Mental health and mental illness

Health:
The World Health Organization (WHO) defines health as ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.’

_A newer definition of health is: ‘Health is the ability to adapt and self-manage.’_ (Mechteld Huber, British Medical Journal, 2010)

So, without mental health there is no health. Without the ability to adapt mentally and self-manage one’s emotional well-being there is no health.

Mental health: WHO defines mental health as ‘a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.’

Mental illness: The Oxford English Dictionary defines mental illness as ‘a condition which causes serious abnormality or disorder in a person’s behaviour or thinking capacity.’

The term ‘mental disorder’ is now used interchangeably with ‘mental illness’. The UK’s Mental Health Act 2007 defines mental disorder as ‘any disorder or disability of the mind’.

There are many types of mental illness and, depending on how mental illness is described, 10 or 25% of people living in the United Kingdom can be considered to have had a mental illness at some point in their lives.

Severe mental illness is a term used for longstanding conditions and effects only about 1-2% of the population.

Mental health problems: ‘Mental health problems’ is a phrase often used to describe problems that may not reach the ‘diagnostic criteria’ or thresholds for the diagnosis of an illness or disorder recognised by psychiatrists.

Some use ‘mental health problems’ rather than ‘illness’ or ‘disorder’ as a less medicalised description.
Physical, Emotional and Social Changes in Pregnancy

The physical changes
From the outset of pregnancy there are normal expected changes to a woman’s body and hormones. However these changes often have physical and emotional effects on women which they find difficult to cope with. The ability to deal with the changes may be compromised for women suffering from mental health problems.

In the first weeks of pregnancy women may experience debilitating tiredness. They may feel nauseous and experience vomiting. Sometimes this is limited to the mornings, but many women experience ‘morning sickness’ at all times of the day.

The main changes during pregnancy are governed by three key hormones:

HCG (Human chorionic gonadotrophin)
HCG is exclusive to pregnancy and forms the basis of most pregnancy tests as it is excreted in large quantities in the maternal urine from early in pregnancy. The function of HCG is to ensure that there is a continued production of progesterone that is crucial to the pregnancy continuing in the early stages.

The high levels of HCG in early pregnancy cause maternal drowsiness, nausea, vomiting and thirst to varying degrees.

Progesterone
Progesterone is produced in increasing amounts throughout pregnancy until just before the onset of labour when the levels drop. Progesterone plays an important role in reducing muscular activity of the uterus in pregnancy and thus preventing premature labour. Progesterone also acts on other plain muscle throughout the body. This may lead to a number of uncomfortable conditions:
• Painful varicose veins
• Breathlessness in pregnancy which is possibly caused by progesterone making the respiratory centre more sensitive to carbon dioxide levels in the blood
• Bladder: resulting in many women experiencing urgency to pass urine, and sometimes stress incontinence
• Gastrointestinal system: contributes to the common problems of heartburn, constipation and haemorrhoids
• Promotion of an increase in body fat during pregnancy which may affect body image
• Relaxation of ligaments that normally stabilise the joints of the pelvis - this can lead to backache, sciatica, pelvic girdle pain (or symphysis pubis diastasis).

**Oestrogen**

Oestrogen levels increase from early in pregnancy and influence the development of the muscle layer of the uterus in pregnancy and prepare it to contract when labour starts.

Oestrogen also makes connective tissue more supple: this is particularly notable in relation to the pelvic joints which become more mobile under the effects of oestrogen, which can cause pain and discomfort.

Increased pigmentation occurs as a result of increased oestrogen levels. It is more evident in darker skinned women and can be a source of embarrassment for women as it commonly appears on the face.

**Pregnancy timeline**

6 weeks
• Uterus enlarging but remains in the pelvic cavity
• Pressure felt in bladder and some frequency of micturition
• Nipples start to become sensitive
• Gums may bleed
• Mood may fluctuate
• Nausea may begin
• Critical period in fetal development due to rapid cell growth and greatest vulnerability to teratogens
12 weeks

Breasts
- Tender and enlarged
- Nipples become sensitive
- Areolar pigmentation increases

Cravings
- Around two thirds of women have strong cravings or aversions
- Taste buds less sensitive in pregnancy
- Common aversions: tea, coffee, meat, fried foods and eggs
- Exaggerated sense of smell

Pica
- More extreme craving
- Non-nutritional products: coal, cleaning materials, soap, ice and toothpaste
- Does not usually affect either maternal or fetal health

Women generally reassured about their pregnancy at this stage as they have their first ultrasound scan and they start to feel pregnant.

16 weeks

- Nausea usually eases by end of week 12
- Tiredness eases off
- Energy levels increase
- Constipation, gum or nasal problems may continue
- Breasts: Milk formation, areola darken
- Development of: linea nigra, facial chloasma, striae gravidarum

As the uterus is now grown and into the abdominal cavity, many women start to have a pregnant bump, which can be reassuring to them. For women who have had previous pregnancies, fetal movements can often be felt as early as 16 weeks.
24 weeks

Key facts:

- Fetal Movements felt
- Braxton Hicks contractions
- Baby can hear in utero
- Skin may ‘glow’, hair-thicker & shiny
- Mood-most women feel well

Common complaints:

- Heartburn
- Shortness of breath
- Varicose veins
- Haemorrhoids

Feeling the baby move is usually very reassuring for women and they often start to talk to their baby and the bonding process becomes stronger. By this stage the fetus is considered legally viable in the UK. Women often enjoy this stage in pregnancy, have good energy levels and have the pregnancy ‘glow’.

32 weeks

Common complaints:

- Oedema
- Backache - increasing size can put a strain on the spine
- Indigestion increases - leading to heartburn
- Breathlessness
- Rib pain
- Urinary frequency, cystitis, incontinence
- Leg cramps
- Dreams occur - often about the baby but can be disturbing (may reflect unspoken worries about the baby/pregnancy or birth)

Due to the advancing pregnancy and increased uterine size, women often feel physically uncomfortable at this stage. However, it is also a time of positive preparation for the baby’s arrival and many women attend childbirth classes.
40 weeks

Frequent complaints:

- Heartburn
- Shortness of breath
- Backache
- Difficulty sleeping
- Difficulty concentrating
- Tiredness
- Frequency of micturition
- Constipation
- Uterine contractions
- Anxiety about birth

By this stage, women will have reached their due date and have expectations that their baby will be born soon. There are mixed emotions in expectation of the birth: anxiety, some fear and apprehension, but also great excitement and anticipation of seeing their baby. Some pregnancies progress to 41-42 weeks, when induction of labour will be required if labour does not commence spontaneously.

Emotional changes

A woman’s emotional response to pregnancy is affected by many factors.

These include:

- her own personal history
  - how she has become pregnant
  - whether the pregnancy was wanted or planned
  - her feelings about her own childhood and mother
- her social context
  - how supported she feels
  - how stable her living situation is
- her own current emotional resilience and well-being.
Transition to parenthood

A first pregnancy is a time when a woman begins the transition to being a mother and development of the ‘maternal self’ takes place. Not all women conform to the ideal image of pregnancy and motherhood commonly promoted in the media. Some will view pregnancy as troublesome time, or a ‘means to an end’ and may not develop a relationship with the fetus or, for some women, even appear to accept the pregnancy until late on or even after birth.

There are a number of milestones in pregnancy that generally support the development of a feeling of attachment by the mother to the growing fetus, but may also lead to ambivalence for some women:

- First ultrasound scan: seeing the baby for the first time can help some parents begin to believe that the pregnancy is real.
- Starting to ‘show’: the growing bump can be a source of reassurance to some women, needing to wear different clothes helps them believe that the baby is growing.
- Beginning to feel the baby move (‘quickening’) by around 20 weeks gestation. Feeling movements can help many women develop some form of relationship with their unborn baby. Many women begin to identify potential characteristics of their baby by their fetal behaviour e.g. if experiencing a lot of fetal movement, the baby will be lively, or if experiencing a lot of night movement, the baby will be a night owl. However, some women experience the baby’s movements as disturbing and intrusive.
- Many mothers hold, stroke and talk to their growing ‘bump’. Many women have a strong sense that they are not alone during pregnancy.

The developing relationship with the unborn baby may make the woman appear very self-absorbed and partners and other children may start to feel left out. Anxieties about the pregnancy tend to reduce as the pregnancy continues, particularly after 12 weeks when the risk of miscarriage reduces and then again after 24 weeks when the fetus is ‘viable’ (able to survive if born). However, these worries may be replaced with anxieties related to the birth process.

There is recognition that the postnatal period is a stressful time involving couples making significant psychological changes and adapting to new roles. The relationships of many couples may be severely challenged during this period and sometimes break down after the birth of a baby. It has been argued that there is a conspiracy of silence surrounding this period which can leave parents feeling that they are the only ones having a hard time. Most couples are able to cope with these changes – tiredness, loss of libido and lack of focus on the parental
relationship, until things improve and some level of normality returns. A study showed that 90% of couples found their relationship deteriorated after their first baby was born (Doss et al, 2009).

Increased recognition of the significance of the changes taking place for both men and women during the transition to parenthood, and the importance of preparing parents for their new roles has underpinned the recent development of preparation for parenthood classes, many of which are replacing the more standard ‘antenatal classes’. These classes focus not only on preparation for the birth but on preparation for early parenthood.

**Maternal adjustment**

<table>
<thead>
<tr>
<th>First Trimester Psychological tasks</th>
<th>Second Trimester</th>
<th>Third Trimester</th>
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</thead>
<tbody>
<tr>
<td>Acceptance of pregnancy</td>
<td>‘I’m going to have a baby’</td>
<td>‘I’m going to be a parent’</td>
</tr>
<tr>
<td>‘I am pregnant’</td>
<td>Feeling of well being</td>
<td>Loss/increase of libido</td>
</tr>
<tr>
<td>Pleasure</td>
<td>Increased attachment to fetus</td>
<td>Altered body image</td>
</tr>
<tr>
<td>Excitement</td>
<td>Stress and anxiety</td>
<td>Effect from minor disorders</td>
</tr>
<tr>
<td>Elation</td>
<td>Increase demand for information and knowledge</td>
<td>Anxiety about labour</td>
</tr>
<tr>
<td>Increased femininity</td>
<td></td>
<td>Anxiety about abnormality</td>
</tr>
<tr>
<td>Dismay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disappointment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotionally labile</td>
<td>Increasing need to detach from work commitments</td>
<td>Increased vulnerability to other stresses</td>
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<tr>
<td>Tearful</td>
<td></td>
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</tbody>
</table>
**Positive/negative influences**

<table>
<thead>
<tr>
<th>Positive Influences</th>
<th>Negative Influences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned pregnancy</td>
<td>Unwanted pregnancy</td>
</tr>
<tr>
<td>Who will the baby look like</td>
<td>Unwilling father</td>
</tr>
<tr>
<td>Sense of fulfilment</td>
<td>Unsupportive/resentful partner</td>
</tr>
<tr>
<td>Embrace impending motherhood</td>
<td>Altered body image/lack of control of body</td>
</tr>
<tr>
<td>At one with peers</td>
<td>Physical effects</td>
</tr>
</tbody>
</table>

**Normal emotional responses**

The perinatal period is a time of many mixed emotions:

**Pregnancy**

- Anxiety about miscarriage
- Anxiety about the baby’s health
- Excitement about a new family member
- Fear and anxiety about coping with a new baby
- Happy about her changing body
- Disturbed by her changing body
- Fed up with discomforts of pregnancy

**Labour**

- Great excitement and anticipation to utter dread
- Fear of the unknown
- Fear of technology, intervention, hospitalisation
- Tension, fear and anxiety about pain (ability to exercise control during labour)
- Concerns about the wellbeing of baby and ability of partner to cope
- Fear of death:
  - Hospital places of illness, death, dying
  - Feelings might intensify if life threatening complications or Caesarean section birth
- Fear of lack of privacy or embarrassment
Postnatal

Immediately following birth:

- Relief
- Cool detachment
- Contradicting and conflicting feelings:
  - satisfaction, joy, elation, exhaustion, helplessness, discontentment, disappointment
- Closeness to partner or baby
- Early skin-to-skin contact helps nurture and builds mother baby relationship
- Disinterest or being very attentive towards baby
- Fear of unknown and sudden realisation of overwhelming responsibility
- Exhaustion and increased emotions
- Increased vulnerability, indecisiveness
- Loss of libido
- Disturbed sleep, tiredness
- Anxiety

(Raynor and Oates, 2009, p.684)

Consider how you would detect if these normal emotional changes had become a mental health problem – what would you do?

Portrayal of motherhood

Women can feel isolated by the unrealistic portrayals of pregnancy and motherhood in the media.

There are many myths surrounding motherhood which stem from a cultural expectation that women adopt the role of mother and have a maternal function. However, some evidence suggests that being a mother is task orientated and not necessarily born of innate instincts. Indeed, issues such as policies on birth, and social and sexual control of women, are believed to contribute to the conflicting views society has regarding motherhood, and which can lead to women developing postnatal illness such as depression. (Ambrosini and Stanghellini, 2012)

The belief that motherhood is synonymous with being a good mother can lead to feelings of maternal guilt, especially when a woman has mental health problems.
Myths of motherhood

Consider the following myths which surround motherhood and think about how you could dispel these:

• Pregnancy is a calm dream-like period, the attainment of which fulfils a woman’s deepest yearnings
• Pregnancy and motherhood are always wanted or needed
• Pregnancy protects against becoming mentally unwell
• Mothers always bond instantly with their baby
• Motherhood is the ultimate fulfilment of life
• Mothers are supposed to have infinite feelings for their baby
• Being a mother is natural and instinctive
• A mother is beautiful, serene, and radiant, as well as an expert housekeeper and cook
• Mothers are supposed to be like those in the Fairy Liquid advert
• Good mothers always have time to play with their children and have wisdom to discipline and guide them.
Maternity care and antenatal appointments

Maternity care

Women will generally find out they are pregnant through a home pregnancy test. This can now be as early as 4 weeks of pregnancy. Women will then contact either their GP or their local midwife. The lead professional for normal pregnancy is the midwife.

Antenatal appointments:

Women who are pregnant with their first baby (primiparous women) will generally have 10 antenatal appointments with their midwife spread through their pregnancy. Women who are having a subsequent baby (multiparous women) will usually have 8 appointments.

The standard appointments are at: 12, 16, 22, 28, 32, 36, 38 and 40 weeks.

At the beginning of pregnancy, the woman will have a long ‘booking’ appointment with the midwife. This is usually between 8 and 12 weeks of pregnancy. This may last over an hour. The midwife will ask the woman about her physical and mental health history, her family physical and mental health history, social circumstances, and her lifestyle including smoking, alcohol and drug use. The midwife will generally take blood samples from the woman to test for a range of conditions that may affect the pregnancy including anaemia, hepatitis, HIV and for blood grouping. Blood pressure and a urine sample will be taken.

From the information shared at this appointment the midwife will identify particular risk factors and whether the woman will have ‘midwife-led’ or ‘maternity team’ care. Women who have midwife-led care in Scotland are allocated to the ‘green pathway’, as they have no particular risk factors. Women with significant mental or physical health problems will be allocated to the ‘amber’ or ‘red’ pathway to receive care shared by the midwife, obstetrician and other members of the multi-disciplinary team.

At subsequent antenatal appointments the woman will have her blood pressure checked and a urine sample taken, the midwife will generally ask her to lie down so that the growth of the baby and the baby’s heart rate can be checked and will ask the woman about her physical and emotional well-being.
Women will generally have two ultrasound scans during pregnancy: one at around 10-12 weeks (when screening for Down’s syndrome is undertaken) and one at around 20 weeks (screening for a range of fetal abnormalities). Some women may have further ultrasound scans during pregnancy if there are any concerns about the baby’s growth, fetal movements or position.

The antenatal appointments and ultrasound scans can lead to a range of emotions: increased anxiety through intrusive questions, fear of needles and blood tests, anxiety prior to scans that a problem will be found. Women may also find some appointments and tests reassuring as they show that everything is progressing normally.

Ideally, maternity services should provide women with a ‘named midwife’ who will provide them with the majority of their care. However, levels of continuity of carer are variable in different areas.

The normal length of pregnancy is between 37 and 42 weeks. Women are usually given a ‘due date’ or ‘estimated date of delivery’ (EDD) based on the date of their last period and measurements on the first ultrasound scan. If a woman does not go into labour by the time she is 41 weeks she will generally be offered induction of labour.

You can find out more information on the ‘Resources and references’ page at the end of this resource - look at the Scottish Woman handheld record and the ‘Ready Steady Baby’ site.
## Mental Illness

### Prevalence (general population)

1 in 10

### Prevalence (pregnant and postnatal women)

1 to 2 in 10

### Main Symptoms

#### Psychological symptoms:
- Continuous low mood or sadness
- Feeling hopeless and helpless
- Feeling low self-esteem
- Feeling tearful
- Feeling guilty
- Feeling irritable and intolerant of others
- Feeling no motivation or interest in things
- Finding it difficult to make decisions
- Finding it difficult to enjoy life
- Feeling anxious or worried
- Having suicidal thoughts or thoughts of self-harm

#### Physical symptoms:
- Moving or speaking more slowly than usual
- Change in appetite or weight (usually decreased, but sometimes increased)
- Constipation
- Unexplained aches and pains
- Lack of energy or lack of interest in sex (loss of libido)
- Changes to menstrual cycle
- Disturbed sleep (for example, finding it hard to fall asleep at night or waking up very early in the morning)
- Finding it difficult to wake up in the morning

#### Social symptoms:
- Not doing well at work
- Taking part in fewer social activities

### Causative/contributing factors

- Psychosocial stressors, including bereavement.
- High levels of stress.
- Personality traits.
- High levels of stress.
- Psychosocial stressors, including bereavement.
- Chronic illness and pain.
- High levels of stress.
- Psychosocial stressors, including bereavement.

### Treatment options in pregnancy

- For mild to moderate depression, talking therapies, including interpersonal therapy and cognitive behavioural therapy can be as helpful as or more helpful than medication.
- A range of SSRIs and TCAs.
- Paroxetine (seroxat) appears to be higher risk in terms of fetal abnormalities than fluoxetine, sertraline or citalopram.
- In severe cases, hospitalisation and/or ECT may be considered.

### Treatment for non-pregnancy

- With some caution around prescribing, weighing up risks and benefits of continuation or discontinuation of treatment.
- Talking therapies to be offered if medication is being reduced and discontinuation suggested.

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<table>
<thead>
<tr>
<th>Depression Score</th>
<th>Treatment Options</th>
</tr>
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<tbody>
<tr>
<td>1-10</td>
<td>Lifestyle changes: diet, exercise, reducing drugs.</td>
</tr>
</tbody>
</table>
### Psychological Symptoms

<table>
<thead>
<tr>
<th>Physical Symptoms</th>
<th>Psychological Symptoms</th>
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</thead>
<tbody>
<tr>
<td>Depression</td>
<td>Phobias – c 1 in 6</td>
</tr>
<tr>
<td>Fatigue</td>
<td>Post-traumatic stress disorder – about 1 in 3 people who experience a traumatic event</td>
</tr>
<tr>
<td>Shortness of breath</td>
<td>More common in women than men</td>
</tr>
<tr>
<td>Muscle aches and tension</td>
<td>Psychological therapies, including CBT</td>
</tr>
<tr>
<td>Trembling or shaking</td>
<td>Support groups, Anti-depressants (SSRIs)</td>
</tr>
<tr>
<td>Dry mouth</td>
<td>Lifestyle changes: diet, exercise, reducing drugs and alcohol</td>
</tr>
<tr>
<td>Excessive sweating</td>
<td>As for non-pregnancy, with some caution around pregnancy and delivery, ensuring medications are in combination to be effective. Changing therapies to be effective, reducing drugs, adjusting dose, delisting, stopping groups (SSRIs)</td>
</tr>
<tr>
<td>Headache</td>
<td>Contraindicated for women in late pregnancy, considering risks and benefits of continuation or discontinuation of treatment.</td>
</tr>
<tr>
<td>Nausea, chest pain,</td>
<td>Talking therapies to be offered if medication is being reduced and discontinuation suggested</td>
</tr>
<tr>
<td>Anxiety disorders</td>
<td>Eventual termination a year after delivery for women, with follow-up for 2 years</td>
</tr>
<tr>
<td>Generalised anxiety disorder</td>
<td>A note of caution: first or longer term treatment</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>Psychosocial symptoms include:</td>
</tr>
<tr>
<td>Phobias</td>
<td>1 in 6 of new mothers</td>
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### Psychological Symptoms

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</table>
### Understanding Maternal Mental Health

Social symptoms include:

- Avoidance of triggers
- Social isolation
- Withdrawal from normal activities
- Drug and alcohol misuse

Other symptoms include:

- Dizziness
- Feeling faint
- A need to go to the toilet
- Ringing in your ears
- Shivering
- Shaking

Obsessive Compulsive Disorder (OCD)

Around 12 in 1000 as in general population

Obsessive compulsive disorder (OCD) affects people differently, but usually causes a particular pattern of thought and behaviour. This pattern has four main steps:

1. **Obsession**: An unwanted, intrusive and often distressing thought, image or urge repeatedly enters your mind.
2. **Anxiety**: The obsession provokes a feeling of intense anxiety or distress.
3. **Compulsion**: Repetitive behaviours or mental acts that you feel driven to perform as a result of the anxiety and distress caused by the obsession.
4. **Temporary Relief**: The compulsive behaviour brings temporary relief from anxiety, but the obsession and anxiety soon return, causing the cycle to begin again.

Genetics, reduced serotonin levels, stressful life events, and personality may play a role.

Psychological therapies including CBT.

If not improved, antidepressants, SSRIs.

Lifestyle changes: diet, exercise, reducing drugs and alcohol.

As for non-pregnancy, with some caution around prescribing, weighing up risks and benefits of continuation or discontinuation of treatment.
# Bipolar Disorder

Bipolar disorder (formerly known as Manic Depression) affects around 1 in 100 people as in the general population. It is characterised by extreme mood swings. These can range from extreme highs (mania) to extreme lows (depression). Episodes of mania and depression can occur at any time, and can last for several weeks or months.

## Symptoms of Mania

- Feeling very happy, elated or over-energised
- Trouble sleeping or sleeping much less
- Talking very quickly
- Having racing thoughts and speaking rapidly
- Feeling important, or that others think you’re important
- Feeling on top of the world or ineluctable optimism
- Staying up all night
- Spending lots of money
- Impulsive actions that you later regret
- Fear of existing or coming danger

## Symptoms of Depression

- Feeling sad or hopeless
- Lack of interest or pleasure in everyday activities
- Difficulty sleeping or sleeping too much
- Fatigue or loss of energy
- Trouble concentrating or making decisions
- Feelings of emptiness or worthlessness
- Feelings of guilt and despair
- Activities you used to enjoy

## Causes

- Genetic inheritance.
- Chemical imbalance in the brain.
- Stressful life event triggers.

## Treatment

A combination of medication to reduce and control mania and depression including mood stabilisers, antidepressants. Psychological therapies, lifestyle advice and adaptations, including regular exercise, good sleep.

Lithium may have significant adverse effects. Specialist advice should be sought.

Medication should not be discontinued suddenly as this brings a high risk of relapse, specialist advice should be sought.

Mood stabilisers may be associated with significant adverse effects on fetal development and valproate, in particular, is contraindicated in pregnancy when used to treat mental illness.

However, medication should not be discontinued suddenly as this brings a high risk of relapse, specialist advice should be sought.
### Understanding Maternal Mental Health

#### Schizophrenia
- Around 1 in 100
- Long-term mental health condition that causes a range of different psychological symptoms:
  - Positive symptoms: represent a change in behaviour or thoughts, such as hallucinations or delusions, confused thoughts and changes in behaviour.
  - Negative symptoms: represent a withdrawal or lack of function which you would usually expect to see in a healthy person. For example, people with schizophrenia often appear emotionless, flat, and apathetic.

#### Genetics, brain disorders, neurotransmitters, pregnancy or birth complications (including low birth weight, premature labour or birth asphyxia), substance misuse including cannabis.

#### Anti-psychotic medication and long-term treatment and care from a community health team, with hospitalisation if required during acute episodes.

#### Lifestyle changes:
- Diet, exercise, reducing drugs and alcohol,
- Psychological therapies

#### Eating disorders
- Anorexia, bulimia, binge eating
- Anorexia 1 in 250 women,
- Bulimia around 1 in 50 women

#### The SCOFF questionnaire can help identify symptoms:
- Sick: Do you ever make yourself sick because you feel uncomfortably full?
- Control: Do you worry you have lost control over how much you eat?
- One stone: Have you recently lost more than one stone (six kilograms) in a three-month period?
- Fat: Do you believe yourself to be fat when others say you are too thin?
- Food: Do you say that food dominates your life?

#### Psychological therapies, including CBT.
- Support groups.
- Anti-depressants (SSRIs).
- Hospitalisation in severe cases.

#### Close monitoring of weight gain and additional investigations if any concerns.

## Family History of Mental Health

<table>
<thead>
<tr>
<th>Psychosocial Therapies</th>
<th>Psychological Therapies</th>
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<tbody>
<tr>
<td>CBT</td>
<td>CBT</td>
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<td>Workplace interventions</td>
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### Psychological Symptoms
- General: Brain disorders,
- Mood or emotion:
  - Difficulty expressing feelings
  - Making decisions or losing control over actions
  - Inability to experience pleasure
  - Difficulty understanding
- Memory problems
- Cognitive impairment
- Learning difficulties
- Communication difficulties
- Poor concentration
- Recent memory loss
- Disorganised thinking
- Being disruptive, impairing relationships and

### Family History of Mental Health

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<th>Education for Scotland</th>
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Understanding why the perinatal period is high risk for women

Our understanding of the aetiology of postpartum bipolar relapse is limited, but there is good evidence to suggest that there is a strong genetic predisposition. It is possible that early postpartum hormone changes (in particular the precipitous drop in oestrogen and progesterone) may act as a trigger for relapse in genetically susceptible individuals.

Evidence suggests that the strongest risk factors for early postpartum severe mental illness, or postpartum psychosis, are: primiparity, a past history of bipolar disorder and a past history of postpartum psychosis. The presence of either of the latter 2 risk factors predicts a risk of early postpartum psychotic disorder of between 1 in 2 and 1 in 4. This risk is further increased if there is additional first-degree family history of either condition.

All this points to a strong link between bipolar disorder and postpartum psychosis. Increasingly, postpartum psychosis is regarded as a variant of bipolar disorder. There are three further pieces of evidence for this association:

Firstly, for women who have an episode of postpartum psychosis, their risk of a future non-childbearing related psychotic illness is as high as 60%. However, a proportion of women will only ever experience psychotic episodes in relation to childbirth. At present, it is not possible to predict which women will go on to have non-childbearing related episodes, and which will not.

Secondly, the vast majority of women who experience postpartum psychosis will have an affective - or mood-related - psychotic episode, rather than a non-affective (or schizophrenia-like) psychosis.

Thirdly, women with bipolar disorder who during pregnancy discontinue medication which they take for preventing recurrence will have a significantly increased risk of developing postpartum psychosis when compared with non-pregnant women, or with their own risk of relapse during pregnancy.

Women who suffer from schizophrenia have a different pattern of postpartum relapse. It is cumulative over the course of the first postnatal year and overall not as great as that experienced by bipolar women. For these women, there does not appear to be the same early, biological or genetic risk of relapse. We know from research on relapse in schizophrenia that high expressed emotion environments act as a precipitant. Pregnancy and, particularly the postnatal period, is a time when women with schizophrenia are likely to be under close
scrutiny because of concerns about their ability to parent. They are likely to have close involvement with social services and health agencies. Additionally, they have increased emotional demands in connection with child-care, which may be more evident as their child grows and develops. These demands in themselves may increase risk of relapse.

For women with bipolar disorder and schizophrenia, concerns over adverse effects of medication in pregnancy or breastfeeding may lead to discontinuation or alteration which, while done with the best of intentions, can in itself increase risk of relapse.
Prescribing in pregnancy

When prescribing in pregnancy, it is important to remember that all psychotropic drugs pass through the placental barrier and into fetal circulation. The concentration of drug in the fetal system varies considerably when compared to maternal concentrations.

SIGN guidelines recommend that women should be closely involved, where possible, in any decisions regarding prescribing in pregnancy. They should also be informed that not treating mental illness in pregnancy may be associated with adverse effects for the fetus or developing child. Switching to alternative drugs on discovering a pregnancy is usually not recommended, although valproate is a notable exception. SIGN and NICE make a number of other recommendations around prescribing in pregnancy and breastfeeding.

The decision to prescribe or not must take into account a number of risks and benefits to the mother, pregnancy and developing infant.

Potential side effects of drugs on a developing fetus may take the form of organ malformation or dysgenesis, alteration to fetal growth, early neonatal problems and long-term problems caused by alterations to brain functioning. Our knowledge base is particularly limited with regard to the last factor as few well-conducted long term studies have followed up infants for any length of time.

SSRIs (Selective Serotonin Reuptake Inhibitors) are the more modern, very common group of antidepressants. These include fluoxetine (marketed as prozac or oxactin), sertraline (lustral), citalopram (cipramil), escitalopram (cipralex) and paroxetine (seroxat). SSRIs may be associated with an increased risk of cardiac defects with exposure in early pregnancy. The absolute risk remains small, at up to 2 in 100 pregnancies. These risks appear to be highest with paroxetine, but there is some evidence that it is present with all SSRIs, and that it may also be a risk with the older tricyclic antidepressants. There have been occasional case reports of problems with the development of the fetal gut, but again, the absolute risk appears to be small. Babies born to mothers who have taken SSRIs in pregnancy may be smaller for dates and more likely to be born prematurely. Fluoxetine, Sertraline and Citalopram are considered to be the safer SSRIs for pregnancy.

The older group of antidepressants are called Tricyclic medications (TCAs). These include imipamine, amitriptyline, doxepin and lofepramine. These are less well researched than the SSRIs but have been used over a longer period of time. They are likely to have a similar or lower risk pattern to SSRIs.
Antidepressants may be associated with increased frequency of some neonatal complications: infants may experience neonatal poor adaptation, a syndrome which may be related to withdrawal of the drug or its ongoing presence in the infant. Symptoms are rarely of a severe nature but may require additional monitoring and time in hospital. A much rarer condition which may be evident in the neonate is persistent pulmonary hypertension of the newborn. This condition may cause breathing difficulties and, in some cases, may be life-threatening. Again, if it is at all increased by use of SSRIs, the absolute risk remains very low at 2-3 in 1000 births.

Lastly, the evidence for long-term neurobehavioural toxicity is very limited. Some recent reports have suggested a possible increased risk of autistic spectrum disorder but the research is inconclusive at present, and there are reports also that untreated depression may be linked with similar outcomes. What is evident is that, if the risk is increased, it remains at a very low absolute level.

It is very important to remember that not treating depression is also associated with potential adverse outcomes and that, in one study of women with significant, recurrent depressive disorder who discontinued antidepressants on discovering their pregnancy, more than two thirds relapsed into illness.

Mood stabilising medications
These include lithium and a number of antiepileptic medications including valproate, carbamazepine and lamotrigine. All have been linked to teratogenic effects on early fetal development and valproate is also associated with long term neurobehavioural problems in children born to mothers taking the drug in pregnancy. For this reason, valproate should not be prescribed for the treatment of mental illness to women of childbearing potential. Other mood stabilising medications require careful discussion with the woman about benefits and risks, which should be done by specialist mental health services. Newer (second-generation) antipsychotic medications are also used as mood stabilising treatments and may be preferable as first-line agents in pregnancy.

Antipsychotic medications
These include ‘first-generation’ drugs such as chlorpromazine, haloperidol and flupentixol, and ‘second-generation’ drugs such as olanzapine, quetiapine and aripiprazole. Antipsychotic drugs may be associated with weight gain and impaired blood glucose control, increasing the risk of gestational diabetes mellitus. They are also associated with alterations in fetal growth and may increase the risk of birth complications.
Prescribing in breastfeeding
Breastfeeding women are understandably reluctant to take any substance that might have a detrimental effect on their infant. Breastfeeding is less common among women who are depressed or who are taking antidepressants. However, prompt, effective management of postnatal mental illness is likely to be of benefit to both mother and infant. Breastfeeding women with mental illness should have rapid access to psychological therapies, but where illness is more severe, the addition of medication may be an essential component of effective treatment. Just as in pregnancy, decisions are complex and need to be based on an individual assessment of risk and benefit. In the majority of cases, women should not need to face a choice between breastfeeding and taking antidepressants or antipsychotic medications. Prescribers should keep up to date on latest evidence and choose drugs which are less likely to pass into breastfed babies.
Understanding Maternal Mental Health

Understanding Maternal Mental Health Key References

The NICE guidance on antenatal and postnatal mental health
NICE antenatal and postnatal mental health guidelines 45
http://www.nice.org.uk/guidance/cg192/evidence

NICE clinical guideline 110: Pregnancy and complex social factors:
http://www.nice.org.uk/guidance/cg110/resources/guidance-pregnancy-and-
complex-social-factors-pdf

management of bipolar disorder in adults, children and adolescents, in primary
and secondary care. NICE Clinical Guideline 38 [online] available at

SIGN Guidelines
SIGN guideline on perinatal mood disorders
http://www.sign.ac.uk/pdf/sign127.pdf

The booklet ‘Mood disorders during pregnancy and after the birth of your baby’,
produced by SIGN and NHS Healthcare Improvement Scotland, aims to make
women and their families aware of the treatment and care they should expect to
receive if they have a mood disorder during pregnancy and after the birth of their

The Triennial enquiries into Maternal deaths:
into maternal deaths’, RCOG, London:
http://www.hqip.org.uk/assets/NCAPOP-Library/CMACE-Reports/33.-2004-Why-
Mothers-Die-2000-2002-The-Sixth-Report-of-the-Confidential-Enquiries-into-
Maternal-Deaths-in-the-UK.pdf


**Eating Disorders**  


Resource references:


Understanding Maternal Mental Health


http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1592154/pdf/10995_2006_Article_90.pdf

Other resources

‘From Bumps to Bundles’, Report on Perinatal mental health services in Greater Glasgow and Clyde, 2013. The report can be viewed here:
http://www.maternal-and-early-years.org.uk/search?q=bumps+to+bundles+report

Tommy’s, Royal College of Midwives, Netmums and Institute of Health visiting undertook research and published a report on Perinatal mental health in 2013. The report can be downloaded here:
https://www.tommys.org/perinatal-mental-health-report

Preconception Care: A Systematic Review


[http://maternalmentalhealthscotland.org.uk/resources/recommended-reading](http://maternalmentalhealthscotland.org.uk/resources/recommended-reading)


Cassandra Vieten [http://www.mindfulmotherhood.org/author.html](http://www.mindfulmotherhood.org/author.html)

Learning resources available for health professional to help them understand the needs of women survivors of sexual abuse and sexual violence and provide high quality care: [http://www.knowledge.scot.nhs.uk/maternalhealth/learning/one-out-of-four.aspx](http://www.knowledge.scot.nhs.uk/maternalhealth/learning/one-out-of-four.aspx)

**Birth Trauma Association:**  
[http://www.birthtraumaassociation.org.uk/what_is_trauma.html](http://www.birthtraumaassociation.org.uk/what_is_trauma.html)

Improving Birth, reducing trauma:  
[http://www.improvingbirth.org/traumatoolkit/](http://www.improvingbirth.org/traumatoolkit/)

**Promoting mental health**

There is a helpful evidence summary Health Scotland about promoting mental health during pregnancy and the postnatal period: [http://www.mnic.nes.scot.nhs.uk/media/23121/mental_health_evidence_review_-_final.pdf](http://www.mnic.nes.scot.nhs.uk/media/23121/mental_health_evidence_review_-_final.pdf)

Antenatal risk factors for postnatal depression: A large prospective study: [http://yorkspace.library.yorku.ca/xmlui/bitstream/handle/10315/2553/Antenatal%20risk%20factors%20for%20postpartum%20depression.pdf](http://yorkspace.library.yorku.ca/xmlui/bitstream/handle/10315/2553/Antenatal%20risk%20factors%20for%20postpartum%20depression.pdf)
Mind-body interventions during pregnancy for preventing or treating women’s anxiety (Cochrane Review):

Effects of antenatal yoga on maternal anxiety and depression: A randomized controlled trial:

Information for women about tokophobia:
http://www.nct.org.uk/pregnancy/tokophobia-fear-childbirth

Guidance for midwives about tokophobia:

Postpartum Depression is a Family Affair: Addressing the Impact on Mothers, Fathers, and Children:

Talking to women about postnatal depression leaflet:

Mental Health Foundation (2012) Mental Health Statistics. [Online] Available at:
http://www.mentalhealth.org.uk/help-information/mental-health-statistics/

Organisation to reduce stigma around mental health:
https://www.seemescotland.org/

English organisation reducing stigma and misconceptions about mental illness: ‘Rethink’
http://www.rethink.org/?gclid=CMqVlrWAw68CFVEjfAodpjiXaw

Organisation that campaigns for raise awareness and improve services for people with mental health problems: ‘Mind’. Their website has helpful information about different conditions and information leaflets. http://www.mind.org.uk/
Alliance of Hope is an organisation offering support to those who are grieving following a suicide:
http://www.allianceofhope.org/?gclid=CN3e543p4LYCFdQctAod0zgA7Q
Survivors of bereavement by suicide
http://www.uk-sobs.org.uk/

Guidance for self-help on stress is outlined in: Steps for Stress
http://www.stepsforstress.org/

For self-help Cognitive Behavioural Therapy, see: Living Life to the Full
http://www.llttf.com/

Healthy Babies for Mothers with Serious Mental Illness: A Case Management Framework for Mental Health Clinicians:

Adults with Incapacity (Scotland) Act 2000: A short guide to the Act:

Health professionals’ audio recordings of their PMH role:
http://maternalmentalhealthscotland.org.uk/for-those-affected/who-will-be-helping-us

General pregnancy information
NHS Scotland pregnancy information: ‘Ready Steady Baby’
http://www.readysteadybaby.org.uk/

NHS England pregnancy information:

Scottish Woman held maternity record
http://www.healthcareimprovementscotland.org/our_work/reproductive_maternal_child/woman_held_maternity_record/swhmr_maternity_record.aspx

Maternity Care pathway in Scotland
Mental health among black and minority ethnic women:
http://www.mentalhealth.org.uk/help-information/mental-health-a-z/B/BME-communities/
http://www.evidence.nhs.uk/search?q=mental%20health%20in%20black%20ethnic%20minority

Lesbian and bisexual women’s mental health
General guidance on lesbian, gay and bisexual mental health issues and support: http://www.nhs.uk/Livewell/LGBhealth/Pages/Mentalhealth.aspx


The experiences of children with lesbian and gay parents:

Scottish Health survey: equality groups report, 2012:

Find out more about Lesbian and gay parenting issues:
http://www.pinkparents.org.uk/
http://www.stonewall.org.uk/at_home/parenting/default.asp

Disability and pregnancy:
Guidance for nurses and midwives on caring for pregnant women with disabilities:

Disability pregnancy and parenting information:
http://www.dppi.org.uk/

Women with a disability’s experience of maternity care:
http://www.biomedcentral.com/1471-2393/13/174

Information about the risks of mental illness for women with a learning disability:
http://www.aboutlearningdisabilities.co.uk/mental-health-issues.html

Infertility and post-infertility support and information:
http://www.infertilitynetworkuk.com/
Health inequalities and mental health:
There are a range of good resources and information about mental health in pregnancy, and particularly about the links with health inequalities here: http://www.maternal-and-early-years.org.uk/topic/pregnancy/mental-health-and-wellbeing-in-pregnancy

Sir Harry Burns on ‘coherence’ and salutogenesis: http://www.ads.org.uk/urbanism/features/sir-harry-burns-s-befs-lecture-on-wellness


Films

Jo Black (perinatal psychiatrist), film ‘Head Up Heart Strong’: https://vimeo.com/devonpartnershipnhstrust/review/100978811/ed3a88bb45

This two minute film describes the symptoms of puerperal psychosis: http://www.youtube.com/watch?v=cvpM2AQ3RY0

A one minute film: PPD and Postpartum Psychosis: Why is there confusion between these two diseases? http://www.youtube.com/watch?v=u9g2H9FvY3A

A four minute film from a woman who suffered from Postpartum Psychosis: http://www.youtube.com/watch?v=fhKKk0z_aGg

App (The UK Postpartum Psychosis Network) http://www.app-network.org/

PANDAS (Pre and Postnatal Depression Advice and Support) http://www.pandasfoundation.org.uk/?gclid=CMyRu5CcrLcCFU3KtAodDR0AGQ