Mothers in DISTRESS

With Pregnancy Week happening in February, the Perinatal1 Mental Health Project (PMHP), an initiative by the Alan J Flisher Centre for Public Mental Health operating at the University of Cape Town, gives some eye-opening information on mental health and pregnancy.

There are many physical, emotional and social changes during pregnancy. Add to this the realities of poverty, violence, abuse and HIV/AIDS, and pregnancy can be a distressing time for many women.[2]

In South Africa, more than one in three women living in poverty will experience mental health problems during and after pregnancy. This is three times the prevalence of developed countries, and it is significantly higher than in other developing states. While postnatal depression affects 10 to 15% of women in developed countries, such as the United States and the United Kingdom, studies have found the rate to be 35% or above in South Africa.[3]

Studies in KwaZulu-Natal and Cape Town report rates of 47 and 39% for antenatal depression respectively. Also, depression during pregnancy can be a sign for postnatal depression.[4]

Depression and pregnancy

One of the most common maternal mental illnesses is depression. This is not the "baby blues". The "baby blues" are considered to be a normal consequence of the hormonal changes which occur after pregnancy. They can start from the third or fourth day after birth, and last anything from three days to six weeks. However, depression lasts longer and signs are usually identifiable during pregnancy. It can interfere with how women are able to function at work and within their families or communities.

HIV/AIDS and maternal mental health

Pregnancy is a time when many women discover their HIV status. A South African study found that 84% of pregnancies among HIV-infected women were unintended.5 This is likely to worsen pregnant women's distress, especially if the situation giving rise to the pregnancy was traumatic.

Mental illness increases one's risk of becoming HIV positive. One reason for this is that a depressed person is less likely to be able to negotiate safe sex due to low self-esteem, a sense of hopelessness, or financial dependency. Also, mental illness adds significantly to the high rates of AIDS-related deaths among South African women.

On the other hand, HIV infection is a major cause of mental illness: almost half (43.7%) of all people living with HIV/AIDS in South Africa will experience a mental illness. This is much higher than the HIV-negative population, where 16.5% are likely to experience a mental illness.6

Why should we worry about mental health?

Antenatal depression can affect the foetus. It is associated with poor physical and cognitive foetal development and infants of depressed mothers have shown increased vulnerability to infectious diseases. Altogether, this has a negative impact on infant survival and the developmental potential in children under five years of age. Research shows that later in life, children of depressed mothers are also more likely to be abused, to perform poorly at school and to develop mental illness themselves.

Untreated depression is also a significant cause of maternal and child morbidity and mortality. Studies in developed countries have shown that suicide as a result of mental illness is a leading cause of maternal mortality, with higher rates of suicide found in women who are under 20 and in their first pregnancy. Maternal depression can also affect women's health-seeking behaviour. Those experiencing psychological distress are less able to access antenatal care and PMTCT (Prevention of Mother to Child HIV Transmission), and are also more likely to delay or discontinue breastfeeding early, not complete immunisation schedules, and not respond in a timely fashion to diarrhoeal episodes in their infants. Thus, maternal mental illness is a public health challenge, with potential negative impacts into future generations.

Facility-based antenatal coverage in South Africa is 92%, where even the poorest and most vulnerable women tend to use antenatal services. Also, during pregnancy, women have increased contact with service providers compared to other times in their lives. For this reason, identifying women who are distressed during pregnancy and providing mental health care at the same site where they receive antenatal care provides an opportunity to address and reduce the burden of maternal mental illness. Poor women need not spend extra resources nor deal with issues of stigma: they can access mental health care at the same place and time as their pregnancy care. By working upstream with mothers in distress, maternal mental health care offers a protective and preventative intervention, contributing positively to women's health as well as early childhood and adolescent development.7

Positive outcomes

Positive mental health amongst mothers promotes natural child birth, breastfeeding, bonding, family cohesion, the ability to identify and optimally use social support, adherence to ARV and TB treatment, and completion of infant immunisations. This has direct implications for decreasing maternal and child mortality, which is one of the four objectives highlighted in the Minister of Health's Negotiated Service Delivery Agreement (the NSDA), as part of the PHC Re-engineering Plan implementation.

What can I do?

As health workers who have regular contact with pregnant women, nurses and midwives have a unique opportunity to alleviate mental health distress among women and girls. In the setting of regular antenatal visits, nurses and midwives can support women who may not otherwise have access to help.

Maternal mental illness is predictable, identifiable, treatable and, in many cases, preventable. With sensitivity, an understanding of maternal mental illness, and simple listening and counselling techniques, nurses and midwives can provide the kind of support women need to alleviate mental distress during and after pregnancy.

Counselling is one way to support women in distress. It offers distressed women an opportunity and a safe space to tell their stories without fear of being blamed or judged. In a time of crisis, counselling

gives women the opportunity to contain their distress, highlight their priorities and identify possible resources. This support empowers women to take the lead in managing their own problems in the future.

Five key steps to counselling

Step 1: Confidentiality

A counselling relationship is based on trust. What is told to the health worker must not be passed on to other people, and must be kept confidential. The health worker may only share confidential client information with other professionals if it is going to assist the woman's care.

Step 2: Empathy

Counselling is about showing empathy. It is feeling for a woman's situation by putting one's self in her shoes, and respectfully imagining what that woman's life is like, without making judgements. Empathy is also about showing that the person's experiences, behaviour and feelings are understood. In order to empathise with another, a health worker needs to be:

- Open-minded – The health worker must set aside, for the moment, her own beliefs, values and attitudes in order to consider those of the other person.
- Imaginative – The health worked needs to imagine the other person's background, thoughts and feelings.
- Committed – The health worker must want to understand another person.
- Knowing and accepting one/own self – Knowing one's self and accepting who one is helps to develop empathy for others.

Step 3: Active listening

Active listening helps establish a relationship between the client and the health worker. Talking about past and current events can be difficult for a distressed woman, yet just the experience of being heard can be healing. Active listening consists of concentrating on what is being said, rather than what needs to be said or done. This allows the health worker to gain a better understanding of a woman's difficulties and her view of the world. The health worker shows empathy, acceptance and genuineness, and only speaks to find out if he or she heard and understood what the woman has said correctly. Verbal and non-verbal responses to what the woman is saying, such as nodding, show that you are listening to her. This encourages her to continue talking about her issues and leaves her with the understanding that she has been heard. The SOLERF method is a useful way to "listen":

S **S**quarely face the person – not turned to the side.
O Use **O**pen posture – without crossed arms and legs.
L **L**ean slightly toward the person – rather than sitting back in the chair.
E Use **E**ye contact – instead of staring into space.
R **R**elax, keep it natural – instead of sitting like a board.
F Look **F**riendly and welcoming – rather than neutral or scowling.

Step 4: Asking questions

The questions that the health worker asks — open and closed — are important for counselling. They can encourage a woman to open up. An open question is used in order to gather lots of information, and is good to keep a mother talking. It has no correct answer and usually requires an explanation. For example:

- What brought you in here today?
- How do you feel about this pregnancy?
- How does that make you feel?

A closed question is used to get specific information. It can normally be answered with either a single word or a short phrase. It is useful for getting necessary information and to help the woman focus her discussion. For example:

- What is your name and date of birth?
- Is this pregnancy planned?
- Where do you work?

Step 5: Reflecting

Reflection can be used at any stage in the counselling session, and is really important for building trust with the woman and exploring her problems. There are four different reflecting skills:

Reflecting feelings

The health worker should focus on feelings. This includes active listening and reflecting back to the client your understanding, in a non-judgemental way, of her verbal and non-verbal communication of feelings. Read body language for non-verbal cues.

Re-stating/re-framing

The health worker must explain what he/she understands from what the woman is communicating. By doing this, the health worker is letting the woman know that what she is saying is understood, or that the health worker is willing to be corrected.

Affirmation

This encourages the woman in her knowledge, behaviour and in the choices she has made. The health worker must also encourage the woman to affirm herself — something that the woman should learn to do for herself, rather than depend on the health worker for it.

Summarising

It highlights the most important areas, feelings, or themes of what the woman has been saying. It draws together the important points from the conversation and makes them clear.

Reflecting helps the woman to clarify for herself her problems and feelings. It also helps the health worker get information about the woman and how she views her situation, and helps to check the health worker's own perception of what the woman communicates.

Whether you have five minutes with your client, or are able to provide additional support through the five steps outlined above, how you interact with your client can greatly improve how she feels.

Developing tools for maternal mental health care

The Perinatal Mental Health Project (PMHP) provides a counselling service in four public obstetric facilities in Cape Town. The PMHP's aim is to make mental health part of routine maternity care. Counselling is a necessary and powerful tool to address mental distress in women during and after pregnancy. Yet the PMHP recognises that screening for mental distress or risk of distress is also an extremely important step in improving maternal mental health.

As part of women's regular antenatal care, screening would occur in a familiar and non-threatening environment, and women would not have to spend extra time and money to access mental health care elsewhere. This way, women would also avoid the stigma associated with seeking help for mental health problems.

In South Africa, the Edinburgh Depression Scale (EDS) has been validated to screen for maternal mental illness. The PMHP uses this as well as a questionnaire on risk for distress. However, these are long questionnaires, and not all staff find them easy to use. What is needed is a short, easily administered tool which does not hamper already busy clinical settings. The PMHP is currently conducting a research study to develop a short, valid screening tool for use in South Africa.

In addition, equipping health workers to support mothers in distress and administer screening tools assists in capacitating the health environment to integrate maternal mental health services.

Conclusion

Left undiagnosed and untreated, mental illness can increase women's risk of HIV infection, violence and abuse, economic insecurity, early sexual debut and unintended pregnancy. This contributes to a vicious cycle in which vulnerable women are unable to rise out of poverty – further aggravating their mental condition. The rationale for preventing and treating maternal mental illness is to provide the meaningful support necessary to empower and enhance the resilience of mothers living in difficult circumstances. A mother who feels supported, who has positive self esteem and who has an ability to work towards a better future, will be better able to negotiate the hardships in her life and optimally nurture the development of her children.

After 10 years of working in maternity services, the PMHP has learnt that providing maternal mental health care improves health worker morale and job satisfaction, pregnancy outcomes for women and girls, development outcomes for their babies and families, and thus makes significant inroads in our country's ability to deliver on its Development Goals, such as reducing infant and maternal mortality.

About the PMHP

The PMHP's vision is for all women to have access to mental health care during and after pregnancy, as part of their ordinary maternity care. The Project has developed a model for providing screening, counselling and psychiatric services during pregnancy. Central to this model is partnering with maternity staff to offer screening for mental health risk, and an onsite, dedicated mental health officer.

The PMHP clinical service at Mowbray Maternity Hospital in Cape Town has been operating since 2002. To find out more about the PMHP or maternal mental health, please visit www.pmhp.za.org or contact the Project at communicate@pmhp.za.org

References:

"Perinatal" refers to the period from conception, through labour, to a year after birth. The terms "prenatal" and "antenatal" refer to pregnancy.

2 Meintjes, I et al (2010) Improving child outcomes through maternal mental health interventions. Journal of Child & Adolescent Mental Health. 22(2): 73-82.

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4 Rochat TJ, et al. (2011) The prevalence and clinical presentation of antenatal depression in rural South Africa. Journal of Affective Disorders. 135: 362-373. Hartley M et al. (2011) Depressed mood in pregnancy: Prevalence and correlates in two Cape Town peri-urban settlements. Reproductive Health. 8:1-9.

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6 Freeman M, Nkomo N, Kafaar Z and Kelly K (2008) Mental disorder in people living with HIV/AIDS in South Africa. South African Journal of Psychology 38: 489–500

7 For a full explanation of the negative outcomes of mental illness and positive impact of mental health promotion, see Meintjes, I et al (2010) Improving child outcomes through maternal mental health interventions. Journal of Child & Adolescent Mental Health. 22(2): 73-82..

SAVE MILLIONS

Christine February, Community Nursing Science Lecturer, Western Cape College of Nursing (Metro West Campus) shares this year's objectives for International World Cancer Day.

World Cancer Day (WCD) occurs annually on 4 February. The fundamental initiative is for the entire globe to unite together in the fight against the world wide cancer epidemic. Global cancer is an epidemic of huge proportions and is set to double over the next 20 to 40 years. This is related to the number of cancer cases and related mortality worldwide.

Main aims of World Cancer Day are to:

- Help save millions of preventable deaths each year by increasing awareness by means of education about cancer and urging governments across the globe to take action against the disease
- Promote and maintain a multi-sectoral response and awareness to cancer
- Develop targets inclusive of indicators which measure the implementation of policies and approaches to prevent and control cancer
- Prevent cancer and raise the quality of life for cancer patients

Significance of World Cancer Day

Cancer is a leading cause of death worldwide and accounted for 7.6 million deaths in 2008. Every month 600,000 people die of cancer and many of these deaths can be avoided by means of increased government support in the funding for prevention, detection and treatment programmes.

Urgent action is required to raise awareness about cancer and develop practical strategies to address the disease, of which millions of people are prematurely dying.

Social media networking is the main medium through which to achieve these objectives. This includes engaging with Facebook/Twitter and sharing in the exchange of key messages (A special Facebook application will be launched for the WCD. Engage today in passing this message on!