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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

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2018

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The development of this manual was possible by a grant from Department of Health Research (Grant No: DHR/11/GIA-2015-16)

NIMHANS Publication No. 146

ISBN: 81-86495-00-X

Year of Publication: 2018

Number of Pages: 162 pages

First edition - 2018

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The material in this manual is for informational and educational purposes only. The names and situations used in case vignettes are purely fictitious and exclusively developed for the conception of this manual. The use of the content of this training manual should be duly acknowledged.

Suggested Citation
Vijayalakshmi P, Sailaxmi G, Ramachandra, Sundarnag G, Geetha D, Chandra. PS. Maternal Mental Health Promotion:Facilitator's Training Manual For Auxiliary Nurse Midwives In India. National Institute of Mental Health and Neuro Sciences, NIMHANS Publication No.146 2018.

Photo courtesy
Ms. Preethi Sriram
https://www.prettypictures.in

Printed at
Aditi Enterprises
aditiprints@gmail.com

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AIDS	Acquired Immune Deficiency Syndrome
ANMs	Auxiliary Nurse Midwives
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
FGD	Focus Group Discussion
GAD	Generalized Anxiety Disorder
HIV	Human Immunodeficiency Virus
ICDS	Integrated Child Development Services Scheme
LAMICs	Low and Middle Income Countries
MO	Medical Officer
MBB	Mother-Baby Bonding
MFA	Maternal-Foetal Attachment
MMH	Maternal Mental Health
OCD	Obsessive Compulsive Disorder
PHC	Primary Health Centre
PTSD	Post-Traumatic Stress Disorder
SHG	Self Help Group
WCD	Women and Child Department
WHO	World Health Organization

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18th June 2018

FOREWORD

Perinatal mental health is an emerging field as the consequences of mental illness during pregnancy and after childbirth are enormous and affect the women as well as their children, families, and societies. According to the National Mental Health Survey (NMHS, 2016), one in every 10 persons in India suffers from depression and 20% of those depressed are pregnant women and new mothers. Indian women are at high risk for mental illness during the perinatal period due to various risk factors such as poor socioeconomic status, less valued social roles and status, lack of family support and gender-based violence. Maternal mental illnesses are often neglected and under treated in India being a developing country with limited resources. Women and families are reluctant to seek mental health services due to stigma and lack of awareness about maternal mental illnesses.

Auxiliary Nurse Midwives (ANMs) are female health workers, mainly involved in providing maternal and child health services for the rural population in India. They have a unique and privileged role with women and their families as relationships are often built up over a number of years. Hence, training these frontline health care providers is crucial to strengthen the capacity to identify, refer, prevent and respond to women with mental health issues during the perinatal period. This manual has covered most of the maternal mental health issues, risk factors and ways in which ANMs can identify and manage issues at the community level. This manual will help the trainer of the ANMs to have a complete idea of how to conduct the training program and how to plan the activities. It provides information about mental health and is a complete guide for the trainer to train the ANMs. I appreciate and congratulate the researchers from Department of Nursing and Perinatal Psychiatry for investing enormous efforts in bringing out this manual. I hope that this training manual will help facilitators to train the ANMs to promote maternal mental health in an integrated fashion.

Dr. B.N. Gangadhar
Director

Preface

Optimal maternal mental health is critical not only for the well-being of the mother but also to ensure that every child born is safe, healthy, nurtured and able to thrive. This is vital as children are 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 maternal and child health care services need to be trained to identify and offer treatment of mental health problems. In the Indian health care system, Auxiliary Nurse Midwives (ANMs) are ideally placed to offer mental health promotion, early identification and linkage for 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 to train ANMs,it may also be useful for other health care providers who care for women during pregnancy and first year after childbirth.

The main aim is to empower 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 maternal mental health and make them understand the significance of their role in maternal mental health issues. We hope that, ANMs and other health care workers trained using this manual will be able to provide better services to mothers and 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 far-reaching impact on the development of the foetus and the infant. Published research suggests that a mother's mental health during pregnancy can influence the health of the progeny even in adolescence. This manual focuses not only on maternal mental disorders but also lays an emphasis on the role of maternal well-being.

Prof. Prabha.S.Chandra
Dr. Sailaxmi Gandhi

Acknowledgement

We would like to express our sincere gratitude to each and every one who have contributed in the successful completion of this manual.

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

Our special thanks to **Prof. S.K. Chaturvedi,** Dean, 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 funds for the 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, Behavioural Sciences, for her valuable guidance, scholarly inputs and constant encouragement in bringing out this manual right 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 helped in creating a conducive environment for our research project.

We greatly acknowledge **Dr. Mythili** for her valuable inputs and suggestions. We are thankful to **Dr. Prabhu Dev M**, Assistant Editor, **Ms. Tejaswani,** Department of Publications, for proof reading and editing the manual.

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 specially thank **Mr. Dinesha Kumar S, Ms. Ansu, Ms. Anet Maria Jose** for providing meaningful illustrations.

We are also grateful to **Mr. Mohan,** from Aditi printers for designing and extending 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 the emotional well-being of a woman during her pregnancy and after childbirth. Recently, maternal mental health has been recognized as a public health priority as it not only affects 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 significant mental health issues during pregnancy and postpartum period. Social determinants are the important causes of mental health problems in pregnant women and new mothers. In India, women are more vulnerable to maternal mental disorders due to various risk factors such as early marriage, poverty, domestic violence, lack of social support, etc. It is evident that mental health problems during perinatal period increases maternal mortality rate due to suicidal attempts among women. Maternal mental health issues such as 'anxiety' and 'depression' are more common during pregnancy and postpartum period. Depression is found to be the greatest burden among various mental disorders and it is twice common in women than men. More over, depression among women during perinatal period is often unnoticed and underreported. Hence, there has been an increasing recognition of the importance of training frontline health care providers to identify and refer women with mental health issues to appropriate 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 the training rendered to ANMs equips them not only with knowledge about perinatal mental illness but also with the skills and confidence to explore issues about mental health of women. Auxiliary Nurse Midwives (ANMs) are 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. Therefore, training ANMs may help to decrease the impact of maternal mental illnesses on mothers, children and families.

AIM

The overall aim of this training manual is to guide the facilitators to help ANMs build capacity in terms of 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** 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 women with common mental disorders with basic counselling skills.
5. **Refer** women who are experiencing mental health problems during pregnancy and postpartum period to mental health services.
6. **Support** women and families with proper guidance in accessing mental health services
7. **Promote** positive mental health among pregnant and postpartum women.
8. **Prevent** maternal mental disorders with appropriate interventions at individual, family and community levels.

WHAT IS THIS MANUAL ABOUT

This manual outlines a three day training program designed 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 women for common mental disorders such as anxiety, depression and for suicidal thoughts. If necessary, ANMs may refer the women for mental health services.
3. **Application of knowledge and skills** in their practice soon after the completion of the training program. The participants will be followed up by the supervisor or a facilitator to ensure that knowledge and skills learnt are utilized in their practice.

OVERVIEW OF THE MANUAL

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

- The first session of the training program aims to welcome the participants, help them get familiar with each other, understand the participants' expectations and associate them with the objectives and ground rules of the training program.
- The second session focuses on exploring participants' understanding of health, mental health and mental disorders and enables them to differentiate Common Mental Disorders from Severe Mental Disorders.
- The third session outlines the concept of maternal mental health, maternal mental disorders and their impact on pregnancy, mothers, children and families.
- The fourth session explores various risk factors for maternal mental disorders and helps the participants to identify women who are at risk of developing mental disorders during pregnancy and postpartum period.
- The fifth session aims to enhance participants' knowledge on the concept of domestic violence and its consequences on mother and foetus/child.

- The sixth session focuses on the aspects of Common Mental Disorders during pregnancy and after the childbirth.
- The seventh session helps the participants to understand various Severe Mental Disorders during 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 disorder. It further enables them to build their knowledge and skills in psychosocial assessment and screening for maternal mental disorders.
- The tenth session aims to help ANMs to understand their role in promotion of maternal mental health and prevention of maternal mental disorders.
- The eleventh session introduces participants to basic counselling skills and its importance in supporting women with maternal mental health issues in their daily practice.
- The twelfth and concluding session of 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 train ANMs in promoting maternal mental health. The manual helps ANMs in understanding their primary responsibility in screening women with mental health issues at an early stage and support to reach appropriate services.

This manual uses a combination of teaching strategies; such as brainstorming, small group activity, Power point/audio- video presentation, role plays and also provides an opportunity for discussion 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: Expectations of the facilitator that he/she desires to achieve at the end of the session.

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

Description: Achievement of the aim through a particular activity by the facilitator.

Suggested training methodology: Teaching strategies adopted for each session.

Material/preparation required: Materials that are required for particular sessions like blackboard, pen, chart paper, laptop, etc.

Duration: Setting approximate time for the completion of each topic.

Process: The step by step instructions on how to implement the activities and running sessions.

Schedule

This manual has been designed for conducting a three-day training program. A total of about 25-30 participants may be scheduled for four sessions of training per 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, which may be subjected to changes if nessesary. It is important that the facilitator carefully monitors the timing of each session as it is likely that sessions may extend the stipulated time.

WHO IS THIS MANUAL FOR

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

An ANM is someone who assists in the provision of maternal and newborn health care, particularly during childbirth and also in the prenatal and postnatal period. They possess some of the basic nursing skills and midwifery competencies.

WHAT ARE THE TEACHING METHODS

Different types of teaching methods that are appropriate to the content are used wherein the facilitator can adopt any of the training methodologies depending on the level of knowledge and experience of the participants.

The teaching strategies often used in the training program are group discussion and role plays using case vignettes. The key purpose is to explore participants' ideas to the larger group and expose them to the various situations faced by women with maternal mental disorders. It helps them to have a first hand experience and empathize women with maternal mental disorders.

Suggested teaching methods to a trainer

- **Mini lectures** 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 plays.
- **Small group 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 may be ideal.
- **Brainstorming** encourages every participant to think and contribute creative ideas through group discussion.
- **Participatory role plays** wherein participants assume roles to demonstrate and reinforce learning. It enables the participants to perceive the role of a woman with mental health issues or a health worker.
- **Demonstration** involves explaining or clarifying with examples in order to provide concrete experience of real life situations. It improves behavioural and cognitive skills and enhances 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

In this programme, the facilitators are the personnel who possess sound understanding of maternal mental disorders.

SELECTION CRITERIA FOR A FACILITATOR

Facilitators are the backbone of the training program. Choosing a right/good facilitator is a critical part in the planning process. While selecting a 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 achieve pre-determined objectives. The facilitator should possess 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
- Create a comfortable learning environment
- Shows respect for the ideas and opinion 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
- Possess 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

- Lay simple ground rules to be followed throughout the training program.
- Be confident and familiar with the content and prepare appropriate materials required.
- Read the session carefully to see how each topic is related to the next topic.
- Case studies and other educational materials to be adopted for the program must be appropriate to the local setting and cultural background of the participants.
- Plan for appropriate translation of the materials like case studies, handouts, role plays and scripts in advance.
- Keep all the required materials needed for the program such as chart papers, marker pens, computer etc.

During the training

- Encourage 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 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 express their views and opinions and give them positive reinforcement for their responses.
- Reflect on the participants' comments to clarify whether the facilitator has understood them clearly.
- Summarise the discussion to ensure that everyone understands the main points.
- Any misinformation communicated by the participants to be addressed in a kind manner.
- Make sure that all objectives are met.
- Direct interpersonal and group communication.
- Use common and standard acronyms or abbreviations that are familiar to the participants.
- Ensure that the entire training program runs on the stipulated time.
- Brief activities that energize and engage the participants actively may adopted in between the sessions to prevent boredom. Standing up and clapping for a while, singing song together may keep participants energetic.
- Obtain feedback with suggestions from the participants before they leave to evaluate the training program.
- Distribution of personalised certificates of attendance at the completion of the training is usually appreciated.

After the training

Imparting training program to participants is only the primary step 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 knowledge and skills of an adult learner, it is important for the facilitator to know about self concept and needs. Adult learning is based

on the principles of andragogy which 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 aspects.

Malcolm Knowles, a pioneer in adult education suggested the concept of five teaching principles

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. It's the right time for them to learn.
5. Learning 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 enable them to learn from mistakes.
- Encourage learners to keep practicing as it promotes memory and absorption of the subject matter.
- Consider participants' own experiences and knowledge.
- Training must be active and effective.
- Use time wisely.
- Keep sessions relevant to the age group.
- Encourage participants to ask questions.
- Make sessions visually-compelling because 83% of learning occurs visually.
- Use charts, pictures, power point/audio-video presentations appropriately.
- Use word games, music etc.

Suggested methods for training

- Brainstorming
- Group discussion
- Case vignettes
- Panel discussion
- Visual aids like charts, power point, projector, handouts, 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	30 minutes
1.2	Participants' expectations and objectives of the training program	20 minutes
1.3	Ground rules	10 minutes
SESSION 2: AN OVERVIEW OF MENTAL DISORDERS		120 minutes
2.1	Health, Mental Health and Mental Disorders	30 minutes
2.2	Severe Mental Disorders (SMD) 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: UNDERSTANDING 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 during perinatal period	30 minutes
5.3	Domestic violence: Role of ANMs	30 minutes
SESSION 6:COMMON MATERNAL MENTAL DISORDERS		120 minutes
6.1	Common Mental Disorders during Pregnancy	60 minutes
6.2	Common Mental Disorders during Post Partum Period	60 minutes
SESSION 7:SEVERE MATERNAL MENTAL DISORDERS		90 minutes
7.1	Severe Mental Disorders during Pregnancy	45 minutes
7.2	Severe Mental Disorders during Postpartum Period	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	Process of Maternal mental health assessment	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		60 minutes
11.1	Concept of Counselling skills	60 minutes
SESSION 12: CONCLUDING SESSION		60 minutes
12.1	Summarizing	30 minutes
12.2	Feedback	15 minutes
12.3	Closing	15 minutes

SESSION BRIEFS

Pre- session process

Preparation

- Plan for three days training program in advance.
- Venue should be well-ventilated with proper/comfortable seating arrangements.
- Ensure there is enough space for activities.
- Ensure arrangements and logistics for drinking water, tea, lunch, etc.
- Keep photocopies of the necessary materials such as hand-outs,pretest or posttest questionnaires, feedback forms, etc, ready.
- Make sure that all the training materials are arranged in proper sequence.
- Ensure that the venue is arranged with necessary requirements like microphones, sound systems, computers, etc.
- Plan for appropriate ice breaking exercises.
- Begin training program on time as per the schedule.
- Plan for activities in such a way that all participants are engaged.
- Request all participants to fill registration forms with required details.
- Distribute kits to all the participants.

Registration

Before the start of the program instruct all 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- posttest questionnaire (Appendix 1)

Pretest questionnaires are provided to participants at the start of the 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 posttest. The difference between pre and post test mean scores helps the facilitators to assess the impact of training program in terms of changes in the level of knowledge of the participants.

Criteria to fill Pre test Questionnaire

- Participants are requested not to write their names on questionnaire as their responses may be kept confidential.
- For the purpose of analysis of data the participants are instructed to write the code number provided by facilitators.
- Distribute the pretest questionnaire and allow 30 minutes for filling it.
- Participants are asked to respond individually and discussions are not permitted.
- Encourage them to answer all questions according to their understanding.
- Make sure that participants understand the questions properly. If required, translate the same into local language.
- Do not explain too much or give many examples.
- Collect questionnaires and keep them aside carefully.

Session 1: Introduction

BACKGROUND

Opening session of the training program is important for creating a conducive learning environment for the participants. It helps the participants to get to know each other which will enhance their communication, co-operation and active participation during the training program. This activity fosters space for setting objectives and ground rules, in determining acceptable behaviour during the training program. This session facilitates 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

To welcome the participants and help them 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
- Build rapport with the facilitators and co-participants.

Description

Facilitator welcomes the participants and initiates a small group activity to enable participants to introduce themselves.

Suggested training methodology

Small group activity

Materials: A small ball or a flower or any 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.
- Asks 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…
- Requests the participants sit in a circle and gives a small ball to one of them. The person with the ball has to tell his/her name and throw the ball to someone else in the group. The person who received the ball must introduce her/him self 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.
- In the event of any participant, not remembering others names, they can be helped out by the co-participants.
- If the participants are not comfortable to throw the ball, a small object like flower or doll can be used.

Note to the facilitators:

- The process 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

To 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 are requested to write their expectations of the training program on the given index cards following which the facilitator introduces them to the objectives of the training program.

Suggested training methodology

Brainstorming

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

Duration: 20 minutes

Process

- Give each participant an index card or a sheet of paper.
- Ask each person to write at least two 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 responses on a flipchart or white/black board.
- Encourage the person to identify the next reader and that person may select another person for the the activity and this goes 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: GROUND RULES

Aim

To enable 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 upon acceptable behaviours during sessions.

Description

Facilitator explains the concept of ground rules and encourages participants to suggest and reach consensus on the same.

Suggested training methodology
Power point presentation (PPT)

Materials: Laptop, LCD projector

Duration: 10 minutes

Process

- Display some common ground rules on PPT and ask participants to help the facilitator to list out the rules according to importance.
- Invite participants for any other comments or suggestions.
- Examples of common ground rules include (but are not limited to)
  1. Turn on mobile phones to 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 may want to give their inputs. Hence, everyone has to speak concisely.
  7. In the large group discussion, participants should request permission from the facilitator before speaking.
  8. Avoid passing judgments.
  9. Avoid discussion among group members.
  10. Give feedback directly and honestly.

Session 2: An Overview 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 may be able to identify and refer individuals suffering from mental disorders. This session also provides a basis to enhance participants' awareness of mental disorders.

Topic outline

2.1: Health, Mental Health and Mental Disorders
2.2: Severe Mental Disorders (SMD) and Common Mental Disorders (CMD)

Session duration: 120 minutes

TOPIC 2.1: HEALTH, MENTAL HEALTH AND MENTAL DISORDERS

Aim

To 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 and 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 gives a presentation on definition 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 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 participants to brainstorm about the meaning of health and mental health.
- Participants are encouraged to express their views about health and mental health.
- Facilitator describes the definition of health and mental health through power point presentation.

- Then participants are divided into small groups and each group is provided with a chart paper and marker pens to draw a picture/cartoon of a person with mental illness based on their imagination.
- Give 10 minutes to the group complete the task.
- Invite 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

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 the cognitive, behavioural and emotional well-being that encompasses the way a person thinks, feels and behaves. 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.[2]

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 his or her community".[3] 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 include a wide range of problems with varying symptoms. However, they are generally characterized by a combination of abnormal thoughts, emotions, behaviour and relationships with others. Most of these disorders can be successfully treated.[4]

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".[5]

TOPIC. 2.2: SEVERE AND COMMON MENTAL DISORDERS

Aim

To help 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 to the larger group and discuss the symptoms. 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: 90 minutes

Process

- Participants are divided into small groups and each group is provided with 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 responses 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 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). 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 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, she 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 in a room due to fear.
- **Auditory hallucinations:** Muttering to self or talking to self.
- **Delusions:** Believes that somebody is following her and a 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 a 24-year-old working woman with a history of psychiatric illness before marriage. Married a year back, she is now a mother of two month 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 changed and she became irritable. She 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 was under treatment from a psychiatric hospital. After marriage, she seemed to be mentally healthy without treatment. Hence, we didn't inform her husband and in-laws about her illness".

Note to the facilitator: 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-current episode of Mania''.**

Case vignette 3

Shanti is a 24-year-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 and therefore prefers 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 being 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 bus.

Note to the facilitator: 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 a 24-year-old married female. Her husband had brought her to the hospital as she was complaining of a severe backache for three days. On examination, she didn't have any noticeable physical problems. When doctor further enquired her husband about her mood, he said she 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 for the past few weeks. He has overheard her having frequent tearful phone conversations with her close friend, which has made him more worried. Although she never expressed about suicidal ideas, nowadays she keeps saying that "life is not interesting, why should I live".

Note to the facilitator: 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

In this manual, mental disorders are classified into:

- **Severe Mental Disorders (SMD):** These are often not easily understandable by the general population. E.g. hearing voices or expressing strange or unusual beliefs.
- **Common Mental Disorders (CMD):** includes symptoms that all individuals experience from time to time. E.g. feeling of fear, anxiety, tension, worry or sadness.

SEVERE MENTAL DISORDERS

Severe Mental Disorders are often manifested as a disturbance in physical, emotional, thinking and behavioural symptoms. They are uncommon and usually involve psychosis that means 'losing touch with reality' or expression of unusually strange beliefs (delusions).

Severe mental disorders are easily recognized than common mental disorders, as the way they think and behave is distinctly different from others. People with severe mental disorders may require hospital treatment.[6]

1. SCHIZOPHRENIA

Schizophrenia is a severe mental illness characterized by fundamental and characteristic disturbance in thinking and perception and by inappropriate or blunted affect.[7]

Schizophrenia is one of the most serious mental disorders that affect around 0.3–0.7 percent of people at some point in their life.[8] Both men and women are affected equally by schizophrenia and clinically the symptoms may rapidly progress over many weeks or slowly over several months. People with schizophrenia may seem like they have lost touch with reality. The symptoms of Schizophrenia are chronic and disabling.[9]

Signs and symptoms

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. E.g. hearing voices, experiencing strange odours, having a "funny" taste in mouth, and crawling sensations on the body. Hearing voices is the most common hallucination among 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. E.g. hearing his or her own thoughts, believes that he or she is God, feels that people are putting thoughts into his or her head, etc.
- **Thought disorders** (unusual or dysfunctional ways of thinking): Disorganized thinking and talking incoherently 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. The symptoms include:

- Flat affect (reduced expression of emotions)
- Inability 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: Impairment in memory and thinking. Symptoms include **:**

- Inability to comprehend and make decisions.
- Poor attention and concentration. [9]

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 and manifested as 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 15 and 30 years. To be diagnosed with mania, the episode should last for at least one 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
- Increased speech
- Decreased need for sleep
- Marked distractibility

- Difficulty in concentration
- Inappropriate sexual behaviour
- Excessive optimism
- Increased self-esteem
- Spend money irresponsibly
- Aggressive
- 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 super human.

- 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 that may result in aggression or violence.
- Neglect of eating, drinking and personal hygiene may leads to dehydration and self-neglect. [7]

COMMON MENTAL DISORDERS (CMD)

People with common mental disorders usually experience physical, emotional, thinking and behavioural symptoms, but not psychotic symptoms. In general, people seek treatment for physical problems such as poor sleep or decreased appetite that are commonly associated with underlying common mental disorders (depression or anxiety).[10]

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.[11] A recent national survey from India shows the prevalence of depressive disorders to be 0.8%.[12]

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 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.[7]

2. ANXIETY DISORDERS

Anxiety is a common mental disorder characterized by feelings of worry, nervousness or fear that interferes with one's daily activities. Anxiety is defined as "a state of intense apprehension, uncertainty and fear resulting from anticipation of a threatening event or situation, often to a degree that normal physical and psychological functioning is disrupted".[13] According to the National Mental Health Survey carried out recently, the current prevalence of anxiety disorders is3.6 percent.[12]

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 six months, about a number of events or activities.

Symptoms include:

- Difficulty to control anxiety and worry
- Restlessness
- Being easily fatigued
- Difficulty 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.[14]

Panic Disorder

A person experiences recurrent attacks of severe anxiety (panic) which usually 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.[14] 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 include:

- Contamination from dirt, germs, viruses, body fluids, etc.
- Irrational fear of harm (Eg. fear of harming oneself or loved one).
- Excessive concern with order or symmetry.
- Obsessions with the body or physical symptoms.
- 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 leakage, taps, door latch)
- Cleaning
- Washing
- Mental compulsions (for example: repeating special words or prayers in a particular manner)
- Ordering, symmetry or exactness
- Collecting and counting.[14]

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 violent death of others, or being 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.[14]

Social Anxiety Disorder
Social Anxiety Disorder also referred to as social phobia, is characterized by an intense fear in social situations that leads to significant distress and creates an impact on the persons ability to function adequately in their day to day life. Social phobias are usually associated with low

self-esteem and fear of criticism that includes fear of being judged by others and of being embarrassed or humiliated. This leads to 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.[14]

Phobia

A phobia is an unwarranted, extreme and persistent fear of a specific object or situation. Fear and anxiety occur immediately upon encountering the feared object or situation and may lead to avoidance or extreme discomfort.[14]

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 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.[7]

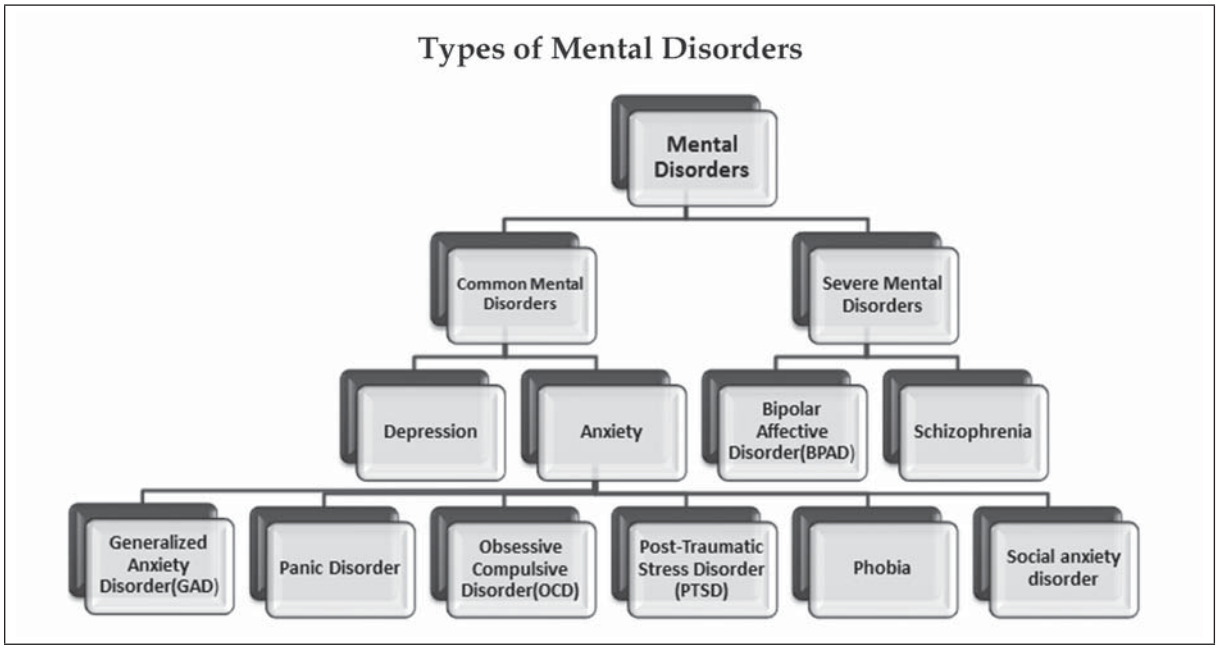
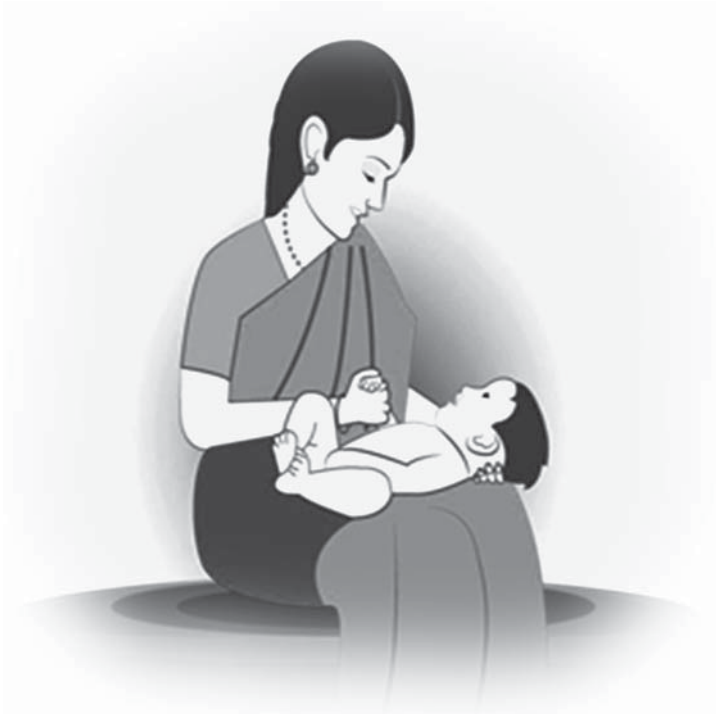


Figure 1: Types of Mental Disorders

Session 3: Maternal Mental Health: Key Concepts



BACKGROUND

This session enables the participants to understand 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, motherhood, children and families. Participants might use the information gained 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: 60 minutes

TOPIC 3.1: CONCEPT OF MATERNAL MENTAL HEALTH

Aim

To help the participants 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" (https://youtu.be/Mq8I3ZHy_OY)* 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: 30 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 give feed back to the larger group at the end of this activity.
- Allow 5-10 minutes for group discussion.
- Invite a volunteer from each group to share their views to the larger group and encourage other group members to participate in the discussion.
- Facilitator uses the following questions to generate 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 a 19-year-old woman, married to an auto driver without her parents' consent. Currently, she is six months pregnant. She does not have proper support from her 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 worried about possible financial difficulties to take care of her children. She doesn't have her parents support as she got married against their wishes. She feels low, tired and anxious all the time. She is not able to sleep and eat properly.

Note to the facilitator:

Identified Risk factors/Problems: Young age, lack of support from husband, in-laws and family, twin pregnancy, financial difficulties.

Impact on mental health of woman: Constantly worried, feelings of low, tiredness, anxious all the time, disturbances in sleep and appetite.

Case vignette 6

Anuradha is a 26-year-old married woman and a home maker from a low socioeconomic background. Six weeks back, she delivered her third child at 31 weeks of gestation and the baby weighed 1900 grams. She became pregnant when her second child was less than a year and her first child was just 4 years old. She is not happy with her third pregnancy and constantly worried about taking care of her children. Moreover, she doesn't have any support from her husband and family members. During a post-natal visit, Laxmi who is an ANM, noticed Anuradha looking dull, inactive and not interested in taking care of her children. On enquiry, she also expressed recurrent suicidal thoughts owing to inability to cope with her household chores and difficulty in taking care of her children.

Note to the facilitator:
Identified Risk factors/Problems: Poverty, premature baby, younger children, lack of support from husband and family.

Impact on mental health of woman: Looks dull, inactive, lack of interest in taking care of children and household chores, recurrent suicidal thoughts.

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 child birth.[15] It is also about the emotional well-being of pregnant women and their children, partners and families. Maternal mental disorder refers to mental illness during pregnancy and one year after child birth.[15]

Perinatal period is defined as the period from conception until the end of the first postnatal year.[16] The terms 'Perinatal' and 'Maternal' are often used interchangeably.

Importance of Maternal Mental Health

Pregnancy and having a baby are the beautiful experiences most of the women can have. Good mental health is a prerequisite to sound physical health especially 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.
- Cope with stress and challenges that occur during pregnancy and after child birth.
- Experience positive pregnancy and satisfying mother-baby bonding.

TOPIC 2.3: IMPACT OF MATERNAL MENTAL DISORDERS

Aim

To help participants understand the impact of maternal mental disorders on women, children 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 brainstrom on the impact of maternal mental disorders on women during pregnancy, postpartum period, 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

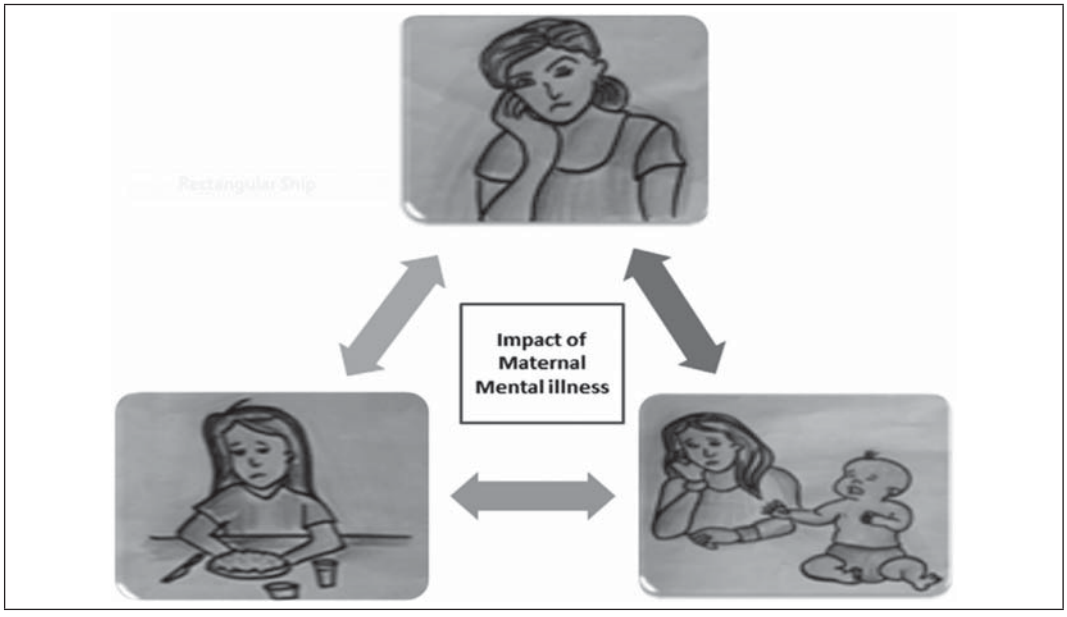
Small group activity followed by discussion and presentation

Materials: Chart paper, marker pens

Duration: 30 minutes

Process

- Divide the participants into four smaller groups (A, B, C, D).
- Give chart papers and marker pens to each group.
- Instruct the participants to brainstorm on the topics given below
  - 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 children
  - Group D: Impact of perinatal mental illness on partners/families
- Allow 10 minutes for discussion and list out the points on a chart paper.
- Invite a volunteer from each group to read out the points written on the chart paper to the larger group.
- Encourage the group members 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 professional experiences.



BACKGROUND MATERIAL

Maternal mental disorders is a major public health challenge, given its contribution to maternal morbidity and indirect mortality.[17] Emerging research shows that maternal mental disorders not only affect a mother's well-being but may also have significant effects on fetal and/or child outcomes.[18]

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 congenital cardiac anomalies.[19, 20]
- Poor prenatal care[21]
- Increased risk for suicide[22]
- Increased maternal mortality rate[23]
- Influences fetal brain development due to maternal cortisol that crosses placenta.[24]

Impact of mental illness on mothers

- Impaired parenting skills and inability to seek support from health care providers.
- After child birth, mothers with mental illness may fail to eat adequately and care for self leading to increased risk for physical illnesses.
- Increased risk for suicide and infanticide (killing of her own baby).[25]
- Impaired bonding that may have long-term impact on child's development.[26]
- Interfere with care for her baby.[27]
- Mothers may not respond at all to their children's behaviour such as crying or they may respond in a negative way.
- Reduced self esteem and guilt.
- Impaired social and occupational functioning.
- Problems with breast feeding or mother may breastfeed for shorter period of time.
- Increased risk for future episodes of depression and other mental health issues.

Impact of maternal mental illness on children

Maternal mental disorders can affect pregnancy outcomes. 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 a lasting impact on children.

- Research found that children of mothers who were anxious or depressed during perinatal period had lower IQs at 11 and 16 years of age and were more likely to have a diagnosis of depression by 16 years.[28]
- Children may be at risk for:
  - Behavioural/emotional problems such as crying louder and longer, spend less time in a quiet and alert state, hyperactivity and inattention.[29]
  - Delayed milestones. E.g. may walk and talk later than others children.
  - Social issues such as difficulty in establishing secure relationships or may be socially withdrawn.[29]
  - Low birth weight, irritability and sleep problems in infancy and academic difficulties when they go to school.[30]
  - Insecure attachment and relationships due to impaired patterns of early interaction between mother and infant.[31]
  - Risk for child abuse and neglect.

Impact of maternal mental illness on their partners/families

- Marital disharmony (increased risk for separation/divorce).
- Partners' depression may have a negative impact on family relations and child rearing.[29]

Session 4: Understanding Risk Factors For Maternal Mental Disorders

BACKGROUND

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

Topic outline

Topic: 4.1. Risk factors for maternal mental disorders

Session duration: 60 minutes

TOPIC: 4.1 RISK FACTORS FOR MATERNAL MENTAL DISORDERS

Aim

To enhance participants' knowledge on various risk factors for maternal mental disorders and help them 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 biological, social and psychological risk factors for development of maternal mental disorders.
- Identify and provide sensitive care to women who are at risk of developing maternal mental disorders.

Description
Participants are divided into smaller groups and are provided with case vignettes. They are encouraged to discuss and identify the risk factors from case vignettes given to them. Facilitator invites a volunteer from each group to present their responses to the larger group. Others 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 each group is provided with a copy of the case vignette.
- They get 5-10 minutes to read the case vignette, discuss and note down their responses.
- Each group should choose someone to write down the responses and someone else to present the same to the larger group.
- Participants are asked to list out the *risk factors* that are identified from the case vignettes given to them.
- Each group may be given 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 participants suggest factors that are in fact not associated with the risk factors of a maternal mental disorder, write this on the board separately 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, a 20-year-old woman, married for two years and a mother of two month old baby is living in a nuclear family. She was working for a small company till her delivery. After delivery, she lost her job as she had to take leave for baby care and her employers could not afford it. Manasa's husband who is currently abroad on an 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 informed her parents and took her to a doctor for treatment.

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

- Nuclear family
- Loss of job
- Husbands' behaviour (Stopped talking)
- Lack of support from husband and family members

Case Vignette 8

Sahana a 26-year-old woman married for six years, was on treatment for infertility. After taking treatment for four years, she got conceived but had a miscarriage in the first trimester. Again after a year Sahana got conceived and was anxious throughout her pregnancy due to previous miscarriage. She had a complication in the third trimester and had undergone preterm delivery. The baby was kept in Neonatal Intensive Care Unit (NICU) for two weeks. She was not able to be with her baby due to restriction from hospital staff. She was worried about her baby's health and had thoughts like whether she will be able to take care of her child. Though she had adequate support from her spouse and family members, she was extremely anxious and expressed low mood, hopelessness, worthlessness and neglected her health. However, she denied any suicidal thoughts..

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

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

Case Vignette 9

Sugandhi, a 17-year-old girl, lost her mother when she was five years old. Father married again and she didn't receive any care and support from her stepmother. So she started feeling emptiness and got into 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 she eloped with him and got married in a temple. After a few months, she conceived again but had continuous thoughts of aborting her current pregnancy due to lack of family support and also reported having disturbed sleep, lack of interest in household activities and planned 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 above-given case vignette

- Loss of mother at an early age
- Teenage pregnancy
- Low socio-economic status
- Lack of support from family members

Case Vignette 10

Geetha, is a 23-year-old woman from a low socio-economic status. She is a mother of two girl children and presently she is six months pregnant. She was brought to the hospital by her mother with complaints of sadness, fatigue, decreased appetite, lack of concentration, poor interaction with family members and attempted suicide twice. Her husband and in-laws wanted a boy baby which did not happen. Her husband would frequently threaten that he would throw her out of the house with her children if she gave birth to a girl child again. He would also beat the children very often. He started consuming alcohol and would abuse her physically almost every day. She was fearful of police involvement and to take legal actions against him. Since she was feeling helpless she attempted suicide, but fortunately she was rescued by her family members and brought to the hospital.

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

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

BACKGROUND MATERIAL

Strong evidence suggests that 20 percent of mothers from low and middle income countries experience depression after child birth.[32]

Virtually every woman can develop a mental disorder during 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[33] • HIV infection[34] • Obstetric complications [6-8] • History of miscarriage[33] • Premature baby, hospitalization of the child and infant death[35, 36] • Younger maternal age (less than 20 years) [33] • Caesarean section[36,37]	• History of personal and family mental illness[34, 35,37,38] • History of mental illness during pregnancy including depression and anxiety [33,35,39] • Child care stress [33] • Low self-esteem [33] • Infant temperament[33] • Thoughts of aborting current pregnancy[33]	• Stressful life events[33,37,40] • Poverty[35,36,39-43] • Domestic violence[33,35,42] • Lack of social support especially from partner[33,35-37,40,42] • Disappointment with birth of a girl child while expecting a boy baby[33,35-40,42] • Unmarried[33] • Nuclear family[38] • Relationship difficulties with husband mother in-law and parents[33,36,38-40] • Husband's use of alcohol [33,34,37] • Working women[42] • Low education[35,39]

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

1. **Poverty**

   It was observed that one of the significant risk factors for poor physical and mental health of women is poverty. Women who live in poverty frequently suffer from anaemia due to improper nutrition. It was also reported that 45 percent of Indian pregnant women are suffering from anaemia which is the highest in the world and 20 percent of maternal deaths are due to the same.[44] Women who don't have access to nutritious food are at high risk for developing anxiety and depression during pregnancy and after childbirth.[44]

   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.[45]

ANMs and other health care providers can help women in gaining access to 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."[46]

Social support is essential for women during pregnancy and postpartum period as it:

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) Paves way for positive pregnancy outcomes. Motherhood requires a lot of support in various forms (e.g., financial, physical, emotional, practical, etc) from partners, family and peers.[47]
d) Enhances quality of life of women.

3. Gender Preference

Gender preference is the most common issue in developing countries. In India, preference for male child 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.[48]

Pregnant women frequently experience prenatal anxiety when there was a strong family preference for a male child.[49] Further, evidence suggests that postnatal depression occurred among women who gave birth to a girl child when they already had girl children.[50] It was reported that mothers' education is the single most significant factor in reducing son preference.[51] Hence, it is essential for health care providers to educate the mother and family members about consequences of gender imbalance in a society.

4. Life Stressors

Negative life events can affect mental health of women during pregnancy and postpartum period. Adverse life events which can predispose women to maternal mental disorders include; loss of job or unemployment,[52] childhood abuse, premature birth and low birth weight, death of a loved one, past history of miscarriage or stillbirths, marital separation, daily hassles (day-to-day stressors such as losing house keys, 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.[53]

5. **History of Mental Illness**

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

   - Untreated anxiety and depression during the pregnancy.[54]
   - Personal history of mental illness.
   - History of postnatal depression after a previous birth.
   - Family history of mental illness.

   It is important to refer women with history of mental illness for a psychiatrist for preconception care to reduce the risk of maternal mental health problems. It is also essential for ANMs to assess emotional well-being of women at every visit and should provide additional support throughout perinatal period.

6. **Substance abuse**

   Substance abuse among women is a growing concern in India. Substance abuse and mental illnesses often occur at the same time, or as a result of each other.[55]

   Substance abuse during pregnancy and postpartum period may cause devastating effects on mothers, infants and their families. Tobacco (smoking, passive smoking and chewing) is found to be one of the most common substance abuse among women in India.

   As per the National Family Health Survey (NFHS)-4, the prevalence of tobacco consumption among Indian women was 6.8 percent.[56] 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.[57]

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

Topic outline

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

Session duration: 1 hour 30 minutes

TOPIC 5.1. CONCEPT OF DOMESTIC VIOLENCE

Aim

To help the participants to deepen their understanding of domestic violence.

Learning outcomes

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

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

Description

Each participant is asked to brainstorm and share their views on domestic violence in turns. Followed by this activity, participants are divided into small groups and each group is allotted a topic on types of domestic violence. They are asked to list out 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
Brainstorming and discussion followed by a 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 turns.
- 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 relate to "Domestic violence"?
- Write down the responses 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 relevant headings.

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

BACKGROUND MATERIAL

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 percent of cases rising by 6 percent over the last four years.[58]

Definition

Domestic violence refers to any kind of abusive behaviour by the husband or their relatives either males 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." [59]

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,etc.
4. **Financial violence -** Not letting a woman to work, refusing to give money, asking for an explanation of how money is spent, making her beg for money, not paying bills,etc.
5. **Social violence-**Preventing a woman from having social contacts with friends or family or restricting the woman going out, etc.

TOPIC.5.2: DOMESTIC VIOLENCE AMONG WOMEN DURING PERINATAL PERIOD

Aim

To explore and enhance the participants' understanding about physical and mental health impact of domestic violence on 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 a woman and foetus/child.
- Discuss the impact of DV on mental health of a woman 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 risk factors and the physical/mental health impact of DV on women and children from the case vignettes. 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 a woman and foetus/child"*. Based on the handouts, 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: 30 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 responses.
- Each group should choose someone to write up the responses and someone else to present the same to the larger group.
- Participants are asked to identify the type of violence, physical and mental health impact of DV on women and children in the given case vignettes.
- Give each group 3 to 5 minutes 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 perinatal period, presently or some time in the past.
- Distribute a copy of handout on *"Physical and mental health effects of domestic violence on a woman and foetus/child"* to all the participants and facilitator leads the discussion based on the handouts.
- At the end, facilitator concludes the session by informing the participants that ANMs play a unique role in identifying and supporting women who undergo DV.

Case Vignette 11

Nandini is a 26-year-old lady from middle socioeconomic status, brought to the hospital by her husband for treatment of injury. She got married two years back and has an eight month old baby. Her husband stated that she fell to the floor and sustained a head injury. On physical examination, it was found that the injury was not compatible with his explanation. She was examined by the nurse. On repeated questioning, she reported that her husband pushed her against the wall. On further enquiry, she described repeated episodes of physical abuse, sexual coercion, controlling and threatening behaviour by her husband. She reported that her husband frequently commented on her appearance as she looked ugly. He would abuse her in front of other family members calling her as a "mad woman". He would repeatedly ask her to leave the home. He does not allow her to talk to her parents and restricted her from meeting friends. This behaviour of husband made her to have negative thoughts about her life and she started thinking that she was good for nothing, cried whenever she was alone, neglected herself and child care activities. 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 on her appearance and stating her as a 'mad woman', asking her to leave the house
- **Social violence:** Not allowing her to talk with her parents and restricting her to meet her friends

Health impact on woman and child

- Negative thoughts about life and self (she feels that she is good for nothing)
- Sad mood as she cries often
- Neglected care of self and child
- Loss of interest in household chores.

Case vignette 12

Ramya is a 20-year-old woman, married, for about a year. Recently, Ramya's in-laws started making demands for dowry. When she could not meet their demands, they repeatedly abused her physically and threatened her of getting their son remarried to another woman. 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 did not have proper food and soon she got conceived and is three months pregnant. During her first visit to a doctor, she was underweight and anaemic. So the doctor had strictly asked her to follow nutritious food and take good rest for three months. Even after doctor's advice, 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 meet any expenditures of hers." They also threatened her that if she does not give birth to a baby boy, then she and her baby would be sent out of their house. Since her parents were poor and she had another sister to get married, she didn't ask help from them. One evening during an argument with her in-laws about dowry, they pushed her forcefully which lead to an abortion due to abdominal trauma. Even after all this, her husband was silent on this issue. She felt helpless and started to worry about her future and neglected her health. During home visit, the health worker met Ramya and on routine examination, the health worker observed that Ramya had lost weight, become anaemic, anxious, had disturbed sleep, socially withdrawn and was worried about something. When she enquired about her problems, Ramya revealed that she was being abused by her in-laws every day. She worried that they may send her out of the home.

Note to the facilitator: Ramya is experiencing domestic violence.

- **Physical violence:** Abdominal trauma that lead to an abortion
- **Psychological violence:** Demanding for dowry, threatening her that she will be thrown out of house, demand for birth of a boy baby

Health impact on woman and child

- **Physical health:** Inadequate nutritious food, loss of weight, anemia
- **Mental health:** Low mood as she feels helplessness, anxious, having disturbed sleep, socially withdrawn and persistent worrying.

Case vignette 13

Narmada, a 24-year-old married woman educated up to 10th standard, hails from a low socio economic family. On the very next day after she got married, she found that her husband had an extramarital affair and also a child. When she inquired about his affair he started beating up and threatened to throw her out of the house if she revealed this to her parents. Her first pregnancy ended in a stillbirth a week back because her husband had forceful, violent sex with her during her last trimester. Following this, he started harassing her saying that she was useless and insulted her by using filthy nicknames and restricted her from visiting parents and other family members. During home visit, Roopa, a health care provider (ANM) observed Narmada being tearful, not able to converse freely in front of her husband. As Roopa also noted that her husband was not leaving her alone, she requested him to leave the room as she wanted to perform a physical examination. On enquiry, she busted out saying that "I am being abused both physically and sexually from the time of my marriage. I am good for nothing.. and I don't feel like living 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:** Husband's extramarital affair threatening her that she will be thrown out of her house, insulting her as she is useless, using filthy nicknames
- **Social violence:** Restricting her to meet her parents and other family members

Health impact on woman and child

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

Case vignette 14

Sujatha, 23-year-old graduate belongs to middle socioeconomic status. She fell in love with Mahesh and married him two years back. Since it was an inter caste marriage, their parents had a great disapproval to this. She started having harassment after one year of marriage when she could not have a child. Now being three months pregnant, she was ambivalent about her pregnancy as her husband had lost his job because of his aggressive behaviour. Following this, he started consuming alcohol every day and abused her physically and sexually. She had no support from her parents and he started demanding her to go to her parents and get money. Since she refused to do this he would scream 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, calling her a dirty female. 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 ventilated her feelings with Susheela, an ANM, and spoke about her husband with tears, "He kicks me, slaps me, pushes me, throw things at me and life has become hell for me and I don't want to live anymore". Susheela provided 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 at her for simple things, and yelling at her as useless, insulting her as a dirty female
- **Financial violence:** Lack of financial support

Health impact on woman 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

Domestic violence during perinatal period is a serious concern as it has tremendous impact on both physical and mental health of the mother as well as the foetus and child. According to WHO multi-country study, the prevalence of intimate partner violence in pregnancy ranges between1 percent to 28 percent.[60] Unfortunately, India has the second highest domestic violence prevalence rate during pregnancy (28%) in the world.[61]

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 • Unemployment • Spousal gambling[62] and extramarital affairs[63, 64] • Low education[64] • Witnessing and experiencing violence as child • Personality disorders	• Young woman who is single, separated or divorced • History of mental illness • History of child abuse • Low literacy • Adolescent pregnancy • Love marriage [64] • History of violence both before and during pregnancy [65,66] • Lack of social support , multi parity[67]	• Poverty • Living in urban slums • Marital conflicts • Lower caste[64]	• Son preference [68] • 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.[69] 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 • Miscarriage • Infection • Poor nutrition • Maternal mortality • Homicide • Low weight gain • Placental abruption • High blood pressure • Ante partum hemorrhage • Caesarean delivery • Frequent hospitalization	• Low birth weight • Stillbirth	• Increased distress • Anxiety • Depression • Somatic complaints (insomnia, headache, pain) • Suicide • PTSD • Relapse of mental illnesses • Lack of attachment to foetus/child	• Nightmares • Startling easily • Poor tolerance to loud noises and bright light • Avoiding physical contact • Difficult to comfort • Problems with breastfeeding • Developmental problems • Excessive separation anxiety

TOPIC 5.3: DOMESTIC VIOLENCE: ROLE OF ANMS

Aim

To explore the participants' views about their role in response to domestic violence among women during 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 women who are experiencing DV.
- Assist 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 provided with a case vignette to enact a role play. Facilitator instructs them to focus on ANMs role in addressing domestic violence. At the end, facilitator provides necessary inputs.

Suggested training methodology

Role play followed by discussion

Materials: Case vignette, papers, pens
Duration: 30 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 discussion invite the volunteers to enact the role play.
- Ask the other participants to watch the role play without any comments and note down their observations.
- Motivate participants to discuss the role of ANMs in identifying, providing immediate interventions and referring women for appropriate services.
- Encourage participants to express their professional experiences.
- Facilitator may provide additional information to the participants.

ROLE PLAY – CASE VIGNETTE 15

Bhavya, a 22-year-old, is seven months pregnant and 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 turned in to an argument and she was been beaten up very badly. Unfortunately, her in-laws also didn't support. Further, she was blamed for questioning her husband. During a home visit, Aruna, who is the ANM, observed Bhavya being sad, tearful, and not talking to her as usual. On physical examination, she also noticed bruise marks on her body. Aruna suspected domestic violence.

BACKGROUND MATERIAL

Recently, domestic violence has been recognized as a public health priority. Being a grass-root level worker, ANMs play an important role in addressing this issue.

Identifying 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 of 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 sessions[70].
- 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.
- Suicidal attempts or presence of suicidal thoughts.
- Anxiety, fear, depression.
- Sleep related problems.[71]

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 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**[72] with five simple tasks. It responds to both emotional and practical needs at the same time.

LISTEN	Listen to the woman closely, with empathy and without judging.
INQUIRE	Assess and respond to her various needs and concerns - emotional, physical, social and practical (eg. child care).
VALIDATE	Understand and believe her. Assure her that she is not to be blamed.
ENHANCE SAFETY	Discuss a plan to protect herself from further harm if violence occurs again.
SUPPORT	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, Aadhar card, voter card, bank passbook, ration card and children's birth certificates, 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 women.

Inform the woman about legal recourse

- ANMs should explain to women regarding places or persons to contact in case they decide to report violence.
- Most districts in the country have a Women's Police Station.
- Woman could also contact functionaries of the Women and Child Department (WCD). These persons will forward her complaints to the concerned "Protection Officer" of the WCD. This officer has been authorized by the government to take action on violence against women. There is a 24-hour toll-free helpline number (Karnataka state -1800-425-90900) to reach this officer.

- The ANM also should provide her with details of Legal Aid Centers existing at district level courts and provide guidance on seeking legal assistance.

Accessing other resources for assistance

ANMs should have the telephone numbers of police helplines (Vanitha Sahayavani in karnataka: ***NAMMA 100***), support organizations and journalists/media personnel.

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:

- Building awareness among public by creating and disseminating materials to improve attitude towards girl child and women.
- Emphasizing the responsibility of men to end violence against women.
- Focusing on abused woman's needs to build self-efficacy and livelihood skills.
- Working collaboratively with ASHAs, Village leaders, Mahila Mandals, NGOs and voluntary organizations to end violence against women.[73]
- Organizing and participating in awareness programs related to violence against women in the community.
- Sensitizing 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 information discussed in 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 a right answer, one credit point has to be given to the group. If the first group answer is incorrect, then the facilitator asks the second group and the question is passed on till the right answer is sought.

Small prizes may be given to the group members who score 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 Bipolar Affective Disorders(BPAD).
5. What is the main difference between severe and common disorders?
   Answer: People with SMD suffer with psychotic symptoms (hallucinations and delusions).
6. Name two symptoms of Severe mental disorders
   Answer: Hearing voices and talking to self.
7. What is hallucination?
   Answer: Experiencing things that are not real. Example: hearing voices, experiencing strange odours, crawling sensations, etc.
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 and depression.

10. Name any two symptoms of depression
    Answer: Persistent low mood, lack of energy, sleep disturbances, feeling of hopelessness, worthlessness and helplessness.
11. What is anxiety?
    Answer: Fear of unknown.
12. Name any two symptoms of anxiety
    Answer: Difficulty concentration, irritability, sleeps disturbance, restlessness, trembling, etc.
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 the time between conception and one year after child birth.
15. What are the risk factors for maternal mental illnesses?
    Answer: Younger age, previous history of mental illness, stressful life events, lack of family support, domestic violence, etc.

Session 6: Common Maternal Mental Disorders

BACKGROUND

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

Topic outline

6.1. Common Mental Disorders during Pregnancy
6.2. Common Mental Disorders during Post Partum Period

Session duration: 120 minutes

TOPIC. 6.1: COMMON MENTAL DISORDERS DURING PREGNANCY

Aim

To enhance participants' understanding of mental disorders during pregnancy and learn effective strategies to deal with women who experience anxiety or depression.

Learning outcomes

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

- Understand common mental disorders that occur during prenatal period.
- Identify common risk factors related to anxiety and depression.
- Differentiate signs and symptoms of various anxiety disorders.
- Recognize 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 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. 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: 60 minutes

Process

- Divide the participants into two groups. Let them read the case vignettes given below amongst themselves.
- They have 5-10 minutes to come up with responses.
- Group A should choose someone to write up the responses and someone else to present the responses to the large group. Similarly group B should discuss among themselves the case vignette and choose 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 discussion.
- At the end, facilitator clarifies doubts of the participants and provides information using power point presentation.

Case vignette 16

Shamala is a 20-year-old female educated up to 10th standard. She got married three years back. She had a history of anxiety when she failed in 10th 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 her husband. After one year of marriage, the couple had planned for pregnancy. Following that, she had a miscarriage. Since then she is scared to conceive due to the constant fear of another miscarriage. Shamala had thoughts like "if I conceive again, definitely I am going to lose pregnancy; my husband is fond of kids but I am scared of having another miscarriage; I am really worried after hearing so many horror stories of pregnancy losses". She missed her period again and urine pregnancy test was positive. She again started worrying about miscarriage that persisted throughout pregnancy. Due to these thoughts, she refused to travel, even for ANC visits, or attending family functions. She found difficulty in doing household chores, daily routines, 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 believed that if she worried constantly, she might be prepared for further disappointments in terms of untoward happenings in life.

Note to the facilitator: Shamala is experiencing symptoms of a common mental disorder.

- **Risk factors:** She had miscarriage twice, 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 even for 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, belongs to low socio-economic status. Her husband a carpenter is an alcoholic. He is not cooperative and abuses her physically and sexually very often. She presents with symptoms of sadness, lack of interest in pleasurable activities, sleep disturbances and loss of appetite for about 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 being 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 third pregnancy. Yet, her husband and in-laws were insisting for a male child. With all these problems, she learned that she was pregnant and was unable to accept it was unplanned. She was constantly worried and had thoughts like 'What would be the gender of the baby?' and How to face financial difficulties. Gradually she started loosing interest in doing household chores and in taking care of her two daughters. She could not enjoy 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 and perhaps had death wishes.

Note to the facilitator: 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,taking care of children and pleasurable activities, crying spells
- **Cognitive symptoms:** Worried about gender of the baby and death wishes

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

BACKGROUND MATERIAL

Motherhood represents a milestone in a woman's life and is often a period of stress and challenges.[74] A recent systematic review found an increase in the incidence of common mental disorders among women in developing countries. The mean prevalence was about 15.6 percent in pregnant women and 19.8 percent among postnatal mothers. The impact of common mental disorders are manifold wherein the entire family including the mother, fetus, infant, partner and others are diversely affected.

1. ANXIETY DISORDERS

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

Risk factors

Research shows 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[76]
- Thyroid imbalance
- Low socioeconomic status
- Childcare stress
- History of smoking [77]
- Infertility treatment[78]
- Younger age (below 20 yrs)
- Stressful life events[79]
- Obstetric complications such as history of miscarriage, fetal loss, preterm delivery etc.[80]

Consequences of anxiety disorders

The important consequences of anxiety disorders on mother and fetus/child include:

On mother

- Poor access to prenatal care[81]
- High risk for antenatal and postnatal depression[82]
- Irritability
- Poor interaction between mother and child
- Fear in dealing with life events.

On foetus/child

- Underweight and stunted growth in children[83]
- Preterm birth[52]
- Impaired cognitive development, emotional problems and concentration difficulties among children [84]
- Increased risk for development of anxiety and depression by the age of 18.[85]

Anxiety disorders can have various presentations

Generalized Anxiety Disorder (GAD)

GAD is characterized by 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 six months. Women with past history of anxiety disorders and child abuse, low education and poor social support were at risk of GAD before and during pregnancy.[86]

During pregnancy women with GAD experience excessive worry about role changes, health concerns of the foetus and bodily changes.[87]

Panic disorder

Panic disorder is a type of anxiety disorder characterized by recurrent severe panic attacks for at least one month. There may be an increased risk of onset or recurrence of panic disorder due to physiological changes during pregnancy.

During a panic attack, mothers are likely to experience similar symptoms as others such as palpitation, dizziness (light headedness), 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.[87]

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 a pathological fear of pregnancy and associated with avoidance of childbirth.[88] The prevalence of Tokophobia was 5.5 percent 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.[89]

Tokophobia is often associated with either avoidance of pregnancy or elective caesarian section in subsequent pregnancies.[90]

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 often associated with impairment in quality of life and socio-occupational functioning of women. The prevalence of OCD during pregnancy has been reported in the range of 0.2 percent to 5.2 percent. [91]

The main risk factors for OCD during pregnancy include: primiparity, miscarriage in previous pregnancies, obstetric complications and family history of OCD. [91]

During pregnancy, obsessions mainly include intrusive thoughts or mental images related to the baby and most common compulsions are cleaning/washing and frequent checking.[87]

Post–Traumatic Stress Disorder (PTSD)

Post-traumatic Stress Disorder (PTSD) refers to a disorder that can occur following the experience or witnessing of life-threatening events such as 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'.[92] A recent Indian study reported that young age, nulliparous status and nuclear family nature were the common risk factors for pregnancy-specific anxiety.[93]

Women with pregnancy-specific anxiety are more likely to practice negative health-related behaviours such as smoking, alcohol use and inappropriate weight gain.[94]

ANTENATAL DEPRESSION

Antenatal depression is of immense public health importance, as it can adversely affect both the mother and developing foetus. The symptoms of antenatal depression can be mis attributed to normal physiological changes occurring during pregnancy. E.g. disturbed sleep and changes in appetite.[95] The recent National Mental Health Survey shows that 20 percent of depression occurs among Indian pregnant women. [96]

Risk factors

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

- Financial difficulties
- Low educational attainment[97]
- Childhood abuse
- Family history of psychiatric illness
- Past history of anxiety and depression[98]
- History of previous abortions and current obstetric complications [97]
- Lack of social support [99]
- Stressful life events [95]
- Domestic violence
- Demand for a male child by the family members.[97]

Consequences of Antenatal depression

- Intrauterine growth retardation
- Failure to thrive [100]
- Developmental delays, including intellectual disability[101]
- Poor mother baby bonding
- Increased risk for post partum depression[102]
- Poor prenatal care [81]
- Obstetric complications and adverse pregnancy outcomes like preterm birth[103]

Symptoms

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

- Persistent sadness
- Getting tired more easily even while doing routine work
- Difficulty concentration
- Forgetfulness
- Anxiety
- Feeling of guilt or worthlessness
- Feeling of hopelessness
- Thoughts of harming self
- Sleep disturbances
- Change in eating habits.[104]

TOPIC. 6.2: COMMON MENTAL DISORDERS DURING POSTPARTUM PERIOD

Aim

To help participants to gain insight into common mental disorders during postpartum period to enable them to identify and provide early interventions.

Learning outcomes

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

- Understand the common postnatal mental disorders such as anxiety and depression.
- Predict various risk factors for postnatal anxiety and depression.
- Describe 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 women 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 the case svignettes 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 followed by video presentation on post partum mental health assessment *(https://youtu.be/4Jjisau1oGE*). 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 pen

Duration: 60 minutes

Process

- Divide the participants into two 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 larger group. Similarly group B should discuss the case vignette among them 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 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 in taking care of the baby. Things were going well and then all of a sudden when my parents decided to return to their native place, I did not know what to do. I was confused, crying and I couldn't breathe properly 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 were leaving and that it was a normal thing which I am going through. I didn't have 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 is 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. 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.

- **Physical symptoms:** Tremulousness, feeling restless, unable to relax, sleep disturbances
- **Autonomic symptoms:** Feeling short of breath, tightening of stomach, racing of heart (palpitation), nervousness
- **Cognitive symptoms:** Fear of being a bad mother, confusion, fear of being alone with baby
- **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…

I started experiencing moodiness soon after Arun, my first son was born. 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 and 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
- **Mood:** Low mood
- **Cognitive symptoms:** Forgetfulness, hopelessness and helplessness, feeling discouraged, extreme sadness, harming self and her 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 during 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. Postpartum Anxiety Disorders (PAD) are often undetected and undertreated.

Risk factors

Common risk factors include:

- Personal history of anxiety before or during pregnancy
- Family history of anxiety or perinatal mental health issues
- History of endocrine dysfunction (thyroid imbalance, diabetes)

- Teenage pregnancy
- Low socioeconomic status
- Lack of social support (friends, family…)
- Stressful life events [106]
- Overwhelmed by changing roles
- Lack of sleep or sleep disturbances
- Worrying about personal appearance (weight gain), 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 that include:

- Low self-confidence in mother
- Poor mother-infant interaction
- Maternal neglect leading to failure to thrive and infanticide
- Inability of the mothers to recognize infants' emotion
- Delay in developmental milestones [108]
- Breastfeeding difficulties[109]
- Risk for conduct disorders as the child grows in to adolescence [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 financial needs, physical appearance, domestic duties, sexual adjustment[113], their ability to care (breastfeeding, soothing, etc.) and well-being of children.[112]

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

Obsessive Compulsive Disorder (OCD)

The period after the child birth is the most vulnerable period for development of OCD symptoms.[115] About 70 percent of women with OCD also suffer 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 infant
- Hyper-vigilance in protecting the infant
- Loss of appetite
- Tremendous guilt and shame[117]
- Unique obsessions about harming their baby and avoiding infants due to fear of acting on such thoughts.

Some examples of postpartum obsessions include: thoughts that the baby could die while sleeping (SIDS), dropping the baby from a high place, an image of dead baby, baby choking and not being able to save him, drowning the baby during a bath, etc.[91, 118]

Contamination obsessions include microorganisms, chemicals or dirt via her hands or the baby's bottles or food.[119]

The most common compulsions are cleaning/washing, checking, not bathing the infant, staying physically isolated from the baby, repeatedly checking the baby's breath or body etc.[52]

Post-Traumatic Stress Disorder (PTSD)

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

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

Untreated PTSD in women may have consequences such as depression, suicidal risk, difficulties with bonding and breastfeeding, tokophobia, hyper vigilance and anxiety about baby's health.[120]

Phobia

The common type phobias that occur during postpartum period include social phobia and phobia of 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 fear of negative evaluation or judgment from others about her parenting skills. Hence, they become hesitant to seek support or joining to a parenting class.[112]

Phobia of the infant

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

Mothers may not allow their infants to sleep owing to the fear that they may stop breathing. Therefore, they wake up the child often to check if they are alive.[121]

Panic Disorder

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.

The common risk factors for panic disorders during postpartum period are women who had never been pregnant, marital disharmony, health, financial and occupational problems. During postpartum period, a woman may interpret panic attacks as something being wrong with her baby.

POSTPARTUM DEPRESSION DISORDERS

Postpartum period is the time 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 one to three days after the delivery and lasts about 10 -14 days of postpartum period. While baby blues are considered as "normal," the blues can evolve into full-blown postpartum depression if symptoms last longer than two weeks and 25 percent of these women develop postpartum depression.

Risk factors

The exact cause of PPB is not known, but various factors involved are:

- Hormonal changes
- Socio-cultural factors such as gender preference[40]
- Poverty
- Lack of support from partner and the family. [125]

Signs and symptoms of postpartum blues

These include:

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

The key differences between Post Partum Blues(PPB) and PostPartum Depression (PPD)are

1. Postpartum blues usually resolve 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)

POSTPARTUM DEPRESSION

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

Postpartum 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 occur 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 percent.[130]

Risk factors

The reported risk factors from developing 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
   - The prevalence of PPD is 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]
   - Multiparity
3. **Psychosocial factors**
   - Domestic violence
   - Marital conflict
   - Lack of support from husband and in-laws[37]
   - Birth of a female baby when baby boy is expected
   - Alcohol abuse in partner
   - Adverse life events.[37]

The clinical features of postpartum depression are similar to the symptoms of major depression. This may include persistent low mood, anhedonia and decreased energy levels. Some times suicidal ideations are also commonly reported.

Consequences of PPD

The effects of PPD on mother include:

- Increased risk for future depressive episodes. [133]
- Influences negatively on her relationships with the baby, partner, elder children and the wider family. [134]
- Undermines mother's confidence.
- Impairs her social functioning and quality of life.
- In serious cases, contributes to infant abuse, infanticides and suicidal behaviour. [134]
- Research shows seven dimensions of 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 promote the healthy development of a child.[136] The impact of PPD on children includes:

a) **Poor mother-infant relationship**: In a meta-analysis it was observed that, mothers with depression were noted to be more irritable, hostile, less engaged and may have lower rates of play (Less vocal behaviour, including 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 experience breastfeeding problems and lower levels of breastfeeding self-efficacy.[138]

Sleep routines: Studies report undesirable sleep practices and sleep problems among women with PPD.[139] For example, placing the infant to sleep in prone position instead of the recommended supine position, the infant sleeping in 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 give less attention to the child's health during infancy.[139] Due to this reason they are unable to seek health care support[139] and this 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

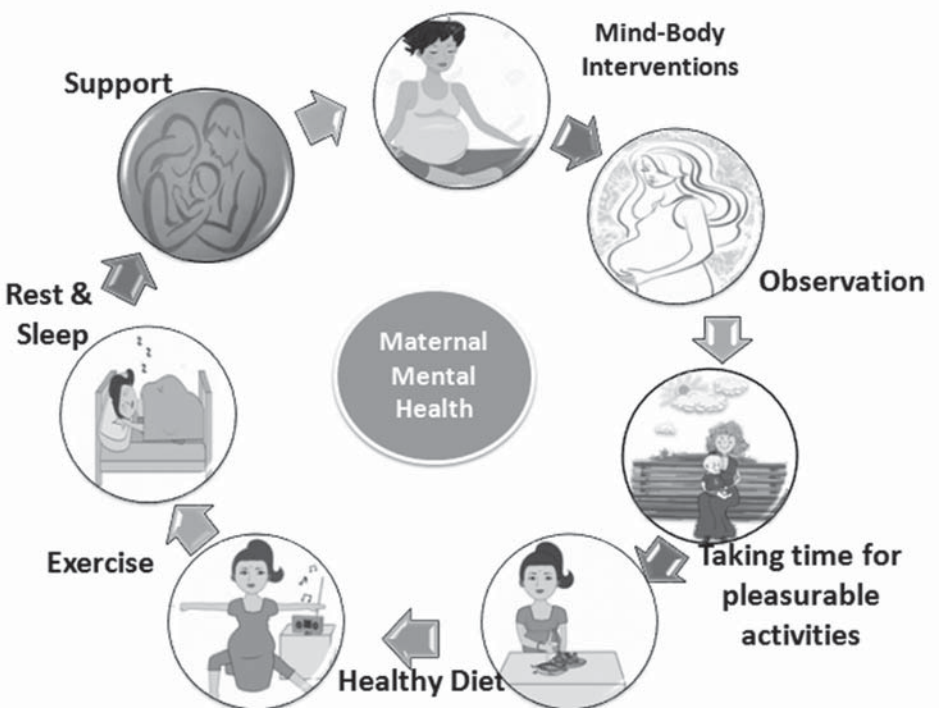
Psychoeducation is to help women and their families to understand mental disorders. Therefore ANMs have to:

- Provide information about the mental illness to women and their family members.
- Talk about how prevalent these disorders are during pregnancy and postpartum period.
- Educate them about the signs and symptoms of common maternal mental disorders.
- Help them to understand 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 treatment and provide them contact details of the referal clinics.
- Explain about expected progress of these disorders.
- Ensure the mother and baby are not separated, even if the mother is on treatment.
- Encourage husband and family members to support and stay calm with the mother.
- Assist women in their baby care needs and household chores.
- Promote breast feeding even when mothers are under treatment and follow the doctor's advice.

2. Selfcare

Self-care is vital for both pregnant and postnatal mothers to keep themselves healthy both physically and emotionally. 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 regarded as an essential approach that acknowledge each person's capacity for self-care.
- Mind-body interventions include relaxation, guided imagery, meditation and yoga. These interventions might benefit women's anxiety during pregnancy.[140]
- Relaxation during pregnancy reduces stress and anxiety. [141]Women must be encouraged to attend relaxation educational sessions during prenatal period.

Observation

- Pregnant women who monitor their babies' movements via fetal movement counting tend to be less anxious about their babies' well-being.
- Foetal movement counting may be associated with improvement in maternal-foetal attachment, which in turn improves pregnancy outcomes and promotes 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, women need to be aware of normal weight gain during pregnancy and postpartum period.
- Observe for appropriate weight gain of the baby.
- Monitor infant's milestones like smiling, rolling over, sitting or crawling, etc.

Taking time for pleasurable activities

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

- **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, e-mailing, calling or meeting a friend, going out for 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 at places in nature such as a garden, beach, etc.[143]

Healthy diet

Balanced diet plays an important role in maintaining physical and mental health of the expectant mother as well as lactating mothers. Eating nutritious food regularly throughout the day will help women to feel better and carry on their daily activities. Guidelines for healthy eating habits include:

- Consumption of whole grains, low-fat dairy products and fresh fruits and vegetables.
- Small and frequent meals including having snacks every two hours from different food

groups, eg. grains, protein, vegetables, etc.

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

Exercise

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

- Boost mood and energy levels.
- Promote good sleep.
- Help to reduce muscle tension and create feeling of relaxation.
- Clear the mind and help to gain a better perspective on depressive or anxious thoughts that can make them easier to challenge.
- Increase self-confidence of the mother.
- Give 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 and postpartum period. 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 depression among women.

Sleep promoting strategies

- Body pillow to support the changing body during pregnancy.
- Create a routine: Wake up and go to bed at the same time.
- Avoid napping during the day if 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.
- Pregnant women should have at least 6-8 hrs of sleep during 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 caffienated drinks 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 biscuits before bed and/or a warm bath.
- Practice breathing exercises or listening music when attempting to fall asleep.
- Create a conducive sleeping environment that is free from bright light and noise. A comfortable bed with normal temperature in the room may be recommended.

Support groups

Social support plays a very important role in helping women to cope with stress and challenges during 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 of the mother. Types of support women can have are: [143]

Emotional support	Practical support	Social network support	Information support
Talk about worries and concerns of her mood and the baby.	To help women in household tasks, and child care. E.g. To have 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 disorders and health care services that can help women.
Possible sources Partner, family members, friends, support groups, etc.	**Possible sources** Partner, family members, friends.	**Possible sources** Mother with similar problems or women from prenatal classes.	**Possible sources** Healthcare professionals including doctors and nurses.

3. Supportive Psychotherapy

Supportive psychotherapy involves offering support, reassurance and psychoeducation to women 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 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 may 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 advised to take medications under the supervision of a psychiatrist. Some of the common drugs used are:

1. Anxiolytics (benzodiazepines)
2. Hypnotics (Non –benzodiazepines)
3. Antidepressants
   - SSRIs (Selective serotonin reuptake inhibitors)
   - SNRIs (Serotonin-norepinephrine reuptake inhibitors)
   - TCAs (tricyclic antidepressants).

Session 7: Severe Maternal Mental Disorders Background

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

Topic outline
7.1: Severe Mental Disorders during Pregnancy
7.2: Severe Mental Disorders during Postpartum Period

Session duration: 90 minutes

TOPIC. 7.1: SEVERE MENTAL DISORDERS DURING PREGNANCY

Aim
To enhance participants' understanding on severe mental disorders during pregnancy and learn to identify and refer women with SMD to 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.
- Recognize common risk factors related to severe mental disorders.
- Identify women with various psychotic features and refer them to mental health services.
- Understand various consequences of severe mental disorders on mother and foetus.
- Describe and identify warning signs of suicide among expectant mothers.

Description
Participants are divided into two groups and each group is provided with a case vignette to discuss among themselves and 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 two groups and provide each group with a case vignette.
- Provide 5-10 minutes for discussing case vignettes.
- Each group should nominate one person to note down the responses and another person to present the same to the large group.
- Participants are asked to list out the symptoms and to identify the type of severe mental disorder the expectant mother might be suffering from.
- Give each group 3 to 5 minutes 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, is married for two years. She had a history of psychiatric illness and was on antipsychotic medication. She became pregnant and discontinued medications thinking that it will affect her baby. She was apparently normal for first three months of her pregnancy. In the second trimester of her pregnancy, her husband noticed drastic changes in her behaviour such as wandering unnecessarily, doing many things at a time without completion and spending lot of time in telephone conversations with her family members or friends. She was highly excited about her pregnancy and didn't want to visit her obstetrician and instead claimed that she is a doctor and can take care of herself. She used to be awake in the night 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 over phone with her family members or friends.
- **Mood :** Highly elated
- **Delusions:** She didn't want to visit her obstetrician saying that she is a doctor and can take care of herself (delusion of grandiosity).
- **Decreased need for sleep and diet:** Being awake at nights and not interested in having food.

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

Case vignette 21

Aruna is a 27-year-old homemaker, educated up to 10th standard and married for five years. Currently, she is five months pregnant. She has a 2-year-old girl child. Aruna was apparently normal one week back and was brought to the emergency department with complaints of talking to self, crying inconsolably and abstaining from food. She would say that mother- in-law wanted to kill her unborn baby by adding poison in the food. On enquiry, her husband revealed that she lost her mother who was suffering from schizophrenia and committed suicide three years back. During mental status examination, Aruna said that some voices were 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 leading to suicide of Aruna's mother
  Behavioural symptoms : Talking to self, crying inconsolably
- **Delusion of persecution:** She believes that her mother-in-law may add poison to her food and stopped consuming it.
- **Auditory hallucination**s: Some voices are disturbing her too much and commanding her to kill her unborn baby.

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 prenatal period which makes them highly vulnerable to psychiatric disorders.[147]

SEVERE MENTAL DISORDERS DURING PREGNANCY

Bipolar Affective Disorders (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 illnesses.[149]

Risk factors

The significant risk factors for BPAD during pregnancy include:

- Discontinuation of anti psychotic medications while planning/ confirmation of pregnancy among women with history of BPAD[150]
- Younger age (below 20 years)
- Previous perinatal episodes of mania or depression
- Family history of BPAD [151]
- Low socio-economic status
- Primiparity
- Pregnancy related complications.[152]

Signs and Symptoms

The signs and symptoms of bipolar disorder during pregnancy and postpartum period are the same. Woman during pregnancy may focus on fears and be excessively worried about the pregnancy or she might be thinking whether she will be a good mother or not.[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, Spending lot of money
Being awake throughout night	Being reckless or taking unnecessary risks
Decreased interest in sex, Increased alcohol and drug use	Increased sex drive
Increased somatic complaints like fatigue or pain	Racing thoughts
Slowing down of thoughts and actions	Rapid speech
Staying away from work	Decreased sleep
Hallucinations and/or delusions	Grandiose ideas
	Hallucinations and/or delusions

Consequences

- Increased hospital admissions due to poor prenatal care
- Poor nutrition
- Increase in alcohol or tobacco use
- Poor maternal-fetal attachment[154]
- Poor maternal self-care
- Poor involvement in pre and postnatal health 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
- Poor family support
- Recent adverse life events
- Lower socio-economic status
- Women with recurrent major depression are at high risk for relapse during pregnancy.[162]

Signs and 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 women will be able to continue with their social, occupational or domestic activities.[163]

Consequences

- Risk for self-injurious or suicidal behaviour
- Inadequate self-care
- Poor compliance with prenatal care
- Decreased weight gain in pregnancy due to decreased appetite [20]
- Increased use of harmful substances (smoking, alcohol and illicit drugs) that increases the risk to foetus[164]
- Poor neonatal outcomes including preterm birth, low birth weight and low 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. About 50-60 percent of these women may become pregnant that are unplanned or unwanted. [165]

Risk factors

- Discontinuation of anti psychotic medications 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

Signs and symptoms

The signs and symptoms of schizophrenia that occur in non-pregnant women or others are the same. Major psychotic symptoms such as delusions (false beliefs) and hallucinations (hearing voices) during pregnancy may have serious outcomes. E.g. delusions that the foetus is evil or dangerous, there by leading the pregnant woman to punch herself in the abdomen or engage in other self or infant destructive behaviours.[169]

Consequences

The consequences of women who suffer from schizophrenia during pregnancy include:

- Delayed identification of pregnancy.
- Poor prenatal care.
- Failure to recognize signs of labour.
- The key manifestation is psychotic denial of pregnancy (a condition wherein a woman denies her pregnancy in spite of clear signs. The woman may avoid prenatal care, misinterprets signs of labour leading to precipitous and unassisted delivery and also fails to adequately bond with her unborn baby).
- Increased risk of domestic violence during pregnancy.
- A reduced likelihood of having a supportive partner or husband.[165]
- Greater incidence of obstetric complications such as placental abruption, low birth weight and congenital cardiac anomalies.[170]
- Induced labour and cesarean delivery.
- Health complications (women who have schizophrenia are likely to suffer from diabetes and high blood pressure as a consequence of anti psychotics 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 the highest in the world with a significant proportion of it occurring among younger women.[173] A recent study revealed that 7.6 percent of suicidal ideation are present 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.

Signs and symptoms

The signs and symptoms of suicide reflect 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. E.g. women might suddenly become less or more concerned about their personal appearance.
- Increased use of drugs and/or alcohol

- Talking about suicide or death
- Giving things away (clothes, expensive gifts)[177]
- Suicidal ideation (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 death and other depressive symptoms should not be ignored. Women with any kind of suicidal ideation should be referred immediately to a psychiatrist for further appropriate interventions.
- Assessment of suicidal risk is discussed in detail in session 9.

TOPIC.7.2. SEVERE MENTAL DISORDERS DURING POSTPARTUM PERIOD

Aim

To help participants to improve their knowledge on severe mental disorders during postpartum period and enable them to identify and support mothers in seeking help through mental health services.

Learning outcomes

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

- Understand the severe mental disorders that occur in postpartum period.
- Predict various risk factors for severe mental disorders.
- Describe signs and symptoms of severe mental disorders.
- Recognize 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 women with severe mental illness during perinatal period.

Description

Participants are divided into two groups and each group will be provided with a case vignette and are encouraged to discuss among themselves. Representatives from each group are requested to enact a 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 inputs.

Suggested training methodology

Role plays followed by discussion and presentation

Materials : Case vignettes, paper and pens

Duration : 45 minutes

Process

- Divide participants into two 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 the woman mentioned in the case vignettes.
- Invite volunteers from group to enact the role play based on the case vignettes given to them and encourage other participants to observe and write down the points for discussion.
- Give each group 3 to 5 minutes to share their responses and get feedback from the larger group followed by facilitator's presentation.

Case vignette 22

Vanaja, a 25-year-old woman working for a multi national company has two months old girl child. She was brought to the emergency department after attempting suicide. On mental status examination, she expressed that she had intrusive thoughts about harming self. She believed that someone is trying to kill her and following her. She said that she could hear clearly that some people were discussing to kill her baby. Hence, she wanted to lock herself with her baby in a room. Her husband reported that she wouldn't sleep as she observed her baby frequently. He further said that they both were very happy about their child and don't understand why she was behaving that way. The doctor convinced him that her condition was treatable but required immediate hospitalization.

Note to the facilitator: Vanaja is experiencing symptoms of a severe mental disorder.

- **Auditory hallucinations:** Hearing voices discussing about killing her baby
- **Delusions:** Someone is trying to kill her and her baby
- **Suicidal thoughts:** She attempted suicide owing to suicidal thoughts.

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

Case vignette 23

Madhavi, a 33-year-old woman, belongs to a low socio-economic status family. She is a mother of three girl children and the younger one is just two months old. Madhavi's husband is an alcoholic and he doesn't help her financially. Jayanthi, an ANM, met Madhavi during her routine home visit and observed Madhavi being sad, inactive and not interacting with her baby. On enquiry, Madhavi said that she was not interested in taking care of her children, had sleep disturbances and was 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 take care of her children and has repeated thoughts of harming herself. Jayanthi convinced her that it was normal to have these feelings but she required help from mental health professionals.

Note to the facilitator: Madhavi is experiencing symptoms of a severe mental disorder.
- **Behavioural symptoms:** Unable to cook and eat, not interested in taking care of her children
- **Mother-baby bonding:** Poor mother-baby bonding as mother is not interacting with her baby
- **Mood:** Low mood
- **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 period is the most vulnerable period for relapse of severe mental disorders in women's life. [147]

BIPOLAR AFFECTIVE DISORDER (BPAD)

Many psychiatric disorders may be triggered during postpartum period. However, no disorder is as profoundly affected by childbirth as bipolar disorder.[179] Some women may experience bipolar symptoms (called an episode) for the first time in the postnatal period even without preexisting mental illness.[180]

Risk factors

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

Signs and symptoms

Woman who is experiencing bipolar disorder may have unusual changes in the way she thinks and behaves.

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

On the other hand, if a mother has symptoms of mania, she experiences high energy levels and requires little sleep even if she had to take care of 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 disorders are at increased risk for intellectual disability[182] and also are at 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

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

Risk factors

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

Signs and symptoms

Psychotic symptoms of women with schizophrenia during postpartum period reflect symptoms of their pre-existing illness including positive, negative and cognitive symptoms.[186] 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 in concentrating and/or following instructions, difficulty in 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 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 among 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 leading to poor mother-baby bonding. [190]

SUICIDE

Suicide is a leading cause of death among postpartum mothers.[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 are:

- Pre-existing mental illness including major depression, bipolar disorders, alcohol and

substance use disorders, schizophrenia and anxiety disorders
- History of suicidal attempts or suicidal thoughts
- Family history of suicide
- Sleep disturbances
- Intimate partner violence
- Previous postpartum psychiatric admission.

Signs and symptoms

Signs and symptoms of women with suicidal ideation during pregnancy and postpartum are alike and has 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 on the woman, her family and community.[194] Hence, ANMs should be proactive in identifying early signs of suicide and assist women in seeking support through 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 pregnant women, mothers and children. Along with providing usual care, ANMs should provide extra care to women with severe mental disorders like:

- **Identifying** women with mental illness.
- Providing **psycho education** about their illness and importance of continuing anti psychotic medication.
- **Preconception planning:** Advice and support women who are planning to have children to seek support from psychiatrist and obstetrician.
- **Antenatal care**
  - Monitoring expectant mothers whether suggestions given by mental health professionals are being followed.
  - 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 an extremely distressing time for women with severe mental disorders. Hence, it is essential to
  - Help women to initiate mother-baby bonding in early postpartum period.
  - Identify and provide support if mother has breastfeeding difficulties.
  - Educate the partner and family members to promote adequate sleep and nutrition among the nursing mothers.
  - Observe early signs of relapse and refer women to psychiatric services.
  - Ensure that women receive adequate postnatal care and child care.

- **Psychosocial support**
  - Listen to women about their concerns with empathy.
  - Encourage women and family members to express their concerns.
  - Provide psycho-education about the illness and assure 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 participants' understanding of positive mother-baby bonding and its importance in maintaining emotional wellbeing of mother and baby. It helps to identify the difficulties to initiate mother-baby bonding. Therefore, ANMs can intervene at an early stage to promote mother-baby bonding. This interactive session enables the participants to enhance 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
8.3: ANMs' role in promoting mother-baby bonding

Session duration: 60 minutes

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

Aim

To help participants to understand the concept 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 concept of mother-baby bonding.
- Gain knowledge 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 request group B to write one idea on "*Importance of mother-baby bonding for the child".* Play light music and encourage the participants to go around and paste their stick notes on the back of the volunteers. Later ask another 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 experiences from their practice followed by a presentation from the facilitator.

Suggested training methodology

Small group activity followed by presentation

Materials: Blind folds,stick notes, pens, laptop and speakers

Duration: 15 minutes

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 light 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 the mother and the new baby.[195] Often, mother-baby bonding begins to happen before delivery. Maternal-Fetal Attachment (MFA) is defined as the affectionate relationship that 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

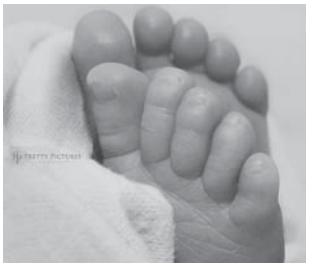
Mother-baby bonding is essential not only for the healthy development of a child but also for the mother to maintain emotional well-being.

Benefits of mother-baby bonding:

For the mother

1. Makes mother feel happy through interacting with the unborn child during pregnancy and infant after 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 herself.
4. Good maternal-foetal attachment reinforces women to have antenatal healthy behaviour and practices such as adherence to healthy diet, regular sleep schedules, increased exercise, utilization of needed medical attention and abstinence from un-prescribed drug use, etc. [198]
5. Decreases risk for anxiety and depression in perinatal period. [199]
6. Enhances optimal health outcomes.
7. Helps the mother in understanding her role in caring and supporting the child.

For the child



1. Ensures the child to have the best possible start in life.
2. Makes the child to feel secure, understand and be calm. This in turn helps in the formation of sound nervous system as the developing brain lays the best foundation for strengthening the child's cognitive and emotional development.[200]
3. A strong emotional attachment between the mother and her baby may help prevent diseases, boosts immunity and enhances the child's IQ.[201]
4. Serves as a prototype for all future relationships.[202]
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 children feel confident and good about themselves.
8. Positive bonding will help the child to cope with disappointments and losses which he/she may 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

To help participants to enhance 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

Divide the participants in to four groups and provide them 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: 30 minutes

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 mother-baby bonding and impact of maternal mental illness on mother-baby bonding.
- Allow 10 minutes for discussion and invite a representative from each group to report their findings to the larger group.
- Participants are encouraged to express their views and share their professional experiences.
- At the end, facilitator adds inputs if required.

Case vignette 24

Nisha is a 20-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 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 insisted family members to keep the baby in the cradle and not next to her.

Note to the facilitator:
Barriers for mother-baby bonding: Unplanned pregnancy (she wanted to continue her education and wanted to be financially 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

Seema is a 24-year-old woman married three years back. Currently, she is a mother of two months old girl baby.She had a history of hospitalization for moderate depression and was on medication.

However, she stopped taking medicines once she got married. Seema was expecting a boy baby through normal delivery. On the contrary, she had to undergo cesarean section due to maternal complications. When her expectation didn't come true her symptoms worsened and she neglected her health and baby care. Her husband stated that she was not interacting with her baby and expressed 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 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 is a 26 -year-old woman, married against her parents' wishes. Since then she didn't have any support from family members. Currently, she is a mother of two months old baby and her husband is also not supportive in taking care of her child. Jaya's husband is an alcoholic and often abuses her physically. He even doesn't support her financially. She didn't receive any moral or financial support from her husband during pregnancy and after child birth. Gradually, Jaya failed to cope with these problems and complained of loss of appetite, difficulty in sleeping and not able to enjoy with her child. Jaya often 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.
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, difficulty in feeding and taking care of child.

Case vignette27

Manjula is a 34-year-old mother of three girl children. She is a homemaker and belongs to middle socioeconomic status. Her husband and family members were very supportive and 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 and 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 thought of harming 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.
Impact of maternal mental illness on mother-baby bonding: Sadness, worthlessness, hopelessness and expresses harming of self and baby.

BACKGROUND MATERIAL

Common barriers to 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/partner support
- A childhood that lacked 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 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 overall development. It adversely affects breastfeeding, mother-baby bonding and parenting quality.[203] 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 outright rejection of the infant. [204]

- 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.[205]
- 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, 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 may be upset when with them)
  - Withdrawn or become passive.

TOPIC. 8.3: ANMs ROLE IN PROMOTING MOTHER-BABY BONDING

Aim

To help 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.
- Come up with 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, the facilitator summarizes and adds inputs if required.

Suggested training methodology

Small group activity followed by discussion and presentation

Materials: Chart paper, marker pens

Duration: 15 minutes

Process

- Divide the participants into two groups.
- Distribute 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 5 minutes for discussion and list out the points on a chart paper.
- Ask volunteer from each group to readout the points written on the chart paper to the larger group.
- Encourage the 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 participants.
- Encourage the participants to express their experiences from their practice.

BACKGROUND MATERIAL

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.[206] ANMs being frontline health care providers, play a key role in promoting mother-baby bonding. They are responsible for providing optimal care to women throughout perinatal period and promoting maternal newborn practices.

Mother-baby bonding is essential for healthy development of a child. Hence, ANMs must be able to recognize impaired MBB 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.[207]

Prenatal

ANMs should educate women about the importance of mother-baby bonding before they plan to have a child. Furthermore, it is essential for ANMs to be aware of antenatal experiences and emotions of women related to their unborn child as these may be a precursor to postnatal communication with their children.[209]

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 the 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 the pregnant woman to spend time thinking about and talking to her unborn child. [209]

- Encourage parents to communicate and visualize their unborn baby during ultrasound scans, foetal auscultation and self-palpation.[200]
- Inform mothers that singing lullabies not only improves maternal-foetal bonding but also has positive effects on neonatal behaviour and maternal stress.[210]
- Promote awareness of baby's movements to strengthen the maternal-fetal relationship.[211]
- 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 well-being of both mother and foetus.[212]
- Encourage pregnant women to communicate verbally with their unborn baby about their daily activities. E.g. *shall we have breakfast together, we are 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 mother's voice. [212]
- The unborn baby also enjoys hearing voices of family members. 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 a 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 perform yoga as these activities strengthen mother-baby relationship.[212]

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.

By encouraging maternal-newborn bonding, ANMs support psychosocial well being of mother and baby.[213] The mother-baby bonding that began at conception will be further enhanced at the moment the mother hears her newborns' first cry.[214]

ANMs should

- Be aware that the first hour after birth is the strongest foundation for mother-baby bonding [215] and the emotion and love formed during these early moments may greatly enhance the maternal-newborn bonding.[216]

- Encourage mothers to have skin-to-skin contact with their babies immediately after birth (Kangaroo Mother Care, KMC). The benefits of KMC:
  - Enables a continuous skin-to-skin contact.[207]
  - Help mothers to feel close and responsible for the care of their newborn.[207]
  - Increases the mother's confidence responding to her newborn needs.[217]
  - Helps to stabilize newborn temperature and cardio-respiratory status, promotes breastfeeding, reduces newborn crying and enhances maternal-newborn attachment.[213]
  - 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." [207]
- 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 bonding.[200]
- Provide an environment that encourages quiet, calm interaction between mother and the newborn.
- Encourage mothers to touch, talk and sing to their babies.
- Encourage mothers to repeatedly cuddle, hold and stroke their baby and advice that she can't 'spoil' a baby by holding too much.[200]
- 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.[200]
- Inform the mother that touch-massage during the first postpartum hour improves mother-baby bonding and relaxation.[217] New born massage also helps the mother to familiarize herself with her baby through fingertip exploration from head to toe.[213]
- Involve mothers in the care of their newborn to develop confidence. For example; to change nappies, touch and talk to their newborns, etc.[207]
- Identify and provide psychosocial support to women who experience difficulties in initiating breastfeeding and mother-baby bonding.
- Help the mother with postnatal mental disorders to improve her interactions with her baby using 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. [218]


Strategies to improve Mother-Baby Bonding

Session 9: Maternal Mental Health assessment

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 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: 90 minutes

TOPIC 9.1: SIGNIFICANCE OF MATERNAL MENTAL HEALTH ASSESSMENT

Aim

To 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 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: 30 minutes

Process

- Divide participants into two 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 are given 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 the larger group.
- As the nominated person reads out the discussion points aloud, the facilitator writes it on the 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 poor outcomes for women, children and families. [219]

ANMs being primary health care providers, have frequent contact with women in the perinatal period. Thus, they are ideally placed to identify women who are at risk for development of maternal mental disorders. World Health Organization also recommends that physiological and psychosocial assessment should begin during the first antennal visit.[220]

> *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.*[219]

Significance 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 during perinatal period:

1. Early identification helps to reduce long-term consequences of maternal mental disorders 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 home visits which have positive impact as:
    a. Screening takes place in a comfortable environment which is less threatening.
    b. Women can avoid 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.[221]
    d. Provides psychosocial support to women.
    e. It creates 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 mood disorders during postnatal period often begin during or before pregnancy.[222]
6. Facilitates a woman's successful transition to motherhood[223]
7. 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 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. E.g. 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[224]
- Fear of hospitalization
- Poverty[225]
- 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 increased work load
- Lack of universal screening tools and guidelines for psychosocial assessment.[226]

TOPIC 9.2: PROCESS OF MATERNAL MENTAL HEALTH ASSESSMENT

Aim

To help participants in developing the necessary skills to screen women for mental health issues during pregnancy and postpartum period.

Learning outcomes

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

- Understand various steps involved in the process of mental health assessment of women during 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.
- Recognize women with mental health issues in perinatal period.
- Get to know local referral pathways to help 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: 60 minutes

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 vignettes and handouts on *"Maternal Mental Health 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 is a 26-year-old well educated and 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 strong support from her husband and family members. Past two weeks she started worrying about toilet 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 and exercise. Though her lab reports for blood sugar level and ultrasound reports were normal, her worries were out of control. She would become anxious if she ate extra food other than her diet plan. She felt that something might go out of her plan and 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 feeling. When her husband asked about her problem, she couldn't express anything and said she was normal. During home visit, Supriya

ventilated her feelings with Geetha an ANM who convinced Supriya that these feelings were common as part of pregnancy but required help through mental health services. So she referred Supriya to a medical officer at PHC for further interventions.

Case vignette 29

Shylaja, a 28-year-old woman educated up to 8th standard, is married for two years and has three months old boy baby. She had episodes of depression during her pervious pregnancy for which she took treatment. During a postnatal visit by Seetha an ANM, family members reported that for the past three weeks, Shylaja was neither taking care of herself nor the baby, not interested to feed the baby and not interacting with others. They also expressed that she was not eating and sleeping well. On enquiry, she said that she doesn't have "normal" feelings towards her child. She also would say that she was not a good mother. Seetha convinced the family members that these behaviours were not normal, she required treatment and referred her to a psychiatry hospital.

Case vignette 30

Sudha is a 24-year-old, four months pregnant woman, from middle socioeconomic status. During a home visit, Girija an ANM observed Sudha being sad, tearful and unkempt. 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 said that for the 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 accept this behaviour from her husband, she felt that she was good for nothing and wished to die by consuming rat poison. Girija convinced her that she needed urgent help from mental health professionals and referred her to a nearby psychiatrist.

BACKGROUND MATERIAL

Mental health assessment includes evaluation of psychosocial risk factors and screening for mental disorders using internationally standardized scales namely Generalized Anxiety Disorder Scale (GAD-2) [227] and Whooley's questionnaire .[228]

The Generalized Anxiety Disorder Scale (GAD-2, 2007): This two-item scale is a brief initial screening tool for generalized anxiety disorder. There is reasonable evidence that this scale may have clinical utility as a case identification tool for anxiety disorders such as Panic Disorder, Social Anxiety Disorder and Posttraumatic Stress Disorder. [227]

Whooley's questionnaire (1997): This scale with two items is found to be the most suitable measure for detecting depression in primary care.[228] A meta-analysis revealed that these questions are efficient at ruling out depression when the population prevalence is low (e.g. <20%).[229]

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

1. Focus on women's emotional wellbeing
2. Her relationship with her foetus /baby
3. Her relationship with her partner and family members. [230]

Process of Maternal Mental Health Assessment include:

1. **Explaining** women and family members about the importance of mental health assessment during pregnancy and postpartum period.
2. **Assuring** women that mental health assessment is voluntary and not compulsory. ANMs also should inform 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. **Discussing** about the confidentiality of responses given by women.
4. **Conducting** assessment privately to ensure privacy. If the woman is literate, give her choice of filling the questionnaires. If she is illiterate, ask questions which reflect symptoms of mental illness and known risk factors.
5. **Communicating** in a language which is comfortable and understood by the mother.
6. **Informing** the mother about referral pathways.

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 either of these risk factors are present, women are prone to develop mental disorders. Hence, ANMs need to provide extra support and sensitive care to these women.*

SCREENING FOR ANXIETY, DEPRESSION AND SUICIDAL IDEATION

GAD-2 Scale	Yes	No
Over the last two weeks, are you Feeling nervous, anxious or on edge		
Not being able to stop or control worrying		
Whooley's Questionnaire	**Yes**	**No**
During the past month, 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 the response is YES for any of the above questions, then women require further assessment for suicidal ideas and help.

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

Suicidal thoughts among women should not be ignored. Refer women immediately to 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.*

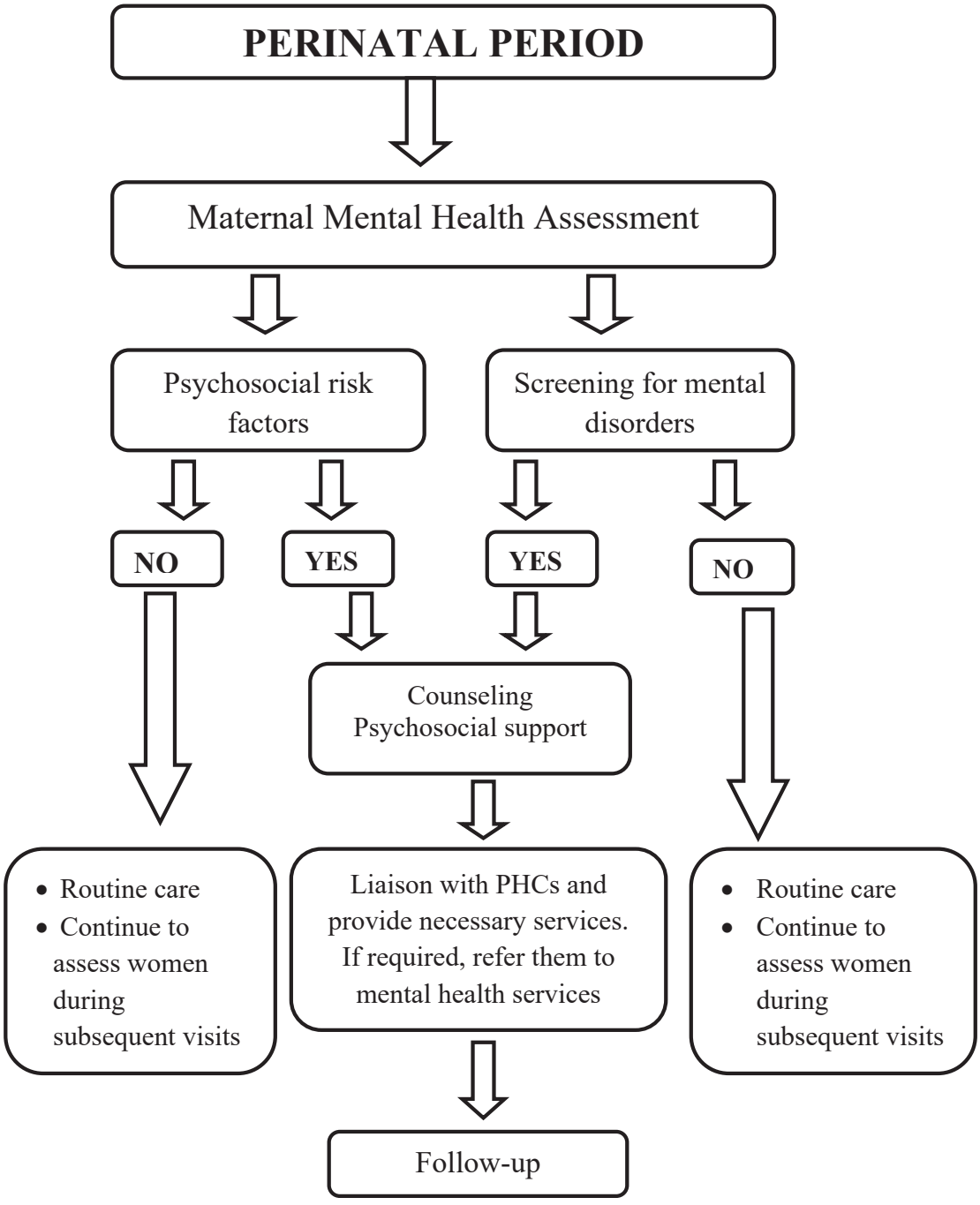


Figure 2: Maternal Mental Health Assessment and Referral

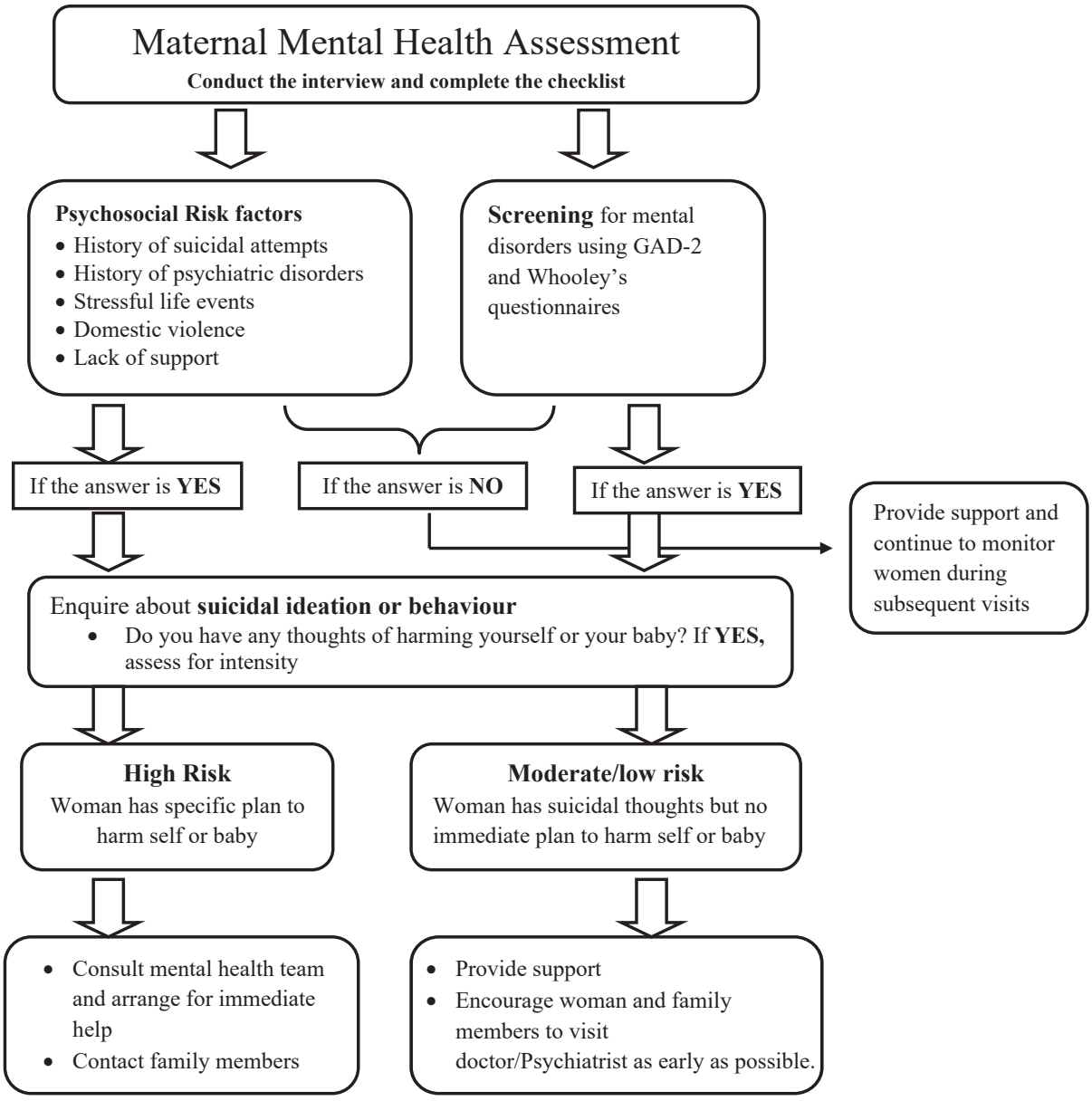


Figure 3: Flowchart for Suicidal Risk Assessment of women during Perinatal period

DAY 3

Activity : **Revision of Day Two**

Time : 30 minutes

Purpose : To revise the information discussed on day two

Materials : Quiz questions and small prizes

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

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

Small prizes may be given to the group members who score 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 compulsive 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 maternal-fetal attachment.
6. Pregnancy specific anxiety includes------
   Answer: Fear of giving birth, fear of bearing a handicapped 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: Thinking that the baby could die while sleeping, dropping the baby from a high place, drowning the baby during bath.

9. When do baby blues occur?
   Answer: Begins one to three days after delivery and lasts for 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: Mind-body interventions, Observation, Taking time for pleasurable activities, Healthy diet, Exercise, Rest and sleep and Support.
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 and follow-up.
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 image of unborn baby, breast feeding, singing lullabies and skin-to-skin contact, getting involved 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 their role in promotion of maternal mental health. It also aims to develop various skills required to provide optimal care to women with maternal mental health issues. It encourages participants to work collaboratively with ASHAs, medical officers, women self-help groups, panchayat members and anganwadi workers to promote maternal mental health and 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: 120 minutes

TOPIC 10.1: ROLE OF ANMs IN PROMOTION OF MATERNAL MENTAL HEALTH

Aim

To help participants to be aware of their role in promotion of maternal mental health of women in 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 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 children.

- Explain about the importance of early identification and interventions for maternal mental disorders.
- Motivate mothers to have good maternal diet to promote physical and emotional well-being of the mother and foetus/child.
- Encourage and teach mothers about stress management techniques to help cope with their stress during perinatal period.
- Work collaboratively with other health care workers and stakeholders to promote maternal mental health.

Description

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

Suggested training methodology

Role plays followed by presentation

Materials: Case vignette, role play scripts (Appendix 2), papers, pen

Duration: 60 minutes

Process

- Participants are divided into two groups.
- Invite volunteers to perform role plays to depict the role of ANMs in promotion of maternal mental health.
- Provide volunteers with case vignettes and role play scripts.
- Request the group (volunteers) to read the case vignettes and discuss within group to enact role plays.
- Instruct the group that the role plays should end in 15 minutes.
- Allow 10 minutes for discussion.
- Ask rest of the participants to observe role plays and note down their observations.
- Encourage participants to share their suggestions and comments to the whole group.
- The facilitator may conclude the session by his/her presentation.

Case Vignette 31

Chaitra, a 22-year-old woman studied up to 12th standard, got married a 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 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 that were held at primary health centre. Gayathri followed up Chaitra every month and when she was seven months pregnant, she found that Chaitra was extremely worried about labour pains and complained of low mood. Gayathri provided consistent and sensitive care to Chaitra throughout her pregnancy.

Case vignette 32

*Kalpana is a 23-year-old graduated woman working for a corporate company and married for 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 her being inactive, looking dull, not interested to converse and above all, she was not responding to her baby's cry. Kalpana's mother complained that for the past 2-3 days, she was not eating properly, not interested to feed and talk to her baby. On enquiry, she also expressed that her sister also had the same issue during postpartum period and had taken treatment from a psychiatric hospital. Anusuya counseled her that these feelings were common after delivery and she might feel good as days go and advised her to keep the baby next to her, feed the baby according to her needs, sing a lullaby to her, and cuddle her. Anusuya advised her family members to provide her adequate rest, sleep and nutritious diet as well emotional support to come out of this problem. Further, she insisted them to observe her behaviour and if it persisted for more than two weeks,advised them, to take her to a psychiatric hospital. Anusuya visited Kalpana after a month and observed that Kalpana's condition had worsened. Therefore, she referred her to a psychiatrist at the district hospital***.***

BACKGROUND MATERIAL

Auxiliary Nurse Midwives being frontline healthcare providers in India play a significant role in promoting mental health and prevention of mental disorders among women during 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 experiences 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 (including preventing or treating risks, illness and death), having an effective transition to positive labour and birth, and achieving positive motherhood (including maternal self-esteem, competence and autonomy).*
>
> **World Health Organization-2017**[27]

Role of ANM

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 perinatal period.
- Risk factors for development of mental health issues during pregnancy and postpartum period.
- Importance of good maternal mental health 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 women during 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 during 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 among women during perinatal period.
4. Be able to provide basic counselling to women with common mental disorders such as anxiety and depression.
5. Have a clear understanding of local referral pathways to help 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 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:

- Providing information on physical and emotional changes that occur during pregnancy and postpartum period.
- Supporting family members to express their concerns to promote psychological well-being of women during perinatal period.
- Educating 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.
- Encouraging family participation throughout the entire course of pregnancy and child birth and accompany women during prenatal and postnatal visits to the doctor. Inform them that these activities will not only support women but also help family members to develop a sense of attachment with unborn child.
- Informing family members about possible ways to support the mother. E.g. accompanying while walking, providing time to rest and sleep, helping them to have nutritious diet, etc.
- Motivating family members to conduct family rituals such ***'Baby shower'*** *(seemantham),* ***'Bangle ceremony'*** during pregnancy and ***'Naming ceremony'*** after the child birth, as these give experiences of love and support to women during perinatal period.

- Understanding 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.
- Involving the woman and her family members in all the decisions about her care and care of the baby.
- Providing 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 delivery. Their involvement begins from preconception level to promote positive maternal health and infant development.

ANMs should

- Involve fathers in all 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 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 well-being of a woman during perinatal period.
- Assist him in providing good maternal nutrition, reduce workload as well as extending emotional support during pregnancy and after 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 provide consistent care throughout 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 recommends integration of mental health care in the existing maternal health programmes and activities to improve mental health of women.[231]

The responsibilities of ANMs include:

- Educating pregnant women and family members about the importance of mental health assessment.

- Reducing stigma and discrimination through regular screening for mental health issues.
- Identifying women who are at risk of developing maternal mental disorders. E.g. family history of mental disorders/preexisting mental illness in the woman, domestic violence, increased stress, etc.
- Assessing risk factors for suicide and suicidal behaviours among women in perinatal period.
- Possessing skills to assess common mental disorders such as anxiety and depression using standardized tools namely Whooley's questionnaire (depression) and GAD-2 scale (anxiety). These scales are simple and reliable to identify mental health problems in women during pregnancy and after childbirth within the context of primary health care.
- Enabling prompt access to appropriate services for women with maternal mental health issues.
- Ensuring that women receiving antipsychotic medication consult a psychiatrist before planning for pregnancy.
- Monitoring closely women who have history of mental illness during past pregnancies or postpartum period.
- Advising family members and partners to support women with severe mental disorder to avoid triggers such as providing adequate time to sleep, follow-up services, etc.
- Providing continuous and consistent care for women with severe mental disorder throughout pregnancy and postpartum period, especially during first few weeks after delivery.
- Encouraging breastfeeding unless it is contraindicated by the psychiatrist viz. if the mother is on antipsychotic medications.

5. Nutrition

Maternal nutrition before and during pregnancy is an influential factor for better health outcomes in the mother and newborn. Research showed that the quality of diet during antenatal period is associatded with mental health of women.[232] Role of ANMs include:

- Emphasizing the importance of healthy diet to the mother and foetus/child in the context of health promotion.
- Educating women and family members about the impact of poor quality of diet on health outcomes of the mother and infant. Nutrition education and counselling may support optimal gestational weight gain (i.e. neither insufficient nor excessive), reduce the risk of anaemia in late pregnancy, increases birth weight and lowers the risk of preterm delivery.
- Encouraging the woman to choose fiber-rich diet from basic 'five food groups' (Grain, vegetables, fruits, milk, meat and fish)
- Distributing pamphlets with self explanatory pictures on maternal nutrition and sources of food groups.
- Motivating women and families to buy 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.

- Supporting women to consume plenty of fluids throughout pregnancy and postpartum period.
- Emphasizing women to have small, frequent meals throughout the day during pregnancy and after child birth.
- Ensuring that women receive micronutrients and food supplements or fortified foods through Anganwadi services.
- Collaborating with ASHAs, Anganwadi workers to facilitate the mother to gain access to supplementary nutrition under Integrated Child Development Services (ICDS) Scheme.
- In addition, pregnant women need to increase their intake of essential vitamins and minerals. The most important ones being:
  - **Folic acid** (fruits and vegetables) - Prevention of neural tube defects.
  - **Iodine** (Iodized salt) - Neurological development of children.
  - **Iron** (meat, whole grains, green leafy vegetables, cereals) - Circulation of oxygen and to maintain energy levels.
  - **Calcium** (milk and milk products, greens) - Bone strength, muscle and nerve health
  - **Omega 3 fatty acids** (fish, bread, cereals)- Foetal brain development and prevention of post-natal depression.
- Instructing and informing 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 (increases 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)[233]

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 mental health of women. [234]

Role of ANMs:

- Educating women about the relationship between poor sleep and mental health of women.
- Encouraging women to establish regular sleep patterns at the beginning of the pregnancy. A healthy sleeping habit is vital in the process of preparation for child birth as it alleviates psychological stress associated with pregnancy and also protects the baby.[235]
- Instructing 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 hours of sleep during night and 60 minutes of a nap during daytime 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 women during postnatal period. Therefore, postnatal women must be encouraged to take small naps whenever possible.
- Encourageingwomen to continue relaxation techniques such as reading books, listening to music, having warm milk or light snacks before sleep, warm bath, few deep breaths, guided imagery, etc.
- Providing written information with self-explanatory pictures about the need for adequate rest and sleep hygiene for women during perinatal period.
- Encouraging women to perform gentle exercises take adequate rest, seek help with caring the baby, share their feelings and ensure access to social support networks.
- Instructing women to avoid caffeine and reduce the fluid intake after evening (frequent urination) to prevent disturbed sleep.
- Advising women to have a comfortable bed and to sleep in left lateral position to reduce pressure on the womb.
- Educating women that sleep problems are common during the postpartum period and could be due to changes in hormones, changes in lifestyle such as breastfeeding, sleep patterns, caring of other children, interpersonal relationships with other family members etc. Therefore, 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 child birth.

ANMs should:

- Educate women and family members about the importance of physical activity to promote physical and mental health of women throughout the perinatal period. Benefits of exercises include:
  - Relieves common discomforts such as backache, fatigue, constipation, heartburn and stress, etc.
  - Prevents gestational diabetes (diabetes that develops during pregnancy).
  - Builds more stamina needed for labour and delivery.[236]
  - Improves emotional health by increasing the levels of feel-good chemicals (endorphins). This in turn, helps 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. E.g. brisk walking for 20-30 minutes, 3-4 times a week.
- Advise 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)[237]

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 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 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 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 programmes 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

To help participants 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 disorders among prenatal and postnatal women and refer them to appropriate services.
- Reduce impact of maternal mental illness by providing support to women and their families.

Description

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

Suggested training methodology

Small group discussion followed by presentation

Materials: Chart paper and marker pen

Duration: 60 minutes

Process

- Divide the participants into three groups and distribute chart papers and pens.
- Provide each group with the following questions (one question to each group) in order to generate discussion.
    - *What does Primary prevention mean to you?List out related activities that are included in primary prevention of maternal mental disorders.*
    - *What does secondary prevention mean to you? List out related activities that are included in secondary prevention of maternal mental disorders.*
    - *What does tertiary prevention mean to you? List out related activities that are included in tertiary prevention of maternal mental disorders.*
- Ask each group to identify a member of the group who may give feedback to the entire group at the end of this activity.
- Ask him/her to write down the points on the chart during discussion.
- Allow 5-10 minutes for group discussion.
- Request group members to share their discussion with the entire group.
- Encourage other group members to respond and provide suggestions.
- The facilitator may end the session by adding inputs through the presentation.

BACKGROUND MATERIAL

Auxiliary Nurse Midwives provide comprehensive care to women throughout pregnancy and postpartum period. Hence they have various opportunities to enhance their role in prevention of maternal mental disorders. 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". [238]

According to the Institute of Medicine (IOM), primary prevention includes universal, selective and indicated preventive interventions. [238]

Definitions of universal, selective and indicated prevention[238]

Universal prevention is defined as 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.

Secondary prevention aims to lower the rate of established cases of the disorders or illnesses 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 illnesses.

The role of ANMs at various levels of prevention of Maternal Mental Disorders, based on the framework for ***Mental health interventions for prevention of mental disorders*** by Institute of Medicine (IOM) is discussed below:

Prevention of maternal mental disorders: Role of ANMs			
Primary prevention		Secondary prevention	Tertiary prevention
Universal prevention	• Creating awareness among public to promote positive maternal mental health. • Providing education about maternal mental disorders, causes, signs, symptoms and treatment. • Promoting positive maternal mental health among women. • Distributing pamphlets on maternal mental disorders. • Displaying posters on maternal mental disorders. • Engaging stakeholders in the community to create awareness. • Reducing stigma against maternal mental disorders. • 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. • Including adequate content on maternal mental health in the curricula in all nursing courses including Auxiliary Nurse Midwives.	• Mental health assessment using Whooley's and GAD - 2 scales at every prenatal and postnatal visits. • Early identification and interventions for maternal mental disorders. • Continuous monitoring of women who are at risk for developing maternal mental disorders. • Appropriate referral. • Follow-up and ensuring that women continue anti psychotic medication.	• Reducing impact of maternal mental illness on mother and child. • Limiting disability • Encourage partner and family to support in recovery of women. • Forming support groups.
Selective prevention	• Educating expectant mothers and families/ partners about physical, emotional changes that occur in women during perinatal period. • Adapting mental health promotion strategies that include good maternal diet, preparing for birth and labour, sleep hygiene, coping with stress, exercises, social support, etc • Accessing to health services, good prenatal and postnatal care. • Supporting breastfeeding and mother-baby bonding.		
Indicated prevention	• Personal or family history of mental illness. • Previous episode of maternal mental disorders. • Exposure to risk factors such as domestic violence, poverty, substance abuse, lack of support from partner, etc. • History of prenatal anxiety/depression. • 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.

Topic outline

11.1. Concept of Counselling Skills

Duration: 60 minutes

Aim

To introduce participants to basic counselling skills that are required to provide emotional support to 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 the women with emotional distress.
- Understand the meaning of counselling and importance of enhanced skills for effective communication to provide optimal care to women in perinatal period.
- Describe the essential qualities of a counsellor.
- Enhance their competence in counselling 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 scripts, 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 them to read the same.
- Provide the role play scripts on 'helpful' and 'unhelpful response'(Appendix 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 note down their observations

- Encourage 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 observations and suggestions on the role plays.
- At the end, facilitator explains the process of counselling and basic skills required during the counselling.

Case vignette 33

Sanjana, a 23-year-old, five months pregnant woman, is a homemaker and from middle socio economic background. She was married to an army officer three years back. 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 government service. But she had lost interest in her future and started to feel hopeless and worthless. 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

Most of the women are prone to encounter mental health problems such as anxiety and depression during pregnancy and after child birth. This may be due to the fact that they are challenged with new roles and responsibilities. If left untreated, it will impact not only mothers but also their babies and families. Midwives are key professionals to address the unique needs of women throughout pregnancy, labour and early parenting. They also are expected to provide supportive counselling to mothers who experience mental health difficulties.

Counselling

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

COUNSELLING IS NOT …

- Giving advice
- Offering solutions
- Taking charge of someone's life
- Doing the other person's work for him/her
- Correcting or reprimanding for wrong deeds
- Sermonizing or labelling the person
- Showing pity towards someone in trouble.[239]

Counselling is a process wherein a relationship is established between the counselor and counselee based on empathy, acceptance and trust. Within this relationship, the counsellor focuses on the client's feelings, thoughts, and actions, and then empowers clients to:

- Develop adequate coping skills
- Explore options
- Make independent decisions
- Take responsibility for those decisions.[240]

Qualities of Counsellor

1. **Respect**: Counsellors should respect a woman'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 feelings.
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 women.
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 women.
7. **Confidentiality:** Maintain confidentiality and develop trust. Avoid revealing women's identity, personal details and other information without consent.
8. **Empathy:** Empathy helps counsellor to understand the feelings and problems of the woman in a better way.
9. **Flexibility:** Flexibility is a need of the counsellor to understand clients while keeping the principle of individualization in the mind.
10. **Positive Regard:** Positive regard means that the counsellor accept and respect women without judging them based on assumptions.
11. **Self-awareness:** Counsellor must be aware of his/her feelings, attitudes towards women with mental illness during perinatal period. [241]

Skills of counseling

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

1. **Listening skills**

   Listening is the key element in the process of counselling. The counselor must empathize his/her self while 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', etc.

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: are used to seek in depth information about an issue/ problem. This type of questions have no correct answer and requires an explanation. Open-ended questions encourage women to keep talking. Eg., could you please tell me more about …

B. Close-ended questions: are used to get specific information. close-ended questions are those that can easily be answered with "yes" or "no". These types of questions are useful for getting necessary information and help the woman to focus on their discussion. E.g. Is this pregnancy planned?

3. Reflection skills

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

Importance of reflection skills

- Essential in developing a **relationship** with confidence, acceptance and compassion.
- Helps the woman to recognize and have a **clarity** about her problems and feelings.
- Helps the counsellor to **get information** about the woman and how she views her situation.
- Enables the counsellor to **verify** her perception of what the woman communicates.[227]

Process of Counselling

Counselling is a process in which the counsellor assists the woman to gain understanding about her problems and also directs her to arrive at making appropriate decisions in her life.

The role of the counsellor is to guide the woman through the process rather than insisting her on what to do. Women are motivated and helped to help themselves.

The steps in counselling process include:

1. **Identification of the need for counselling:** Identifying the need and reason for counselling is the first important step.
2. **Preparation for Counselling:** Successful counselling requires preparation that includes:
   - Selection of a suitable place with minimal interruptions and distractions.
   - Choose the time which is convenient for both counsellor and counselee. Ensure that the session is limited to only about an hour. In case the woman requires more time another session may be planned.

- Notify the woman well in advance.
- Organize information such as why, where, and when the counselling will take place. The counsellor must review relevant information such as: reason for counselling, facts and observation about the counselee, recognition of issues, salient points for discussion and development of an action plan.
- Outline the counselling session components with the information sought to ascertain what to discuss during the session. A written outline helps the counsellor to organize the session and enhances chance of positive results.
- Plan counselling strategies such as directive, non- directive and combined approaches depending on the situation of the woman.
- The counsellor must create a suitable atmosphere that enables two-way communication between counsellor and the woman.

3. **Conduct of Counselling Session**

While conducting the counselling session, the counsellor should be flexible and focus on the following fundamental steps:

a) **Opening the session:** In this step the counsellor must explain the purpose of the session and develop a mutual understanding of the problems. This may done by allowing the woman to express her issues freely without any hesitation while the counsellor actively involves in listening.

b) **Developing a plan of action:** A plan of action identifies a method for achieving a desired result. The plan of action must be specific.

c) **Recording the session:** Documenting is vital as it serves to be a reference and also enables to know the action plan, woman's progress in terms of coping/ solving her issues.

d) **Closing the session:** The counsellor must wind-up the session by summarizing the key points. The woman should be inquired whether she understood the plan of action and expectations 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 facilitates the participants in reinforcing the salient points that were discussed in the previous sessions. This session also motivates the participants to identify and appreciate the special talents among the co-participants. This interactive session encourages the participants to give their honest feedback on sessions which may help the facilitator to further improve the training program.

Topic outline

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

Total session time: 60 minutes

TOPIC 12.1: SUMMARIZING

Aim

To help participants be aware of the key messages drawn from different sessions.

Learning outcomes

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 of paper to match questions and answers. After five minutes, collect the answer sheets and invite a volunteer to present their responses to the larger group. Items are displayed on PPT one after another for each group. The answers of each group are displayed on the PPT one after another. Participants are encouraged to give a big round of applause for right answers and one point

may be credited. In case of wrong answer, encourage the next group members to come up with right answer. Facilitator may provide right answers if other participants are unable to do so.

Suggested training methodology

Small group activity, discussion and power point presentation

Materials required: Computer and LCD projector

Duration: 30 minutes

Process

- Divide participants into three groups and each group is provided with a sheet of paper containing ten items to match the answers (Appendix 4).
- Give 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 answer from the concerned group.
- Encourage the other participants from the larger group to give a big round of applause, if it is a right answer, one credit point may be given to them. 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 who answered. If participants are unable to come up with right answer, the facilitator may provide the same.
- Allow for discussion and reflections.
- Encourage them to ask questions and clarify their doubts.

TOPIC 12.2: FEEDBACK

Aim

To get feedback from participants about the content and teaching methodologies adapted for the training program. Participants are also encouraged to give their suggestions to improve the training program.

Learning outcomes

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

Description

Feedback formats are distributed to the participants to write down their opinions about the training. Invite few participants to give an honest feedback and share their learning experiences.

Suggested training methodology

Filling the feed back forms

Materials required: Photocopy of feedback forms and pens

Duration: 15 minutes

Process

- Distribute feedback forms to all the participants (Appendix 5).
- Ask them to write their honest opinions and suggestions without any hesitation.
- Inform them that writing their names 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

To acknowledge the participants for spending their valuable time and putting enormous effort during the training program.

Learning outcomes

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

Description

Each participant may be provided with three pieces of papers, wherein 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". (A "star moment" is referred to as a talent, gift or contribution a participant had towards the group).

Suggested training methodology

Writing on the chit

Materials required: Paper pieces, pens or marker pens

Duration: 15 minutes

Process

- Request the participants to read out what they had written about co-participants and facilitators. This activity should go on till all the participants complete their turn.
- The facilitator may suggest some star shines he/she has observed during the training program.
- Carefully handle negative comments made by the participants.
- Distribute certificates to all the participants by a dignitary for having successfully completed the training program.

Bonding all together

- ***"Begin with the end in mind"*** - Steven Covey
- It is important to take some time at the end of the training program to provide "togetherness" feeling to the group.

- Invite all the participants along with the facilitators to stand in a circle to thank each other as mark of gratitude.
- **Blow bubbles:** Give small containers of bubbles with wands and ask the participants to blow them with background music. This celebration winds the training program with a feeling of overwhelming satisfaction and joy.
- Finally, the facilitator thank all the participants and closes the entire program by singing the national anthem.

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Appendices

APPENDIX 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 tick mark. Example: [√]. We also request you not to write your names as your responses will be kept confidential. Please identify a unique code provided to you may have to remember as you will also need to mention 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 during pregnancy or after childbirth? If Yes, please describe _____
10. How would you rate your professional training (ANM course) on maternal mental disorders?
    Excellent Good Fair Poor Never received training
11. Have you undergone any previous training related to maternal mental disorders? If yes, please describe _____

Section B: Knowledge questionnaire on Maternal Mental Disorders

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 Compulsive disorder					
6. Baby blues					
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 stress 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) 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) Physical health of the mother
   c) Physical and mental health of the mother along with foetus and child
   d) 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 is
   a) Assurance of mother with mental illness about recovery
   b) Identify 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 cause 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 Puerperal Psychosis includes
   a) Worthlessness
   b) Hopelessness
   c) Hearing of voices when nobody is there
   d) Anxiety
12. Management of Puerperal 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 Obsessive-Compulsive Disorder
   c) Mother with cesarean section
   d) Mother with physiological disorders

14. Whooley's questionnaire assesses
    a) Schizophrenia
    b) Mania
    c) Obsessive-Compulsive Disorder
    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 "baby blues"?
    a) Understanding, empathy and support
    b) Baby care hospitalization
    c) Psychotherapy
    d) Referring women to a psychiatrist
20. Which of the following is required for 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 child birth
    a) Within 2-5 days
    b) Within 10-14 days
    c) After one year
    d) Within 3 months

22. Approximately_____percentage of Indian mothers experience postpartum depression.

a) 5%
b) 22%
c) 30%
d) 50%

23. Which of the following statement 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 suicidal 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

The correct answers for the multiple choice questions are highlighted.

Section C: Attitude questionnaire on Maternal Mental Disorders

Please rate your level of agreement for the items given below.

Item	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
1. Depression is normal during pregnancy and after child birth.					
2. Puerperal psychosis is not a treatable condition.*					
3. Woman with maternal mental disorders cannot become a good mother.*					
4. Domestic violence may affect mental health of women during pregnancy and postpartum period.					
5. The baby should be separated from mother if she 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 perinatal period.*					
9. Women who have had a history of severe mental illness following delivery have a higher chance of recurrence.					
10. Anti psychotics should be withdrawn on confirmation of pregnancy as these may be teratogenic.*					
11. Breastfeeding should 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 need to be routinely screened for anxiety and depression during home visits by ANMs.					
2. As an ANM, I must be aware of "normal" emotional changes that occur during pregnancy, so as not to ignore or misdiagnose common maternal mental disorders.					
3. It is my responsibility to identify and refer women with common maternal mental disorders to appropriate mental health services.					
4. I feel confident in assessing suicidal thoughts in women with depression.					
5. I don't want to enquire a woman about maternal mental disorders because I am not aware of it.*					
6. I do not have time to follow-up women with mental health problems after making a referral. *					
7. I am confident in caring for women with physical illnesses than 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 woman, who is 6 months pregnant. Her 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 Suma's physical health. She also observes Suma being inactive, sad and therefore 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, 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 by
    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 Lakshmi (ANM), Suma delivered a girl baby at the 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 a 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) Medical Officer at PHC/Psychiatrist
    d) Traditional healers

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

1. Can you please tell me about the number of pregnant and postnatal women you are responsible for?
2. Among 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 women with mental health issues?
5. Number of women identified with Maternal Mental disorders and referred to the Medical Officer at PHC/Psychiatrist
6. Please list out the diagnosis and treatment of women with maternal mental disorders.
7. List out the <u>three most common important barriers</u> in identifying and referring women with maternal mental disorders.

APPENDIX 2- ROLE PLAY SCRIPTS- ROLE OF ANMs IN PROMOTION OF ANTENATAL AND POSTNATAL MENTAL HEALTH

Case vignette 31

Home visit (at first month)

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.

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 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 complications.

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 products.

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 members to maintain the physical and mental health of your self and 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 to practice yoga as per advise by your Yoga Instructor.
If you are practicing yoga and meditation please continue .....
Take some time 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

Home visit (at seventh 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, 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 like 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 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 a 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.

Case vignette 32

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 : For the 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 have 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 have 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 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 behavour, 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 Medical Officer.... 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…

APPENDIX 3- ROLE PLAY SCRIPT - 'HELPFUL' AND 'UNHELPFUL' RESPONSE

Case vignette 33

Role Play 1 – 'An unhelpful response'

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 life.
(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 feelings?

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.

APPENDIX 4 - QUESTIONS FOR SUMMARIZING
MATCH THE FOLLOWING

Please match the correct answers by choosing the right answer from the column beside.

First group

Column A	Column B
1. Perinatal period **I**	A. Common mental disorders
2. Anxiety **J**	B. Persistent low mood during pregnancy
3. Panic attack **D**	C. Irrational fear
4. Obsessive-Compulsive Disorder (OCD) **K**	D. Pounding heart, fear of dying, trembling, difficulty in concentration, dizziness
5. Baby blues **G**	E. Soon after conception to till the delivery
6. Postpartum depression **H**	F. It is rare condition, occurs one in 1000 of postnatal mother
7. Prenatal period **E**	G. Persistent low mood observed in first week after delivery
8. Anxiety and depression **A**	H. Persistent low mood for more than two weeks after child birth.
9. Postpartum psychosis **F**	I. Soon after conception to one year after child birth
10. Antenatal depression **B**	J. Fear of unknown
	K. Fear of contamination, repeated checking, hand washing to the point where the skin is damaged
	L. Harming self

Second group

Column A	Column B
1. Schizophrenia **E**	A. GAD-2 and Whooley's questionnaires
2. Domestic violence **F**	B. To screen for depression
3. Hallucinations **D**	C. Maternal diet
4. Delusions **L**	D. Hearing voices when no one is there
5. Suicide **G**	E. The prevalence is less than 1% in general population
6. Whooley's Questionnaire **B**	F. Women are at greater risk for depression
7. Mother-baby bonding(MBB) **H**	G. Deliberate self harm
8. Suicidal thoughts **C**	H. Essential for physical and mental wellbeing of mother and child
9. Maternal mental health assessment **A**	I. Singing and talking to the unborn baby, introducing family members, enjoying foetal movement
10. Maternal-foetal attachment(MFA) **I**	J. To be enquired when women are depressed and cannot be ignored.
	K. Soon after conception to one year after child birth
	L. False fixed unshakable belief. E.g. I am the prime minister of India.

Third group

Column A	Column B
1. MOTHER-S **B**	A. Skin to skin contact, breast feeding, cuddling the baby, singing lullabies, massaging the baby
2. Mother-baby bonding(MBB) **A**	B. Mind-body interventions, Observation, Spending Time, Healthy diet, Exercises, Rest and sleep, Support
3. Women with history of psychiatric illness **D**	C. Mother and baby to be separated
4. Auxiliary Nurse Midwives(ANMs) **K**	D. Encourage the mother to visit the psychiatrist before planning pregnancy or soon after the confirmation of pregnancy
5. Mother with postpartum psychosis **F**	E. 22 percent
6. Prevalence of postpartum depression **E**	F. To be admitted in to mother baby unit at a tertiary care centre
7. Counselling **L**	G. Killing her own baby usually associated with postpartum psychosis
8. Levels of prevention **J**	H. Harming self
9. Infanticide **G**	I. Elevated mood, increased energy, decreased need for sleep and rest
10. Mania **I**	J. Primary, secondary and tertiary levels
	K. Identify and refer women with mental health issues
	L. Active listening, empathy and support

APPENDIX 5- TRAINING FEEDBACK FORM

Date: _____

Instructions: Please indicate your level of agreement with the statements listed below. Please give your opinion genuinely and help us to improve the training program.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1. The training program was interesting.					
2. Teaching sessions were applicable to my field practice.					
3. Case studies were realistic.					
4. 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 women with maternal mental disorders.					
8. I will be able to refer women with mental health issues to appropriate services.					
9. Overall, I found the training program 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