



PNDSA

POST NATAL DEPRESSION SUPPORT ASSOCIATION SOUTH AFRICA

Volume 9 Issue 2.

005-295 NPO

August 2005

MATERNAL MENTAL HEALTH

Dr Mark Tomlinson

As recently as midway through the twentieth century the notion that childbirth may, in some way, be implicated in the mental health difficulties of women, fitted squarely in the realm of science fiction. This changed in 1968 after Pitt published his seminal study '*Atypical depression following childbirth*' which showed that depression associated with childbirth may be different from depression at other times. Since this early study, the parallel fields of the development of clinical interventions for women with mental health difficulties during the puerperium, and research into the impact of childbirth on parenting, have grown in leaps and bounds. The knowledge that has emerged has revolutionised the field of clinical interventions, added crucial data to the body of knowledge into prevalence rates and causes of postnatal depression, and provided significant data on early infant and child development in the context of postnatal depression.

While clinical and pharmaceutical interventions have become more refined, and the research more sophisticated, the role of advocacy for the rights of women with mental health problems in the puerperium has also been crucial. The role of PNDSA and Liz Mills in South Africa has been central in this regard, and it is in no way a hyperbole to suggest that a large part of the public face of postnatal depression in South Africa is due to the work of PNDSA. The sad retirement of Liz has facilitated a certain level of soul searching within PNDSA on its future direction. The appointment of Colleen Knutsen as manager of PNDSA is the first step in this reformulation.

The second step is a more difficult one. Postnatal depression in the developing world has received little clinical and research or clinical attention. John Cox's study in Uganda in 1983 was the first study from the developing world, while South Africa had to wait until 1999 for the first published report on prevalence rates of postnatal depression and the associated impact on mother-infant interaction. In this context, the real challenge for PNDSA is how to not only continue the good work that we are presently engaged in (our groups, the help-line, our internet website, and being an information resource in South Africa), but also to expand into communities and

areas that we traditionally have not managed to fully engage with. This will involve work with impoverished and marginalised women and families, with mothers and infants with HIV, as well as in the prevention and treatment of postnatal depression. Another area that PNDSA needs to expand its activities into is that of antenatal depression and the mental health of women and families in the puerperium more generally. For instance, it is becoming increasingly apparent that antenatal depression may be crucial in the development of postnatal depression, its chronicity, as well as the development of later maternal and child difficulties.

PNDSA is as well placed as any organisation to take the lead in both the work in communities not traditionally served, as well as in the area of clinical intervention with and research into antenatal and postnatal depression. It is incumbent upon PNDSA and its members to facilitate this process and ensure that PNDSA remains a central force in the field of mental health during the puerperium period.

To this end we are obviously dependant on securing funding for both the survival of PNDSA (in the first instance) but also for the implementation of both clinical interventions and research studies. We are in the process of attempting to secure such funding somewhat urgently because as things stand at present we have sufficient funding for survive for a further six months. Given the urgency of the situation any suggestions or proposals from our members will be eagerly followed up.

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LIZ MILLS FOUNDER-PRESIDENT PNDSA

A celebration, at Greenways Hotel in Wynberg, was held on Friday 22 April 2005 to honour Liz Mills who has now officially retired from PNDSA. She remains within the organization as a director of the board and consultant. The reins have now been handed over to Colleen Knutsen, who will manage the organization under the guidance of the PNDSA Board of Directors. At the celebration, Hilary Rosenthal paid tribute to this remarkable woman.

A really warm welcome to you all on behalf of the Board of PNDSA. We are so pleased that you are able to be here to celebrate Liz's achievements.

Liz's concern for woman suffering from PND started many years ago when she was working at the Parent Centre. Liz took responsibility for running support groups for women suffering from PND. Realizing that she had suffered from it, gave her a special insight and empathy. The groups were enormously successful.

Although committed to the work of the Parent Centre, Liz saw the perinatal period of particular importance, and felt that there was a need for an organization especially dedicated to serving new families in distress. She saw very clearly how parents are often overwhelmed by the stresses, strains and changes after the birth of a baby, and how seldom they were given the appropriate information and support.

She decided, with 13 others, to launch a new organization. This was in February 1997. These women were health professionals and some PND survivors.

A thumbnail sketch of events from then until now:

- A constitution was drawn up, a board was chosen and the organization was registered as an NPO.
- The mission statement focused on 4 main areas: -
 - Providing support and information for mothers suffering from PND;
 - Increasing awareness among professionals concerning the incidence and nature of PND;

- Educating the public, to combat ignorance and the stigmatization of women with PND
- Encouraging research on PND and disseminating.

These 14 stalwarts launched into action, but especially Liz and Deborah de Klerk, and by the first AGM in 1998 they had addressed all of the main areas listed in the mission statement

I'll give a rough summary of the stats (Extract from Report, (1988)), which illustrate this: -

- *Membership to date*
 From the 14 original foundation members, our current membership stands at 123, of whom 89 are professionals, GP's, Gynaecologists, Psychiatrists, Psychologists, Midwives, Social Workers, Nurses, etc. The others are recovered PND sufferers who are volunteers, many of them doing sterling work for PNDSA. Thank you to everybody.
- *Achievements to date:*
 To summarise our achievements to date:
 We have received, Debra and I, 1768 Helpline calls.
 1028 people have attended lectures by PNDSA.
 153 people have attended Support Workers Workshops.
 542 people have received mail shots.
 1026 mothers have been visited in maternity wards.
 125 PND assessment Interviews have been completed.
 86 women have attended Support Groups run by my colleagues and me.
 At least 14 new support groups have been set up in different centres.
 We have had 3 radio interviews.
 We have had PNDSA material on display 5 times in different centres.
 We have exposure and articles in 9 different Magazine articles, and are, as well, currently advertising in Living & Loving.
 Over 5000 PNDSA leaflets have been distributed.
 Over 120 posters have been distributed.

The organization has grown steadily with different changes and emphasizes at different times.

- Growth to new geographical areas; Johannesburg, Durban, East London; West Coast
- Focus on the needs of women in the public health sector, with PNDSA getting involved in various projects.
- Organizing different ways of fundraising-events, applying for grants, sponsorship from companies like Netcare.
- Setting up a web page and chat room
- Reorganizing the workload in the last 6 months so that Liz could be more a consultant than hands on and to this end appointing Colleen Knutsen as Manager.

To me it is amazing what has been achieved in the last 8 years. Liz's involvement has been on various levels. She has helped hundreds on the helpline, in counselling and in the groups she has run. She has literally saved some women's lives.

On a different level Liz has given many talks and lectures, trained many people, written articles, pamphlets, done research, which was published in SAMS. Liz has also made her mark Internationally. In spite of the fact she hates public speaking- her passion has enabled her to give papers at International

Conferences and make a significant contribution on the world scene. Her contacts and reputation made it possible for PNDSA to host an amazing conference in 2002 with the top researchers in the field internationally and nationally participating.

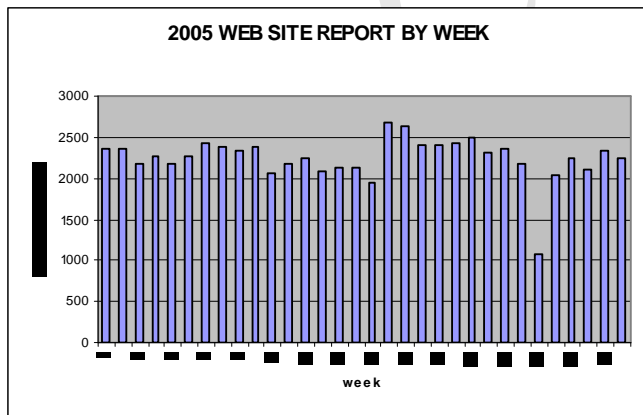
Of course Liz has not done all this single-handed. She has received help and support from many people, but their stories are for another time. I must mention Derrick, her husband. Derrick has made it possible for Liz's vision to become a reality due to his incredibly generous financial support. During the year he and his company have donated an enormous amount to PNDSA to help women and their families. Not only that, but he has given her emotional support and practical help and advice regarding the organization of PNDSA & its finances. He has paid for this wonderful occasion.

To me it is inspiring and hopeful to see a couple like Liz and Derrick making an important and unique contribution in the wider community

Not only are Liz and Derrick involved but also their large and talented family have been supportive both emotionally and practical ways sharing their time and expertise. One of the very important and significant things that Liz has done is to get people from completely different backgrounds professionally and otherwise to co-operate creatively for the benefit of new mothers and their families. Members include midwives, general practitioners, paediatricians, gynecologists, occupational therapists and survivors.

Birth involves the body, mind, soul and environments of mothers, babies and their families. Amazing how things happen when these professionals and others pool their knowledge and resources. When they share and co-operate they can provide a safe Nurturing healthy place for new mothers and their babies to be and grow.

Perinatal distress is always a crisis for mothers and their families, but if worked through in a creative way it can put woman in touch with their inner strength and their unique talents. This has been illustrated in Liz's amazing achievements. On behalf of all of us, I would like to express our deep gratitude to Liz.



OFFICE UPDATE

Colleen Knutsen

I recently attended a course at the University of Stellenbosch, Business School, specifically designed for those running NPO's. The course was run over a 6 day period. Topics covered were Financial Management, Fundraising with a Marketing approach, Project Management, Environmental Scanning and Strategic Management, legal Environment, Volunteer Management and Business Computer Applications. The standard of the lecturers was outstanding. Being able to network with people from other NPO's was very helpful. I hope to now implement the knowledge gained on the course in my work at PNDSA

Strategic Planning Meeting

The Board met with Marcus Coetzee, a Strategic Planner, who is assisting us in drawing up a Strategic Plan for PNDSA. This will assist us in submitting funding proposals.

Website

- Our website is very well utilized and continues to help many women from around the world suffering from PND.
- **Analysis shows that PNDSA receives 2000 hits a week.**
- Roger Weiss our Webmaster has suggested that the site be refreshed. Depending on costs this will be done in the next few months.

Fundraising / Marketing

- Lundbeck have been approached for funding. Awaiting reply.
- Have applied to the National Lotteries Board for funding. They have supported us in the past and we hope that they will continue to do so.
- A Business Consultant, the husband of an ex group member has approached us to help with funding. He would like to hold an art exhibition early next year and have ex group members who are artists together with well-known artists exhibit their work.
- DLA (Delivery Lifestyle Answers) distribute information packs on behalf of medical aids to pregnant women. Would like to include our material in these packs.

Hospital Visits

- Hospital visits continue to be done on a weekly basis at Constantiaberg Medi-Clinic, Kingsbury, Newlands Surgical, and Milnerton Medi-Clinic. Thank you to Leanne Miles, Sanette Mouton and Vanessa de Castro for giving of their time to visit mothers in hospitals.
- We are looking for volunteers to do hospital visiting at Vincent Pallotti, Cape Town Medi-Clinic and Christiaan Barnard. Please contact the office on (021)797-4498 if you are able to assist (training will be given).

Talks

- PNDSA continues to offer talks to antenatal classes and coffee mornings. Alison Beere, a PND "survivor", recently gave a talk to moms at the Parent Centre coffee morning. This was very well received.

Groups

- Emerentia Esterhuysen continues to run a very successful group in the Table view area.
- Linda Lewis has started a support group in Rondebosch and would like to start a second group. Linda can be contacted on (021)685-6172 for details.

Helpline

The National helpline continues to be a very important part of the services offered by PNDSA and receives a steady number of calls from all over South Africa

The Perinatal Mental Health Project at Liesbeeck Midwife Obstetric Unit

By: Simone Honikman, Director

As discussed previously in PNDSA's newsletters, postnatal mental health problems like depression and anxiety frequently occur during pregnancy. These may be identified and managed in order to prevent symptoms from getting worse. The consequences for the baby may thus, also be prevented. A women-centred mental health service is offered to pregnant clients at Liesbeeck Midwife Obstetric Unit in Mowbray, Cape Town.

The Perinatal Mental Health Project (PMHP) has featured in previous newsletters. This article serves to remind readers of the work that has been done and to inform of the plans for the Project's expansion.

Background

Perinatal¹ mental health problems are epidemic in the low-income and informal settlements surrounding Cape Town. *One in three* women in informal settlements such as Khayelitsha suffers from postnatal depression.² This is nearly *three times higher* than the prevalence in developed countries.³

Depression during and after pregnancy is associated with serious negative consequences for mother, infant and the community. The risk factors associated with perinatal mental health problems are endemic in this setting of socio-economic adversity. These include recent stressful life events; adolescent pregnancy; domestic violence; rape; lack of emotional and logistical support from a partner; and previous mental illness, particularly in the perinatal period. This is compounded by the high prevalence of HIV within these communities.⁴

Recently, anxiety has been shown to be as common as depression around the time of pregnancy. When either condition is present during the pregnancy, it is likely to persist into the postnatal period. In fact, it has been shown that in the vast majority of cases, mental health problems postnatally are present in the antenatal period. This may cause particularly negative effects on the developing foetus. However, the natural history of emotional distress around pregnancy provides a unique opportunity for early identification of problems antenatally. Further, pregnancy is a time of high contact with health services. In this way, a

¹ The term "Perinatal" refers here to the period during pregnancy (antenatal), labour and up to one year after the birth (postnatal).

² Cooper PJ et al (2002). Impact of a mother-infant intervention in an indigent peri-urban South African context. *British Journal of Psychiatry*, 180:76-84.

³ Warner R et al. (1996). Demographic and obstetric risk factors for postnatal psychiatric morbidity. *British Journal of Psychiatry*, 168:607-611.

⁴ Tatano Beck C (1996). A meta-analysis of predictors of postpartum depression. *Nursing Research*, 45(5):297-302.

professional response may prevent *worsening* of symptoms as well as prevent *continuation* of symptoms into the postnatal period.

Despite the high prevalence perinatal mental distress in South Africa's impoverished communities, the public health service is currently not capable of providing a holistic mental health service to women during and after pregnancy.

The Design of the Perinatal Mental Health Project

In response to this, a volunteer-based Perinatal Mental Health Project (PMHP) pilot has operated for nearly three years in the Liesbeeck Midwife Obstetric Unit (MOU). This pilot project has provided screening and counselling for women during and after pregnancy.

The nursing staff at Liesbeeck Midwife Obstetric Unit have undergone specific training in perinatal mental health issues. They offer the screening to pregnant women at their second antenatal visit. This involves completing an informed consent form and two questionnaires. The questionnaires are designed to identify those experiencing symptoms of depression and anxiety as well as those with risk factors. They are available in English, Afrikaans, Xhosa and French. Based on the scores of the questionnaires, the midwives may offer referral for counselling to one of the highly experienced volunteers involved with the Project.

Counsellors attend the clinic and offer sessions on an appointment basis. The team includes a Xhosa-speaking counsellor and a French-speaking counsellor.

They provide an opportunity for women to feel heard – a private space where their feelings can be validated and some therapeutic work may take place. The counsellors may refer to a range of appropriate organisations if particular needs arise, or they may refer to the volunteer woman psychiatrist who also attends the clinic weekly. All sessions are free of charge and all information is kept strictly confidential.

The Project is managed by the doctor who attends the clinic. Recently, a Project co-ordinator with a background in development work, has joined the team.

Training and development workshops in perinatal mental health have been provided to all maternity units in the Cape Town public health system as well as to several community workers linked to HIV and development NGOs. *The Perinatal Mental Health Handbook: a resource for health workers in maternal care* has been developed, together with Liz Mills, to complement this training and to act as a permanent resource for health workers.

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Outcomes

The PMHP pilot has screened almost 2000 women, of which about 25% have qualified for counselling. Counsellors have seen 376 women for 606 sessions. A psychiatrist has seen about 50 clients for about 120 sessions. Evaluation of the Project has shown that it has been extremely well-received by both staff and clients. Many women will chose to come back for follow-up visits with their counsellors after their births, and may bring their babies with them – a treat for all concerned!

The Project has received international recognition, and was honoured by an award of commendation bestowed by The World Health Organisation (WHO) and World Federation for Mental Health in 2004. This certificate was awarded after a paper on the Project was published in the WHO document, *Mental Health Promotion: Case Studies from Countries in 2004*.

The Way Forward

The PMHP pilot project is now ready to formalise itself as a Not-for-Profit Organisation and expand. Ultimately the vision is to integrate perinatal mental health services within routine maternal care within South Africa. However, the initial goal is to expand the Project to the Hanover Park and Heideveld Maternal Obstetric Units (MOUs).

These MOUs are located in impoverished communities in desperate need of the mental health services provided by the PMHP. A site has been identified directly adjacent to Hanover Park MOU. The medical and community workers at the Hanover Park and Heideveld MOUs are strongly supportive of the Project.

The Metro District Health Service has been involved in the proposal for initial expansion and have committed to providing the building structure and the two contract personnel salaries for the first year. In order to realise the vision of the PMHP, additional donor support is needed.

The total cost of the PMHP for the first year is estimated at approximately R 1,2 Million. This includes all capital, personnel, training and development and recurrent costs. It is anticipated that 4320 women will undergo mental health screening. This represents 96% of the annual population of women booking at the two MOUs. In addition, slightly less than 1400 counselling sessions would be possible. This will allow for nearly a third of those screened to receive counselled.

The PMHP addresses a critical health need experienced by low-income women in Cape Town. It coheres perfectly with the basic tenets of "Healthcare 2010", the government's tool to providing *primary level, community-based* care that is *preventative* in nature.

Further, the PMHP's objectives and design accord directly with the South African Mental Health Care Act of 2002. This Act recognises that health is a state of physical, mental and social well-being and that mental health services should be provided as part of primary, secondary and tertiary health services. The Act states that access to mental health services should be *integrated* into the general health services environment.

The PMHP provides an innovative solution to a widespread health problem and will have considerable long-term benefits for mothers, infants and the community. The PMHP has the support of the provincial administration. To realise the vision of a better mental health service for all women during and after pregnancy, donor support is needed so that the Project can be expanded.

REGIONAL REPORTS

GAUTENG

The new number for the **Gauteng helpline is 082 3737373**.

We are in the process of screening potential candidates for another training course we are hoping to run in September. Based on the number of people we decide on, the course will go ahead. If not we will run the course in February 2006 and will advertise locally for more volunteers.

The phone is working and we have the current volunteers on the roster until the New Year. Hospital visits are being done.

We are also receiving numerous requests for articles in the local newspapers and for talks at various organisations. As you can see we are busy and enjoying the exposure.

Jo-Anne Herr

PORT ELIZABETH

There is not much to report from this side... Seems things have gone a bit quiet. However, still the following:

1. Making weekly visits to St. George's Hospital, handing out brochures and chatting to new moms.
2. Ensuring that there are brochures in Maternity Wards of Greenacres and St. George's Hospitals.
3. Have done talks at "Mom's Club" at St. George's Hospitals on postnatal depression.
4. Has been an increase in the number of individual clients referred to me by gynaecologists.

Lynette Dean

THE PAIN OF POST NATAL DEPRESSION

Adele Hamilton, freelance journalist,
(021) 465-1032, 082-577-4555

While baby blues will pass, for some mothers the depression that sets in after birth can take all the joy out of the experience. Here's how to know whether you could be suffering from post-natal depression

For many new mothers, the day after they come home from the hospital with a new baby can be a very difficult one. Not only is time to face the reality of having to cope without the professional help of a maternity ward, but it can also be the time that hormone levels dip, causing what is commonly called the 'baby blues.' Push through the blues, be kind to yourself and you will probably rise out of the other side tired but able to ride the emotional rollercoaster most days.

For some 10 to 15 per cent of mothers, however, the baby blues can be just one stop on an unpleasant journey into serious post-natal depression (PND). It's made all the more painful that you will be expected to be feeling euphoric, that people all around you will be filled with joy, and where you had hoped for an instant connection with your baby you may feel nothing. Post-natal depression is an illness that can strike any kind of woman from any background, but may be more common in high achievers, perfectionists who are used to controlling every aspect of their lives. Among the well-known sufferers from this problem have been Princess Diana and Brooke Shields, both women known for setting very high standards for themselves. High expectations of yourself as a mother can result in feelings of failure and inadequacy (and let's face it, every new mother is faced with those at the best of times). You may not feel that instant bond with the baby – it's quite natural to take a while to connect with the baby as being yours, and with yourself in this alien role of mother. You would be by no means the first mother to feel that you had been handed a baby and were completely unready and somewhat unwilling to take on this huge responsibility.

The loss of a sense of self can be profound, and some women report going through exactly the same feelings with the second or third pregnancy. A loss of interest in sex, an inability to think and act clearly and decisively, are common feelings that can be associated with adapting to the new role of motherhood. While all these feelings will occur in some form for many new mothers, for women who suffer from PND, they will only get worse and become harder to cope with. True post-natal depression will not just go away – if not handled correctly it can linger for years, according to Liz Mills of the Postnatal Depression Support Association of South Africa (PNDSA), a remarkable group that aims to inform and give support to women who find themselves among this unfortunate minority. Women who suffer domestic abuse will be more susceptible to the effects of PND, and if a woman has supportive family and friends around her she might be less likely to fall prey to it, but nothing can stop it altogether, Liz explains. Even for women with a loving home environment, hiding postnatal depression can become a huge burden, as women who suffer from it try hard not to let their partners, their families and the broader society see that

they are fighting a sense of depression and anxiety every minute of the day.

Nor is it only a hormonal fluctuation that will heal with time – even adoptive parents can suffer from PND, without having been through the hormone changes of pregnancy and birth.

Where it begins

For some women who end up suffering from PND, there may be signs during the pregnancy that all is not well. It's not unusual to be anxious that something will be wrong with the baby or go wrong with the birth, but some women start to obsess over these unforeseeable negatives. Likewise, pregnancy mood swings are the butt of so many jokes because they are common, but for some women the mood may swing low and stay there, becoming worse as the pregnancy progresses. This is as many as one in 10 women, a significant number of the mothers in any antenatal class or clinic waiting room.

Women who have had previous bouts of depression are more likely to suffer from PND, so be sure to inform your doctor if you've ever been diagnosed with depression, no matter if it was 10 years before you fell pregnant.

The environment and circumstances of the pregnancy are also contributing factors which may increase a new mother's risk of developing PND: If the pregnancy is unplanned and unwanted, or the result of rape, for example. Or, if the financial and practical circumstances make the prospect of another mouth to feed a very daunting one. Stresses such as job uncertainty, the death or illness of a loved one, or a lack of support from the partner can be contributing factors too. Even positive stresses like moving to a new home or deciding to adjust to a more flexible career path can add to the pressure a mother feels.

Could it be you?

There is no perfect checklist of symptoms – women may experience PND in very different ways: some feel sad and cry a lot, others feel extremely anxious, while others say they feel numb to everything. Here are some of the warning signs that may suggest you have a problem that needs checking out, especially if you have felt this way for more than a week.

Physical symptoms: being unable to sleep, even when dog-tired, or being unable to wake up. Sudden weight loss or gain, headaches, nausea, lethargy or restlessness.

Depression: feelings of sadness, exhaustion, guilt, loneliness, and being unable to make decisions. Feeling suicidal and hopeless, or feeling nothing at all for the baby or anything else, even things that used to bring you joy.

Anger: postnatal depression may manifest as feelings of anger and hostility towards your partner, the baby and others around you. You may feel trapped and irritable, unable to relax and be calm.

Anxiety: Worrying that you might harm the baby or yourself, fearing that something may happen to the baby or the baby's father. Feeling panicky and anxious.

Helping yourself

While it's important to realise that you can never make yourself 'snap out' of PND, there are ways to create an environment that is more conducive to recovery.

* Be kind to yourself physically. When you feel tired allow yourself to have a nap when the baby does. Don't let perfectionism about things like housework or looking perfect for guests get in the way of a good hour between the sheets.

* Get out of the house for a while every day. Whether you put the baby in a pram and walk around the block, or pop down to your favourite coffee shop for an hour while a family member takes charge at home, getting out of the house is a vital sanity-saver.

* Eat well and healthily. You are not Posh Spice, you do not need to fit into those tiny jeans tomorrow. Allow your body its natural time to ease back into shape, and accept that you may be left with stretch marks or a Caesarean scar – your badges of honour.

* Take a reality check: Write down all the myths and expectations about motherhood that may be getting in your way. You are not perfect, nor is any mother.

* Reach out for support. That friend from work who offers to bring over a lasagne – yes please! Your mother's offer to change the baby while you have a shower – yes please! The domestic worker who offers to carry the baby on her back when he's niggling – yes please! Draw strength from those around you, as they will appreciate it that you allow them to be of help. And one day when you are stronger, you can repay the favour by reaching out a helping hand to them in turn.

* **Call the Post Natal Depression Support Association on (021) 797-4498, or visit their excellent, informative website www.pndsa.org.za**

RESEARCH

Paternal Depression May Hinder Children's Early Development

News Author: Laurie Barclay, MD

June 27, 2005 — Paternal depression may hinder early behavioral and emotional development of men's children, according to the results of a prospective study published in the June 25 issue of *The Lancet*.

"Depression is common and frequently affects mothers and fathers of young children," write Paul Ramchandani from the University of Oxford, England, and colleagues from the ALSPAC (Avon Longitudinal Study of Parents and Children) study team. "Postnatal depression in mothers affects the quality of maternal care, and can lead to disturbances in their children's social, behavioural, cognitive, and physical development. However, the effect of depression in fathers during the early years of a child's life has received little attention."

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Clinical Context

Worldwide, depression is the fourth largest cause of disability and a major health problem, with an increase in incidence expected by 2020. Symptoms of depression can interfere with responsive parenting, and the quality of early parenting can have persistent effects on later development. Maternal postnatal depression affects the quality of maternal care and predicts later social, behavioral, cognitive, and physical development. According to the authors, the effect of depression in fathers during the first months of their children's lives has been little studied. There is research to show that the adolescent children of depressed fathers have increased rates of psychopathology.

This is a prospective cohort study examining 13,351 mothers and 12,884 fathers of newborns within eight weeks of birth and correlating maternal and paternal postnatal depression with behavior of their offspring at age 3.5 years.

- Children of fathers with depression during the postnatal period are at increased risk of behavioural problems at age 3.5 years.
- Increased risk of behavioural problems in children of fathers with postnatal depression is higher in boys than girls and specific to conduct and hyperactivity rather than emotional problems.

"Our findings indicate that paternal depression has a specific and persisting detrimental effect on their children's early behavioural and emotional development," the authors write. "Our findings further indicate that the association between paternal depression and child behaviour problems is stronger in boys than in girls. This notion warrants further investigation."

MEDSCAPE JULY 20, 2005

A longitudinal, prospective study on emotional adjustment before, during and after consecutive fertility treatment cycles

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BACKGROUND: A longitudinal study into the course of the emotional response to IVF from pre-treatment to 6 months post-treatment and factors that contributed to that course. **METHODS:** A total of 148 IVF patients and 71 partners completed self-report questionnaires on anxiety, depression, personality characteristics, meaning of fertility problems, coping, marital relationship and social support at pre-treatment. Assessments of anxiety and depression were repeated immediately following the final treatment cycle and again 6 months later (follow-up). **RESULTS:** Women showed an increase of both anxiety and depression after unsuccessful treatment and a decrease after successful treatment. Men showed no change in anxiety and depression either after

successful or after unsuccessful treatment. In the 6 months after unsuccessful treatment, women showed no recovery. At follow-up, >20% of the women showed subclinical forms of anxiety and/or depression. Personality characteristics, meaning of the fertility problems, and social support determined the course of the emotional response. **CONCLUSIONS:** Most women adjusted well to unsuccessful treatment, but at follow-up, a considerable proportion still showed substantial emotional problems. Personality characteristics, pre-treatment meaning of the fertility problems and social support have demonstrated the adjustment to unsuccessful IVF in women. This allows early identification of women at risk as well as tailored interventions. **Key words:** anxiety/depression/IVF/longitudinal study/prospective study

Nutrition: Of Diet, Mood and Babies to Come

By ERIC NAGOURNEY

Stress and fatigue can lead pregnant women to change their eating habits, for better and for worse, a new study shows.

Writing in the current Journal of the American Dietetic Association, researchers from Johns Hopkins said that in general, the pregnant women studied ate more, if not more healthily, when they were fatigued, under stress or anxious. The lead author was Kristen Hurley.

The researchers followed the pregnancies of 134 women, periodically surveying them about their emotions and eating habits. The women were checked for anxiety, depression, anger, fatigue and stress and asked about how much social support they were receiving. Most reported taking in too little iron, folate and fiber and too much protein and fat, the study found. But different patterns emerged when the researchers compared diet with mood. Women who said they were fatigued, for example, reported taking in more energy over all, including more carbohydrates, fats, proteins and zinc. Women who were under stress said they ate more breads, as well as fatty foods and sweets. Anxious women also went for fats, oils and sweets, and they appeared to take in too little vitamin C..

The results, said Dr. Laura Caulfield, one of the researchers, suggest that doctors who are counselling women about their diets during pregnancy should take into account their emotional situation.

NEW YORK TIMES

June 7, 2005

Don't Let Your Baby Blues Go Code Red

By JANE E. BRODY

When a celebrity writes about experiencing a health problem, especially an emotional disorder that severely disrupts feelings of self-confidence and competence, it is bound to receive considerable public attention.

And so, I hope that Brooke Shields's new book "Down Came the Rain" (Hyperion, \$23.95) about her recent battle with a serious postpartum depression will call

attention to this common but under diagnosed and under treated problem.

Ten to 20 percent of women experience a serious depression within weeks or months of giving birth, but fewer than one woman in five is treated for it. Yet failure to get needed help can prolong the misery, resulting in a battle with depression that can last a year or more and create havoc in a household.

Ms. Shields, too, let far too many weeks pass - weeks that found her hiding in her bed, barely able to care for herself or the child she struggled for years to bear - before she finally sought professional help.

Here's her message to women who find themselves surprised and overwhelmed by a postpartum mood disorder:

"Do not waste time! Get help right away. Postpartum depression is extremely treatable, and there are many ways to cope with and get through it. And remember: postpartum depression is beyond your control. Having it does not mean you are not a good mother or that you are crazy. The most important thing is that you don't wait for it to pass."

This is a very important message, because the consequences of not treating postpartum depression can be quite devastating for the mother, for her spouse or companion and especially for her baby.

Symptoms and Risks

The so-called baby blues experienced in the days after childbirth are very common. About 70 percent of women are likely to experience mood swings or feel weepy and emotional about the slightest untoward event or remark.

These feelings, which mimic the symptoms many women experience just before their menstrual periods, are most likely brought on by the abrupt decline that occurs at childbirth in the hormones estrogen and progesterone. These baby blues pass on their own, usually within two weeks and do not require treatment.

But for some 400,000 American women each year (representing about 10 percent of births), a more severe mood disorder results. They may feel sad, hopeless, overwhelmed, unable to cope, irritable and afraid of harming themselves, their partners or their babies.

Crying, uncontrollable mood swings, a fear of being alone, a lack of interest in the baby, loss of energy and motivation, withdrawal or isolation from friends and family, and an inability to make decisions or think clearly are also common symptoms.

Physical symptoms may occur as well, including extreme fatigue, sleep disturbances, loss of appetite, headaches, chest pains, palpitations and rapid breathing.

Ms. Shields experienced most of these, yet resisted for too long the urging of friends and family to seek the help she clearly needed.

All the while, she felt unattached to her daughter and feared harming herself as well as her marriage and the emotional development of her baby.

The most severe form of the disorder, postpartum psychosis, occurs after 1 or 2 of every 1,000 births, usually within six weeks of delivery. Symptoms may include delusions, hallucinations, sleep disturbances and obsessive thoughts about the baby. Untreated, the result can sometimes be suicide or murder of the baby, the spouse or other children in the family.

Some women are more likely than others to be afflicted with postpartum depression, and researchers are now trying to better identify them and devise therapies to use before childbirth or immediately after it.

Known risk factors include a personal or family history of depression or substance abuse (Ms. Shields has a family history of alcoholism); lack of support from family and friends; problems with a previous pregnancy or birth (Ms. Shields went through numerous in vitro attempts and a miscarriage); depression after a prior pregnancy; marital or financial problems; being a young or single mother; complications during labour and delivery (Ms. Shields required an emergency Caesarean delivery); a major life change at the time of the birth; and having a baby with serious health problems.

Treatment Options

Treatment possibilities include individual or group psychotherapy; medication with antidepressants, hormones or both; and various things a woman can do for herself.

Psychotherapy usually is short, perhaps 6 to 12 sessions, and is especially helpful if symptoms are severe, as they were for Ms. Shields.

Many cases of postpartum depression are treated with the newer antidepressants called S.S.R.I.'s, selective serotonin reuptake inhibitors. Though such drugs are excreted in breast milk, they are considered generally safe, but the effects are not well studied.

Neglecting to treat postpartum depression can definitely cause lasting damage, including poor mother-infant bonding and later cognitive and behavioural problems in children.

Studies under way are testing the effectiveness of estrogen therapy in preventing and treating postpartum depression. One study showed that women with postpartum depression who used an estrogen patch every day were less depressed than those who did not. But there can be side effects, since estrogen can decrease milk production in nursing women and may raise the risk of blood clots

Women can also help themselves by turning to family and friends, getting as much rest as they can, eating wholesome foods, getting exercise, making time for

themselves, talking to others about how they feel and discarding notions of perfection.

In addition to seeing a therapist and taking an antidepressant, Ms. Shields finally hired a nurse for a week to get the baby on a schedule, relieving Ms. Shields of some of the responsibilities of child care and providing reassurance and information that helped her cope much better on her own.

Friends and family can do much the same by giving the new mother a chance to get out of the house, caring for the baby during the night, preparing nutritious meals, running errands, paying bills, cleaning house, caring for older children and even making appointments with doctors or mental health professionals.

Jane E. Brody can be reached at personalhealth@nytimes.com. [Following publicity about Brooke Shields' going public about her experience, Tom Cruise made some inappropriate and uninformed critical remarks. These led to a public debate on the value of medication.]

USA PRIORITISES PPD

GOOD NEWS in the NEW SENATE BUDGET

The new Senate budget regarding mental health and particularly postpartum depression, regarding MCHB, The Committee also provides \$2,000,000 for mental health programs and activities in the States. The Committee expects that the programs will include mental health grants for prevention and early intervention services for children and youth ages 0 to 24 years and for women's mental health as it relates to their role in the family, particularly for women diagnosed with postpartum depression [PPD]. One out of every ten new mothers suffers from PPD, a treatable condition that presents a range of emotional and physical changes.

Providing Professional Support Specifically Tailored to a Woman after She Brings home her New Baby may be the best way to Prevent Postpartum Depression, research suggests

TORONTO (CP) An analysis of 15 international studies by the University of Toronto shows strategies initiated before birth, including pre-natal classes targeting postpartum depression, appear to be ineffective in preventing the disorder.

"Mothers are busy and they often do not attend these pre-natal classes, so they weren't receiving a sufficient dosage of the intervention," researcher Cindy-Lee Dennis of the faculty of nursing said Wednesday

What she did find is that support provided by a health professional - for instance, a public health nurse or midwife - may be able to prevent postpartum depression if it is geared to the individual woman and based on her specific needs.

That could mean a mom who is having marital difficulties after the birth of her baby being referred for family counselling or a low-income mother getting steered towards financial assistance, Dennis said.

More than one in 10 women experience depression after giving birth, ranging from mild baby blues to a severe form of the illness those in rare cases can include psychosis.

But most women are reluctant to seek help or even talk about it to friends and family, Dennis said.

"There's a stigma attached to being depressed in the postpartum period because it's supposed to be a happy time."

The reason pre-natal measures don't seem to work is because it's virtually impossible to predict which women will develop postpartum depression, although those at greatest risk are women of low socioeconomic status, those with relationship difficulties, a past history of psychiatric problems or pre-natal depression and anxiety.

Dennis analysed 15 research projects that involved almost 7,700 women, going back to the 1990s. The studies investigated various methods to see if they could prevent postpartum depression.

"Individual, flexible postpartum care provided by a health professional and based on maternal need may have a preventive effect," concluded Dennis, who advises that new moms be assessed by a health professional during the first four weeks after birth and referred for treatment if needed.

"For mild depression, interventions that might be beneficial would be, say, support groups or talking to another mother about their experience and home visits by public health nurses. When you have severe depression, that's when you really need expert assistance from mental health experts."

Antidepressants are one form of treatment, although many women don't want to take drugs while they are breastfeeding, said Dennis, noting that psychotherapy can be as effective in alleviating postpartum depression.

The drugs have been the subject of a public spat between actor Brooke Shields, who says they helped her after she gave birth to her first child, and actor Tom Cruise, who calls antidepressants unnecessary. (Cruise is a follower of Scientology, a religion that teaches that psychiatry is a destructive pseudo-science.)

Saying she hadn't been following the controversy, Dennis would only offer that "Antidepressant medication isn't for everyone, but if a woman feels comfortable to take it and it's beneficial for her, then that's more than appropriate.

Caring for a new child is a tough job, she said.

"Many women who are sleep-deprived because they're caring for their children 24-7, they are going to have challenging days.

"And I think it's important for them to recognize that . . . and if they're feeling as if they're really struggling - having these feelings of sadness, loss of appetite, not able to sleep properly, feeling like they're incompetent as a mom - if these feelings persist for more than two weeks, then I think the mother really needs to go and seek treatment."

Dennis, whose study appears in the latest issue of the British Medical Journal, has received a \$1-million grant from the Canadian Institutes of Health Research to investigate whether having new moms talk to women who have recovered from postpartum depression would help them dodge the disorder. © The Canadian Press, 2005

Are Family Physicians Appropriately Screening for Postpartum Depression?

Dean A. Seehusen, MAJ, MC, USA; Laura-Mae Baldwin, MD, MPH; Guy P. Runkle, LTC, MC, USA; Gary Clark, LTC, MC, USA J Am Board Fam Pract. 2005; 18 (2): 104-112.
©2005 American Board of Family Practice

Abstract and Introduction

Abstract

Purpose: Despite the availability of screening tools for postpartum depression (PPD), there is a general consensus that the condition is underdiagnosed. This study was conducted to determine how frequently family physicians screen for PPD, what methods they use to screen, and what influences their screening frequency.

Methods: A survey of members of the Washington Academy of Family Physicians was conducted. Three hundred sixty-two (60.9%) mailed surveys were returned. The 298 physicians who saw postpartum women and children younger than 1 year of age were included in the study.

Results: Of the study population, 70.2% always or often screened for PPD at postpartum gynaecologic examinations, and 46% always or often screened mothers at well-child visits. Of those who screened, 30.6% reported using a validated screening tool. Of those, only 18% used a tool specifically designed to screen for PPD. Logistic regression modelling showed that female sex [odds ratio (OR) = 2.2], training in PPD during residency (OR = 8.1), training in PPD through medical literature (OR = 2.1), and agreement that postpartum depression is common enough to warrant screening (OR = 1.9) were all significantly associated with more frequent screening at postpartum

gynaecologic visits. Agreement that screening takes too much effort was associated with less frequent screening (OR = 0.8)

Conclusions: Although family physicians believe that PPD is serious, identifiable, and treatable; screening is not universal and use of screening tools designed for PPD is uncommon. Training in postpartum depression and female sex are the variables most strongly associated with frequent screening.

The 25th Conference on Priorities in Perinatal Care will be held at Champagne Sports Resort from 7 to 10 March 2006.

Venue: Champagne Sports Resort is situated in the Central Drakensberg with beautiful views of Champagne Castle and Cathkin Peak.

Topics: Topics will include perinatal audit, maternal mortality, intrapartum hypoxia, appropriate technology for neonatal care, neonatal resuscitation, preterm delivery, HIV/AIDS, antenatal care and intrapartum care. Emphasis for oral presentations will again be placed on studies that are attempting to solve identified problems.

Registration packs will also be available from the website: www.perinatalpriorities.co.za from the end of September 2005.

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