



Caring for a person experiencing mental illness in the Perinatal period

A woman in the perinatal period may have a pre-existing clinical diagnosis of mental illness (for example, bipolar affective disorder) or may develop a mental illness specific to this period (for example, postnatal depression). When caring for women in the perinatal period, please read this information in conjunction with the MIND Essentials resource that is relevant to the specific presenting mental illness.

Case study

Sunita is 32 and in the third trimester of her second pregnancy. She presents to the midwife at her local hospital for her final antenatal appointment. Sunita appears withdrawn and anxious and mentions that she has been struggling to sleep for the past few weeks. As part of the normal routine for a final antenatal appointment, the midwife asks Sunita to complete the questions on the Edinburgh Depression Scale (EDS) — a screening tool for identifying people at risk of depression in the perinatal period. Sunita obtains a high score, which indicates that she is either currently experiencing depression or at high risk of developing depression, and so further assessment and monitoring is required.

The following information could help you nurse a patient like Sunita.

What is the perinatal period and why is mental illness relevant?

Perinatal and infant mental health (PIMH) refers to the emotional wellbeing of a woman, her partner and their infant from conception until 24 months postpartum. This period represents a transitional life stage that can be associated with increased vulnerability to experiencing mental health disorder. A major concern during this change is the health and welfare of the developing foetus and of the infant.

Women in the antenatal and postnatal period are vulnerable to having or developing the same range of mental disorders as other adults. The range and course of the majority of these disorders is as for other adults. However, sometimes the nature and treatment of mental disorders occurring in the perinatal period can differ because of the higher vulnerability to mental illness during this transitional life stage. Additionally, there is a change in the risk-to-benefit ratio that affects decisions around psychotropic medication use, and there is potential for greatly increased detrimental impact on the family unit, particularly the infant.

In addition, women who have already experienced mental health disorders are more likely to become ill during the perinatal period than at other times.

Severe mental illnesses may develop much more quickly, or be more serious after giving birth, than at other times. Sometimes women stop medication when pregnant or breastfeeding, and this may make an illness return or become worse.

Also, the risk of developing perinatal and infant mental health disorders is higher for women who have a history of depression, experienced recent life stresses, a low level of partner support, experienced abuse or neglect, a tendency to worry, low self-esteem or an unwanted pregnancy.

Relevance of perinatal mental illness for wellbeing of infants

Parental responsiveness and sensitivity are significant predictors for secure infant attachment. Maternal mental illness can directly affect a mother's responsiveness and sensitivity during interactions with her baby. Internal preoccupations and symptoms will interfere with parental capacity to respond appropriately to an infant's needs, which can result in an insecure attachment relationship between mother and infant.

The effects of maternal mental illness on infants occurs early, so it is important to identify and treat those at risk as early as possible in order to ensure the wellbeing of the mother, infant and other family members. If left untreated the effects of parental mental illness can impact on the lifelong physical development and social, emotional wellbeing of infants.

What is the normal response to birth?

Between three and 10 days after giving birth, almost 80 per cent of Australian women experience a very common reaction known as the 'baby blues'. This is **not** a mental illness. The major symptom of the 'baby blues' is feeling particularly emotional and overwhelmed, which is primarily caused by changes to hormone levels throughout the pregnancy and the significant demands of the new role as a mother. The 'baby blues' usually disappear after a few days and do not require any specific treatment other than support from family, friends and clinical staff.

What are the types of mental illness seen in the perinatal period?

While the 'baby blues' is considered a normal reaction to birth, there are two serious mental illnesses that can develop in and are specific to women in the perinatal period – **antenatal** or **postnatal depression** and **anxiety**, and **postnatal psychosis**.

Antenatal and postnatal depression and anxiety

Antenatal depression may develop in the lead-up to the birth and affects approximately one in 10 Australian women; postnatal depression can develop from one month to one year after birth and affects almost one in six Australian women. Women experiencing either of these conditions will display the same symptoms as those displayed by a person with depression. These include:

- ◆ lowered mood
- ◆ feelings of sadness, hopelessness or helplessness
- ◆ appetite, weight or sleep disturbance
- ◆ diminished concentration
- ◆ low self-esteem
- ◆ feelings of guilt
- ◆ suicidal thoughts

Postnatal psychosis

Postnatal psychosis can emerge in the first few weeks following the birth. This condition is rare. It is estimated that it affects one in 500 Australian women. The symptoms of postnatal psychosis

include hallucinations, delusions, paranoia and thought disturbance. Such symptoms indicate a psychiatric emergency requiring immediate medical assistance.

Other disorders

It is important to note that in the perinatal period due to a range of factors the partner is at an increased risk of developing depression; and the infant is at an increased risk of developing an attachment disorder. Factors such as increased and changed role demands, and vulnerabilities or depression of the new mother may adversely impact on the partner's and infant's emotional state.

Difficulties in diagnosis

While the nature of some mental illnesses may change during the perinatal period, it is generally recommended that for the purpose of diagnosis, health workers follow the usual diagnostic guidelines (for example, DSM IV, ICD 10 etc.). However, specific caution is recommended around symptoms that may be influenced by context (for example, sleep disturbance, loss of libido and/or anxiety about difficulties bonding with infant).

A person's perspective on what it is like to experience postnatal depression

'It surprised me how this overwhelming feeling just crept over me and wouldn't leave. It was such an isolating experience and being hormonal, sleep deprived and generally just having such high expectations of myself to always cope. I couldn't see and didn't know what was normal any more. I was just trying to survive the onslaught of this 24 hour job, getting to the next feed or the next sleep. The birth bit felt so easy and then I was straight back out into society without the support and checks that I felt I was offered in the prenatal period. I felt desperately alone and helpless. It was only when someone took the time to ask some questions about how I was feeling that I began to see just how overwhelmed and depressed I was.'

Some reported reactions to people experiencing mental illness in the perinatal period

Nurses who have worked with people experiencing mental illness in the perinatal period have reported the following reactions:

Worry When a mother or mother-to-be is struggling to manage the symptoms of a mental illness, the nurse may also develop feelings of worry and concern about how the woman and family will cope or if they are able to cope with the demands of a new baby.

Other responses A range of other reactions may occur, as described in other MIND Essentials resources, depending on the type of mental illness presented. In particular, those reactions described in the MIND Essentials resource 'Caring for a person experiencing depression' may be relevant.

Goals for nursing a person experiencing mental illness in the perinatal period

When caring for someone during the perinatal period, be mindful of the following goals:

- ◆ Develop a relationship with the person based on empathy and trust.
- ◆ Promote an understanding of common reactions to pregnancy and childbirth, as well as mental illnesses specific to the perinatal period.
- ◆ Promote effective strategies for coping with the mental illness in the perinatal period.

- ◆ Promote effective strategies to help bonding and attachment between the mother and her infant.
- ◆ Identify the degree to which there is a risk of anomalous parenting as a result of the mental illness and follow usual protocols if there are risks identified.
- ◆ Promote the person's engagement with their social and support network.
- ◆ Ensure effective collaboration with other relevant service providers, through development of effective working relationships and communication.
- ◆ Support and promote self-care activities for partners, families and carers of the person experiencing the mental illness.
- ◆ Be alert to and regularly monitor suicide risk. Refer to the MIND Essentials resource 'Caring for a person who is suicidal'.

Guidelines for responding to a person experiencing mental illness in the perinatal period

- ◆ A person's cultural background can influence the way symptoms of mental illness are expressed or understood. It is essential to take this into account when formulating diagnosis and care plans. Indigenous Mental Health Workers or Multicultural Mental Health Coordinators and the Transcultural Clinical Consultation Service from Queensland Transcultural Mental Health Centre are available for advice and assistance in understanding these issues. For further information please visit www.health.qld.gov.au/pahospital/qtmhc/default.asp
- ◆ Ask if the woman and her partner (if relevant) have a history of mental health problems and how they are currently managing.
- ◆ Provide education about the 'normal' feelings experienced in the usual antenatal and postnatal circumstances.
- ◆ Provide realistic expectations for parenting and self-care. These can help a family develop more resilience.
- ◆ Provide information about the attachment needs of the infant and the importance of the parental role meeting these needs.
- ◆ Reassure the woman and her family that mental illness does not mean that she will necessarily struggle with the parental role.
- ◆ Help the person and her partner or family identify the likely parental role issues that may be impacted on by the mental illness.
- ◆ After negotiation with the woman, include the partner or family in discussions around treatment options and supports.
- ◆ Most families during the perinatal period are accessing a variety of services. Be consistent with communication and develop agreed plans of care to ensure collaborative working relationships.
- ◆ In assessing parenting, consider:
 - the degree to which the woman is fulfilling or has the capacity to fulfill the parenting role (for example, attending to the infant's physical, intellectual, social and emotional needs)
 - the impact of the mental illness on the woman's functioning
 - the capacity of both parents (if relevant) to support the family
 - the style of partnership between the parents (if relevant)
 - the child's needs and functioning
 - any environmental stress
 - the availability of support to the family.

- ◆ Referral to mental health practitioners should be considered if a high score is obtained when conducting the Edinburgh Depression Scale (EDS).
- ◆ As appropriate, provide family members and carers with information about the illness, as well as reassurance and validation of their experiences with the person. Encourage family members and carers to look after themselves and seek help or support if required.
- ◆ Be aware of your own feelings when caring for a person with a mental illness in the perinatal period, and that you may reconnect with your own feelings and parenting experiences. Arrange for debriefing for yourself or for any colleague who may need support or assistance – this may occur with a clinical supervisor or an Employee Assistance Service counsellor.

The Employee Assistance Service provides confidential, short-term counselling free-of-charge to Queensland Health staff to assist them to resolve personal and work related problems. For more information visit <http://qheps.health.qld.gov.au/eap/home.htm>

Treatment of mental illness in the perinatal period

Standard treatments for mental health disorders should be provided to women in the perinatal period when they are indicated on clinical grounds. However, potential physical and emotional risks to the foetus need to be considered, and the woman must be informed of these should treatment be recommended. Safety of the woman and her infant is paramount, but untreated mental disorder can also have serious consequences for later life outcomes for both mother and infant.

Medication

There is little evidence to suggest that pharmacological treatments have any differential benefit in the perinatal period compared with other adult populations. However, there is a shifting risk-to-benefit ratio with an increased risk to the foetus or infant arising from teratogenic and neurodevelopmental risks associated with the use of psychotropic medication.

These risks are relative and need to be balanced carefully against the likely benefits of treatment and risks of an untreated mental disorder. There may also be changes in the pharmacokinetics of drugs when used in pregnancy, or the degree to which side effects can be tolerated. More information can be found on www.motherisk.org or by contacting 13HEALTH (13 43 25 84).

Discharge planning

Discuss referral options with the person and consider referrals to the following:

- ◆ GP
- ◆ Community Child Health
- ◆ Community Health
- ◆ Mental Health Services (infant, child and youth or adult)
- ◆ Private service providers

To access the contact numbers and details for your local services use QFinder (available on QHEPS) or call 13HEALTH (13 43 25 84).

Further reading

For more information, see the following:

Clinicians Knowledge Network at <https://sp.cknservices.dotsec.com/ckn/>

PIMH Print Books are listed in the Queensland Health Libraries catalogue 'HealthCat' <http://healthcat.slq.qld.gov.au/cgi-bin/Pwebrecon.cgi?DB=local&PAGE=First>

Mares, S., Newman, L., Warrne, B. & Cornish, K. (2005). *Clinical skills for infant mental health clinicians*. Adelaide: ACER.

Zero to Three at www.zeroto3.org.au

beyondblue at www.beyondblue.org

Mental Health First Aid Manual at www.mhfa.com.au (internet access required)

Children of Parent with a Mental Illness (COPMI) at www.copmi.net.au/

Sources

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