

# A psychological plan for perinatal care

Pauline Slade and Michelle Cree offer some practical recommendations

Pregnancy and the process of childbirth and new motherhood require major physical and psychological adaptations for a woman. In addition, the pathway of development from embryo to fetus to neonate to infant has the potential to exert critical influences on the mental and physical health of the new individual throughout their life. Psychology has generated new understandings of these processes that are relevant to the mental health of both mothers and their children.

This article is an 'action plan' for improved care in this phase of life. It aims to identify psychological ways of facilitating transition to motherhood and the health and well-being of women and their babies. It is a personal perspective, rather than an attempt to provide a comprehensive review of the literature or clinical guidelines relating to the full breadth of perinatal mental health care (see National Institute of Clinical Excellence, 2007).

1. Provide specifically targeted emotional care for women from early in the pregnancy. We need to maximise the psychological well-being of women in pregnancy. This phase of life may be the most critical one of all for the new individual in that the baby's brain and central nervous system is developing. Having input

to the well-being of women in pregnancy may be the most help we can ever be at both an individual and societal level. The evidence is accumulating that high levels of anxiety and stress in pregnancy may influence the interuterine environment and potentially affect the neurobehavioural development of the fetus and child (Austin et al., 2005). Exact mechanisms, timings and impacts are still the subject of investigation.

It is important to recognise that the same woman experiences pregnancy, birth

and the postnatal phase and that continuities will outweigh the differences. Unsurprisingly, anxiety in pregnancy is a good predictor of emotional status in the postnatal period (Heron et al., 2004). Efforts have been made to predict postnatal depression, but typically their positive predictive value has been deemed inadequate to meet the rigours of a screening instrument (Austin & Lumley, 2003). However, this misses the critical point – that psychological status during pregnancy is in itself crucial and worthy of intervention.

While there is evidence that antenatal stress can have potentially serious and long-term effects on the infant, the limited research available on the impact of antenatal interventions is disappointing (NICE, 2007). Good-quality research is thus imperative to demonstrate how a pregnant woman can best be helped to maximise her psychological well-being at this time. This will allow resources to be refocused to include the antenatal as well as the (currently better resourced) postnatal period.

Advances in the understanding of the mechanisms of the brain suggest that social support plays a crucial part in damping down the threat/stress systems within the brain (Gilbert, 2005). The Nurse–Family Partnership is an exciting example of an approach where intensive support and education has been provided antenatally and postnatally to young, socially disadvantaged first-time mothers. Research in the US has demonstrated remarkable long-term outcomes for both the mothers and their offspring (Olds, 2002) and is now being piloted around Britain using specifically trained health visitors and midwives. More generally, midwives or other workers must have the time and training to discuss emotional issues and the opportunity to refer on to other professionals as required.

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## 2. Recognise the potential for care processes to create anxiety and concerns

Currently pregnancy is for many a phase of anxiety compounded by pressure to 'get it right'. Women are bombarded with strictures and advice of dubious pedigree. Whilst information on smoking is clearcut many of the other prohibitions are more nebulous, and it is important care does not become reduced to a list of restrictions. The overall emotional impact not only of well-intentioned advice but also antenatal checks such as ultrasound scans remains to be evaluated, but may have hidden adverse consequences in intensifying women's anxiety. This may have an effect on the developing fetus counter to the one desired. Certainly high levels of anxiety are experienced by a significant proportion of women during pregnancy (Heron et al., 2004). We need to allow women to be more relaxed and where possible to enjoy this phase of life, or to quote Odent (2004): 'The main preoccupation of doctors and other health professionals involved in prenatal care should be to protect the emotional state of pregnant women.'

## 3. Facilitate the transition to motherhood and attachment during pregnancy through providing an opportunity to think and talk about the self as a mother.

There is the opportunity to help women to start to make such cognitive and emotional shifts through talking about what becoming a mother means, what sort of mother the woman does and does not want to be and where those ideas come from (Laxton-Kane & Slade, 2002). Women who are well supported may have opportunities for discussion with close others and develop their sense of self as a caregiver. Unfortunately this is not available for all. A qualitative study of socially disadvantaged pregnant teenagers indicated they had no opportunity to think about or discuss such issues, and the unattainable expectations of many raised the potential for major

disappointments with the mothering role (Oxley, 2005).

4. Provide care in pregnancy that allows adequate opportunity for discussion of labour and childbirth, and helps women to approach childbirth with a tolerance for imperfection, unpredictability and uncertainty. Midwives will talk with women briefly about labour in relation to birth plans, but this is rarely considered in depth. Fear of labour has been identified as a major health issue for the well-being of women and has also been linked to the rising rate of caesarean sections (Saisto & Halmesmaki, 2003). The evidence is that caesarean sections are associated with more adverse physical health outcomes than vaginal deliveries. However, women often perceive them as safer, and where carried out in the absence of clear medical reasons, they may relate to the experience of a previous traumatic birth or fears of pain or loss of control. Psychology has developed effective interventions for fears and phobias, and these have been used in the context of fear of childbirth in Scandinavia. There is evidence that with such input the perceived need for caesareans reduces. Where women with a prior caesarean have a trial of vaginal delivery this usually proceeds well, and women themselves are pleased by the outcome (Nerum et al., 2006). Fear of labour can be effectively treated, and there should be clear identification processes and the opportunity for intervention (Saisto et al., 2001).

We can also borrow from substantial research into the psychology of pain management to utilise approaches such as hypnosis; using language, visualisation, relaxation and understanding of the body to impact upon the ability of the woman to manage the process of labour and birth (Cyna et al., 2004). There is evidence that use of coping strategies in labour is associated with greater satisfaction with self (Slade et al., 1993). There have also been initiatives to facilitate women's existing coping strategies (Escott et al.,

2004) that have shown promising results.

General approaches to preparation for labour and delivery need to be coupled with tolerance of the fact that the process of birth is by its very nature unpredictable. Whilst women can usefully provide a general outline for what they would wish their care to be, there is a need for flexibility about what care may actually be required in terms of analgesia or mode of delivery, and to adapt to this situation. In addition, first childbirth is a new experience, and it is important to help women not to expect themselves to be completely calm and in control (Slade et al., 1993). Setting personal standards for behaviour for the unpredictable arena of labour has the potential to generate distress and dissatisfaction with the self and a sense of failure.

## 5. Ensure that the psychological impact of the midwife on the birthing process is understood via training and policy implementation.

In order for a woman to be able to labour and birth effectively she needs to feel safe and calm. Perceived and actual threat may have a physiological effect that may slow and even stop labour (Simkin, 1986). A sense of safety will come in part from perceiving the midwife as an attachment figure (Page & Percival, 2000). Thus changeovers in midwives during labour have the potential to create a significant level of distress. In addition the midwife can become a source of threat through insensitive communication, or can be a vital source of soothing and safety. It is crucial to understand the profound neurophysiological impact that criticism, voice tone, and facial expression can have on one's sense of safeness (Gilbert, 2005) and thus potentially on the birth process itself. This has implications in terms of employing sufficient midwives to provide one-to-one care for as large a part of the birth as possible. Understanding the power of communication skills and the provision of sensitive care in the delivery suite should be as much a part of midwifery training as medical procedures.

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Post-traumatic stress symptoms after labour are associated with perceptions of insensitive care, poor communication and feeling unsupported by staff (Czarnocka & Slade, 2000). This once more reinforces the importance of clear, open, respectful and sensitive communication so that women feel well informed and supported by staff. It is important for staff to recognise that what may be a routine experience to them may be an entirely new and potentially frightening experience for the woman, and indeed her partner as well.

6. Facilitate available support in the natural environment – don't forget the dads.

This principle applies at all stages of pregnancy, childbirth and the postnatal period. One of the main benefits of antenatal education has been the formation of social networks (Hillier & Slade, 1989). Whilst this is not a specific service aim, the fact that such services have been dramatically reduced in scope over recent years may have increased isolation and reduced support at this important period. Some specific brief intervention studies aimed at providing additional professional support external to existing relationships have shown generally disappointing results. It may be that it is more useful to consider facilitating support between partners.

Lack of support from the partner is one of the strongest predictors of postnatal depression in women (Beck, 2001). Divorce and serious arguments with one's partner are two of the most significant causes of antenatal stress linked to a long-term developmental impact on the child (O'Connor et al., 2002). Partners of women with maternal depression are also more likely to become depressed themselves (Benazon & Coyne, 2000). Services therefore need to adapt to include the father. There may also be scope for enhancing couples' communication skills. This could take the form of both promoting understanding of each other's needs during the birth and

postnatal period and developing understanding of normal changes in partner, social and sexual relationships as a couple become a family unit (Iles, 2008). However, inclusion of the partner is complex. For example, the presence of the father at the birth is often valued highly by the woman in labour and is now expected in most Western countries, but evidence for the positive impact upon the woman's birth experience and outcome is mixed (Chalmers & Wolman, 1993). Indeed, being present at the birth may also have a negative impact on the father (Bartels, 1999). Thus careful consideration should be given to how best support both partners and their relationship through pregnancy, birth and the postnatal period.

7. Maximise opportunity for, and understanding of, mother-infant bonding.

There is a significant number of mothers who struggle to bond with their infants (Taylor et al., 2005). This is sometimes referred to as the 'last taboo' with mothers often unable to admit their lack of feelings, or to experiencing feelings of irritation, dislike or hostility, towards their child. This may resolve over time but if it does not it has the potential to become a hidden but serious problem that can have a profound effect on the child's long-term development (Bowly, 1988). Literature provided routinely after birth may help to destigmatise bonding difficulties and suggest approaches or services that might facilitate early improvement in the mother-infant relationship.

In the longer term, mental health difficulties can have a detrimental effect on the quality of bonding between mother and infant (Murray & Cooper,

2003). However, treatment of the mental health difficulty does not necessarily have a significant impact on the mother-infant bond (Milgrom et al., 2006). Few services are available to treat mother (and father) bonding difficulties. There is now a growing pressure to develop NICE guidelines for infant mental health (See Association of Infant Mental Health UK) as a separate document to the NICE guidelines for antenatal and postnatal mental health (2007) to reinforce the importance of skilled intervention for the parent-infant relationship.

8. Recognise the range of postnatal distress and ensure appropriate care is available.

In particular, it is important to recognise the wide range of distress from anxiety, panic to post-traumatic stress, obsessive compulsive disorder and depressive symptoms. We have become focused on postnatal depression in perhaps an unhelpful way (Brockington et al., 2006). There should be routine discussion of psychological issues postnatally as part of the routine care, within an ongoing supportive relationship. The PoNDER study is a trial of training health visitors both to identify and intervene with women experiencing depressive symptoms (Morrell et al., 2009). Whether health visitors were trained in person-centred counselling or cognitive behavioural approaches did not seem to

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matter, but new mothers where their health visitors received training all fared better at both at six and 12 months postnatally than those in a usual care group. Interestingly the benefits appeared across the range of distress and were unrelated to level of input. It may be it is the availability of help, within the context of a long-term ongoing supportive relationship with a competent and trained professional, that is the important element.

Providing early identification of risk for post-traumatic stress is also important. It is now recognised that post-traumatic stress may follow childbirth in a small proportion of women (Czarnocka & Slade, 2000). Approximately one third of women report the experience of childbirth as being traumatic (Creedy et al., 2000). Several simple questions concerning perinatal experiences of fearfulness could be asked postnatally prior to hospital discharge to identify women potentially more at risk of adverse reactions. This information could enable health visitors to check whether a woman was later experiencing psychological symptoms in relation to her childbirth experience. If so, she could then facilitate appropriate referral for what currently is an important, but hidden and poorly recognised problem that may have adverse implications for women's perceptions of their infant (Davies et al., 2008). There is some early evidence from Australia that suggests the value of brief telephone counselling, but this requires further development and evaluation (Gamble et al., 2005).

Where serious mental illness presents postnatally, such as puerperal psychosis (a rare but severe form of bipolar illness that can develop rapidly a few days following delivery) or severe depression, health professionals need to feel confident in identifying the illness, and to know where to refer to. Such serious psychiatric illnesses have been identified as one of the main causes of maternal death (Oates, 2007), so it is imperative treatment can be offered swiftly. Emergency access to

treatment is thus required where a woman can be treated without being separated from her baby. This is being addressed, but in many places no such services exist.

## Conclusions

These ideas stress the value of facilitating mental health during pregnancy rather than focusing purely on the postpartum. They emphasise helping a woman to feel valued supported and unpressurised throughout this time. The themes underlying these ideas are (a) to maximise support available both professionally and in the woman's natural environment to facilitate reducing anxiety and depression, (b) to identify and intervene with fears, help women tolerate uncertainty and unpredictability and to avoid setting themselves unachievable standards, and (c) to facilitate women's concept of self as a mother. We also need to give careful consideration as to how to involve partners without reducing it to an obligatory attendance at the birth.

Pregnancy and the early postpartum are phases of life of relatively intense input from healthcare professionals, in particular from midwives, doctors and health visitors. Alongside this the mental health of women at this particular time impacts not only on themselves but in a crucial way on the well-being and development of the baby. Pregnancy and the postnatal period therefore provide the ultimate opportunity for preventative care. Consideration of mental health and development of parenthood needs to be a routine part of all consultations. To achieve this there needs to be an ongoing programme of staff training focused in these areas. There also needs to be an emphasis on continuity of antenatal and postnatal care; this allows the establishment of trust and also helps in recognition of change in an individual's mental health.

Psychological input into perinatal services is currently limited and geographically highly varied. NICE

guidelines (2007) recommended that psychological treatment should be offered as the front-line treatment rather than medication because of the potential impact of medication on the fetus and the breast-feeding infant. Furthermore it recommended that it should be offered before women reach clinical levels of mental health difficulties because of the potential long-term consequences of mental health difficulties upon the fetus and infant. At present these recommendation can rarely be met. Changing commissioning perceptions to seeing routinely integrated psychological care as 'an integral part of the cake' rather than as the 'icing on the cake' is needed if real change is to be made and sustained. Following the recent initiative for Improving Access to Psychological Therapy, a Positive Perinatal Practice IAPT Guide has been developed which may assist commissioning of services (IAPT, 2009). Effective mental health care in pregnancy and the early postpartum together with facilitating transition to parenthood has the potential to set the scene for more healthy individuals, families, communities and indeed societies.

(See [www.bps.org.uk/ppsig](http://www.bps.org.uk/ppsig) for the Division of Clinical Psychology's Faculty of Perinatal Psychology)



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