Helping parents with perinatal mental health

Welcome to the September 2016 issue of *Perspective*. Our main theme is the mental health of mothers and their partners.

It’s quite staggering to know that up to one in five new mothers experience mental health issues. These can range from ‘mild’ forms of stress and anxiety to more severe conditions such as post-traumatic stress disorder, postnatal depression and puerperal psychosis. Mothers and their partners may be reluctant to talk about their mental health problems, owing to stigma and fear that their baby will be taken away if the problem is disclosed.

For practitioners there has never been a better opportunity to find new ways to support parents in their mental health, and eliminate the stigma around mental illness. As the NCT’s new *Parents in Mind* training programme gets underway for volunteer peer supporters, we hear from practitioners of different specialisms about supporting mothers with mental health issues, and the work of Maternity Services Liaison Committees towards establishing local perinatal mental health and care pathways. We also highlight new research on diagnostic tools for health disorders, a new intervention for mothers with anxiety during pregnancy, and useful resources for practitioners. Good news too from NCT senior policy advisor Elizabeth Duff, that the recommendations from the Maternity Review in England are being implemented, bringing hope of a real difference to women’s experiences up to the birth of their baby.

And don’t forget the *NCT Big Push* campaign!

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Next issue: Infant Feeding - December 2016
Elizabeth Duff tells Julie Clayton how her concerns for maternal and child health led to her position as senior policy advisor at NCT, and an influential role on the National Maternity Review team

How did you become involved with NCT?

I did NCT antenatal classes when I was expecting my first baby, over 30 years ago. I remember I had to look NCT up in a telephone directory and call from a landline! Later, at an NCT coffee morning I was asked if I might be willing to run a postnatal group. I thought, you must be joking, this baby takes up at least 24 hours a day! But another mum and I ran a postnatal group, getting together every week for coffee or in the playground. Some of those friendships have gone on for years.

I had previously worked in publishing, so helped to edit the local NCT branch newsletter, before returning to paid work as assistant editor on the Royal College of Midwives journal. I was then nominated by NCT to join the local community health council and was on the local MSLC, so my voluntary work moved to representation. The whole idea of health policy began to take shape and the fact I was working on a midwifery journal integrated and complemented the work I was doing on women’s health generally.

I later worked for the International Confederation of Midwives editing a news journal and travelled a lot, which really opened my eyes to what was happening elsewhere in the world. I became more interested in maternal and child health and policy, and eventually took the job of senior policy advisor at NCT in 2009.
What is your role in the NCT policy team?

Rosie Dodds and I form a small policy team. It’s a fascinating job: much is advocacy – representing the charity, speaking at conferences, taking part in review teams or task forces in all four countries of the UK, from the NHS, the royal colleges involved in women and child health, and other partner charities such as Maternity Action and Working Families. We cover issues such as maternity benefits, shared parental leave, discrimination against women through pregnancy and maternity in the workplace as well as support and wellbeing around childbirth.

Rosie is especially good on all aspects of nutrition in pregnancy and afterwards, and infant feeding. She also covers care of young babies, including sleeping, swaddling, crying, colic, teething, bathing babies, transporting babies, ensuring that NCT provides information and evidence.

My remit is more about the maternity services and the family services postnatally. So I link with midwives and health visitors; I look at evidence and health policy around the UK. I think NCT is positioned in such a useful way because we look at the first 1000 days. We look at that whole process, not as a seamless experience, because the birth is always going to be the big key change in the middle, but trying to help parents understand how the first 1000 days integrates into the rest of their lives. The learning in our antenatal classes is not just about the birth, it’s about parenthood too. The NCT ethos of signposting women to information, helping them to understand evidence, supporting them through decision making, is preparation for life, and not just parenthood. Ideally, moving from being a couple to a family should be a huge horizon-broadening experience.

We are also concerned with trying to improve perinatal mental health services and treatment. There’s huge scope for helping people with mild depression or anxiety or those who have been quite ill and are getting better but are feeling anxious or upset that they have missed out. We encourage parents to take part in local activities and join networks, enabling them to stop that pressure of guilt – ‘I’m not the perfect mummy’ – that we all struggle with.

This lays the foundations for how you can approach other situations. Right through the 1000 days period NCT has a big role in helping parents to understand what is happening to them and give them that strength and knowledge and network to do things for themselves, empowering and increasing their confidence and self-efficacy.

NCT has been quite under fire sometimes, supposedly for making people feel guilty because they didn’t have a normal birth, didn’t breastfeed, or had pain relief. This is a perception and clearly not something we set out to do. But if you can talk to someone who is in that situation about the decisions they made and their reasons, 99% of parents will always say they made the best decision at the time with the knowledge they had, with the best of intentions.

You might look back and think, ‘I wish I’d done something else’, but you can’t turn the clock back. So the other option is to look forward and say, ‘I won’t make the same mistake again, I’ll find other information and talk to other people, and then make a decision and move forwards. Goodness, there are an awful lot of years ahead to be the parent you want to be. And perfect doesn’t exist.
You have played a key part in the National Maternity Review in England¹ – which aspects stand out most for you personally?

It was a fascinating experience. It looked comprehensively at every aspect of maternity. I particularly wanted to push for how maternity services could be improved to lessen the impact of social inequalities; the way women are cared for when they have a baby can improve their knowledge and networks and confidence in a way that might help them in future, particularly those from low income backgrounds.

There’s also a strong emphasis on continuity of carer – the ability of a woman to meet and form a relationship, usually with a midwife, but sometimes with a doctor if the woman has a particular medical condition. Holistic care with a midwife improves outcomes including reducing preterm birth, which can be a risk and can be so distressing for families. Sadly, more preterm babies die neonatally than babies born at term, or they require a lot of extra help. But if a woman can form that relationship with her carer, it really improves outcomes and reduces the costs of neonatal intensive care. Every woman would prefer to have a midwife that she knows and trusts. It also helps with things like smoking cessation, and reduction of alcohol consumption. But if women who are smoking or drinking get fragmented care and see different midwives, they’re not going to tell each one how bad they feel about smoking or drinking, and how difficult it is to stop. But if they talk to one person who knows and understands, and is trained to use interventions that are sympathetic and supportive, and who is available at follow up visits, it’s such a better experience. And for women in other difficult situations, such as violence in their families, or mental health disorders, it’s terribly difficult to disclose even once. It is not rocket science to understand how much better it is for a woman to see the same midwife but it is apparently rocket science to put continuity of carer in place. I don’t think we could ever have a system where you can say you can always have the same midwife, but you can reduce the number of people she may see and try and make sure she has met the midwife she will see in labour.

How does the Maternity Review link to perinatal mental health?

Fortunately there’s a lot of work already going on in perinatal mental health, coordinated by the Maternal Mental Health Alliance, of which NCT is part, and I think the Maternity Review recommendations will further fuel that work. NCT is involved in perinatal mental health in various ways, for example training peer support volunteers around mental health and further training for our practitioners, as well as community events like The Big Push at NCT branches. It’s been a very fast pace of change in the last four or five years. It’s so awful that quite a large proportion of maternal deaths are in women with serious depression who unfortunately take their own lives in the perinatal period, but are treatable.
NCT and many other charities are active in this area and statutory services are catching up. We really hope to see achievements there.

Elizabeth Duff reviews the highlights and historical context of the National Maternity Review: Better Births report in the September 2016 issue of MIDIRS Digest.²

References


Introducing parents to attachment theory

Comforting a crying baby or giving in to demand? Some parents may be confused about Attachment Theory-based ideas, but attending to babies’ emotions can help them to feel safe and secure, and will help establish the foundations on which babies will thrive.

By Helen Hans, NCT Antenatal teacher

It’s hard to remember exactly how it feels when you have a baby and the day-to-day challenges of being a new parent. It’s even harder to put these feelings into words. What if your baby cries a lot? How does that make you feel? Does it knock your self-confidence? If it’s hard to explain how we as adults feel, how much harder is it to explain how a baby feels, or how he begins to understand his place in the world and relationships with other people?

I began my NCT career as an antenatal teacher, driven by a passion for birth, which came from my own positive first birth experience. I put this down in no small part to the education I received from my NCT teacher, Sue Dunkley. A few years later, it seemed to me that there were lots of opportunities for
exploring and preparing for birth, but far fewer for considering parenthood and its impact. I wanted to offer support to parents in the early postnatal period, as they struggled with assuming a new identity, relinquishing some of what they had and were before, and working out how to raise their family. My subsequent training as a postnatal leader led to me to a radical re-think of my antenatal sessions, in particular how I supported expectant parents to think about the impending psychological changes for them and their developing baby.

The cross party manifesto, *1001 critical days*, recognises that what happens from conception till the age of two has a lifelong effect on health, life chances and mental wellbeing. And reports such as those by Field and Allen, as well as my own reading, increased the urgency I felt about informing parents about the significance of the first three years of life through Attachment Theory, Theory of Mind and baby brain development. But as an NCT practitioner, how could I pass on this information without making parents simply feel terrible or making myself sound evangelical? The concepts are complicated and difficult to convey without making people feel criticised or more anxious – the last things new parents need!

What follows is my approach to teaching parents about Attachment Theory – and some of the difficulties I have experienced along the way.

**What is Attachment Theory?**

Attachment Theory was first proposed by John Bowlby, whose work demonstrated the importance of children’s earliest relationships. He saw children’s first experiences of relationships as setting an internal working model — a blueprint — for how relationships work and what to expect from them. As infants live these early experiences, they register a sense of how they are perceived in that particular relationship and begin to behave accordingly. Bowlby saw this partly as a survival strategy, a way of ensuring proximity with caregivers, and also was aware of its long-term impact on a person’s behaviour. He strongly believed that a disruption in the relationship between a child and his mother could lead to emotional difficulties and antisocial behaviour. If an infant feels unloved by his primary caregiver, he may come to feel unlovable and behave with others in a way that anticipates the same response from them.

As with any theory, ideas about Attachment Theory have grown and developed. In the ’60s and ’70s, Mary Ainsworth expanded upon Bowlby’s initial concepts, and formulated three categories of attachment; Mary Main later added a fourth. Of these four, only one is designated ‘secure.’ (It is worth remembering that being insecurely attached does not necessarily mean that a person is unable to function in society, although it may mean that their relationships are less rewarding). Since Bowlby, it has been shown that a child can develop more than one attachment style, for example, one with his mother and different ones with his father and/or other caregivers. I am sure that the idea of behaving differently with different people is familiar to most of us.

**Consequences of insecure attachment**

As mentioned above, being insecurely attached does not mean being unable to function in society or lead a normal and fulfilling life. However, it may present other challenges, such as experiencing more anxiety and finding everyday situations more difficult. Those who are insecurely attached may
be more vulnerable to peer pressure, self-doubt and depression. In romantic relationships, an insecurely attached person may be more clingy or need more reassurance than a securely attached person. Some psychotherapists argue that insecurely attached children will externalise their anxiety and display difficult behaviours, subsequently labelled as ADD or ADHD. Those whose parents’ behaviour was the most erratic and unreliable are likely to be the most severely affected.

**Benefits of secure attachment**

A child who has a secure attachment (or multiple secure attachments), has a secure base from which to learn. A secure attachment bond ensures that a child will feel secure, understood, and be calm enough to experience optimal development of his or her nervous system. Secure attachment provides a child with the best foundation for life: a feeling of safety that results in eagerness to learn, healthy self-awareness, trust, and empathy.

With regard to brain development, more research is needed to understand exactly how early experiences affect this. But there is a lot of support for the idea that positive interactions with caregivers will promote healthy emotional and cognitive development, with lasting effects on a child’s sense of security and confidence.

**Meeting resistance from new parents**

I have felt compelled to share this knowledge with the couples in my NCT groups, given its enormous implications for their child’s emotional wellbeing. It feels hard at times to remain non-judgemental and neutral as I would like parents to embrace it wholeheartedly. Unfortunately, much of what the theory suggests feels counter-intuitive, especially to someone who hasn’t yet had a baby or experienced the emotions of being a parent. And so I have often encountered resistance to these ideas.

Many commonly held ideas about babies, reinforced by populist literature and television programmes, contradict Attachment Theory. For example, ‘he’ll learn that, if he wants something, all he has to do is cry and you’ll come running’. As a practitioner, I have heard such truisms hundreds of times. It may be unsettling for clients to hear that responding consistently to a very young baby – picking him up when he cries – will probably result in a more independent, adventurous and self-reliant child. How can we, as NCT facilitators, encourage our clients to explore such ideas and begin to integrate them into their way of thinking without burdening them with more guilt? Becoming a parent for the first time is wonderful and terrifying, probably in equal measures. We must guard against adding to these fears.

**Challenging parents to think about parenting**

For many years, I have introduced a range of ideas about parenting to my antenatal groups, asking them to consider the advantages and disadvantages of different approaches for parents and baby. We discuss their response to the ideas, mostly arriving at the conclusion that there is no magical solution which works for all parents. Recently, one father grumbled that he had been certain how he would approach parenting prior to the session and now he was confused. He thought he had made up his mind and now I had put the cat among the pigeons. I felt quietly pleased to have challenged his thinking.
broadening his horizons. This father is not alone in his feelings of confusion following this particular session, and that is the challenge facing practitioners: to increase our clients’ understanding of babies’ development without fuelling anxiety.

**The baby’s point of view**

I believe it is important to emphasise that parents do not have to be perfect. Indeed, some would argue that being perfect is detrimental to the developing infant’s mental and emotional health: the baby needs to struggle a little, but with the support of his parents. I suggest to clients that perhaps the greatest responsibility they have is to help their baby regulate his/her emotions. One example might be a door slamming. As adults, we have learnt that a door might bang shut for many reasons and so we can use logic to calm ourselves after hearing an unexpected loud noise. The baby, on the other hand, has not learnt this yet, but will, with repeated reassurances that he ‘…needn’t worry about that noise – that was just the wind blowing the door shut. Everything’s alright.’ These simple steps can help an infant develop the sense of his parent/s as the secure base and safe haven that Bowlby described, from which he can explore but also return to when he needs comforting.

I try to present the world from the baby’s point of view where possible, to speak on his behalf; for example, by asking the group whether there is anything in the baby’s experience that remains unchanged at birth. Clients quickly conclude that nothing remains the same except their presence. This allows me to reframe the first few months of the baby’s life as a time when he ‘unlearns’ what he has known and begins to learn how the world works now. I hope that my demonstrating the stark contrast between the only sleeping position the baby has known before birth and the one we expect him to assume immediately after birth will stick with them. I daresay they retain an odd image of me adopting the two positions myself! However, I hope that it serves to moderate their expectations of their newborn and helps them to understand why their newborn prefers their chest to the Moses basket.

Discussion about sleep during Early Days sessions is an opportunity for promoting Attachment Theory, albeit subtly. Parents often forget – or find it hard to imagine – that babies need to be calm in order to fall asleep. What if a baby is anxious? By linking to their adult experiences, new parents can begin to relate to their baby’s feelings. If they were worried about something, their sleep may be disturbed and it can be the same for babies. Repeated, soothing experiences before bedtime help the baby recognise what is coming next and consequently feel more relaxed.

**Parents want what’s best for their baby**

My training and work as a Parent-Infant Psychotherapist have deepened my understanding of Attachment Theory and all its complexity, as well as the impact of insecure attachments on infants. I see the effects of this on a daily basis. However, it is important to remember two things: i) the vast majority of parents want to do the very best for their children, which is a positive starting point; ii) early intervention can help change the situation for the child. Even in later life, attachment status can be altered with the support of a caring individual who demonstrates that relationships can be a source of pleasure and comfort.
The cross-party manifesto, The 1001 Critical Days\(^1\) to which the NCT has pledged its support, stresses the importance of practitioners who work with parents having a good understanding of infant mental health and attachment. The NCT is fantastically well placed to introduce parents to Attachment Theory, but there is so much room for misunderstanding! Rather than try to teach it as a discrete subject, we can model the approach instead. Babies do experience emotions and these need to be attended to as much as their physical needs; something which is often unclear to new parents. But we don’t need to be perfect every time!\(^1\)! Simply introducing these ideas and threading them through all our work – both antenatally and postnatally – helps to sow and nurture the seeds of understanding in parents’ minds.

**Practice points:**

- Attachment Theory is complex, so messages need to be clear and concise.
- Parents don’t need to be perfect! We all make mistakes, but being willing to stay with the infant’s emotion and help him/her with it is what counts. Knowing that other people care about your feelings but don’t necessarily share them is a very important life lesson!
- Arguably the central message from Attachment Theory is that helping their child to regulate his emotions is the most valuable thing parents can do for him. This is not always easy, but it is a vital part of healthy infant development.

**References**

NCT practitioners: from strength-to-strength on perinatal mental health

As NCT embarks on perinatal mental health training, we ask practitioners from different specialisms to share their experiences of supporting mums through anxiety and depression, and see how one mum is actively helping others

Antenatal practitioner: anonymous

I remember vividly the first time a pregnant woman on a course asked me if having previously had depression meant that someone would be more likely to get postnatal depression. Looking at her face and body language, I knew why she was asking. Depression is part of my life experience, and that of many people I know. The approach of NCT practitioners is to be aware; be quietly alert; know the limits of our role.

We accept responsibility for raising points about emotional and mental wellbeing, and weaving these throughout our courses. When I have needed support for a woman with puerperal psychosis and her partner, and advice for myself, the NCTP network and many other colleagues have responded within 24 hours. This has happened more than once. Initially the women’s partners have been glad to talk to others who have had the same experience. In the longer term, I have maintained email contact.
Offering to have coffee with someone is, I hope, a powerful message, that illness is simply that – illness. But any support that I have been able to give is nothing compared to that of other parents in antenatal groups. In my experience, people offer the non-intrusive support that we have explored antenatally: deliver cooked meals; mind the baby for a while; offer the level of social contact that is wanted and manageable; love, and refuse to judge. I have found it difficult to write about this. Even anonymised, it seems like sharing too much that is personal to clients. It is at the core of my practice to be aware of mental health and emotional wellbeing. We know that for some clients in the group there is bound to be much more going on than one is typically aware of. If I were the first person a client had approached for help, I would refer them on for other appropriate support – whether from midwife, GP, health visitor, or another person or organisation. I try to be observant, consciously compassionate, and available within appropriate limits.

**Breastfeeding counsellor: Sophie Macfadyen**

NCT breastfeeding counsellors are trained in person-centred listening and counseling skills, so in many ways we are approaching the mother with an open agenda. Every mother and her situation will be different, and our conversation will follow the route that she wishes to pursue.

Mothers approach us with something that they want help with. Embedded within a breastfeeding issue we may encounter any of an entire spectrum of mental health issues in the early postnatal period, from anxiety and baby blues through all the different types of perinatal mental health issues up to people needing hospitalization and so on. Because we work with women in a therapeutic way we are likely to uncover things that they won’t necessarily have shared before. It’s far from unusual to hear about something else besides breastfeeding.

Mothers are very likely to talk to us about coping, expectations, issues like sleep and relationships, and their feelings. Rather than asking questions we reflect back what the person is saying, giving them the space in which to explore their issues. We do not have an agenda for that mother, it’s her agenda and it’s got to explore what she wants to do. We are working to enable mothers (and sometimes fathers and other family members) to find what they want to do in their situation, and find constructive ways to move forwards.

With the NCT breastfeeding line we often listen once to a mother. She may call to discuss a specific problem but we often find that underlying issues are also explored. We have the luxury of being able to devote a lot more time than say a health professional, which allows us to really explore different aspects of what’s going on, if she wishes to do so. At the end of the call we may also provide a direct number for contacting us again individually. Women who attend our antenatal breastfeeding sessions will also have our contact numbers. And many breastfeeding counsellors attend local drop-in sessions, where they can see mothers repeatedly over a prolonged period.

Antenatal teachers and postnatal leaders are also likely to pick up on underlying mental health issues, including a heightened anxiety leading up to the birth or during early parenting. When we encounter women with heightened anxiety and isolation we can signpost to local groups and networks, which can be a huge source of help. If a mother seems very worried
then just by being very open with her we may hear that she is talking to the health visitor about it or receiving some other form of care and statutory support. We can offer additional support alongside this, mainly by listening and signposting. But we sometimes need to be a bit more proactive in signposting the mother to links into the local healthcare systems for better support.

It’s also important not to underestimate the volunteer network within NCT. Many of our groups have a person keeping an eye on everyone in the group, introducing them to others and making sure they feel welcome and included. Women say it’s an absolute lifesaver. The feedback is that it keeps them going; informal coffee groups are keeping many women sane. I went to a coffee group 26 years ago and the women I met there are still among my closest friends. We kept each other going in the early years and later as our children became teenagers and are now going through university!

We need to stress the importance of networks and informal support as well as more in-depth work. NCT is in a good position to give a lot of support in the low-intervention (milder) end of the mental health spectrum. Everybody has experienced feeling really wobbly and that they can’t cope, and they’ve struggled at some point. I definitely think it’s a sliding scale. Everybody is on the same scale and some people are at the extreme end. A lot depends on underlying mental health issues and personal circumstances and levels of support.

We also need to be on the lookout for women who have complex mental health issues so that we can offer support alongside the care that they receive within the NHS.

Anna Hammond: NCT postnatal practitioner

In my role as a postnatal practitioner, I have supported hundreds of women experiencing the normal ups and downs of life with a new baby. Many women experience what Donald Winnicott described as primary maternal preoccupation which ‘in any other circumstances might seem almost an illness, but in the parent of a young baby is just what is required’.1 This overwhelming responsibility that a new mother may feel, not only focuses her attention on the actual survival of her baby but also his thriving. Although the baby will thrive cognitively, emotionally and physically with ‘normal everyday parenting’ the new mother may feel pressured to be a ‘supermum’. Many women feel vulnerable at this time, which in more primitive times would have been an important survival function. Nowadays this may be experienced as greater than normal anxiety,2 which can often be exacerbated by fatigue, pain and hormonal swings.

I use my knowledge of postnatal mental health to support my practice, providing an environment for women to explore self-help strategies. I use an approach that normalises feelings, and accepts rather than shames, which can help women to feel less angry with themselves and more willing to allow themselves to heal emotionally and physically.

Building resilience in new mothers is essential for their mental health. I focus on encouraging women to understand their experiences in a wider context, to maintain perspective and to be positive and hopeful. I focus on exploring strategies for them to build strong loving relationships with their partner...
(if they have one), as well as with their families, friends and communities, recognising how and when to ask for help and acknowledging its value. By using a simple ‘What, so what, now what’ reflective tool, they can build their emotional intelligence and improve resilience. Where appropriate, NCT postnatal groups provide opportunities to focus on solutions. I provide an environment in which mothers explore how to nurture themselves and be nurtured by others. I discuss the importance of eating well with a balanced nutritious diet, including foods rich in omega 3 fatty acids (such as salmon and mackerel), which may reduce a systemic inflammatory response (thought to be linked to postnatal depression) and improve mental health.3

I discuss the importance of exercise, of spending time in the fresh air, and making use of relaxation techniques and taking opportunities to rest. Some women disclose mental health difficulties to me in private, some share them with the group and some not at all. But the principles of support that a postnatal leader provides are consistent. Mental illness can manifest as anxiety, depression or obsessive behavior, and the NHS recommends three strands of treatment: self-help strategies, talking therapy and medication. It is important to ensure that women know about locally available options and are signposted to more specialist support when necessary.

References

Getting out and about: new mum Sarah Jones

At the postnatal reunion of my antenatal class, Sophie Jamieson, our antenatal teacher, noticed that I wasn’t doing so well. I had a difficult birth and my baby had tongue-tie (which made breastfeeding difficult). I started to bottle feed her, which I felt really ashamed of, and I couldn’t leave the home.

Sophie suggested something for me to focus on, which was to set up a Baby Ramblers group. As the organiser, I had to leave the house and reach out to other mums. I advertised it on Facebook as a monthly get-together, and also promote it at our local children’s centre. On the first occasion there was torrential rain, but another mum desperately wanted to do it and we ended up going to a pub. She was breastfeeding but had never breastfed in public; she breastfed in the pub and was very proud.

In the initial stages of organizing the walks I saw my health visitor. She knew how I was feeling and referred a few people my way. A few were having similar problems around breastfeeding. It was quite nice to talk to them about how they were feeling.
On the second occasion there were 12 mums and babies. Everyone is keen to do it more frequently, for example, weekly. We find a buggy-friendly route, and often have dogs or toddlers coming along too. I didn’t know any of them at first.

Each time we meet I ask someone else to volunteer to organise the next one.

The host makes everybody feel welcome; we begin by standing in a circle and saying our name and our baby’s name and age. The good thing about being the host is that if you’re having a bad day and don’t feel like going out it forces you to, and then you feel better afterwards. I wanted others to have that benefit, and for it to continue when I finish maternity leave. It makes you feel like you’re doing something really positive.
Parents in Mind gets underway
Volunteers and practitioners to benefit from NCT’s new perinatal mental health training and resources.

By Julie Clayton

In March 2016 NCT successfully won a contract from the Department of Health for its Parents in Mind programme, to train volunteers to provide peer support specifically to mothers with mental health issues during and after pregnancy. It was recognition of NCT’s considerable potential to deliver training across multiple regions of the country, particularly to help mothers or partners experiencing mild-to-moderate mental health issues such as feeling low and anxious. With at least one-in-ten mothers likely to have a mental health problem, including anxiety and depression, there is enormous need for such support.

A two-day training workshop for NCT trainers took place with the Institute of Health Visiting in early July 2016, and preparations are now underway to deliver the first training session to peer supporters in November 2016.

Building on NCT’s previous experience of training community peer supporters, three locations in England have been selected for the training, each with different community demographics, and strong branch interest in the topic. The first location will be Coventry and Warwickshire, followed in 2017 by training in Tower Hamlets and Newham, and then Runcorn and Widnes.
The structure and content of the service will be adapted in response to local requirements, but at its core, the project will involve recruitment of volunteers with lived experience of perinatal mental health issues who can empathise and nurture the confidence of mothers going through similar problems. The peer supporters will establish a local support service, in group and 1:1 settings, with carefully considered safeguarding procedures built in. Their training will include active listening skills, how to support mothers in their own recovery, and signposting to local support and care as required. Their role will not be diagnostic, or to replace the need for other services, particularly those of specialist health professionals.

Alongside Parents in Mind, NCT is fundraising through local volunteer branches with The Big Push campaign, to support the delivery of training that brings together volunteers and practitioners, to raise awareness of perinatal mental health issues and promote signposting and support activities. The aim is to promote and normalize discussion of mental health alongside physical health, and to cascade out the benefits of the Parents in Mind programme in terms of learning and resources.

'We want to reduce stigma and raise awareness for parents about mental health, to equip them to talk about how they’re feeling and where they can get help,’ says Beckie Lang, Perinatal Mental Health Project Manager for NCT. However, at the same time, getting involved in supporting women and their partners through mental health difficulties may also trigger strong feelings and memories for some volunteers and NCT practitioners. ‘Learning about this topic may highlight the need for some practitioners and volunteers to take care of themselves. So we need to be mindful of supporting across our network, and that women and partners know how to find information and support whether for themselves or someone they are supporting’.

**Useful resources**

**All babies count: spotlight on perinatal mental health - prevention in mind, NSPCC**


**Perinatal mental health. Experiences of women and health professionals,** Boots Family Trust Alliance


**The costs of perinatal mental health,** Centre for Mental Health and LSE PRSSU


**Perinatal mental health toolkit,** Royal College of GPs


Designed for a variety of practitioners working in the field of perinatal mental health.
Maternal Mental Health Network
http://www.maternalmentalhealth.org.uk
Online network including discussion forums for health professionals, volunteers and practitioners involved in perinatal mental health support programmes.

For general further information key websites are:

**Everyone’s Business**
http://everyonesbusiness.org.uk/

**The Maternal Mental Health Alliance**, of which NCT is a member
http://maternalmentalhealthalliance.org/

For women to gain information the following are good and trusted sites:

**Action on Postpartum Psychosis**
http://www.app-network.org/

**Action for Postnatal Illness (APNI):**
https://apni.org/

**Best Beginnings**: Baby Buddy app to download on Android or Apple phones
https://www.bestbeginnings.org.uk/baby-buddy

**Maternal OCD**
http://www.maternalocd.org/

**Tommy’s the baby charity**
https://www.tommys.org/pregnancy-information/pregnancy-and-your-life/your-mental-wellbeing-pregnancy
Integrating mental health care for mothers in Milton Keynes

In this first of two linked articles, we see how the stories of women’s personal experiences are helping to make critical improvements to local maternity services.

By Julie Clayton

Jo Manning was receiving treatment for depression before she became pregnant with her first child. She came off the medication in preparation for pregnancy, and felt fine until her son was three months old, in December 2014. ‘At three months I felt I had been hit by a bus. I managed to get home and phoned my partner and said “I need help.”’

Jo’s partner took her to A&E in their home town of Milton Keynes, and she later saw the local mental health team who prescribed medication. But she did not see a specialist perinatal mental health nurse for another four months, in April 2015. ‘I was feeling very emotional and struggling to adapt. I didn’t want to get out of bed. The sheer exhaustion and suddenly feeling like you’ve lost your old life. I felt I had to do something serious before anybody would listen to me. I had to fight and if it were not for family and friends I’m not sure what would have happened.’
Jo felt that she had slipped through the system with no consistency of care. Her son’s birth was traumatic: Jo had to be induced because of meconium waters, the umbilical cord was wrapped around her baby’s neck, and his heart rate kept falling during labour. Jo had to have a forceps delivery and was then separated from her baby in order to be taken to surgery to be stitched. Postnatally, the birth experience appears to have taken its toll, with possible mild psychosis, severe anxiety and postnatal depression. Eventually Jo received the specialist care she needed. However, she felt so strongly about wanting to ensure other women did not have the same experience that she joined the Milton Keynes Maternity Services Liaison Committee, Maternity:MK [http://www.maternitymk.co.uk/](http://www.maternitymk.co.uk/) to add her voice as a service user. The MSLC comprises a mix of parents and their representatives and healthcare providers including obstetricians, midwives, public health and mental health teams, and is chaired by NCT antenatal teacher Leanne Stamp. It is one of many MSLCs around the country which listens to the experiences of parents and presents their needs in the planning of service development. They share best practice, review research evidence and guidelines, and provide information and links to local services and self-help activities. Jo recalls her first participation at Maternity: MK as a very emotional time. ‘I felt very passionate about my experiences and challenged them when I first joined. My experience at that point was very raw. It was great to speak to other women within Maternity: MK and in the community, listen to their stories and give feedback to the health professionals to help to make positive changes. It’s great to be able to do something that will help others.’ Jo is also able to express the fears of mothers that their baby may be taken away if they disclose a mental health issue. ‘I hear it on the ground – “I’m not going to go to the health visitor because they’d take the baby away.”’ The Milton Keynes MSLC is assisting a clinician-led Milton Keynes Perinatal Mental Health Collaborative in scoping and orchestrating the necessary steps in developing an integrated perinatal mental health pathway. This will provide evidence-based guidance on achieving timely referrals, diagnosis, treatment and care for a range of mental health issues before, during and after pregnancy, for up to one year post-birth. It will involve a written care plan for each patient, and information-sharing and communication between different health and care professionals, including GPs, midwives, obstetricians, health visitors, social workers, and specialist services such as drug and alcohol services and the Milton Keynes mother and baby unit. ‘Currently, there is no perinatal mental health provision [in Milton Keynes]. Women or partners go through normal adult or adult mental health, or IAPT – which is self-referral - but there is nothing specific for people going through perinatal mental health problems. This new development means a dedicated service with a psychiatrist, a psychologist and a perinatal mental health practitioner,’ says Maternity: MK chair Leanne Stamp. Contributions by service users including Jo Manning help to ensure that the pathway remains woman-centred. ‘Clinicians are very supportive – we need to make sure this is right for women.’ The Milton Keynes Perinatal Mental Health Collaborative is a multidisciplinary working group with representatives from NHS, local council and other partner agency teams, and has produced a draft perinatal mental health pathway which was launched for local GPs in June 2016, and is due for wider dissemination.
The Collaborative will gather case studies and monitor its implementation. Similar developments are taking place in many parts of the UK, including Bromley (see report below by Laura James). These efforts are encouraged by the Maternal Mental Health Alliance which is bringing together the NHS, social services and other organisations to address gaps in mental health care provision for mothers. In 2014, the Maternal Mental Health Alliance revealed in startlingly bright red colour coding, the lack of provision in more than 50% of regions covered by CCGs around the UK.3

References
Building a new perinatal mental health pathway in Bromley

By Laura James

In the early part of 2015, the urgent need for a better mental health care pathway for pregnant women in Bromley was powerfully illustrated by the testimonies of two women who felt severely let down during their pregnancies.

Gail wrote of her antenatal depression during her second pregnancy and that the specialist midwife was unable to see her for two months because she was so overstretched. Gail finally managed to access care through her GP two weeks before her due date, having suffered debilitating depression for most of her pregnancy. She wrote, ’Despite being proactive in asking at the earliest possible opportunity I did not get the support that I needed. When I think about having another child the decision is certainly influenced by the impact that it might have on my mental health care and the lack of support currently. I do not want any other woman to have to feel so alone during her pregnancy, so unsupported.’

Similarly, Sarah told her midwife that she had a history of depression in her first antenatal appointment and was told there was a specialist midwife that she could contact if she felt she wanted extra support. She wrote, ’I didn’t feel I needed this straight away, but in the last month of my pregnancy I experienced a sudden and dramatic increase in anxiety and depression. Because it came so close to my due date, I found that nobody really knew what to do with me. As I had seen so many midwives, there was nobody that had seen me throughout who could notice the change in me. I broke down in front of one midwife, who said I should get in touch with my GP. The specialist midwife I had been told about before was not available at short notice.’
Sarah became increasingly anxious before her son’s birth. Two weeks after his birth she was admitted to hospital for three days. On return home she made a suicide attempt. She wrote, ‘From that point, I was given a lot of support, but it really feels as though I had to almost lose my life before any real joined-up approach was agreed between Stepping Stones, my GP and the counselling I was then given.’

These brave, honest and moving accounts revealed that Bromley needed an overhaul in its approach to perinatal mental health. In May 2015, I and other members of the Bromley Maternity Services Liaison Committee (MSLC) invited Gail and Sarah to submit their testimonies to the Bromley Clinical Commissioning Group (CCG), which was developing a business case for a new perinatal mental health pathway in the borough. Until then, Bromley, like many other boroughs around London, had only limited perinatal mental health provision.

In April 2014, the Maternal Mental Health Alliance Everyone’s Business Campaign rated CCGs across the country for their provision of perinatal services, with scores from level 0-5 and colour coding from red (0) to green (5). As indicated on the map below, Bromley scored as level 0/red (no provision), providing further evidence in support of the case for change.1,2,3

Although women requiring perinatal mental health support had access to mainstream services, such as GPs, midwives, health visiting, the NHS Improving Access to Psychological Therapies (IAPT) programme, and secondary care mental health services, the care was fragmented. There was a real need for ‘an integrated care pathway with maternity and health visiting services so that comprehensive, co-ordinated care for women with additional mental health needs could be provided in a timely manner.’4

The CCG governing body reviewed Gail and Sarah’s cases together with other key information, and agreed to an investment of around £270K per annum to fund an integrated, multi-disciplinary, perinatal mental health pathway.

Nicola Symes, one of the senior contract managers involved in the bid, thanked Gail and Sarah personally via the MSLC and underlined the value their stories lent to the case. ‘It really does highlight the gap in our current services, and the positive impact that a new service could have for women, their children and families in the future. Their experience and stories will really add value to the business case, and emphasise in a very personal and powerful way, outcomes and issues that have been quite difficult to describe in anything other than a very generalised way.’

The new service was made available in July 2016, provided by Oxleas Mental Health NHS Foundation Trust, and is working closely with other providers such as the maternity teams at the Princess Royal University Hospital, other local mental health providers, children’s centres and health visitors. The service includes a perinatal mental health clinic at the main hospital, staffed by a team including a specialist mental health midwife, consultant obstetrician, perinatal psychologist and virtual pharmacist. This specialist team aims to work closely with GPs and maternity services during pregnancy and with health visiting services for postnatal care, providing joint clinics for those women requiring high levels of support, care coordination for those considered to be at highest risk, and medicines management advice for those on psychiatric medications. Dawn Newman-Cooper, Maternity commissioner...
for the CCG said, ‘The benefits of our new service are wide-ranging for both women and their families. In particular, for women with a history of significant mental ill health who are considered to be at risk of relapse or recurrence of their illness associated with pregnancy and the postnatal period, and those women who become acutely unwell during pregnancy or the postnatal period.’

Bromley MSLC is thrilled that this new pathway has been implemented and that the committee could play such an important role in its development. The MSLC will continue to liaise with the service provider and the CCG and will help to publicise the pathway when it is established. We also intend to seek out and provide ongoing feedback about the new service to maternity leaders and commissioners from the women who are accessing it.

References

Further resources
Royal College of General Practitioners Perinatal Mental Health toolkit
Spotlight on research

Breastfeeding and maternal mental health

NCT breastfeeding counsellors Graziella Iossa and Jessica Figueras highlight two recent studies exploring the complex interplay between breastfeeding and maternal mental health

Breastfeeding difficulties and postpartum depression

By Graziella Iossa

Mental illness is a growing concern worldwide: depression is 50% higher in women than in men and is the leading cause of disease burden in women aged 15-44 years in low-, middle and high-income countries,¹ and in England, one in four people will experience a mental health problem.²

These statistics are stark and the disproportionate effect on women is of particular interest to practitioners and health professionals. Particularly relevant to me as a breastfeeding counsellor is how stressful it can be for mothers when they experience difficulties with breastfeeding. Their stress may be heightened by breastfeeding promotion, and a perceived strong social
pressure to breastfeed, which in turn can exacerbate difficulties experienced whilst breastfeeding and may lead to poor mental health. I have therefore chosen to highlight the study by Chaput and colleagues, which investigates the link between breastfeeding difficulties and postpartum depression.


Available from: http://cmajopen.ca/content/4/1/E103.full.pdf+html
Accessed 8/7/16

The authors recruited 442 women who intended to breastfeed, from all maternity hospitals in Calgary, Canada, within 72 hours of birth. They then gave the mothers questionnaires at birth, six weeks and six months, focusing on breastfeeding difficulties, breastfeeding support and postpartum depression. The authors only included mothers of full-term babies and excluded mothers who intended to bottle-feed, so as to focus on women who were at risk of experiencing breastfeeding difficulties.

The vast majority of mothers who responded (87.3%) reported moderate to severe difficulties with breastfeeding, and nearly all (98.9%) received some form of breastfeeding support. About 14% experienced postpartum depression at six weeks and 15% at six months, which is in line with estimates. However, those mothers who did experience breastfeeding difficulties but did not report a negative experience with the support received, had a significant decrease in the risk of postpartum depression. In other words, the support given to mothers with breastfeeding difficulties — so long as the support was not negative — helped to protect them from postpartum depression. Positive breastfeeding support in the early days after birth appeared to have a positive influence on mothers’ mental health.

The work we do with mothers in the early days after birth, and whenever the need for breastfeeding support arises, is crucial not just for the outcome of the breastfeeding experience but also, more generally, for the mothers’ overall wellbeing. This study highlights how positive breastfeeding support (or at least non-negative support) can help to reduce the incidence of postpartum depression.

References

2. Mental Health Foundation. Statistics; 2013. Available at: https://www.mentalhealth.org.uk/statistics
Understanding the true link between breastfeeding and postpartum depression

By Jessica Figueras

Traditionally, breastfeeding has been thought to protect against postpartum depression, but an increasing body of research is indicating that the relationship between breastfeeding and postpartum depression is more complicated than this. I have chosen to highlight the study by Borra et al, which although first published online in August 2014, still stands out in the literature as a high-quality study that aims to tease out the many different factors that could contribute to depression.


This longitudinal cohort study involved around 14,000 mothers of babies born in the Bristol area in the early 1990s. Mothers provided detailed information about themselves, their experiences and their babies throughout pregnancy and following birth.

The authors questioned whether there was a correlation between not breastfeeding and depression (measured using the Edinburgh Postnatal Depression Score at various points during pregnancy and after birth). They considered other factors which could affect a mother’s tendency to suffer from depression, including sociodemographic characteristics, pregnancy and birth experience, mental and physical health in pregnancy, interpersonal relationships, stressful life events, and personality.

After taking these other factors into account, the link between not breastfeeding and postpartum depression mainly disappeared. But more importantly, the relationship was different for different groups of women.

The authors identified two key factors that determined how breastfeeding affects mood: whether mothers had shown signs of depression during pregnancy, and whether they had intended to breastfeed.

For mothers who did not show symptoms of depression during pregnancy, breastfeeding did indeed decrease the risk of postpartum depression amongst mothers who had intended to breastfeed. The beneficial effects of breastfeeding were strongest at eight weeks after birth, but weaker at eight months and onwards. For mothers who showed signs of depression during pregnancy, the protective effects of breastfeeding as planned were weaker overall but exclusive breastfeeding for four weeks had a protective effect.

But mothers who intended to breastfeed but did not manage it were more likely to be depressed. For mothers who had not intended to breastfeed, breastfeeding actually increased the risk of depression. This sobering finding is highly relevant for health professionals looking to increase breastfeeding rates amongst the groups least likely to breastfeed.
The key finding from this study, therefore, is that we need to avoid generalising about the relationship between breastfeeding and postpartum depression. Women’s experiences are complex and many factors are involved. Those suffering from this terrible condition need our support however they are feeding their babies.

Jessica Figueras is an NCT breastfeeding counsellor and a research networker. She lives in London with her husband and two daughters. Graziella Iossa is an NCT breastfeeding counsellor and a research associate at the University of Lincoln studying animal behaviour and behavioural ecology.
The ACORN study – finding ways of helping with high levels of anxiety in pregnancy

Introducing a new group-based intervention (CALM) for pregnant women

By Heather O’Mahen and Paul Ramchandani

Should we worry about anxiety in pregnancy?

For many women, pregnancy is a positive experience. However, for a significant number of women, pregnancy can intensify existing areas of anxiety and introduce new concerns. Having a baby is a deeply important experience for many people, and when that is combined with low perceived control and the unpredictability associated with pregnancy, birthing and raising a baby, and changes in the couple relationship, many women and men can become unsettled. In up to 8% of pregnant women, these intensifying concerns can lead to levels of anxiety that interfere with the woman’s ability to function in her relationships and at work. Women who have had previous miscarriages or negative birth experiences may be especially likely to have intense worries. Women who are isolated or have poor support are also at risk for having more struggles with anxiety. These feelings can have a considerable impact on the woman during pregnancy and can also leave her at an increased risk of postnatal anxiety and depression. If left untreated, both anxiety and depression are conditions which can make it challenging for the mother to provide care for her baby, and can interfere with the formation of a secure emotional bond between mother and infant.
Although some level of worry during pregnancy and the postnatal period is normal, it is important for health providers working with women to assess whether or not her worries are intensifying and interfering with her ability to get on with her life as she normally would. NICE now recommends that all health providers ask women two questions about anxiety: “In the past two weeks, how often have you been bothered by feeling nervous, anxious, or on edge? Not being able to stop or control worrying?” The key feature of these two questions is to assess how much time women spend feeling anxious and not able to stop the worrying because the more time women spend feeling anxious, the more likely it is that these worries are interfering with their life. If a woman indicates that she is struggling a good deal of the time, then further assessment should be conducted and the health provider should talk to the woman about her options for treatment for her anxiety.

Despite the fact that both depression and anxiety are common during pregnancy and may have adverse consequences for the mother and her baby, most of the research on interventions during this period is only for depression; there is very little research into the best and most acceptable ways of helping women with anxiety. Recent national guidelines in the UK, USA, Canada, and Australia have stressed the crucial importance of identifying and offering treatment for antenatal anxiety and depression. These guidelines recommend screening for all women as a routine part of antenatal care, along with timely access to appropriate services for assessment and psychological intervention in pregnancy. These recommendations were made despite the lack of robust evidence to guide the direction of treatment for women who have anxiety during pregnancy and the absence of systematic research examining the impact of treating antenatal anxiety on maternal and infant outcomes. This missing link is critical, as the potential opportunity for reducing distress for women in pregnancy is large, as is the potential for preventing later problems both for the woman herself and her developing child. Further, some interventions for trauma-related responses have been found to be harmful, so it is important to offer appropriate interventions that effectively reduce women’s anxiety.

**Developing a new intervention**

There are some psychological interventions that are known to help with anxiety, such as cognitive behavioural therapy; however, none have been extensively tested for women in pregnancy – a time when the worries are often different, and different approaches to treatment may be needed. A team of us, including women with lived experience of anxiety during pregnancy, experienced psychologists, midwives, psychiatrists, and other researchers set out to adapt and develop a new intervention for women experiencing high levels of anxiety during pregnancy. Building on work from Australia undertaken by Jeanette Milgrom, Jennifer Ericksen and colleagues (Towards Parenthood), we developed a brief group intervention for anxiety that takes place during the second trimester of pregnancy. The original Towards Parenthood intervention was an individual, 10-session, guided self-help programme. Clients received a workbook and were supported in telephone calls by trained mental health professionals. The content of the intervention focussed on thinking about and planning for the baby, with a particular focus on managing thoughts, emotions and communication with important others.
The new intervention that we have developed (CALM) is briefer, and is tailored specifically for use with pregnant women experiencing antenatal anxiety. It includes content that addresses pregnant women’s concerns (i.e., fear of miscarriage and birth, worries about becoming a parent). It is delivered in a group format jointly by a midwife and psychological therapist. Embedding the intervention in routine antenatal care in a brief midwife/psychologist-led group format means that it has the potential to be a cost-effective mode of delivery and one that is robust to changing healthcare environments, requiring less time and input from midwives than an individual psychological approach, and being widely available to women experiencing difficulties with anxiety. The design of the intervention means that women suffering from anxiety who are already attending, or are interested in attending, antenatal courses could participate in CALM as a more targeted set of antenatal classes. Integrating mental health classes within the structure of overall antenatal education potentially de-stigmatises the treatment and also provides an opportunity to focus holistically not just on baby, but also on the mother’s mental health and the parents’ relationship – features our service users strongly advocated for. Further, the group setting allows both mothers and their partners or important others to share and normalise their experiences. As such, CALM has the potential to improve outcomes for a wide range of pregnant women and their infants, thereby reducing the overall population burden of anxiety during pregnancy. With funding from the National Institute of Health Research we have been able to develop this programme and test it in a small trial to see if it is effective in reducing symptoms of anxiety.

What does the intervention involve?

The programme involves attending three group sessions. The sessions are held at two to three week intervals and each session lasts for about 1.5 hours. Wherever possible we try to include partners or a close supporter of the mother and we run some of the sessions separately for mothers and their partners/supporters. However we offer the programme to all who are eligible, and so are very happy for women to come on their own if they prefer. During these sessions women and their partners/supporters (where relevant) are given information about stress and anxiety during pregnancy, and learn a variety of techniques and strategies to help with these feelings. These include strategies from cognitive behaviour therapy as well as some mindfulness and compassion approaches. For example, the course applies skills in both problem solving and tolerating uncertainty to pregnancy fears (including miscarriage), and incorporates reflective learning strategies for partners/supporters to assist women with problem solving.

What stage is the research at now?

We have run seven groups to date in London and Exeter, testing the CALM intervention against women’s treatment as it usually occurs (e.g., this may involve mental health screening from a midwife and follow-up from a GP or primary care mental health care provider) to see if the treatment helps to reduce women’s anxiety. A detailed evaluation of the programme is currently underway (known as the ACORN study). All participants have completed standardised questionnaires about anxiety and depression, and detailed interviews have been conducted with many women and their partners. Whilst we are still in the process of analysing all the results, the initial findings are...
promising, with high rates of women agreeing to take part and many women finding that it addresses their concerns and helps to reduce their levels of anxiety. One of the attendees said, 'I think it’s made a big difference to me and I feel…. without it... I would feel still very anxious and quite alone.' Another said, 'All my physical needs have been met really, really well by the general NHS programme. I was really pleased to be involved in the study, for the chance to be able to talk about more of the emotional things which I hadn’t realised isn’t really touched on at all and there are really big changes.’

**What next?**

We aim to test the intervention on a larger scale, and also begin to implement it in a small number of new services areas – there is still much to learn, and whilst we are happy that we have an intervention that does seem to be helpful for women with anxiety in pregnancy, it is important to evaluate this carefully and thoroughly, including measuring any effects on longer term outcomes such as mother-baby attachment. If it is found to be effective, it offers the potential to help a wide range of women, as it is a group intervention, easily deliverable by professionals once they have received appropriate training.

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**References**


Recognising and acting on perinatal mental health

Susan Ayers and Amy Delicate

Practitioners have a key role in promoting good mental health and in understanding when mothers and fathers may need extra support for mental health problems.

Introduction

Pregnancy, birth, and becoming a parent is a time of great change and adjustment. For some people this period can therefore revive or worsen pre-existing mental health problems, or act as a trigger for new mental health problems. It has been estimated that up to 20% of women develop some form of mental health problem in pregnancy or after birth and that this costs the UK £8.1 billion per annual cohort of births, which equates to approximately £10,000 per birth.¹ There is also emerging evidence that men can be affected.² For every woman who develops a severe mental health disorder there are many more women who suffer from moderate symptoms which can still be distressing and have a negative impact on women and their families. Mental health and illness are therefore not categorical but more like a continuum from positive mental health to severe illness. Women can fall anywhere on this continuum and move up or down depending on events and circumstances.

Many different types of mental health problems can arise during this time. The most severe disorder is puerperal psychosis, which occurs in 0.1% of women. Women with puerperal psychosis are at high risk of harming themselves and their baby so require immediate hospitalisation. Women are more at risk of puerperal psychosis if they have a personal or family history of psychosis or bipolar disorder. The most common perinatal mental health problems are depression and anxiety, which affect between 10 and 15% of women in pregnancy and after birth.³ However, there are many other disorders that are often missed because professionals who work in perinatal services are less aware of them. These include posttraumatic stress disorder (PTSD), obsessive compulsive disorder (OCD), phobias, panic, adjustment problems, bipolar disorder and bonding disorders. These disorders are not as common as depression and anxiety but still affect a large number of women. For example, 3-4% of women will develop PTSD following a traumatic birth, which equates to at least 21,000 women per year in the UK.⁴ Birth-related PTSD is particularly interesting because of the possibility of preventing it through antenatal preparation and appropriate support and care during birth. Risk factors for birth-related PTSD are depression during pregnancy, fear of childbirth, negative experiences during birth, an assisted or caesarean birth, poor support, and dissociation during birth.⁵
A number of general risk factors make it more likely that women will have perinatal mental health problems. Some of these risk factors are remarkably consistent across different cultures and different mental health problems. For example, mental health problems are more likely to occur if women live in social adversity (e.g. deprivation, low socioeconomic status, domestic violence), have a history of psychological problems or childhood adversity, and poor social support. In addition, if women are anxious or depressed during pregnancy this is a risk factor for continued mental health problems postpartum.

Signs that a woman may have perinatal mental health problems vary. Severe disorders, such as psychosis or bipolar disorder, are usually very noticeable and symptoms include (but are not limited to) delusions, mania, confused thought and paranoia. The more common affective disorders can be harder to spot because women may hide their problems through shame, stigma, or fear their baby will be taken away. Figure 1 shows the results of an online survey of 1,500 women who experienced perinatal mental health problems.

In this survey 30% of women never spoke to a healthcare professional and a third of these women hid their feelings because they were concerned their baby would be taken away.

Figure 1.
Perinatal Mental Health Survey
(reproduced with kind permission from the Boots Family Trust Alliance)
Women with perinatal mental health problems frequently withdraw from social interaction so if a woman stops going out, rarely socialises, cancels or misses repeated appointments, it could be a sign that she has perinatal mental health problems. Common signs to look out for are if women are flat emotionally or tearful, which could be a sign of depression, or have excessive or uncontrollable worry, which is a common symptom of anxiety disorders. Key symptoms of PTSD are intrusive thoughts, nightmares or flashbacks about the traumatic event. Many women with PTSD also suffer from depression which means that in some cases the depression is picked up first. Recommended treatments differ for different disorders so it is important to check for a range of symptoms. However, until recently maternity services only screened for depression. Latest NICE guidelines recommend screening for depression and anxiety but this will not pick up all the women with less recognised disorders.

The impact of perinatal mental health problems

Mental health problems during and after pregnancy are important because of the negative impact they have on women and their families. This is illustrated in Figure 1, which shows that 22% of women in this survey said they had thought about suicide, and 28% said they had problems bonding with their baby. This is consistent with the broader literature, where perinatal mental illness is a key indirect cause of maternal death. Qualitative studies suggest wide-ranging effects on women and their families. For example, an interview study with women who had birth-related PTSD found women reported changes in physical wellbeing, mood, behaviour, social interaction, fear of subsequent childbirth, as well as negative effects on their relationship with their partner such as sexual dysfunction, disagreements, and blame for events of birth.

Perinatal mental health problems can also have a significant impact on the baby. Women’s mental health during pregnancy can affect the developing foetus through neuro-biological foetal programming which can have a long term effect on the child’s development and health. Infants of mothers who are stressed and anxious in pregnancy show more fearful behaviour and increased physiological stress responses. Longer term, anxiety and depression in pregnancy are associated with poor emotional and behavioural development which can persist into adolescence. For example, a study of 7,944 families in England showed maternal anxiety and depression in pregnancy is associated with a child being twice as likely to have a mental disorder.

Vulnerability to mental health problems can therefore be transmitted from one generation to the next. This intergenerational transmission of vulnerability is due to many factors such as epigenetic mechanisms, exposure to difficult circumstances and adversity, and parental mental health and parenting styles which influence how infants respond to events and regulate their emotions. After birth, mental health problems can impact on the relationship between a mother and her baby. There is evidence that women with postnatal depression are less sensitive to their baby’s emotional state and may have problems parenting, such as being withdrawn and unavailable to the baby or over-intrusive. These babies are therefore more likely to develop an insecure or disorganised attachment style, which in turn is
associated with poor mental health in childhood and adulthood. Gender is also a risk factor with boys appearing to be more adversely affected than girls. These are just some of the mechanisms through which mental health problems and social adversity can be transmitted from one generation to the next.

Women’s partners can also be affected. During this time couples’ mental health is interlinked with one partner’s emotional health being significantly associated with the other. There is emerging evidence that men can suffer from a range of perinatal mental health problems themselves, including anxiety, depression and PTSD symptoms through witnessing a traumatic birth. However, it is not clear how many men are affected or whether men express mental illness differently to women at this time. This is an area where a lot more research is needed.

The impact of perinatal mental health problems on a couple’s relationship has been less examined but there are case studies and qualitative studies illustrating the impact of conditions such as postnatal depression and PTSD upon relationships. For example, postnatal depression is associated with a greater decline in relationship satisfaction during the transition to parenthood than usual and a deterioration in the couple’s relationship. Women report a loss of desire to be around a partner or have sex, lack of understanding from partners, ignorance of concerns, problems with communication, and arguments. Research on the impact of PTSD on a couple’s relationship shows a similar pattern with increased strain on the relationship, sexual problems, anger and blame, problems with communication and arguments, unwillingness to have subsequent children because of fear of childbirth, and relationship breakdown.

Treatment and interventions at this time are important to prevent the negative impact of perinatal mental health problems on the individual, couple’s relationship, and baby. Progress in this regard is patchy, with a recent report showing very few areas in the UK have adequate perinatal mental health services. More advances have been made in providing parenting interventions, some of which have been shown to be effective at improving parenting and secure attachment in infants. The impact of perinatal mental health problems on families shows how important it is that interventions consider the family and help strengthen couple relationships. It is also important that interventions with parents at this time are evaluated to ensure they are effective.

What can NCT practitioners do?

There are many ways in which NCT practitioners can help prevent or reduce perinatal mental health problems. In terms of prevention, practitioners can facilitate open discussions about mental health to help normalise such problems and reduce perceived stigma. The fact that NCT services are usually separate to NHS services may mean couples see it as a safe space in which they feel more able to discuss problems. Research shows women are more likely to talk about perinatal mental health problems if they know and trust the professional they are talking to.

In terms of treatment, practitioners are well placed to identify women and men who have perinatal mental health problems and signpost them to help,
advice and services. This is especially valuable given the great variation in services in different areas of the UK.\textsuperscript{26} If practitioners are familiar with local services and have contacts within these services it can help parents access treatment more easily and quickly. This knowledge of local services is invaluable in signposting parents to available services. In addition, there are national services parents can access, such as Improving Access to Psychological Therapies (www.iapt.nhs.uk); as well as online therapy courses for people with mild or moderate symptoms, such as the Netmums ‘Helping with Depression’ course (http://www.netmums.com/parenting-support/depression-and-anxiety/helping-depression-sign-up). A review of online therapy for perinatal mental health found it may be particularly effective for women with postnatal depression.\textsuperscript{29}

Figure 2 illustrates some of the ways practitioners can help in terms of raising awareness, educating and empowering clients, developing self-supporting groups of parents, and signposting services. When providing support for people with perinatal mental health problems it is important that there are clear boundaries to protect both practitioners and clients. NCT practitioners are there to support and signpost parents to services but not to diagnose or counsel. It can be emotionally draining supporting people with perinatal mental health problems so it is crucial that practitioners have access to their own support such as mentoring and supervision.

**Figure 2.**

*Potential role of practitioners in perinatal mental health*

If practitioners are aware of the range of perinatal mental illnesses and potential impact upon families this knowledge can be filtered through to parents. Practitioners can raise awareness, begin to normalise and reduce stigma for perinatal mental illness, therein breaking down some of the barriers to accessing support.\textsuperscript{30} Figure 3 summarises key actions suggested
by NCT expert practitioners for trying to prevent or reduce birth trauma, many of which are relevant for perinatal mental health more generally. This outlines possible ways to increase awareness, confidence and empower parents in pregnancy; and to support those after birth who develop mental health problems and make sure they access help.31

Social support is critical in good mental health so developing bonded, self-supporting client groups can provide invaluable peer support and friendships.32 Antenatal teachers may like to consider the use of single sex classes which provide a peer-based platform for deeper understanding of emotional and wellbeing topics, which may be especially beneficial for men.32 NCT doulas and breastfeeding counsellors have a key role in supporting parents through the birthing process and early parenting so are well placed to identify and support parents who experience mental health problems.33,34

Similarly, looking at provision and content of courses may enable practitioners to better support parents with previous or current perinatal mental health problems, particularly those who have traumatic birth experiences. Reunions are an integral part of antenatal courses and practitioners facilitating reunions could reflect on the structure of these sessions to ensure that there is time and space for parents to talk about their birth experiences (if they wish) and therefore gain acknowledgement and suitable signposts to support.35 Local branch activities and postnatal Early Days courses provide a valuable opportunity to signpost services to parents experiencing mental health difficulties. Practitioners may want to develop their practice further (or promote the practice of a fellow practitioner) in areas such as relax stretch and breathe, yoga for pregnancy and baby massage. These courses allow NCT to extend its reach in terms of the timescales of working with women, as well as working with women from wider demographic backgrounds.

Figure 3.
Practitioners’ tool-kit to prevent or reduce birth trauma
Summary and conclusion

In summary, perinatal mental health problems affect up to 20% of women in pregnancy or after birth. Men can also be affected, although there is not enough evidence to be able to say how many. Perinatal mental health problems are numerous and include psychosis, anxiety, depression, as well as less well-recognised problems such as PTSD, OCD, phobias, panic, adjustment and bonding problems. Although recommended treatment pathways are available for the most severe and common disorders, there is huge regional variation in services. Stigma and other concerns mean women and men might not disclose their mental health problems or access services. In addition, those with mild or moderate symptoms may not meet the threshold for referral to psychological services. NCT practitioners are well placed to raise awareness in parents about perinatal mental health, reduce stigma, identify parents with perinatal mental health problems, and provide advice and support. A number of ways in which NCT practitioners could help have been outlined in this article. It is important that support is also available to practitioners to help them develop their skills in recognising and managing perinatal mental health problems, as well as in safeguarding issues. Finally, it is important for evaluation to be an integral part of interventions to help us provide effective prevention and treatment programmes for perinatal mental health problems.

References


Broadening the net: assessing the full range of perinatal mental health problems

New mothers can experience many types of mental health difficulties during pregnancy and the first postnatal year. Here, Rose Coates outlines how these problems are currently identified, recent policy developments relating to perinatal mental health assessment, and their strengths and limitations.

Kate’s story

I wanted a home birth and it was all going fine up until the last minute when I was transferred to hospital, and during that few minutes whilst we were waiting for the ambulance, I was beginning to feel a bit angry and thinking, why has this happened? Over time I think actually I got worse, I got more and more upset because people close to me – my husband, my mum – were telling me not to dwell on it, they just said ‘Oh you know, you’ve got a healthy baby, you’re fine, she’s fine, it could have been a lot worse.’
Types of mental health problems

It is estimated that 10-20% of new mothers will experience a mental health problem in pregnancy or in the year after having their baby. Psychotic illnesses such as schizophrenia, psychosis and bipolar disorder fortunately are rare (usually estimated at 1 to 2 per 1000 births based on admissions to psychiatric hospitals) and because their symptoms are serious and noticeable their identification usually involves urgent engagement with health services such as the GP or mental health crisis teams. This article will focus on the identification of non-psychotic mental health problems that are common but often not noticeable.

Antenatal and postnatal depression, anxiety disorders (generalised anxiety, panic, social anxiety), obsessive compulsive disorder, posttraumatic stress disorder, eating disorders and personality disorders are some of the recognised non-psychotic disorders that women may experience. But there are also problems specific to pregnancy and new motherhood that are not formally recognised in classification systems of mental health disorders. Examples are an extreme fear of childbirth (called tokophobia) or maternally focussed worry disorder, which can be defined as uncontrollable worry about motherhood or the baby. In addition, disorders of the mother-infant relationship can be characterised by a mother’s response of pathological anger, aversion, or hatred toward her new baby. Although not well known disorders, the associated symptoms are recognised by mothers. In a recent UK survey of over 1,500 mothers who had experienced a perinatal mental health problem, almost half of women reported anger as a problem and almost three in ten reported having problems bonding with their baby. Even more common symptoms were tearfulness and low mood (in eight out of ten women) while four out of ten had high levels of anxious energy. It is important to note that these are only some of the symptoms that women experience and each woman’s experience will be different. With identification and appropriate treatment symptoms can resolve and outcomes for the whole family can improve.

Screening and assessment

Perinatal mental health problems affect the mother, her baby and the wider family. For this reason it is particularly important that problems are identified, and the increased contact with health professionals during this time provides a great opportunity for identification and support. However, the evidence available shows that more than half of women with postnatal anxiety or depression aren’t identified.
Current policy

Systematic universal screening does not take place for perinatal mental health problems in the UK. Instead, clinical guidance for health professionals issued by the National Institute for Health and Care Excellence in the UK recommends an assessment strategy. In 2007 the guidance recommended asking women two questions relating to postnatal depression. It is encouraging that the more recent guidance published in 2014 recommends asking about anxiety too (see box for current assessment questions). These questions should be asked at the first ‘booking’ appointment in pregnancy, and then at the discretion of the health professional in all their contacts with the mother. If a mother responds with ‘yes’ to either of the depression questions, or scores three or more on the anxiety questions, further questionnaires should be used as part of a fuller assessment. The latter address depression and anxiety only. As the questions only touch on a few mental health issues, it is important for all of us who support women perinatally to consider other possible mental health problems. Encouragingly, the use of questionnaires is recommended only as part of a fuller discussion with the mother about her mental health and wellbeing. The guidance also stresses the importance of instilling hope and optimism about the effectiveness of treatment. Building a trusting relationship with the mother and delivering the questions in a supportive, non-judgemental manner will be important to facilitate disclosure. Healthcare professionals need to recognise that women who have (or may have) a mental health problem may be fearful of stigma, negative perceptions about them as a mother, or of having their baby taken away. This may lead to an unwillingness to disclose their symptoms or talk about how they feel.

New directions

Many of the mental health problems outlined above would not be flagged up using the current assessment questions. Whilst it is important to remember that the questions are only intended to identify those needing further assessment, research is underway to develop different approaches. One possibility is to use a short questionnaire measure that includes areas such as trauma, coping and support in addition to depression and anxiety. Measures like this are used in other areas of mental health and are currently being tested with women in the perinatal period. A further possibility is to ask one or two general questions to target any kind of distress, for example, ‘In the last two weeks have you felt very stressed, anxious or unhappy, or found it difficult to cope, for some of the time?’ This and a follow-up question asking how bothered the mother is by these feelings have been developed and piloted in Australia, and need further validation to ensure they are effective at identifying distressed mothers.

Impact on mothers being missed

If a mother is experiencing an undiagnosed mental health problem it can be difficult for her to know what to do. In a qualitative study of women with babies under one year old who had experienced postnatal distress, a key theme was the lack of identification with postnatal depression, leading to feeling bereft of information or support. There was a perception that support
was available for postnatal depression but if the threshold for diagnosis was not met, if the mother was not proactive in seeking support, or if the mental health problem was not depression, support was not easy to access or not available. Women felt that the impact of distress on their daily functioning and on relationships with their child and partner meant that support should be available, but was not forthcoming. It was suggested that support did not need to be formal and could be as simple as a health visitor or midwife who was visiting to take time to talk. Accessing the GP was sometimes considered a 'last resort' yet midwives and health visitors were perceived as too busy to help. There was also a feeling that potential postnatal difficulties, for example with feeding, needed to be discussed but were not.8

Sarah’s story

Within about three days of having him I had the baby blues but I think everyone has that. I had a caesarean and then we got let out but then didn’t get breastfeeding established – we ended up getting sent back in and having a second hospital stay and I ended up getting incredibly emotional. He was just perfect at first – he hadn’t been through any birth trauma so he just lay and looked at people. So within a few days everyone was saying “Oh, he’s so easy.” Then as the weeks progressed he obviously developed his personality and he’s not easy. If he’s got a reflux bout there can be an awful lot of screaming and I don’t think I have got the kind of personality that deals very well with it. I tend to take the screaming personally. I can’t make it stop and he has a very, very angry scream. So this is why maybe I have the anxiety – it makes me feel very panicky, out of control, at times angry.

I remember a few weeks after he was born thinking, I don’t feel awful or anything but wondering when I would feel normal, and that not really happening. At one point I thought I might have postnatal depression but then I read the test (the Edinburgh Postnatal Depression Scale) and thought maybe ever so slightly, but not really. I didn’t really identify with a lot of the postnatal depression symptoms. I’ve never had a problem for instance with getting out and going to groups. In fact I knew that I really needed to. It’s the only way I kept sane. I wasn’t crying all the time. The only time I would cry is if he’d driven me to a panic. I might have a day that was bad but then I’d be my normal self and see the funny side of things, and I’d be able to enjoy my time with him.

The woman at the children’s centre said “No, I wouldn’t say you’re depressed but I do think you’re anxious.” I’ve had some forms of anxiety in the past. I think the main anxiety has just been that I didn’t really like being left with him for the whole day – there’s 10 hours ahead and what are we going to do? But also a lot of it is just non-specific fear of what might happen, which I’ve realised isn’t even really logical. My fear was of if he started crying and I wouldn’t understand it and I wouldn’t be able to get him to be quiet. I don’t know how much other people experience this but when he cries it gets like somebody drilling my brain: you can’t think, you can’t do anything, it’s just utterly paralysing. I used to be very scared of that.

That’s all getting better. The best thing I did was have a plan for getting out the house every day, and it really did work.
Conclusions
All healthcare professionals working with women during pregnancy and postnatally can have a positive impact by being aware of how mental health problems are currently assessed and the problems that might be missed. Acknowledging that postnatal mental health issues are common and can be overcome with appropriate support may encourage mothers to seek support (see ‘Sources of help’).

Assessment questions currently asked by health professionals
Depression assessment questions:
- During the past month, have you often been bothered by feeling down, depressed or hopeless?
- During the past month, have you often been bothered by having little interest or pleasure in doing things?

Anxiety assessment questions:
- 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?

‘Not at all’ scores 0; ‘Several days’ scores 1; ‘More than half the days’ scores 2; ‘Nearly every day’ scores 3.

Sources of help for women with postnatal mental health problems and further reading
UK charity offering support to women who have had a traumatic birth. Support via email is available.

The Centre of Perinatal Excellence (COPE) [http://cope.org.au/](http://cope.org.au/)
Australian website with useful information about different mental health problems in the perinatal period.

Cry-sis [http://www.cry-sis.org.uk](http://www.cry-sis.org.uk)
Support for families with excessively crying, sleepless or demanding babies. Telephone helpline available every day 9am-10pm: 08451 228 669.

Support for any parent experiencing mental illness. Telephone helpline available every day 9am-8pm: 0843 28 98 401.
References


Become an NCT Mentor!

NCT is providing new training opportunities for practitioners to become mentors, as Cathy Evans, NCT mentor coordinator, explains

‘It allows me to work one-to-one on something in much greater depth – and it’s really interesting work!’

Why does NCT need more mentors?

NCT mentors work with a variety of practitioners in order to support their professional development. At the moment we are only able to work with a few categories of practitioner as there are so few mentors (currently 14, with a new cohort of six due to start training in September 2016). Mentors routinely work with probationers and newly qualified practitioners, as well as with practitioners as part of a support and developmental pathway after either a difficult assessment or a complaint, with practitioners who have received poor feedback, and with practitioners who simply want to use this developmental opportunity. We would like to work with more practitioners but cannot do this without having more mentors to do the work!

Dates and location

We offer a three-day training package. Our 2016 training sessions involve two days in London (Thursday 29th and Friday 30th September) and one day in Huddersfield (Thursday 13th October) - all 3 days must be attended. Our 2017 training involves attending on Saturday 4th and Sunday 5th March, and Monday 3rd April (location to be confirmed depending on student travel distances and costs).
What the training involves

This is an in-house NCT training module. The study days involve looking at theoretical and practical aspects of mentoring, and doing role-play mentoring with other course members, and telephone mentoring with peers between study days. There is also recommended reading prior to and during the training, and teleconferences (or Skype conferences) after the study days to support learning and to share ideas and achievements. A volunteer mentee works with each mentor-in-training to enable further learning and development. Participants undertake a written reflective assignment which is double-marked and moderated. The current course fee is £200, which can be paid either up front, in instalments, or through a pay-as-you-earn arrangement. Participants will need to cover their own travel expenses and purchase of books etc. If a practitioner is up-to-date with her specialism CPD requirements, she can use either one or two of the training days as her CPD for that year. This would mean she can claim travel from the PSA as for any other study day.

What do practitioners get out of being a mentor?

A great deal! Mentors say they gain skills, particularly deepening and extending listening and questioning skills; self-development in terms of confidence and efficacy; ideas for their own practice; and a supportive cohort – a community of practice!

Feedback from mentors includes:

• ‘Course fee was acceptable and I see it as value for money’
• ‘I thoroughly enjoyed your day and got a huge amount out of it.’
• ‘We had a great Introductory Study Day ...which unpicked a lot of ideas and got us all in the right frame of mind’.
• ‘It’s great being part of something wider within NCT – especially something a bit challenging!’
• ‘We’ve created a really supportive group of practitioners’
• ‘The training has deepened my listening skills’

Booking info

Email Catherine.Evans@nct.org.uk for further information or check the babble page at https://babble.nct.org.uk/info-resources/nct-mentors

There’s more information about payments etc at https://babble.nct.org.uk/info-resources/tools-your-role/nctps-and-students/house-module-costs

NCT antenatal teacher Jenny Barrett has gained much enjoyment from becoming a mentor for other practitioners, and cites the improvement of her own work as a practitioner among the benefits. ‘As practitioners we’re encouraged to use reflective practice, and mentoring forces you to do that in a different way. Talking through your colleague’s challenges makes you think how you’d handle it yourself. You’re quite privileged as a mentor because you get to know a person as a whole person – it’s a safe and confidential space.’