



Lebanese Republic
Ministry of Public Health
National Mental Health Programme



Maternal Mental Health Guidelines for Healthcare Providers

October 2021



In partnership with

Canada

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Table of contents

Foreword	3
Acknowledgements	4
List of acronyms	5
List of tables and figures	5
I. Overview	6
1- Background	6
2- Scope and audience	6
3- Development method	7
II. Maternal mental health conditions: prevalence and risk factors	8
III. Principles of care	12
1- Guiding principles	12
2- Mental health assessment and treatment considerations	13
3- Rapport and effective communication	15
4- Cultural considerations	16
IV. Psychosocial risk assessment in pregnancy and postnatally	18
1- Social support and resources	18
2- History of mental illness	19
3- Mother-infant interaction	19
V. Specific mental health conditions in pregnancy and postnatally: identification and intervention	29
1- Postpartum blues	29
2- Depression and anxiety disorders	30
3- Obsessive-compulsive disorder	37
4- Eating disorders	40
5- Alcohol and other substance use disorders	41
6- Severe mental illness: bipolar disorder, schizophrenia, and psychosis	41
VI. Traumatic births, stillbirths, miscarriage, and infant illness	44
VII. Child development	45
VIII. Conclusion and key recommendations	51
IX. References	53
X. Appendices	56

Foreword

As part of the national mental health strategy for Lebanon, the National Mental Health Programme (NMHP) at the Ministry of Public Health (MOPH), in collaboration with the United Nations Population Fund (UNFPA) in Lebanon, and with the generous support from the Government of Canada, has developed the following guidelines on maternal mental health, which focus on addressing general and context-specific psychosocial stressors and mental health conditions.

This guide, aimed at relevant healthcare and social care professionals in the maternal health field, serves as reference for identifying, assessing, and managing mental health conditions in women in different stages of pre-pregnancy, during pregnancy, and post-pregnancy.

We hope that this document will be beneficial to professionals in the public health system as a key and guiding tool in identifying and managing maternal mental health with the ultimate goal of improving Maternal and Child Mental Health for all persons living in Lebanon.

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Head of the National Mental Health Programme

Acknowledgements

The contributions of obstetric gynecologists, midwives, pediatricians, and nurses from local hospital and community health centers have been instrumental to the development of this guide.

A special thank you to local experts, professional bodies, and UN agencies for their input, recommendation, and feedback during both the inception and development phases.

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Funded by:

The Government of Canada

List of acronyms

CBT: Cognitive Behavioral Therapy	NMHP: National Mental Health Program
COPE: Center of Perinatal Excellence	OCD: Obsessive Compulsive Disorder
EMDR: Eye Movement Desensitization and Reprocessing	PHQ: Patient Health Questionnaire
EPDS: Edinburgh Postpartum Depression Scale	PPD: Postpartum Depression
GAD: Generalized Anxiety Disorder	ppOCD: Postpartum Obsessive Compulsive Disorder
GBV: Gender-Based Violence	PTSD: Post Traumatic Stress Disorder
HICs: High-Income Countries	SBS: Step-by-Step
IPT: Interpersonal Psychotherapy	SSNRIs: Selective Serotonin-Norepinephrine Reuptake Inhibitors
LMICs: Middle-Income Countries	SSRIs: Selective Serotonin Reuptake Inhibitors
MENA: Middle East and Africa	TCA: Tricyclic Antidepressant
mhGAP-IG: Mental Health Gap Action Program-Intervention Guide	UNFPA: United Nations Population Fund
MOPH: Ministry of Public Health	WHO: World Health Organization
NICE: National Institute for Health and Care Excellence	Y-BOCS: Yale-Brown Obsessive Compulsive Scale

List of figures and tables

Figure 1 12	Table 1 23
National values and principles for the mental health system	Guidance when assessing possible high-risk of suicide
Figure 2 14	Table 2 37
Approach to maternal mental health	Support for anxiety and depression
Figure 3 15	Table 3 46
Effective communication	Age two to six months developmental milestones
Figure 4 18	Table 4 47
Level of social support	Age six to twelve months developmental milestones
Figure 5 20	Table 5 48
Factors of mother-infant interaction problems	Age one to two years developmental milestones
Figure 6 29	Table 6 49
Postpartum blues identification	Age two to three years developmental milestones
Figure 7 37	Table 7 50
OCD core symptoms	Age three to five years developmental milestones
Figure 8 38	Table 8 50
Common obsessions and compulsions	Summary milestones by age
Figure 9 39	Table 9 52
OCD level of severity	General key recommendations

I. Overview

1- Background

These guidelines were developed in line with the national mental health strategy for Lebanon which aims:

To ensure the development of a sustainable mental health system that guarantees the provision of and universal accessibility to high quality mental health curative and preventive services through a cost-effective, evidence-based and multidisciplinary approach, with an emphasis on community involvement, continuum of care, human rights, and cultural relevance.

Ministry of Public Health, 2015, p. 27

In particular, it falls under the implementation of the below two strategic objectives:

- **3.1.3** Integrate evidence-based mental health promotion and prevention into maternal and child health programmes
- **2.2.2** Develop a capacity building proposal tailored for non-specialized health and social welfare/protection care staff at all levels of care in collaboration with all relevant actors (syndicates, orders, scientific societies, associations, etc.).
This includes health and social care professionals working in the domain of maternal health and care.

2- Scope and audience

This guideline serves as a reference for identifying, assessing, and managing mental health conditions in women planning pregnancy, pregnant, or in postpartum. It is useful for healthcare professionals dealing with women antenatally and up to one year postnatally. This guideline is most relevant to:

- Obstetric gynecologists
- Nurses
- Midwives
- Pediatricians

It addresses general and context-related psychosocial stressors as well as specific mental health conditions including postpartum blues, depression and anxiety, obsessive compulsive disorder, eating disorders, substance and alcohol use disorders, and severe mental illnesses. The guideline also provides an overview of early childhood development and practical points in relation to identifying and managing developmental delays.

The guideline is to be used as a reference for routinizing screening of maternal mental health conditions, providing support, and making treatment decisions. The healthcare professionals' clinical judgement and responsibility should be the guiding compass for the application of this guideline's recommendations.

3- Development method

In an effort to provide a robust and acceptable reference guide, this guideline was developed using an evidence-based participatory approach. Preliminarily, UNFPA in close collaboration with the National Mental Health Program (NMHP) at the Ministry of Public Health (MOPH) defined the scope of the guideline. Subsequently, relevant stakeholders, UN agencies, and healthcare professionals were involved through consultative meetings to identify current mental health needs of women of reproductive age in Lebanon as well as available resources and perceived limitations. Recommendations from these stakeholders were considered at both the initial development phase and the review phase. To consolidate the content of the guideline, focus group discussions were held with groups of obstetric gynecologists, midwives, nurses, and pediatricians. The focus group discussions informed the final review in terms of content, cultural relevance, feasibility, and acceptability. This guideline was based on a review of the evidence centered around international maternal mental health guidelines and maternal mental health research in LMIC, the Arab region, and Lebanon. It is founded on important international guidelines, namely WHO's "Mental Health Gap Action Program (mhGAP-IG) Intervention Guide", the Center Of Perinatal Excellence (COPE)'s "Mental Health Care in the Perinatal Period Australian Clinical Practice Guideline" and National Institute of Health and Care Excellence (NICE)'s "Antenatal and postnatal mental health: clinical management and service guidance".



II. Maternal mental health conditions: prevalence and risk factors

Maternal mental health is a general public health concern due to its associations with significant negative outcomes for both mother and child (Sukran et al., 2011). Motherhood is a unique experience for new mothers. On one hand, it is associated with the excitement of a new life experience and a new family, and on the other, pregnancy and childcare, especially in the early years, can be very challenging experiences for parents, and women in particular. Physical and psychological changes in the prenatal and postpartum periods have been heavily associated with negative experiences (Qutteina et al., 2018). Postpartum blues, defined as mild depressive symptoms that occur within the first two weeks after childbirth and resolve on their own, is the most common postnatal psychological difficulty estimated at 50% (Balaram & Marwaha, 202; Henshaw, 2003). This experience of negative emotions during the early weeks postnatally is not considered a mental illness but rather a psychological difficulty. Postpartum depression (PPD) has been identified as the most common mental illness that women experience, followed by anxiety disorders, obsessive compulsive disorder (OCD), eating disorder, alcohol and substance use disorders, and severe mental illnesses such as psychosis, bipolar disorder, and schizophrenia during the perinatal period.

The rates of postpartum psychological distress have been found to be higher in LMICs compared to high income countries (Doraiswamy et al., 2020). It has been identified that:

Around 10% of pregnant women and 13% of women in the postpartum period have some type of mental health problem with anxiety and depression being the most common (Hendrick et al., 1998).

Fisher et al. (2011) estimated that in LMICs:

15.6% of pregnant women and 19.8% of women in the postpartum period experienced psychological distress.

General postpartum psychological distress were found in 84% of Lebanese women from 40 days up to 6 months postpartum.

(Kabakian-Khasholian, Shayboub & Ataya, 2014).

A more concerning finding was the treatment gap found in new mothers suffering from postpartum mental health conditions. The vast majority of these women were unlikely to seek professional psychological or psychiatric care (Kabakian-Khasholian, Shayboub & Ataya, 2014). Despite the elevated rates of perinatal psychological distress in LMICs, the Arab region, and in Lebanon specifically, there is major scarcity in maternal mental health resources and support centers in this region (WHO, 2011).

Postpartum depression

Globally around 10–15% of women experience PPD. In Lebanon, these rates were found to be at 21% in a study conducted in 2002 (Chaaya et al., 2002) and at 12.8% in a more recent study conducted in 2014 (El Hachem et al., 2014). The prevalence rates in Lebanon are close to those reported in Low- and Middle-Income Countries (LMICs) which range between 19–25 % (Rahman, Iqbal, & Harrington, 2003) and those in the Arab region ranging between 15–25% (Ayoub, Shaheen, & Hajat, 2020). Depression in pregnant women has been found to be underdiagnosed and undertreated compared to non-pregnant women despite prevalence rates being similar (Ko et al., 2012). The antenatal period seems to be as fragile as the postpartum period, with 33% of postnatal depression beginning in pregnancy and 27% in pre-pregnancy (Wisner et al., 2013). The prevalence of depression among pregnant women followed up at a private hospital in Beirut was reported to be around 13.9% (Lteif, Kesrouani, Richa, 2005). In a Lebanese governmental hospital, 32% of mothers who gave birth to healthy at term babies were found to have depressive symptoms at two weeks postpartum (Yared Georges et al, 2020).

In Lebanon, some specificities in relation to PPD have been identified. For instance, **refugee mothers** residing in Lebanon have shown higher levels of postpartum depression compared to low-income Lebanese mothers (Stevenson et al., 2019). **Prevalence of PPD** was found higher in Lebanese rural areas compared to Beirut (Chaaya et al., 2002). Preliminary findings suggest the association of **multiple social and health factors** with maternal depression and anxiety in Lebanon including maternal level of education, number of children, perinatal and postpartum complications, unhappy marriage, infant night awakenings, and infant feeding habits and health (Hobeika et al., 2021). In the Arab region, similar **risk factors for PPD** have been identified, namely, low income and socioeconomic status, complications during pregnancy, undesired pregnancy, infant's poor health, formula feeding, poor social support, marital problems, stressful life events during pregnancy, and a history of depression (Ayoub, Shaheen, & Hajat, 2020).

Globally, the **method of delivery** has been shown to be strongly associated with maternal postpartum mental health (Dekel et al., 2019; Eckerdal, 2017). Having had a **cesarean section or vaginal instrumental birth** was found to be linked to higher somatization, obsessive compulsive disorder, depression and anxiety regardless of other health and psychosocial maternal and newborn factors (Dekel et al., 2019). Moreover, women who had an **unplanned cesarean section** had increased levels of childbirth-related Post Traumatic Stress Disorder (PTSD) symptoms (Dekel et al., 2019). **Emergency cesarean section or vacuum extraction** were found to be a strong risk factor for PPD (Eckerdal, 2017).

In line with these findings, in Lebanon the type of delivery has been associated with an increased rate of depressive symptoms at two weeks postpartum; 43% of women who underwent a c-section had depressive symptoms compared to 29% of women who had a natural delivery (Yared Georges et al., 2020). El-Hachem et al. (2014) found that postpartum blues were associated with unplanned c-sections, transfer of the mother to the Intensive Care Unit (ICU), transfer of the newborn to the Neonatal Intensive Care Unit (NICU), and the mother's negative perception of the pregnancy and delivery. A **history of depression and early depressive symptoms** at day two postpartum were found to be risk factors for postpartum depression in a Lebanese sample (El-Hachem et al., 2014).

Anxiety disorders

Anxiety disorders were found to have a 15–20% prevalence rate in pregnant women and a 10% prevalence rate in postpartum women (Dennis, Falah-Hassani, & Shiri, 2017). Perinatal anxiety disorders were found to be more prevalent in **Low-to-Middle-Income Countries (LMICs)** compared to High-Income Countries (HICs) (Dennis, Falah-Hassani, & Shiri, 2017). In Lebanon, there have been no studies assessing prevalence of perinatal anxiety until recently where a study by Hobeika et al. (2020) found high prevalence rates of anxiety among Lebanese mothers. The results showed that 54.7% of Lebanese mothers had mild to moderate symptoms and 13% showed severe symptoms of anxiety 4–6 weeks postpartum (Hobeika et al., 2020). Generally, perinatal anxiety has been associated with the following risk factors: history of mental illness, problematic relationship with partner, childhood abuse, low social support, stressful life events, and some coping and personality traits (Karaçam & Ançel, 2009; Giakoumaki et al., 2009; Giardinelli et al., 2012). In Lebanon, postpartum depression, premature birth, and the use of instruments during delivery were associated with higher rates of postpartum anxiety (Hobeika et al., 2020).

Obsessive compulsive disorder

OCD has been reported to be more common in pregnant and postpartum women compared to non-pregnant women (Russell, Fawcett, & Mazmanian, 2013; Fairbrother et al., 2016). In the general population prevalence of OCD is around 0.7–2.3%, while in the perinatal period the prevalence of OCD has been shown to be between 0.2–3.5% (McGuinness, Blissett, & Jones, 2011). Having a history of major depressive disorder (Labad et al., 2005) and pre-existing dysfunctional beliefs (Abramowitz et al., 2006) were found to be risks factors for **postpartum OCD (ppOCD)**. Additionally, Zambaldi et al. (2009) found that mothers with a history of previous mental illness, somatic complaints, or obstetric complications in pregnancy/birth, and who carried multiples were at an increased risk of developing ppOCD. The **most common obsessions** in ppOCD were violent thoughts, contamination fears, and washing/cleaning and checking compulsions (Zambaldi et al. 2009). OCD in pregnant women was found to be the highest in the Middle East and Africa and lowest in Asia and Europe (Remes et al., 2016).

Eating disorders

Eating disorders during the perinatal period are relatively less common but around 15% of pregnant women have been found to have had a history of an eating disorder (Micali, Treasure, & Simonoff, 2007). Thus, screening and support are essential to prevent relapse during the perinatal period. **Alcohol** is a major teratogen and is contraindicated during pregnancy and should be limited for lactating women (Howard & Khalifeh, 2020). A recent systematic review showed that around **one in ten women** use alcohol in pregnancy, globally, with one in sixty-seven having a child with fetal alcohol syndrome (Estrin et al., 2019). **Maternal deaths** have been linked to substance misuse during pregnancy (Knight et al., 2018). In terms of severe mental illness defined as having bipolar disorder, schizophrenia, and psychosis, a systematic review estimated that 20% of women with pre-existing bipolar disorder were to experience a severe postnatal mental illness (psychosis, mania and/or hospitalization) (Wesseloo et al. 2016).

There is insufficient research in Lebanon and in LMICs to indicate prevalence and risks related to anxiety, Post-Traumatic Stress Disorder (PTSD), and psychosis (Fellmeth, Fazel, & Plugge, 2017). Nonetheless, pregnant women and women during the postpartum period in LMICs are presumed to be at **higher risk of mental illnesses** in general and associated maternal mortality, suicide and self-harm compared to HICs (Howard & Khalifeh, 2020).

Contextual impact on maternal mental health in Lebanon

Most recently, Lebanon has suffered great turmoil on economic, social, and safety levels. A **major economic crisis** has led to high rates of unemployment (Bosqui, 2020) classifying over the third of Lebanese population **under the poverty line** (World Bank, 2020). In the midst of that economic crisis, protests and political instability arose leading to school closures and road closures in 2019 (Bosqui, 2020). These internal struggles were exacerbated by the pandemic that has put Lebanon in full lockdowns leading to further income losses and daycare and school closures. On August 4th, 2020 a tragic disastrous explosion hit Beirut leaving the country in further social, economic, health, and safety turmoil. The current situation in Lebanon is bound to aggravate the negative experiences of pregnant women and new mothers. In this current situation, risk factors for mental health are increasing, and protective factors are decreasing for all the population, including for pregnant women and new mothers, putting them at increased risk of mental health conditions. In fact, **43%** of Lebanese pregnant women showed high levels of anxiety during and after COVID19 lockdowns compared to only **14%** before the pandemic (Ghazal et al., 2021).

In a complex and challenging context such as the current situation in Lebanon, pregnant women and new mothers, a generally vulnerable population, are put at further disadvantage.



III. Principles of care

1- Guiding values and principles

In accordance with national and international mental health guiding principles, it is crucial to adopt a respectful, collaborative, and dignified approach that fosters autonomy and empowerment. The National Mental Health Strategy highlights the importance of relying on the following values when addressing mental health needs: autonomy, dignity, participation, empowerment, accountability and integrity, and quality (*Ministry of Public Health, 2015*).

Autonomy

Independence and self-sufficiency

Dignity

Equal access to opportunities, services and care practices

Participation

Participation in planning and treatment decisions

Empowerment

Adequate level of control, decision-making power, and access to adequate resources and information

Accountability and integrity

Maintenance of transparency and the respect of the rule of law

Quality

Evidence informed practices, responsive and regulatory approach, universal accessibility, and comprehensiveness of services and continuity of care

Figure 1: National values and principles for the mental health system

It is the healthcare professional's duty to ensure that pregnant women and new mothers are:

- Treated with respect and dignity.
- Provided with confidentiality and privacy rights in terms of information and clinical setting.
- Given access to accurate and simplified information about their condition/concerns, treatment options, and associated risks and benefits.
- Asked to give informed consent to treatment.
- Engaged in care planning.
- Encouraged to participate in decision making.

2- Mental health assessment and treatment considerations

In line with the National Mental Health Strategy, it is important to realize that assessment and treatment should address the multiple factors that impact mental health in line with the biopsychosocial model of care. As such, consider in the assessment and treatment plan:

1. Biological aspects (genetic, chemical, hormonal, physical health problems)
2. Psychological factors (personality, cognitive and thought patterns, coping style...)
3. Social factors (family, economic status, culture, community...)

To gain a full understanding of the challenges faced by a woman, it is important to create an equal partnership. The patient's input is equally important to that of the professional and even more so as she is the only one who can best describe her own experience. Taking her perspective is crucial to ensure an accurate and conducive assessment and treatment. The aim of mental health assessment and support is to provide the patient with relevant information and resources while empowering her to make appropriate decisions for her and her child. Healthcare providers need to focus on giving the patient opportunities to identify her strengths and weaknesses so that she can actively and independently make changes leading to a better quality of life. Patients who are provided with transferrable knowledge, skills, and behaviors can autonomously enhance their mental health and quality of life.

In cases of suspected or reported traumatic experiences, particular attention is to be given to creating a safe non-judgmental space for empathetic and effective communication (*refer to section III.3*).

Based on these guiding principles, healthcare professionals attending to maternal mental health are encouraged to adopt:

- A biopsychosocial approach: where both assessment and care encompass all aspects of the woman's experience. It is a comprehensive approach that takes into account the interplay between biological, social, and psychological factors. It often requires close collaboration with a multi-disciplinary team.
 - ✔ Recognize that the patient's experience is more complex than a symptom checklist.
- A person-centered approach: where the epicenter of the care is the woman herself. This approach ensures the inclusion of women in decision-making without discrimination. It focuses on viewing things from the perspective of the patient and acknowledging her active role in the process of care.
 - ✔ Recognize that the patient is the expert on her own experience.
- A recovery-oriented approach: where the process of care aims at fostering autonomy and empowering women to find meaningful life experiences, lead independent lives, and have a positive sense of self.
 - ✔ Support the patient to find her own strengths and weaknesses, to make informed choices, and to live a fulfilling life.
 - ✔ Focus on maximizing safety, trust, and empowerment in a particularly sensitive manner.

Healthcare providers should also consider these important elements that facilitate and enable appropriate care:

- **Engaging persons** in their own mental health care is crucial for fostering empowerment and ownership. Prioritize informed consent for every step of the assessment and plan. Include women in the decision-making process about their treatment by providing relevant and comprehensive information, openly responding to questions, and actively asking for women's opinion.
- **Including partners and family members** in the assessment of a person's mental health is important but requires caution. Information about social support, relational problems, and mother-infant relationship can be provided by these family members. Nonetheless, it is the right of the woman to accept or refuse involving her partner or family in the process. Special consideration should be given to suspected or known cases of domestic violence and problematic relationships. Women are not to be asked about domestic violence in the presence of the partner or any family member, this type of assessment is conducted with the woman alone.
- **Confidentiality** when assessing mental health is crucial. Yet it is important for the healthcare provider to clearly communicate to women that confidentiality can be broken when there is a risk of harm to self or baby. It is important to highlight that it is the provider's duty to share such information but he/she can only disclose information related to the risk of harm.
- **Identifying systems for follow-up** is necessary before any mental health screening or assessment is conducted. Healthcare providers working within healthcare systems that have set referral pathways and enabled multi-disciplinary coordination are at an advantage. Those who are working in different settings should consider collegial consultation, clinical supervision, available professional networks, and community-based referral pathways. It is the healthcare providers' responsibility to ensure continued coordination with other professionals involved in the woman and baby's care.
- **Ensuring continuity of care** is important to ensure positive outcomes. The rapport built between the patient and the healthcare professional takes time, trust, and emotional involvement. Women benefit from coordinated comprehensive care when all care providers have a full understanding of the plan of care, share information, and work in close coordination (*WHO, 2016; Sandal et al., 2016*).

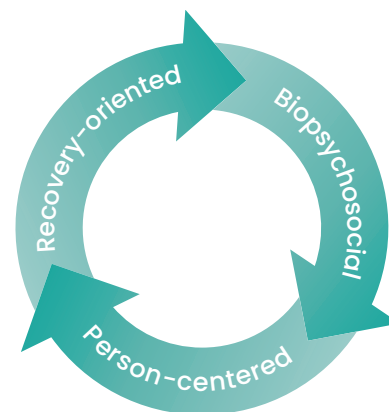


Figure 2: Approach to maternal mental health

3- Rapport and effective communication

Addressing maternal mental health requires a certain level of rapport that extends beyond the usual patient–health provider exchange. Women antenatally and postnatally are generally in a fragile stage of overwhelming change. Women’s experience of a range of emotions is often considered normal and is at risk of being dismissed as a hormonal/natural process that does not require attention. Indeed, most women will experience a wide range of negative emotions before, during, and after pregnancy as each of these stages holds a set of physical, emotional, and social challenges. Most women won’t be classified as clinically anxious or depressed.

Nonetheless, this does not mean that most women should endure these struggles. A significant portion of these women will become clinically ill if unsupported. The role of early screening and support is to prevent the development of mental health conditions during this vulnerable life-changing experience. It is only through an intimate yet professional relationship that healthcare workers are able to provide support and recognize conditions requiring care.

This kind of relationship is founded on the guiding principles of care and built through an effective exchange in a trustworthy environment. When effort is put into creating a safe space for women to express needs, discuss concerns, and share vulnerabilities with a trusted provider, the screening and support process becomes straightforward. To build that space, it is essential to engage with women in a non-judgmental, culturally sensitive, and fully present manner. Women need to feel heard, understood, and included in the process of decision-making. Healthcare professionals can rely on principles of effective communication to further foster this relationship and properly involve women in care planning:

- Active Listening: being fully attentive and present, showing understanding and empathy.
- Non-verbal and verbal communication: sending clear effective messages that show empathy, care, respect, interest, and support.

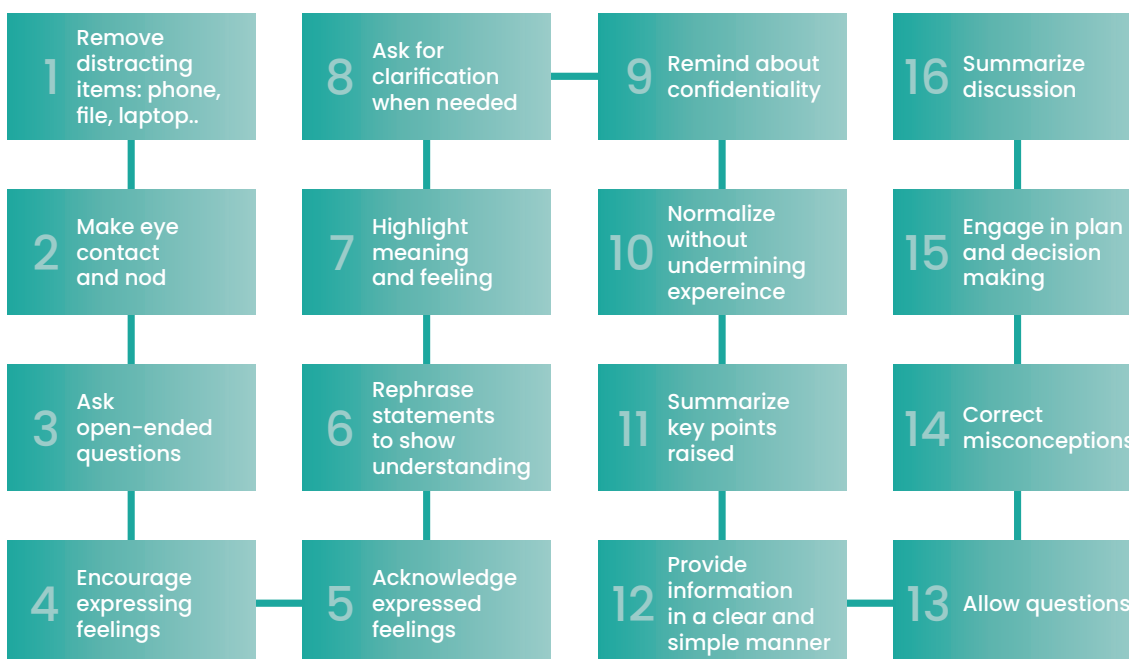



Figure 3: Effective communication

 Healthcare professional: *"How have you been feeling?" (open-ended question)*

Woman: *"I have been extremely tired, sleeping most of the day"*

Healthcare professional: *"Must be tough being this exhausted and unable to do much during your day (rephrasing). Many women at this stage of pregnancy feel heavier and low on energy, it can be difficult to deal with (normalizing). Tell me more about your experience with this" (open-ended question)*

Woman: *"I just feel my body is not mine anymore. I don't have the energy to do the things I used to do. I can't wait for all of this to end. I mean it is a blessing I know I'm just really done with this whole pregnancy phase. Everything in my body hurts. What's worse is that I can't stop thinking about how hard things are going to be once the baby is here."*

Healthcare professional: *"Seems like it's been a difficult phase both physically and mentally. It's hard to feel that your body is no longer able to do the things it used to do (rephrasing). One thing to keep in mind is that it is temporary and soon you will get your energy and physical strength back. The baby is bigger and is taking more space in your body, which makes it harder to move. This is the time to slow down enjoy more rest and look for fun activities that don't require a lot of effort like small walks, reading, listening to music, watching your favorite show...(clear simple information)
I notice you are worried about the challenges a baby can bring to your life (acknowledging feelings). Would you like to discuss this further?" (engaging)*

4- Cultural considerations

In matters of mental health, a clear understanding of the cultural and subcultural context is crucial. Women who are pregnant or in postpartum may have both positive and negative experiences related to cultural influence. Generally, in Lebanon and the Arab region the involvement of family members and close communal relationships may provide social support and added pressure at the same time. It is important for healthcare providers to take into account the background, culture, and context of the woman and the whole family. Special consideration is to be given to adolescent married girls in highly patriarchal subcultures. Ensuring that the adolescent pregnant girl or adolescent mother is engaged in the treatment plan and decision-making process and not being pressured by any family member is crucial. The healthcare provider can help women balance between seeking familial and social support and creating healthy boundaries to fend off pressure, guilt, and shame. Nonetheless, a deep understanding of the local and cultural context is essential to avoid causing any unintended harm. If the healthcare provider finds it difficult to empower the woman in a specific context and is concerned for her safety, it is advised to consult with a Gender-Based Violence (GBV) specialist/organization or social worker (Refer to the latest S/GBV Mapping of Services).

- ✔ Consider including the partner as well as immediate and extended family members in the assessment and treatment process only if the woman wishes so.
- ✔ Empower the woman to set appropriate boundaries with careful consideration to the cultural context.
- ✔ Correct misconceptions family members may have and attempt to reduce shame and blame towards the woman.



IV. Psychosocial risk assessment in pregnancy and postnatally

During this life stage for women, there are circumstances that can either mitigate or exacerbate the challenges of pregnancy and motherhood. Generally, pregnancy and motherhood are life changing experiences that leave women with a magnitude of emotions and transformations to navigate. Dealing with shifts in body image, lifestyle, habits, routine, and roles can be a daunting experience for anyone. It is, however, more difficult for women who are already at risk due to existing mental health conditions to adapt to these major changes. Healthcare providers ought to pay particular attention to past and present life conditions that can impact maternal mental health. Psychosocial risk can be assessed using a tool or an unstructured interview.

1- Social support and resources

Women's experience of pregnancy and motherhood can be very isolating when there are cultural, societal, and familial expectations to positively enjoy this experience of growing and bringing life to the world. Particularly, in cultures where mental health is generally stigmatized and where gender roles and societal expectations are rigid, it is more difficult for women and for those around them to appreciate the challenges of the perinatal period and acknowledge its impact on the woman's mental health. It is important for women to feel supported by their partners and families during that period. Low social support, defined as having one or zero persons available for support in the woman's life, has been associated with a higher risk for post-partum depression (*Chaaya et al., 2002*). Low income has also been associated with poorer maternal mental health (*Bennett et al. 2014*). A general idea about the woman's socioeconomic status provides further insight about the level of psychosocial risk. It is important to recognize problematic relationships and to inquire about the level of physical and emotional support from the father, the family, and close friends. This assessment can be done using simple questions such as:



Figure 4: Level of social support

2- History of mental illness

One of the most proven predictors of poor maternal mental health is the presence of a mental illness prior to pregnancy (*Sūdžiūtė et al, 2020*). Healthcare providers attending to the mother's care when planning pregnancy, pregnant, or in postpartum ought to routinely check for a history of mental illness. Identifying this risk factor as early on as possible will likely reduce the risk of another episode or a new presentation of a mental illness. Women with a history of mental illness themselves or in their family require more support than those who don't have that kind of history.

- Educate women with a history of mental illness about the risk of relapse or new presentation during or after pregnancy.
- Discuss red flags for relapse (Recurrent sleep problems, sadness, loss of functionality at work and/or home, loss of pleasure or interest, bizarre thinking or behavior, thoughts of self-harm or suicide, substance or alcohol use, agitation) or new presentation and identify helpful steps to be taken (Refer to a Psychiatrist as soon as possible).
- Periodically screen for onset of any mental illness.
- Inform about available resources for support (*Appendix D*). The National Lifeline, Community Mental Health Centers, and the "Step by Step" online self-help intervention.

3- Mother-infant interaction

Maternal mental health and mother-infant interaction have a bidirectional relationship. The negative impact of maternal mental health on mother-infant bonding and parenting behaviors has been heavily documented (*Johnson, 2013*). Additionally, poor mother-infant bonding and relationship can lead to poor maternal mental health and poor child outcomes (*Nolvi et al., 2016*). Through observation and direct inquiry, healthcare providers should assess for the quality of the mother-infant relationship. It is important to attend to some red flags that may indicate a problematic mother-infant relationship. Generally, mothers experiencing strong negative emotions towards the pregnancy and the infant such as rage, resentment, regret, denial, blame, guilt... struggle to bond well with the baby. A history of childhood traumas and unresolved problematic family relations make it more difficult for mothers to build a healthy attachment with their babies. In addition to these maternal elements, some factors related to the baby's pattern of behavior, physical needs, and temperament can affect mother-infant interactions. As such, mothers of babies with colic, gastric problems, feeding and sleep difficulties require special attention and support. If the pediatrician, nurse, or any healthcare provider identifies poor infant growth and development, it is essential to inquire further about mother's response to baby's needs and cues, mother-baby interactions, and mother's consistent follow up on baby's health and wellbeing. To assess for mother-infant interaction problems, pay attention to the following:

Maternal factors

Unresolved issues with family of origin
History of abuse, neglect, violence or trauma
Past pregnancy loss
Unplanned or unwanted pregnancy
Interaction on the day of birth
Did the mother have responsibility for infant care during the first week of life?
Availability of support
How much time does the mother spend away from the baby?

Infant factors

Infant's physical growth
Is the infant reaching appropriate developmental milestones?
Are there feeding difficulties, reflux, gastric distress, sleep difficulties?
Is the infant colic and difficult to soothe?

Relationship factors

Is the mother sensitive and responsive to baby's needs?
Can the mother describe the baby's daily routine?
Is the mother attentive and aware of baby's development?
Is the mother empathetic and caring towards the baby?
Does the mother play or talk to the baby?
Does the mother spend enjoyable time with the baby?
Is the mother consistent in her behavior towards the baby?
Does the baby trigger strong negative emotions in the mother?

Figure 5: Factors of mother–infant interaction problems

- Assess mother–infant interaction as early as possible postpartum and refer to licensed clinical psychologist working with parent–infant relationships as needed.
- If mother–infant interaction was found to be problematic, assess for risk of harm to the infant and the mother.

Certain severe presentations of certain mental health conditions and extreme lack of social support might put the mother and infant at risk of harm. If the mother–infant interactions are difficult this could be an indication that there might be a risk of neglect or potential harm to self or to the baby.

Healthcare providers attending to the mother's health should be well equipped to screen for suicide and infanticide risk (*see the next page*). Explain to the mother and involved family members that this is part of the routine screening for mental health conditions.

To be able to assess the risk of harm, it is important to have a trustworthy relationship with the mother and to rely on guiding principles of care to facilitate the disclosure of such difficult emotions and intentions. Using non-judgmental, sensitive, and empathetic communication is

crucial to create a safe environment for such a difficult disclosure. An introduction for this type of assessment can help ease the mother's pain, guilt, and shame associated with discussing negative feelings and rage towards the baby. The healthcare provider can for instance start with normalizing difficult mother–infant bonding, explaining the repercussions on the baby, and introducing the need for further assessment:

"It can be difficult for some mothers to feel connected to the baby and have a positive relationship directly after childbirth. Sometimes feelings of anxiety, anger, resentment, or rage can spiral and lead to very negative thoughts and behaviors towards the baby. A lot of mothers experience these difficult emotions and struggle to manage their relationship with the baby. In certain cases, the emotions are so strong that unknowingly the baby can be put at risk. I have noticed that it has been a difficult experience bonding with the baby. I will have to ask you some questions so that together we can assess the extent of your struggle."

The healthcare provider can rely on the following questions taken from the Postpartum Bonding Questionnaire (Brockington et al., 2006) and adapted to the perinatal context to identify the degree of risk to the baby's safety:

- Have you felt irritated by being pregnant or by your baby?
- Have you had significant regrets about becoming pregnant or having the baby?
- Does the baby feel like it's not yours at times?
- Have you wanted to harm your unborn child or shake or slap your baby?
- Have you ever harmed your baby?

- If the answer is "No" to both questions 4 and 5 but yes to any of the other questions, the level of risk is considered mild. Involve the father or another family member to support the mother in the care of the infant as a first step. Refer for psychological care by a licensed clinical psychologist. Inform about the national lifeline.
- If the answer is "Yes" to question 4 but "No" to question 5, the level of risk is judged as medium. Involve the father or another family member to dominantly care for the infant. Refer mother for psychological care by a licensed clinical psychologist. Inform about the national lifeline.
- If the answer is "Yes" to both questions 4 and 5, the level of risk is considered high. Child protection services may need to be contacted (*Refer to the latest CP Mapping of Services*). Refer mother for psychological care by a licensed clinical psychologist.

Risk of suicide is another consequence of mental health conditions most often associated with depression but can commonly occur in conjunction with other disorders or in the absence of a psychiatric diagnosis, such as when going through severe distress or in response to chronic pain. Thus, disclosure of death wishes, suicidal thoughts, or plans is never to be taken lightly. The healthcare provider ought to take into consideration the woman's history of suicidal risk/attempts, context, psychosocial risk factors, and current mental status when assessing for suicide risk. Using their own clinical judgment, healthcare providers should assess three important elements in suicide risk, based on WHO's mhGAP-IG:

- History of thoughts of self-harm/suicide
- History of acts of self-harm/suicide, and
- The woman's current mental status/presentation.

Direct questions are important and do not increase risk of attempting suicide or self-harm. Instead, being straightforward and asking about thoughts, plans, and behaviors related to suicide and self-harm can help decrease the risk and make the patient feel understood. Indeed, empathetic effective communication and a trusting relationship are the cornerstones of such an assessment. An introduction such as the following can make the disclosure much less difficult:

"It seems to me that you haven't been feeling very well. Sometimes negative feelings during pregnancy (or after childbirth) can be hard to manage. Dark thoughts can dominate our minds and make us feel hopeless or desperate. Many women experiencing these difficult emotions may have the tendency to harm themselves. It is important to me that you feel better and that you are safe. I will have to ask you a few questions so that together we can evaluate how difficult the situation has been for you."

Assessing risk of self-harm and/or suicide

Service Provider: "You mentioned that you have thoughts about self-harm. It is not uncommon for people to have these thoughts, but I am worried about you because you feel that way. Although such thoughts can be very powerful, it is very important not to give in to them because they are linked to our feelings at that moment and their intensity can change, and we often return to feeling, even partially, a decrease in distress that helps us to find appropriate solutions. I want to ask you some questions to make sure you are safe. Is that okay?"

Guidance when assessing thoughts of suicide

- Ask the questions as they are written in the assessment.
- When asking questions about suicide, avoid using less direct words that could be misunderstood. Direct questions help the person feel that they are not being judged for having thoughts or plans of suicide or having made attempts in the past.
- Some people may feel uncomfortable talking with you about suicide, but you can tell them that it is very important for you to clearly understand their level of safety.
- Asking questions about suicide will not put ideas in a person's head to end their life if they had not thought about this before.

General info

Name of service provider:

Name of service user:

Date:

Time:

1. In the past month, have you had suicidal thoughts?

YES NO

If YES, ask the service user to describe thoughts. Write details here:

If YES, proceed to question 2 and 3.

If NO, proceed to question 5.

2. Do you currently have a plan for suicide?

YES NO

If YES, ask the service user to describe the plan. Write details here:

Proceed to question 3 in any case.

3. Have you taken any actions, as in, have you prepared how you want to end your life?

YES NO

If YES, ask the service user to describe the actions to you. Write details here:

If YES, users are at high-risk for suicide. Proceed to high-risk protocol.

If NO, proceed to question 4.

4. Do you plan to end your life in the next two weeks?

YES NO UNSURE

If YES or UNSURE, users are at high-risk for suicide. Proceed to high-risk protocol.

If YES and they say they are about to act, users are at imminent risk for suicide. Proceed to Imminent-risk protocol.

If NO, proceed to question 5.

5. Have you tried to end your life in the last year?

YES NO

If YES, the service user is at medium risk for suicide. Refer to Medium-Risk protocol.

If YES, and based on your observation of verbal and non-verbal cues, if the person is experiencing any of the below:

- Extremely agitated
- Violent
- Severely distressed
- Uncommunicative

They are at an imminent risk of suicide. Refer to Imminent-Risk protocol.

If NO, the service user is at low risk for suicide.

Table 1. Guidance when assessing possible high-risk of suicide

Risk categories and actions

- **Low risk:** The service user answers positively on question 1 and negatively on all other questions. Follow-up with the participant again during the week and make a safety plan.
- **Medium risk:** The service user answers positively on questions 1 and 2 but negatively on questions 3 and 4, or answers positively on questions 1 and 5 and IS NOT CURRENTLY extremely agitated, violent, severely distressed, or uncommunicative. Make a safety plan and say that you will call once in between the weekly calls.
- **High risk:** The service user answers positively on questions 3 or 4. Follow high-risk procedures below.
- **Imminent risk:** The service user answers positively on 3 and 4 and is about to act now, or answers positively on 1 and 5 and IS CURRENTLY extremely agitated, violent, severely distressed, or uncommunicative. Follow Imminent-Risk procedures below.

Safety protocol for low risk of suicide

1. Provide psychoeducation to the service user.
2. Develop a safety plan (i.e., identify warning signs and coping strategies, ask the service user to write down people and places to call if and when they feel suicidal).
3. Ask the service user to nominate someone you can contact to ensure their safety (family member, a friend, a neighbor, etc.).
4. Offer and activate psychosocial support by providing psychoeducation to their carers/the nominee, and informing them of measures to take to remove access to harmful means (including access to open windows, ropes, shoelaces, plastic bags, sharp objects, etc.) and coordinate with them for needed steps in the safety plan put in place.
5. Monitor and assess the situation by keeping contact with the service user each week for as long as suicidal ideation persists.
6. Ensure safety by regularly contacting the carers/the nominee.
7. Remind the service user that they can call 1564, the National Hotline for Emotional Support and Suicide Prevention, between 12 PM and 5:30 AM. They can do a missed call and the line will call them back.
8. If suicidal ideation persists for a few weeks, refer the person to MH professionals, or call the National Hotline for Emotional Support and Suicide Prevention for referral options.

Safety protocol for medium risk of suicide

1. Provide psychoeducation to the service user.
2. Develop a safety plan (i.e., identify warning signs and coping strategies, ask the service user to write down people and places to call if and when they feel suicidal).
3. Ask the service user to nominate someone you can contact to ensure their safety (family member, a friend, a neighbor, etc.).
4. Offer and activate psychosocial support by providing psychoeducation to carers/the

nominee, and informing them of measures to take to remove access to harmful means (including access to open windows, ropes, shoelaces, plastic bags, sharp objects, etc.) and coordinate with them for needed steps in the safety plan put in place.

5. Monitor and assess the situation by keeping contact with the service user each week for as long as suicidal ideation persists.
6. Ensure safety by regularly contacting the carers/the nominee.
7. Remind them that they can call 1564 the National Hotline for Emotional Support and Suicide Prevention on the number 1564 between 12 PM and 5:30 AM. They can do a missed call and the line will call them back.
8. Refer the service user to a MH professional who will contact them for a comprehensive assessment and management of the suicidal risk within the next week.

"From our experience, we know that the way you feel right now is temporary, and seeing a specialist might help you see things differently again."

Safety protocol for high-risk of suicide

Note: For the management of suicide risk, follow the internal protocols of your organization where available, before deciding to proceed with the below generic steps.

Steps	Trained Healthcare Staff	MH Professional
1. Stay with the service user (in person or on the call) while you follow the safety protocol till the end. Do not leave them alone.	Yes	Yes
2. Develop a safety plan. (i.e., identify warning signs and coping strategies, have the patient write down people and places to call if and when they feel suicidal).	Yes	Yes Assess if the service user needs immediate hospitalization.
3. Ensure they are not alone and see if there is someone who can support them. (i.e. <i>"I would also like you to contact someone in your community to ensure you are safe. Who would that be? Can this person bring you to X Hospital, or take you to see a mental health specialist?"</i>)	Yes	Yes
4. Explain that you are concerned for their safety and you want them to seek support. i.e., <i>"From our experience, we know that the way you feel right now is temporary, and seeing a specialist might help you see things differently again."</i>	Arrange an immediate appointment with a MH Professional or call the hotline for a referral to a mental health professional	Start with detailed safety planning and management of high-risk suicide. Consider assessment using the Brief Columbia Suicide Severity Rating Scale (Brief-CSSRS).

<p>5. IF their follow-up appointment with a MH professional is not going to be immediate, agree on a safety plan for the coming days.</p>	<p>Ask the service user to:</p> <p>Get rid of the means (i.e. bridge, balcony, substance, weapons, knife, etc.).</p> <p>Discuss what to do if these thoughts become stronger (i.e., call a friend, go for a walk, get out of bed, wash face, pray, etc.).</p> <p>Encourage Help-seeking: Agree with the service user to call the provider or the Lifeline if they start feeling worse. Ask them if they can inform a family member or a trusted friend that can support them.</p> <p>Make a non-suicide contract (i.e. Agree with the service user that they will not harm themselves, defining start and end date of the contract.)</p>	<p>NA</p>
<p>6. IF the service user refuses to seek professional help.</p>	<p>Call the National Lifeline for Emotional Distress and Suicide Prevention (1564), immediately while staying with the service user.</p> <p>Inform them that by law you must inform the ISF.</p>	<p>Negotiate on the benefits of seeking professional help.</p> <p>Consider involuntary hospitalization.</p> <p>Inform them that by law you must inform the ISF.</p>
<p>7. If you require assistance/guidance in supporting the person in this situation, call the National Lifeline for Emotional Support and Suicide Prevention (1564).</p>	<p>Yes</p>	<p>NA (Consider calling the Lifeline for information on service mapping)</p>

Safety protocol for imminent-risk of suicide

Note: For the management of suicide risk, follow the internal protocols of your organization where available, before deciding to proceed with the below generic steps.

Steps	Trained Healthcare Staff	MH Professional
1. Follow the High-risk suicide protocol.	Yes	Yes
2. Agree on a safety plan for the coming hours.	<p>Ask the service user to:</p> <p>Get rid of the means (i.e. bridge, balcony, substance, weapons, knife, etc.).</p> <p>Discuss what to do if these thoughts become stronger (i.e., call a friend, go for a walk, get out of bed, wash face, pray, etc.).</p> <p>Encourage Help-seeking: Agree with the service user to call the provider or the Lifeline if they start feeling worse. Ask them if they can inform a family member or a trusted friend that can support them.</p> <p>Make a non-suicide contract (i.e. Agree with the service user that they will not harm themselves, defining start and end date of the contract.)</p>	<p>Ask the service user to:</p> <p>Get rid of the means (i.e. bridge, balcony, substance, weapons, knife, etc.).</p> <p>Discuss what to do if these thoughts become stronger (i.e., call a friend, go for a walk, get out of bed, wash face, pray, etc.).</p> <p>Encourage Help-seeking: Agree with the service user to call the provider or the Lifeline if they start feeling worse. Ask them if they can inform a family member or a trusted friend that can support them.</p> <p>Make a non-suicide contract (i.e. Agree with the service user that they will not harm themselves, defining start and end date of the contract.)</p>
3. IF the service user is about to take action.	Call the National Lifeline for Emotional Distress and Suicide Prevention (1564), immediately while staying with the service user.	<p>Discuss reasons to live and reasons not to live.</p> <p>Gently help the person come up with important reasons to stay alive and realize that their reasons to die are most likely only temporary. (i.e. <i>Are there any family members or friends you are staying alive for? Are there some things that you have enjoyed in life? Recently? Long ago? Have you always felt this way? If not, what did you used to enjoy in life? What are some hopes that you have for your future?</i> Help them to think about solving their practical problems, reducing their emotional problems, etc.)</p> <p>Arrange for immediate hospitalization in a Psychiatric Ward of a general hospital.</p>

Specific considerations for high and imminent-risk suicide situations:

1. If the assessment and intervention are being done remotely:
 - a. Ask for the location (address) of the service user then call the National Lifeline for Emotional Support and Suicide Prevention (1564).
 - b. Make sure you are using another communication device to call the National Lifeline for Emotional Support and Suicide Prevention (1564) as you would need to stay on the line with the service user at risk.
2. If the service user is a minor:
 - a. Inform them that you have to inform their parents and/or caregivers.
 - b. Involve their parent(s)/caregivers in the safety plan.
3. When calling the National Lifeline for Emotional Distress and Suicide Prevention:
 - a. Dial 1564 between 12:00 PM and 5:30 AM.
 - If the high-risk situation happens outside these hours, reach out to a MH professional, preferably a psychiatrist.
 - b. As soon as they answer:
 - Proceed by telling them your name and the organization in which you work.
 - Inform them that you have a case of suicide with you and that you are requesting support to assist them better.
 - c. Regularly update the service user on the steps being taken and the progress being made.
 - While talking to the service user, ask them again to get rid of the means of harm (i.e. put down the weapon, walk away from the bridge, throw away the substance, etc.) and check with them if they did.
 - d. Specify exactly what the situation is:
 - Service user is at risk of suicide.
 - Service user about to take action.
 - Service user refusing treatment.
 - Unavailability of a MH professional for an immediate referral.
 - e. Keep the operator informed of the steps you are taking, while reassuring the service user that you are still with them. If you need a few seconds to listen to what the operator has to say, make sure you inform the service user that you would need a few seconds just to know how to support them better.
 - f. Inform the service user of the next steps and stay with them until the requested support is received. Provide psychosocial support and use active listening.

V. Specific mental health conditions in pregnancy and postnatally: identification and intervention

1- Postpartum blues

Postpartum blues or commonly known as “baby blues” generally refer to the sad mood and mild depressive symptoms that women experience in the first few days up to two weeks after childbirth (Howard et al., 2014). Women can experience sadness, crying, fatigue, anxiety, poor sleep, low concentration, irritability, and mood swings. These symptoms are limited in time, fleeting, non-persistent, and do not lead to significant dysfunction. They typically occur within two to three days of postpartum, become more intense over the next few days, and should resolve within two weeks without intervention (Balaram & Marwaha, 2021).

Prevalence of postpartum blues has been reported at around **50%** of women within the first couple of weeks after childbirth (Henshaw, 2003). It is important for healthcare providers to be able to identify postpartum blues and provide needed support. Women who experience postpartum blues have been shown to be **4 to 11 times** more likely to develop postpartum depression (Balaram & Marwaha, 2021).

Screening and assessment

Healthcare providers dealing with women early on after childbirth can identify symptoms of postpartum blues by assessing onset, severity, and course of the depressive symptoms. Between the second and third day postpartum, women showing increased crying, low mood, irritability, mood instability, poor sleep, and poor concentration can be flagged as possibly experiencing postpartum blues. Symptoms should be mild, not leading to great dysfunction, and transient. These symptoms should disappear on their own within two weeks. If women keep on experiencing symptoms beyond two weeks they may be diagnosed with postpartum depression (See section V.2). It is important to keep in mind that some of these symptoms may be a normal adaptation to the changes that come with childbirth. To differentiate between normal emotional reactions to change and postpartum blues, healthcare providers should look for abnormal mood changes and low activity levels beyond what is expected after childbirth.



Figure 6: Postpartum blues identification

Support and treatment

Postpartum blues do not require treatment and disappear on their own within two weeks of onset. Nonetheless, this does not mean that women ought to struggle alone and push through these difficult symptoms. Healthcare providers can provide support and guidance to help women manage these negative emotions effectively.

- Provide education about postpartum blues: symptoms, prevalence, and time limit.
- Validate women's experiences and reassure that this is temporary.
- Provide tips on sleep hygiene and self-care, and encourage women to seek social support (*see Appendix E for self-care tips*).
- Inform about the National Hotline for Emotional Support and Suicide Prevention "1564" and available resources.
- Monitor severity and course of symptoms. If symptoms do not resolve after two weeks postpartum depression may be considered (*see section V.2*).
- Screen for risk of suicide and/or harm towards the baby.

2- Depression and anxiety disorder

Screening and assessment

Depression and anxiety disorders are under-recognized among pregnant women and women in postpartum. Therefore, it is recommended that a discussion of these symptoms is conducted at the initial visit in the early stage of pregnancy and as early as possible during the postpartum period.

For depression

Routine screening and discussion of depressive symptoms is important for up to one year postpartum. Symptoms of depression can sometimes be confused with a medical problem or an adjustment to certain life conditions. Thus, the healthcare provider ought to take a broad and comprehensive approach when assessing for depression. To assess for depression and anxiety healthcare providers can start with a broad interview that assesses the mental status of the woman. They can also use validated screening tools such as the Patient Health Questionnaire 2 (PHQ-2), such that a positive answer on either question will warrant further screening via the Edinburgh Postpartum Depression Scale (EPDS) or the Patient Health Questionnaire 9 (PHQ-9). These are all available in Arabic (*Appendix A*). When possible and when trained, with pregnant or breastfeeding women, the EPDS should be used instead of other available tools as its 10-item questions include anxiety symptoms, which are a prominent feature of perinatal mood disorders, and exclude other symptoms of depression, such as changes in sleeping patterns, which can be common in pregnancy and the postpartum period. The inclusion of these constitutional symptoms in other screening instruments, such as the PHQ-9, the Beck Depression Inventory, and the Center for Epidemiologic Studies Depression Scale reduces their specificity for perinatal depression. Questions about depression or anxiety should be smoothly introduced by normalizing these feelings and providing a safe space for self-expression, some guiding introductions and questions for depression include:

"It is very common for pregnant women/new mothers to experience feelings of sadness or hopelessness. The major bodily and life changes can be hard to deal with. Let us explore together how you have been feeling lately."

- ? During the past two weeks, have you often been bothered by feeling down, depressed or hopeless?
- ? During the past two weeks, have you often been bothered by having little interest or pleasure in doing things?

- If a woman answers yes to any of the 2 PHQ-2 questions above, consider further screening with PHQ-9 or the EPDS. If the score is positive, refer them to a mental health professional (licensed psychologist or psychiatrist) for a comprehensive assessment.

Keep in mind that symptoms of depression should be present for two weeks or more (not to be confused with postpartum blues), cause significant distress and dysfunction, and are not due to a medical problem. For instance, anemia or thyroid problems can cause fatigue, low energy, sleep or weight changes often confused with symptoms of depression when medical conditions are not ruled out.

The two core symptoms of depression are:

1. Persistent sad/depressed mood and significant lack of interest and/or
2. Loss of pleasure in usually enjoyable activities.

Women with depression also experience a range of the following symptoms:

- Disturbed sleep
- Worthlessness/guilt
- Significant increase/decrease in appetite
- Hopelessness/despair (marked weight gain/loss)
- Loss of energy/fatigue
- Poor concentration/indecisiveness
- Slowness in movement and/or speech
- Restlessness
- Suicidal thoughts or plan

For anxiety disorder

Some anxiety regarding pregnancy, fetal health, childbirth, baby, and parenting is expected and even functional as it directs the mother's attention to be able to notice any concern/ risk. Nonetheless, excessive worrying and restlessness that persists despite reassurance, is beyond reasonable concern, is highly distressing, and significantly impacts the woman's functioning is the kind of anxiety that warrants further assessment.

The core symptoms of Generalized Anxiety Disorder (GAD) are:

1. persistent and excessive worry that is difficult to control,
2. accompanied by physical or cognitive symptoms such as restlessness, fatigue, difficulty concentrating, disturbed sleep, and muscle aches.

The topic of the worry can vary and encompass multiple aspects of the women's life. A broad interview is always essential to screen for mental health conditions, the following introduction can be used to facilitate screening of anxiety:

"It is very common for pregnant women/ or new mothers to experience great worry and nervousness about different aspects of that experience. Some anxiety about the baby, adapting to a new lifestyle, bodily changes, or medical concerns are normal and part of the journey. But sometimes these worries can get out of control and become difficult to manage. Let us explore together how you have been feeling lately."

Some guiding questions for anxiety screening taken from Generalized Anxiety Disorder (GAD)-2 include:

- ? Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious or on edge?
- ? Over the last 2 weeks, how often have you been bothered by not being able to stop or control worrying?

- If a woman scores 3 or more on the GAD-2, consider further assessment using the Generalized Anxiety Disorder (GAD-7) or the "Perinatal Anxiety Screening Scale" (PASS) both available and have been translated to Arabic (*Appendix B*). If severe anxiety is suspected (PASS score 42-93 or GAD-7 score > 15), it is recommended that the woman is referred to a mental health professional (licensed psychologist or psychiatrist) for a comprehensive assessment.

- ! Use the two question tools for anxiety and depression at every visit during pregnancy and up to a year after delivery.

Support and treatment

Step 1: Psychoeducation

Following the guiding principles and using effective communication, healthcare providers should always start by educating women about mental health conditions that may occur during pregnancy and postnatally. It has been shown that psychoeducation can help prevent the development of depression and anxiety. Women identified as having depression/ anxiety should be educated about their condition. Healthcare providers ought to aim at normalizing the woman's experience by providing accurate and scientific information.

Important messages to convey when educating women about depression are (taken from the mhGAP-IG and adapted to the perinatal context):

- Depression is a very common condition in general and in women during pregnancy and postpartum in particular.
- The occurrence of depression does not mean that the person is weak or lazy.
- Negative attitudes of others (e.g. "You should be stronger", "Pull yourself together") may be due to the fact that depression is not a visible condition, unlike a fracture or a wound.
- There is also the misconception that people with depression can easily control their symptoms by sheer willpower.
- Women with depression tend to have unrealistically negative opinions about themselves, their ability to be good enough mothers, their ability to care for the baby, and their future.
- Their current situation may be very difficult, but depression can cause unjustified thoughts of hopelessness and worthlessness.
- These views are likely to improve once the depression improves.
- Thoughts of self-harm or suicide are common. If they notice these thoughts, they should not act on them, but should tell a trusted person and come back for help immediately.

Important messages to convey when educating women about anxiety are:

- Anxiety is very common in the general population and can be aggravated by life changing situations such as pregnancy and childbirth.
- Generally, anxiety at healthy levels helps keep us safe from danger. It makes pregnant women take extra precaution as to not harm their baby and it pushes new mothers to assume responsibility and attend to the baby's needs.
- It becomes concerning when the anxiety is extremely stressful, preoccupying, disproportional to the situation, and leads to dysfunction.
- People with anxiety tend to be hyperalert most of the time, tensed up, and have difficulty relaxing.
- This excessive worry is unreasonable and often occurs in the absence of a real threat.
- It is very difficult to shake off these worries and just let go.
- There are specific skills a woman can learn to be able to manage the anxiety and not allow it to disturb her daily life.

Step 2: Social support and stress management

Social isolation and poor stress management are often a result of depression and anxiety. Nonetheless, these two factors can be a trigger for the development of depression and anxiety. As such, encouraging social support, identifying and reducing stressors can form a solid armor for women during the perinatal period and protect them from the development of anxiety and depression. General lifestyle advice such as maintaining a healthy diet, sleep hygiene, physical activity, social connection, and relaxation exercises can be of great value to women during this phase.

- Provide lifestyle and wellbeing advice for all women during the perinatal period regardless of mental health history or status.

For women suffering from depression and anxiety, there are specific tips that can help these women improve their mood and reduce their anxiety levels. Depression is very much associated with a feeling of loneliness and social isolation. People with depression often retreat from life activities and social gatherings. They develop a lack of interest and of pleasure in being in social groups and in doing recreational activities. It becomes too physically demanding for their low level of energy to engage in physical activities and in community life. Without noticing, they start to slowly slip into solitude and idleness. Likewise, people with anxiety spend a lot of their time preoccupied with worrying thoughts and building catastrophic worst case scenarios in their minds. This preoccupation with the topic of worry prevents them from engaging with others and from doing distracting and enjoyable activities. Helping women suffering from either depression or anxiety regain a sense of connection to their social network and slowly re-engage in physical, social, and recreational activities is of utmost importance and is in line with the recovery-oriented approach. Social support and an active life provide us with a sense of belonging and a sense of meaning, both of which shield us from feelings of worthlessness, loneliness, nervousness, and negative outlooks. Generally, women suffering from anxiety and/or depression tend to have difficulty handling stress. It is important to identify sources of stress in a woman's life and guide her to eliminate or reduce these stressful factors. Suggesting small steps towards achieving some self-care activities is more helpful than advising major lifestyle changes. Women with depression and anxiety can greatly benefit from slight reintroduction in social life, some physical movement, and a slow engagement in activities. Additionally, finding ways to unwind and reduce stress can be of great help, these ways may include breathing exercises, self-help books, yoga classes, small walks, listening to music...

As a healthcare provider, it is advised to:

- Identify sources of stress (this can be done during the psychosocial risk assessment) and problem-solve to eliminate or reduce them.
- Identify supportive family members and friends and encourage connecting with them.
- Encourage women to reactivate social networks and engage in previously enjoyable activities. Suggest spending time with friends and family and taking up leisure or recreational activities.
- Emphasize the importance of physical wellbeing by maintaining a healthy sleep schedule, regular eating habits, and some physical activity.
- Inform about the National Lifeline for Emotional Support and Suicide Prevention "1564" and the "Step by Step" e-guided self-help intervention.

Step 3: Psychological interventions

Women with depression and anxiety benefit from evidence-based brief psychological interventions. These interventions are usually provided by licensed clinical psychologists. The aim of these interventions is to build skills needed to improve mood, manage anxiety, and enhance quality of life.

The most evidence-based interventions for anxiety and depression are Cognitive Behavioral Therapy (CBT) and Interpersonal Psychotherapy (IPT). Both CBT and IPT have been shown to decrease depression in the perinatal period. Many agencies have developed treatment manuals for the use of CBT and IPT for depression. WHO has three relevant manuals:

1. Problem Management Plus¹, which describes the use of behavioural activation, relaxation training, problem solving treatment and strengthening social supports;
2. Group Interpersonal Therapy (IPT) for Depression manual is for the group treatment of depression² and
3. "Thinking Healthy" which is a CBT for perinatal depression.

Another relevant programme that persons with depression can be referred to is the "Step-By-Step" intervention developed by the National Mental Health Program (NMHP) in collaboration with the World Health Organization (WHO). Step by Step is a free, confidential, minimally guided, self-help intervention for adults proven to be effective for the treatment of depression. It is available through an app and through a website (see appendix D).

Consider referring to brief psychological interventions if a woman:

- Has mild to moderate depression and/or anxiety in the perinatal period (Mild Depression: PHQ-9 >5, Mild Anxiety: GAD-7 > 10).
- Has moderate to severe depression and/or anxiety in the perinatal period (Moderate-Severe Depression: PHQ-9 >15, Severe Anxiety: GAD-7 > 15).

Step 4: Pharmacological interventions

Generally, pharmacological interventions are to be avoided for pregnant and breastfeeding women with depression and/ or anxiety whenever possible. It is strongly advised to consult with a psychiatrist, ideally a psychiatrist specialized in maternal care. It is recommended that antidepressant medications are prescribed for pregnant or breastfeeding women by psychiatrists only.

A shared decision-making is crucial when it comes to prescribing antidepressants during pregnancy. Women need to be fully aware of the associated risks of the use of antidepressants when pregnant or breastfeeding. Generally, antidepressants are prescribed when the benefits largely outweigh the risks for both the baby and the mother. It is typically recommended to opt for high intensity evidence-based psychological interventions whenever possible prior to the use of medication and in severe cases in conjunction with the use of medication.

1 http://www.who.int/mental_health/emergencies/problem_management_plus/en/

2 http://www.who.int/mental_health/mhGAP-IG/interpersonal_therapy/en
http://www.who.int/mental_health/maternal-child/thinking_healthy/en

For pregnant women with severe depression, Sertraline is generally safe, Paroxetine is the least safe of the Selective Serotonin Reuptake Inhibitors (SSRIs). In breastfeeding women, Sertraline is also the drug of choice. Fluoxetine and other long-acting antidepressants are to be avoided for breastfeeding women. Whenever antidepressants are prescribed, discontinuation symptoms of the neonate should be monitored.

Cases in which psychotropic medication for depression/anxiety is considered for a pregnant woman are:

- If a woman has a history of severe depression/ anxiety but initially presents with mild depression/ anxiety.
- If a woman has moderate to severe depression, declines psychological interventions or has not responded well to those interventions.

Nonetheless, there are many considerations that need to be accounted for when prescribing psychotropic medications to pregnant women: If SSRIs are prescribed, consider the woman's past response to SSRI treatment and whether she has risk factors for miscarriage (e.g. thyroid dysfunction) or preterm birth (e.g. previous preterm birth, active smoking during pregnancy), factors that may increase risk of postpartum hemorrhage and the half-life of the treatment (e.g. risk of poor neonatal adaptation syndrome is increased with SSRIs with a short half-life such as paroxetine). If long-acting benzodiazepines are repeatedly prescribed in late pregnancy there may be an increased risk of respiratory difficulty in the newborn. The use of both short-acting and long-acting benzodiazepines have been associated with poor neonatal adaptation syndrome.

Cases in which psychotropic medication is considered postnatally for depression/anxiety:

- SSRIs are used as first-line treatment for moderate to severe depression postnatally. The risks associated with severe depression on mother-infant bonding outweigh the minimal risk of exposure for the infant through breastmilk. Sertraline and Paroxetine are considered safe while Fluoxetine is not recommended during breastfeeding.
- Benzodiazepines are used for treating moderate to severe symptoms of anxiety on the short-term while awaiting onset of action of an SSRI.

For pregnant women who have been on medication before becoming pregnant consider the following:

- Refer to the psychiatrist for a re-assessment to determine severity and course of treatment.
- If the pregnant woman is taking a Tricyclic Antidepressant (TCA), Selective Serotonin Reuptake Inhibitor (SSRI), or Selective Serotonin-Norepinephrine Reuptake Inhibitors (SSNRIs) for mild to moderate depression/ anxiety consider gradually stopping the medication and initiating self-help or psychological interventions.
- If the pregnant woman is taking the medication for moderate depression/ anxiety and wishes to stop, refer to high intensity psychological interventions, switch to a lower risk medication that is effective for her, discuss risks and benefits of stopping the medication.
- If the pregnant woman is taking the medication for severe depression/ anxiety, continue with the medication or consider changing to a lower risk medication that is effective, refer to high intensity psychological interventions in combination with medication or alone if she wishes to stop.
- In case severity of symptoms is difficult to establish, switch to a lower risk medication and refer to high intensity psychological interventions.

Depression	Anxiety
Provide psychoeducation	Provide psychoeducation
Reinforce social support and stress management	Reinforce social support
Focus on increasing daily activities and involvement in social life	Give stress management tips
Inform about the National Lifeline and the “Step by Step” intervention	Inform about the National Lifeline and the “Step by Step” intervention
Refer to psychological interventions	Refer to psychological interventions
Monitor at follow up	Monitor at follow up
Carefully consider psychotropic medications if no improvement or severe case in consultation with a psychiatrist	Carefully consider psychotropic medications if no improvement or severe case in consultation with a psychiatrist

Table 2: Support for anxiety and depression

3- Obsessive-compulsive disorder (OCD)

Screening and assessment

Obsessive Compulsive Disorder (OCD) is characterized by obsessions in the form of persistent thoughts, impulses, or images and compulsions in the form of repetitive behaviors or rituals. The obsessions are unwanted, highly distressing, and cause marked anxiety. The compulsions are excessive, cause significant distress, and are time consuming (take up more than hour a day) or have remarkable impact on the person’s daily functioning or relationships. Often, people with OCD avoid situations that trigger obsessions to avoid the associated distress or anxiety.



Figure 7: OCD core symptom



Figure 8: Common obsession and compulsions

For women during the perinatal period, OCD has been found to have a unique presentation. In pregnant women, OCD is mainly associated with contamination fears while in new mothers it is characterized by obsessions of harm befalling the infant (Abramowitz & Fairbrother, 2008; McGuinness, Blissett, & Jones, 2011). The obsessive thoughts about harming the infant are different from those present in postpartum depression. Women experiencing these obsessions are aware that the obsessions are unreasonable and do not have the desire to intentionally harm the infant but are rather afraid that they will harm the infant. Due to the distress caused by these obsessions, women with postpartum OCD tend to avoid certain situations that may trigger these obsessions such as bathing the infant or being around kitchen knives (McGuinness, Blissett, & Jones, 2011). In some instances, women with postpartum OCD may isolate themselves from the infant in fear of harming him/ her. This avoidance of the infant comes only due to the anxiety caused by the obsession and not because of a mother–infant bonding problem or postpartum depression.

To assess for perinatal OCD, healthcare professionals can use specific screening tools such as the Yale–Brown Obsessive Compulsive Scale (Y-BOCS) available in Arabic (Appendix C) and general interview questions such as:

“It is not uncommon, during life transitions or major change that we experience high levels of anxiety. Sometimes this anxiety can be due to persistent thoughts that get stuck in our minds and are difficult to control. These thoughts can cause us to do certain acts repetitively to get rid of that feeling of anxiety. During pregnancy or postpartum, these symptoms may occur suddenly or become worse in case they were present in the past. Let’s reflect together on the past month and check if you have been experiencing these symptoms.”

- Have you been bothered by unwanted, excessive, and persistent thoughts/images that are hard to control? These can be thoughts of something bad happening, unwanted violent/sexual images, concerns of contamination/ cleanliness, worry about symmetry or order...
- Have you had the urge to perform certain rituals or behaviors repetitively to be able to get rid of those thoughts? These can be excessive washing/cleaning, arranging and ordering, praying, checking and re-checking, redoing certain behaviors...
- How much time do you spend preoccupied with these thoughts and performing these acts? How many hours a day?
- Have you felt the need to avoid certain people, places, or situations to prevent these thoughts and behaviors?
- How have these thoughts and behaviors affected your life?

Severity of these symptoms is indicated by four main elements: time spent, interference with daily life, level of distress, and degree of control (taken from the Y-BOCS).

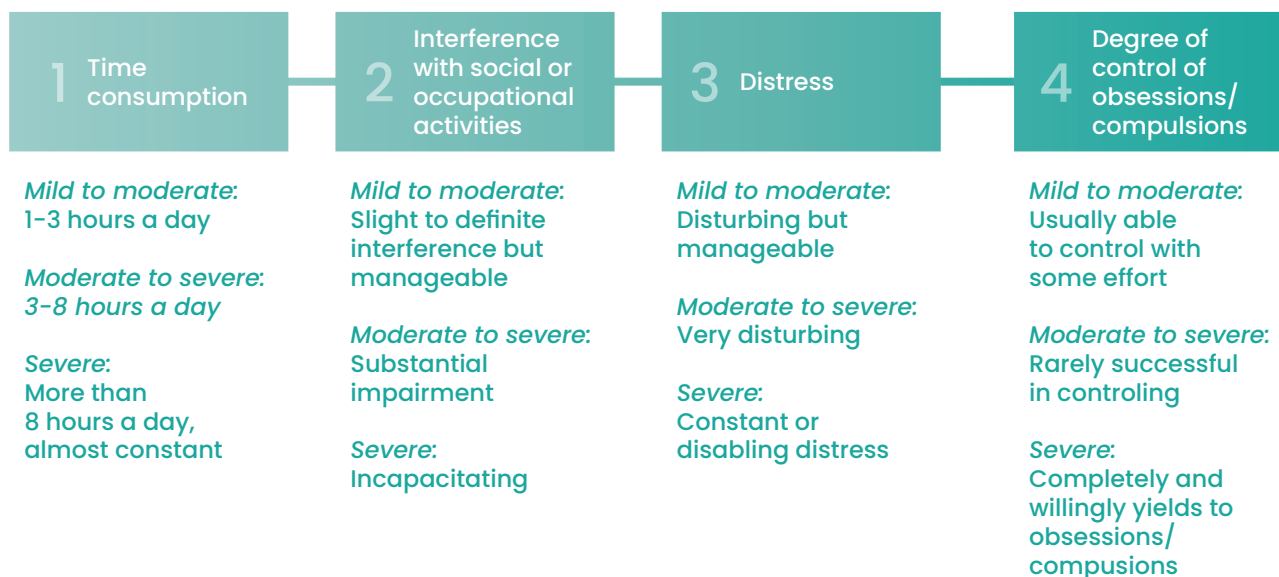


Figure 9: OCD level of severity

Support and treatment

All women planning pregnancy, pregnant, or in postpartum should be asked about history of OCD and educated about onset of these symptoms and risk of worsening or relapse during the perinatal period.

- If a woman is identified as having symptoms of OCD during the perinatal period, refer to specialist for clear assessment and treatment.
- If OCD is mild to moderate, the mental health professional will usually refer to psychological interventions, CBT mainly by a licensed clinical psychologist.
- If OCD is severe, the psychiatrist will usually consider a combination of pharmacological interventions and psychological interventions. A combination of a safe SSRI and CBT is the most evidence-based approach. During pregnancy and breastfeeding, Sertraline is the safest SSRI. Paroxetine is the least safe during pregnancy and Fluoxetine is to be avoided for breastfeeding women (*refer to pharmacological interventions in section V.2*).

4- Alcohol and substance use disorders

Screening and assessment

Women with high psychosocial risk or a history of mental illness are at a greater risk of using and misusing alcohol and other substances (Swendsen et al, 2010). As part of routine assessment, it is advised to screen for alcohol and substance use (i.e. ask if the woman is using alcohol or any other substance). There is no safe quantity for alcohol consumption during pregnancy and women should be advised to stop consumption. Every pregnant woman or every woman planning for a pregnancy should be informed about the negative consequences and dangers of consuming even small quantities of alcohol, tobacco and/or other illicit substances. Every current pregnancy or planned pregnancy should be considered as a privileged moment to stop these substances. Therefore, women should be oriented to substance use response services to meet this purpose.

Support and treatment

All women who are planning pregnancy or pregnant should be advised to avoid/stop alcohol and drug consumption. Healthcare providers should provide information about Fetal Alcohol Syndrome and the associated risks to the fetus. Consumption of alcohol postnatally poses a risk to the infant as well and should be limited. Breastfeeding sessions are to be timed after blood levels fall to zero, two hours for every one drink. Women of childbearing age identified as having drug misuse should be asked about their menstrual cycle and informed that drugs can interfere with the menstrual cycle leading to false perceived contraception.

If a woman is identified as having a harmful or dependent substance misuse during pregnancy or postnatally:

- Discuss risks to fetal development.
- Refer to a specialized substance misuse service for recommendation and treatment. Service should include psychiatric and psychological interventions.
- In collaboration with the specialist, offer assisted alcohol withdrawal/ substance detoxification in an inpatient setting.
- After detoxification, monitor closely for risk of accidental overdose in women who stop or decrease use in pregnancy and start again postnatally.
- Pregnant women identified as dependent on opioid should be given buprenorphine as a substitution treatment.
- Babies of drug users should be screened for withdrawal symptoms/ neonatal abstinence syndrome. A low dose of opioids may be used for infants with the syndrome.

5- Eating disorders

Screening and assessment

All women pregnant or planning pregnancy should be screened for an eating disorder, especially those with a concerning Body Mass Index. An eating disorder is characterized by:

- fear associated with weight gain,
- restrictive eating,
- significantly low weight,
- amenorrhea, or episodes of binge eating and compensatory behaviors.

Pregnancy and postpartum are highly sensitive periods that trigger body image issues where many women struggle with weight gain and bodily changes. Therefore, it is a particularly risky phase for women with a history or a present eating disorder.

If a woman is identified to have an eating disorder during pregnancy or postpartum:

- Discuss risks associated with fetal development and breastfeeding.
- Inform about importance of healthy eating during and after pregnancy.
- Refer to an evidence-based psychological intervention such as cognitive behavioral therapy.
- Monitor the woman's status and the fetal growth.
- Monitor the woman's condition carefully throughout pregnancy and the postnatal period.

6- Severe mental illness: bipolar disorder, schizophrenia, and psychosis

Screening and assessment

All women presenting for a first antenatal or postnatal visit should be asked about any past or present severe mental illness, treatment by specialist, inpatient care, and perinatal mental illness in the family.

For women who have a family history of perinatal severe mental illness monitoring symptoms of postpartum psychosis for 2 weeks after childbirth is indicated (*NICE, 2014*).

Women of child-bearing age diagnosed with a severe mental illness should be offered ample information about the importance of contraception if not planning pregnancy, risks of medication on fertility, likelihood of relapse in pregnancy and postpartum, and the challenges that motherhood brings in the context of their illness. Having a mental disorder is not a contraindication for becoming a parent. All women should be supported in their journey for becoming a parent. Persons with severe mental disorders with proper physical and mental health care can go through the journey of pregnancy, delivery and child-rearing and be as good parents as any. There are a lot of misconceptions around the capacity of doing so for persons with severe mental disorders; none of it is founded.

For women planning pregnancy, discuss medication to be used postnatally in relation to breastfeeding with them, their partner (if they wish) and their treating psychiatrist.

Cases of severe mental illness that require referral to a specialized mental health service for assessment and treatment include:

- Women who have or are suspected to have a severe mental illness (such as Schizophrenia, Bipolar disorder, or any other mental illness that causes severe functional impairment).
- Women who have a history of severe mental illness.
- Women who have a family history of perinatal severe mental illness. Monitoring symptoms of postpartum psychosis for 2 weeks after childbirth is indicated for these women (NICE, 2014).
- Women who show sudden onset of psychosis are referred for urgent assessment and treatment by specialist within hours of identification.

Support and treatment

For pregnant women with a severe mental illness:

- Closely monitor signs of relapse especially if medication is stopped.
- Educate about healthy eating, smoking, alcohol and substance use.
- Monitor weight gain and gestational diabetes in women taking antipsychotics.
- Refer to appropriate mental health care such as community-mental health centres as early as possible.

For women with severe mental illness in the postpartum period:

- Cautiously monitor onset of symptoms in the first month and regularly follow up afterwards. Sleep deprivation is a strong consideration for relapse.
- If there is relapse and need for inpatient treatment, co-admission of mother and infant is recommended if possible.
- If mother's mental health is at stake due to breastfeeding at night, it is recommended that support and resources such as linkage with a lactation consultant are provided. In cases where sleep disturbance is posing great risk to the mother's mental state, pumping milk for night feedings by another family member is advised and if not possible night weaning from breastmilk is recommended.
- Access to parenting support and specialists working with mother-infant attachment is needed for women with severe mental illness.

Psychoeducation and psychological interventions

Encourage them to follow-up with a mental health professional and stress on the importance of support with the partner and family members. Psychological therapies such as cognitive behavioral therapy or family therapy may be helpful especially when there is secondary depression or anxiety.

Pharmacological interventions


- Consult with or refer to a psychiatrist, ideally a maternal mental health specialist.
- Discuss risks associated with ceasing medication such as risk of relapse and neonatal complications.

For women with psychosis planning pregnancy, pregnant, or breastfeeding, a psychiatrist would usually:

- Consider low-dose oral haloperidol or chlorpromazine or olanzapine.
- Do not prescribe anticholinergics or depot antipsychotics.
- Monitor extrapyramidal symptoms in the neonate.

For women with a manic episode in bipolar disorder, a psychiatrist would usually:

- During pregnancy and breastfeeding avoid prescribing valproate, lithium, and carbamazepine.
- Consider potentially olanzapine, or a low dose of haloperidol or lamotrigine (lower than 300 mg/day with a supplementation of folic acid) (*Larsen et al., 2015*). In the case of an acute mania, olanzapine is preferred. Lamotrigine is used for maintenance of bipolar disorder.
- If acute mania is developed while on mood stabilizers during pregnancy, change medication to low dose haloperidol or olanzapine.

 Conduct a comprehensive neonatal assessment of newborns of mothers who have taken psychotropic medication.



VI. Traumatic births, stillbirths, miscarriage, and infant illness

Women who experience significant birth complications, miscarriage, and infant illness or death are considered at high risk for developing associated mental health conditions (*Leight et al., 2010*). Undeniably, these difficult experiences are bound to leave their mark on the woman, her partner and family. Advice and support are critical for women who have had a traumatic birth or miscarriage and are open to discussing their experience. It is recommended that women are offered post-traumatic counseling, which involves explaining the details of the birth, allowing the woman to discuss her labor, birth and post-birth experiences; and answering any questions. During this time, healthcare providers should:

- Show empathy and validate experiences.
- Provide space for the woman to express herself without pressure.
- Provide scientific explanation to remove any associated guilt and self-blame and to offer closure.
- Consider the impact of the experience on the partner.
- Encourage the couple to rely on family and close friends for support.

Women having lived these experiences may develop childbirth-related Post Traumatic Stress Disorder (PTSD) (*Dekel et al., 2019*). Signs of PTSD include recurring flashbacks, intrusive thoughts, or nightmares related to the childbirth accompanied by strong fear and anxiety. Women with PTSD may avoid reminders of the experience and be generally hyper alert to loud noises or signs of threat. These symptoms disrupt daily functioning, interrupt sleep, and are highly distressing.

- Women with PTSD should be referred for high intensity psychological intervention such as trauma-focused CBT or Eye Movement Desensitization and Reprocessing (EMDR).

Stillbirth is one of the most common adverse pregnancy outcomes. Women and their partners who have experienced a stillbirth or the death of an infant are better provided with support in collaboration with a specialist that provides psychosocial services in-line with the general principles of bereavement care immediately after stillbirths or in the next few days. These principles include providing individualized care, using good communication, involving them in shared decision making, recognizing their parenthood, acknowledging a partner's and families' grief, acknowledging that grief is individual, providing awareness of burials, cremation, and funerals, providing ongoing emotional and practical support. Practical actions to support women and their partners who have experienced a stillbirth, or the death of an infant can include: seeing a photograph of the baby (if they wish to), keeping a souvenir of the baby, seeing the baby, holding the baby, among others. It is also advised that service providers ensure that women are not pushed to be sad, nor advised to get pregnant again immediately, nor told that the baby is an "angel".

- ! In times of medical complications leading to traumatic births, stillbirths, or infant illness or death, healthcare providers tend to focus on the medical procedures. It is important not to neglect the emotional experience of the woman and her partner.
- ! Avoid pushing the woman or her partner to "re-live" the traumatic experience by asking for detailed narratives and pressuring them to talk.

VII. Child development

Generally poor mother–infant/child interaction minimizes opportunities for bonding, learning, stimulation, responsive care and growth. Infants and children thrive when their basic needs are met, they are loved and cared for, and when they are provided with ample opportunities to interact and explore the world around them (*Rochat et al., 2019*). In the first 1000 days, from pregnancy to age three, children’s brains develop at a markedly fast pace if provided with love, protection, nutrition, and stimulation. Children flourish when caregivers especially mothers, attend to the baby’s needs (through nutrition, protection, hygiene, sleep, physical health) with love and care (through touch, carrying, showing affection, and using a calm and soothing tone), and create opportunities for learning (through talk, play, music, and exploration). In extreme cases of neglect or abuse, infants or children may show significant delays in their development. In other cases, they will fall short of reaching their potential. The mother’s mental health and behavior is not generally a direct cause of child developmental problems but it is a major contributing factor that needs to be addressed as early as possible. Sometimes lack of education and awareness may lead to lack of stimulation, creating barriers to appropriate development.

As a healthcare provider:

- Identify problems in mother–infant interaction as early as the first postnatal visit.
- Educate mother and partner about the importance of the 1000 days for the baby’s development and the role they have in creating a loving, safe, and stimulating environment.
- Inform mother and partner about upcoming developmental milestones and advise conducive behavior and activities.
- Regularly monitor parenting behavior and child development.
- If problems in mother–infant interaction persist after education, refer to mother–infant specialist or licensed child clinical psychologist.

On the other hand, child developmental delays, neuropsychological disorders, and genetic abnormalities pose great challenges for the mother and the family. Mothers can experience significant emotional turmoil as they learn of such a diagnosis and struggle to deal with the lifelong challenges. Thus, having a child with difficulties may place the mother and her partner at risk of developing mental illness (*Emerson, 2003; Bourke et al., 2008*).

- Provide support for mothers and partners who have a child with developmental difficulties, especially as they learn about the problem whether during pregnancy or anytime postnatally.
- Provide ample information about the child’s condition, course, and treatment.
- Ensure appropriate early referral for multi-disciplinary and comprehensive care for the child.
- Consider connecting mother with support parent groups or community-based support groups.
- Screen mother for psychological distress, mental health conditions and refer to individual psychological interventions if needed.

Developmental milestones by age

Healthcare providers dealing with women and their babies ought to pay particular attention to child developmental milestones especially in the first three years of life. Some delay in achieving some milestones is not a cause for alarm in general. Rather, healthcare providers should look for patterns of delay in any area of development and advise parents accordingly. Below is a general refresher of developmental milestones by age, a more in depth and detailed understanding of child development is required to provide support and guidance.

Two to six months old

Physical	Cognitive and language	Socio-emotional
When standing, supports weight on legs and might bounce	Responds to sounds by sounds	Knows familiar faces and recognizes strangers
Rocks back and forth, sometimes crawling backward before moving forward	Strings vowels together when babbling	Likes to play with others, especially parents
	Responds to own name	Responds to other people's emotions
	Makes sounds to show joy and displeasure	Likes to look at self in the mirror
	Begins to say consonant sounds (jabbering with «m», «b»)	
	Brings things to mouth	
	Tries to get things that are out of reach	
	Passes things from one hand to the other	

Table 3: Age two to six months developmental milestones

Six to twelve months

Physical	Cognitive and language	Socio-emotional
Gets to a sitting position without help	Responds to simple requests	Is shy or nervous with strangers
Pulls up to stand, walks holding on to furniture ("cruising")	Uses simple gestures, shaking head "no" or waving "bye-bye"	Cries when mom or dad leaves
May take a few steps without holding on	Makes sounds with changes in tone	Has favorite things and people
May stand alone	Says "mama" and "dada" and exclamations like "uh-oh"	Shows fear in some situations
	Tries to say words you say	Hands you a book when he wants to hear a story
	Explores things by shaking, banging, throwing	Repeats sounds or actions to get attention
	Finds hidden things easily	Puts out arm or leg to help with dressing
	Looks at the right picture or thing when it's named	Plays games such as "peek-a-boo"
	Copies gestures	
	Starts to use things correctly	
	Bangs two things together	
	Puts things in a container, takes things out of a container	

Table 4: Age six to twelve months developmental milestones

One to two years

Physical	Cognitive and language	Socio-emotional
Stands on tiptoe	Points to things or pictures when they are named	Copies others
Kicks a ball	Knows names of familiar people and body parts	Gets excited when with other children
Begins to run	Says sentences with 2 to 4 words	Shows more and more independence
Climbs onto and down from furniture without help	Repeats words overheard in conversation	Shows defiant behavior/ tantrums
Walks up and down the stairs holding on	Points to things in a book	Plays mainly beside other children, but is beginning to include other children
Throws ball overhead	Finds things even when hidden under two or three covers	
Makes or copies straight lines and circles	Begins to sort shapes and colors	
	Plays simple make-believe	
	Builds towers of 4 or more blocks	
	Might use one hand more than the other	
	Follows two-step instructions	
	Names items in pictures	

Table 5: Age one to two years developmental milestones

Two to three years

Physical	Cognitive and language	Socio-emotional
Climbs well	Follows instructions with 2 or 3 steps	Copies adults and friends
Runs easily	Can name most familiar things	Shows affection for friends without prompting
Pedals a tricycle (3-wheel bike)	Understands the words "in", "on" and "under"	Takes turns in games
Walks up and down stairs, one foot on each step	Says first name, age and sex	Shows concern for crying friend
Toilet training	Names a friend	Understands the idea of "mine" and "his" or "hers"
	Says words like "I", "me", "we", and "you" and some plurals (cars, dogs, cats)	Shows a wide range of emotions
	Talks well enough for strangers to understand most of the time	Separates easily from mom and dad
	Carries on a conversation using 2 to 3 sentences	May get upset with major changes in routine
	Can work toys with buttons, levers, and moving parts	Dresses and undresses self
	Plays make-believe with dolls, animals, and people	
	Does puzzles with 3 or 4 pieces	
	Understands what "two" means	
	Copies a circle with pencil or crayon	
	Turns book pages one at a time	
	Builds towers of more than 6 blocks	
	Screws and unscrews jar lids or turns door handle	

Table 6: Age two to three years developmental milestones

Three to five years

Physical	Cognitive and language	Socio-emotional
Stands on one foot for 10 seconds or longer	Speaks very clearly	Wants to please friends
Hops; may be able to skip	Tells a simple story using full sentences	Wants to be like friends
Can do a somersault	Uses future tense (for example "Grandma will be here")	More likely to agree with rules
Uses a fork and spoon, and sometimes a table knife	Says name and address	Likes to sing, dance, and act
Can use the toilet on his own	Counts to 10 or more	Is aware of gender
Swings and climbs	Can draw a person with at least 6 body parts	Can tell what's real and what's make-believe
	Can print some letters or numbers	Shows more independence
	Copies a triangle and other geometric shapes	Is sometimes demanding and sometimes very cooperative

Table 7: Age three to five years developmental milestones

Summary milestones by age

Age	Major thing that needs to happen
0-2 months	Making sounds, moving hands and feet, smiling to people
2-6 months	Babbling, standing and sitting with help, responding to familiar people
6-12 months	Standing and sitting alone, taking a few steps, gesturing, first words, fear around strangers
1-2 years	Walking, two-word sentences, oppositional behavior, excitement around peers
2-3 years	Running, climbing, holding conversations, using buttons, toilet training, affection towards friends
3-5 years	Speaking clearly, counting, knowing shapes and colors and copying them, independence, following rules, forming friendships

Table 8: Summary milestones by age

If the child is failing to meet appropriate milestones in any or multiple motor, cognitive, social, emotional, and language aspects of development:

- Conduct a comprehensive assessment in your area of expertise.
- Refer to a multi-disciplinary child and adolescent mental health/neuropsychological service. Primarily, the child should be seen by a child and adolescent psychiatrist or a pediatric neurologist. Ideally, the assessment is conducted in collaboration with different specialists including but not limited to child and adolescent psychologist, neuropsychologist, speech and language pathologist, feeding specialist, psychomotor/occupational therapist, special educator, and physical therapist.

VIII. Conclusion and key recommendations

Women in the perinatal period are at greater risk of developing mental illness in general with some being more vulnerable than others. Low socio-economic status, poor social support, problematic relationship with partner, history of mental illness, difficult infant health, sleep and feeding habits, as well as obstetric complications have all been associated with poorer mental health. Healthcare providers have an important role to play: they can highlight the importance of mental health for the mother and for the family, can initiate screening, assessment and initial management and link with appropriate specialized care for the mother and the child. Clear recommendations in this guideline can help healthcare providers make important shared decisions with women needing support and/or interventions before, during, and after pregnancy.

Action	For whom	Comments
Screen for mental health conditions	All women	Regular monitoring Particular attention given to women with risk factors
Provide psychoeducation	All women	Especially those with a past or current mental illness
Involve partner/ family members	All consenting women Not in cases of GBV	Particular attention to cultural context
Discuss risk of relapse	Women with past history of mental illness	
Consult specialists, especially psychiatrists	Women with a moderate to severe mental health condition Women already on psychotropic medication Women with alcohol or substance use disorder	
Discuss risk and benefits of medication	All women requiring pharmacological treatment	
Ensure appropriate monitoring of the neonate	Women on psychotropic medication or with substance use disorder	
Plan for breastfeeding	All women	Provide support for women with severe mental illness as long as their mental health state allows
Coordinate with a multidisciplinary team with mental health professionals	Women with a severe mental health condition	Especially those requiring admission to hospital
Refer to psychological interventions	Women with a mild to moderate and moderate to severe mental health condition	CBT IPT EMDR

Refer to psychiatrist for pharmacological interventions	Women with a moderate to severe mental health condition Women refusing psychological interventions Women not responding to psychological interventions	
Ensure assessment of suicide and self-harm risk	All women with psychological distress or a mental health condition	Especially those with depression and severe mental health conditions
Ensure assessment of infant risk	Women with mother-infant relationship problems	
Follow protocols from mhGAP-IG	Women with risk of self-harm/suicide	
Involve partners and families	Women with mild infant risk	
Involve child protection services	Women with high infant risk	
Emphasize activation of social support network	Women with depression and/or anxiety	Going out Talking to friends Seeking support from family
Highlight reengagement in pleasurable activities	Women with depression and/or anxiety	Scheduling daily activities Small step by step activities
Recommend facilitated self-help such as the "Step by Step" program by MOPH	Women with distress or depression	
Post-traumatic birth counseling	Women who experienced traumatic births	Provide space for self-expression, explain what happened during birth, give medical explanation in simplified language, answer questions
Mother-infant psychological interventions	Women with postpartum depression Women with mother-infant relationship problems Women with a severe mental health condition	

Table 9: General key recommendations

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X. Appendices

Appendix A – Screening Tools for Depression

Patient Health Questionnaire 2 (PHQ-2)

اسم المريض:	رقم ملف المريض:
التاريخ:	اسم مسؤول الاستبيان: <input type="checkbox"/> ممرض <input type="checkbox"/> عامل اجتماعي <input type="checkbox"/> معالج نفسي <input type="checkbox"/> طبيب <input type="checkbox"/> غيره (حدد) _____

خلال الأسبوعين الماضيين، كم مرة عانيت من أي من المشاكل التالية؟ (ضع علامة "✓" للإشارة لجوابك)	ولا مرة	عدة ايام	اكثر من نصف الايام	تقريبا كل يوم
1. قلة الاهتمام أو قلة الاستمتاع بالقيام بأي عمل	0	1	2	3
2. الشعور بالحزن أو ضيق الصدر أو اليأس	0	1	2	3

Edinburgh Postpartum Depression Scale (EPDS)

ARABIC

سيدتي:

بما أنك قد أنجبت طفلاً مؤخراً ، فنود ان نعرف مشاعرك. نرجو أن تضعي خطاً تحت أنسب جواب يعبر عن مشاعرك في الأيام السبعة الماضية، وليس مشاعرك اليوم فحسب. واليك المثال التالي:

لقد شعرت بأنني سعيدة:

— نعم، في كل الأوقات

— نعم، في معظم الأوقات

— كلا، ليس أغلب الأحيان

— كلا، أبداً

هذا يعني: "لقد شعرت أنني سعيدة معظم الوقت" خلال الأسبوع الماضي. نرجو أن تكلمي الأسئلة الأخرى بنفس الطريقة

FOR OFFICE USE ONLY English version of EDS introduction

As you have recently had a baby we would like to know how you are feeling. Please underline the answer which comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today. Here is an example, already completed:

I have felt happy:

Yes, all the time

Yes, most of the time

No, not very often

No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

خلال الأيام السبعة الماضية

1. لقد تمكنتُ من الضحك ورؤية الجانب المضحك من الأمور:

- بالمقدار الذي إستطعته دائماً

- ليس تماماً بالمقدار نفسه الآن

- قطعاً ليس بالمقدار نفسه الآن

- كلا، مطلقاً

2. لقد تطلعتُ الى الأمور بمتعة:

- بالمقدار نفسه مثل أي وقت مضى

- نوعاً ما، أقل مما إعتدتُه

- قطعاً أقل مما إعتدتُه

- نادراً

3. لقد لمتُ نفسي بدون لزوم عندما سارت الأمور على غير ما يرام:

- نعم، في معظم الأحيان

- نعم، في بعض الأحيان

- ليس أغلب الأحيان

- كلا، أبداً

4. لقد كنتُ قلقة ومشغولة البال بدون سبب وجيه:

- كلا، مطلقاً

- نادراً

- نعم، في بعض الأحيان

- نعم، أغلب الأحيان

(الرجاء قلب الصفحة للإجابة على بقية الأسئلة.)

BINDING MARGIN - NO WRITING
FILE IN CLINICAL RECORD

REORDER INFORMATION

POSTNATAL EDINBURGH SCALE-

CR NO.69.

Patient Health Questionnaire 9 (PHQ-9)

استبيان عن صحة المرضى - 9 (PHQ-9)

تقريباً كل يوم	أكثر من نصف الأيام	عدة أيام	ولا مرة	خلال الأسبوعين الماضيين، كم مرة عانيت من أي من المشاكل التالية؟ (ضع علامة "✓" للإشارة لجوابك)
3	2	1	0	1. قلة الاهتمام أو قلة الاستمتاع بممارسة بالقيام بأي عمل
3	2	1	0	2. الشعور بالحزن أو ضيق الصدر أو اليأس
3	2	1	0	3. صعوبة في النوم أو نوم متقطع أو النوم أكثر من المعتاد
3	2	1	0	4. الشعور بالتعب أو بامتلاك القليل جداً من الطاقة
3	2	1	0	5. قلة الشهية أو الزيادة في تناول الطعام عن المعتاد
3	2	1	0	6. الشعور بعدم الرضا عن النفس أو الشعور بأنك قد أخذت نفسك أو عائلتك
3	2	1	0	7. صعوبة في التركيز مثلاً أثناء قراءة الصحيفة أو مشاهدة التلفزيون
3	2	1	0	8. بطء في الحركة أو بطء في التحدث عما هو معتاد لدرجة ملحوظة من الآخرين / أو على العكس من ذلك التحدث بسرعة وكثرة الحركة أكثر من المعتاد
3	2	1	0	9. راودتك أفكار بأنه من الأفضل لو كنت ميتاً أو أفكار بأن تقوم بإيذاء النفس

_____ + _____ + _____ + _____ = Total Score: _____ (FOR OFFICE CODING)

إذا أشرت إلى أية من المشاكل أعلاه، فإلى أية درجة صعبت عليك هذه المشاكل القيام بعملك، الاعتناء بالأمور المنزلية، أو الانسجام مع أشخاص آخرين؟

هناك صعوبات بالغة التعقيد

هناك صعوبات شديدة

هناك بعض الصعوبات

ليست هناك أي صعوبة

لقد طور هذا الاستبيان كل من الدكتور روبرت سبيتسر، الدكتورة جانيت ويليامز، الدكتور كيرت كورنيك وزملائهم، وتم ذلك بفضل منحة من مؤسسة Pfizer Inc. ليست هناك أية حاجة للحصول على تصريح من أجل الاستنساخ أو الترجمة أو العرض أو التوزيع.

Appendix B – Screening Tools for Anxiety

Generalized Anxiety Disorder (GAD-7)

GAD-7				
كل يوم تقريباً	أكثر من نصف الأيام	بعض الأيام	أبداً	خلال الأسبوعين الماضيين، كم مرة أقلقتك المشاكل التالية؟ (ضع علامة "✓" للإشارة لجوابك)
3	2	1	0	1- الشعور بالغضب أو القلق أو الانفعال الشديد.
3	2	1	0	2- عدم القدرة على إنهاء القلق أو التحكم فيه.
3	2	1	0	3- القلق المفرط على أشياء مختلفة.
3	2	1	0	4- الصعوبة في الاسترخاء.
3	2	1	0	5- شدة الاضطراب لدرجة صعوبة البقاء في هدوء.
3	2	1	0	6- السرعة في الانزعاج أو الانفعال.
3	2	1	0	7- الشعور بالخوف كما لو أن شيئاً فظيماً قد يحدث.

(_____ + _____ + _____ = Total Score T _____ For office coding)

إعداد الأطباء روبرت إل سبيتزر، جانيت بي دبليو وليامز، كيرت كرونك والزملاء، بمنحة تعليمية من شركة Pfizer Inc. لا يلزم الحصول على إذن لإعادة النسخ أو الترجمة أو العرض أو التوزيع.

Perinatal Anxiety Screening Scale (PASS)

كم هي عدد المرات التي واجهتي فيها الحالات التالية خلال الشهر الماضي:

#	السؤال	أبدأ	عالياً	في بعض الأحيان	دائماً
1	قلق حيال الطفل أو الحمل	0	1	2	3
2	الخوف من أن يصاب الطفل بأذى	0	1	2	3
3	الشعور بالفرح من أن شيئاً ما سيحدث	0	1	2	3
4	القلق حول أمور متعددة	0	1	2	3
5	الخوف من المستقبل	0	1	2	3
6	الأحساس بالتهر	0	1	2	3
7	مخاوف قوية تجاه بعض الأشياء مثل: الإبر، الدم، الولادة، الألم... الخ	0	1	2	3
8	الشعور بإنففاعية مفاجئة بسبب الخوف أو عدمه	0	1	2	3
9	صعوبة إيقاف أفكار متكررة أو التحكم بها	0	1	2	3
10	صعوبة النوم حتى في حال تفرقت لك الفرصة المناسبة	0	1	2	3
11	القيام بالأعمال بطريقة معينة	0	1	2	3
12	السعي للمثالية	0	1	2	3
13	تشعر بالحاجة على أن تسيطر على الأمور	0	1	2	3
14	صعوبة التوقف بالتنقيق أو تكرار الأمور	0	1	2	3
15	الشعور بالتقلب والدهجة	0	1	2	3
16	مخاوف بشأن أفكار متكررة	0	1	2	3
17	الشعور بالحرص والحذر حيال الأمور	0	1	2	3
18	الإستياء من التكريرات والكوابيس المتكررة	0	1	2	3
19	القلق حول احراج نفسك أمام الآخرين	0	1	2	3
20	الخوف من انتقادات الآخرين السلبية	0	1	2	3
21	الشعور بعدم الاستقرار بين الحشود	0	1	2	3
22	تجنب الأنشطة الاجتماعية بسبب الشعور بالقلق	0	1	2	3
23	تجنب الأمور المسببة للقلق	0	1	2	3
24	تشعرين بالانفصال الذاتي (كأن تربت نفسك في فلم)	0	1	2	3
25	فقدان المسار من الوقت وعدم تذكر ما يحصل	0	1	2	3
26	صعوبة التأقلم مع الأشياء	0	1	2	3
27	الشعور بالقلق حول القدرة بقيام الأعمال	0	1	2	3
28	صعوبة التركيز بسبب تسابق الأفكار	0	1	2	3
29	الخوف من فقدان السيطرة	0	1	2	3
30	الشعور بالذعر	0	1	2	3
31	الشعور بالهيجان	0	1	2	3
	المجموع الاجمالي				

Appendix C – Screening Tools for OCD

Yale-Brown Obsessive Compulsive Scale (Y-BOCS)

اسم المريض: رقم الملف: التاريخ:

رجاءً .. ضع علامة (✓) على يمين الجملة التي توضح معدل حدوث كل بند خلال السبعة أيام الماضية بما فيها وقت هذه الجلسة.

١ - مقدار الوقت الذي تستغرقه الأفكار الوسواسية

٠	لا شيء	<input type="checkbox"/>
١	أقل من ساعة في اليوم ، أو تتكرر أحيانا (بمعدل ٨ مرات فأقل يوميا)	<input type="checkbox"/>
٢	من ساعة إلى ٢ ساعات في اليوم ، أو تتكرر كثيرا (أكثر من ٨ مرات في اليوم لكن معظم ساعات اليوم خالية من الأفكار الوسواسية).	<input type="checkbox"/>
٣	من ٢ إلى ٨ ساعات في اليوم ، أو تحدث كثيرا جدا (تحدث أكثر من ٨ مرات في اليوم وفي معظم ساعات اليوم)	<input type="checkbox"/>
٤	أكثر من ٨ ساعات في اليوم ، أو تحدث بشكل دائم (أكثر من تحملها ونادرا ما ماتم ساعة بدون وساوس كثيرة)	<input type="checkbox"/>

٢ - مقدار التعارض الذي تحدثه الأفكار الوسواسية مع نشاطاتك الاجتماعية والعملية.

٠	لا يوجد	<input type="checkbox"/>
١	تعارض خفيف مع النشاطات الاجتماعية أو العملية ولكن النشاط العام لا يتأثر.	<input type="checkbox"/>
٢	تعارض واضح في النشاطات الاجتماعية أو العملية ولكن يمكن السيطرة عليه.	<input type="checkbox"/>
٣	تسبب خللا كبيرا في أداء النشاطات الاجتماعية أو العملية.	<input type="checkbox"/>
٤	تسبب خللا بليغا.	<input type="checkbox"/>

٣ - مقدار التوتر والقلق المصاحب للأفكار الوسواسية.

٠	لا يوجد	<input type="checkbox"/>
١	خفيف (أحيانا) ، ليس مزعجا.	<input type="checkbox"/>
٢	متوسط (غاليا) ومزعجا ولكن يمكن السيطرة عليه.	<input type="checkbox"/>
٣	شديد (أغلب الوقت) ومزعج جدا .	<input type="checkbox"/>
٤	توتر بليغ (دائم) لحد الإعاقة تقريبا .	<input type="checkbox"/>

٤ - مقدار الجهد الذي المبدول في مقاومة الأفكار الوسواسية (بغض النظر عن نجاحك في المقاومة).

٠	لا أبذل جهدا حتى أقوم دائما (أو أن الأفكار قليلة جدا بحيث لا حاجة للمقاومة).	<input type="checkbox"/>
١	أحاول أن أقوم معظم الوقت.	<input type="checkbox"/>
٢	أبذل بعض الجهد حتى أقوم.	<input type="checkbox"/>
٣	أستسلم لكل الأفكار الوسواسية بدون محاولة للسيطرة عليها، وإن حاولت السيطرة فيكون بعد تردد.	<input type="checkbox"/>
٤	أستسلم كلية وبارأني للأفكار الوسواسية كلها.	<input type="checkbox"/>

٥ - مقدار سيطرتك على الأفكار الوسواسية

٠	سيطرة تامة.	<input type="checkbox"/>
١	سيطرة كبيرة، عادة يمكنني أن أوقف أو أصرف انتباهي عن الوسواس عند بذل بعض الجهد والتركيز.	<input type="checkbox"/>
٢	سيطرة متوسطة، بعض الأحيان أستطيع إيقاف أو صرف انتباهي عن الوسواس.	<input type="checkbox"/>
٣	سيطرة قليلة، نادرا ما أُنجح في إيقاف الوسواس، أستطيع فقط صرف الانتباه وبصعوبة.	<input type="checkbox"/>
٤	لا سيطرة ، نادرا ما أستطيع صرف الانتباه عن الوسواس ولو للحظات قليلة.	<input type="checkbox"/>

مجموع الدرجات = ()

٦- مقدار الوقت الذي تمضيه في القيام بالأفعال القهرية

٠	لا شيء	<input type="checkbox"/>
١	أقل من ساعة في اليوم ، أو تقوم بالأفعال أحيانا (لا تزيد عن ٨ مرات في اليوم)	<input type="checkbox"/>
٢	من ساعة إلى ثلاث ساعات في اليوم، أو تقوم بالأفعال كثيرا (أكثر من ٨ مرات في اليوم ولكن معظم الساعات تخلو من الأفعال القهرية)	<input type="checkbox"/>
٣	أكثر من ثلاث ساعات في اليوم ، أو تقوم بالأفعال كثيرا جدا (أكثر من ٨ مرات في اليوم وخلال معظم ساعات اليوم) .	<input type="checkbox"/>
٤	أكثر من ٨ ساعات في اليوم أو تقوم بالأفعال بشكل دائم (أكثر من أن تحصيها ونلرا ماتمر ساعة لا تقوم فيها بالأفعال)	<input type="checkbox"/>

٧- مقدار التعارض الذي تحدثه الأفعال القهرية في نشاطاتك الاجتماعية والعملية

٠	لا يوجد	<input type="checkbox"/>
١	تعارض خفيف مع النشاطات الاجتماعية أو العملية ، ولكن النشاط العام لا يتأثر	<input type="checkbox"/>
٢	تعارض واضح مع النشاطات الاجتماعية أو العملية ولكن يمكن السيطرة عليه	<input type="checkbox"/>
٣	تسبب خلاا كبيرا في أداء النشاطات الاجتماعية أو العملية	<input type="checkbox"/>
٤	تسبب عجزا كبيرا	<input type="checkbox"/>

٨- مقدار التوتر والقلق الناتج في حال الامتناع عن القيام بالأفعال القهرية

٠	لا يوجد	<input type="checkbox"/>
١	قلق بسيط عند الامتناع عن القيام بالأفعال .	<input type="checkbox"/>
٢	يظهر القلق لكن يمكن تحمله.	<input type="checkbox"/>
٣	قلق واضح ومزعج للغاية.	<input type="checkbox"/>
٤	قلق شديد يسبب عجزا بليغا.	<input type="checkbox"/>

٩- مقدار الجهد المبدول في مقاومة الأفعال القهرية (بغض النظر عن مدى نجاحك في المقاومة)

٠	أبذل جهدا حتى أقوم دائما (أو أن الأفعال القهرية قليلة بحيث لا حاجة للمقاومة)	<input type="checkbox"/>
١	أحاول أن أقوم معظم الوقت	<input type="checkbox"/>
٢	أعمل بعض المحاولات للمقاومة.	<input type="checkbox"/>
٣	استسلم لكل الأفعال القهرية بدون محاولة للسيطرة عليها ، وإن حاولت السيطرة فيكون بعد تردد.	<input type="checkbox"/>
٤	أستسلم كلية وبإرادي لكل الأفعال القهرية.	<input type="checkbox"/>

١٠- مقدار سيطرتك على الأفعال القهرية

٠	سيطرة تامة.	<input type="checkbox"/>
١	عادة ما أوقف الأفعال القهرية بصعوبة	<input type="checkbox"/>
٢	أحيانا أستطيع إيقاف الأفعال القهرية بصعوبة.	<input type="checkbox"/>
٣	أستطيع بصعوبة أن أؤخر - فقط - الأفعال القهرية لكن يجب على القيام بها حتى النهاية.	<input type="checkbox"/>
٤	نلرا ما أستطيع أن أؤخر القيام بالأفعال القهرية ولو للحظات.	<input type="checkbox"/>

مجموع الدرجات = ()

مجموع الدرجات الكلي = ()

التصحيح

ماذا يعني تقييمك في مقياس بيل - براون للوسواس القهري:

المعدل في مقياس بيل - براون للوسواس القهري	شدة اضطراب الوسواس القهري
صفر - ٧	خفيف جدا
٨ - ١٥	خفيف
١٦ - ٢٣	متوسط
٢٤ - ٣١	ملحوظ
٣٢ - ٤٠	شديد

صفر - ٧: أعراض وسواس قهري خفيفة جدا. في الغالب لا تحتاج إلى العلاج إلا إذا كان معدلا قليلا لأنك تتجنب مواقف كثيرة أو لديك أفعال قهرية فقط أو وسواس فقط.

٨ - ١٥: أعراض خفيفة والتي من المحتمل أن تتعارض في حياتك بطرق ملحوظة. (إذا كان لديك وسواس أو أفكار فهذا يعني شدة متوسطة)

١٦ - ٢٣: أعراض متوسطة ، إحراز ١٦ نقطة هو الحد الأدنى المطلوب لدخول دراسات علاج اضطراب الوسواس القهري.

٢٤ - ٣١ : أعراض ملحوظة والتي من المحتمل أن تقسد نوعية حياتك بصورة كبيرة.

٣٢ - ٤٠ : أعراض شديدة والتي من المحتمل أن تسبب عجزا بالغا. قد تحتاج إلى علاج يقوم به اختصاصي في اضطراب الوسواس القهري.

Appendix D – National resources

- 1. National Lifeline “1564”:** a hotline for emotional support and suicide prevention.
- 2. Community Mental Health Centers:** available in different geographical areas in Lebanon. These can be identified by using the 4Ws (Who is Doing, What, Where and until When) Online mapping Platform of mental health and psychosocial support services for Lebanon: <https://app.moph.gov.lb/4ws/> or by calling the National Lifeline to be oriented to nearest services.
- 3. Step by Step” online intervention:** e-guided self-help intervention for adults with depression. Can be accessed through:
 - Mobile application, downloaded on:
Apple store: [Step-by-Step on the App Store](#)
Playstore: [Step-by-Step - Apps on Google Play](#)
 - Website: <https://khoutouwat.com>

Appendix E – Self-care tips

Taking care of your mental health is just as important as taking care of your physical health. Self-care activities can vary from one individual to the other, they are not an emergency response plan, and should not be activated only when stress becomes overwhelming. Instead, working on self-care plans early on will help you avoid reaching various psychosocial adversities.

Tools of self-care are available to help you take care of your physical, psychological, professional, and spiritual health.

Tips for self-care on a physiological level

- Try to take time to eat, rest, and relax even for short periods of time.
- Engage in a healthy and moderate diet and eat from all food groups.
- Be active, and have regular physical activity (unless otherwise recommended by your health care provider).
- Engage in a regular and healthy sleep pattern.
- Practice breathing techniques.

Tips for improving sleep hygiene

Sleep hygiene refers to appropriate sleeping habits. Some techniques are:

- Have a bedtime routine. Have a fixed schedule and specific bedtime habits such as going to bed when you are tired and using the bed for only for sleeping (and not for watching television, reading, or eating), as well as always getting up at the same time in the morning.
- Reduce environmental noise:
 - Ensuring that the bedroom is quiet, relaxing, dark, and of comfortable temperature.
 - Removing electronic devices (i.e. televisions, computers, tablets, smartphones, etc.) from the bedroom.
 - Not using electronic devices before sleeping.
- Avoid large, heavy meals, spicy food, drinking alcohol, coffee, or tea and other stimulants as well as nicotine before bedtime.
- Try to engage in regular exercise. Being more physically active during the day helps you sleep better at night.

Tips for practicing a breathing exercise

When we feel stressed or anxious, our heart begins to beat faster, and our breathing often quickens and shortens. While this is helpful when we want to respond to a physical threat, it can also lead to headaches, chest pain, and feelings of tiredness, dizziness, and other uncomfortable feelings.

Slow breathing is a technique used to relax and manage some symptoms of stress and anxiety. By slowing the rate of our breathing and taking breaths from our stomach instead of our chest,

we send a message to our brain that we are relaxed and calm. The brain then communicates this message to the rest of our body, and we feel relaxed. Let's try this together!

1. Try to find a quiet place. If there isn't, ask your family to give that time and place. It's okay to request time for yourself throughout the day. "Me time" is important for wellbeing.
2. Get in a comfortable position. You can lie on your back in bed or on your mattress, sit in a chair with your shoulders, neck, and head supported against the back of the chair.
3. Shake out your arms and legs and let them go loose. Roll your shoulders back and gently move your head from side to side.
4. Close your eyes and put one hand on your belly just below your ribs and the other hand on your chest.
5. Breathe in through your nose for 3 seconds. As you breathe in, imagine that there is a balloon in your belly you are trying to inflate. Notice how your belly is rising and pushing your hand out. Your chest should not move.
6. Breathe out through your lips for 3 seconds as if you were whistling. As you breathe out, feel your belly lower. Imagine that you are blowing out all your stress and anxiety.
7. Repeat for 5 to 10 times.
8. Great! Notice how you feel at the end of the exercise.

Tips for self-care on a professional level

- If you are working from home, create for yourself a separate "office-like" space, if possible.
- Practice time management. Keep reasonable working hours and a balanced workload.
- Take breaks.
- Try to move away from your workstation and engage in simple stretching exercises for your neck, back, shoulders, arms, and legs.
- Talk to a colleague or a supervisor about challenges you are facing at work. You may find that your colleagues may be facing similar challenges and you can figure out ways to better support each other.
- Separate between professional and personal boundaries.
- If applicable to your organization, access your formal staff care system and encourage peers to access it as well.

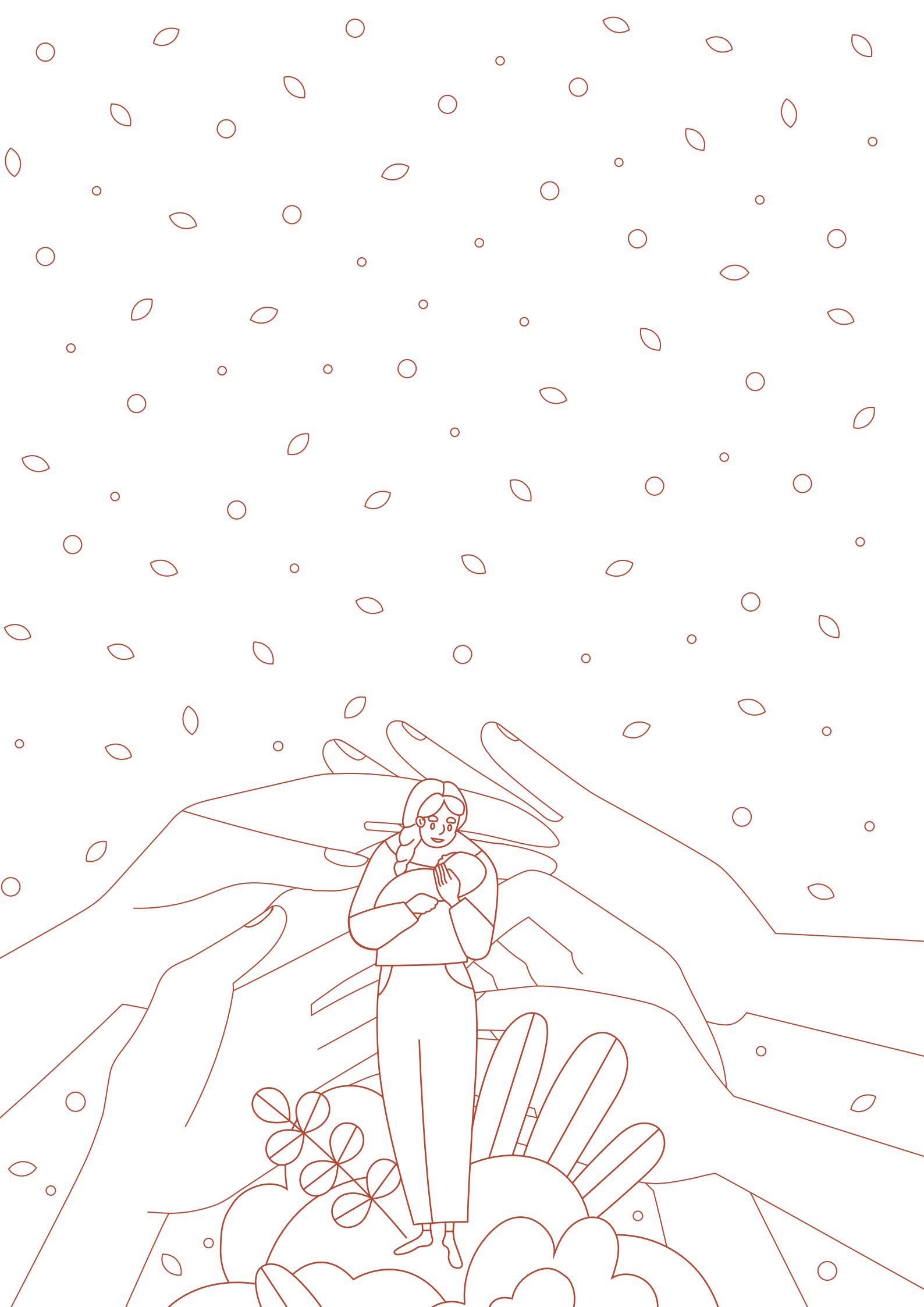
Tips for self-care on a psychological level

- Remember that your feelings are normal responses to events.
- Reflect on what has helped you cope in the past.
- Talk to yourself in a friendly way, just as you would to a friend in distress.
- Talk with friends, loved ones or other people you trust for support.
- Try to dedicate some time of your day to things that you enjoy (i.e., drawing, playing/ listening to music, going for a walk, etc.).
- Try to practice mindfulness exercises to help yourself relax.
- Ask for help. Do not wait until you reach a breaking point before reaching out for support.

Tips for self-care on a spiritual level

- Remember that happiness is not the only measure of wellbeing.
- The key is to identify what you care about most in life; the everyday stressors start to pale in comparison.





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<https://www.moph.gov.lb/en/Pages/6/553/nmhp>