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# Understanding Perinatal Mental Illness

## Awareness, Stigma, Communication and Self-Care for Healthcare Professionals

# HOUSEKEEPING

Thank you for joining this webinar!

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# Perinatal Mental Health Training for Primary Care Professionals

PATH is an EU-funded project which will enable women, families and healthcare professionals to prevent, diagnose and successfully manage mild and moderate perinatal mental health issues.

The PATH team would like to invite you for a 3 part webinar on Perinatal Mental Health Training for Primary Care Professionals.

| | Session Title | Speakers |
|---|---|---|
| **Week 1** | Awareness of Perinatal Mental Illness | **Dr Bosky Nair**, Consultant Perinatal Psychiatrist, KMPT<br>**Bonita King**, PATH Team Lead and Perinatal Clinical Nurse Specialist, KMPT |
| **Week 2** | Stigma related to Perinatal Mental Illness | **Jo Harrison**, Peer Support Worker, KMPT |
| **Week 3** | Improving communication between patients and professionals & Self-Care | **Rachel Marriott**, PATH Development Officer, Devon Mind<br>**Linda Robinson**, Wellbeing Practitioner, Devon Mind |

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# Part 1: Awareness of Perinatal Mental Illness

# Session Aims

1. **Improving awareness of mild to moderate perinatal mental illnesses (PMI)**
2. Understanding and challenging stigma related to PMI
3. Improving communication between patients and professionals
4. Self-care for professionals

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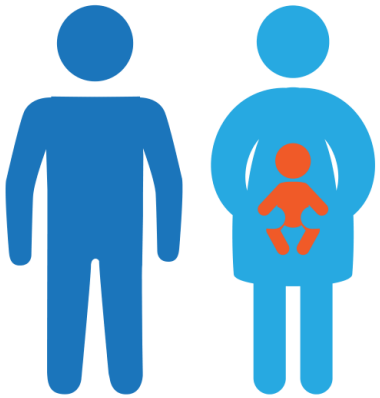
# Understanding PMI

LSE PSSRU Personal Social Services Research Unit

Centre for Mental Health

## The costs of perinatal mental health problems

Annette Bauer, Michael Parsonage, Martin Knapp, Valentina Iemmi & Bayo Adelaja



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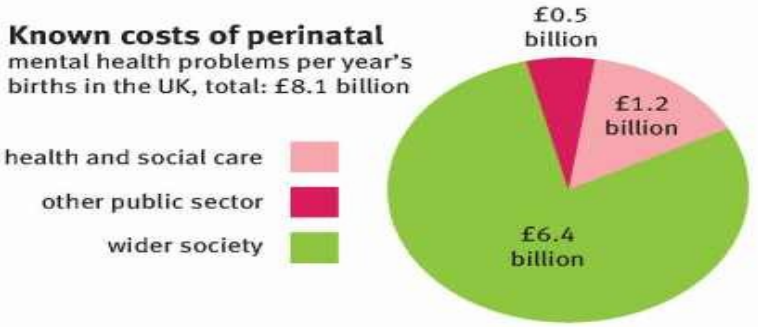
## Key points from the report

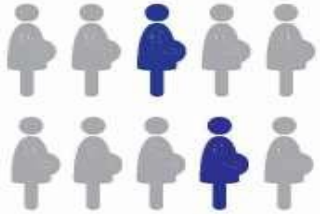
**Known costs of perinatal** mental health problems per year's births in the UK, total: £8.1 billion




Of these costs

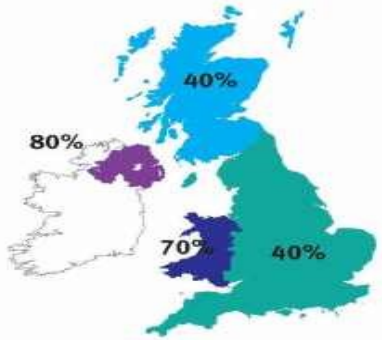
**28%** relate to the mother

**72%** relate to the child



**Up to 20%** of women develop a mental health problem during pregnancy or within a year of giving birth

**Women in around half the UK** have NO access to specialist perinatal mental health services




**Suicide** is a leading cause of death for women during pregnancy and in the year after giving birth

**Costs v improvement**

The cost to the public sector of perinatal mental health problems is **5 times** the cost of improving services.

# Perinatal mental illnesses (PMI)

- Definition of PMI: Psychiatric disorders that are prevalent during pregnancy or until 1 year after delivery
- Can affect more than 1 in 5 women & 1 in 10 men during pregnancy and the first year after childbirth
- Can impact on the child's development
- Can impact on parents' capacity to maintain social networks and employment

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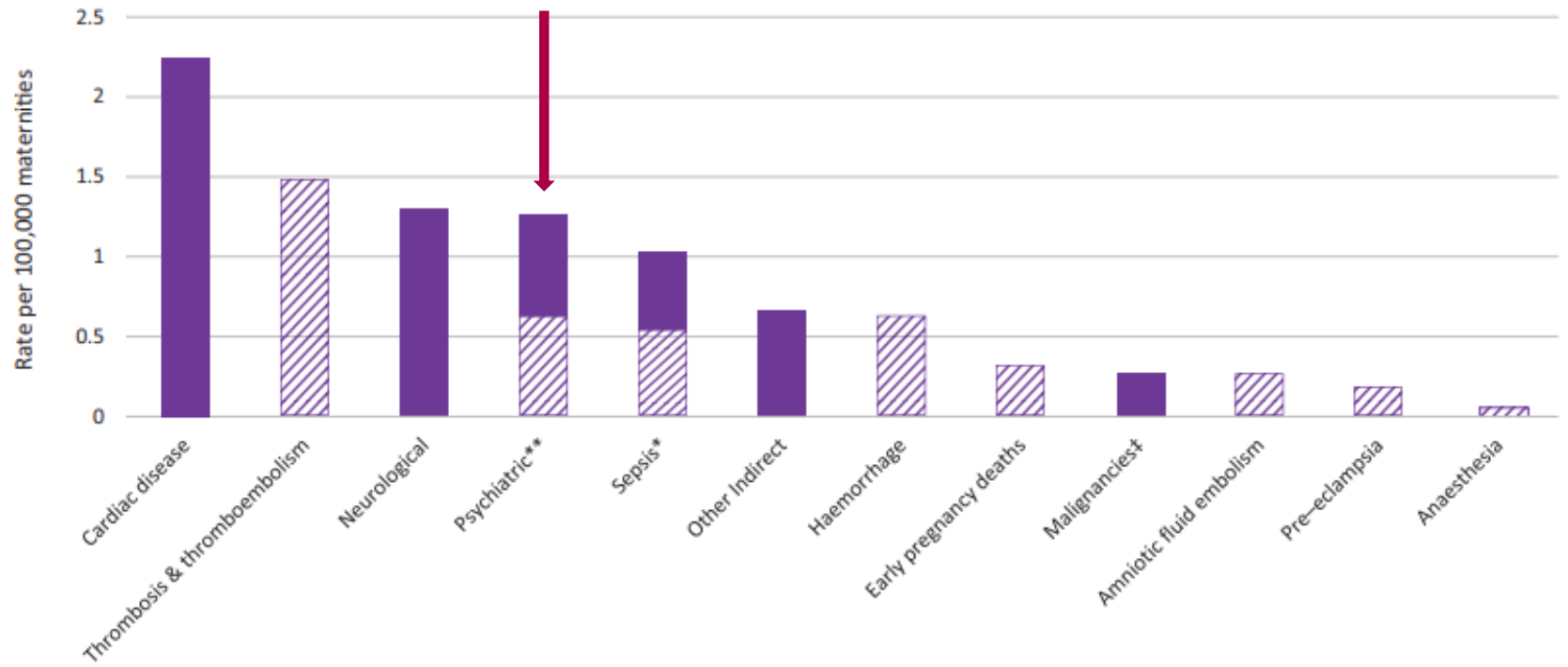
# MMBRACE-UK report 2020

**Figure 2.3: Maternal mortality by cause 2016-18**

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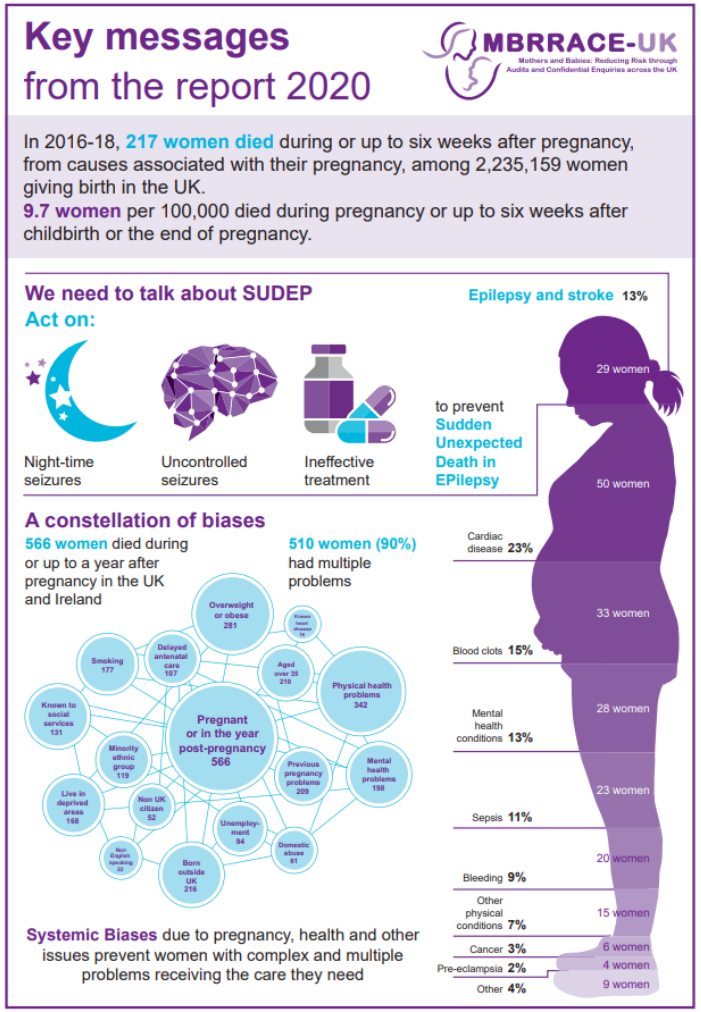
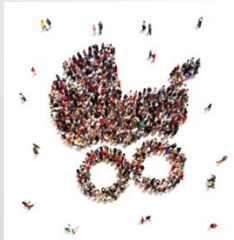
Rate for suicides (direct) is shown in hatched and rate for indirect psychiatric causes (drugs/alcohol) in solid bar

# Why it matters?

Mental health disorders are the leading cause for maternal deaths



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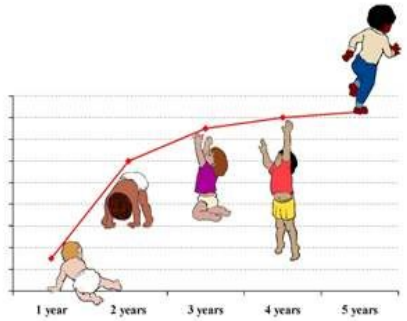
# Prevalence

| Psychiatric disorder | Rate (per 1000 maternal deliveries) |
|---|---|
| Postpartum psychosis | 2 |
| Chronic serious mental illness | 2 |
| Severe depressive illness | 30 |
| Mild-moderate depressive illness and anxiety states | 100-150 |
| Post-traumatic stress disorder | 30 |
| Adjustment disorders and distress | 150-300 |

**Table 1** Rates of perinatal psychiatric disorders per thousand maternities [3]


# Impact on child development

Physical development




Attachment theory

Chronic maternal stress may:

- Delay foetal nervous system maturation
- Restrict the neuromuscular development and alter the stress response of the neonate
- Impair mental development
- Increase fearful behaviour in the infant
- Reduce grey matter in children
- Increase the risk for emotional and cognitive impairment

# First 1001 days


- Pregnancy provides a critical window to detect and treat PMI at the earliest opportunity, maximising the opportunity for good outcomes for the child across the life-course.

In order to thrive emotionally, an infant needs to:

- Experience, regulate and express emotions
- Form a secure attachment
- Explore the environment and learn

# Who is more at risk of perinatal mental illness?

- Socio-economic status
- Exposure to trauma, negative life events and stress
- Domestic violence
- Migration status
- Relationship and social support
- Reproductive intention
- Personality traits: high neuroticism
- Prior psychopathology: depression, anxiety, PTSD, substance misuse
- Age
- Genetic and hormonal susceptibility
- Chronic diseases
- Medical illness
- Pregnancy complications

# Perinatal Depression

**Prevalence 10-15%**

- Onset often antenatal
- Similar clinical presentation - additional features and risks may include:
- Anxiety re baby's welfare and ability to cope, guilt,
- Infanticide in addition to suicide

Future risk for developing PND

- History of depression - 30%
- History of PND 40-50%

- Impact of depression on pregnancy / mother & baby
- Child development (effects on cognitive, emotional and behavioural development)

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# Perinatal anxiety disorders

**Prevalence 10-15%**

- Generalised Anxiety disorder
- Panic Disorder
- Phobias e.g. agoraphobia
- PTSD
- OCD
- Social anxiety disorder

- Potential impact of pregnancy/motherhood on disorder
- Impact of disorder on the mother and baby interactions/attachment/parenting

- Treatments – Guided self help/Psychosocial/Psychological (eg CBT)
- Pharmacological eg SSRIs

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# Eating disorders

**Prevalance 1.5-7.5%**

## Anorexia Nervosa

- disturbance of body image ("morbid fear of fatness")
- continuous attempts to lose weight or avoid weight gain
- restricted dietary choice, excessive exercise, induced vomiting and purgation, and use of appetite suppressants and diuretics

## Bulimia Nervosa

- Continuous preoccupation with weight
- Recurrent bingeing with compensatory acts such as self induced vomiting

## Binge Eating Disorder

- Dieting and binge-eating, significant weight gain, can be very distressing for the individual

Potential impact of pregnancy/motherhood on disorder

- Conflicting desires – striving for low BMI vs motivation to nurture baby
- Potential impact of disorder on pregnancy/child- miscarriage, pre-term birth, low birth weight, complications during labour e.g. intra-uterine growth retardation
- Psychological interventions
- Monitoring
- Referral if indicated

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# Post Traumatic Stress Disorder (PTSD)

- Negative subjective experience of childbirth is known to be the most important predictor for postpartum PTSD

- Common symptoms of PTSD include:
- Reliving the trauma through flashbacks, nightmares, intrusive thoughts and images

- Feeling hypervigilant or feeling on edge

- Avoidance behaviours

- Difficult feelings and beliefs

Evidence based treatments for PTSD or birth trauma include:

- Trauma focussed cognitive behavioural therapy (CBT)

- Eye movement desensitisation and reprocessing (EMDR)

- Medications can be offered if there is concomitant anxiety or depression.

# Severe perinatal mental illness

- Bipolar Disorder, type 1 & 2
- Hypomanic and depressive episodes
- Women with BD type 1 at high risk for puerperal psychosis

- Past history of BD Type 1 or puerperal psychosis

– risk of relapse postpartum around 50%

- Personal history BD Type 1 with family history of puerperal psychosis

- even higher risk of relapse postpartum (around 70%)

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# Post partum psychosis

- Prevalence: 1-2 in 1000 deliveries
- Onset – highest risk in first month, can occur immediately after delivery

Clinical Features:

- Mood disturbance  (elevated or depressed)
- Irritability, Insomnia, Confusion, Perplexity
- Disorganised behaviour
- Psychotic phenomena  (often involve baby) e.g. Delusions, Thought Disorder, Hallucinations
- Sudden onset, florid presentation, rapid deterioration

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# Red Flags

Requiring urgent psychiatric assessment:

- Recent significant change in mental state or emergence of new symptoms
- New thoughts or acts of violent self-harm/suicidal ideation
- New and persistent expressions of incompetency as a mother or estrangement from the infant.

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# Refer to secondary care when…

- Significant risks to self or others in context of mental disorder e.g. risk of harm or neglect to self or others
- Significant impairment of functioning in context of mental disorder (including parenting)
- Symptoms do not respond to primary care interventions
- Difficulties more complex.

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# Support services for mild to moderate PMI

- Peer support and online forums e.g. netmums.com
- GPs, health visitors, midwives
- Primary care counselling and psychology (IAPT)
- Parenting support e.g. children's centres, Sure Start, Home Start
- Other support e.g. Relate, family matters, Cruse
- DV support e.g. Freedom Project
- Support for alcohol / substance misuse e.g. Turning Point
- Eating disorder primary care liaison nurses
- Third sector organisations

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https://path-perinatal.eu/uk/professionals-page/

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# Part 2: Understanding and challenging stigma related to Perinatal Mental Illness

# Session Aims

1. Understanding different types of stigma
2. Acknowledging different barriers
3. Challenging stigma

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# PMI Stigma and How to Reduce It

Unfortunately, some people still have a negative perception of mental illness and this can result in stigma towards people who experience mental health difficulties.

Stigma involves three different elements:

- Stereotypes: beliefs that are often based on exaggerations and misconceptions
- Prejudice: attitudes that result negativity and bias
- Discrimination: behaviours that result in unfair or unequal treatment.

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# Different Types of Stigma

## Social Stigma

Social stigma (also called public or external stigma) refers to perceptions held by the general public towards the person experiencing mental illness and is largely based on misconceptions or misunderstandings. People may think that those experiencing PMI:

- Are bad or abusive parents
- Harm themselves or their children
- Don’t love their children
- Are abnormal

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# Different Types of Stigma: Continued

## Self Stigma

Self-stigma (also called internal stigma) occurs when stigmatized individuals internalise the negative attitudes and stereotypes and apply it to themselves. People experiencing self stigma might feel:

- Guilty
- Shameful
- Isolated

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# Different Types of Stigma: Continued

## Disclosure Stigma

Disclosure stigma (also called treatment stigma) refers to negative perceptions around seeking professional help. Seeking help might make feel:

- Scared that Social Services will be involved
- Worried that children will be taken away from
- Guilt or shame for taking medication for PMI

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# Story of lived experience

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# Barriers to *accessing* support

## Individual level barriers

- Lack of knowledge about perinatal mental health
- Negative attitudes towards mental illness
- Fear of judgement and child being taken away
- Lack of access to: transport, phone, interne, childcare etc.
- Not having adequate space and time to talk about experiences
- Self stigma and negative beliefs

## Sociocultural-level factors

- Language barriers
- Differences in cultural values

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# Barriers to *providing* support


## Workforce level factors

- Confidence in identifying **and** supporting with stress, anxiety and depression
- Gaps in knowledge/training
- Attitudes
- Time pressures

## Organisational-level factors

- Inadequate resources
- Fragmented services: role clarity and conflict

## Structural-level factors

- Unclear policy around appropriate and acceptable use of assessment tools

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# How can you challenge stigma?


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# Challenging stigma in your practice

- Encourage equality between physical and mental illness
- Be honest about treatment
- Advocating fair representation and treatment
- Share information with colleagues and patients to challenge stigma
- Facilitate effective communication between colleagues
- Understanding the role and impact of attitudes within family and social networks
- Be mindful about inaccurate representations or negative judgments

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# Challenging stigma in society

- Talk openly about mental health
- Educate yourself and others
- Be conscious of language
- Show compassion for those with mental illness
- Choose empowerment over shame
- Don't harbour self-stigma
- Reframing stigma as a social injustice and not just as a health problem


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# Examples of ways you can help

| When | Attitude | Outcome |
|---|---|---|
| First contact | • Express understanding that mental health care is an important part of the care provided<br>• Show willingness to address mental health concerns during care practice | Shared understanding that offering support for mental health needs are crucial to perinatal care. |
| During care | • Communicate importance of assessment and screening of mental health needs<br>• Be motivated to advise and signpost to relevant sources of support | Acknowledge the importance of continued support, appropriate monitoring and non-judgemental approach in supporting mental health needs |
| Multi-disciplinary working | • Show willingness to work inter-professionally and share responsibilities with other HCPs regarding mental health care | Acknowledge importance of involving relevant HCPs and creating a network of support to manage mental health needs appropriately |

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# Comfort break

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# Part 3: Improving Communication & Self Care

# Supporting Parents with PMI

- **Rapport and relationships** - Stigma can make it difficult for parents to honestly tell us about how they are struggling.
- **Listen** - Feeling like you have been heard, understood and believed can be a key step in mental health recovery. This can give the parent confidence to continue seeking and accepting support.
- **Communication** - A key element to building that confidence for parents lies within our communication with them

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# Top tips for effective communication in perinatal mental health

- **Anticipate & assess risk** – PMH of MH problems should trigger planning for support antenatally
- **Explore expectations** – the initial booking consultation is an important time to gauge feelings about motherhood, her own childhood and what she is expecting so help teach resilience.
- **Be aware of your own prejudice** - Lose your preconceived ideas about what 'depressed/anxious/ill' looks like - the symptoms and signs are not always obvious.
- **Beware of stigma** – perinatal mental health illness does not discriminate – it can and does affect anyone including partners, health professionals and women of all backgrounds
- **Acknowledge** – it takes courage to seek help for mental health problems and will have taken a lot for a woman to come to see you in the first place

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# Top tips for effective communication in perinatal mental health

- **Listen don't just hear** – look out for hesitation or pause, read non-verbal cues and notice what is not said, sometimes this is as important as what is actually said
- **Open the door to disclosure** - "Is motherhood everything you thought it would be?"
- **Reassure** - This is not her fault; she is not alone; she will get better. If she is concerned about the involvement of social services, advise her the risk of separation from her baby is extremely unlikely.
- **Encourage discussion** - allow her to talk about her feelings and listen without judgment.
- **Promote self-care** – encourage her to take time for herself. Breaks are a necessity; fatigue is a major contributing factor to worsening symptoms
- **Offer hope** – there is effective, evidence based treatment for perinatal mental health - women can and do get better

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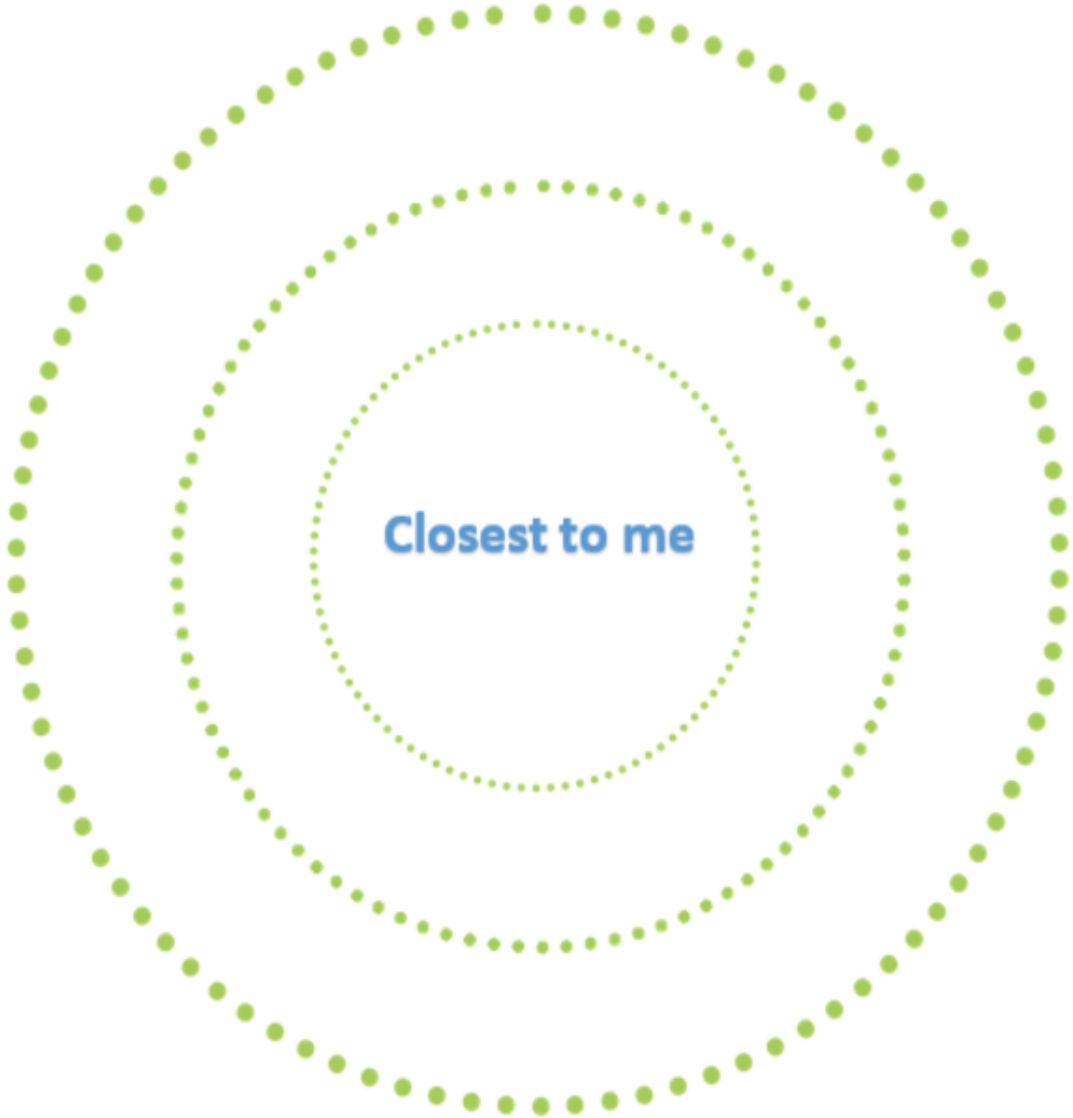


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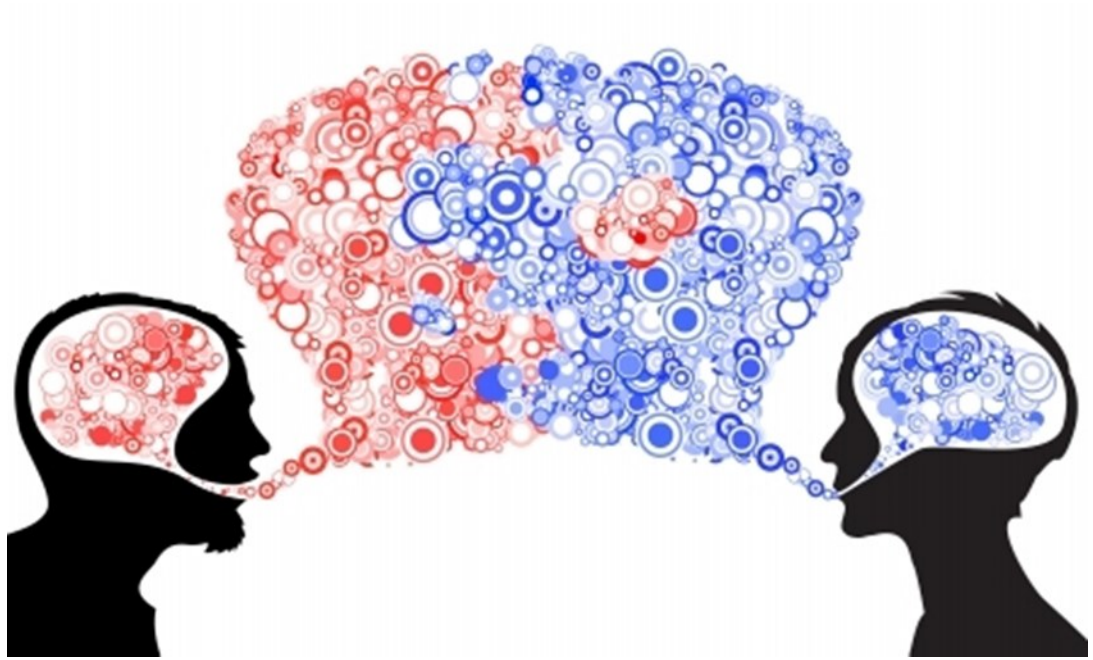
# What are the barriers to good communication?



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# What are the barriers to good communication?

- Jumping to conclusions
- Different levels of knowledge
- Different perceptions
- Lack of interest/ clarity/ information
- Language – Jargon, Abbreviation, acronyms
- Personality – too forceful, too patronising, too pedantic, too vague
- Performance anxiety.....where we can be internally judging our 'performance'. E.G. avoiding asking a question if we are not feeling confident, we might want to appear competent and worry about showing gaps in our knowledge

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# 'How to Ask' women about perinatal mental health at FIRST CONTACT for anxiety & low mood

- The HCP may be apprehensive in broaching the subject of mental health for fear of asking questions insensitively or perhaps not knowing what to do with the information divulged.

WHAT HELPS?

Normalising & raising awareness of perinatal mental health by using:

- Opening statements
- Exploratory questions
- Direct questions

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# ‘How to ask’ cont’d……..

**Opening statements**: Communicating normalising introductory statements about mental health is an effective way of explaining your intentions and creating a neutral, open space for discussion:

**Example**……

‘Pregnancy, childbirth and looking after a newborn baby can be a difficult time in a woman’s life. It is common for women to feel anxious or low in mood, and they may hide these feelings for fear of seeming like they cannot cope. We can discuss anything here, and I’d like to help wherever possible, so tell me, how have you been feeling recently?’

**TIP…….**

**It is important to keep an open mind and be prepared for anything the woman may say, free from surprise or judgement. You may perhaps be the first person to enquire seriously about a woman’s mood, and she may be hiding her feelings well**

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# ‘How to ask’ cont’d……

**Exploratory questions:** Once a rapport has been established, it is important to continue with exploratory questions. The aim of these questions is to explore her concerns, and gather information on any symptoms she is experiencing. Ultimately, you are looking to decide if the parent would benefit from referral to mental health services, so listen carefully to what she has to say:

**Examples are:**

‘How are you feeling at the moment?’

‘How has your mood been recently?’

‘Do you have any concerns or anxieties?’

‘Do you feel more support would be helpful?’

‘How are you coping at the moment?’

‘How are your sleep/appetite/energy levels?’

‘Are you able to find enjoyment in things?’

‘Have you had any unusual experiences recently?’

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# ‘How to ask’ contd…….

**Direct questions:** Once you have a focus for discussion, it’s important to ask more direct (closed) questions to probe for concerns that the parent may be fearful to divulge. The structure of these questions should not be leading, to avoid providing a false sense of security for the parent or indeed yourself.

**Example:**

A woman struggling with severe vomiting, where it is known that previous eating disorders are a potential risk factor, resist the temptation of saying ‘But, you’re not worried about gaining weight or looking fat?’ as it leads the woman to affirming the negative, and may in fact serve as practice for continually hiding her innermost thoughts and feelings until she is in an extreme situation.

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# ‘How to ask cont’d……

## Ethical issues:

There is no evidence that discussing mental health or suicidal ideation leads to an increased risk of self-harm or suicide, and in fact it is known to decrease the rate of completed suicide.

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Perinatal mental health: how to ask and how to help. The Obstetrician & Gynaecologist. 2017

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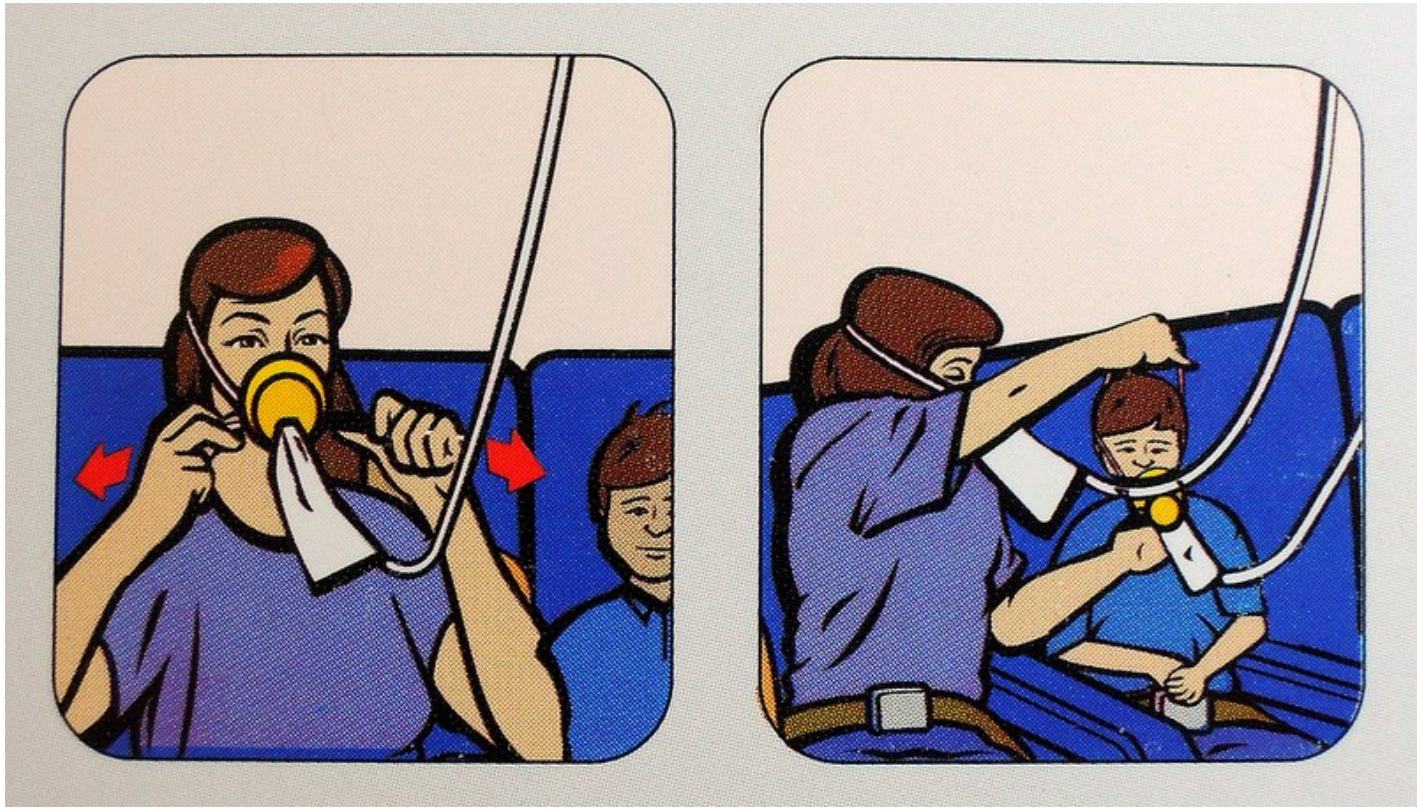
# Self care for parents



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# Self care for Health Care Professionals

- When continuously caring for physically/mentally ill patients, there is a high risk of developing burnout, compassion fatigue & distress by virtue of the challenges presented in the daily care of these patients.

"Managing emotional highs and lows requires knowing yourself, & the things that bring you joy"

Michelle Obama, when talking about her "low grade depression" that she was struggling with.
(JUNE 2020 during COVID-19)

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# Self care plan

**PROFESSIONAL Self-care strategies**

- Regularly appraise and regulate: Workload/Control/Reward
- Create a network of peers & co-workers and stay connected with them on an ongoing basis. Avoid de-personalisation (distancing from work both emotionally & cognitively)
- Improve communication & skills by seeking additional training
- Practice reflective writing

**PERSONAL Self-care strategies**

- Adopt a healthy lifestyle with regular exercise, holidays
- Use recreation, hobbies, exercise to promote life-work balance
- Practice mindfulness and meditation
- Prioritise personal relationships such as family and close friends

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# Self care for Health Care Professionals


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# Any questions?

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