

3rd Edition • 2013



www.pmhp.za.org

MATERNAL MENTAL HEALTH

A handbook for health workers



Perinatal Mental Health Project
Caring for mothers. Caring for the future.

A project of the Alan J Flisher Centre for Public Mental Health
at the University of Cape Town



Alan J. Flisher Centre for
Public Mental Health

MATERNAL MENTAL HEALTH

A handbook for health workers

2013

Perinatal Mental Health Project

Caring for mothers. Caring for the future.

Alan J Flisher Centre for Public Mental Health
Department of Psychiatry & Mental Health
University of Cape Town
46 Sawkins Road, Building B
Rondebosch 7700
South Africa

ISBN (print) 978-0-620-56427-4
ISBN (ebook) 978-0-620-56428-1

The contents of this Handbook may be used, disseminated and expanded on for non-commercial purposes, with proper acknowledgment to the PMHP, and the information so created must remain freely accessible in the public domain. The Creative Commons License does not apply to material copyrighted by a third party.

Creative Commons Licence



Foreword

The Perinatal Mental Health Project (PMHP) provides training to health workers and community-based workers involved in caring for mothers. This handbook is intended as a supplement to this training programme and as a resource to anyone involved with mothers and mothers-to-be.

The handbook should be used in an active way: use it and add to it as best suits your local setting. The intended outcome of this handbook is to improve the quality of service offered to women in emotional distress and to meet the needs of maternal health workers, like you, who want to be better equipped in this task.

The handbook covers a range of topics. Each chapter has a clear set of learning objectives and a summary. Some chapters include practical activities which should help with linking the theory with your practice.

Chapter 1 provides an overview of maternal mental illness, and explains why it is an important issue for health workers.

Chapter 2 explains why the perinatal period is a crucial time in a mother's life and highlights the importance of the relationship between you and the mothers in your care.

Chapter 3 helps you understand what mental illness is and the common types of mental illnesses which can present during the perinatal period.

Chapter 4 outlines why pregnant women should be screened for mental illness and gives tips on how to screen.

Chapter 5 highlights several practical tips for making referrals and what you can do when these are not possible.

Chapter 6 gives an overview of treatment options, such as counselling, for women who are experiencing mental health problems.

Chapter 7 provides an overview of special issues that health workers should think about when caring for mothers with particular needs.

The **Resources** section includes several resources that you may find useful while working with mothers.

Background to maternal mental illness in South Africa

In this handbook, the ‘perinatal period’ refers to the period from pregnancy, through labour, up to one year after birth. Pregnancy is a difficult time for many women, and those with the most need for mental health care often have the least access to it. Also, during this time, both mental illness and poverty impacts on the woman, the foetus or infant, the family and the wider community. Maternal and mental health services need to begin to address this serious public health problem.

Women access health services for their maternal care during the perinatal period. This presents an opportunity to provide care for women in mental distress. By getting involved at this early stage, preventive work, involving screening and counselling, can be done. This could help women, their children and society in general.

About the Perinatal Mental Health Project

The PMHP was started in 2002 to address the high rates of mental distress among pregnant women and mothers living in difficult situations. The Project began at the Liesbeeck Midwife Obstetric Unit at Mowbray Maternity Hospital in Cape Town, and now also operates at three other Midwife Obstetric Units. The service includes three main components: screening, counselling, and psychiatry. These are provided free of charge and integrated into the maternity clinic. The PMHP also provides training for health workers and community workers, conducts research to help improve service delivery, and is involved in advocacy work.

The PMHP believes that ‘caring for mothers is caring for the future’. Recognising the need for public maternal mental health services, it is the PMHP’s vision for all women to have access to quality maternal mental health care, integrated into regular maternity services. To achieve this vision, the PMHP partners with the Department of Health and works with civil society, international organisations and academic institutions to implement its four inter-related programmes. These programmes form an innovative model for integrated mental health services.

PMHP’s long-term objective is to provide a model of maternal mental health, with effective tools and strategies, to partnerships and agencies capable of rolling out maternal mental health services nationally.



Simone Honikman
Director

Contents

Foreword	ii
Acknowledgements	vi

1. Introduction

1.1	Why is it important to focus on maternal mental health?	2
1.2	Risk factors linked to poor maternal mental health	4
1.3	Summary	6

2. Maternal care: A relationship between you and the mother

2.1	The mother and the perinatal period: a time of change	10
2.2	Why is your relationship with the mother so important?	10
2.3	The emotional state of women in your care	12
2.4	The emotional state of the health worker	20
2.5	A journey through 'secret histories'	25
2.6	Summary	31

3. Maternal mental illness

3.1	Why is mental illness often overlooked?	34
3.2	Types of mental illness	35
3.3	Signs and symptoms of maternal mental illness and distress	43
3.4	Why is an early diagnosis so important?	48
3.5	How can you help women with mental health problems?	48
3.6	Summary	49

4. Screening for maternal mental illness

4.1	Why screen pregnant women for mental illness?	52
4.2	The screening process	53
4.3	Screening tools	58
4.4	Summary	66

5. How to refer a woman with mental health problems 69

5.1	Types of referrals	70
5.2	Practical issues	74
5.3	How to make a successful referral	76
5.4	When you cannot refer for counselling: some suggestions	79
5.5	Summary	82

6. How to help women with mental health problems 83

6.1	What do women who experience mental distress need?	84
6.2	What is counselling?	86
6.3	Providing supportive care: sharing information	87
6.4	How to really 'listen'	87
6.5	What happens when someone is sent for professional counselling?	97
6.6	Speaking and being heard	99
6.7	Summary	102

7. Special issues 103

7.1	Poverty	104
7.2	Lack of support	104
7.3	HIV status	105
7.4	Adolescent pregnancy	106
7.5	Being a refugee	107
7.6	Drug or alcohol misuse	108
7.7	Domestic violence and abuse	109
7.8	Child abuse	117
7.9	Suicide	112
7.10	Grieving and loss: miscarriage and stillbirth	127
7.11	Summary	132

8. Resources 135

8.1	Screening tools	136
8.2	Maintenance Orders	150
8.3	Child Support Grants	152
8.4	Protection Orders	155
8.5	How to make a referral	160
8.6	South African national helplines	162

Acknowledgements

Several members of the PMHP team dedicated their hours and insights to the development of this handbook. This work was also greatly enhanced by the generous and invaluable contributions of many experts in the field of maternal mental health.

Concept and Original Content Development

Simone Honikman
Sally Field

Technical Consultation & Additional Content

Emily Baron
Bronwyn Evans
Sheila Faure
Angela Hutchison
Linda Lewis
Ingrid Meintjes
Karen Miller
Liz Mills
Joan Raphael-Leff
Hilary Rosenthal
Lisa Sanders
Bridget Schweitzer

Editing

Emily Baron
Sally Field
Simone Honikman
Natasa Meli
Ingrid Meintjes
Sarah Skeen
Julie van der Vlugt

Illustrations

Graeme Arendse

Layout

Ingrid Meintjes

The PMHP is grateful to the MTN SA Foundation
for sponsoring the publication of the
PMHP Maternal Mental Health Handbook



Introduction

This chapter provides an overview of maternal mental illness, and explains why it is an important issue for health workers.

Learning Objectives

By the end of this chapter you will know:

- Why maternal mental health is so important
- How widespread maternal mental illness is
- How maternal mental health can affect infants, children, and families
- How maternal mental health can affect communities and society
- The factors that are linked to maternal mental illness

1.1 Why is it important to focus on maternal mental health?

What is mental illness?

Mental illness is a general term used to refer to any psychological or emotional disorder, illness or condition which prevents a person from functioning 'normally'. *Mental illness* can disrupt a person's thoughts, emotions or behaviour.

A specific type of *mental illness* can be identified by a combination of how a person feels, acts, thinks, or how a person perceives things. The way a person feels and behaves can cause suffering to the person and others.



What is the difference between mental illness and mental distress?

The term *mental illness* is used when a person has a diagnosable mental condition. The term mental disorder may also be used.

When it is clear that a person is experiencing some sort of mental suffering, the more general term used is *mental distress*.

For example, a mother may be distressed about her baby being in hospital, but she does not necessarily have a *mental illness*. However, *mental distress* over a period of time can impact on a person's mood and general well-being, and may lead to a more serious mental condition.

Some people also use other words for mental illness such as: 'poor mental health', 'mental health problems', or 'psychological stress'.

Mental illness during and after pregnancy is very common

Pregnancy and the postnatal period is a psychologically distressing time for many women, particularly those living in poverty, or with violence, abuse or HIV/AIDS. The burden of maternal mental illness (mental illness during and after pregnancy) in low and middle-income countries is high.

In South Africa, nearly half of poor pregnant women experience depression, anxiety or other mental illnesses. This is three times higher than the prevalence found in developed countries. It is also significantly higher than the rate in other developing countries such as Nigeria or Uganda.

Though postnatal depression (depression after giving birth) is more commonly understood, both depression and anxiety are highly prevalent during pregnancy. Studies in KwaZulu-Natal and Cape Town report rates of 47% for antenatal depression (depression during pregnancy) and 39% for postnatal depression. Antenatal depression is a strong predictor of postnatal depression. When maternal mental illness is left untreated, it can lead to maternal mortality and result in poor outcomes for maternal and child health.

Suicide is the newest leading cause of maternal deaths in developed countries. In most low and middle-income countries (including South Africa), suicide data is not accurately recorded. Yet, if the high rates of maternal depression are considered, coupled with poverty, unemployment and substance use, maternal suicide is likely to be very high in these regions.

There are not many postnatal services for women in low- and middle-income countries. In South Africa, there are no formal screening programmes to identify women who are at risk of mental illness and no dedicated mental health services during the perinatal period. For the common mental disorders (CMD) depression and anxiety, very few management procedures and treatment options exist. Plus, it is difficult for health workers to pick up on women's psychological problems because of staff shortages, high patient numbers and inadequate staff training in mental health.

Impact on infants, children and families

Mental illness can have long-lasting consequences from one generation to the next: studies show links between mental illness in parents and poor emotional, physical, and developmental outcomes for infants and children.

For example:

Mental illness in pregnant women is associated with:

- poor foetal growth
- premature delivery

As a result, infants could be

- more vulnerable to infections and diseases
- more frequently admitted to hospital

These health outcomes are linked to infant mortality and impaired development of children under five years - especially in contexts of poverty, violence, and poor education. Also, children of mothers with mental illness are more likely to:

- be abused
- perform poorly at school
- develop mental illness themselves

Impact on society

Because parental mental distress has a negative effect on the social, emotional, cognitive and physical development of children, poor parental mental health can have a negative impact on the educational and economic potential of children in a country.

Therefore, addressing the mental health needs of mothers has positive implications for the well-being of women, their children and families, as well as their wider communities and society.

In South Africa, there are many risk factors which can contribute to maternal mental illness, especially among women living in poverty.

Social, economic and physical factors can contribute to women's risk for maternal mental illness. Some of the primary risk factors are described in this section.

1.2 Risk factors linked to poor maternal mental health



Definition: risk factor

The *risk* is the likelihood of suffering from an illness, harm or loss based on certain characteristics. A *risk factor* is something that increases the chances of a person developing a particular illness or disease.

Poverty

Women who live in poverty are more likely to develop mental illness due to the added stress of unemployment, poor housing, and food insecurity. At the same time, women with mental illness are more likely to slide into poverty as they experience growing isolation and stigma, limited ability to engage in income generating activities, and increased health costs.

Violence and abuse

Women can be at increased risk of domestic violence during pregnancy. Domestic violence also tends to become more severe as pregnancy progresses. Women who experience violence are more likely to become depressed and anxious.

The opposite is also true: women with mental illness are more vulnerable to become victims of violence.

Rape

Rape can affect women's mental health, while women with poor mental health can be more vulnerable to this type of abuse.

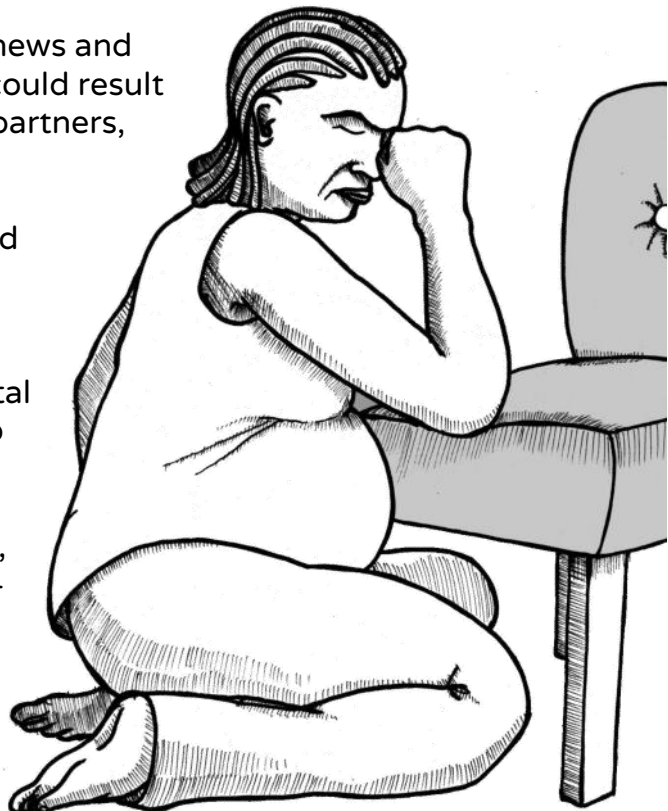
HIV/AIDS

Women with HIV/AIDS have special mental health needs. Many women learn their HIV status for the first time during pregnancy.

The process of adjusting to this news and disclosing to family and friends could result in guilt, stigma and rejection by partners, family or the community.

HIV/AIDS can affect the brain and adapting to medication can also cause emotional distress.

On the other hand, positive mental health can improve adherence to anti-retroviral medications including Prevention of Mother to Child Transmission interventions, and can improve the use of antenatal care.



Adolescent pregnancy

Adolescents are particularly at risk: they are twice as likely to experience depression compared to pregnant adults. Also, teen mothers with depression are more likely to get pregnant again within 1 to 2 years than those teens who are not depressed.

Refugee status

In fleeing their countries of origin, refugee women may have experienced extreme trauma, violence, rape, the loss of loved ones and great emotional distress. They are also more likely to experience post-traumatic stress disorder.

Substance use

Substance use and mental illness often occur at the same time, or as a result of each other. This can have devastating effects on both the mother and the child. For example, South Africa has some of the highest rates of Foetal Alcohol Syndrome in the world, which is a result of the widespread misuse of alcohol during pregnancy.

Additional information about these risk factors is provided in more detail in Chapter 7.

1.3 Summary

- Maternal depression has reached very high levels. The burden in low- and middle-income countries is especially high.
- Mental illness, during or after pregnancy, can have serious negative consequences for the mother, infant, family and wider community. These consequences can have an impact that lasts across generations.
- Mental illness or distress during pregnancy can impact on the developing foetus. These effects can continue into childhood and adolescence.
- Women who live in poverty are more likely to develop mental illness, while women with mental illness are more likely to slide into poverty.
- Other factors, such as rape, HIV/AIDS, adolescent pregnancy, refugee status and substance use, are linked with poor maternal mental health.

References

The information in this chapter draws from the following articles:

Austin M (2004) Antenatal screening and early intervention for 'perinatal' distress, depression and anxiety: Where to from here? *Archives of Women's Mental Health*. 7: 1-6.

Barnet, B (2008) Depression linked to subsequent pregnancy in black teens. *Archives of Paediatric and Adolescent Medicine*. 162: 246-252.

Cooper P, Tomlinson M, Swartz L, Woolgar M, Murray L, and Molteno C (1999) Post-partum depression and the mother-infant relationship in a South African peri-urban settlement. *British Journal of Psychiatry*. 175: 554-558.

Enoch MA (2006) Part II. Neurobiological processes, genetic and environmental influences on the development of alcoholism: Resilience vs. Risk. *Annals of the New York Academy of Sciences*. 1094: 193-201.

Hartley M, Tomlinson M, Greco E, Comulada WS, Stewart J, le Roux I, Mbewu N, et al. (2011) Depressed mood in pregnancy: Prevalence and correlates in two Cape Town peri-urban settlements. *Reproductive Health*. 8: 1-9.

Meintjes I, Field S, Sanders L, van Heyningen T, and Honikman S (2010) Improving child outcomes through maternal mental health interventions. *Journal of Child and Adolescent Health*. 22 (2): 73-82.

Piyasil V and Meemarayat P (1998) Risk behaviours in Thai Adolescents. *Journal of Thai Paediatrics*. 1: 1-9.

Rochat TJ, Tomlinson M, Bärnighausen T, Newell M-L, and Stein A (2011) The prevalence and clinical presentation of antenatal depression in rural South Africa. *Journal of Affective Disorders*. 135: 362-373.

Sawyer A, Ayers S, and Smith H (2010) Pre- and postnatal psychological wellbeing in Africa: a systematic review. *Journal of Affective Disorders*. 123(1-3): 17-29.

[illegible]

Maternal care:

a relationship between you and the mother

This chapter explains why the perinatal period is an important time in a mother's life. It also highlights the importance of the relationship between you and the mothers in your care.

Learning Objectives

By the end of this chapter you will know:

- What the 'perinatal period' is
- Why mental health care is important during the perinatal period
- The importance of your relationship with mothers in your care
- How to understand the untold or 'secret' history of the mother and yourself
- How the 'secret history' can impact on the mother and yourself

2.1 The mother and the perinatal period: a time of change ---

What is the 'perinatal period'?

The perinatal period is defined as the time from the beginning of pregnancy through childbirth, to the end of the first year of being a parent.

Why focus on the perinatal period?

During the perinatal period, women experience changes in body, self-image, expectations and relationships. They are also faced with new challenges and responsibilities. It is a major life transition, which can be stressful and make mothers very vulnerable to mental illness. This is why pregnancy and childbirth can be very difficult times for women.

In many low- and middle-income countries, women and girls can experience severe traumatic events during their lives. Domestic violence, rape, crime, HIV, poverty, a lack of supportive relationships and previous traumatic births or pregnancies are just some of the challenges pregnant women may face. These situations can make the difficult perinatal period even more stressful.

2.2 Why is your relationship with the mother so important? ---

A mother who is experiencing emotional difficulties is more likely to have health problems, such as birth complications, traumatic birth experiences and postnatal depression. These problems can be avoided or improved if the mother receives gentle and compassionate care. This is why the role of the health worker is so important.

By caring for the mother's overall well-being, you can also have a positive impact on the mother's ability to care for her infant and the development of her child. A mother who feels safe, understood and well cared for will be better able to bond with, breastfeed, and care for her baby.

This concept is encouraged by The Better Births Initiative (BBI).

The Better Births Initiative (BBI)

The BBI is an international project which aims to improve the quality of care during labour and childbirth. By adopting the BBI principles and practices - which are based on scientific evidence - you can prevent harm and improve the health of women and their babies. The BBI principles are useful in the South African setting, and have been adopted in many maternity units in low- and middle-income countries.



Principles

- Humanity: women are to be treated with respect
- Benefit: provide care that is based on the best available evidence
- Commitment: health workers are committed to improving care
- Action: develop effective strategies to change harmful practices

Practices

Avoid practices which have no proven benefit, for example:

- shaving
- enemas
- supine position at delivery (lying on the back)
- withholding fluid and food in labour

Avoid procedures for which there is no proven benefit, for example:

- perform an episiotomy only when clinically required
- reduce early amniotomy (rupturing of membranes) unless progress in labour is abnormal
- only use suction for babies when meconium is present

Promote practices which have proven to be of benefit:

- allow mothers to move during labour
- allow mothers to be in different positions for delivery
- provide fluids and food during labour for energy and hydration
- encourage and ensure that mothers have a companion during labour
- ensure that HIV-positive mothers can prevent mother-to-child transmission
- provide magnesium sulphate for treating eclampsia
- provide oxytocin in the third stage of labour to prevent postnatal complications

If you would like to know more about the BBI:

- Speak to the BBI representative or manager at your facility
- Read more online at the World Health Organisation Reproductive Health Library website: www.who.int/rhl/en/
- Contact the Effective Care Research Unit at the Frere Cecilia Makiwane Hospital. Tel: 043 708 2120/34 Fax: 043 709 2483

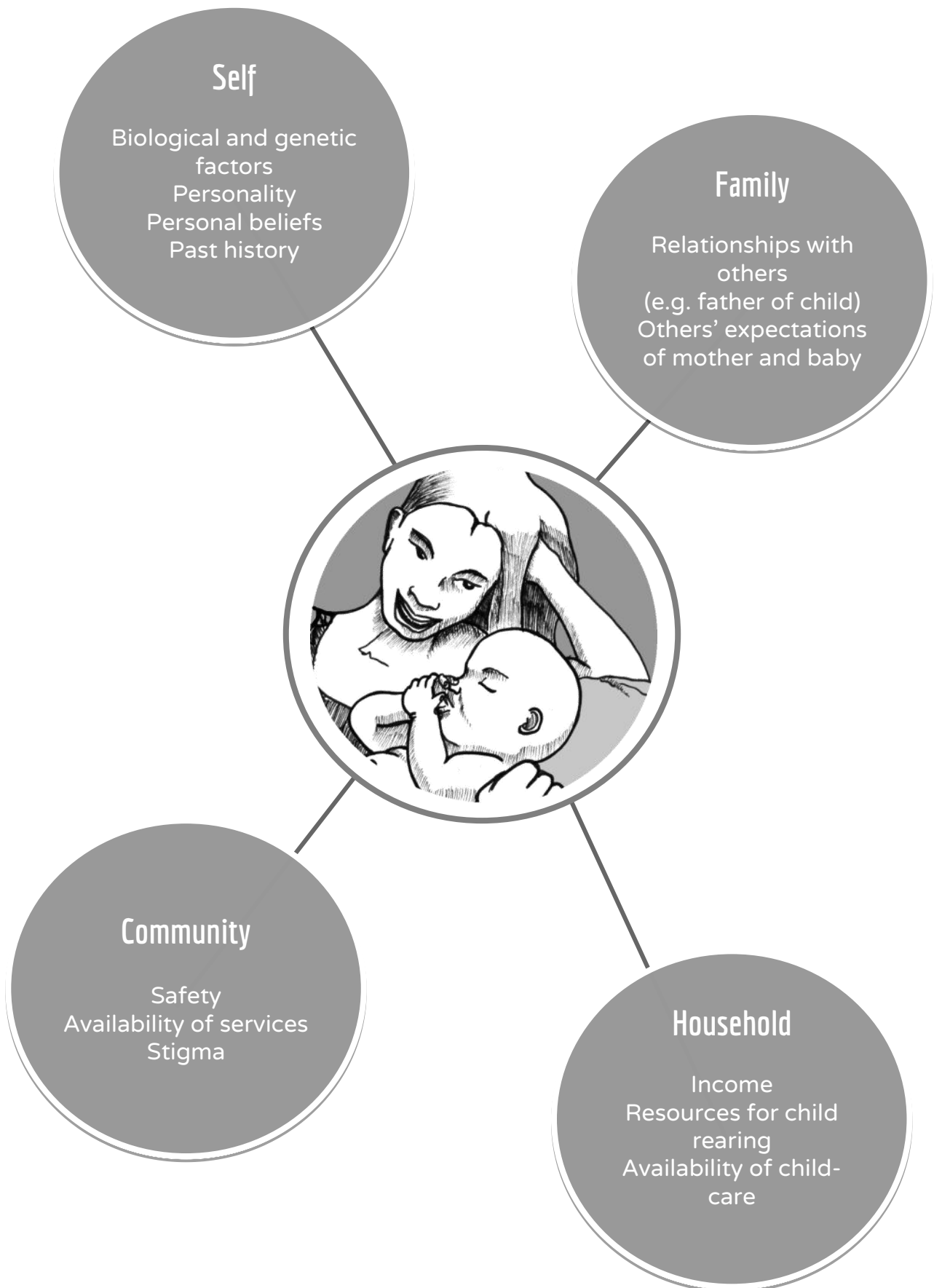
2.3 The emotional state of women in your care

We usually expect women to be happy about being pregnant and having a baby, but for many women this is a time of extreme stress.

What influences women in the perinatal period?

The following image shows the different factors which can influence a woman's emotional state during the perinatal period. In order to provide better care, health workers need to consider her whole life experience.

What influences women in the perinatal period?



Understanding different backgrounds and circumstances

Each mother is different. It is challenging to care for each woman as an individual. It is important to acknowledge that you may be dealing with:

- HIV-positive women
- teenagers
- women who did not plan their pregnancy
- women who have been physically, mentally or sexually abused
- women who have moved from rural to urban areas during their pregnancy to look for better health care
- women living in poverty
- women who speak other languages, or come from other countries
- women who have been rejected by their communities and families because of their choices or circumstances
- women who feel isolated and alone
- women who are far from their own mothers and in need of 'mothering' care and support
- women who want to, or are expected to, follow traditional rituals associated with childbirth and becoming a mother



Activity

The 'secret history'

The clinical setting does not allow you to get to know each mother very well. The mother may also not have had the opportunity to tell you her story. However, it is helpful for you (and the mothers) to try and understand the point of view of the mothers in your care.

You may be able to do this by trying to imagine her 'history'. The following activity can help you with this.

Try to imagine the 'secret history' of any of the following:

- an HIV-positive mother
- a teenage mother
- a rural mother
- a mother from a traditional or religious culture
- a single mother
- a physically abused mother
- a refugee mother



Answer the following questions as if you, yourself, were one of the mothers described:

- How did you feel when you found out you were pregnant?
- Who did you tell?
- How did they respond?
- What kind of support did you have?
- What happened at work/school?
- What were your thoughts in the early days of your pregnancy?
- What decisions did you make? Why did you make these particular decisions?
- What have the outcomes been?
- What are you most worried about?



Your notes

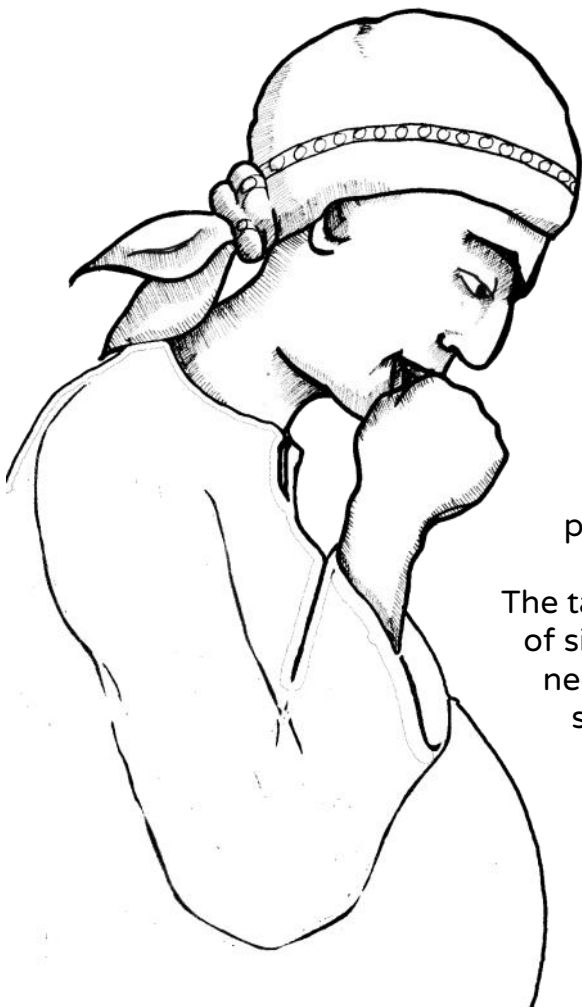
After thinking about these questions, write down some points which would be important to remember when dealing with mothers from any of the above circumstances.

Note

There may be reasons why women do not feel comfortable speaking about their lives. Different status, levels of education, poverty, or gender could be barriers to women revealing their story.

Also, women who are poor or uneducated could be disempowered and find it difficult to tell their story.

This is known as 'the silence of powerlessness'.



The mother's feelings about her pregnancy

Emotional changes are common during pregnancy and in the first weeks following the birth of a baby.

There are many stressful events that can arise at different stages of pregnancy and have a negative effect on a mother's emotional health.

However, there are also many positive aspects that can benefit the mother.

The table on the next page highlights examples of situations that could lead to positive or negative emotional responses during each stage of pregnancy.

Factors leading to positive and negative emotions

Trimester	Positive Emotions	Negative Emotions
1 st	- Planned pregnancy - Timing of pregnancy suitable - Positive reactions of important people - Feeling physically well	- Unplanned pregnancy - Poor timing of pregnancy - Negative reactions of important people - Feeling physically drained or sick - Struggling with work and family commitments
2 nd	- Development of emotional attachment to the foetus - Supportive network in place - Starting to think and prepare for the baby - Feeling physically and emotionally healthy	- Lack of emotional attachment to the foetus - Isolation and lack of support - Problems with the baby's development - Feeling physically and/or emotionally unwell
3 rd	- Positive relationship with partner - Improved sex life	- Relationship problems with partner - Problems with sex life - Physical discomfort - Major life changes, such as stopping employment - Economic stress associated with new child - A lack of family support or maternal figure to assist new mother

The mother's feelings about her maternity care

Once the mother becomes part of the clinic or a hospital system, she may feel:

- de-personalised because she is referred to as a 'patient' or a number, instead of a 'person' or a 'mother'
- that she is not in control of the situation
- overwhelmed or afraid
- uncomfortable, because she may have to wait for hours, discuss highly personal information with strangers, and undergo medical procedures and tests
- that she is not treated with respect
- that she has many questions and concerns that cannot be addressed in a short consultation, and that she is rushed to make way for the next mother

The mother's feelings about labour and childbirth

Labour and childbirth can be an extremely stressful time for the mother and the father. The mother may be:

- scared of the pain
- scared of doing something wrong
- scared that something might go wrong causing death or damage to her baby
- scared of losing control of herself
- scared of being in an unfamiliar place
- scared of being alone
- missing her own mother
- having memories of previous trauma such as sexual abuse, rape, miscarriage, stillbirth, abortion or another previous negative birth experience
- scared of the doctors, midwives or medical equipment
- feeling helpless, degraded or embarrassed

The mother's feelings after the birth

Mothers usually experience a mixture of feelings after the birth. These can be both positive and negative, as can be seen in the table below:

Positive	Negative
Joy	Disappointment
Relief	Anxiety
Closeness to her partner	Exhaustion
Delight in her baby	Loneliness
Feeling of achievement	Detachment
Exhilaration	Disinterest in the baby
Sense of pride in motherhood	Sense of failure
Sense of caring and commitment	Helplessness
Hope for the future	Overwhelming feeling

In the first few days after birth, many new mothers can be irritable, sad and anxious, or cry a lot. This emotional state is usually called 'the baby blues' (see **Chapter 3, Section 3.2**).

The 'baby blues' is very common and can be related to hormonal changes linked to breastfeeding, or related to exhaustion, unexpected birth experiences and the adjustment to a new role. Emotions can be felt very strongly because of the physical changes and discomfort new mothers experience. These include:

- sore breasts
- pain from an episiotomy or torn perineum
- constipation
- haemorrhoids
- hot and cold flushes
- incontinence
- 'after pains'
- weight gain

Sometimes, the mother's feelings are expressed in a negative way. She may express her fear as:

- 'flight': missing appointments, not taking responsibility, ignoring advice
- 'fight': being rude, showing aggressive behaviour

It can be difficult for a health worker to realise the underlying cause of these behaviours. Rough treatment or uncaring health workers can easily upset new mothers, especially if they are having difficulty adjusting to their new situation and responsibilities.

For example, if a new mother is finding it difficult to breastfeed, she may feel like she is a 'bad mother' and any harsh treatment may make her feel very emotional or depressed. Perhaps some want to be 'mothered' and looked after, while they learn to mother their own baby.

In cases where the 'baby blues' is not temporary, mothers could be suffering from depression. This is more serious than the 'baby blues' and can cause mood swings, anxiety and on-going sadness, with negative long-term consequences for both mother and child.



Definition: depression

Depression is a type of mental illness. It is characterised by a low mood and other symptoms lasting for at least two to four weeks. It is common in women during and after pregnancy. *Depression* during the perinatal period can be called antenatal, postpartum, postnatal or maternal depression.

Note

Women who experience these emotions need a supportive approach. Harsh or disapproving treatment can make things worse for both mother and health worker.

"When I shout at a mother who is not co-operating, I end up feeling exhausted at the end of my shift. It also doesn't make her listen to me."

Midwife, Cape Town

See **Chapter 3, Section 3.2** for more information about the baby blues, depression and other mental illnesses. Screening for mental illnesses, such as depression, is discussed in **Chapter 4**.

2.4 The emotional state of the health worker

As a health worker involved with pregnancy and childbirth, you have a very important role to play in the lives of mothers and babies. There are many physical and psychological demands made on you, the mother and the baby. Your work is rewarding and exciting, but can also be stressful and draining.

Yet, you may also face many stresses, both in your professional and personal life. So, you too need support, compassion and appreciation. For you to provide the best possible care to your mothers and babies, you have to ensure the best possible care for yourself.

First, you need to understand the factors that affect you personally while you are doing your job. These factors range from external pressures (such as the work environment and personal relationships) to internal pressures (such as your emotional state).

Health workers, like everyone, are influenced by their own experiences, families, communities and cultures. This means that you have your own expectations and attitudes to the mothers you are working with, no matter how professional and experienced you are.

Understanding how all these factors affect you and your interactions with mothers in your care, helps you to step back and separate your personal issues from your work.

Stressful factors affecting health workers

Health workers often identify the following stressful factors related to work:

- Difficult relationships between staff members
- Equipment shortages or inadequate equipment
- Abuse of patients and/or staff
- Lack of support from management
- Broader problems within the hospital such as problems with management
- Issues around pay levels and increases
- Issues around promotion and taking on new responsibilities
- Low morale of staff
- High rates of absenteeism
- Burden of high numbers of HIV/AIDS patients
- Very little time to spend with each mother

There are also personal issues which can affect health workers' performance, such as:

- Financial stress
- Anxiety about the future
- Parenting your own children
- Environmental changes
- Crime
- Poor personal health
- Stressful living conditions (e.g. housing conditions; public transport)
- Marriage difficulties
- Death, bereavement and loss
- Unemployment of your partner
- Lack of time for your family
- Lack of time for yourself



Your notes

What are some of the stressful factors you experience at work?

If you understand how these factors affect your thoughts and actions, you may be able to manage your own emotions better, improve your own well-being, as well as the quality of your work. This allows you to provide better care to mothers, while still taking the best care of yourself.

Providing care under stressful circumstances

As a health worker, it is easy to become angry and irritated with mothers who are in a poor emotional state before, during or after birth. Allowing your frustration to show, however, could make the situation much worse. If health workers or staff shout at mothers, or are aggressive in other ways, mothers can begin to feel more frightened and threatened, and become more angry and uncooperative.



Sometimes you can have a strong positive or negative reaction to a mother. It is important to reflect on why you feel this way. The following activity is a quick way to understand your feelings about a mother and how they might affect your behaviour towards her.



Activity

Understanding your own reactions

Think about a mother to whom you have had a strong negative reaction.

- Why do you think you felt strongly about this mother?
- Were you reminded of a painful event or bad relationship from your own life?
- Did you judge her because of your own attitudes, culture, tradition, or religious beliefs?
- How could you have handled this situation in a positive way?
- What would it take for you to provide this mother with the best possible care?

Note

Be aware of situations which may cause strong reactions. For example:

- A teen mother may remind you of your own teenage daughter and your concerns about her becoming pregnant.
- A mother screaming and uncontrollable in labour may remind you of your own labour when you were alone and terrified.
- A verbally abusive mother may remind you of an abusive family member at home.
- A refugee woman from the Congo may remind you of your negative feelings toward foreigners living in South Africa.
- A very poor woman with many children may make you feel angry with her for having so many children that she is unable to care for.



Tips

The relationship with a mother may improve if you keep these thoughts in mind:

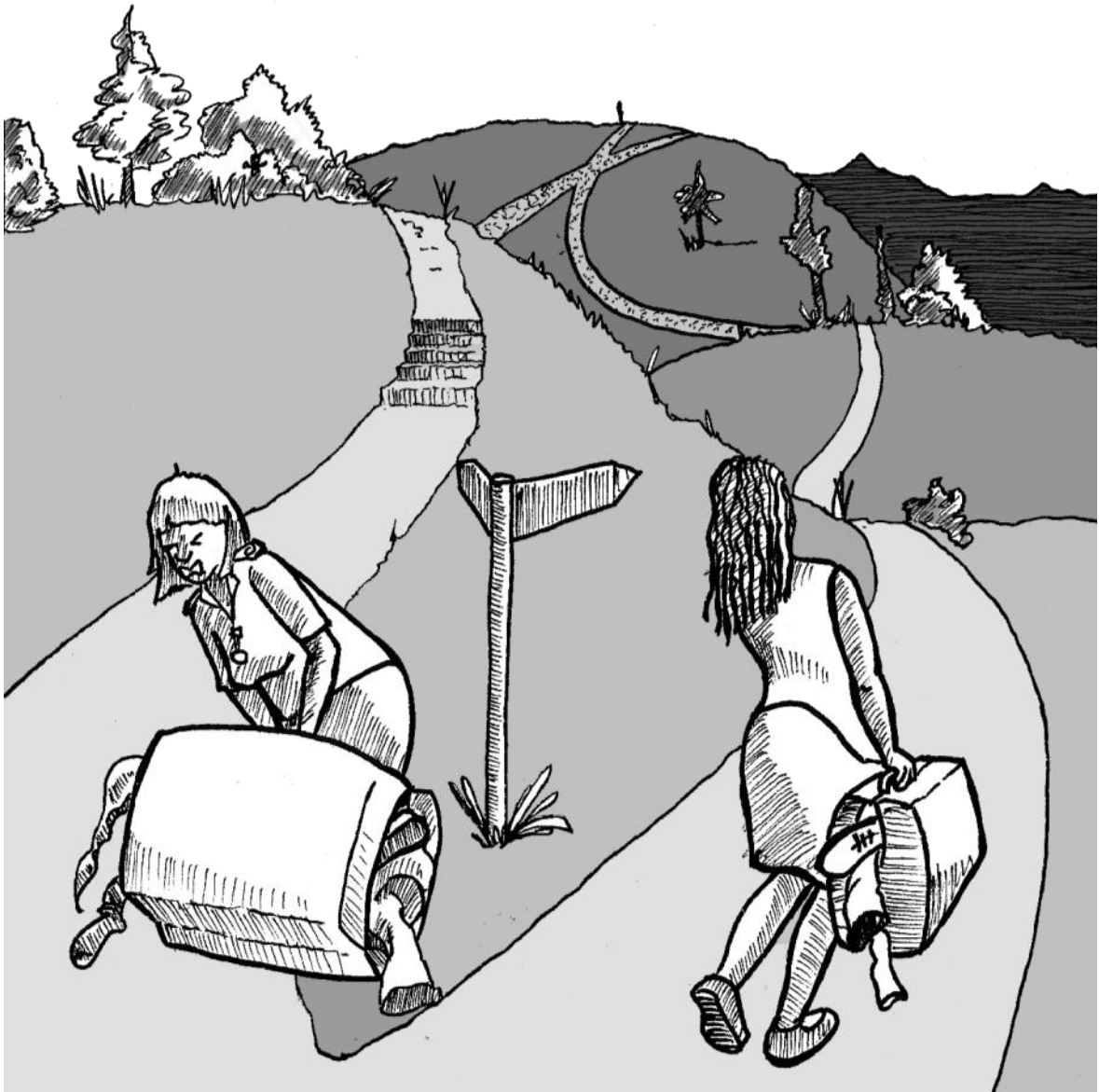
- Your personal problems are real and important, and it is important to get support to help you cope with these.
- Problems at work may feel overwhelming, but you can improve them by working together with colleagues and using the correct channels to raise your concerns.
- Being supportive of your colleagues can create a better working environment, and may mean that they are more supportive towards you. For example, offer to cover shifts, give positive feedback for work well done, offer to sit and listen to a colleague's problems or smile at your colleagues and greet them warmly.
- It can be easy for health workers' own negative feelings to spill over into interactions with mothers. Try to remain professional and separate personal problems from relationships with mothers.
- Remember that the most difficult, demanding, uncooperative mother may be the most afraid and vulnerable.
- As a health worker, try to develop your intuition and compassion to look beyond the woman's uncooperative behaviour, so you can understand the real problem. This is what makes the health profession so challenging, but also rewarding: it gives you the chance to be creative and to use your emotional intelligence to provide quality care for mothers.

2.5 A journey through 'secret histories'

In order to provide the mother with quality care and support, it is necessary to understand her untold story as best you can.

At the same time, you need to be aware of the stresses and strains in your own life and how they can affect your work. This can be difficult to do, but the next activity may help.

This activity is designed for health workers, and intended as a group activity. Half of the group 'become' Sr Sarah Jack, the other half 'become' Johanna Booi. Half-way through the journey, the groups exchange roles, becoming the other person.





Activity

Two sides to every story: The 'secret history' of Sr Sarah Jack and Johanna Booï

Step 1: Read through the following journeys of two women, a health worker and a pregnant mother. Imagine yourself as each of these women. You will find out a bit more about each woman as the journey progresses. Reflect on what you think your **feelings** and **needs** would be at each point along the way.

First antenatal visit

You are Johanna Booï from Township X. You are 23 years old with one child and are unbooked at 25 weeks pregnant. You arrive for your first visit at 10am at the clinic where you delivered previously.

You are Sr. Sarah Jack, a divorced mother of two children, aged 4 and 2. You are working two extra shifts this week to make enough money for rent. Johanna is 3 hours late for her first visit.

How do you feel? What do you need?

Second antenatal visit

You are one week late for your second appointment as your previous employer threatened to fire you for days of missed work. Now your contract is over and you are unemployed, but your neighbour wanted help with a casual laundry service this morning. This was the first opportunity for you to earn money in 2 weeks as your child had been sick at home with TB. The sister starts to ask why you did not come at the proper time.

The full quota of 18 new bookings was filled at 7:30am as usual. You are the only sister in the clinic and are half-way through seeing your patients. You have not taken tea yet. Johanna has a blank face when you ask why she did not attend her second appointment.

How do you feel? What do you need?

Third antenatal visit

You default the clinic date that was given to you as you were beaten up by your boyfriend the day before and had had to move out and stay with a friend in another township. You did not have money for taxi fare on that day. It is now 2 weeks later. You are still staying with your friend. You finally manage to attend for another clinic visit. The same nurse calls you into her cubicle.

You have had a bad night with a sick child. You had to get up at 4am to take him to your ex-mother-in-law to look after him for the day. Johanna tells you she no longer lives in the catchment area of your clinic.

How do you feel? What do you need?

Labour

You are back living with your boyfriend in Township X. You are 36 weeks pregnant now and had a huge fight with him last night. Your membranes ruptured at 5am. It is now 2pm. You have had to arrange childcare for child and have had to borrow money for taxi fare to take her to your mother. You arrive in the labour ward where you see the same sister.

You are on labour ward duty even though you have been working full shifts in the clinic as your colleague has gone off with her 4th migraine this month. You have just delivered a 15 year-old primigravida who swore at you throughout the labour. You see Johanna arrive and see from the notes that her membranes ruptured many hours ago.

How do you feel? What do you need?

Postnatal visit

After delivery, the baby was transferred to another hospital for respiratory distress and discharged 2 days later. You went home to your boyfriend's house only to hear that he said he is not the father. You have not been able to sleep at night even though you are exhausted. You attend the clinic on Day 4 for postnatal care. The same sister is on duty.

You have been called by the junior nurse in the postnatal clinic to give advice about the weight loss and dehydration of Johanna's baby. Johanna has said that she cannot breastfeed and requests help with getting formula.

How do you feel? What do you need?

Step 2: After thinking about Sr Jack's and Johanna's secret histories', write down your thoughts about how each of them are feeling. Then write down what they need.

Sr Jack

Johanna

How do you feel?

What do you need?

Conclusions

You may have come to the following conclusions from this exercise:

- Both Sr. Jack and Johanna are going through difficulties in their lives at the moment. They need to interact at an intimate level over important maternity care issues, yet neither of them is aware of the other person's distress.
- The strain of their personal lives may break down the vital relationships between them. This may discourage the nurse further and may also be dangerous for the mother and the baby. When women feel the disapproval and resentment of staff, they are far less likely to attend the clinic appropriately or report important medical information. This again can make the working conditions of the staff more difficult.
- Sr. Jack's secret history is a vital part of who she is. She deserves to have assistance for her problems. However, as a professional, Sr. Jack should try to separate her own issues from her interaction with Johanna. If not, the interaction may be destructive for both of them.



2.6 Summary

- The perinatal period is a major life change which can be very stressful.
- There are certain circumstances that can make mothers particularly vulnerable, such as teenage pregnancy, being in an abusive relationship or being HIV positive.
- Health workers are in a special position to have a positive impact on mothers' well-being and their ability to care for their infants and their development.
- Health workers also experience stress in both their professional and personal lives, and are in need of support, compassion and appreciation.
- It is important for health workers to be aware of the factors that are affecting them, such as the work environment, personal relationships or their emotional state.
- Health workers are likely to have their own expectations and attitudes about mothers in their care.
- By understanding a mother's untold or 'secret history', and by being supportive and non-judgemental about the mother's circumstances, health workers can be in a better position to give the mother improved quality care.

References

The information in this chapter draws from the following article:

Fisher J, Cabral de Mello M, Patel V, Rahman A, Tran T, Holton S, Holmes M (2012) Prevalence and determinants of common perinatal mental disorders in women in low- and middle-income countries: A systematic review. *Bulletin of the World Health Organization*. 90: 139-149.



Your notes

[illegible]

Maternal mental illness

This chapter helps you understand what mental illness is, and the common types of mental illnesses which can present during the perinatal period.

Learning Objectives

By the end of this chapter you will know:

- The difference between mental illness and mental distress
- Some reasons why mental illness is commonly overlooked
- Signs and symptoms of mental illness
- The types of mental illness that can occur during the perinatal period
- Who is likely to be at risk for developing mental illness
- Cultural expressions of mental illness and distress
- Why early diagnosis of maternal mental illness is important

3.1 Why is mental illness often overlooked?

Many people do not understand what mental illness is, or that it can be treated. When people feel very down for long periods of time, they often believe that this is 'normal' for them, that nothing can be done to feel better or that it is their own fault. Mental illnesses may not be recognised because of stigma, lack of knowledge about mental health and because of isolation.



Definition: stigma

Stigma is a severe social disapproval of personal characteristics or beliefs.

People with mental illness experience a great deal of stigma, which adds to the negative outcomes of the disorders. Some women may not want to report that they are feeling psychologically unwell because they feel ashamed and they fear that their baby will be taken away from them.

Health workers can also disapprove of people with mental illness, and as a result, do not feel comfortable giving care to them.

Lack of knowledge about mental health

Most health workers have been trained in a way that separates physical well-being from emotional well-being. This leads to the diagnosis and management of physical symptoms without understanding the influence of psychological factors.

Sometimes, physical problems result from mental illness. For example:

- Abdominal pains and gastrointestinal problems could be symptoms of anxiety
- Headaches, chest pain and nausea could also be signs of anxiety, particularly post-traumatic stress disorder (See below, Section 3.2)
- Obstructed labour could indicate the presence of Tocophobia, which is an extreme fear of labour (See below, Section 3.2)
- Chronic aches and pains can be symptoms of depression (See below, Section 3.2)

Women are more isolated during pregnancy

Pregnant women's social networks could be weakened because they are no longer at work or at school. Some women may no longer have the support of close relatives, such as refugees who have fled from other countries or women who have been abandoned by their partners. It is also common for rural women to leave their families and move to urban areas during pregnancy to access maternity care.

This means that there may not be anyone around to notice a mother's change in mood and emotional well-being, to provide support or to assist her in getting help.



Definition: isolation

Isolation refers to a lack of social interactions, contacts and relationships. This can be so, even if someone is physically surrounded by people.

3.2 Types of mental illness

Pregnancy and giving birth can be a stressful time, and it is common for women to feel down or anxious. In fact, many women feel emotional just after childbirth, and this is known as the 'baby blues'.

The 'baby blues'

The 'baby blues' is a temporary psychological state, which involves sudden mood swings (feeling very happy, then very sad), crying for no apparent reason, feeling impatient, unusually irritable, restless, anxious, lonely and sad. These symptoms last only a few hours or as long as 1 to 2 weeks after delivery, and do not always require treatment.

However, if these emotions and feelings become so bad that they interfere with a woman's daily life, and she has difficulty with carrying out her usual daily tasks, then it is possible that she is suffering from a mental disorder.

In general, mental disorders during and after pregnancy can be classified in two different groups: non-psychotic disorders and psychotic disorders.

Non-psychotic disorders are more common and typically refer to 'mood disorders' or 'emotional disorders', such as Depression or Anxiety. Psychotic disorders are less common but tend to be more severe, where the sufferer becomes out of touch with reality.



Definition: symptom

A *symptom* is a sign or feature indicating a condition of disease or illness.

Non-psychotic disorders

Depression (Major Depressive Disorder)

Depression is characterised by low mood, loss of interest and enjoyment, as well as reduced energy for at least two to four weeks. Other common symptoms of depression include:

- Extreme sadness, tearfulness
- Difficulty in concentrating, forgetfulness
- Disturbed appetite or sleep (too much or too little)
- Thoughts that one is not as good as others (low self-esteem)
- Feelings of guilt
- Helplessness and worthlessness
- Hopelessness about the future
- Irritability
- Extreme tiredness
- Loss of sex drive
- Many physical symptoms
- Ideas or attempts of self-harm or suicide

In severe cases, depressed people may have symptoms of psychosis.

Note

It is possible for a woman to suffer from both depression and another disorder at the same time, such as anxiety or alcohol and substance use disorder. In this case, symptoms from different disorders will be present. All of them must be addressed and treated to improve the woman's mental health.

Bipolar Affective Disorder ('Manic Depression')

A woman who suffers from Bipolar Disorder experiences extreme mood swings, from depression to mania, with a usual recovery stage between the two states.

The onset of manic symptoms can be very slow, and can take several weeks or months before it can be recognised.



Definition: mania

Mania refers to an extreme increase in energy and activity in a person suffering from Bipolar Affective Disorder. The period during which a person experiences mania is called a manic episode. Common symptoms of mania include:

- A very happy mood or irritability
- Rapid talking
- Not sleeping
- Boosted self-esteem
- Unrealistic plans or ideas
- Spending a lot of money
- Increased sexual energy or inappropriate sexual behaviour
- Little understanding that one is behaving in an unusual way

Anxiety Disorders

Anxiety is a common disorder in pregnant or postnatal women. It is characterised by an abnormal and great sense of uneasiness, worry or fear. Symptoms of anxiety include:

Emotional symptoms such as:

- Nervousness
- Worry
- Panic
- Irritability
- Feeling of dread
- Tiredness
- Fear of being alone

Physical symptoms such as:

- Sleep disturbance
- Physical tension
- Sweating
- Increased pulse
- Muscle tightness
- Body aches or stomach problems (e.g. feeling sick, diarrhoea)
- Difficulty concentrating

These symptoms are normal if there is a real threat present. However, when someone suffers from these symptoms in response to ordinary events, and the symptoms interfere with daily tasks, then it is known as Generalised Anxiety Disorder (GAD).

There are other types of anxiety disorders: Obsessive-Compulsive Disorder, Tocophobia and Post-Traumatic-Stress Disorder are discussed below.

Obsessive-Compulsive Disorder (OCD)

Obsessive-Compulsive Disorder, or OCD, is one of the more common mental illnesses occurring during the perinatal period. Women already suffering from OCD are likely to experience a worsening of symptoms during pregnancy.



Definition: OCD

OCD is characterised by obsessive thoughts and compulsive behaviour to relieve the stress associated with the obsessive thoughts. Symptoms can range from mild to severe.

Persons with OCD experience 'obsessive' or unwanted thoughts that occur repeatedly in their mind. For example, a woman with OCD may have:

- Constant fears that harm can come to herself or a loved one
- An unreasonable concern with becoming sick or infected with a disease
- An overwhelming need to do things correctly or perfectly

The woman experiences the disturbing thoughts again and again. They are unpleasant and they produce high levels of anxiety. These obsessions cause the woman to act out repetitive or 'compulsive' behaviours, such as:

- Washing hands often because of fear of contamination
- Checking and re-checking things
- Storing things unnecessarily or excessively
- Counting
- Making lists
- Repeating phrases to herself
- Following certain patterns of behaviour like a ritual

The woman performs these behaviours in the belief that these actions will prevent harm to herself or others, such as her child. These patterns provide relief from anxiety for a little while, but this relief is only temporary. These behaviours then become involuntary and difficult to control.

If severe and left untreated, OCD can severely affect a person's ability to function at work, school or at home. Sometimes, women with OCD can feel ashamed and are then less likely to look for help. It is therefore important to recognise these symptoms. OCD can be accompanied by depression, eating disorders, substance abuse, attention deficit disorder, or another anxiety disorder.

Tocophobia

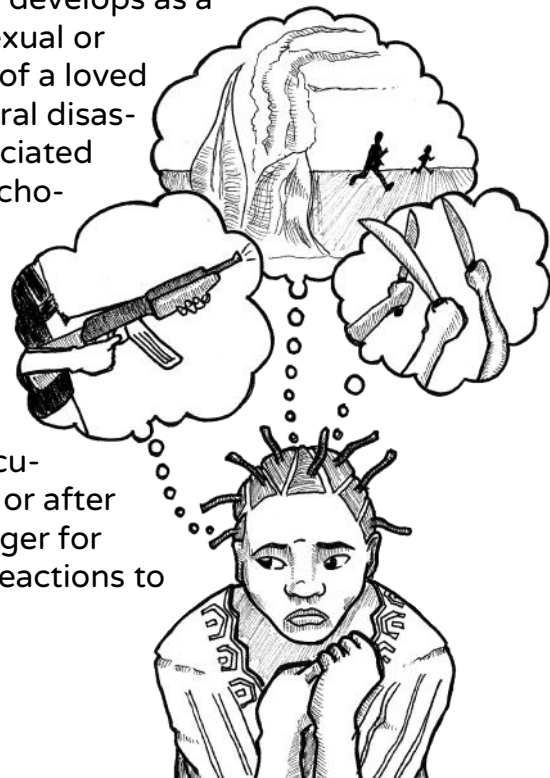
Tocophobia is an abnormal and persistent fear of childbirth. It occurs in all cultures and social groups and affects one in seven women. It can be related to previous traumatic birth experiences, sexual abuse or rape. Sometimes, it can lead to a frightening or traumatic delivery. In such cases:

- The mother may be 'unco-operative' – panicking or displaying aggression
- She may experience an obstructed or prolonged labour
- She may be at increased risk of needing a Caesarean section

Post-Traumatic Stress Disorder (PTSD)

Post-Traumatic Stress Disorder (PTSD) develops as a result of a traumatic event such as a sexual or physical attack, the unexpected death of a loved one, an accident, war, torture or a natural disaster. The traumatic event is usually associated with serious physical, emotional or psychological harm, or the threat of harm.

Women who have experienced rape, sexual or emotional abuse, crime, torture or war, or previous traumatic birth experiences (such as previous emergency Caesarean or stillbirth) are particularly at risk of developing PTSD during or after pregnancy: pregnancy can act as a trigger for negative memories of, and emotional reactions to past traumas.



Definition: PTSD

PTSD is a common anxiety disorder, where a traumatic event or extreme hardship from the past is repeatedly re-experienced emotionally.

Symptoms of PTSD include:

- *Repeatedly re-living the traumatic event through realistic nightmares or flash-backs:* a mother with PTSD may have very strong mental and physical reactions if reminded of the event, such as sweating, increased heart-rate, screaming and uncontrollable crying.
- *Avoidance:* a mother with PTSD may avoid thoughts, feelings or conversations that remind her of the event. This can lead to her becoming numb to her surroundings, losing interest in important activities and feeling that there is nothing to look forward to in the future.
- *Increased agitation:* she can show excessive emotions, feel that she can never relax and must be on guard all the time; she may have trouble sleeping, be easily startled or 'jumpy' and have angry outbursts.

There are also other physical symptoms, such as:

- Headaches
- Increased blood pressure and heart rate
- Rapid breathing
- Muscle tension
- Nausea
- Diarrhoea or other gastro-intestinal distress
- Immune system problems
- Dizziness
- Chest pain
- Discomfort in other parts of the body

PTSD can lead to pre-term delivery. It can also occur co-morbidly with depression, other anxiety disorders, alcohol or other substance use disorders.



Definition: co-morbidity

Co-morbidity refers to the presence of one or more mental or physical disorders at the same time. Often co-morbid disorders affect each other negatively.

Psychotic disorders

Postnatal psychosis is the most common psychotic disorder in the perinatal period. However, other mental disorders, such as Bipolar Affective Disorder, or Alcohol or Substance Use Disorders, can lead to psychotic symptoms, especially when the symptoms are severe and not treated.

Postnatal Psychosis

The onset of postnatal psychosis is often sudden, within a week of birth, and can become severe quickly. Psychotic symptoms include:

- Delusions (false beliefs) , such as thinking that others are trying to harm her
- Hallucinations (false perceptions not shared by others), such as seeing, hearing, smelling or tasting things that are not there
- Loss of sense of reality



Definition: post-natal psychosis

Postnatal psychosis is the term used to describe the onset of psychotic symptoms following childbirth.

Psychotic symptoms can also lead to difficulties with social interactions. A woman with severe symptoms can also have problems with carrying out daily activities. Other symptoms of postnatal psychosis can include:

- Strange behaviour e.g. talking to herself
- Inappropriate emotions e.g. laughing at something sad
- Violent behaviour
- Agitation and restlessness
- Poor concentration
- Lack of motivation
- Social withdrawal
- Ignoring responsibilities at work or at home

False beliefs are very real to a woman, and cannot be overcome through reasoning. Also, hallucinations, such as hearing voices, can feel very real to the woman, and frighten her. For example, it is not uncommon for these voices to 'instruct' to self-harm or harm others. Remember that a woman who hears voices might look like she is talking to herself, but in fact she is answering the voices.

Other disorders can lead a woman to experience psychotic symptoms, such as alcohol or drug abuse, or withdrawal from alcohol or drug abuse. In severe cases of bipolar disorder, women can also have hallucinations or delusions during the period of depression or mania. It is important to understand the differences between postnatal psychosis and psychotic symptoms related to other disorders, head injury or medication, as these do not require the same treatment.

Alcohol and Substance Use Disorders

Some women may try to cope with stress, anxiety or depression with alcohol or other types of substances. For this reason, it is common for women who suffer from a mental disorder to also present with alcohol and substance use disorders. On the other hand, alcohol and substance misuse can also lead to the development of a mental disorder or symptoms of mental illness (e.g. depression, hallucinations, memory loss).



Definition: dependence

Dependence refers to when a person starts using alcohol or substances and develops a need to continue, both physically and psychologically. When a person is dependent and stops drinking alcohol or taking substances, the person shows withdrawal symptoms such as:

- Trembling hands
- Sweating
- Vomiting
- Increased blood pressure
- Agitation

It is commonly accepted by health workers that any use of alcohol or substances during pregnancy is not recommended, in particular for the development and outcomes of the foetus. However, the use of alcohol or other substances becomes particularly harmful to a woman when:

- It is a problem at work, at home, with friends or in the community - violent and aggressive behaviour (e.g. getting into fights); not being able to care for children
- It has negative effects on her physical health - confusion, blackouts, liver or heart failure, sleep problems

- The woman is physically and mentally dependent on the substance
- Financial problems and poverty are made worse due to the cost of alcohol/substances and the inability to work

During pregnancy, it has been shown that women can be particularly motivated to quit or reduce the use of alcohol and substances. This provides health workers a valuable opportunity to intervene at this time.

In general, maternal mental illnesses can be better understood when listing symptoms on a scale of severity. The table on the next page compares the 'baby blues', depression and anxiety, and postnatal psychosis, showing them on a scale from 'mild' to 'severe' conditions.

3.3 Signs and symptoms of maternal mental illness and distress

Identifying signs of mental distress and mental illness

Health workers need to be able to identify symptoms of the different types of mental illness.



Definition: mental distress

Mental distress includes a range of possible symptoms such as: confused emotions, rage, anxiety and depression. However, a person with mental distress is not considered 'ill' in a medical sense because the distress does not last long enough, and functioning is not affected.

It is important to note that many of the usual physical symptoms of pregnancy can be confused with the symptoms of mental health problems. For example, changes in sleep or appetite, aches, pains and tiredness are common symptoms in pregnant women, but they can also indicate possible mental distress or illness.

Mild to severe mental disorders

Severity	Mild	Mild to Moderate	Severe
Conditions	<i>Baby Blues</i>	<i>Non-psychotic disorders (e.g. Depression & Anxiety)</i>	<i>Psychotic disorders (e.g. Postnatal Psychosis)</i>
About	• Affects 60-80% of women • Considered 'normal' emotional response, which usually resolves with general support • Usually lasts about 2-3 days, but can last up to 6 weeks	• Affects 10 – 50% of women • Depression and anxiety can occur separately or together • Many women suffer with depression and/or anxiety for much of their lives and these symptoms sometimes get worse around pregnancy • Maternal depression and/or anxiety usually start during pregnancy, meaning that there is an opportunity for health workers to pick up problems early and manage them appropriately	• Affects 0.1 – 0.2% of women • The mother can be very agitated or withdrawn • Staff may not identify the disorder and think the mother is just 'being difficult' • Requires urgent psychiatric attention
Symptoms	• Insomnia • Exhaustion • Tearfulness • Agitation • Confusion • Feeling overwhelmed • Anxiety/worry	Emotional • Tearfulness, sadness • Anger, irritability • Ideas of suicide • Difficulty coping • Rumination – thinking or worrying about the same thing all the time • Fear of being alone/with others • Panic Physical • Sleep & appetite disturbance (an ↑ or ↓ in either) • Physical complaints – pain, heart racing, weakness etc. • Slowing down/blunted • Loss of energy, tiredness • Loss of sex drive Cognitive (thoughts) • Low self-esteem • Feelings of hopelessness • Feelings of guilt and inadequacy • Feeling overwhelmed, out of control • Decreased concentration • Decreased motivation • Decreased enjoyment in things • Lack of joy towards infant • Thoughts of self-harm/harm to infant	• Loss of sense of reality • Hallucinations • Delusions • Paranoia • Distorted thinking • Violent behaviour • Obsessive-compulsive behaviour • Homicidal or suicidal thoughts and behaviour • Panic • Agitation or 'locked-in'
Onset	Day 3 or 4 after birth (linked to hormonal shifts during breast-feeding)	Birth to 12 months (or during pregnancy)	• Day 3 to 1 month • Often very rapid onset

A health worker needs to be able to tell which women are experiencing the 'usual' symptoms of pregnancy and which women need help for their emotional well-being. Below are some useful tips for picking up mental distress and mental illness:

- Does the mother return often with a range of different physical symptoms, such as aches and pains?
- Has she visited many different health workers?
- Is she showing signs of false labour? This may be a sign of underlying distress.
- A woman's body language and behaviour can often show that she is 'sad' or 'worried'. For example:
 - Is she taking care of her appearance?
 - What is her facial expression like? Does she look sad or distressed?
 - What does her voice sound like? Does she sound distressed?
 - Does she avoid eye-contact?
 - What is her posture like? Does she seem low or dejected?

Another sign could be that the mother is talking about many other problems in her life, and not just her health. These can include:

- Work issues
- Problems with relationships
- Problems with her other children

The interaction between the mother and the baby can give you clues about her emotional state. The mother could be experiencing mental distress if:

- Breastfeeding is difficult, especially if the difficulty is related to low self-esteem, hopelessness or excessive worrying
- The mother does not play or communicate with her child
- The mother shows hostility to the child
- The mother's interaction with her baby is either remote or intrusive
- The mother repeatedly describes the baby as 'irritable', 'fussy' or 'colicky'



Definition: intrusive interaction

A depressed mother shows an *intrusive interaction* with her child when she is too rough, for example when she is tickling, poking, tugging or fussing over the baby.

Note

Trust your own 'feeling' about the mother. Can you sense that she feels down, agitated or overwhelmed? Does she make you feel down? Take note of how you feel when you are with her.

Symptoms in traditional cultures

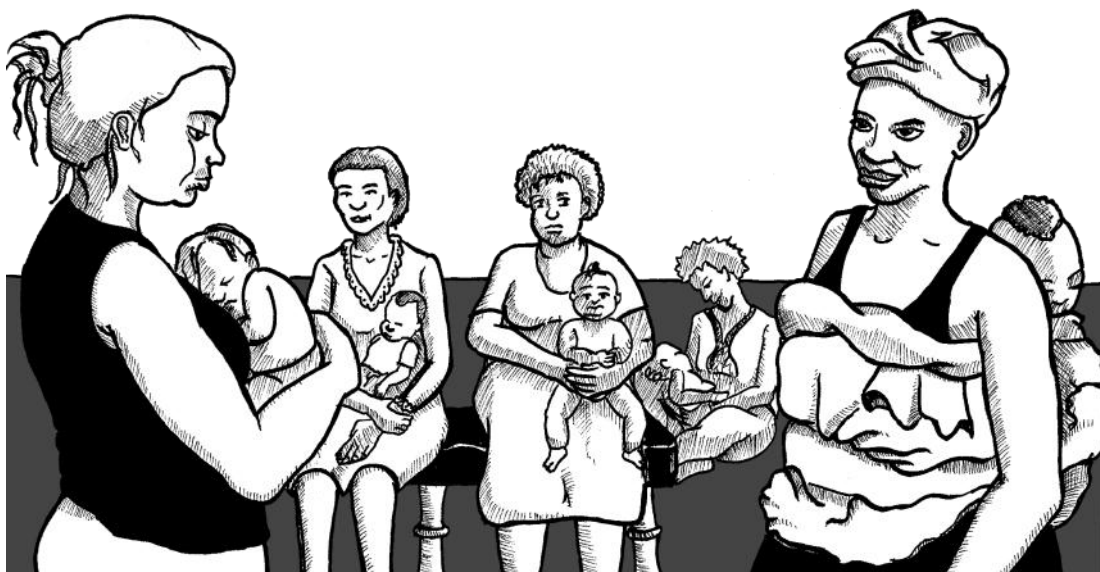
The way people experience illness is linked to their social and cultural backgrounds and the language they use to describe it.

Doctors, nurses and health workers in general are usually trained in a clinical setting and understand illnesses in a medical sense. However, people from other cultures may have a different way of understanding illnesses. This means that some people might describe mental illness in different ways than you would.

How do you identify symptoms in mothers of a different culture?

Women from different cultures may have a different set of beliefs about mental illness. They may describe their emotional distress in terms of ancestors, spirit possession, contamination, curses, or poisoning. Try to find out a bit about these beliefs from your friends and colleagues.

In some cultures, women do not have a 'language' for mental illness, or a way of expressing how they feel. Instead, they 'speak with their body'. For example, they may speak of pain, tiredness, or general physical symptoms. It is important to be aware of that, as this can tell you a lot about their mental state.



Expressing mental distress in physical terms

Whether women are from a different culture or not, they may speak of mental illness in physical terms. A reason for this is that it may be easier for some women to discuss physical problems compared to mental ones. In the same way, health workers sometimes prefer, and find it easier to deal with physical problems, compared to mental ones.

A woman may use physical health problems as a 'call for help' from health workers. This may be her way of making contact with a health worker whom she believes can help her with her 'real' underlying problem. Or, she may not be aware that there is an emotional part to her physical problem.

Look out for these presenting symptoms which could indicate mental distress:

- Fear, 'butterflies', worrying about things and aggression could indicate anxiety.
- Tiredness or a lack of energy could indicate depression.
- Stories about problems with relationships, work or with other children could indicate depression or anxiety.
- General words such as 'stress' or 'worry' or 'thinking too much' are also often used to indicate emotional distress.

Beware the 'door handle' sign!

Often, the 'real' problem is revealed when the woman has her hand on the door handle. She is about to leave and so feels that it is safe to raise her real problems. She then has the option of 'running away' or avoiding the problem because she is halfway out the room. This can be the most important part of the consultation. By gently drawing the woman back into the room and consultation, she may be able to open the discussion on the 'real' problem.

Note

Mothers could be used to consulting with others for help, such as traditional healers or family members. You can often overcome cultural barriers with mothers in your care by treating them in a gentle and non-judgmental way.

3.4 Why is an early diagnosis so important?

It is extremely important to diagnose mental illness in women as early as possible. There are effective treatment options available, which can lead to long-term benefits for the mother and child. Without treatment, the mother's mental illness may become worse. This can have several negative outcomes, such as:

- Increasing suicide risk
- Increasing chances of substance or alcohol misuse
- Increasing risk of harming the child (infanticide or child abuse)
- The infant failing to thrive (not grow)
- Poor cognitive development in the infant
- Difficulties forming attachments (developing a close relationship between mother and child)
- Behavioural problems in the child
- Mental illness in the child which could continue into childhood and adolescence



Definition: cognitive

The term *cognitive* refers to processes of the mind, including how people think about, learn about, remember, and perceive information.

3.5 How can you help women with mental health problems?

- Women who are distressed or suffer from a mental health problem need someone who can listen, guide them and provide information. They can feel isolated and vulnerable and need to be encouraged to make social connections to form support systems.

- They require different types of treatment and care, depending on the severity or level of their distress.
- Information can empower women and help them to feel in control of their situation. Listening skills and empathy, however, are also vital tools to help mothers in distress.

Note

Women need someone to help them cope during the difficult perinatal period. **Chapter 6** explains how to provide supportive care to pregnant women with mental health problems.

3.6 Summary

- Many people do not understand what mental illness is, and that it can be treated.
- The main reasons for not recognising mental illnesses are stigma and a lack of knowledge about mental health.
- Types of mental illness common during the perinatal period are depression and anxiety. Other illnesses that could occur during this time include postnatal psychosis, obsessive-compulsive disorder, tocophobia and post-traumatic stress disorder.
- Health workers need to be able to identify symptoms of the different types of mental illness during and after pregnancy.
- Many of the usual physical symptoms of pregnancy can be confused with the symptoms for mental health problems.
- People of different cultures may describe mental illness in different ways.
- It is important to diagnose mental illness as early as possible as there are effective treatment options available. This can contribute to long-term benefits for the mother and child.

References

The information in this chapter draws from the following articles:

Anderson CM, Robins CS, Greeno CG, Cahalane H, Copeland VC, Andrews RM (2006) Why lower income mothers do not engage with the formal mental health care system: perceived barriers to care. *Qualitative Health Research*. 6(7): 926-943.

Meintjes I, Field S, Sanders L, van Heyningen T, Honikman S (2010) Improving child outcomes through maternal mental health interventions. *Journal of Child and Adolescent Mental Health*. 22(2): 73-82.



Your notes

Screening for maternal mental illness: a relationship between you and the mother

This chapter outlines why pregnant women should be screened for mental illness and give tips on how to screen.

Learning Objectives

By the end of this chapter you will know:

- The importance of screening pregnant women for mental illness
- The steps involved in screening
- How to use three different mental health screening tools

4.1 Why screen pregnant women for mental illness?

During pregnancy, women usually use the health system regularly. For some women, the only time they come into contact with health workers is when they are receiving antenatal care.



Definition: screening

Screening is a strategy used to detect an illness in a large group of individuals, such as mothers attending antenatal clinics. It is usually done using a questionnaire.

If someone screens positive (above a cut-off score), it is likely that she has mental illness, but this is not definite. If someone screens negative (below cut-off score), it is likely that she does not have mental illness, but this is not definite. Your certainty in either case depends on the screening tool used and the population being screened.

A mental health *diagnosis* can only be made by a mental health professional or by a diagnostic assessment.

This provides health workers with a special opportunity to assist women who are experiencing mental health problems.

It is routine for health workers to screen for medical problems during antenatal visits (e.g., anaemia, syphilis, Rhesus disease). As there is a high prevalence of maternal mental health problems and long-term consequences for women and their children (See **Chapter 1**), screening for mental illness could also be part of every woman's routine health care in the perinatal period.

Mental health screening during pregnancy can have a number of positive impacts:

- Screening occurs in a familiar and non-threatening environment
- Women can avoid the stigma associated with seeking help for mental health problems
- Women do not have to spend extra time and money to access mental health care

Note

During regular antenatal visits, health workers can help women who need mental health care but who would not otherwise have access to help.

4.2 The screening process

Before starting screening

Before screening can be started, a referral system must be in place so that those women who are at risk or experiencing symptoms of mental illness can be appropriately referred to support groups, counsellors, psychiatrists, mental health nurses, social workers or any other service. See **Chapter 5** for suggestions regarding referrals for your particular setting and community.

Who do you screen?

Your clinic or facility may not be able to screen all women who are attending antenatal care. Where there are not enough resources, certain high-risk groups may be selected for screening. High-risk groups that could be prioritised for screening include:

- Adolescents
- HIV-positive women
- Poor women
- Women with social problems
- Women that are 'worrying' or who seem 'stressed'
- Women with a past or present history of mental illness

How do you screen?

There are some simple steps you can follow which can help you to make the screening process more effective.

Note

It may be easier for staff, and more acceptable to the mothers, if you make mental health screening part of routine booking procedures or history-taking.

Step 1: Explain why you are screening

A useful thing to say is that you are concerned about the mother's mental health and her physical health. Explain to her that the questionnaires could help you discover if she needs some extra support. This support may not be available at your facility, but by finding out what she needs, you can refer her properly.

Some examples of what you could say to the mother:

- Here at _____ clinic we are not only interested in your physical health, we are also interested in your emotional well-being.
- The questionnaire helps us to know how you are feeling inside.
- The questionnaire helps us decide whether we should offer you extra support, like in the form of counselling for example.
-



Definition: booking

Booking generally refers to a woman's first official antenatal appointment at a health care facility. This is when the midwife or nurse collects background information, and schedules the rest of the client's maternity care.

Step 2: Explain that screening is voluntary and not compulsory

It is a good thing to assure the mother that she will still receive good care if she does not want to be screened for mental illness. Assure her that it is her decision to make, not yours.

Step 3: Discuss confidentiality

Explain to the mother that everything you discuss, including the screening results, remains strictly confidential. Let her know that only the clinic staff will have access to the completed screening forms. If possible, arrange for the forms to be stored in a locked cabinet, and inform the mother of this.



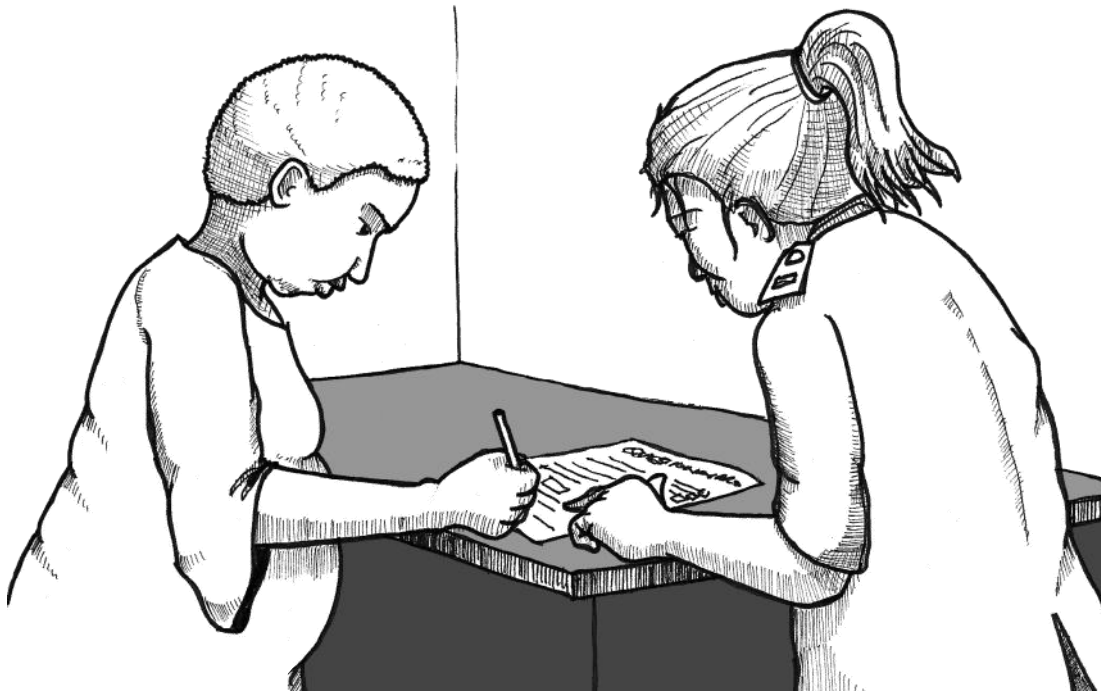
Definition: confidential

Confidential means that the information the mother gives to you remains private. Only authorised health workers will have access to this information when it is necessary for her care. It should be made clear that you will not discuss this information with her partner, family, friends, or anyone other than those involved in her health care.

Step 4: Ensure privacy

To ensure confidentiality, the screening should be conducted privately. This means that no partners, mothers or other people must be present while the mother fills in the questionnaire. Someone looking over the shoulders of a mother during screening may cause her to feel pressured to answer 'properly' and not necessarily how she feels.

Give the mother the choice of filling the form in either by herself, with support, or verbally with you filling in the answers.

**Step 5: Language**

If the mother chooses to fill in the questionnaire by herself, ask her which language she would prefer. Ensure that your screening forms are available in the languages spoken by the mothers who attend your clinic (For examples, see the Resources section at the end of the handbook).

Step 6: Check the mother's level of literacy

Some women may not be able to read and write well. A friendly way of helping the mother could be to say 'Please call me to help you if you have any problem completing the questionnaire.'

Step 7: Check that the form has been filled in correctly

Sometimes items are left out by mistake. Sometimes they are avoided on purpose. If the questionnaire was not filled completely, ask the mother if there is anything else she would like to add.

Step 8: Try to score the questionnaire

Try to score the questionnaires while the mother is still in the clinic or waiting to see you. You may not get another chance. You can also complete any information (such as age, gestation age, contact details etc.) which the mother may have missed and make referral arrangements more easily while she is in the clinic.



Note

Your clinical judgement may override the screening guidelines. If you feel the mother is experiencing a lot of distress or has a strong risk for this, you should feel free to offer referral, even if she does not make the cut-off score.

Step 9: Explain the result of the score to the mother

A score below the cut-off does not necessarily mean that the mother is 'fine'. Simply explain that it means you will not suggest referral at this stage. However, also explain that she is free to request help or referral if she would like this – either now or at another time.

Explain to a mother with a score at or above the cut-off, that you are concerned about her. You could 'normalise' the situation by saying that many of the mothers in your clinic, who score above the cut-off, do well with some extra support.

Step 10: Referral

If you do offer a referral, explain that this is voluntary. Explain to the mother what she can expect when she is referred to the counsellor, service or organisation. More information on how to refer is in **Chapter 5**. More information about the counselling process can be found in **Chapter 6**.

Offer an open-door policy. This allows a mother, who does not take up the referral the first time, to change her mind at a later stage and to return to you. It is useful also to have an open-door policy for mothers who do not arrive for their referral appointments. You cannot always know the reasons for why they were not able to attend their appointments.



- Contact the psychiatric nurse, midwife, sister, or doctor in charge.
- Do not leave the mother alone, even if the screening score is 'normal'.
- **Be prepared for emergencies:** Find the names and numbers of appropriate people and organisations to contact in case of an emergency and keep them in a handy place.

This image shows a single sheet of white paper with horizontal blue ruling lines. The lines are evenly spaced and run across the width of the page. There are approximately 20 lines visible. The paper has a slight shadow on the right side, suggesting it's resting on a surface.

4.3 Screening tools

The Edinburgh Postnatal Depression Scale (EPDS)

The EPDS is a set of questions used to assess whether or not a woman may be suffering from depression or anxiety, or both. It can be used antenatally and postnatally. It is one of the most widely accepted tools in the world. It has been validated through research in many different cultures and countries.



Definition: validated

A tool that has been *validated* when that the tool has been tested against a diagnostic 'gold standard' assessment, and proven to be an adequate screening tool for assessing depression and anxiety.

Note

The version of the EPDS provided here has been adapted for use in South Africa, and specifically for use in a Midwife Obstetric Unit in Cape Town. It is based on the work of: Cox JL, Holden JM & Sagovsky R (1987) Detection of postnatal depression, development of the 10 item postnatal depression scale. *British Journal of Psychiatry*. 150: 782-6.

Health workers may use this questionnaire but only if it is copied and used in full. **Do not use the copy on the next page.** Rather, copy the questionnaires **without scores** in the Resources section at the end of this handbook.

The Edinburgh Postnatal Depression Scale

My feelings now that I am pregnant or have had a baby.

As you are pregnant or have had a baby, we would like to know how you are feeling. It may help us in choosing the best care for your needs. The information you provide us will be kept private and confidential.

There is a choice of four answers for each question. Please circle the one that comes closest to how you have felt *in the past seven days*, not just how you feel today.

[SCORES ON RIGHT HAND SIDE]

In the past seven days:

1. I have been able to see the funny side of things:

- | | |
|----------------------------|-----|
| As much as I always could | [0] |
| Not quite so much now | [1] |
| Definitely not so much now | [2] |
| Not at all | [3] |

2. I have looked forward with enjoyment to things:

- | | |
|------------------------------|-----|
| As much as I ever did | [0] |
| A little less than I used to | [1] |
| Much less than I used to | [2] |
| Hardly at all | [3] |

3. I have blamed myself when things went wrong, and it wasn't my fault:

- | | |
|-----------------------|-----|
| Yes, most of the time | [3] |
| Yes, some of the time | [2] |
| Not very much | [1] |
| No, never | [0] |

4. I have been worried and I don't know why:

- | | |
|----------------|-----|
| No, not at all | [0] |
| Hardly ever | [1] |
| Yes, sometimes | [2] |
| Yes, very much | [3] |

5. I have felt scared or panicky and I don't know why:

Yes, quite a lot	[3]
Yes, sometimes	[2]
No, not much	[1]
No, not at all	[0]

6. I have had difficulty in coping with things:

Yes, most of the time I haven't been managing at all	[3]
Yes, sometimes I haven't been managing as well as usual	[2]
No, most of the time I have managed quite well	[1]
No, I have been managing as well as ever	[0]

7. I have been so unhappy I have had difficulty sleeping:

Yes, most of the time	[3]
Yes, sometimes	[2]
Not very much	[1]
No, not at all	[0]

8. I have felt sad and miserable:

Yes, most of the time	[3]
Yes, quite a lot	[2]
Not very much	[1]
No, not at all	[0]

9. I have been so unhappy that I have been crying:

Yes, most of the time	[3]
Yes, quite a lot	[2]
Only sometimes	[1]
No, never	[0]

10. I have thought of harming myself or ending my life:

Yes, quite a lot	[3]
Sometimes	[2]
Hardly ever	[1]
Never	[0]

Step 1: Ask the mother the questions or leave her to complete the questionnaire on her own

Make sure that she has ticked all the questions. The EPDS questionnaire is made up of ten multiple-choice questions. These questions ask the mother about how she has felt in the last seven days. Each question has four possible answers. These answers are given score values, from 0 to 3. The scores indicate how strongly the mother was feeling about something. A higher score indicates a more serious symptom.

Step 2: Some questions might require double-checking

Question 7: 'I have been so unhappy I have had difficulty sleeping.'

Check if the mother is having difficulty sleeping because of her feelings, or because of being physically uncomfortable due to the pregnancy.

Question 10: 'I have thought of harming myself or ending my life.'

If the mother gives an answer with a score of 1, 2 or 3 on this question, you must ask her further questions to determine if she is suicidal.

Step 3: Scoring

After the client has completed the questionnaire, score her answers. The example of the EPDS given on the previous two pages includes scores. Note how the ordering of highest or lowest score is not the same for each question. Add up each of the scores the mother got for the ten questions. The TOTAL score is important.

Step 4: Add up the scores

If TOTAL score is:

- **Below 10**
= the mother is probably fine and does not need to be referred
- **Above 10**
= she is at risk of depression and anxiety and may need to be referred
- **13 and above**
= the women needs to be referred



If the mother has previously attempted suicide, or has a thought-out plan for how she may harm herself, you need to refer her **URGENTLY**.

It does not matter what her overall score is.

The Risk Factor Assessment (RFA)

This questionnaire was developed by the PMHP team in Cape Town. While the EPDS screens for symptoms of maternal mental illness, this questionnaire assesses the risk factors for mental illness.

This is a screening tool which is quick and easy to use in busy settings. It is important to note that this tool has **not yet been validated** like the EPDS. However, it has been developed based on international research and on the PMHP experience with women during the perinatal period. The PMHP is conducting a study to find out if this is a valid tool to use. Research shows that it is better to screen for both mood symptoms and risk factors. We have found it very helpful to combine the EPDS with the RFA tool, although this may take too long for some settings.

The Risk Factor Assessment (RFA)		
My situation now that I am pregnant/have had a baby.		
We are interested to find out how your situation is in your pregnancy/now that you have had your baby. This questionnaire may help us suggest extra care for you if necessary. Your answers will be kept confidential. Please answer either yes or no to the following questions. Tick the box.		
Question	Yes	No
1. I feel pleased about being pregnant/having had a baby.	Yes	No
2. I have had some very difficult things happen to me in the last year (e.g. losing someone close to me, losing my job, leaving home etc.)	Yes	No
3. My husband/boyfriend and I are still together.	Yes	No
4. I feel my husband/boyfriend cares about me (say 'no' if you are not with him anymore).	Yes	No
5. My husband/boyfriend or someone else in the household is sometimes violent towards me.	Yes	No
6. My family and friends care about how I feel.	Yes	No
7. I have experienced some kind of abuse in the past (e.g. physical, emotional, sexual, rape).	Yes	No
8. My family and friends help me in practical ways.	Yes	No
9. On the whole, I have a good relationship with my own mother (indicate 'no' if your mother has passed away).	Yes	No
10. I have experienced one of the following in the past: miscarriage, abortion, stillbirth, or the death of a child any-time after birth.	Yes	No
11. I have had serious depression, panic attacks or problems with anxiety before.	Yes	No

Step 1: Ask the mother the questions or leave her to complete it on her own

Make sure that she has ticked all the questions.

Step 2: Scoring

Questions 1, 3, 4, 6, 8 and 9

- **NO** answers to these questions indicate the woman is at risk
- give a score of 1 for each of these questions if the answer is NO
- **YES** answers to these questions indicate low risk
- give a score of 0 for each of these questions if the answer is 'yes'.

Questions 2, 5, 7, 10 and 11

- **YES** answers to these questions indicate the woman is at risk
- give a score of 1 for each of these questions if the answer is YES
- **NO** answers to these questions indicate low risk
- give a score of 0 for each of these questions if the answer is NO

Question	Yes	No
1	0	1
2	1	0
3	0	1
4	0	1
5	1	0
6	0	1
7	1	0
8	0	1
9	0	1
10	1	0
11	1	0

Step 3: Add up the scores

Based on the scoring instructions, add up the scores. Use the table to the left as a guide by counting the answers in the shaded areas. If a woman's total score is **3 or above** she needs to be referred to a counsellor.



Because this assessment identifies serious risk factors, a **referral is needed with a score of 3 or above**, no matter what the mother's EPDS score is.

The 5-item Short Risk Factor Screen

This shorter risk factor screening tool was developed in 2007 by the PMHP, **but it has not been validated.**

Information was collected from about 1000 women who had completed the EPDS and the 11-item RFA. By analysing the RFA against the EPDS, 5 questions were identified which could predict if a woman was at risk of mental illness. A research study is being done to try and validate this new short tool.

Question	Yes	No
1. Have you had some very difficult things happen in the last year?	Yes	No
2. Are you pleased about this pregnancy or now that you have had your baby?	Yes	No
3. Is your partner supportive?	Yes	No
4. Have you had problems with things like depression, anxiety or panic attacks before?	Yes	No
5. Is your partner or someone at home sometimes violent towards you?	Yes	No

For total, add the answers according to the shaded areas in the table above.

TOTAL: _____ / 5

Other risk? Yes / No

Action

Step 1: You may ask the mother the questions or leave her to complete the form on her own.

If a mother is finding it difficult to answer the questions, you may need to explain each one. Some examples are outlined here.

1. Have you had some very difficult things happen in the last year? For example:

- Losing someone close
- Losing a job, or a partner losing a job
- Moving home
- Illness in the home
- Divorce
- Being a victim of crime

2. Are you pleased about this pregnancy / now that you have had your baby?

- If still pregnant, this question refers to the current time, not how she may have felt when she found out she was pregnant.
- If the mother has already had her baby (postnatal), ask her the second part of this question: 'Are you pleased now that you have had your baby?'

3. Is your partner supportive?

Does the woman's partner provide the following type of support:

- Emotional: cares about her and/or the baby
- Financial: contributes money
- Practical: helps out at home

4. Have you had problems with things like depression, anxiety or panic attacks before?

Find out if the mother has had or has any significant history of mental illness where her symptoms:

- Required treatment (of any kind)
- Affected functioning at work or at home
- Caused her to take drugs or alcohol 'to cope'
- Affected her ability to care for herself or her family
- Lasted 6 months or longer

5. Is your partner or someone at home sometimes violent towards you?

This question refers to anyone, not just the mother's partner. It includes threats of violence.

Step 2: Add up the scores

- Give 1 point for each answer in the shaded boxes.
- 1 or above = risk for mental illness, the woman may need to be referred.

Note

If your unit has few resources for referral, perhaps raise the cut-off score and use 2/5 or 3/5.

Step 3: Other risks

Make a note of other risk factors such as adolescent pregnancy, refugee status, HIV status etc. See **Section 1.1** for a list of other risk factors.

4.4 Summary

- Screening can be an efficient way for busy health workers to identify women who are likely to suffer from a mental illness or who are at risk of developing a mental illness.
- Making screening a routine part of pregnancy care makes it more acceptable for mothers and health workers.
- Routine screening allows for many vulnerable mothers to be referred to other services and to have access to supportive care.
- Practical tips can make screening easier and more effective.

References

The information in this chapter draws from the following articles:

Cox JL, Chapman G, Murray D, Jones P (1996) Validation of the Edinburgh Postnatal Depression Scale (EPDS) in non-postnatal women. *Journal of Affective Disorders*. 39(3): 185-189.

Lawrie TA, Hofmeyer GJ, de Jager M, Berk M (1998) Validation of the Edinburgh Postnatal Depression Scale on a Cohort of South African Women. *South African Medical Journal*. 88(10): 1340-1344.

[illegible]

How to refer a woman with mental health problems

This chapter highlights several practical tips for making referrals and what you can do when these are not possible.

Learning Objectives

By the end of this chapter you will know:

- What steps to follow when you have identified that the mother has a mental health problem
- How to refer the mother to the services and support she needs in the most effective way
- What you can do for the mother if there are no referral services available

5.1 Types of referrals

You have screened the mother for mental health problems, have identified risk factors that might make her vulnerable for mental health problems, and noted symptoms of possible mental illness. Now you need to refer the mother to a service which can help her such as a:

- Counsellor
- Psychologist
- Psychiatrist
- Non-governmental organisation

Referral is a very important part of mental health care, but can only be made if there are appropriate resources available. Later in this chapter, suggestions are given for supporting the mother if no referral services are available (See **Section 5.4**).



Definition: referral

Referral is the direction of a patient to another person, place or service for help or information. The word 'referral' is often used in medical settings. It is the act of recommending more specialised services to the mother.

There are different types of mental health resources available. These differ from place to place, so it is important to identify what is available in your community. There may be both governmental services and community-based services in your area. Below are examples of the types of services and resources which may be available.

Community mental health nurses

These nurses are usually based in clinics, community health centres or district hospitals. They often work together with psychologists and psychiatrists. They are also sometimes known as community psychiatric nurses. It may be useful to refer all mothers with psychotic features, suicidal plans or severe mental health symptoms that affect functioning.

Social workers

If the mother has a problem related to social issues, like accessing social grants, housing or other social services, you could refer her to the social worker at your facility or in your community. Social workers can also provide assistance with family issues, such as domestic abuse or adoption.



Emergency care

The mother's condition can be considered an emergency if:

- She is suicidal, or has thoughts about harming herself
- She has thoughts of harming others
- She is psychotic

Contact the community mental health or psychiatric nurse, or the doctor in your ward or facility. They will need to refer the mother to the nearest health facility offering psychiatric services.



In emergencies, it is very important that the mother is referred on the same day.

Support to families affected by substance misuse

If a woman or her partner misuses alcohol or drugs, she can get psychological support and information from special organisations that will deal with addiction problems (see **Chapter 8: Resources** for more information).

Other local resources

You need to look for organisations in your area which could be able to assist you. Non-governmental support services in your community may include:

- Religious organisations
- Income-generating groups or micro-finance lending schemes
- Support groups
- Treatment and rehabilitation centres
- Community care organisations
- Counselling centres
- Trauma services
- Shelters

In South Africa, some examples of social assistance are maintenance orders and the Child Support Grant.

Maintenance orders

If a woman's partner has left her, she can report him to the Maintenance Office for child support. There are Maintenance Officers at Magistrate's Courts who can help women apply for maintenance. They also deal with applications to increase or reduce maintenance payments.

If the partner denies paternity, he can be forced to take a paternity test. This is a complicated procedure, but it can be worth doing as it may provide some financial support for the mother. Below are some facts about maintenance orders in South Africa.

Child Support Grant

If a woman is the primary caregiver of a child (her own or someone else's child), she can apply for a Child Support Grant. Parents and primary caregivers do not have to pay school fees for children who are benefitting from a Child Support Grant. Details about these grants, as well as the process to follow to apply are available in the **Resources** section.

Other forms of government support

A woman can also apply for 'indigency status' at her Municipal Office. This can allow her to get assistance with the cost of water, electricity and property rates.

If a woman has applied for a grant, but has not yet received it, she can apply for urgent support. People in desperate need of support can apply for temporary assistance called 'Social Relief of Distress'. This is normally issued as a food parcel but can also be a voucher or cash payment. If a woman receives cash, this will be deducted from the grant money she eventually receives.

Note

Maintenance orders: facts

- Both parents have a legal duty to support their children.
- The parent who is looking after the child has a right to apply to the Maintenance Court for the other parent to contribute to the costs of parenting.
- If the child is not living with the mother or the father, the person who is looking after the child can also apply for maintenance from the parents. For example, if a child is living with the grandparents, the grandparents can apply to get maintenance from the father and the mother of the child.
- Once there is a court order instructing a parent to pay child support, it is a criminal offence not to pay.
- There are special Maintenance Courts at most Magistrate's Court.
- For details on how to apply for a Maintenance Order and what to do when payment is not made, go to the **Resources** section.



Tips

- Work together with your colleagues to draw up a list of useful organisations and resources in your area.
- Having a handy resource file in your clinic can make referrals more efficient.
- Remember to update your resource file over time!
- Making a personal contact with someone working at the resource organisation can be extremely useful.
- When you are able to provide the mother with options, it can help the mother in the long-term and make you feel a greater sense of job satisfaction.

5.2 Practical issues

You may encounter difficulties with setting up appointments for referral. For many reasons, women often '**default**' their appointments.



Definition: defaulting

Defaulting means that someone has stopped taking medication or has not attended an appointment, and so has lost the benefits of the treatment programme.

Practical obstacles

Many women affected by mental illness are often living in poverty or other difficult situations, which make it difficult to keep their appointments. For example, they may not have money for transport, they may not be able to get time off work, or they may not be able to arrange child care.

Myths and beliefs

Mothers may have certain beliefs about mental illness and its treatment, which can prevent them from taking up services. For instance, some women may be afraid that they will be judged as an unfit mother and have their baby taken away.

Stigma

Women may be scared to think and talk about their problems. They may worry that they will be seen as 'crazy'. Many people think that a person with mental health problems is stupid or weak in some way. There is also a common misunderstanding that people with mental illness do not get better. Health workers can play an important role in addressing stigma, both with their patients and with their co-workers.

Trust

Women may be concerned that the health worker or counsellor will tell other people about their problems. Creating a trusting environment and explaining confidentiality could help the mothers open up to you. Trust can also reduce the risk of mothers defaulting their appointments.

Depression and/or anxiety

Mental illnesses can impact on a woman's ability to keep her appointments. A mother may not be able to make the necessary arrangements to get to her appointment because of depression or anxiety:

- Decreases motivation
- Can make the mother feel that she is not worthy of getting help
- Can make practical and emotional tasks seem overwhelming
- Can make her forgetful

By taking care to set up a referral appointment properly, and by bearing in mind these practical issues, you give the mother the best chance of getting the help she needs (see section 5.3 for additional tips on making successful referrals).

5.3 How to make a successful referral ---

The aim of a good referral is:

- For the mother to receive good quality care
- To make the most of the time spent by you and the referral service

Tips for referral

Give information

Explain to the mother **why** she is being referred. She may be more accepting of your referral if you express concern for her well-being and the impact of her situation on her and her family.

Choose resources you know and trust

Your choice of the referral organisation or service makes all the difference. Make personal contact with a staff member there, and learn about what they do. This will make it easier for the mother and for you when you follow-up on her.

See what is feasible for the mother

Explore the mother's situation to work out whether she is **able** to use the referral:

- Will she go to the service or organisation you have suggested?
- Does the time and place suit her?
- What practical or emotional challenges could stop her from going to her appointment?
- Can she take time off work? Does she have transport money? Can she make child care arrangements?

Write a referral letter

Write a detailed referral letter and be sure to ask for a reply to you. Should the mother be referred to a counsellor, your referral letter should explain that the mother is experiencing mental distress or has symptoms of mental illness. If you don't have much time, write in bullet points. Put your name and contact number on the letter. See **Section 8.5** for an example of a referral letter.

Follow-up

Try to find out from the mother if she went to her appointment. If she did go, find out if the appointment was useful or not. If she was unable to keep her appointment, find out why. Try not to seem disapproving. You may need to make another referral, possibly to another place.

Have an open-door policy

You may feel frustrated when a mother defaults or refuses your referral – but it is important not to judge her, to be angry or to punish her.

It is important to keep an ‘open-door policy’. Quite often, at a later stage or in a crisis, the mother changes her mind and returns to a place or person where she felt supported. It is important that she has access to mental health care when she needs it. When a mother returns by choice, she is more likely to follow up on her appointments and treatment.

In the Resources section you can find an example of a Referral Letter and a Referral Evaluation Form. The Referral Letter template can be used as a model for letters that you send with the mother to the new service. The Referral Evaluation Form can be used when you have a follow-up appointment with the mother, after the referral.

Practical steps when referring for counselling

Counselling is covered in detail in Chapter 6. If you trust the quality of the counselling the mother will receive, you could describe what counselling will provide for her:

- If a woman is being referred during pregnancy, reassure her that it is a good thing to have the opportunity to talk to a counsellor before the baby is born, and that she will feel more prepared when the baby comes.
- Discuss what she expects to happen in a counselling session.
- Assure the mother that she will receive sensitive, supportive and reliable care.
- Explain that the counsellor will listen carefully to what she says, and will allow her to speak and express her feelings in her own words and in her own way.
- Explain that the counsellor will not express opinions, or give direct advice. ‘Patient-centred’ counselling allows the mother to understand her own feelings and improve her self-esteem. Then she can develop her own solutions and gain confidence in her ability to cope.
- Explain that a counsellor could be a link between crisis and coping.

A wide variety of problems can benefit from referral to counselling

In addition to mental distress, counselling can benefit the following problems:

Crisis or severe mental health symptoms

If the mother is in crisis or has had serious symptoms for a long time, you should refer her to a psychiatrist. If she refuses, try to refer her to a counsellor. It is very important for her to have at least one person she can trust and whom she can contact during a crisis.

Isolation and stress

If the mother is isolated and stressed but not in crisis, refer her to counselling. The counsellor can try to help her identify possible ways of coping, relaxing and getting support.

- Is there a friend or family member she trusts and feels that she can talk to?
- Is there a support group in her community? What other resources are there?

Severe anger

If the mother is feeling very angry, refer her to counselling. A counsellor can encourage her to write a letter to the person she is angry with, getting out all her feelings and the reasons for her anger. After she has written it, she can decide to send it or not. Sometimes, having the opportunity to express feelings can help her to feel less angry.

Abuse

If the mother was abused as a child, or is currently experiencing abuse, assure her that it is not her fault and refer her to counselling. Affirm her feelings. If she wants to talk about this more, support her to do so. If she does not, do not push her, remain supportive, and listen to what she wants to talk about.

5.4 When you cannot refer for counselling: some suggestions

What if you cannot refer the mother? This is a difficult situation, but there are other ways to assist a woman who is experiencing mental health problems.

Listen to the mother's story

Many women may feel isolated and have no support. The PMHP experience shows that having someone to talk to, even for a short time, has real and positive effects for women. While you are doing the booking procedures, taking the history and checking the physical health of the mother, you can listen to her story. Listening to the mother and showing empathy is one of the most important things you can do for her.

There is more information about empathy and listening in **Chapter 6**.



Note

Often, health workers don't ask women how they are feeling, because it takes too much time to listen properly to the answer or because they find it difficult to hear about other people's feelings and problems. However compassionate care does not need to take much more time than the routine engagement with the mother.

Set up a support group

Support groups provide a useful space for women to share their experiences and to learn about mental health issues or other pregnancy-related matters. Support groups help people feel less alone with their problems. Feeling supported is particularly important for the recovery of women suffering from a maternal mental illness.

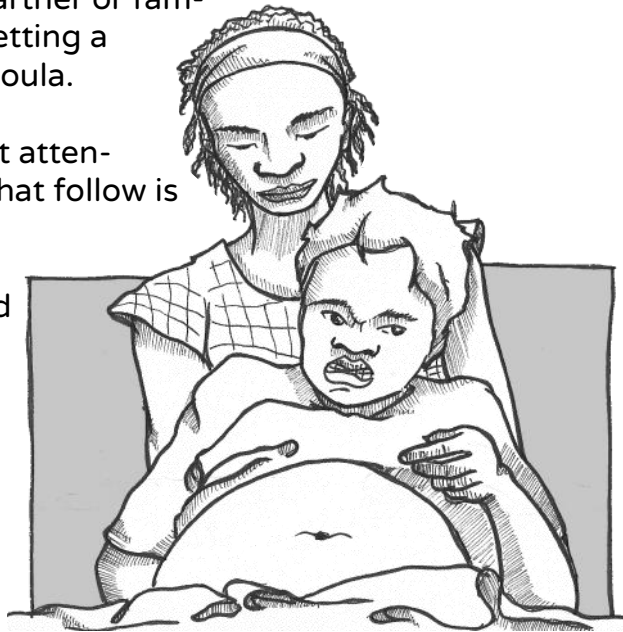
Read **Chapter 6** to find out more details about setting up a support group.

Help the mother to get a doula

If the mother is alone and has no partner or family support, you could help her in getting a birth companion, also known as a doula.

To have another woman in constant attendance during birth and the weeks that follow is an old practice with many benefits.

Traditionally, other women who had previously given birth would surround women in labour. These women would gather to support and encourage the labouring mother.



Definition: doula

The word *doula* comes from the Greek language and means ‘a woman who helps other women’.

A doula’s function is to care for and support the birthing mother. The doula offers emotional and physical support to the birthing woman, and also those who are with her during her labour.

A doula can:

- Encourage the birthing woman
- Help the woman focus on the fact that she is bringing a new life into the world, a powerful process
- Provide physical support, such as massaging the woman and helping her find comfortable positions for labour
- Give the birthing woman energy-sustaining foods and fluids
- Give on-going support from the first stages of labour at home, through the journey to the hospital, during labour and after the birth, until the baby has successfully breastfed and the whole family is settled

All mothers need to be able to trust the people around them during the birthing process.

The doula creates a safe environment where the mother feels protected and calm. A doula does not perform any medical tasks but actually can assist the medical birth team. The benefits of a doula during labour include:

- A positive effect on the mother: continuous support promotes the steady release of hormones which help the mother to feel calmer, more comfortable and experience less pain
- A lower chance of experiencing mental distress during labour or in the postnatal period
- A shorter labour
- Fewer forceps or vacuum deliveries, and fewer caesarean sections
- Less need for pain medication
- An increased chance and duration of successful breastfeeding

You could provide basic counselling

Professional counselling can only be given after training. Identifying a registered training organisation to equip you and your colleagues with professional counselling skills can enhance the care you can provide for women. This can also increase your own job satisfaction and enable you to care for your own psychological well-being.



Chapter 6 gives some guidelines on offering the mother basic counselling by listening to her and giving her information about pregnancy and birth.

5.5 Summary

- There are different types of mental health resources available. These differ from place to place, so it is important to identify what is available in your community. There may be both governmental services and community-based services in your area.
- In emergencies, it is very important that the mother is referred and assessed on the same day. Contact the community mental health or psychiatric nurse, or the doctor at your nearest facility.
- It is important to keep in mind that there may be many reasons for why women default their mental health appointments.
- In order to make a successful referral, it is necessary to give information to the mother, give her a choice, assess what is feasible for her, write a referral letter, follow-up if possible, and have an open-door policy so that she can come back.
- Referral to professional counselling can be beneficial for women who are in crisis or who have severe mental health symptoms but who refuse to be referred to a psychiatrist. Referral to counselling can also be beneficial for women who are isolated, stressed, extremely angry or who have experienced abuse.
- When you cannot refer, there are other options such as listening to the mother's story, setting up a support group, and/or helping the mother to identify a woman to support her through the birthing process, known as a doula.

How to help women with mental health problems

This chapter gives an overview of treatment options, such as counselling, for women who are experiencing mental health problems.

Learning Objectives

By the end of this chapter you will know:

- What type of care is needed by distressed mothers
- How to have a positive impact on women who are experiencing mental distress
- How to provide basic counselling to the mother in the form of listening
- What happens when you refer the mother somewhere else for professional counselling

6.1 What do women who experience mental distress need?



Activity

Close your eyes, and think about a period in your life when you were very unhappy.

If you could choose someone with whom you could talk and share your pain, even if they could do nothing to change your painful circumstances, what qualities would you want that person to have?

You are likely to choose someone you trust who would:

- accept your feelings
- not try to give you advice
- not interrupt you
- make you feel safe

Women experiencing mental distress need:

- Someone who really 'listens' to them
- Time, and a safe space to talk to someone and share their feelings
- Supportive health workers who do not judge them
- Respect
- The chance to explore their own possible solutions
- The opportunity to identify practical options
- Contact with supportive mothers who have had similar experiences
- A birth companion

Note

There are 3 messages that a woman suffering from emotional distress should hear:

- You are not alone
- You are not to blame for how you feel
- There is help available for you

Treatment options depending on need

By now, you may have a better idea of how severe a woman's psychological distress is from:

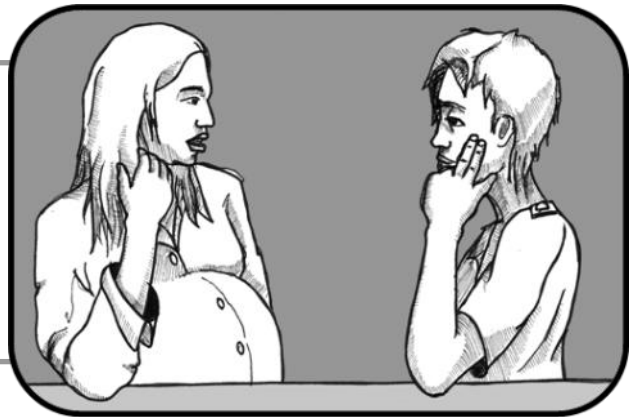
- Investigating mothers' circumstances and history (**Chapter 2**)
- Screening (**Chapter 4**)
- Your own judgement

The image below summarises the different kinds of support a mother may need depending on her level of distress.

Different kinds of support

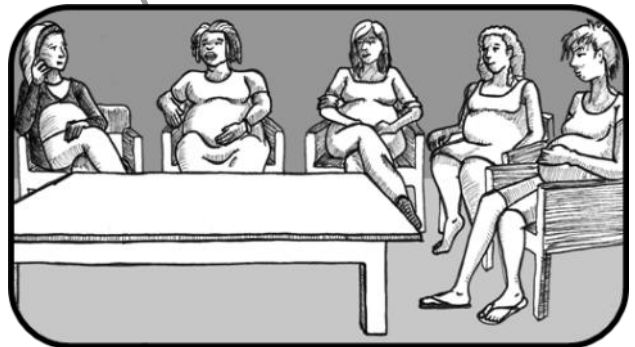
Mild distress

- Emotional support
- Acceptance
- Education and information
- Re-assurance
- Someone to listen



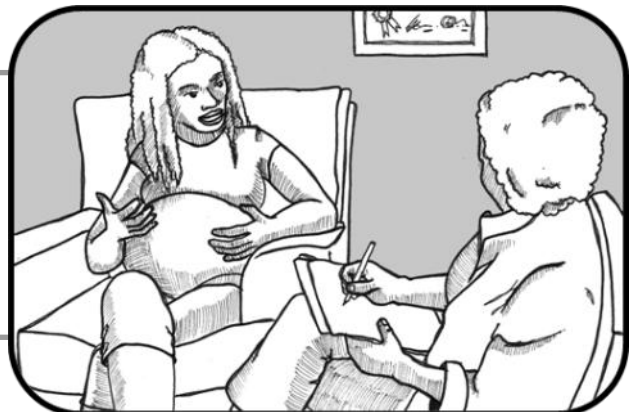
Mild to Moderate distress

- Emotional support
- Acceptance
- Education and information
- Sharing
- Support groups
- Counselling (therapy)
- Professional care
- Medication



Severe distress

- Professional medical care, e.g. psychologist, psychiatrist
- Medication
- Hospitalisation



6.2 What is counselling?

Counselling is an important tool in addressing mental distress. It is not about giving advice: it is about listening, validating, and empowering the person to think through her problems, develop her own solutions and put them into practice.

Note

Learning how to be a professional counsellor requires special training. However, there are some simple, yet powerful skills that any health worker can use when caring for mothers, such as:

- giving information about pregnancy and birth
- applying listening skills
- showing positive regard

What can counselling do?

Counselling can provide:

- Support and encouragement
- A safe space for a mother to be heard and to express her feelings without feeling judged or blamed
- A feeling of mutual respect between the counsellor and the mother
- Information about the emotions connected to pregnancy, labour and the postnatal period. Knowing that she is 'not alone' or that many other women feel like her can help the mother understand what she is feeling and lower her anxiety.
- Information about what to expect when the baby arrives and the resources that are available
- The opportunity to explore problems and develop solutions
- The identification of new or existing skills and support systems (boost resilience)
- The opportunity to identify the need for emergency or special care
- An opportunity to reflect on how childhood problems could be affecting the experience of pregnancy, childbirth and being a mother



Definition: positive regard

Positive regard is an attitude of unconditional acceptance and support of a person, regardless of what the person says or does.

6.3 Providing supportive care: sharing information

One way to provide supportive care to a mother in distress is to give her information and educate her about pregnancy and childbirth. Information can empower a woman and help her to feel in control of her situation. This can also make her feel less afraid and anxious. Below are some things that you can do to help an anxious or scared pregnant woman feel calm and reassured:

- Explain what to expect during labour. This is especially important for first-time mothers. Taking the ‘mystery’ out of childbirth can help a woman relax.
- Describe the signs of labour. Explain to the woman what is normal and what is not normal. This can help her to remain calm, and to know when to ask for help if her labour is not progressing normally.
- Be careful not to scare her with too much or too complicated information. Stories of other women’s bad pregnancy outcomes can be very frightening.

6.4 How to really ‘listen’

Knowing how to listen is an important step towards understanding what a mother needs and knowing what type of help she requires. Many doctors and nurses are trained to focus on the physical side of health care. Yet, people find it easier to cope, and to find solutions to their problems, when they talk to someone who is really listening. The simple act of listening can be a great support. By listening to the mother, you give her an opportunity to:

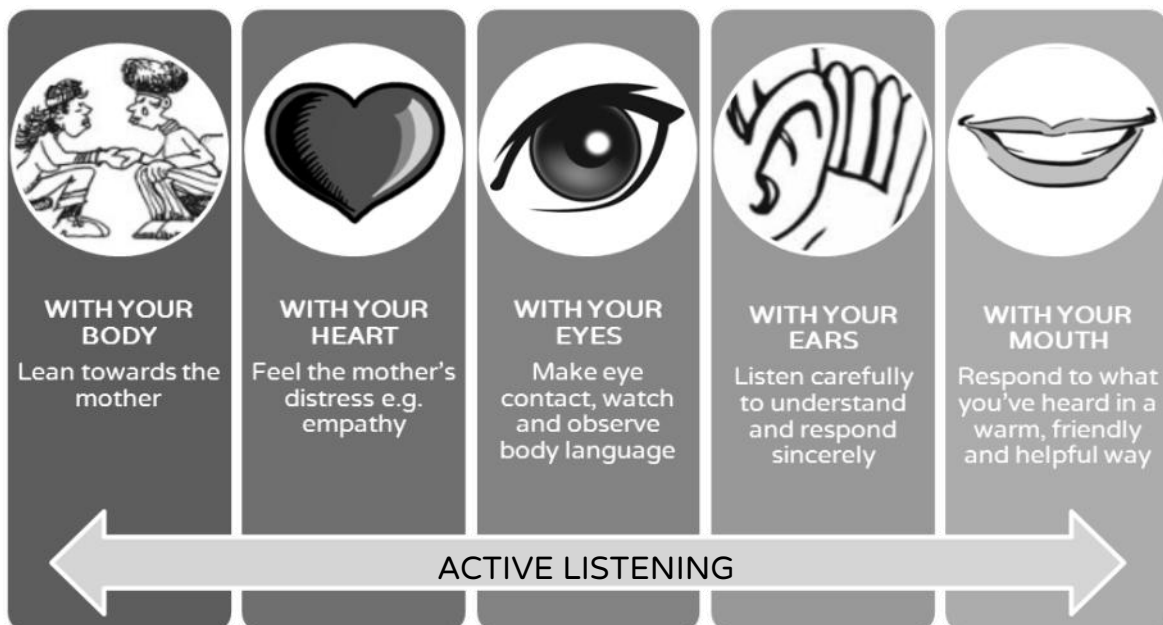
- Tell her story
- Explore her own understanding of her problem, without imposing your own advice or opinions on her
- Explore the factors contributing to her distress
- Explore her own possible solutions

Note

The listening process is very different from taking a medical history. It requires a different set of skills, and includes empathy, which health workers need to learn.

Listening requires more than just hearing what the mother is saying. You also need to observe other aspects of her behaviour. The image below summarises the many ways you can show that you are really listening to your client. These are called active listening skills.

Active listening skills



Definition: active listening

Active listening is paying careful attention to what someone is saying, as well as their verbal and non-verbal communication. It requires you, as the listener, to give sincere feedback to show empathy and that you have understood what the person has said.

In this way, the speaker feels heard and her feelings are validated. The listener's responses should focus on the client, and **not express judgement or personal opinions**.



Definition: empathy

Empathy is the act of identifying, understanding, being aware of or being sensitive to the feelings, emotions or experiences of another person. This happens without necessarily having experienced the same feelings, emotions or experiences.

Empathy is different from sympathy. Sympathy is 'feeling sorry for' or feeling pity for someone else's suffering.

Empathy is considered to be a more useful action when dealing with mental distress: it is trying to understand what she is going through, so as to provide appropriate care.

What is the difference between a good listener and a poor listener?

A good listener...

- Is aware of his/her own feelings and responses
- Finds a private, quiet place to talk
- Feels empathy for the mother
- Waits for the mother to speak
- Gives the mother an opportunity to tell her story in her own way
- Does not interrupt
- Is comfortable with silence
- Lets the mother know that they are willing to listen further if she has more to say
- Asks a few questions when they need more information to understand the situation
- Makes sure that the way they understand the situation is correct
- Looks interested and sits still, using body language to show that he/she is giving careful attention
- Makes gestures to show that he/she cares, like touching the mother's hand or shoulder
- Clarifies, paraphrases and gives feedback to show that he/she is listening
- Uses senses and body language to 'listen actively'. See the image on the previous page.

Note

A good listener should make eye contact with her client and avoid distractions such as phone calls, texting or 'multi-tasking'.



A poor listener...

- Talks about himself/herself or their own experiences
- Uses clichés e.g. 'Everything will be okay'
- Tries to solve the mother's problems
- Is overly sympathetic or feels 'sorry' for the mother
- Does not believe what the person is saying e.g. 'That can't be true! You must be wrong'
- Breaks confidentiality
- Feels uncomfortable with someone's feelings
- Minimises the problem e.g. saying 'It could be worse!'
- Interrupts or stops to talk to other people or answer the phone
- Concentrates only on the facts, not on the mother's feelings
- Displays body language which indicates that he/she is not focused on the mother e.g. yawning
- Takes the side of the other person e.g. saying 'You should have listened to your mother'
- Rushes the appointment
- Asks too many questions, gives advice or judges

Guidelines for listening and responding

- Show positive regard
- Don't be judgemental
- Don't impose your morals
- Empathise
- Don't sympathise or pity
- Don't encourage blaming
- Don't try to solve the mother's problem: help her find her own solution
- Emphasise the positive aspects
- Don't be shocked
- Don't negate feelings
- Don't make false promises
- Don't say you know how she feels
- Look for relevant examples of where she has shown strength in the past

Useful responses

Part of listening is being able to respond in a helpful way. Below are 3 useful ways of responding: clarification, paraphrasing and giving feedback.

Clarification

Sometimes it is useful to check with the mother that you understand her problems clearly. Asking for clarity is a way of showing her that you are listening because you are taking more time to understand the details of her story. It also helps the mother to focus on the issue, which is helpful when she is feeling very emotional or confused.



Note

Be careful not to interrupt, or to ask too many questions.

Seek clarity by asking the mother gentle questions when appropriate. For example, you can say:

- So you are saying that...
- Did you mean that...
- Can you just tell me what you meant when you said...

Paraphrasing

Paraphrasing is repeating what the mother has said in your own words. It is a way of showing the mother that what she has said is important and that you have been listening. It also provides an opportunity to check with the mother if you have understood her correctly. Try starting sentences with these words and 'paraphrasing' may come more naturally:

- What I'm understanding is ...
- In other words...
- So basically what you're saying is...
- Do you mean... ?
- It sounds as if...
- I'm not sure that I understand you correctly, but...
- I gather...



Definition: validate

To validate someone's feelings means to give value to her feelings, and show acceptance that they are true and real.

Giving feedback

Once you have understood what the mother is saying, and you have asked for clarity about certain issues, you can give feedback. It is a way to share your understanding, insights and reactions with the mother. This should be done in a sensitive, supportive manner.

Giving feedback also gives you the opportunity to validate the mother's feelings and concerns, and thus empowers the mother as she realises her feelings and problems are real and important.

For example, if the mother says 'I am depressed':

- You could validate her feelings by saying: 'I can hear that you are down. How long have you been feeling this way?'
- Not validating her feelings would be to deny that her feelings are real: 'I'm sure that you're not depressed, maybe you're just having a bad day?'

Note

Try to empathise with the mother as you give feedback. This is not an opportunity to give advice, judge or preach. To give feedback, you could start by saying: 'It sounds to me as though you are feeling ... because ...'

More responses

If she says ...	You could say ...
I hate my husband.	What bothers you about him?
There's no God.	When did you start to think that?
I'm such a failure.	You're finding everything very difficult right now, aren't you?
It's all his fault.	Tell me how he's involved.
What should I do?	What are your choices? Let's talk about them.
I'm so tired because my baby cries all the time.	It takes courage to say how you really feel.
I smacked my baby really hard.	• What do you think drove you to do this? • How often has it happened? • I think you need to be referred to someone to help you with this problem. More information about child abuse is in Chapter 7
I'll never be the same again.	That must be a scary feeling.
I feel terrible.	Tell me about your feelings.
I want to kill myself.	• Why do you think suicide is a way out? • How long have you been feeling this way? More information about suicide is in Chapter 7

© Adapted from Liz Mills



On the next two pages are suggestions for mothers who are experiencing emotional distress. You can copy this information and give it to mothers to read.

A few suggestions...

- Stay close to people who are supportive, sensitive and who do not criticise you. Stay away from people and places which make you feel bad.
- It can be useful to have a 'mother-person' who you can turn to in times of crisis. This is someone who can help you feel safe and supported. Maybe you know another woman who can support you, even if your own mother is not there.
- Ask others to help you. Ask clearly for the type of help you need. Some examples are:
 - Ask a friend or relative to look after your older children
 - Find someone you trust to look after your new baby sometimes, to allow you to have a break and to rest
 - Ask someone to help with your housework or run your errands for you
- If people offer to help you, thank them, and allow them to do so – do not feel guilty.
- Lower your housekeeping standards. It is more important to take care of yourself and your baby than to have a tidy house.
- Even if you cannot sleep, rest whenever you can.
- Be well informed. Ask your health workers questions about things that worry you. If you can, visit a library or look on a website for information on pregnancy, motherhood or parenting.
- Get to know what to expect during pregnancy and labour. Your experience may not be what you expected and it is important to know that you have not 'failed' as a woman or as a mother if things do not go according to plan.
- The arrival of your baby will be a big change, so try not to make any other major changes to your life at this time. Try to simplify your life as much as possible.
- If you are feeling very anxious or depressed most of the time, try to do something about it. Talk to someone you trust about how you feel: your clinic sister, community caregiver, doctor, your partner, mother or a trusted friend.

- Counselling and/or medication for depression during pregnancy can help prevent some difficult, negative effects of maternal depression, which could affect you, your baby and your family.
- You may need to cry sometimes, or feel sad, and this is completely acceptable. It is not helpful to say 'pull yourself together'. Instead, be kind to yourself.
- Try to make healthy decisions, like eating properly and quitting smoking or taking drugs.
- If you have a partner, try to keep communication open and friendly. If this is not easy, or you are experiencing other problems in your relationship, try to get counselling for both of you.
- Mental distress does not mean that you are a bad mother, weak or 'crazy'. Many people who have experienced mental health problems now live normal and happy lives.

About 1 out of every 3 pregnant women suffers from depression during or after pregnancy. It is not your fault. You are not a bad mother. You can, and should get help.

Useful phone numbers

FAMSA (Family and Marriage Society)	Cape Town	021 447 7951
	Gauteng	011 975 7106
Lifeline		0861 322 322
SA Depression and Anxiety Group		011 262 6396
AIDS Helpline		0800 012 322
Crisis counselling for women		0800 150 150
National Mental Health Information Line		0800 567 567

Other

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

'Listening'

A poem

You are not listening to me when...

You do not care about me;

You say you understand before you know me well enough;

You have an answer for my problem before I've finished telling you what my problem is;

You cut me off before I've finished speaking;

You finish my sentence for me;

You feel critical of my vocabulary, grammar or accent;

You are dying to tell me something;

You tell me about your experience, making mine seem unimportant;

You are communicating to someone else in the room;

You refuse my thanks by saying you haven't really done anything.

You are listening to me when...

You come quietly into my private world and let me be;

You really try to understand me even if I'm not making much sense;

You grasp my point of view even when it's against your own sincere convictions;

You realise that the time I took from you has left you a bit tired and drained;

You allow me the dignity of making my own decisions even though you think they might be wrong;

You do not take my problem from me, but allow me to deal with it in my own way;

You hold back your desire to give me good advice;

You do not offer me religious solace when you sense I am not ready for it;

You give me enough room to discover for myself what is really going on.

Anonymous

6.5 What happens when someone is sent for professional counselling?

At some point, you may want to refer the mother for counselling or other types of support. See Chapter 5 for advice on how to refer the mother. If you think a mother requires professional counselling, make arrangements for her to see someone who has received this training.

Just like counselling from non-mental health professionals, the professional counselling process consists of:

- Opening: establishing a relationship and building trust
- Exploring: good listening
- Understanding: clarifying, reflecting, summarising problems
- Supporting: counselling, identifying resources and referral to improve coping and functioning

Before professional counselling starts

Professional counselling requires a lot of skill and time. Before committing to counselling, a professional counsellor must ensure that there is sufficient time to follow through. A counsellor should plan for 4 to 6 counselling sessions for the mother, but there is a chance that she will only be able to come less often. Many times 1 or 2 sessions is what is manageable.

Before meeting a mother for the first time, it is helpful for the counsellor to check for information that came with the referral. If you are referring someone for professional counselling, be sure to provide as much information as possible, such as mental health screening forms, notes on her background history or letters from other health workers.

Different types of counselling

Different problems need different counselling styles:

- **Trauma counselling** for traumatic life events, e.g. violent attack
- **Bereavement counselling** for loss, e.g. death of a family member, previous stillbirth or miscarriage
- **Interpersonal Psychotherapy** if there is evidence that a woman is struggling with her close relationships

- **Cognitive Behaviour Therapy** for depression, anxiety and on-going negative thoughts
- **Motivational interviewing** for substance-use problems
- **Problem-Solving Therapy** is a technique for depression and suicidal thoughts
- **Progressive relaxation and visualisation** for tension and fear of child-birth, especially if a woman has experienced a previous traumatic birth or rape

Some counsellors will use a combination of styles during therapy.

There is research evidence that many of these types of therapies work well in developing countries and when delivered by trained non-mental health professionals.



6.6 Speaking and being heard

The following story was written by Ntombomzi, a PMHP service user.

Things are easier for women today, because we are independent. Our mothers were not respected. They didn't have the rights we have now and didn't have the same opportunities. They were like slaves. These days if there is a problem, there is help available, something that I was fortunate to have when I discovered that I was suffering from postnatal depression.

When I first became a mother, I didn't know about depression. Now I would like to let everyone know about this problem so that people can stand up and do something about it.

I was born, one of twins. My parents divorced when I was only two months old. Because my mother was alone she couldn't do what she was supposed to do as a mother and I grew up with her family. There was really no one to talk to or to discipline us and I became pregnant at the age of 14. I have suffered depression since then.

Having a baby at such an early age was really hard. I had to leave school and was forced to work as a domestic worker, which I couldn't really do because I was so young. I tried very hard, but I just couldn't do it. So, I decided to go back to school when my baby was three years old. I passed my standard nine [penultimate year of high school], but didn't have enough money to register for my final year. I was forced again to go back to work as a domestic worker, which I am still doing to this day.

When I was twenty-one years old, I got married to my husband. He is not the father of my first child. A couple years after being married, we had a child together. I again suffered very much from postnatal depression, although I did not know what it was called at the time. The clinic I went to

in the township did not know anything about depression. So, I was unable to get help from them. Luckily, my husband was always there for me and supportive throughout my depression, even though he didn't always understand what I was going through.

Since then, I suffered from depression until I was able to get help from the Perinatal Mental Health Project in 2004. This was the first time I heard about perinatal or postnatal depression. I had suffered from depression all these years, but I didn't really know what it was. Finally, I was able to get help.

When I was pregnant with my last baby, I was working for Linda, a psychologist. I was not at all happy to be pregnant. I was just very stressed and worried about telling her. I knew it was not the right time for me to become pregnant and I was very concerned about my job and all the things that I needed money for. But I realised that I needed to tell Linda, not only because she was my employer, but because I needed help. Everything was very hectic for me and nothing that I was experiencing seemed to be good. I knew that I was becoming more and more depressed.

I finally told Linda when I was 5 months pregnant. It turns out that she specialises in women who have perinatal and postnatal depression and when she heard my history she thought I was suffering from it. She decided to take the step to get help for me by sending me to the Mowbray Maternity Hospital which provides the Perinatal Mental Health Project.

At Mowbray, I met with a counsellor. It was very good to speak to her about how I was feeling and to just talk out about everything. That was what was killing me, having to keep all my feelings inside of me for a long time. I was so lonely and there were so many things that I needed someone to listen to. I needed to express my feelings and to be heard when I was

saying something. I needed someone who could understand and who could listen when I was talking. Meeting with this counsellor gave me that chance to finally speak out, which helped so much. They also sent me to a psychiatrist to get medication for my depression. Now I am doing just fine and coping very well with motherhood.

Dealing with perinatal and postnatal depression is a very difficult thing. When you are depressed there are so many things that are affecting you. You may not be able to tell exactly what it is that is making you feel so bad, but just that you can't get out from the fog you are in. Everything can feel like it is just falling apart, that nothing is happening right or according to plans. You may not know to take it seriously when you are first suffering from it, but it is very important to address it and to find a way out. There are so many women who are dying inside from this thing. They don't know how to deal with it or how to cope. Everything in their lives is turning upside down. And they need someone who will understand and not judge them.

That is why I talk about this depression with everyone. I even talk to mothers I see on the bus. I want everyone to know about this problem. I want the mothers to listen.

If I could have my way, each and every one of the hospitals would have these kinds of counsellors, especially the government hospitals which are for everybody. That way everyone, including all black women who really don't know anything about this depression, could get help.

Until that happens, I hope that all the mothers out there, who are suffering from perinatal and postnatal depression, will take care of themselves and find support. You only live once, and it does not have to be a life filled with depression!

6.7 Summary

- Women experiencing mental distress or mental illness have special needs.
- Treatment depends on how bad the mother's level of distress is.
- Information can empower a woman and help her to feel in control of her situation.
- Women may require counselling to help them to deal with their problem.
- Being a counsellor requires special training. There are, however, things that you can do to support the mother, such as listening to her.
- There are several ways to develop good listening skills. Knowing how to respond, by clarifying, paraphrasing and giving feedback, is also helpful.

Special issues

This chapter provides an overview of special issues that health workers should think about when caring for mothers.

Learning Objectives

By the end of this chapter you will know:

The range of background factors or 'special issues' that can make women more vulnerable to mental distress around their pregnancy

Whether women are being referred to a professional counsellor, nurse, social worker or any kind of health worker, there are a number of special issues which should be considered when caring for mothers.

7.1 Poverty ---

Women living in poverty are at a greater risk of developing a mental illness, and those with mental illness are more likely to slide into poverty. Current studies show that as much as 1 in 3 women living in poverty in South Africa experience depression during their pregnancy.

There are many issues associated with poverty which can affect a woman's mental health, such as:

- Losing her job or being unemployed
- A change in social class or status, e.g. being divorced, being foreign, losing her home
- Housing problems, overcrowding
- Losing access to social grants or other forms of income
- Malnutrition
- Domestic violence
- Abuse
- Past or recent trauma
- Sick children or relatives requiring her care

When supporting a woman to identify the resources that are available, it must be kept in mind that women living in poverty face these significant challenges. However, it is important to be aware that the 'vicious cycle' relationship between poverty and mental ill-health can be broken, if the correct interventions are put into place.

7.2 Lack of support ---

Without support, a woman can feel lonely and overwhelmed, and may be less likely to get the help she needs during her pregnancy. This is why she is more likely to experience psychological problems.

It is PMHP's experience that even women living in busy or overcrowded settings can feel completely alone and in despair.

This may be because:

- The women don't feel worthy of support
- The women don't feel strong enough to seek out support
- The community disapproves of the women
- The community is not used to being supportive to women
- The community is trying to survive in a difficult environment

Signs that a woman may not be supported are:

- Difficult relationships with her partner or mother
- Little support from a partner or mother, such as financial and emotional support
- Difficult relationships with the wider family or community
- Isolation, because of being rejected due to her HIV status, an unintended pregnancy or her choice of partner

Note

Women value the support that comes from the people close to them. Women may feel supported if practical help or financial assistance is given. Emotional support is considered extremely important to mothers.

7.3 HIV status

Mental illness is much higher among HIV-positive people. This is because an HIV infection can make someone more vulnerable to mental illness. At the same time, having a mental illness can make someone much more vulnerable to HIV infection. So, in general, HIV-positive pregnant women have much poorer mental health than those who are HIV-negative.

When it comes to HIV-positive pregnant women, there are several issues that a counsellor should be aware of during and after the pregnancy.

During pregnancy:

- Some women learn of their HIV status for the very first time. They are then faced with the diagnosis, as well as a pregnancy that may be unwanted.
- If they disclose that they are HIV-positive, they might be accused of being unfaithful, be isolated, beaten or thrown out of the home by their partners or family.

They also face having to adjust to the Prevention of Mother to Child Transmission (PMTCT) Programme or having to take the Highly Active Antiretroviral Treatment (HAART).

After pregnancy:

- HIV-positive women face difficult decisions around feeding their infant
- If they choose to bottle feed, they run the risk of family and friends becoming suspicious of their HIV status
- Women experience guilt and anxiety that their babies may also be HIV-positive

Mental illness can also have a very negative impact on the progression of HIV/AIDS. Mental illness that is not treated can lead to:

- Poorer adherence to AIDS treatment, e.g. PMTCT or HAART
- Higher risk of AIDS-related maternal death

7.4 Adolescent pregnancy



Pregnant adolescents are at greater risk of developing mental illness. Also, young women who are depressed are more likely to become pregnant during their teenage years.

Counsellors should keep in mind that adolescence is a time when a number of physical and emotional changes take place.

Adolescent girls are vulnerable, and may have difficulties dealing with crises or recovering from trauma. They also may experience pressure to engage in sex or alcohol and drug use.

Pregnant adolescents need special mental health care that is non-judging and supportive.



‘Typical’ adolescent behaviour, such as aggression or withdrawal, may be the natural ‘fight or flight’ responses to the terrifying situation in which the adolescent finds herself. A health worker validating her fear and showing empathy can make a positive difference to the outcome for the girl and the pregnancy.

7.5 Being a refugee

Women who have had to leave their home countries, because of war or economic difficulties experience high rates of trauma. They may have experienced violence during war or during their travels to South Africa. Refugee women are also particularly vulnerable to being raped. In addition, they are often living in poverty and may find it difficult to access health care.

Because refugees have been separated from their families, they often have very few sources of support, or no support at all. They may find it difficult to communicate in the local language. Some communities are violent toward refugees, so refugee women may also face social isolation, discrimination and even violent forms of xenophobia.

These experiences, on top of previous trauma of violence, economic hardship, the death of loved ones, torture or rape, can lead to very poor mental health among refugee women.

Counselling a refugee woman can be difficult, as she may:

- Be very scared
- Not trust strangers or people in positions of power, such as health workers
- Find it difficult to express herself in your language
- Not understand the procedures of the clinic or what is happening during her pregnancy or labour.

"Loneliness, loss of identity, poverty and trauma are the main stressors that we see. Many refugee women have no one to talk to, and pregnancy makes them more vulnerable."

Charlotte Mande-Ilunga
French-speaking PMHP counsellor

7.6 Drug or alcohol misuse

Drug and alcohol misuse are serious health problems and may require the mother to be referred to addiction specialists. But, being aware that the mother has a substance misuse problem is important for your own treatment of the mother, and for her overall antenatal care. The most commonly misused substances in South Africa are alcohol, cannabis, 'tik' (or methamphetamine), crack/cocaine and heroin. Alcohol misuse is the biggest substance misuse problem in South Africa.

Note

Drug or alcohol abuse is also a mental illness, and can be treated. By being supportive, you can make a positive impact in her recovery.

Drug or alcohol misuse can lead to mental illness, and in some cases, mental illness can make a person more likely to misuse drugs or alcohol. The signs of drug or alcohol misuse can be similar to depression or anxiety:

- Agitation, irritability or mood swings
- Isolation from other people or not wanting to be around people
- Inability to keep up with responsibilities due to time spent trying to find drugs or alcohol
- Inability to keep up with responsibilities because of regularly being high or not being sober
- Inability to take care of oneself or children because of being high or not being sober

If you are concerned, you can ask informal questions to determine if the mother uses drugs or alcohol. Non-threatening questions could help you start this conversation. For example:

- Have you ever used alcohol or drugs in the past?
- Have you ever used anything to help you relax?

If the mother is using substances, refer her for appropriate assessment and treatment. Brief motivational interviewing has been shown to be useful for addiction problems. If your facility does not have such services, try to find a suitable referral organisation in your community.



Direct questions such as 'are you drunk?' are threatening and may sound judgemental. This may make the mother defensive.

7.7 Domestic violence and abuse

There are very high rates of rape and violent assault in South Africa: it has the highest rate of violence against women in the world.

Specifically, experiencing domestic violence is common in South Africa, and domestic violence is likely to increase during pregnancy. It is important for the counsellor to pay special attention to these situations as they can affect a woman's mental health.



Definition: domestic abuse

Domestic abuse is defined as abusive acts that threaten a person's physical safety, freedom, health and emotional well-being. Abusive acts can be physical, sexual, emotional and financial. These are committed by someone the person lives with, or used to live with (a domestic relationship).

E.g. a partner or ex-partner, boyfriend/girlfriend, parents, children, family member or a person sharing the same home.

Domestic violence is abuse which often has a specific purpose in mind. It is used by someone to gain and maintain control over the person. This use of control is designed to make the person feel fearful of the abuser, so that control over the person's life can be maintained.



Definition: intimate partner violence (IPV)

Intimate partner violence (IPV) is defined as threatened, attempted, or completed physical or sexual violence or emotional abuse by a current or former intimate partner.

IPV can be committed by a spouse, an ex-spouse, a current or former boyfriend or girlfriend, or a dating partner.



Definition: emotional abuse

Emotional abuse is the repeated use of controlling and harmful behaviours by a partner to control a person. As a result of emotional abuse, a person may live in fear and have altered thoughts, feelings and behaviours, as well as deny personal needs, to avoid further abuse. Emotionally abusive behaviour by someone's partner may include:

- Harsh, unreasonable and repeated criticism
- Unreasonable or unrealistic demands or expectations
- Unpredictable behaviour
- Aggressive behaviour such as blaming, threatening and demanding
- Humiliation and other verbal assaults
- Isolation
- Using 'fear tactics' or 'guilt trips'
- Threats of abandonment, or threats of having an affair
- Threats of harm to the person, or the person's children, friends or family
- Exploitation
- Forced sexual acts
- Control of person's sexual and reproductive choices
- Financial control (see financial abuse below)

Remember, the abuser uses emotional abuse to damage someone's feelings of self-worth and independence. People who have experienced emotional abuse may feel that there is no way out of their relationship, or that 'they are nothing' without their abusive partner. They will often blame themselves for the abuse.



Definition: physical abuse

Physical abuse is physical injury inflicted on a person, on purpose, with the intention of being cruel and/or hurtful.

Physical abuse can refer to punching, beating, kicking, biting, burning, shaking, or any other way of harming someone's body physically.

Physical abuse can happen just once, or can be on-going.



Definition: sexual abuse

Sexual abuse is any contact or interaction (physical, visual, verbal or psychological) between one person (victim) and another who is in a position of power (abuser). The difference between rape and sexual abuse is that sexual abuse can be any act which uses someone for sexual stimulation. It can happen just once, or be on-going.

When sexual abuse is committed by a person who is a blood or legal relative, this is incest.



Definition: rape

Rape is any sexual act which has been forced onto another person. It can include, but is not limited to, acts of sexual penetration into the vagina, anus or mouth of another individual without their consent. A person can be raped by their partner, a family member, a friend, someone they know, a stranger, or by several people. When rape is committed by a person who is a blood or legal relative, this is incest.

Rape is a violent, traumatic and life changing experience that can happen to anyone. It can create stressful situations within a person's relationship, family and community.



Definition: financial or economic abuse

Financial abuse is a way of exercising control over another person. Financial abuse may include:

- Strict control over a person's finances, such as restricting the person to an 'allowance' or 'pocket money'
- Withholding money
- Withholding basic necessities, such as food, clothes, medicine or even shelter
- Preventing a person from working or from choosing a career
- Sabotaging a person's job, such as causing reasons for the person to miss work, calling or going to the person's workplace frequently
- Stealing from a person or forcibly taking the person's money

Why do women stay in abusive relationships?

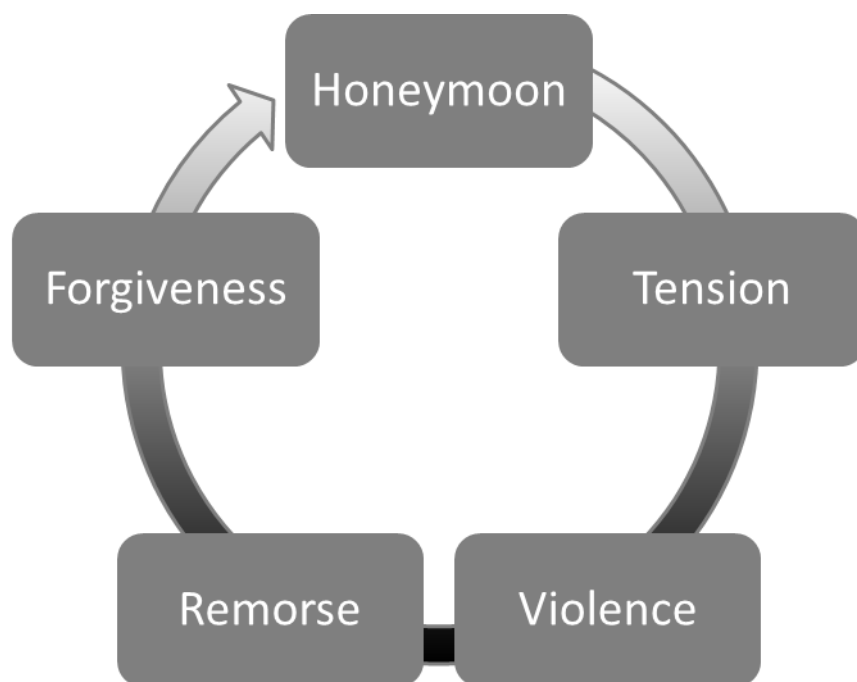
There are many reasons why women stay in abusive relationships. A woman might:

- Feel she is dependent on the abuser to support her and her children financially
- Think it is best that the children grow up with their parents living together
- Feel she has nowhere else to go
- Have been threatened by the abuser if she were to leave
- Feel worthless
- Hope that the abuser will change and stop being abusive

The cycle of violence

Domestic violence often occurs in a cycle.

- **Honeymoon:** a violence-free period
- **Tension:** as the relationship progresses, arguments start; the abuser's reaction seems extreme and tension builds up
- **Violence:** the abuse begins, and can be of any form (e.g. physical, emotional etc.)



- **Remorse:** the abuser shows remorse and repeatedly apologises and begs forgiveness
- **Forgiveness:** the woman starts feeling guilty, thinking perhaps she was the cause of the outburst, and accepts the abuser's apology
- **Honeymoon:** the quiet, violence-free period starts again and the cycle continues

The cycle goes on and on, most of the time because the woman hopes that the abuser will change and go back to the person she once knew.

How can you tell if a woman has been or is being abused?

Women are not all the same, yet there are some common signs that women show when they are experiencing abuse.

Rape and other forms of abuse can have a range of effects on women, such as:

- **Physical effects:** shock, physical injury, nausea, tension headaches, disturbed sleeping and eating patterns, HIV or other sexually transmitted infections, pregnancy
- **Behavioural effects:** crying more than usual, difficulty concentrating, restlessness, listlessness, withdrawing from people and relationships, not wanting to be alone, being easily frightened and jumpy, being easily upset, irritability, fear of sex, loss of sexual pleasure, changes in lifestyle, increased substance misuse and behaving as if the rape did not occur
- **Psychological effects:** anxiety and fear, guilt, helplessness, humiliation and embarrassment, shame, lower self-esteem, anger, feeling alone and misunderstood, losing hope for the future, numbness, confusion, aggression, personality changes, loss of memory, having flashbacks of the rape, nightmares, anxiety, depression and suicidal thoughts



If a woman does not show any of these reactions or symptoms, it does not necessarily mean that she has not been abused.

Women who are experiencing abuse by their partner may:

- Seem afraid or anxious to please their partner
- Go along with everything their partner says and does
- Check in often with their partner to report where they are and what they are doing
- Receive frequent, harassing phone calls from their partner
- Talk about their partner's temper, jealousy or possessiveness

Warning signs of physical abuse can include:

- Frequent injuries, with the excuse of 'accidents'
- Frequently missing work, school or social occasions, without explanation
- Dressing in clothing designed to hide bruises or scars (e.g. wearing long sleeves in the summer or sunglasses indoors)

Warning signs of isolation and emotional abuse can include:

- Being restricted from seeing family and friends
- Rarely going out in public without the partner
- Have little or no access to money
- Not being able to make appointments with doctors, counsellors or anyone else because the partner does not approve

What should I do if the mother is being abused?

Women who are suffering from domestic violence can feel very vulnerable and alone. So, it is especially important to support them emotionally and provide practical support. This can be done by helping them understand their situation and what their options are, and refer them to community organisations for legal and social support.

Note

Many health workers avoid asking about abuse, perhaps because they are worried it will take a lot of their time and energy to deal with, they do not feel properly trained to help, or because they do not know about options for care.

Emotional support

- Ask the mother how she is feeling
- Express your concern
- Listen to her and acknowledge what she tells you
- Avoid pressuring her to leave her abuser, unless her safety can be guaranteed
- Women are often most vulnerable to violence and murder after they attempt to leave.
- Use the basic but powerful listening and counselling skills covered in Chapter 6 of this handbook.

Provide options

- Explain to the mother that she has a right to human dignity, freedom of movement, equality and life. Explain that the way she is being treated goes against her rights.
- Explain that she can apply for a Protection Order (in South Africa), which will legally forbid the abuser from committing any acts of domestic violence against her.
- There is more information about the process of applying for a Protection Order in the Resource section at the end of the handbook.
- Try and get to know the NGOs, support organisations or shelters that work with domestic and gender-based violence in the community: you can refer the woman to one of these so she can get legal, social and emotional support.
- Contact details of several relevant organisations in South Africa are provided in the Resource section.

Remove the woman from immediate harm

- In extreme situations, the woman may have to remove herself from immediate harm, and stay in a shelter or at a friend's or relative's home.
- This is a difficult and important step for a woman victim of domestic abuse: it is essential that you show empathy and emotional support.



If she does decide to take action:

1. The abuser might suspect that she is leaving, so she may not want to disclose her plans. Try to be patient, understanding, and not pressure her to talk.
2. She is especially vulnerable, as she will no longer have the financial or practical support she had in her home. Try to make sure that there is someone (e.g. sibling, cousin, friend, or someone from a support organisation) who can support her and help her stay away from harm.
3. Try to support her choice, no matter what she decides to do.

Attend to the woman's physical health

Besides mental health, women's physical health is also affected by domestic violence. Because domestic violence tends to get worse when women are pregnant, try to be especially aware of the physical conditions of the women in your care who report domestic violence. They may require medical assistance or medical referral, in addition to regular antenatal or postnatal care.

Note

A woman may deny she is being abused when she is asked about it. However, by simply asking, you are showing the mother that you care. She will appreciate that, and may feel safe to disclose at a later stage.

7.8 Child abuse

While working, you may come across mothers who are engaging in or witnessing abuse of their own children.

What is child abuse?

Child abuse is when a child is being hurt, on purpose, in any way, physically or emotionally. This includes emotional, physical and sexual abuse, and emotional and physical neglect.

Abuse

- Emotional abuse is constantly criticising, humiliating and mocking a child.
- Physical abuse is any act of physical assault (e.g. hitting) or physical exploitation (e.g. forced child labour) by parents, caregivers or strangers. This includes cuts, fractures, bruises, shaking, burns and internal injuries.
- Sexual abuse is any act of sexual assault and sexual exploitation of minors by parents, caregivers or strangers. It can happen just once or be on-going. It includes fondling a child's genitals, intercourse, rape, sodomy, exhibitionism and pornography.

Neglect

- Emotional neglect is the on-going failure to provide a child with appropriate emotional support, attention and affection.
- Physical neglect is the failure to provide children with adequate food, clothing, shelter and medical care. Physical neglect also includes abandonment, expulsion from home and failure to enrol children in school. It is important to distinguish between neglect on purpose, and a parent's failure to provide food, clothing and shelter because of poverty.

What are some of the causes of child abuse?

It is common for abusive parents to report being physically, sexually or emotionally abused as children. However, there are parents who have not been abused as children who become abusive, as well as parents who have been abused as children who do not abuse their own children.

Some of the reasons parents or caregivers can become abusive are:

- Low self-esteem
- Hostility and anger
- Feelings of isolation, loneliness or being overwhelmed
- Anxiety
- Depression
- Apathy
- Fear of rejection
- Emotional immaturity
- Difficulty with being able to trust others
- Drug or alcohol misuse
- Adjusting to being a first-time parent, especially if the infant cries a lot, is 'difficult' or does not sleep well
- Parents' lack of knowledge about childhood development
- Lack of parenting skills and inappropriate attitudes e.g. acceptance of violence as a way to solve problems
- Unwanted pregnancy
- Physical illness
- Being unable to empathise or relate to the child



None of these factors make abuse a certainty. It is important to explore carefully all the details before making a claim of child abuse.

What types of children are at risk?

The child's age and physical, mental, emotional and social development can increase or decrease the chance of abuse. Younger children, due to their physical size and developmental status, are more vulnerable to certain forms of abuse, such as the 'battered child syndrome', the 'shaken infant syndrome' and the 'failure to thrive syndrome'.

The child's behaviour, (e.g. crying, being unresponsive or irritable) can increase the likelihood of abuse, particularly if a parent is not able to relate to the child, or has difficulty controlling his or her own emotions.

In general, children who are thought to be 'different', such as disabled children, are at greater risk of abuse. Children who are socially isolated can also be at high risk. For example, a child who does not have close relationships with his family and has few or no friends can be more vulnerable.

What types of families are at risk?

The situation of some families can increase the likelihood of abuse, such as:

- Conflict in the marriage
- Domestic violence
- Unemployment and financial stress
- Social isolation

Abusive families are often isolated from their neighbours and the community. As a result, abusive families tend to participate less in community activities and make less use of available economic, health and social resources. You may also notice over-reactions to the child's negative behaviour, and very little reaction to positive behaviour. In addition, abusive parents often use inconsistent and inappropriate forms of punishment and discipline.

It is important to remember that cultural or religious differences can make it difficult to identify or act on child abuse. What one culture defines as child abuse can be a socially acceptable act in another culture.

For example, values concerning the role of the child in the family, and attitudes about the use of physical punishment, differ between cultures. It is important to be sensitive and careful in these cases.

What can you do about child abuse?

It is your duty and obligation by law as a health worker to take action if child abuse is taking place. You may notice that a mother is not coping. She might say something that causes you to be concerned, such as:

- When I am stressed I hit or shake my baby
- I'm afraid that I'm really going to hurt my baby
- I want to shake my baby until she stops crying
- I often feel out of control

It is important to take these comments seriously. Some examples are given here of what you can say to a mother if you are concerned that she may hurt her baby.



Note

Child abuse may be a mild, single event, or more serious or on-going. Your responses should adapt to the level of abuse.

If the mother only hurt her child once, you can help the mother think about some short-term solutions. You can say:

- This sometimes happens if someone is feeling very stressed. However you must make sure that this does not happen again, to avoid harming the child physically and emotionally.
- If you can, take a quick walk outside, have a bath or wash your face.
- Breathe deeply and slowly.
- Count to ten.
- Only go back to your baby when you feel you can control your emotions.
- Hitting a pillow, or shouting into the pillow can help release some of your stress.
- Talk to someone you trust.
- If you feel like this again, walk out of the room after making sure that your baby is safe. Then, phone your partner, mother, friend or counsellor.
- Help the mother understand the baby's needs and behaviour. For example, explain that the baby is not trying to frustrate her on purpose. If you think that she should be referred to a counsellor, you can introduce the idea by saying: 'It sounds as though you are extremely stressed and that you need help immediately. I need to refer you to someone who will be able to give you the help and support you need. They might want to speak to you, your partner or your family about the situation.'

If you are concerned that the mother has hurt her child more than once, you may have to call Social Services or Child Welfare. The mother may have said things like:

- Yesterday I really hit my child hard, I felt like I was losing control
- I was so frustrated that I shook my baby
- I threw my child on the bed

The mother may feel unsure or even scared about Child Welfare getting involved in her life. Many mothers fear that their child/children will be taken away from them.

- Explain that you are going to phone Social Services/Child Welfare, which supports families in times of crisis. Explain that they help families to avoid tragedy and to overcome crisis situations.
- You must be firm about contacting Social Services or Child Welfare because the child's life is at risk.
- Be empathetic. Listen to the mother's feelings and allow her to share her fears and concerns.
- Do not sound shocked.
- Do not judge the mother.
- Assure her that Social Services/Child Welfare will do what is best for the baby and the mother.

If you think that the mother has abused her child more often, or you believe the mother is likely to hurt her child again, you can offer her some longer-term suggestions, like:

- You need to take this incident very seriously. It shows that something in your situation must change.
- You should get help in finding ways to reduce your stress levels.
- Therapy can help you to feel calmer and help you find solutions to your problems.
- Sometimes stress, depression or anxiety can result in you hurting your child. Counselling or medication can help with this. A therapist can help you decide if medication is an option for you.
- You may need more support from your partner, family, friends or neighbours.
- You may need practical help, like help with your housework. It is important for you to understand that more help may be necessary to have relief from the baby. This does not make you a bad mother. Making sure you get relief and support so that you can take better care of your baby is a good thing.

7.9 Suicide

Suicide is one of the greatest causes of maternal mortality in developed countries such as the United Kingdom and the United States of America.

Researchers believe that the suicide rate is also very high in South Africa. However, suicide is usually not reported correctly, possibly because family members often try to hide the fact that a suicide has taken place, due to the stigma of mental illness.

Some potential reasons for a high suicide rate among pregnant women are:

- The impact of HIV/AIDS on women's mental health
- A high rate of adolescent pregnancies – adolescents are at higher risk of mental illness and are more likely to commit suicide than adults
- Poverty and social problems

You may have heard many stories about suicide and the type of people who commit suicide, and those who do not. Some of these are incorrect, as can be seen in the table on the next page.

Danger signs

Sometimes a woman can show very clear signs that she wants to hurt herself. However, it is important to remember that there are no rules. A woman who is suicidal may not exhibit any of these signs, but may still be in danger of harming herself.

These are possible signs:

- The mother has made direct comments about wanting to commit suicide
- The mother has said that she wants to die
- The mother has talked about how she plans to commit suicide
- The mother feels that 'the baby would be better off without me'
- The mother is getting her affairs in order, like making plans for her children, or giving away her most valuable and important possessions

- If you have met the mother before, you may notice changes in her mood and/or behaviour, for example,
 - She may be eating less, or more
 - Her sleeping patterns have changed
 - She has withdrawn from other people
 - The mother is severely depressed

Other signs that the woman may be at higher risk of hurting herself are:

- She has made previous suicide attempts
- She has a history of severe mental disorder
- She is dependent on drugs or alcohol
- She is a victim of violence, e.g. rape, domestic violence, abuse
- She is a person who 'acts out' her feelings instead of 'talking them out'



If the risk seems high, and you think the mother is in danger of acting on her plan, do not leave her alone.

GET HELP URGENTLY!

Common myths about suicide

Incorrect	Correct
People who talk about suicide do not commit suicide.	Eight out of ten people who commit suicide give warnings.
Suicide happens without warning.	Studies show that the suicidal person gives many clues and warnings before attempting suicide.
Suicidal people want to die.	Most suicidal people are undecided, but take chances and unusual risks. These actions can be a cry for help, and may be asking someone to save them.
Improvement following a suicidal crisis means that the crisis is over.	Most suicides occur within the 3 months after the person has recovered from a previous suicidal episode. This 'improvement' sometimes means that the person now has the energy to put his/her suicidal thoughts and feelings into action. Sometimes the 'improvement' is because he/she feels relieved at having made his/her final decision.
Suicide is the act of a psychotic or 'mad' person.	Although the suicidal person is extremely unhappy, the person is not necessarily suffering from a severe mental illness. The person does not have to be psychotic to be suicidal.
Once suicidal, always suicidal.	Often a suicide attempt occurs during a particularly stressful period. If that period can be managed and good coping strategies can be developed, the person can continue with a normal, happy life.

What you can do

It is important to take any threat or hint of suicide seriously. If the mother shows one or more of the above signs, you should take action.

- Let the mother know you care about her.
- Do not make out like she is being 'silly'.
- Do not ignore her feelings, put her down for feeling this way, or scold her.
- Do not judge her.
- Empathise, but do not encourage the mother to feel sorry for herself.
- Be supportive, but do not make unrealistic promises. It is not your job to 'rescue' the mother: instead, care for her and make sure you refer her so she can get the help she needs.
- Talk openly about suicide.
- Ask the woman how she plans on committing suicide. The more detailed her plan is, and the more time she has spent thinking about how to commit suicide, the higher the risk.

Note

The way that you speak to the mother is very important.

Possible ways to get help

- Inform the doctor or sister-in-charge immediately
- Call her partner or a family member (but not someone she is afraid of or who she does not trust)
- If available, contact the psychiatric nurse at the nearest facility
- Call a helpline, so she can speak to a counsellor on the phone (see the Resources section)
- Call the woman's Minister, Pastor or religious leader if she has one, or contact your own if you think they can help
- Give her the telephone numbers of helplines and emergency services

What you can say

This is a very difficult situation and it is important to stay calm while speaking with the mother. Below are some suggestions for what you can say to her:

- It sounds as if life has become very difficult for you.
- Have you felt like this before?
- Have you thought about how you might do it?
- When we feel extremely stressed, we sometimes think of extreme solutions. We feel there is no way out. But this is a serious step to take. I don't want to argue about how you feel. It is clear that you are feeling very, very bad. But together we can find ways of dealing with your extreme stress.
- Other people have felt suicidal, and feel as badly as you do now, and they have found help.
- When we feel suicidal, it means that we have more pain than we can cope with. Can you give yourself time to think about ways to cope? Can you wait 24 hours before doing anything? We can use this time to think about other solutions to cope.
- You are not a bad person, or crazy, or weak, because you feel suicidal. It may not mean that you really want to die – it may mean that you have more pain than you can cope with right now. You deserve to get help. You deserve to feel better.
- You can be proud for speaking to someone about how you feel. It means that you want to survive this; that some part of you wants to live. It shows that you are a survivor.
- I feel that I need to contact your partner/doctor/family to let them know how desperate you are feeling. You need support right now, and they can help in different ways to support you.



Get support for yourself!

If you can, talk to someone you can trust afterwards. While respecting the confidentiality of the mother, you may need to debrief after helping someone who is in a lot of pain. This experience can be traumatic for both of you.

7.10 Grieving and loss: miscarriage and still-birth

When a woman loses her baby through termination, miscarriage, stillbirth or neonatal death, she, and her partner if present, are in need of emotional support. They could have a range of needs related to this experience.

- They may be in shock.
- They may need time to sort out their feelings.
- They should be given plenty of time to make decisions, e.g. whether they want to hold the baby.
- They may need on-going counselling, especially if this has happened before.

How to help women who experience miscarriage

During or after a miscarriage you can:

- Acknowledge the loss of 'a baby', no matter how early the miscarriage. Avoid using words like "miscarriage", "embryo" or "foetus" as these may seem impersonal to some women.
- Explain that the miscarriage is not the mother's fault and that it can happen in as many as a third of pregnancies.
- Recognise that parents can experience intense grief, however early the miscarriage. You can help them to acknowledge these feelings.

How to help women who experience late miscarriage, stillbirth or neonatal death

Late miscarriage

When a baby dies before birth and the mother has not experienced the baby as separate from herself, the death can be experienced as a loss of part of herself. This can be experienced as a sense of emptiness.

Often a miscarriage is not recognised as a 'loss of a baby'. This can make recovery very difficult. Many mothers find it helpful to mourn their loss and to create a memory of their baby. This makes the experience and the baby 'real'.

Here are ways you can help her:

- Help the mother talk about the baby even if their time together has been brief
- Help her remember the baby's behaviour during pregnancy
- Support her in holding and saying goodbye to her baby, if appropriate
- Be supportive while she decides to have a funeral or not

It is important to remember the baby, and the death, as a real event. Grieving properly can deeply affect a mother's mental well being in the future, especially if she plans on having more children.



Stillbirth or neonatal death

Help the woman and her partner express and manage their feelings when they know before the birth that the baby is dead. Before and during the birth you can help the mother, and her partner if he is present, to discuss their wishes for the baby:

- Do they want to see the baby?
- Do they want to have the baby delivered into her arms?
- Do they wish to cuddle the baby while he/she is still warm from the mother's body warmth?
- Have they chosen a name so the baby can be greeted by name at birth?
- Do they want a photograph of the baby?

Treat the baby gently at birth, e.g. wrap the baby in warm blankets.

Practical suggestions for after the birth

- Parents may not know how to be with their dead baby. Watching the health worker's tender interaction with the baby may help to show them.
- Offer to show the stillborn baby to the parents and other members of the family, if they wish, and help them cuddle the baby if that is what they want. Point out positive features, e.g. beautiful little hands.
- Support parents in deciding whether to stay with a dying or dead baby, and help them care for the baby if they want to do this. Do not judge their decision, whatever it is.
- Give parents privacy with their baby for as long they want after the birth. Put a bereavement (grieving) notice on the door.
- Help parents to obtain photographs and other mementos, such as a foot or hand print or lock of hair, if this is what they want.
- Tell parents where their baby has been taken in case they want to see their baby again.
- Explain to them the procedures that will take place after the birth, e.g. Will there be a post-mortem? What will the funeral and administrative arrangements be?

See the text box on the next page for more suggestions on how to help women and their partners who have experienced loss.

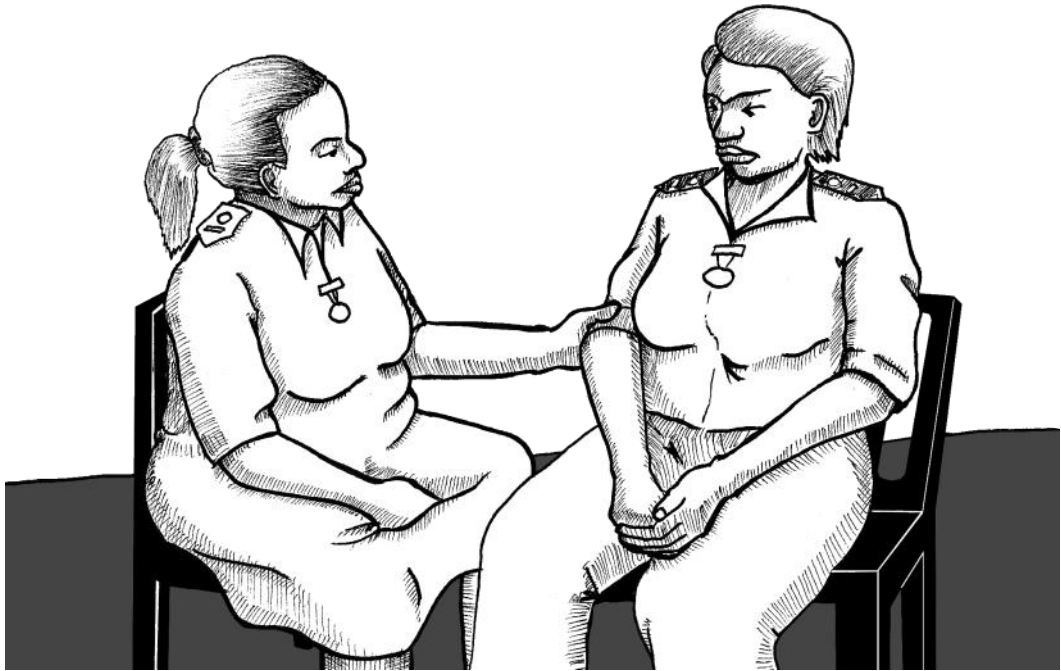


Tips

How to help women and their partners who have experienced a loss

- Stay close, and provide emotional support.
- Create an atmosphere of trust.
- Talk with both parents, if possible, so that the mother is not burdened with all the grief and so that the father's grief is acknowledged.
- Be aware that either parent may express anger. They may want to blame someone.
- Explain what has been done to save the baby and answer their questions about whether anything else could have been done.
- Be prepared to talk through likely outcomes of future pregnancies.
- Help parents express their feelings, particularly their fears.
- Empathise with the parents. It is acceptable to show some of your feelings, but be careful not to get too involved, to avoid the parents feeling concerned about your feelings and grief.
- Ask parents what they want to know and give relevant information. Do not assume they know more than they do. They may be upset and confused. Give explanations, where appropriate, to help them understand what has happened.
- Put parents in touch with support services, such as support groups or counsellors (see the **Chapter 8: Resources**)

Look after yourself



The loss of a baby, a late miscarriage or stillbirth can be very upsetting for everyone involved. It may help the parents to see you share their sadness and grief, and this can validate their feelings and show them that grief is a normal reaction.

Do not be afraid to show your emotions. However, make sure you are not putting too much of a burden on the parents by being upset. Instead, you may need to talk to someone else about the experience.



Do not be afraid to ask for support or a debriefing if you need it.

7.11 Summary

- There are several special issues that need to be taken into account when providing care and treatment for mothers.
- These include their level of poverty, how much support they have, their HIV status, if they are adolescents, refugees or substance users, their experience of abuse and whether they might be involved in abusing their own children.
- If a mother is suicidal she requires special attention and there are number of steps you can take to support her and get help.
- Miscarriage, stillbirth or loss of a baby is a traumatic experience for parents. There are a number of steps you can take to help them deal with this experience.
- These issues can also affect you as health workers. Try to get support or arrange a debriefing if you feel a particular mother's experience has affected you in some way.

References

The information in this chapter draws from the following articles:

- Abiodun OA (2006) Postnatal depression in primary care populations in Nigeria. *General Hospital Psychiatry*. 28: 133-136.
- Ertem I, Leventhal J, Dobbs S (2000) Intergenerational continuity of child physical abuse: How good is the evidence? *The Lancet*. 356: 814-819.
- Fisher J, Cabral de Mello M, Patel V, Rahman A, Tran T, Holton S, Holmes M (2012) Prevalence and determinants of common perinatal mental disorders in women in low- and middle-income countries: a systematic review. *Bulletin of the World Health Organization*. 90: 139-149.
- Hartley M, Tomlinson M, Greco E, Comulada WS, Stewart J, le Roux I, Mbewu N, et al. (2011) Depressed mood in pregnancy: Prevalence and correlates in two Cape Town peri-urban settlements. *Reproductive Health*. 8: 1-9.
- Rochat T J, Tomlinson M, Bärnighausen T, Newell M-L, Stein A (2011) The prevalence and clinical presentation of antenatal depression in rural South Africa. *Journal of Affective Disorders*. 135(1-3): 362-373.
- Palladino CL, Singh V, Campbell J, Flynn H, Gold KJ (2011) Homicide and suicide during the perinatal period: findings from the national violent death reporting system. *Obstetrics & Gynaecology*. 118 (5): 1056-1063.
- Patel V & Kleinman A (2003) Poverty and common mental disorders in developing countries. *Bulletin of the World Health Organisation*. 81: 609-615.
- Prince M, Patel V, Saxena S, Maj M, Maselko J, Phillips MR, Rahman A (2007) No health without mental health. *The Lancet*. 370: 859-877.
- United Nations (2003) The seventh United Nations survey on crime trends and the operations of criminal justice systems (1998-2000). Available at: <http://www.unodc.org>
- World Health Organization (2010) Atlas on substance use (2010): resources for the prevention and treatment of substance use disorders. Available at http://www.who.int/substance_abuse/publications/Media/en/



Your notes

[illegible]

Resources

This section provides copies of the screening tools discussed in this handbook, guidelines around applying for a Maintenance Order or Child Support Grant and referral tools.

Content

1. Screening tools
2. Maintenance Orders
3. Child Support Grants
4. Protection Orders
5. How to make a referral

8.1 Screening tools

The screening tools in this section can be copied and used for screening. Some of the screening tools are provided in English, Afrikaans, isiXhosa and French.

My feelings now that I am pregnant/have had a baby.

As you are pregnant/have had a baby, we would like to know how you are feeling. It may assist us in choosing the best care for your needs. The information you provide us will be kept private and confidential. There is a choice of four answers for each question. Please mark the one that comes closest to how you have felt in the past seven days, not just how you feel today.

In the past seven days:

1. I have been able to laugh and see the funny side of things:

- ☐ As much as I always could
- ☐ Not quite so much now
- ☐ Definitely not so much now
- ☐ Not at all

2. I have looked forward with enjoyment to things:

- ☐ As much as I ever did
- ☐ A little less than I used to
- ☐ Much less than I used to
- ☐ Hardly at all

3. I have blamed myself when things went wrong, and it wasn't my fault:

- ☐ Yes, most of the time
- ☐ Yes, some of the time
- ☐ Not very much
- ☐ No, never

4. I have been worried and I don't know why:

- ☐ No, not at all
- ☐ Hardly ever
- ☐ Yes, sometimes
- ☐ Yes, very much

5. I have felt scared or panicky and I don't know why:

- ☐ Yes, quite a lot
- ☐ Yes, sometimes
- ☐ No, not much
- ☐ No, not at all

6. I have had difficulty in coping with things:

- ☐ Yes, most of the time I haven't been managing at all
- ☐ Yes, sometimes I haven't been managing as well as usual
- ☐ No, most of the time I have managed quite well
- ☐ No, I have been managing as well as ever

7. I have been so unhappy I have had difficulty sleeping:

- ☐ Yes, most of the time
- ☐ Yes, sometimes
- ☐ Not very much
- ☐ No, not at all

8. I have felt sad and miserable:

- ☐ Yes, most of the time
- ☐ Yes, quite a lot
- ☐ Not very much
- ☐ No, not at all

9. I have been so unhappy that I have been crying:

- ☐ Yes, most of the time
- ☐ Yes, quite a lot
- ☐ Only sometimes
- ☐ No, never

10. I have thought of harming myself or ending my life:

- ☐ Yes, quite a lot
- ☐ Sometimes
- ☐ Hardly ever
- ☐ Never

Thank you

My gevoelens nou dat ek swanger is/my baba gekry het.

Nou dat jy swanger is/die baba het, wil ons graag weet hoe jy voel. Dit mag ons help om die beste sorg vir jou behoeftes te beplan. Die inligting wat jy aan ons verskaf sal privaat en vertroulik hanteer word.

Daar is 'n keuse van vier antwoorde vir elke vraag. Omsirkel asseblief die antwoord wat die beste beskryf hoe jy gedurende die afgelope sewe dae gevoel het, nie net hoe jy nou vandag voel nie.

Gedurende die afgelope sewe dae:

1. Kon ek die snaakse kant van dinge sien:

- ☐ So maklik soos ek altyd kon
- ☐ Nie heeltemal so maklik nie
- ☐ Defnitief nie so maklik nie
- ☐ Glad nie

2. Kon ek met genot na dinge uitsien:

- ☐ So baie soos ek altyd het
- ☐ 'n Bietjie minder as wat ek altyd het
- ☐ Baie minder as wat ek gewoonlik het
- ☐ Amper glad nie

3. Het ek myself blameer wanneer dinge verkeerd gaan, al was dit nie my skuld nie:

- ☐ Ja, meeste van die tyd
- ☐ Ja, soms
- ☐ Nee, nie dikwels nie
- ☐ Nee, nooit nie

4. Was ek bekommerd en ek weet nie hoekom nie:

- ☐ Nee, glad nie
- ☐ Omtrent nooit
- ☐ Ja, soms
- ☐ Ja, dikwels

5. Het ek bang en paniekerig gevoel en ek weet nie hoekom nie:

- ☐ Ja, nogal baie
- ☐ Ja, soms
- ☐ Nee, nie so baie nie
- ☐ Nee, glad nie

7. Het ek gesukkel om dinge te hanteer:

- ☐ Ja, meeste van die tyd sukkel ek om dinge te hanteer
- ☐ Ja, soms hanteer ek dinge nie so maklik soos gewoonlik nie
- ☐ Nee, meesal hanteer ek dinge redelik goed
- ☐ Nee, ek hanteer dinge so goed as wat ek altyd kon

7. Was ek so ongelukkig dat ek sleg geslaap het:

- ☐ Ja, meeste van die tyd
- ☐ Ja, soms
- ☐ Nie dikwels nie
- ☐ Nee, glad nie

8. Het ek hartseer en ongelukkig gevoel:

- ☐ Ja, meeste van die tyd
- ☐ Ja, nogal dikwels
- ☐ Nie dikwels nie
- ☐ Nee, nooit nie

9. Was ek so hartseer dat ek gehuil het:

- ☐ Ja, meeste van die tyd
- ☐ Ja, dikwels
- ☐ Net soms
- ☐ Nee, nooit

10. Die idee om myself leed aan te doen het al by my opgekom:

- ☐ Ja, nogal dikwels
- ☐ Soms
- ☐ Amper nooit
- ☐ Nooit

Baie dankie

Edinburgh Postnatal Depression Scale (EPDS)

isiXhosa

Indlela endiziva ngayo ngexa ndikhulelweyo naxa disasandula ukufumana umntwana.

Njengokuba ukhulelewe okanye usandula ukufumana usana sifuna ukwazi ukuba uziva njani. Oko kungasanceda ukukhetha eyona ndlela esingathi sancedisane nemfuno zakho. Yonke inkcazelo oyakuthi usinike yona izakugcinwa iyimfihlo.

Kunentlobo ezine zempendulo kumbuzo ngamnye, Nceda yenza isangqa kwenye ethe yasondela kwindlela ubuziva ngayo kwintsuku ezisixhenxe ezidlulileyo, hayi ngendlela oziva ngayo ngoku.

Kwintsuku ezisixhenxe ezidlulileyo:

1. Ndibenakho ukubona icala lezinto ezingalunganga:

- ☐ Kangangoko bendisenza
- ☐ Hayi kangako
- ☐ Ngokuqinesekileyo akukho kangako ngoku
- ☐ Akukho kwaphela

2. Izinto ndizijonga ndinolonwabo:

- ☐ Njengoko bendihlala ndisenza
- ☐ Kancinane kunokuba ndisenza
- ☐ Kancinci kakhulu kunokuba bendisenza
- ☐ Hayi konke konke

3. Bendibeka ityala kum xa izinto zingandihambeli kakhule, ibe ingeyompazamo yam:

- ☐ Ewe amaxesha amaninzi
- ☐ Ewe ngelinye ixesha
- ☐ Hayi kangako
- ☐ Hayi kwaphela

4. Bendikhathazekile kwaye ndingamazi unobangela:

- ☐ Hayi konke konke
- ☐ Kunqabile ukuba kwenzeka
- ☐ Ewe ngamanye amaxesha
- ☐ Ewe kakhulu

5. Bendiziva ndisoyika okanye ndinexhala kwaye ndingamazi unobangela:

- _____Ewe kakhulu
- _____Ewe ngamanye amaxesha
- _____Hayi kangako
- _____Hayi konke konke

6. Ndifumene ubunzima kakhulu ukumelana nezinto:

- _____Ewe ixesha elininzi bendikwazi ukumelana nezinto
- _____Ewe ngelinye ixesha bendingakwazi ukumelana nezinto ngendlela ebendimelana nazo ngayo
- _____Hayi ixesha elininzi bendiphumelela kakhulu
- _____Hayi bendingafumani bunzima kwaphela

7. Bendingonwabanga kakhulu kwaye bendifumana ubunzima xa kufuneka ndilele:

- _____Ewe ixesha elininzi
- _____Ewe ngalinye ixesha
- _____Hayi kangako
- _____Hayi konke konke

8. Bendizive ndibuhlungu kwaye ndixhalisekile:

- _____Ewe amaxesha amaninzi
- _____Ewe ngolonahlobo
- _____Hayi kangako
- _____Hayi konke konke

9. Bendingonwabanga kakhulu ndisoloko ndilila:

- _____Ewe ixesha elininzi
- _____Ewe ngolonahlobo
- _____Ngamanye amaxesha
- _____Hayi azange

10. Ingcinga yokuzenzakalisa ike yandifikela:

- _____Ewe ngolonahlobo
- _____Ngamanye amaxesha
- _____Ayizange kwaphela
- _____Ayizange

Enkosi kakhulu

Mes sentiments, maintenant que je suis enceinte/que j'ai un bébé.

Comme vous êtes enceinte/vous avez un bébé, nous aimerions savoir comment vous vous sentez. Cela nous aidera à choisir les meilleurs soins dont vous avez besoin. Les renseignements que vous nous fournirez demeureront privés et confidentiels.

Il y a un choix de quatre réponses pour chaque question. Encerclez celle qui se rapproche le plus de la manière dont vous vous êtes sentie **les sept derniers jours**, et pas seulement la manière dont vous vous sentez aujourd'hui.

Les sept derniers jours:

1. J'ai été capable de voir le côté amusant des choses:

- ☐ Autant que je l'ai toujours pu
- ☐ Pas autant maintenant
- ☐ Certainement pas autant
- ☐ Pas du tout

2. J'ai attendu les événements avec impatience et plaisir:

- ☐ Autant que je l'ai toujours fait
- ☐ Un peu moins qu'auparavant
- ☐ Bien moins que d'habitude
- ☐ Presque pas

3. Je me suis blâmée quand les choses n'allaient pas bien et que ce n'était pas ma faute:

- ☐ Oui, la plupart du temps
- ☐ Oui, quelquefois
- ☐ Pas beaucoup
- ☐ Non jamais

4. J'étais inquiète, et je ne savais pas pourquoi:

- ☐ Non, pas du tout
- ☐ Presque jamais
- ☐ Oui, quelquefois
- ☐ Oui, beaucoup

5. Je me suis sentie effrayée et pleine de panique et je ne savais pas pourquoi:

- ☐ Oui, beaucoup
- ☐ Oui, quelquefois
- ☐ Non, pas beaucoup
- ☐ Non pas du tout

6. J'ai eu des difficultés à faire face aux événements:

- ☐ Oui, la plupart du temps, je n'ai pas pu me débrouiller
- ☐ Oui, quelquefois, je n'ai pas pu me débrouiller comme d'habitude
- ☐ Non, la plupart du temps, je me suis assez bien débrouillée
- ☐ Non, je me suis pas débrouillée aussi bien qu'avant

7. J'ai été si malheureuse, que j'ai eu des difficultés à dormir:

- ☐ Oui, la plupart du temps
- ☐ Oui, quelquefois
- ☐ Pas beaucoup
- ☐ Non, pas du tout

8. Je me suis sentie triste et misérable:

- ☐ Oui, la plupart du temps
- ☐ Oui, beaucoup
- ☐ Non, pas beaucoup
- ☐ Non, pas du tout

9. J'ai été si malheureuse que j'ai pleuré:

- ☐ Oui, la plupart du temps
- ☐ Oui, beaucoup
- ☐ Quelquefois seulement
- ☐ Non, jamais

10. La pensée de me faire du mal m'est venue:

- ☐ Oui, souvent
- ☐ Quelquefois
- ☐ Presque jamais
- ☐ Jamais

Merci

THE RISK FACTOR ASSESSMENT (RFA)

English

My situation now that I am pregnant/have had a baby.

We are interested to find out how your situation is in your pregnancy/nor that you have had your baby. This questionnaire may help us suggest extra care for you if necessary. Your answers will be kept confidential.

Please answer either **yes** or **no** to the following questions. Tick the box.

	Yes	No
1. I feel pleased about being pregnant/having had a baby.		
2. I have had some very difficult things happen to me in the last year (e.g. losing someone close to me, losing my job, moving home, etc.)		
3. My husband/boyfriend and I are still together.		
4. I feel my husband/boyfriend cares about me (say 'no' if you are not with him anymore).		
5. My husband/boyfriend or someone else in the household is sometimes violent towards me.		
6. My family and friends care about how I feel.		
7. I have experienced some kind of abuse in the past (e.g. physical, emotional, sexual, rape).		
8. My family and friends help me in practical ways.		
9. On the whole, I have a good relationship with my own mother (indicate 'no' if your mother has passed away).		
10. I have experienced one of the following in the past: miscarriage, abortion, stillbirth, or the death of a child any time after birth.		
11. I have had serious depression, panic attacks or problems with anxiety before.		

NAME _____

FOLDER NUMBER: _____ GRAV: _____

GESTATION: _____ PARA: _____

DATE: _____ EPDS: _____

AGE: _____ RFA: _____

The Risk Factor Assessment (RFA)

Afrikaans

My situasie nou dat ek swanger is/my baba gekry het.

Ons stel daarin belang om uit te vind wat jou situasie is in jou swangerskap. Hierdie vrae kan ons help om moontlik extra hulp vir jou aan te bied indien nodig. Jou antwoorde sal vertroulik hanteer word. Antwoord asseblief **ja** of **nee** op die volgende vrae. **Maak 'n kruisie.**

	Ja	Nee
1. Ek voel gelukkig nou dat ek swanger is/my baba het.		
2. Baie moeilike dinge het in die afgelope jaar met my gebeur (bv. iemand na aan my is dood, ek het my werk verloor, ek het getrek).		
3. My man/vriend en ek is nog bymekaar.		
4. Ek voel dat my man/vriend gee om vir my (merk Nee as julle nie meer bymekaar is nie).		
5. My man/vriend of iemand anders in die huis tree soms agressief teenoor my op.		
6. My familie en vriende gee om hoe ek voel.		
7. Ek was al in die verlede mishandel (bv. fisies, emosioneel, seksueel, verkrag).		
8. My familie en vriende help my op praktiese maniere		
9. Oor die algemeen het ek 'n goeie verhouding met my eie ma(merk Nee as jou ma reeds oorlede is).		
10. Ek het een van die volgende in die verlede ervaar: miskraam, aborsie, stilgeboorte, dood van my kind enige tyd na geboorte.		
11. Ek het van te vore aan ernstige depressie gelei, paniek aanvalle of probleme met angs gehad.		

NAME: _____

FOLDER NUMBER: _____ GRAV: _____

GESTATION: _____ PARA: _____

DATE: _____ EPDS: _____

AGE: _____ RFA: _____

The Risk Factor Assessment (RFA)

isiXhosa

Imeko endikuyo njengokuba ndikhulelwe/naxa ndifumene umntwana.

Sinomdla wokwazi injani imeko okuyo njengokuba ukhulelewe okanye ufumene umntwana. Lemibuzo ingasinceda ukuthi sikwazi ukukubonelela ngoncedo xa kuyimfuneko. Impendulo yakho iyakugcinwa iyimfihlo. Nceda phendula apha **ewe** okanye **bayi** kulemibuzo ilandelayo. **Hlaba kwibhokisi.**

	Ewe	Hayi
1. Ndiziva ndixolile njengokuba ndinzima/njengokuba ndifumene umntwana.		
2. Ndibenezinto ezibuhluu kakhulu ezindehleleyo kulonyaka uphelileyo (umzekelo ndaye ndaphulukana nomsebenzi, ndaphulukana nomntu owayesondele kakhulu kum, ndafuna indawo yokuhlala ngokutsha).		
3. Umyeni/isoka lam sisekunye kunye (uthi hayi ukuba anisahlali kunye).		
3. Ndicinga ukuba umyeni/isoka lam lindikhathalele kakhulu.		
5. Umyeni/isoka lam okanye omnye umntu endlini ngamanye amaxesha babanobundlongondlongo kum.		
6. Izazalwane kunye nezihlobo zam ziyikhathalele indlela endiziva ngayo.		
7. Ndifumene ingxaki yokuphatheka kakubi kwixesha elidlulileyo (umzekelo ngokwasemzimbeni, ngokwasemphefumleni, ngokwesondo nangokudlwengulwa).		
3. Izizalwane nezihlobo zam bezindinceda kwizinto ezenziwayo.		
9. Ngokupheleleyo ubuhlolo phakathi kwam nomama buhle kakhulu.		
10. Ndifumene ezingxaki kwixesha elidlulileyo: ukuphuma isisu, ukuqhomfa, ukuzala umntwana sele etshabile, okanye ukuswelekelwa ngumntwana sendimfumene.		
11. Ndike ndaba nokudakumba okuxhalabisayo komphefumlo, ndaziva ngathi. Ndivaleka umphefumlo, intliziyo ibetha ngamandla, ndinokudinwa okugqithileyo kwixesha elidlulileyo.		

NAME _____

FOLDER NUMBER: _____ GRAV: _____

GESTATION: _____ PARA: _____

DATE: _____ EPDS: _____

AGE: _____ RFA: _____

The Risk Factor Assessment (RFA)

French

Ma situation, maintenant que je suis enceinte.

Nous aimerions connaître votre situation durant votre grossesse. Ce questionnaire nous aidera à suggérer des soins supplémentaires pour vous, si c'est nécessaire. Vos réponses seront confidentielles.

	Oui	Non
1. Je suis heureuse d'être enceinte.		
2. J'ai connu des difficultés au cours de l'année dernière (par exemple: perte de quelqu'un de cher, perte de mon emploi, déménagement, etc).		
3. Mon mari/compagnon et moi sommes toujours ensemble.		
4. Je sens que mon mari/compagnon m'aime toujours (dites Non, si vous n'êtes plus avec lui).		
5. Mon mari/compagnon, ou quelqu'un d'autre à la maison est quelquefois violent avec moi.		
6. Ma famille et mes amis se soucient de la manière dont je Me sens.		
7. J'ai souffert quelque forme de mauvais traitement dans le passé (ex. physique, émotionnel, sexuel, viol).		
8. Ma famille et mes amis m'aident dans les choses pratiques.		
9. Dans l'ensemble, je jouis d'une bonne relation avec ma propre mère (écrivez ' non ', si votre mère est morte).		
10. J'ai subi l'un des chocs suivants dans le passé: fausse-couche, avortement, enfant mort-né ou la mort d'un enfant quelque temps après la naissance).		
11. J'ai souffert de dépression sérieuse, panique ou des problèmes d'anxiété au passé.		

NAME _____

FOLDER NUMBER: _____ GRAV: _____

GESTATION: _____ PARA: _____

DATE: _____ EPDS: _____

AGE: _____ RFA: _____

The 5-Item Short Risk Factor Screen

We are interested to find out how your situation is in your pregnancy/now that you have had your baby. This questionnaire may help us suggest extra care for you if necessary.

Your answers will be kept confidential. Please answer either **yes** or **no** to the following questions. **Tick the box.**

	Yes	No
1. Have you had some very difficult things happen in the last year?		
2. Are you pleased about this pregnancy or now that you have had your baby?		
3. Is your partner supportive?		
4. Have you had problems with things like depression, anxiety or panic attacks before?		
5. Is your partner or someone at home sometimes violent towards you?		

NAME _____

FOLDER NUMBER: _____ GRAV: _____

GESTATION: _____ PARA: _____

DATE: _____ EPDS: _____

AGE: _____ RFA: _____

8.2 Maintenance Orders

This information applies to South Africa. It is worth finding out about relevant laws and processes in your country.

The process

- The mother (or other caregiver)* needs to go to the Maintenance Office at the Maintenance Court in her area to apply for the court order. The mother will need to fill in a form.
- The Maintenance Officer will send a summons to the father, asking the father to come to the Maintenance Office on a certain date.
- On the date, the mother and the father must go to the office to determine how much that person must pay for the children.
- The Maintenance Officer will help the mother work out all the things she must pay for every month, how much money she earns and how much money the father earns.
- If the father says that he is not the father of the child, the mother needs to ask the court to order a paternity test.



Note

The information that the mother must take with her to the Maintenance Office:

- The name and address of the other parent, and the details of where she and the other parent work
- Her identity document
- The children's birth certificates
- A letter of attendance from the school principal for any school-going child
- A copy of the divorce order (if applicable)
- Proof of her income (like a salary slip)
- Her papers, receipts and accounts, showing all the things the mother must pay every month

*For the sake of simplicity, we will refer to a mother applying for a Maintenance Order in this section. However, fathers and other primary caregivers can also apply.

- The Magistrate will listen to both the parents' stories. They will ask both parties to show how much they earn and how much they pay every month for things like rent, electricity and food.
- The Magistrate then decides how much the father must pay for the children. The Magistrate will make this amount an 'Order of Court', in writing.
- If the mother agrees with how much the father must pay for the children, the Maintenance Officer will get both parents to sign a paper called an 'Order of Court'. This says that the father must pay the agreed amount of money every week or every month.
- If the mother does not agree, or if the father does not come to the office on that date, then the officer will say their case must go to the Maintenance Court. The court sends notices to both parents telling them to come to the Maintenance Court on a certain date.
- The father must pay the maintenance amount every week or month to the Maintenance Office. The mother must then collect the money from the Maintenance Office. The money can also be paid into her bank account. This will save her from having to collect the money from the office.

What if the person ordered to pay maintenance does not pay?

- The mother needs to go to the Maintenance Office and complain. It is important to make a formal complaint every time that the other parent does not pay.
- The Maintenance Office records each time payments are made. This record will show when payments are not made and how much is owed.
- If the other parent is employed and fails to pay maintenance, the mother must ask the court to make an order to get the maintenance directly from the other parent's employer.
- If the other parent does not pay, the person is not obeying the order of court. This is a crime. The court will send the other parent a notice telling the person to come to court on a certain date. The person must then explain why they did not pay the money. If there is not a good reason, the court will usually tell the other party to pay all the maintenance the person owes, or the person will go to jail.

For more information contact the Maintenance Officer at your local Magistrates' Court.

8.3 Child Support Grants

This information applies to South Africa. It is worth finding out about relevant laws and processes in your country.

- The Child Support Grant is a monthly payment to help parents or primary caregivers in financial need to support the children in their care.
- The amount changes every year. From 1 April 2012 the Child Support Grant was R280 per month.
- Parents or primary caregivers can apply for this monthly payment on behalf of the children in their care.
 - When primary caregivers apply for a grant for a child, they must declare under oath that they are the primary caregiver, and provide some documentary proof of this. They cannot receive this grant for more than six children, unless the children are legally adopted.
 - Children who are heading households, and who are between the ages of 16 and 18, can apply for the Child Support Grant with the help of a supervising adult, like a social worker.



Definition: primary caregiver

A *primary caregiver* is anyone, other than the biological or foster parents, who is over the age of 16 and is mainly responsible for looking after the child. They can be a family member, including a brother, sister or grandparent.

- Parents or primary caregivers who earn below a certain amount can also access this grant.
 - A single parent or caregiver who earns R2,800 or less per month (or less than R33,600 per year) can apply for this grant.
 - A married couple who together earn R5,600 or less per month (or less than R67,000 per year) can apply for this grant.
- Parents or primary caregivers must be South African citizen or permanent residents of South Africa. They and the child must be living in South Africa.

The process

Parents or primary caregivers can apply for a grant at their nearest South African Social Security Agency (SASSA) office. There is no cost to apply. The parent or primary caregiver will need:

- A South African identity document and the identity document for the child, which must be bar-coded
- The child's birth certificate
- If the parent or primary caregiver is married, proof of the person's marital status
- Proof of income: salary slip, bank statements for three months, or pension slips, and any other proof of income
- If the parent or primary caregiver is unemployed, the Unemployment Insurance Fund (UIF) card, also known as the 'blue book', or a discharge certificate from the person's previous employer
- If the primary caregiver is not the child's parent or guardian, a written note of permission from the parent or guardian that the person should take care of the child
- If the primary caregiver is not the child's parent or guardian, information about how the person has tried to get the parents to pay maintenance
- Information that shows that the person is the child's primary caregiver



Note

The parent or primary caregiver can still apply without an identity book, or if some of the other necessary documents are missing.

At the SASSA office, the parent or primary caregiver will be asked to complete and sign a form known as a 'sworn affidavit', confirming who the person and the children are. The parent or primary caregiver will also be asked to bring an affidavit from a reputable person (like a councillor, traditional healer, social worker, priest or school principal) who can verify that they know the person. SASSA may also ask for other documents, like a clinic card or the child's school report.

- At the SASSA office, the parent or primary caregiver will be assisted to complete the forms. The person will be interviewed and fingerprints will be taken.
- If the parent or primary caregiver cannot go to the office, a friend or family member can take the documents, with a letter from the person and a doctor saying that the person cannot go to the SASSA office. A SASSA official will then arrange to visit the person at home.
- When the parent or primary caregiver makes the application, the person must say how he/she would like the money to be paid. The person can:
 - Collect it on a specific day each month, or
 - Have it paid into a bank account. This can be changed at any time by filling in a form at the SASSA office.
- In some SASSA offices, applicants are told immediately whether or not they qualify for a grant.
 - SASSA cannot take longer than 3 months, from the date of the mother's application, to start paying the grant.
 - The payments will be backdated to the date the parent or primary caregiver applied for the grant, if it takes this long.
 - The parent or primary caregiver can phone the free SASSA helpline: 0800 601 011 to find out what has happened to the application and when the person can expect payment.
- The parent or primary caregiver does not need to renew the grant.
 - Every year, SASSA will send the person a registered letter asking to provide up-to-date information about the person's financial situation.
 - If the person's financial situation gets better before SASSA sends this letter, it is the person's responsibility to let SASSA know.

It is the person's responsibility to let SASSA know of any other changes in his/her situation.

- Child Support Grants will be stopped:
 - When the child turns 18.
 - If the child is admitted to a state-funded institution for over six months.
 - If the child dies.

For more information contact a local SASSA office.

8.4 Protection Orders

This information applies to South Africa. It is worth finding out about relevant laws and processes in your country. This information below is taken from Miller R. (2003). It's an Order! A simple guide to your rights. Cape Town: Mosaic Training, Service and Healing Centre for Women.

What is a Protection Order?

A Protection Order is a document which legally forbids an abuser from committing any acts of domestic violence against the applicant (e.g. woman)*.

The types of abuse covered by Protection Orders are:

- Physical abuse
- Sexual abuse
- Verbal abuse
- Emotional abuse
- Psychological abuse
- Economic abuse
- Harassment

Anyone who has been or is being abused can apply for a Protection Order. Also:

- Someone else can apply for a Protection Order on behalf of the woman, with her written permission. In this written consent, the woman must explain why she is not able to make the application herself.

*In this section, we will refer to a woman applying for a Protection Order.

- The child of the woman can apply for a Protection Order without requiring the assistance of the woman as parent or guardian, however the case will be referred to the Children's Court.
- The woman can apply for a Protection Order on behalf of her children, without their permission, whether they are her natural, adopted or foster children.

Depending on the severity of the abuse, once the application forms and affidavit have been completed, an Interim Protection Order might be granted for a short period until the date the abuser must appear in front of the magistrate for the hearing of the case. Once the Protection Order is finalised, the Protection Order is permanent. A Protection Order can be withdrawn.

The process

All courts process Protection Orders slightly differently, but the procedure that most courts follow is described below.

Applying for the Protection Order

A woman can apply for a Protection Order at any magistrates' court nearest to where she lives or works, nearest to where her abuser lives or works, or nearest to where the abuse took place.

- The woman will have to fill in an Application form for a Protection Order and write out a statement (Affidavit) about the abuse. She will be asked to make a sworn statement to the clerk that what she has written is true, and sign the Application form. Her file will be passed on to the magistrate.
- The magistrate will read through the Application form and decide if the woman qualifies for an Interim (Temporary) Protection Order or not.
 - If it is granted, the clerk will tell the woman what her court return date is, and will give her an Application Number.
- The magistrate will issue a Notice to Appear in court to the abuser, which will inform him that an application for a Protection Order has been made, and that he must appear on the return date to give his side of the story.
- The police or sheriff will go to the abuser's address and serve the copy of the Interim Protection Order on the woman's abuser.
- The police or the sheriff will fill in the Return of Service form, and return it to the court when the Protection Order has been served.

- Then, the woman will be entitled to receive an Interim Warrant of Arrest, which she must get from the court. That is why some courts may only give a Final Warrant of Arrest when a woman appears in court for the Protection Order to be made final. If the clerk does not give the woman one, she must demand one or report it to the chief magistrate.
- The woman's court return date should not be less than 10 days after the Interim Protection Order has been served on the abuser. However, there is no time limit as to how far in advance the date should be made for the final court hearing.

Note

The information that the woman must take with her to the Magistrates' Court:

- Her identity document (if not available, her date of birth)
- The abuser's identity document (if not available, the abuser's date of birth or age)
- The abuser's home or work address.
- A Protection Order cannot be granted if the address of the abuser is not known.

**Who pays for the Interim Protection Order?**

- If the woman is able to pay for the sheriff to serve the Interim Protection Order, she will have to take two copies of her Application and Interim Protection Order forms to the sheriff's office.
- If the court has money to pay for the service for the woman, the court will provide the woman with a note to say that the State has agreed to pay the sheriff to have the Protection order served on the abuser.
 - The woman will not need to take a Return of Service form to the sheriff.
- If neither the woman nor the Court can pay for the Interim Protection Order to be served on her abuser, the woman will have to get the police to serve the Interim Protection Order.
 - The clerk will give the woman a Return of Service form, which the woman will have to take to the police, along with two copies of her Application and Interim Protection Order forms.

Finalising the Protection Order

- The Interim Protection Order lasts until the woman and her abuser have to go back to court on the woman's return date to find out if she can get a Final Protection Order.
- During her hearing in court, the magistrate, and lawyers (if she or the abuser have one) will ask questions to her and her abuser.
- The magistrate will decide if the woman can have a Final Protection Order on the basis of her Affidavit and on the basis of what she and the abuser said in court.
- With the Final Protection Order, the woman will also get a Final Warrant of Arrest.
- If the woman's Protection Order is lost or destroyed, it can always be replaced if she goes back to court and asks for another copy.

What happens if the abuser breaches the Protection Order?

- If the woman is abused after she has received her Interim or Final Protection Order, she must take the Interim or Final Warrant of Arrest and her copy of the Interim or Final Protection Order to the police so that they can arrest her abuser.
- The woman will have to return to court to get another Warrant of Arrest when the police take her Warrant of Arrest away from her when they arrest her abuser.
- If she does not have a Warrant of Arrest, then she will have to take her Protection Order with her to the police station and lay a charge of assault against her abuser.



Tips

- Normally, application can be made at the court on any day of the week, and after-hour applications must go to the police station.
- However, not all courts have the same schedule: some only handle Protection Order applications on certain days, some every day but during certain hours.
- It is best to telephone the clerk to ask on what days and at what times the woman can apply for a Protection Order at her court.
- Most courts take applications on a 'first come first served' basis, so the woman should go early (by 9am at the latest). The application process can take most of the day.
- The woman should give a copy of her Protection Order to someone she trusts so that they can keep it safe in case hers gets lost or destroyed.
- She can also take a copy to her nearest police station and ask them to open a file and keep her Protection Order for her.
- She can always get another copy at the court where it was granted to her.

8.5 How to make a referral

Use the template below to draft a letter of referral.

Contact at referral organisation Name of referral organisation Address of referral organisation Town Date Dear <i>[include name of contact person here]</i> Re: <i>[include name of patient here]</i> Thank you for considering <i>[include name of patient here]</i> She is _____ years old. I am concerned about this patient because _____ _____ _____ _____ _____ I hope that you will be able to assist her with her difficulties. Please contact me for further information and to let me know that this referral has been successful. My telephone number is <i>[insert your telephone number here]</i> Yours sincerely <i>[include your signature here]</i> Your name Job Title	Address of your health unit Town, District Your telephone number
--	--

After referring your client, follow-up on your client. Use the evaluation form below to find out if your client got the help she needed.

Date referral made
Who made referral?
If referred, where?
Date of appointment?

Did you go? **Yes / No**

If **No**, what stopped you?

If **Yes**, did you get help for your problem? **Yes / No**

What help was given?

What do you think about the help that was offered?

Would you recommend that place to a friend? **Yes / No**

Why?

8.6 South African Helplines

National Mental Health Information Line 0800 567 567

Organisation	Number
Advice Desk for Abused Women	031 262 9673/9679
AIDS Helpline	0800 012 322
Alcoholics Anonymous	0861 435 722
Care Assist (health & psychiatric concerns helpline)	011 359 5000
Child Line	080 005 5555 or 021 461 1114
Child Welfare	0800 435754
Compassionate Friends	011 440 6322, 082 317 4947, 021 981 9540
Domestic Violence Assistance Programme	031 260 1588
Emergency contraception helpline	0800 246 432
FAMSA	021 447 7951
Gay & Lesbian Association	011 717 4239
Lifeline	0861 322 322
Love Life Sexual Health Line	0800 121 900
Marie Stopes	0800 11 77 85
Mental Health Info Centre	0800 600 411, 021 938 9229
Mental Health Society	011 614 9890
Narcotics Anonymous	083 900 6962
Obsessive-Compulsive Disorder Association	011 786 7030
People Opposing Women Abuse (POWA)	011 642 4345/4346
Postnatal Depression Association of SA	SMS 'help' and your name to 082 882 0072
Rape and Trauma Line	021 447 9762 or 083 222 5158
SA Depression and Anxiety Group	011 262 6396
Safeline	0800 035 553
Schizophrenia Foundation of SA	0860 100 541
Sexual Health Helpline	0860 100 262
South African Social Security Agency	0800 601 011
Crisis counselling for women	0800 150 150
Western Cape Mental Health Service Directory	021 483 4003/ 4270/ 5660/

Afterword

Whether you have read this book from cover to cover, or have looked at a chapter or two, we hope that you will return to it often. We would love you to make it your own - scribble notes, thoughts, your stories and ideas. Add what you find is missing. Perhaps you will want to share some parts of the book with colleagues, superiors or those you train or supervise?

Many health workers face enormous personal and professional challenges. We hope this resource helps you in caring for mothers by being able to understand their challenges and circumstances. We also hope it reminds you of all your own wisdom, skills and experience, and how to draw on these. We acknowledge the difficulties in your work and we acknowledge you, the carer, and thank you for what you do.

P.S. We would be grateful if you would send us feedback about how you have used, or not used the book. What was helpful - what was not? What did you need that you didn't see in the book? Has your practice changed as a result of using the book? We would like to improve this book for the next edition, and we need your input. We would love to hear from you, even a few lines of an email or letter would be valuable to us.

Please email info@pmhp.za.org or send mail to **PMHP, 46 Sawkins Road, Building B, Rondebosch, 7700.**

Take care,
Simone Honikman (Director)
and the PMHP team



Perinatal Mental Health Project

Alan J Flisher Centre for Public Mental Health

Department of Psychiatry & Mental Health

University of Cape Town

46 Sawkins Road | Building B | Rondebosch 7700 | South Africa



+27(0)21 689 8390



info@pmhp.za.org



www.pmhp.za.org

ISBN (print) 978-0-620-56427-4

ISBN (ebook) 978-0-620-56428-1