auxiliary Nurse Midwives should be aware of

- Physical, psychosocial and behavioural changes associated with pregnancy and childbirth
- Common mental health problems that women may encounter during the perinatal period.
- Risk factors for the development of mental health issues during pregnancy and postpartum period
- Importance and impact of poor mental health on mother baby bonding process.
- Supporting women to meet physical and emotional needs of their babies
- Strategies to promote mother infant bonding during perinatal period

To promote mental health of women, ANMs should

1. Update their knowledge to provide holistic care rather than focus traditionally on the physical health of the women in the perinatal period.

2. Attend regular refresher training courses, workshops and conferences to learn in-depth about strategies to prevent mental illness and promote emotional well being of women in during the perinatal period.
3. Be confident in assessing mental health of mothers, and use evidence-based tools (Whooley's questionnaire and GAD-2 scale) to identify anxiety and depression in women during perinatal period.
4. Be able to provide basic counselling to the women with common mental disorders such as anxiety and depression
5. To have a clear understanding about local referral pathways to help the women with mental disorders

**2. Family support**

Pregnancy is a joyous time not only for the couple but also for the family. Traditionally, the family plays a significant role in the successful transition of a woman to motherhood. Family support is crucial for the physical and psychological well being of women during the perinatal period.

ANMs being primary health care providers function as a bridge between families and the health care system. They are generally viewed with positive regard by families and this enables them to develop a close and trusting relationship during home visits and influence them with the following activities;

- Health education on physical and emotional changes that occur during pregnancy and postpartum period.
- Support family members to express their concerns to promote psychological well-being of women during perinatal period.
- Educate the family members that their support can help the woman to cope successfully with her new role as mother and provide a feeling of security for herself and her baby
- Encourage family participation throughout the entire course of pregnancy and child birth and accompany the women during prenatal and postnatal visits to her doctor. Inform them that these activities will not only support the women but also help family members to develop a sense of attachment with unborn child.
- Inform the family members about possible ways to support the mother. For example; accompanying while walking, providing time to rest and sleep, helping them to have nutritious maternal diet etc.
- Encourage the family members to conduct family rituals such as baby shower (*seemantham*) during pregnancy and naming ceremony after childbirth, as these are experience of love and support to the women during perinatal period.

- Understand the risk factors for mental disorders such as previous history of mental health issues, lack of social support, traumatic events, domestic violence, gender preference, poverty and take necessary timely steps to intervene.
- Involve the woman and her family members in all the decisions about her care and care of the baby
- Provide educational materials related to maternal mental disorders to reduce stigma and empower women and their families to seek help from mental health services.

**3. Partner/fathers role**

Fathers play a significant role in providing emotional support throughout pregnancy and after the delivery. Their involvement begins from preconception level to promote positive maternal health and infant development.

ANMs should

- Involve fathers in all the decisions related to health of the expectant mother
- Assist the father to help mother to experience successful transition into motherhood.
- Support the father to accompany his wife for antenatal check-ups and also to attend the antenatal classes and consultations to prepare him for childbirth and fatherhood.
- Encourage the father to have skin-to-skin contact with their baby to promote infant bonding and healthy development of the child.
- Educate the father about psychosocial needs of women during perinatal period
- Raise awareness about possible maternal mental health issues and promote emotional wellbeing of a woman during the perinatal period.
- Assist him in providing good maternal nutrition, reduce workload as well as extending emotional support during pregnancy and after the delivery
- Explain the importance of spending time with his partner and encourage her to express fears and concerns she may have during this challenging period.

**4. Early identification**

Auxiliary nurse midwives are ideally placed to identify mental health issues in women as they are providing consistent care throughout their pregnancy and postpartum period. Early identification and referral to appropriate mental health services may limit its impact on the mother, child, and families.

World Health Organization also recommended integration of mental health care in the existing maternal health programmes and activities to improve maternal health of women.[224]

The responsibilities of ANMs include:

- Educating the pregnant women and family members about the importance of mental health assessment.
- Reducing the stigma and discrimination through regular screening for mental health issues.
- Identify the women who are at the risk of developing maternal mental disorders. For example; Personal and family history of mental disorders, Domestic violence, increased stress etc
- Assess the risk factors for suicide and suicidal behaviours among women in perinatal period
- Skills to assess for common mental disorders such as anxiety and depression using standardized tools Whooley's questionnaire (depression) and GAD-2 scale (anxiety). These scales are simple, reliable to identify mental health problems in women during pregnancy and after childbirth within the context of primary health care.
- Instruct the women and family members that positive response to these scales doesn't diagnose mental disorders but requires further assessment.
- Enable prompt access to appropriate services for women with maternal mental health issues.
- Ensure that women receiving antipsychotic medication consult a psychiatrist before planning for pregnancy.
- Monitor closely the women who have history of mental illness during past pregnancies or postpartum period
- Advice the family members and partners to support women with SMD to avoid triggers such as providing adequate time to sleep, follow-up services etc.
- Provide continuous and consistent care to women with SMD throughout pregnancy and postpartum period especially first few weeks after the delivery.
- Encourage breastfeeding unless it is contraindicated by the psychiatrists

**5. Nutrition**

Maternal nutrition before and during pregnancy is an influential factor for better health outcomes in the mother and newborn. Research showed that antenatal diet quality is associated with mental health of women.[225] ANMs have a unique opportunity to educate the women, father, and families about

- Importance of a healthy diet to the mother and foetus/child in the context of health promotion.
- The relationship between quality of diet and mental health of women in the perinatal period.
- Impact of poor quality of diet on health outcomes of mother and infant. Nutrition education and counselling may support optimal gestational weight gain (i.e. neither insufficient nor excessive), reduce the risk of anemia in late pregnancy, increase birth weight, and lower the risk of preterm delivery.
- Encourage the woman to choose fiber-rich diet from basic 'five food groups' (Grain, vegetables, fruits, milk and meat, fish)

- A written pamphlet with self explanatory pictures on maternal nutrition and sources of food groups to be provided to the women and families.
- Encourage women and families to buy the organic vegetables and fruits which are available seasonally. Seasonal foods not only retain more nutrients but are also available at cheaper rates than processed ones.
- Educate and support women to consume plenty of fluids throughout pregnancy and postpartum period.
- Encourage women to have small, frequent meals throughout the day during pregnancy and after child birth.
- Ensure that women receive micronutrients and food supplements or fortified foods through Anganwadi services.
- ANMs must collabouratively work with ASHAs, Anganwadi workers to mobilize the community and facilitate the mother to access supplementary nutrition under Integrated Child Development Services (ICDS) Scheme.
- In addition to this, pregnant women need to increase their intake of essential vitamins and minerals. The most important ones are:

Folic acid (fruits and vegetables) to prevent neural tube defects ,Iodine (Cranberries, Strawberries, baked potato) for neurodevelopment of child, Iron ( meat, whole grain, cereals) to circulate oxygen, maintain energy levels, calcium (milk and milk products, greens) for bone strength, muscle and nerve health and omega 3 (fish, bread, cereals) for fetal brain development and to prevent post-natal depression.

- Instruct and inform the women to avoid certain foods that affect the health of the mother and the unborn child. Such foods include raw seafood, liver and liver products (high levels of Vitamin A can cause birth defects), alcohol (Fetal Alcohol syndrome), caffeine (increase the risk of miscarriage, low birth weight), and smoking (foetal stress).

*A healthy diet during pregnancy contains adequate energy, protein, vitamins, and minerals, obtained through the consumption of a variety of foods, including green and orange vegetables, meat, fish, beans, nuts, pasteurized dairy products and fruits.

**World Health Organization (2016)[1]**

**6. Rest &sleep**

Adequate rest and sleep enhance physical and mental well being of women in the perinatal period. Research shows that sleep deprivation affects the maternal mental health of women. [226]

ANMs should educate women about

- Relationship between poor sleep and mental health of women
- Encourage the women to establish regular sleep patterns at the beginning of the pregnancy. A good sleep pattern plays an important role in the preparation for birth and protects the baby from the psychological stresses and strains of pregnancy.[227]
- Instruct family members that pregnant women usually feel fatigue and excessive sleepiness due to increased secretion of progesterone during sleep. Thus, it is important to allow women during pregnancy to have at least 6-8 hrs of sleep during night and 60

minutes of a nap in the daytime (around lunch) which is essential to improve mental well being of women.

- Good sleep and rest are important for healing and restoration of mental well being of postnatal women as well. Thus, encourage the postnatal women to take small naps whenever possible
- Encourage women to continue relaxation techniques such as reading books, listening to music, having warm milk or snack before sleep, warm bath, few deep breaths, guided imagery etc.
- Provide written information with self-explanatory pictures about the need for rest and sleep and sleep hygiene for the women during perinatal period
- Encourage the women to do gentle exercises, take adequate rest, seek help with caring the baby, share their feelings and ensure access to social support networks.
- Instruct women to avoid caffeine and reduce the fluid intake after evening (frequent urination) to prevent disturbed sleep.
- Inform women to have a comfortable bed, and advice, pregnant women, to sleep in left lateral position to reduce pressure on the womb.
- Educate women that sleep problems during the postpartum period is not uncommon and it is not only due to changes in hormones but also due to changes in the lifestyle such as breastfeeding, sleep patterns, caring of other children, interpersonal relationships with other family members etc. The mother has to be prepared well during prenatal classes to cope with new challenges.

**7. Exercise**

Exercises including yoga are important to maintain physical and emotional well being of women during pregnancy and after birth.

ANMs should

- Educate the women and family members about the importance of physical activity to promote the physical and mental health of women throughout perinatal period. The benefits of exercises include
    - Relieves common discomforts such as a backache, fatigue, constipation, heartburn and stress
    - Prevents gestational diabetes (diabetes that develops during pregnancy),
    - Builds more stamina needed for labour and delivery.[228]
    - Improves emotional health by increasing the levels of feel-good chemicals (endorphins). This, in turn, helps the women to experience positive motherhood
- Instruct that exercises should be adjusted in intensity and duration according to the suggestions given by the obstetrician or yoga instructor. For example; brisk walking for 20-30 minutes, 3-4 times a week.
- Advice the women to stay hydrated, avoid exercises in extreme hot or cold environments and to wear comfortable clothing.

**8. Stress management**

Stress is very common in women during pregnancy and after child birth due to physical

and psychological changes. But chronic stress during pregnancy may affect the unborn child and mother-baby bonding during the postpartum period.

> Stress is defined as "a state of psychological and physiological imbalance resulting from the disparity between situational demand and the individual's ability and motivation to meet those needs."
>
> ***Hans Selye (1936)***

ANMs should

- Educate the mother and families about the causes of stress (common discomforts such as nausea, vomiting, backache, hormonal changes, worry about labour and taking care of the baby etc) during the perinatal period.
- Provide information about negative effects of chronic stress on health and its effects on mother and the child
- Discuss with family members/ fathers about the ways to support the women to cope with stress successfully and enable them to experience positive pregnancy and motherhood.
- Teach and ensure that women practice stress management techniques such as
    - Meditation
    - Yoga and exercises(Walking)
    - Healthy diet
    - Positive thinking
    - Positive relationships
    - Spending time with family and friends
    - Talking about worries and concerns with trusted persons such as mother, health care professionals, partner, and friends
    - Alternative and Complementary therapies
    - Develop support system
    - Good sleep habits

**9. Collaborative work of ANMs in the community**

ANMs should work collaboratively with ASHAs, Medical Officers, Women Self-help groups, Panchayat members, and Anganwadi workers.

- ANMs should encourage ASHAs in motivating the pregnant women for antenatal check-ups at primary health centres (PHCs) or Sub-centres.
- Educating ASHAs and other health workers about the importance of balanced diet (seasonal fruits, vegetables, and green leaves), Iron and folic acid tablets.
- Guiding the ASHAs to identify early signs of mental illness during pregnancy and postnatal period.
- ANMs should collaborate with Anganawadi workers(AWW) and ASHAs in organizing health day programme once or twice a month at Anganawadis and should orient women on health-related issues such as the importance of nutritious food, personal hygiene, immunization, physical and emotional care during pregnancy and postnatal period.

## TOPIC.10.2: ROLE OF ANMS IN PREVENTION OF MATERNAL MENTAL DISORDERS

**Aim**

Help the participants to gain insight into their role in prevention of maternal mental disorders

**Learning outcomes**

At the end of the session, participants will be able to:

- Understand their role in creating awareness among general population on prevention of maternal mental disorders
- Identify common mental health issues and address them with basic counselling skills
- Identify mental health disorders among prenatal and postnatal women and refer them to the appropriate services
- Reduce the impact of maternal mental illness by providing support to the women and her family.

**Description**

Participants are divided into three groups and each group is provided with a question to discuss on role of ANMs in the prevention of maternal mental disorders followed by the presentation from the facilitators.

**Suggested training methodology**

Small group discussion followed by presentation

**Materials:** Chart paper and marker pens

**Duration:** 45 minutes

**Process**

- Divide the participants into 3 groups.
- Provide them a chart paper and pen.
- Provide each group, the following questions (one question to each group) in order to generate the discussion
    - *What does the primary prevention mean to you and list out related activities that are included in the primary prevention of maternal mental disorders?*
    - *What does the secondary prevention mean to you and list out related activities that are included in the secondary prevention of maternal mental disorders?*
    - *What does the tertiary prevention mean to you and list out related activities that are included in the tertiary prevention of maternal mental disorders?*
- Ask each sub- group to identify a member of the group who will give feedback to the entire group at the end of this activity.
- Ask him/her to write down the points on the chart during the discussion.
- Allow 5-10 minutes for group discussion.
- Ask the sub-groups to share their discussion with the entire group through presentation

- Ask other group members to respond and provide suggestions
- The facilitator will end the session by adding inputs through the presentation.

**BACKGROUND MATERIAL**

While Auxiliary Nurse Midwives provides comprehensive care to women throughout pregnancy and the postpartum period, there are opportunities to enhance their role in the prevention of maternal mental disorders in the community. However, they should be well informed about ways to prevent maternal mental disorders.

Prevention of maternal mental disorders is a challenge for health care system in developing countries like India and ANMs play a critical role in the prevention of maternal mental health issues.

**PREVENTION OF MATERNAL MENTAL DISORDERS**

*Mental disorder prevention refers to "reducing incidence, prevalence, recurrence of mental disorders, the time spent with symptoms, or the risk condition for a mental illness, preventing or delaying recurrences and also decreasing the impact of illness in the affected person, their families and the society"* [229]

According to the Institute of Medicine (IOM), primary prevention includes universal, selective and indicated preventive interventions. [230]

Secondary prevention aims to lower the rate of established cases of the disorder or illness in the population (prevalence) through early detection and treatment of diagnosable diseases. Tertiary prevention includes interventions that reduce disability, enhance rehabilitation and prevent relapses and recurrences of the illness.

**Definitions of universal, selective and indicated prevention[230]**

**Universal prevention** is defined as those interventions that are targeted at the general public or to a whole population group that has not been identified on the basis of increased risk.

**Selective prevention** targets individuals or subgroups of the population whose risk of developing a mental disorder is significantly higher than average, as evidenced by biological, psychological or social risk factors.

**Indicated prevention** targets high-risk people who are identified as having minimal but detectable signs or symptoms foreshadowing mental disorder or biological markers indicating a predisposition for a mental disorder but who do not meet diagnostic criteria for the disorder at that time.

According to the Institute of Medicine (IOM) framework of mental health intervention for prevention of mental disorders, the role of ANMs at various levels prevention is discussed bellow

| Prevention of maternal mental disorders: Role of ANMs | | | |
|---|---|---|---|
| **Primary prevention** | | **Secondary prevention** | **Tertiary prevention** |
| Universal | • Creating awareness among public to promote positive maternal mental health<br>• Education about maternal mental disorders, causes, signs, and symptoms, treatment<br>• Promotion of positive maternal mental health among women<br>• Distribution of pamphlets on maternal mental disorders<br>• Display of posters on maternal mental disorders<br>• Engage stakeholders in the community in creating awareness<br>• Reducing stigma against maternal mental disorders<br>• Educating all health care providers through training workshops on maternal mental health and maternal mental disorders to ensure consistency in regular assessments for maternal mental health<br>• Including adequate content on maternal mental health in curricula in all nursing courses including Auxiliary Nurse Midwives. | • Mental health assessment using Whooley's' and GAD scales at every prenatal and postnatal visit<br>• Early identification and intervention<br>• Continuous monitoring of women who are at risk<br>• Appropriate referral<br>• Follow-up and ensuring women to continue medication | • Reducing impact of maternal mental illness on mother and child<br>• Limiting disability<br>• Family and partner Support<br>• Support groups |
| Selective | • Educate expectant mother and families/ partner about physical emotional changes that occur in women during the perinatal period.<br>• Mental health promotion strategies that include good maternal diet, preparing for birth and labour, sleep hygiene, cope with stress, exercises, social support etc<br>• Access to health services, good prenatal and postnatal care<br>• Support breastfeeding, Mother- Baby bonding | | |
| Indicated | • Personal or family history of mental illness<br>• Previous episode of maternal mental disorders<br>• Exposure to risk factors such as domestic violence, poverty, substance abuse, lack of support from partner,<br>• History of prenatal anxiety/depression<br>• History of miscarriage, stillbirth | | |

# Session 11 Counselling

**BACKGROUND**

This session helps the participants to be aware of basic counselling skills while caring for women with mental distress in perinatal period. This session enhances the importance of counselling skills for effective communication in their daily practice.

**Session duration**

45 minutes

**Aim**

Introduce the participants to the basic counselling skills required to provide emotional support to the women with perinatal mental health issues.

**Learning outcomes**

At the end of the session, participants will be able to

- Reflect on their own experiences of counselling women with emotional distress
- Understand the meaning of counselling and importance of enhanced skills for effective communication to provide optimal care to the women in perinatal period
- Describe the essential qualities of a counsellor
- Enhance their competence in counselling the women with mental health issues.

**Description**

Facilitator invites the volunteers to perform a role play and provides them with case vignettes. All other participants are asked to observe the role play and write down the important points. Participants are encouraged to share their views on role play followed by the facilitator's presentation on counselling skills.

**Suggested training methodology**

Role play followed by discussion and presentation

**Materials**

Case vignettes, Role play script, paper, pen, and markers

**Process**

- Choose four volunteers from the group and pair them as counsellor and counselee
- Provide the volunteers with case vignettes and ask the volunteers to read the case vignette
- Provide role play script on 'helpful' and unhelpful response'(Annexure 3).
- Allow 10 minutes for discussion followed by role play. Before starting the role play, volunteers are asked to read out their case vignettes to the larger group and introduce the characters

- Ask all other participants to observe the role play and to note down observations
- Encourage the participants to observe
    - Non-verbal communication
    - Rapport between counselee and the counsellor
    - Counsellor's listening skills
    - Counsellor's understanding regarding woman's concerns
    - Counsellor's ability to paraphrase
    - Counsellor's ability to provide help to the woman
    - Conclusion of the session
- Ask the participants to share their observation and suggestions on the role play.
- At the end, facilitator explains the process of counselling and basic skills required during the counselling.

**Case vignette33**

*Sanjana 23-year-old, five month pregnant woman is a homemaker and from middle socio economic background. She was married to an army officer three years back and she has a two year old girl child. Her husband passed away two months back in a terrorist attack. After that incident, Sanjana has become emotionally numb, not talking to anyone, not taking food properly, sitting alone and crying in the room. Since her husband was a government employee, she had an opportunity to join for government service. But she had lost interest in her future and started to feel hopelessness and worthlessness. Sanjana's mother was worried about her health and brought her to a hospital for treatment. She was referred to a counsellor (Chaitanya) for further interventions.*

**BACKGROUND MATERIAL**

Pregnancy and having a child is a beautiful experience for women, yet it is a challenging period with new roles and responsibilities. Thus, they are more prone to encounter mental health problems such as anxiety and depression. If left untreated, it will impact not only the mother but also their babies and families. Midwives are key professionals to address the unique needs of women throughout pregnancy, labour, birth and early parenting. They also are expected to provide supportive counselling to the mothers who experience mental health difficulties.

**Counselling**

Counselling is a talking therapy that involves listening, supporting the women to deal with emotional issues in the perinatal period.

***COUNSELLING IS NOT …***

- Giving advice
- Offering solutions
- Taking charge of someone's life
- Doing the other person's work for him
- Correcting or reprimanding for wrong deeds
- Sermonizing or labelling the person
- Showing pity towards someone in trouble[231]

Counselling is a process, based on a **relationship** that is built on **empathy, acceptance, and trust**. Within this relationship, the counsellor focuses on the client's feelings, thoughts, and actions, and then empowers clients to:

- Cope with their lives,
- Explore options,
- Take their own decisions, and
- Take responsibility for those decisions.[232]

**Qualities of Counsellor**

1. **Respect**: Counsellors should respect a person's inherent strength, capacity and right to choose his/her own alternatives to make his/her own decisions
2. **Authenticity:** Counsellor should have genuineness, honesty, and simplicity and avoid superiority feeling
3. **Non-possessive warmth:** Demonstration of concern, interest, and value for others and a deep concern for the well-being of the other person.
4. **Non-judgmental attitude:** Avoid bias, making assumptions or judgments about the client
5. **Accurate understanding of the client:** It includes precise evaluation of the perceptual and cognitive behaviour of the individual
6. **Recognizing the clients' potential:** Recognizing the strengths and abilities of the client
7. **Confidentiality:** Maintain confidentiality and develop trust. Avoid revealing client's identity, personal details and other information without consent. Assure confidentiality of the client.
8. **Empathy:** Empathy helps counsellor to understand the feelings and problems of the client in a better way.
9. **Flexibility:** Flexibility is a need of the counsellor to understand the clients while keeping the principle of individualization in the mind.
10. **Positive Regard:** Positive regard means that the counsellor should not judge clients based on assumption but thinks about clients positives.
11. **Self-awareness:** Counsellor must be aware of his /her feelings, attitudes towards women with mental illness during the perinatal period. [233]

**Skills of counseling**

The following counselling skills are necessary for ANMs to help the women to relieve their emotional distress.

1. **Listening skills**

   Listening is the most important part of good communication and involves more than just hearing the woman's words.

   A. **Active listening** refers to "Listen for meaning". In active listening, the counsellor says very little but conveys empathy, acceptance, and genuineness. The counsellor speaks to find out if she/he have heard or understood correctly

   B. **Verbal listening:** Verbal responses show that the counsellor is listening to the woman and encourages her to ventilate her feelings. Verbal responses include: "mmm-mmm' uh-huh' or 'yes'

**C. Non-verbal listening**

Non-verbal listening includes SOLER-F method.

**S** **Squarely** face person-not turned to the side
**O** use **Open posture** without crossed arms and legs
**L** **Lean** slightly toward the person rather than sitting back in the chair
**E** Use **eye contact** instead of staring off into deep space
**R** **Relax,** keep it natural instead of sitting like a board
**F** Look **Friendly** and welcoming rather than neutral

**2. Asking questions**

Open and closed questions are important for counselling.

**A. Open-ended questions:** is used in order to gather lots of information. This type of questions has no correct answer and requires an explanation. Open-ended questions encourage the women to keep talking. Example: Could you please tell me more about …

**B. Closed questions:** is used to get specific information. Closed questions are those that can easily be answered with a "yes" or a "No". These types of questions are useful for getting necessary information and help the woman to focus their discussion. Example: is this pregnancy planned?

**3. Reflection skills**

Reflection gives back to the woman what she has communicated to a counsellor. Example: "You sound worried and overwhelmed"

**Importance of reflection skills**

- Valuable in **building a relationship** with the woman by communicating trust, acceptance, and understanding
- Helps the women to recognize and have a **clarity** about their problems and feelings
- Helps the counsellor to **get information** about the woman and how she views her situation
- Helps the counsellor to **verify** her perception of what the woman communicates.[234]

**Process of Counselling**

Counselling is a process in which the counsellor, or therapist, helps the client understand the causes for problems and guides the person through the process of learning to make good life decisions

*The counsellor's role is to guide the client through the process and not tell what the client should do. The clients are helped to help themselves.*

The steps in counselling process include:

1. **Identification of the need for counselling:** It is first important step to identify the need and reason for counselling.

2. **Preparation for counselling:** Successful counselling requires preparation that includes
   - Selection of a suitable place with minimal interruptions and free from distracting sights and sounds.
   - Schedule the time which is convenient for both counsellor and counseleee. Generally a counselling session should last less than an hour. If the client needs more time, a second session may be scheduled.
   - Notify the person or the client well in advance
   - Organize information such as why, where, and when the counselling will take place. The counsellor should review all pertinent information like purpose of the counselling, facts and observations about the client, identification of possible problems, main points of discussion, and the development of a plan of action.
   - Outline the counselling session components using the information obtained, the counsellor should determine what to discuss during the counselling session. A written outline helps the counsellor to organize the session and enhances the chance of positive results.
   - Plan the counselling strategy depending on the clients and the situation such as directive, nondirective, and combined approaches.
   - The counsellor must establish the right atmosphere which promotes two way communications-between the counsellor and client.
3. **Conduct of Counselling Session**

   While conducting the counselling session, the counsellor should be flexible. However he/she should address the following four basic components of a counselling session.
   a) **Open the session:** In the session opening, the counsellor should state the purpose of the session and establish a client centered setting. The counsellor and the client should attempt to develop a mutual understanding of the issues by letting the client do most of the talking and the counsellor can use active listening, respond, and question without dominating the conversation.
   b) **Develop a Plan of Action:** A plan of action identifies a method for achieving a desired result. The plan of action must be specific.
   c) **Record and close the session:** Documentation serves as a reference to the agreed upon plan of action and the client's accomplishments, improvements, personal preferences, or problems. To close the session, the counsellor should summarise its key points and ask if the client understands the plan of action. Invite the client to review the plan of action and what is expected of the counsellor.
4. **Follow up:** Appropriate measures after counselling include follow up counselling, making referrals, and taking corrective measures.

# Session 12: Concluding Session

**BACKGROUND**

This session aims to conclude the training program by summarizing all the sessions, obtaining feedback and suggestions.

**Topic outline**

Topic 12.1: Summarizing
Topic 12.2: Feedback
Topic 12.3: Closing

**Total session time: 1** hour 30 minutes

**TOPIC 12.1: SUMMARIZING**

**Aim**

Helps the participants to be aware of the key messages from different sessions

**Learning outcome**

By the end of the session the participants will be able to

- Recall the important points from all the sessions.
- Explain and clarify the doubts if they have
- Inculcate positive attitudes towards women with mental health issues in perinatal period.

**Description**

Participants are divided into three groups and each group is provided with a sheet to match the answers. After five minutes collect the answer sheet and invite a volunteer to present their responses to the larger group. Items are displayed on PPT one after another from each group and facilitator read the item and chosen responses from the concerned group. Participants are encouraged to give a big round of applause for right answers and one point will be credited. In case of wrong answer, encourage the next group members to come up with right answer. Facilitator may provide the right answers if other participants are unable to answers.

**Suggested training methodology**
Small group activity, discussion and Power point presentation

**Materials required:** Computer and LCD projector

**Duration: 30** minutes

**Process**

- Divide participants in to three groups and each group is provided with a sheet of papers which contains ten items to match the answers (Annexure 4).
- Allow them 10 minutes to read, discuss and complete the task
- Collect the answer sheets from all the groups
- Invite a volunteer from each group to present their responses to the larger group
- Display the items on PPT one after the another from each group
- Facilitator will read the item and the chosen response from the concerned group.
- Encourage the other participants from the larger group to give big round of applause, if it is a right answer and one credit point to them. In case, if it is a wrong answer ask the next group members to come up with right answer and credit points can be given to the group. If participants are unable to come up with right answer facilitator may provide the right answers.
- Allow for discussion, and reflections.
- Encourage them to ask questions and clarify their doubts

**TOPIC 12.2: FEEDBACK**

**Aim**
Get the feedback from the participants about the content and teaching methodologies adopted for the training program. Participants are also encouraged to give their suggestions to improve the training program

**Learning outcome**
By the end of the session the participants will be able to provide their valuable feedback to help the facilitator to incorporate their suggestions in upcoming training programs.

**Description**
Feedback formats are distributed to the participants to write down their opinion about the training. Invite few participants to give a honest feedback and share their learning experiences.

**Suggested training methodology**
Filling the form

**Materials required:** Photocopy of feedback form and pens

**Duration: 30** minutes

**Process**

- Distribute the feedback form to all the participants (Annexure 5)
- Ask them to write their honest opinion and suggestions without any hesitation
- Inform them that writing their name on feedback form is optional
- Invite two or three participants on behalf of the group to give their feedback orally - both what they liked and what could have been better.
- Listen carefully and note down all the points for further review without making any comments

**TOPIC 12.3: CLOSING**

**Aim**

Get feedback from participants on the relevance of content, methodologies and facilitator's skill, get their suggestions for further improvement and acknowledge them for their participation and hard work during the training program.

**Learning outcome**

By the end of the training programme both participants and facilitators get feedback from each other

**Description**

Participants will be provided with three pieces of papers, they have to write in short the "Star Moment they saw in three people (it might be for the facilitators or co-participants) in the whole training programme". In front of the whole group, ask all the participants one by one to read the chit they had written and hand it over to the person to whom they had written the chit for.

**Suggested training methodology**

Writing on the chit

**Materials required:** Paper Pieces, pens or marker pens

**Duration:** 30 minutes

**Process**

- At the end of the activities, ask each member of the team to write three "star moments" they saw in other members. (it might be for the facilitators or co-participants) (A "star moment" is referred to as a talent, gift or contribution a participant had towards the group).
- In front of the whole group, ask all the participants one by one to read the chit they had written and hand it over to the person to whom they had written the chit for
- Make sure every member of the team gets a star moment. The trainer may suggest some star shines he/she has observed during the training.
- Carefully handle the negative comments made by the participants.

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# Annexures

## ANNEXURE 1- PRE AND POST TEST QUESTIONNAIRES

**Code No:** ☐

This questionnaire is designed to evaluate the effectiveness of a training program on Maternal Mental Health. It will take approximately 20-30 minutes to complete the questionnaire which assesses your understanding and opinions related to maternal mental health. Please mark your responses as a simple tick. Example: [√]. We also request you not to write your names as your responses will be kept confidential. Please identify a unique code that you will remember as you will also need to put it on the post-training evaluation questionnaires.

**Section A: Socio-demographic details**

1. Age: _____
2. Education: _____
3. Current designation
4. Religion: a) Hindu b) Muslim c) Christian/others
5. Place of residence: a) Rural b) Urban
6. Marital status: a) Married b) Unmarried c) Widowed/Divorced
7. Years of professional experience:
8. Have you come across any person with mental illness in your professional experience? a) Yes b) NO
9. Have you come across any women with mental illness in women during pregnancy or after childbirth? If Yes please describe _____
10. How would you rate your professional training (ANM course) on maternal mental health disorders
    Excellent Good Fair Poor Never received training
11. Have you undergone any training related to maternal mental disorders? If yes, Please describe _____

**Section B: Knowledge questionnaire on Maternal Mental Disorders**

On a scale of 1-5, please indicate your current knowledge on mental health problems in women during pregnancy and postpartum period.

| | Poor | Fair | Good | Very good | Excellent |
|---|---|---|---|---|---|
| 1. Antenatal depression | | | | | |
| 2. Postnatal depression | | | | | |
| 3. Antenatal anxiety | | | | | |
| 4. Postnatal anxiety | | | | | |
| 5. Obsessive thinking | | | | | |
| 6. Fatigue /sleeping problems | | | | | |
| 7. Schizophrenia | | | | | |
| 8. Puerperal psychosis | | | | | |
| 9. Suicide | | | | | |
| 10. Bipolar affective disorder | | | | | |

1. What does Mental health mean to you
   a) A person who is sensitive
   b) A person who is rich
   **c) A person who realizes his/her own ability and work productively**
   d) A person who is good to everybody
2. Which of the following is an example of severe mental illness
   a) Anxiety
   b) Post-traumatic disorder
   **c) Schizophrenia**
   d) Obsessive-Compulsive Disorder
3. The most common risk factors for the development of maternal mental disorders include all except
   a) H/O Personal and family mental illness
   b) Stressful life events
   c) Lack of family support
   **d) Black magic**
4. Maternal Mental disorders can cause all of the following except
   a) Obstetric Complications
   b) Increased risk for suicide
   **c) The positive experience of motherhood**
   d) Breastfeeding and bonding difficulties
5. Domestic violence during pregnancy and after childbirth can affect
   a) Mental health of the mother
   b) The physical health of the mother
   **c) The physical and mental health of the mother along with foetus and child**
   d) The financial status of the family

6. Mother-baby bonding is important because
   a) Bonding helps to have a healthy child
   b) Bonding improves the mental health of the parents
   **c) a & b**
   d) None of the above
7. The most important role of ANMs in promoting the maternal mental health of women includes
   a) Assurance of mother with mental illness about recovery
   **b) Identify the women with mental health issues and refer to appropriate services**
   c) Give more importance to physical health
   d) To avoid discussion on mental illness
8. The most important causes for anxiety in pregnancy include
   a) Morning sickness
   **b) Past history of miscarriage**
   c) Modern lifestyle
   d) Hormonal changes
9. Symptoms of an anxiety attack include all of the following except
   **a) Increased sleep**
   b) fear of dying
   c) Pounding heart
   d) Feeling irritated and agitated
10. Baby blues hits in
   **a) The first week of delivery**
   b) The sixth week of delivery
   c) The third week of delivery
   d) Fourth week of delivery
11. The most important symptom of postnatal psychosis includes
   a) Worthlessness
   b) Hopelessness
   **c) Hearing of voices when nobody is there**
   d) Anxiety
12. Management of postnatal psychosis includes
   a) Separate the baby from mother
   b) **Admit the mother to mother-baby unit**
   c) Doesn't require any medication and counselling may be sufficient
   d) Electroconvulsive therapy
13. During perinatal period suicide is common in
   **a) Depressed mother**
   b) Mother with OCD
   c) Mother with cesarean section
   d) Mother with physiological disorders

14. Whooley's questionnaire assesses
    a) Schizophrenia
    b) Mania
    c) OCD
    **d) Depression**
15. Assessment of mental health of women during pregnancy starts at
    **a) First visit**
    b) Second visit
    c) Third visit
    d) Not required during pregnancy
16. The GAD-2 scale is used to assess
    a) Depression
    **b) Anxiety**
    c) Schizophrenia
    d) Mania
17. Which of the following is associated with depression during pregnancy?
    a) Preference for a boy baby
    b) Domestic violence
    c) Low socioeconomic status
    **d) All of the above**
18. The approximate percentage of women suffering depression during pregnancy who subsequently attempt suicide is
    a) 1%
    b) 10%
    **c) 15%**
    d) 25%
19. What is the recommended management for the "baby blues"?
    **a) Understanding, empathy, and support**
    b) Baby care assistance
    c) Psychotherapy
    d) Referral to a postpartum disorder support group
20. Which of the following is required for a diagnosis of postpartum depression?
    a) Weight gain
    b) Frequent mood swings
    c) Preoccupation with cleanliness
    **d) Persistent low mood for more than two weeks**
21. Postpartum depression most commonly occurs after the birth
    a) Within 2-5 days
    b) Within 10-14 days
    c) After one year
    **d) Within 3 months**

**22.** _____ percentage of mothers who experience postpartum depression is approximately

a) 5%
**b) 15%**
c) 30%
d) 50%

23. Which of the following statements is correct?

a) Without treatment, 80% of women recover spontaneously from postpartum depression.
**b) Women experiencing postpartum depression are more likely to develop postpartum depression in a subsequent pregnancy.**
c) Women experiencing postpartum depression do not develop suicide ideation or attempt suicide.
d) Approximately 5% of all pregnant women develop puerperal psychosis following childbirth.

24. What is the most common reason for pregnant women with mental disorders for not receiving adequate help?

a) Lack of social support
b) Lack of support from healthcare providers
**c) Lack of recognition of symptoms of mental disorders by healthcare providers**
d) Poor access to treatment for depression

25. ANM as a Counsellor

a) Should force the mother to tell her story
b) Should use closed-ended questions
**c) Should use open-ended questions**
d) Should use probing questions

**Section C: Attitude questionnaire on Maternal Mental Disorders**

*Please rate your level of agreement for the below-given items(1-5)*

| Item | Strongly disagree | Disagree | Neutral | Agree | Strongly agree |
|---|---|---|---|---|---|
| 1. Depression is normal during pregnancy and after child birth and doesn't require any treatment.* | | | | | |
| 2. Puerperal psychosis is not a treatable condition* | | | | | |
| 3. Women with maternal mental disorders cannot become a good mother * | | | | | |
| 4. Domestic violence may affect the mental health of women during pregnancy and postpartum period. | | | | | |
| 5. The baby should be separated from mother if a mother develops maternal mental disorders.* | | | | | |
| 6. Pregnancy protects women from developing maternal mental disorders* | | | | | |

| Item | Strongly disagree | Disagree | Neutral | Agree | Strongly agree |
|---|---|---|---|---|---|
| 7. Maternal mental disorders influence healthy development of children | | | | | |
| 8. Mental health is not a priority as physical health of women during the perinatal period* | | | | | |
| 9. Women who have had a history of severe mental illness following delivery have a higher chance of reoccurrence. | | | | | |
| 10. Pregnant women those are antipsychotics to be stopped themselves as soon as confirmation of pregnancy as these drugs affect development of foetus * | | | | | |
| 11. Breastfeeding to be stopped, in case if a mother develops depression.* | | | | | |
| 12. Women who have mental health problems shouldn't have children.* | | | | | |
| **Role of ANMS** | | | | | |
| 1. All the pregnant women needs to be routinely screened for anxiety and depression during home visits by ANMs | | | | | |
| 2. I must also be aware of the "normal" emotional experiences relating to pregnancy so as not to ignore or misdiagnose anxiety and depression | | | | | |
| 3. It is my responsibility to identify and refer women with mental health disorders to appropriate mental health services | | | | | |
| 4. I feel confident in assessing suicidal thoughts in women with depression | | | | | |
| 5. I don't want to inquire a woman about maternal mental disorders because I am not aware of it.* | | | | | |
| 6. I do not have time to follow up with the women with mental health problems after making a referral. * | | | | | |
| 7. I am confident in caring for women with physical illness than women with maternal mental disorders. | | | | | |
| 8. I feel confident in identifying women with mental health problems | | | | | |
| 9. I feel confident in supporting women with maternal mental disorders (Counselling, psycho-education about illness etc) | | | | | |
| 10. I feel comfortable talking to a woman with death wishes | | | | | |
| 11. I feel comfortable in asking about family and personal history of mental illness | | | | | |
| 12. I have a unique opportunity to help women with maternal mental disorders | | | | | |

**Negatively worded items*

**Section C: A Case study**

**Suma's story- Prenatal**

Suma is a 26 years old and 6 months pregnant woman whose partner is an alcoholic and abuses her physically. She has a 2-year-old girl child and her in-laws are demanding for a boy baby. Hence, Suma worried about the gender of her second pregnancy. Lakshmi (ANM) visits Suma at her home and enquires about Sumas' Physical health. She also observes Suma being inactive, sad and enquires about her sleep pattern. Suma reports that she is worried about the gender of her unborn baby. She also says that she is not able to sleep or eat, fearful and has difficulty in taking care of her first child.

1. In your opinion, what mental disorder, Suma is suffering from?
    a) Mania
    b) Depression
    c) Psychosis
    d) Schizophrenia
2. According to you, Suma is more worried about
    a) Economic status
    b) Dowry issues
    c) Gender of the baby
    d) Her health
3. Being an ANM, Lakshmi can help Suma
    a). Brief counselling and advising the couple to attend antenatal classes
    b). Prescribing medication
    c). Assuring Suma that she may have 'Boy baby'
    d) Ignoring the complaints of Suma

**Suma's story- Postnatal**

With the help of the Lakshmi (ANM), Suma delivered a girl baby at a hospital without any complications. On the third day of delivery, she started getting irritated when the baby cries and complaints of low mood. Lakshmi during her postnatal home visit assures Suma and family members that these symptoms will be resolved by two weeks and advises her to have proper rest and nutritious diet. One month later, when she visits Suma, family members report that Suma is socially withdrawn, doesn't eat or sleep well. She says that she felt like crying all the time and didn't want to feed her baby. In addition to these symptoms, Suma says "I am not a good mother and I don't want to live, I am the burden to everyone and I want to end my life". Lakshmi identifies that Suma has serious mental health issues that need urgent treatment and refers her to hospital.

1. In your opinion, Suma is suffering from ----------
    a) Psychotic disorder
    b) Postpartum Depression
    c) Anxiety
    d) Mania

2. Identify the most serious mental health problem of Suma in this case study
    a) Low mood
    b) Isolation from family members
    c) Sleep disturbances
    d) Death wishes
3. According to you, how can Lakshmi help Suma to come out of this problem,
    a) Ignoring the symptoms
    b) Identify and refer to mental health services
    c) Assuring Suma and family members that 'everything will be alright"
    d) Separating the mother from child
4. As an ANM, whom do you refer Suma to
    a) Priest (Religious practices)
    b) Black magic
    c) PHC Doctor/Psychiatrists
    d) Traditional healers

**Additional Questions to ask the participants at 3rd and 6th months**

1. Can you please tell me about the number of pregnant and postnatal women you are responsible for?
2. Among the pregnant and postnatal women, how many of them are experiencing domestic violence?
3. Describe identification and support of women with domestic violence?
4. Are you confident in using Whooley's and GAD-2 questionnaires in identifying the women with mental health issues?
5. Number of women identified with Maternal Mental disorders and referred to the PHC doctors/Psychiatrists
6. Please list out the diagnosis and treatment of the women with maternal mental disorders
7. Can you list out the most common three important barriers in identifying and referring the women with maternal mental disorders during perinatal period?

## ANNEXURE 2- ROLE PLAYS SCRIPT- ROLE OF ANMS IN PROMOTION OF ANTENATAL AND POSTNATAL MENTAL HEALTH

### Antenatal case vignette

**First visit**

**Gayathri** : Hi Chaitra good morning, how are you..?

**Chaitra** : Good morning, I am doing good.

**Gayathri** : How many months now..?

**Chaitra** : Two months, I just visited the doctor yesterday to confirm my pregnancy

**Gayathri** : Are you happy with your pregnancy..?

**Chaitra** : Yes…… I love children so much …. I am waiting eagerly to see my baby. Me and my husband planned to have this baby

**Gayathri** : What about your husband and in-laws, are they happy with your pregnancy?

**Chaitra** : Yes…… all are happy and excited since they are going to have a baby after 25 years at home.

**Gayathri** : Good. What baby you and your family members are expecting to have…… a girl or boy baby..?

**Chaitra** : No issues with a gender of the baby. We are happy…. with a healthy baby.

**Gayathri** : Did your parents come here to see you after confirmation of your pregnancy?

**Chaitra** : Yes. My father, mother, mother- in -law and father- in - law had come to see me.

**Gayathri** : Good. As part of my routine screening, I will be asking a few questions please feel free to share the information. Is it OK with you?.....

**Chaitra** : Sure.....

**Gayathri** : Do you have any mental health issues? Past or present?

**Chaitra** : No...

**Gayathri** : Is there anyone in your family suffering from mental health issues (either in mother's or father's family)?

**Chaitra** : No...

**Gayathri** : Is everything OK with your husband and your in-laws?

**Chaitra** : Yeah .. Everything is fine. My husband is very supportive and understanding... They all are good to me and they take good care of me.....

**Gayathri** : Good. You have to come to PHC for antenatal check-up regularly with your husband or family members.

**Chaitra** : Sure. Please let me know how frequently I have to see the doctor..

**Gayathri** : You had already attended the first visit. Next, you have to come for the second visit.
1st visit: Within 12 weeks—preferably as soon as pregnancy is suspected—for registration of pregnancy and first antenatal check-up
2nd visit: Between 14 and 26 weeks
3rd visit: Between 28 and 34 weeks
4th visit: Between 36 weeks and term
And you can see your doctor if in case of emergency....

**Chaitra** : Ok....

**Gayathri** : We will monitor your weight, blood sugar level, blood pressure, fetal growth, fetal heart sound or check for any signs of complication.

Chaitra : Ok...

Gayathri : You have to take two doses of T.T. injection. The first dose should be taken soon after the ANC registration and the second dose is to be taken with one month interval.

Chaitra : Ok....next time when I come for the checkup I will take.

Gayathri : Chaitra you should have iron, calcium, protein and vitamin rich diets like green leafy vegetables, fruits, egg, fish, meat, whole grains, milk and other dairy product.

Chaitra : OK..yes.., doctor also told me the same and I have started to have some of these items.

Gayathri : Good. Are you taking iron, folic acid and calcium supplements which was prescribed by the doctor?

Chaitra : Yes ... I am following the same thing.

Gayathri : OK fine. You also have to take adequate rest (eight hrs of sleep in the night and small nap in the afternoon), go for walk ( 20-30mts per day, 3-4 days a week)along with your husband or family member to maintain the physical and mental health of you and your baby.

Chaitra : OK...I will practice.

Gayathri : Do you have nausea, vomiting, back pain or giddiness?

Chaitra : I am fine..slight vomiting is there and I am taking the tablet which is prescribed by the doctor

Gayathri : Chaitra, do you know one thing .....emotional wellbeing is also equally important during this time...so I suggest you....yoga
If you are practicing yoga and meditation please continue .....
Take some times to read good novels which you like... ,
Listen to calm, melodious music,
Go for walk along with your partner, mother, or friends....
Talk about your concerns or fear with someone whom you trust,
Talk about the baby with your spouse and plan for the baby arrival.

Chaitra : Ok I don't know about yoga and meditation ...I will try to learn .but other things surely I will do..

Gayathri : Ok Chaitra. I will meet you again in the next month. Take.. care.. bye.

Chaitra : Ok...bye..

*Gayathri meets Chaitra every month and assesses physical and mental health using GAD-2 scale and Whooley's questionnaire*

**AT SEVEN MONTH**

**Gayathri** : Hi Chaitra..Good morning…How are you feeling now?

**Chaitra** : ( looks dull ) not responding

**Gayathri** : Hi Chaitra, good morning, how are you ....?

**Chaitra** : I am OK.

**Gayathri** : Chaitra you look upset. Can you please share with me....? Is there something bothering you...

**Chaitra** : Yes. I am worried about my labour pain..... if I express this to my mother, but she is not considering it seriously... I am feeling sad...I am not interested in anything. I don't want to watch TV. I don't want to talk with anyone,

**Gayathri** : Oh.. Is it.... Can you please tell me what is bothering you...?

**Chaitra** : I am worried because.... I feel I may die ... during labour..... I also think my baby may die. My friend told me that labour pain is horrible.... finally she had undergone a cesarean section.

**Gayathri** : I understand Chaitra.... Having these kinds of thoughts are very common... you know.... Labour is normal physiological process every pregnant woman has to undergo. It will be painful but not the way you think..... Just think of your baby and relax.... If you are so concerned about labour pains, we will speak to your doctor about epidural analgesia..... If you worry your baby also may suffer from some problems as low birth weight, and may also affect the mental health of your baby in future.... Do the things which your unborn baby will enjoy.....

**Chaitra** : OK ...

**Gayathri** : Yesterday we have discussed in the prenatal class about the healthy activities such as meditation, walking, reading books, not horror novels, listening to music, talking to your husband, mother, and family members and friends...You need to follow these for maintaining good physical and mental health.

**Chaitra** : OK ...I will try... after talking to you I feel bit relaxed.

**Gayathri** : **OK** Chaitra, I will come and see you in next two weeks. Still, if you are having the same problem, I will take you to the doctor at our primary health center ... OK....

**Chaitra** : OK ..., thank you so much .....

*After this Gayathri met Chaitra very often and her pregnancy proceeded uneventfully and finally in her 9th month she delivered a healthy baby.*

## B. POSTNATAL CASE VIGNETTE

**First visit**

**Anusuya** : Hi… good morning, congrats Kalpana..How are you..? How is your baby…?

**Kalpana** : (looks dull) not responding…

**Anusuya** : ( asks her mother) what happened to Kalpana..? She looks dull.

**Mother** : From past 2-3 days she is not eating properly, not interested to feed and talk to her baby

**Anasuya** : Was she happy about this pregnancy..?

**Mother** : **Yes.** Kalpana and her husband were happy about this pregnancy.

**Anusuya** : Oh! What about her pregnancy period. Was she OK…?

**Mother** : Absolutely she was fine...She didn't have any issues during pregnancy.

**Anusuya** : Did Kalpana had any mental health issues before this.

**Mother** : No…..

**Anusuya** : Did anyone in your family had mental health issues…?

**Mother** : Yes. Her sister also had the same issue during her postpartum period and had taken treatment from a psychiatric hospital.

**Anusuya** : Did she had any expectation about gender of the baby..(Boy or girl baby)

**Mother** : Not at all.. Since this was her first pregnancy, she is ok with boy or girl baby.

**Anusuya** : What about her husband and in-laws, do they have any expectation about this..?

**Mother** : No….

**Anusuya** : Does she have any complications during delivery..?

**Mother** : No. She had undergone normal delivery..

**Anusuya** : How was she feeling soon after delivery….?

**Mother** : She was very happy …..

**Anusuya** : How old is the baby now..?

**Mother** : one week.

**Anusuya** : Since when she has become dull?

**Mother** : She was normal only…after three days of delivery, slowly she started to become sad, not eating properly, getting irritated very easily for baby s cry and not feeding baby properly. I am really worried about her health.

**Anusuya** : Don't worry. I will talk to her…

**Anusuya encourages Kalpana to express her feelings**

**Anusuya** : Hi Kalpana. Can you please share with me....? Is there something bothering you... I will try to help you to come out from this problem.

**Kalpana** : Yes. I am feeling uneasiness. I don't know how to take care of my baby, he cries ceaselessly and I get irritated very often. I feel tired and not interested to feed him. Sometimes I even feel like my baby may die because of my ignorance.

**Anusuya** : I can understand your feelings Kalpana... these feeling are common after delivery, you will feel good as days goes , you need to always keep your baby next to you, feed your baby according to her demand, sing lullaby for her, cuddle her, encourage your partner to cuddle the baby along with you and slowly you will start to enjoy your motherhood.

**Kalpana** : Ok I will try to follow this…

*Anusuya also advices the family members to provide her adequate rest, sleep and nutritious diet, to assist her in baby care as well as to provide adequate support for her to come out of this problem. …Observe her behaviours, if it is persisting more than two weeks, it is better to take her to the psychiatric hospital*

**After one month – Second visit**

**Anusuya** : How Kalpana is doing now……..?

**Mother** : Kalpana's condition got worsened. She is locking herself in the room and not talking with others, not having food properly, not feeding her baby...Now the baby is on bottle feeding.

**Anusuya** : Why didn't you take her to a hospital..?

**Mother** : We are worried that baby may be separated from the mother **i**f we take her to a psychiatric hospital and people also may label her as "mad". so we had taken her to temple and did pooja. Now we are waiting for her to get recovered

**Anusuya** : I remember that Kalpana's sister also had the same problem and got treatment from a psychiatric hospital. You can do Pooja .. but she also needs help from mental health services which is also very essential for her recovery. If you are not giving her right treatment at the right time it may affect both the mother and the baby adversely.

**Mother** : Ok…tomorrow itself we will take her to a psychiatric hospital. But we don't know where to take her for treatment.

**Anusuya** : First you meet our PHC doctor. Then he will suggest you where to go for the appropriate treatment

**Mother** : Ok. Thank you so much for your support.

**Anusuya** : Don't worry….She will be fine very soon and please follow the instructions given by the doctor. I will meet you again……

**Mother** : Ok…

## ANNEXURE 3- ROLE PLAYS SCRIPT - 'HELPFUL' AND 'UNHELPFUL' RESPONSE

**Role Play 1 – An unhelpful response to Sanjana**

**Chaitanya** : Good morning Sanjana how are you feeling? (Sanjana appears sad and didn't answer)

**Chaitanya** : (louder) Sanjana, I asked how are you feeling today?

**Sanjana** : I feel sad and don't want to talk.

**Chaitanya** : Why are you sad? Why don't you want to talk?

**Sanjana** : I lost interest in everything since my husband passed away. There is no hope in my life. Even if I talk to you, you won't be able to wipe my tears as my husband won't come back.

**Chaitanya** : ( appearing irritated) I know I can't help you in that. But you can ventilate your feelings and we can plan for your recovery.

Sanjana looks more distressed

**Chaitanya** : What was your husband?

**Sanjana** : He was an army officer...

**Chaitanya** : Since your husband was a government employee you can join for government service and lead your life happily with your children.

**Sanjana** : I don't think it's possible. I don't have interest in work.

**Chaitanya** : (shouting) I think you are just being lazy, you don't like your children and you are not worried about their future....you should join for a job to lead a good future.

: Sanjana becomes even more distressed.

**Role Play 2 – Helpful response**

**Chaitanya** : Good morning Sanjana… how are you feeling?

Sanjana appears distressed and didn't answer

**Chaitanya** : (speaking softly) Sanjana you appear to be a little distressed….Are you feeling ok?

**Sanjana** : I feel lonely. I am not interested in my life.

**Chaitanya** : (again speaking softly) can you let me know what is bothering you Sanjana?

**Sanjana** : I feel lonely because my husband passed away two months back. He was caring for me too much. Now nobody is there to care and support me.

**Chaitanya** : Sorry Sanjana. May I know more about your family?

**Sanjana** : I got married three years back and now I am pregnant for the second time.. My husband was an army officer, he lost his life in a terror attack. He was taking care of me and my daughter very well.

**Chaitanya** : Can you tell me more about your hopelessness?

**Sanjana** : We don't have support from in-laws at home. I am feeling lonely without my husband. I can't imagine life without him. I can't do anything without him.

**Chaitanya** : "I am wondering what made you decide that you have failed in your life. Still, you are young...So much is there to achieve in your life. You should be very proud of your husband. He sacrificed his life for our country.

**Sanjana** : Of course…I am proud of him…. He was an efficient officer.

**Chaitanya** : **(**speaking softly**)** I can understand your feelings. Sorrow is not the solution to your problem. Face the situation. You have to take care of your health properly since you are pregnant. If you neglect your health how will you look after your daughter?

**Sanjana** : I lost hope in life. Don't know how to move forward.

**Chaitanya** : Take over the government job and move on. Take care of your daughter and present pregnancy too. Take support from your family and friends.

**Sanjana** : I will try this. I feel a bit relaxed after talking to you.

**Chaitanya** : Good. Attend the antenatal classes without fail. Take the medications as prescribed the doctor. See you in next session.

**Sanjana** : Ok. I will follow your suggestions. Thank you.

## ANNEXURE 4 - QUESTIONS FOR SUMMARIZING

### MATCH THE FOLLOWING

**First group**

| S.NO | A | B |
|---|---|---|
| | Perinatal period | Common mental disorders |
| | Anxiety | Persistent low mood during pregnancy |
| | Panic attack | Fear of contamination, repeated checking, hand washing to the point where the skin is damaged |
| | OCD | Pounding heart, fear of dying, trembling, difficulty in concentration, dizziness |
| | Baby blues | Soon after conception till delivery |
| | Postpartum depression | It is rare condition, occurs one in 1000 of postnatal mother |
| | Prenatal period | Persistent low mood observed in first week after delivery |
| | Anxiety and depression | Persistent low mood for more than two weeks after delivery |
| | Postpartum psychosis | Soon after conception to 1year after child birth |
| | Antenatal depression | Fear of unknown |

**Second group**

| S.NO | A | B |
|---|---|---|
| | Schizophrenia | GAD-2 and Whooley's questionnaires |
| | Domestic violence | To screen for depression |
| | Hallucinations | False fixed unshakable belief ex: I am the prime minister of India |
| | Delusions | Hearing of voices when no one is there |
| | Suicide | The prevalence is less than 1% in general population |
| | Whooleys Questionnaire | Women are at greater risk for depression |
| | Mother baby bonding | Deliberate self harm |
| | Suicidal thoughts | Essential for physical and mental wellbeing of mother and child |
| | Maternal mental health assessment | Singing and talking to the unborn baby, introducing family members, enjoying foetal movement |
| | Maternal-foetal attachment | To be inquired when women are depressed and cannot be ignored. |

**Third group**

| S.NO | A | B |
|---|---|---|
| | MOTHER-S | Skin to skin contact, breast feeding, cuddling the baby, singing lullabies, massaging the baby |
| | Mother baby bonding | Motivation, Observation, spending Time, Healthy diet, Exercises, Rest and sleep, Support |
| | Women with history of psychiatric illness | Identify and refer women with mental health issues |
| | ANMs | Encourage the mother to visit the psychiatrist before planning pregnancy or soon after the confirmation of pregnancy |
| | Mother with postpartum psychosis | 15% |
| | Prevalence of postpartum depression | To be admitted in to mother baby unit at a tertiary care center |
| | Counselling | Killing her own baby usually associated with postpartum psychosis |
| | Levels of prevention | Active listening, empathy and support |
| | Infanticide | Elevated mood, increased energy, decreased need for sleep and rest |
| | Mania | Primary, secondary and tertiary levels |

## ANNEXURE 5- TRAINING FEEDBACK FORM

**Date: _____**

***Instructions: Please indicate your level of agreement with the statements listed below. Please give your opinion honestly and help us to improve the training program***

| | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |
|---|---|---|---|---|---|
| 1. The training program was interesting | | | | | |
| 2. The teaching sessions were applicable to my field practice | | | | | |
| 3. The case studies were realistic | | | | | |
| 4. The professional experiences from colleagues (other participants) improved my understanding of maternal mental disorders | | | | | |
| 5. The training program improved my knowledge on maternal mental disorders | | | | | |
| 6. The training program improved my confidence in identifying maternal mental disorders | | | | | |
| 7. The training program inculcated positive attitudes towards persons with mental illness | | | | | |
| 8. I will be able to refer the women with mental health issues to the appropriate services | | | | | |
| 9. Overall I found the training program is valuable | | | | | |
| 10. I would recommend the training program to other ANMs | | | | | |

11. What did you like most about this training?

12. What aspects of the training could be improved?

13. Additional comments are welcome