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Chapter 1: Introduction

Sue Gellhorn

This book is intended to be a helpful resource and source of inspiration for all midwives, health visitors, children’s centre staff and others working to develop the care they can offer to women with maternal mental health difficulties and their babies. It is hoped that it may also be of use to GPs, obstetricians, practice nurses and other professionals providing psychological care in primary and maternity care settings.

All the contributors are passionate about maternal mental health and have a very strong commitment to training, teaching and supervising. Recent statements from the Department of Health (2015) and the professional bodies for midwifery and health visiting have noted that midwives and health visitors can feel ill-equipped and lacking in confidence to ask about and offer help with maternal mental health difficulties. Good training on perinatal mental health is only just beginning to shape up as service need is finally recognised. Many of the contributors have had to find their training and learning experiences on an ad hoc basis. Robust and comprehensive training in maternal mental health is not yet available for all those staff who need skills in this area. This means that providing care for women with mental health needs can feel like an isolated business. It is hoped this volume will serve as something similar to a knowledgeable and supportive colleague when challenging work provokes questions and doubt.

Mental health and the maternity journey

Having a baby is a powerful physical experience for a woman. It is also a powerful psychological experience, particularly for first time mothers, but also for women repeating the experience of childbirth at a different point in their lives.

Recent campaigns and national reports aimed at raising awareness (Bauer et al, 2014) have highlighted that the idea that little intervention is required in postnatal depression is very far from the case. Apart from the distress and psychological cost to mother and baby, the social and health costs of untreated perinatal mental health difficulties are huge. These include the costs of child and adolescent mental health services dealing with children’s behavioural problems, special education provision, family courts, social services and probation services.
In the UK, maternity services, although at times overstretched, are well placed to provide physical and medical care to the pregnant woman in a variety of settings, including in her own home. However, services are now also becoming mindful of the psychological care or mental health support services a mother and baby may need in order to flourish, progress and enjoy life in the first year of parenting. Even more importantly for the new infant these are the formative experiences that will shape the foundation for the whole of their life. The NSPCC’s *Prevention in Mind* report found that 122,000 babies under one were living with a parent who has a mental health problem (Hogg, 2013).

Whether her baby was planned or not, women come to motherhood with a personal history and a set of dreams and aspirations which affect the unfolding mother-baby relationship in two important ways. Firstly, they affect how the mother experiences her pregnancy, the events of giving birth and how she views herself as she begins to take on her role as mother. Secondly, they affect how she sees her baby, from the minute they are born to how she makes sense of their behaviour, cries and early infantile relating. These ideas of early mother-baby relationships will be explored in more depth in later chapters which will examine concepts such as attachment and ‘mentalisation’ (essentially the imagining of the mind of another) and how they shape the interplay of responses and connections between mothers and their babies (see Chapter 6).

When a mother is depressed, withdrawn or distressed by other psychological difficulties, if these issues are not picked up and attended to by others, her isolation and troubled state of mind may create a negative maternal journey. In another scenario, where a mother is making her best attempt at attentive and thoughtful care, but a good connection with the baby is lacking, then other sorts of help or treatment may be required. Of course there will be ups and downs in the journey of new motherhood, but ideally mistakes and bad days are balanced by a generally positive mother-baby connection. Caring for a baby involves a relationship, therefore providing professional care for these mothers and babies must involve building a relationship with both.

Postnatal depression is the best known, although not necessarily best understood, of the range of perinatal mental health difficulties. Recent research and developing clinical expertise have shown that it is important not to group all sorts of maternal mental health difficulties under this heading. For one thing, many women are known to experience a variety of mental health difficulties in pregnancy. For example, antenatal anxiety is now found to be extremely common and has a measureable impact on maternal and infant well-being. In addition, depression in the postnatal period has many differing presentations and without a knowledge base of the range of difficulties that can be experienced, misconceptions are likely, and help and treatment may not be accessed.
Case example: Catherine

Catherine was a successful lecturer in dance and theatre studies. She had always worked extremely hard to do well. She had a horror of acknowledging any personality traits which she saw as indicating ‘weakness’. After the birth of her first baby she found the sleep deprivation and lack of structure to her day disorienting. She felt that she had lost sense of who she was and felt little connection to her new baby. For a few weeks she found it difficult to even communicate with her family and was unable to leave the house alone. Her GP diagnosed postnatal depression and recognised that she was quite unwell and in need of treatment and careful monitoring. A combination of GP support, medication and practical and emotional support from family helped her recover after a frightening couple of months.

Summary of key facts from NSPCC report

Prevention in Mind (Hogg, 2013)

Maternal mental health difficulties are diverse and complex. With a better understanding of their nature midwives, GPs, obstetricians, health visitors and children’s centre workers can work on prevention, identification and treatment of women to mitigate against the effects on families’ and children’s future well-being. This chimes with the Government recognition of ‘no health without mental health’ for real progress in public health (Department of Health, 2011).

Some women have no previous history of mental health difficulties prior to pregnancy and motherhood but for a number of reasons find the adjustment of lifestyle, relationships and the role that motherhood requires makes it difficult for them to cope. Other women may have a pre-existing mental illness which persists, deteriorates or recurs during the perinatal period. Women with schizophrenia and bipolar disorder are at a heightened risk of relapse of their illness when having a baby. Sadly, many women also avoid taking medication which has been keeping them well up until their pregnancy, often because they do not take advice about the best plan for their care and sometimes because they are ill-advised (see Chapter 9). Puerperal psychosis, which is much less common, is a very serious mental illness presenting risks to both mother and baby. The onset is typically within two weeks of the birth (and often in the first few days) and constitutes a psychiatric emergency.

Depression is especially common, with 10 to 14% of mothers affected either in pregnancy, postnatally or across their whole maternity experience. Tearfulness, feeling low, poor concentration, irritability and feeling overwhelmed are very common symptoms observed or reported by women. However anxiety is also now
known to be very common, both in pregnancy and after giving birth. Anxiety often takes the form of excessive concern about the baby’s well-being and after birth can lead to hypervigilance towards the baby and sometimes sleep difficulties as a result. Much of the focus in previous decades has been on depression but there is now better recognition of anxiety symptoms, both as part of the clinical picture in perinatal depression but also as part of other disorders, such as perinatal obsessive compulsive disorder and post-traumatic stress disorder (PTSD), and existing as a clinical problem in its own right.

PTSD appears to be more common in pregnant women than in the general population. Symptoms of earlier trauma can emerge at this time, especially for women who have experienced childhood abuse or sexual abuse. For these women, pregnancy, becoming a parent and the physical intimacy of delivery and baby care can create problems.

For many women there is a continuity in their symptoms from pregnancy to early motherhood and therefore there is scope for professionals to support and intervene early on in pregnancy to work on prevention. Indeed, for women who have been depressed earlier in their life, sometimes for several years, intervention when they become pregnant is especially important.

Taking the opportunity to offer mental health care

The frequency of health care contacts when women are pregnant or have just given birth presents good opportunities to offer services to women with mental health difficulties who may not have been diagnosed or offered treatment before. The first step is recognition and detection (see Chapter 3) facilitated by asking about psychological health and well-being. This can then be followed by listening, sensitive support and the offer of effective treatment approaches. Women also need to be kept in mind by the different parts of primary care and community services, so that women who do not take up or feel comfortable with what is first offered can be followed up and offered a different kind of service or treatment.

Babies’ development and urgency in maternal mental health care

Help for perinatal mental health problems needs to be sensitive and prompt – a baby’s development is unfolding day-by-day and their experience is minutely influenced by their mother’s mood, sense of well-being and daily functioning.
Postpartum psychosis
Postpartum psychosis is a severe mental illness that typically affects women in the weeks after giving birth, and causes symptoms such as confusion, delusions, paranoia and hallucinations.
Rate: 2/1000 maternities

Chronic serious mental illness
Chronic serious mental illnesses are longstanding mental illnesses, such as schizophrenia or bipolar disorder, which may be more likely to develop, recur or deteriorate in the perinatal period.
Rate: 2/1000 maternities

Severe depressive illness
Severe depressive illness is the most serious form of depression, where symptoms are severe and persistent, and significantly impair a woman’s ability to function normally.
Rate: 30/1000 maternities

Post traumatic stress disorder (PTSD)
PTSD is an anxiety disorder caused by very stressful, frightening or distressing events, which may be relived through intrusive, recurrent recollections, flashbacks and nightmares.
Rate: 30/1000 maternities

Mild to moderate depressive illness and anxiety states
Mild-moderate depressive illness includes symptoms such as persistent sadness, fatigue and a loss of interest and enjoyment in activities. It often co-occurs with anxiety, which may be experienced as distress, uncontrollable worries, panic or obsessive thoughts.
Rate: 100-150/1000 maternities

Adjustment disorders and distress
Adjustment disorders and distress occur when a woman is unable to adjust or cope with an event such as pregnancy, birth or becoming a parent. A woman with these conditions will exhibit a distress reaction that lasts longer, or is more excessive than would normally be expected, but does not significantly impair normal function.
Rate: 150-300/1000 maternities

* There may be some women who experience more than one of these conditions.
Source: Estimated using prevalence figures in guidance produced by the Joint Commissioning Panel for Mental Health in 2012 and ONS data on live births in England in 2011.

Figure 1.1: Estimated numbers of women affected by perinatal mental illnesses in England each year. Reprinted with permission from Hogg S (2013) Prevention in Mind. All Babies Count: Spotlight on perinatal mental health. NSPCC.
There are three key tasks for parents in the early months of caring for their baby.

1. To establish a secure attachment to their baby so that the baby can begin to learn about the world, themselves and how to relate to others with parental help reliably available.

2. To help the baby with emotional regulation. This means helping the baby recognise and manage the ups and downs of daily life and the range of emotional states.

3. Build up secure attachment by everyday sensitive and responsive care from parents, noticing and attending to their baby’s needs (see Chapter 6).

Studies have shown that babies’ emotional and cognitive development is adversely affected by care giving from a mother who is clinically depressed (Murray et al, 2010).

These effects are mediated in complex ways. The two main ways the developing infant is affected are:

1. A neurophysiological impact on the baby’s developing nervous and endocrine system.

2. A psychosocial impact on an infant’s learning about themselves and how they can relate to others through a good connection (or otherwise) with their mother.

Studies have shown that pregnant women experiencing significant depression or anxiety produce higher levels of the stress hormone cortisol (Glover et al, 2010). This cortisol crosses the placenta and affects the developing nervous system of the foetus both in terms of neural structure and physiology. Babies with this inheritance do not regulate stress and emotions well and may be primed to be anxious and jumpy or suppress their emotions if cortisol levels are excessive and too high to be regulated.

Taken together, studies of infant development and neurophysiological research show that stress in infants is real and may have a significant impact on their emotional regulation and resilience as they develop (Glover et al, 2010; Gerhardt, 2015). It is recognised that the severity and chronicity of the mother’s difficulties will mediate the effects on her baby. Glover (2014) also points out that some of the early effects measured that were linked to postnatal depression might have been the result of anxiety in late pregnancy which is now known to impact on hyperactivity and attention difficulties seen in young children. Studies are just beginning to provide evidence that the maternal care provided continues to influence the developing neurophysiology of a baby after birth (Bergman, 2010). This is encouraging for intervention programmes where mothers are known to have been stressed or depressed in pregnancy.
Avoiding the catch-all label

In National Guidance (NICE, 2014; Hogg, 2013) use of the term ‘postnatal depression’ is cautioned against. This is for a number of reasons, some of them highlighting serious consequences which have emerged from reports examining maternal and infant deaths.

Firstly, the Centre for Maternal and Child Enquiries (Oates & Cantwell, 2011) report underlined how when the term postnatal depression is used, women’s mental health difficulties in the perinatal period can easily be seen as less serious than they actually are, in terms of severity of disturbance and risk. Secondly, evidence has shown that where women’s difficulties are incorrectly given this label, without careful assessment or diagnosis it can obscure the details of other symptoms or experiences she is actually having. For example, a woman may be beginning to have symptoms which indicate puerperal psychosis, believing she is not the mother of her child or that her child is threatened by malevolent forces. Or she may be suffering from PTSD and experiencing flashbacks, panic attacks and de-personalisation. These disorders are not the same as postnatal depression but may be misdiagnosed as such. These difficulties will have a different impact on the woman and her baby and the intervention required will be very different.

The third reason why using the term postnatal depression as a catch-all label for new mothers is advised against is that, where there is a lack of knowledge about perinatal mental health, it can be confused with the so-called ‘baby blues’. The ‘baby blues’ is a period of low or changeable mood and tearfulness which is very common after giving birth and passes in two to five days. It therefore needs little attention or intervention apart from reassurance that it is very common and will pass. This is not the case for many maternal mental health difficulties inappropriately referred to under the umbrella term ‘postnatal depression’.

Overview of content and contributors

The book is a collaborative effort and has brought together multidisciplinary expertise from clinical psychology, midwifery, health visiting and perinatal psychiatry. All the contributors have an interest in excellent mental health service provision. They also have an interest in attachment and psychoanalytic ideas and especially care that thoughtfully acknowledges women and their individual stories.

Chapter 1: Introduction (by Sue Gellhorn)
This chapter has introduced postnatal depression and the spectrum of maternal mental health difficulties that women can experience across their maternity
journey. Key facts from the epidemiology of maternal mental health in the UK have been presented. The opportunities for offering mental health support and the crucial timeliness of this, in terms of protecting infant emotional development, have also been highlighted.

Chapter 2: Perspectives on postnatal depression (by Sue Gellhorn)
This chapter outlines how the understanding of maternal mental health has evolved over the past few decades and how it is conceptualised by different professional groups and academic specialties. How some of this thinking continues to inform our current understanding of women’s difficulties and service provision in the area is examined.

Chapter 3: Detection, recognition and assessment of maternal mental health difficulties (by Sue Gellhorn)
This chapter examines the approaches and tools that are currently available for the detection and assessment of maternal mental health difficulties. Some of the barriers to the detection and recognition of these difficulties, for both professionals and the women themselves, are considered.

Chapter 4: Levels of intervention, treatment and support (by Sue Gellhorn)
This chapter looks at the levels of intervention, support and treatment that may be needed and the community, psychological and medical treatments that are typically offered in the UK at the time of writing. The national and professional guidance on treatment recommendations are considered.

Chapter 5: Normal anxieties in early motherhood and those needing professional attention (by Sue Gellhorn)
This chapter presents some of the common worries encountered in new mothers. Understanding the roots of some of these worries is explored. The chapter goes on to examine when pregnant women and mothers who are expressing worries to professionals might need further professional intervention. The vulnerability factors for postnatal depression are discussed.

Chapter 6: Keeping the baby in mind: baby-mindedness in parents and professionals (by Eleanor Grant)
This chapter introduces the concept of a mother's attachment to her infant and the impact of postnatal depression on this attachment. The theoretical understanding of maternal mental health difficulties from the perspective of a woman’s own parenting and attachment history are considered. New clinical services which aim to support attachment relationships between mothers and their newborn infants are introduced.
Chapter 7: Working with the whole family (by Sue Gellhorn)
This chapter examines the impact of maternal mental health difficulties on the wider family. Working with fathers and partners in ante-natal preparation and postnatally, and supporting family members in different family contexts are considered. Cultural factors in different family situations are discussed.

Chapter 8: Supporting mothers in complex family contexts (by Sue Gellhorn)
This chapter examines the challenges of supporting pregnant women and new mothers approaching childbearing and parenting in complex family contexts. Providing care for asylum seekers and refugee families and supporting mothers and babies who are homeless are considered. Ways of working with mothers experiencing domestic violence and drug and alcohol addictions are also introduced.

Chapter 9: Severe perinatal mental health difficulties (by Agnieszka Klimowicz and Elizabeth Best)
This chapter gives key information about the less common but more severe perinatal mental illnesses, including postpartum psychosis and severe postnatal depression. The learning points from the CMACE (2011) enquiries are highlighted. The role of perinatal psychiatry services and mother and baby units and of midwives and health visitors in liaising with these services is described.

Chapter 10: Other types of maternal mental health difficulties (by Sue Gellhorn)
This chapter considers a number of common maternal mental health difficulties which need to be understood as distinct from postnatal depression, but may also be found as co-morbid conditions alongside postnatal depression. These include obsessive compulsive disorder, anxiety disorders, post-traumatic stress disorder and personality disorder.

Chapter 11: Challenges for midwives (by Heather Jenkins)
This chapter considers the particular challenges for midwives and maternity services in providing care for women with maternal mental health difficulties. The challenges of having sensitive conversations with women where continuity of care is compromised are examined. Training and organisational issues for midwives are considered. The role of supporting women taking medication and making decisions about medication and breastfeeding is covered.

Chapter 12: Challenges for health visitors (by Gemma Caton)
This chapter explores the variety of roles taken up by health visitors in relation to maternal mental health. The opportunities provided by an ongoing relationship with young families are highlighted. The theoretical concepts underpinning
listening visits and new mother-baby interventions are discussed, and organisational challenges for the health visiting profession are presented.

Chapter 13: Perinatal mental health pathways and networks (by Eleanor Grant and Gemma Caton)
This chapter looks at how to make care pathways for maternal mental health a reality. National and professional developments focusing on improving care pathways are highlighted. Making good professional links and referrals to other community and expert providers is considered. The development and role of local service champions are discussed. The importance of clinical supervision and self-care for professionals working with mothers and babies in difficulty is emphasised.

References


