The Marcé Society for Perinatal Mental Health

RESOURCE PACK CONTENTS LIST ON PAGE 8

Preface

The Marcé Society is an International Society for the Understanding, Prevention and Treatment of Mental Illness Related to Childbearing. With the information contained in this packet, it is our hope that this piece will be another tool in advancing support for perinatal and women's mental health. Focusing intervention on the perinatal period builds upon women's interest in embracing positive health behaviors to invest in the welfare of their offspring, such as decreased smoking and alcohol use. Moreover, successful interventions have the potential to reduce maternal disability as well as mitigate negative impacts upon the children and family. The Marcé Society has developed this publication as a professional education resource for clinicians, midwives, health visitors, students, residents, nurses, and other professionals who care for women during the perinatal period and who wish to update their skills and knowledge of mental health issues surrounding this time. The focus of this resource will be to educate clinicians how to understand and recognize symptoms of mental disorders which impact mothers and their babies. The focus of this piece is not solely postpartum depression – importantly, the guidelines encompass a spectrum of psychosocial and mental health issues known to impact women and families during pregnancy and postpartum. In addition to the information provided, this packet will guide clinicians through many typical scenarios facing women during childbearing including miscarriage, stillbirth, financial crisis, lack of support from partner, unwanted pregnancy, medication usage, etc. This publication will serve as a critical source for clinicians, caretakers, nurses, and midwives looking for answers as to how to best serve their patients and families, providing critical information on mental healthcare at a critical time in life. For more information on other resources available from The Marcé Society, please visit: http://www.marcesociety.com/.

History of the Marcé Society

By Nine Glangeaud –Freudenthal
President of the Marcé Society, founding member and past-president of the Société Marcé Francophone (SMF).

Original information gathered by Nine Glangeaud, assisted by Jane Honikman, Carol Henshaw, Margaret Oates, Gene Paykel, Ian Brockington and Marianne Kumar and partially published in

- *The Marcé Newsletter (Issue 11, February 2001)*
- *Psychological Medicine, 2002, 32, 559-561 by Glangeaud-Freudenthal N MC "Channi Kumar's Contribution to Perinatal Psychiatry. A personal tribute from France".*
- *Archives of Women's Mental Health 2003, 6/sup2, 79-82 by Glangeaud-Freudenthal N MC "Channi Kumar and the History of the Marcé Society".*

In 1996, and again several times later, when I felt discouraged about the prospects of establishing a Francophone section of the Marcé Society, Channi Kumar encouraged me by telling me the story of the Society's beginnings. Like many others, I miss Channi's support and sympathy.

Channi explained that before the 1980s, although quite a few people, in different disciplines and professions, were working on postnatal disorders, they had no way to share their knowledge and ideas. Channi Kumar, James Hamilton, and Ian Brockington, exchanging views at meetings, came up with the idea of founding an international society; open to all professionals, aimed at improving the understanding, prevention and treatment of mental disorders related to child-bearing. They wanted members of the society, from all over the world, to meet at least biennially to exchange information and ideas about their practice and research and to initiate collaborative research.

In the *Bulletin of the Society* (spring 1993) Gene Paykel wrote:

> *'The parents of the Marcé Society were Jim Hamilton, Channi Kumar, Ian Brockington, Bob Kendell and George Winokur. An unusually large number for one child and also entirely single-sexed, but the Society has made up for that since then'.*

Recently, Ian Brockington answered my question on the origins of the MS saying:

> *"The idea of the Society arose out of correspondence I had with Jim Hamilton, starting about 1977 when I wrote to con-sult him about a mother with a bonding disorder (which was then terra incognita). I think he suggested it. There was a small meeting at Queen Charlotte's organised by Merton Sandler, and I think I discussed the matter with Channi Kumar there. He and I discussed many things related to mother & baby units etc. In June 1980, I took the initiative of arrang-ing an international conference, to which Jim Hamilton and Ralph Paffenbarger were invited. Although we advertised it only 7-8 months ahead, we had about 150 delegates. After the conference, my wife hosted a dinner for 6 individuals -Jim and myself, Channi, Ralph Paffenbarger, Bob Kendell and George Winokur - all Anglo-Saxon men, I am afraid. It was decided to found the Society there and then. It was left to Channi and me to do the work. During the next year we worked it all out, including the constitution and Channi arranged the second conference, at the Maudsley, in 1982, at which the first committee was elected. The original constitution stipulated a Founding Committee consisting of the 6 founders (not "founding members" - there were many of those) and past presidents."*

Ian Brockington also wrote in his obituary of James Hamilton:

> *"On the evening of Friday 20th we held a dinner at my house.. .attended by three Americans {James Hamilton, Ralph Paffenbarger and George Winokur)*

*and three Britons (Robert Kendell, Channi Kumar and myself).James...urged us to create the new society. This was the birth of the association from which Channi Kumar suggested the name of Marcé Society".(*Archives of Women's Mental Health, 1998, 1: 2)

Recently, Margaret Oates wrote to me, also answering my question on the origins of the MS:

"The Marcé Society was "conceived" in Frank Margison's house in Manchester in early 1980. Physically present at the meet-ing were Frank, Ian Brockington, Channi Kumar, John Cox and myself. I think Bill Deakin may also have been there. Paffenbarger, James Hamilton and George Winokur were contacted on the telephone. This group, together with Bob Kendell were the original "founding fathers" or "steering committee".

This Manchester meeting must have been a very stimulating and productive meeting.

Channi Kumar also told me that he was fascinated by the very early work of a French physician, Louis Victor Marcé, who was one of the first to describe specifically puerperal mental disorders. It was for this reason that he suggested naming this new association after Marcé. Recently Marianne Kumar told me a nice story:

"At this time, Channi talked so much about this French physician that I looked for LV Marcé's book in all the used book-shops in Paris until I found it and could give it to him for Christmas".

Louis Victor Marcé (1828-1864) was born in Paris. In 1858, he wrote *"Traité de la Folie des femmes enceintes, des nouvelles accouchées et des nourrices* (Treatise on psychoses of pregnant women, and newly delivered and nursing mothers)" and some other works on mental illness. The treatise is said to have been translated at Keele University but no trace of this translation has been found (Carol Henshaw,

2006). In the Spring 1994 Marcé Bulletin, John Cox published some extracts and comments from it, together with LV Marcé's curriculum vitae.

The Marcé Society (MS) was officially launched during the first academic meeting on Puerperal Mental Disorders held in Manchester in July 1980. The first MS President was Ian Brockington, Channi Kumar was Vice-president, and Frank Margison was Secretary/Bulletin Editor. The first "real" Biennial General Meeting (BGM}, however, was held in London in 1982, organised by Channi Kumar at the Institute of Psychiatry.

Channi Kumar was elected President at the BGM held in San Francisco (California) in 1984. The next president was John Cox, elected at the 1986 Nottingham BGM. The BGMs were then held in Keele in 1988 and in York in 1990. Margaret Oates took over the presidency at the1989 annual meeting in Amsterdam, succeeded by Gene Paykel, who took over at the 1992 Edinburgh BGM and served until 1994. During his presidency the constitution was rewritten, including pro-visions for two-year presidential terms. Brice Pitt was elected at the 1994 BGM in Cambridge, followed by Mike O'Hara in London (1996) and Louis Appleby in Iowa (1998). During Appleby's term, MS executive meetings began to be con-ducted by e-mail. The constitution was also amended to meet the Society's developing needs. These changes included the granting of official status to national groups. The first two were the Australasian and Francophone Societies - and the direct election of the President and other officers by the Marcé Society members. During the 2000 BGM in Manchester, Philip Boyce was elected president and Lynne Murray president-elect. Philip Boyce organised the next BGM, held in Sydney in 2002, Lynne Murray held the 2004 meeting in Oxford and the 2006 Biennial International Scientific Meeting and BGM were held at Keele University UK. Bryanne Barnett held the 2008 Biennial International Scientific Meeting and BGM in Sydney Australia. Kathie Wisner held the 2010 Biennial International Scientific Meeting in Pittsburgh USA. Nine Glangeaud –Freudenthal will host the meeting in Paris in October 2012.

Presidents

Ian Brockington	1982-1984
Channi Kumar	1984-1986
John Cox	1986-1989
Margaret Oates	1989-1992
Gene Paykel	1992-1994
Brice Pitt	1994-1996
Michael O'Hara	1996-1998
Louis Appleby	1998-2000
Philip Boyce	2000-2002
Lynne Murray	2002-2004
Carol Henshaw	2004-2006
Bryanne Barnett	2006-2008
Kathie Wisner	2008-2010
Nine Glangeaud	2010-2012
Jane Hanley	2012 -2014

Secretaries

Frank Margison	1982-1988
Beth Alder	1988-1991
Trevor Friedman	1991-1996
Suzanne Steinberg	1996-2000
Jane Fisher	2000-2008
Jane Hanley	2008-2012

Bulletin Editors

Frank Margison	1982 - 1988
Bill Deakin	1988 - 1992
Louis Appleby	1992 - 1996
Beth Alder	1996 - 1 998

Information Editors

Carol Henshaw	1998 - 2002
Nine Glangeaud & Kristina Hofberg	2002-2006
Nine Glangeaud	2006 -2008
Marie-Paule Austin	2006- 2008

Treasurers

unknown	1982 - 1984
Ian Brockington	1984 -1986
unknown	1986 - 1992?
Diana Riley	1992? - 1996
Vivette Glover	1996 - 2004
Paula Brownsett	2004 – 2008
Vivette Glover	2008 - present

Marcé Medal

Margaret Oates wrote to me

> *"The Marcé medal was minted with a grant from Boots Pharmaceutical Co and is given on behalf of the current President and Executive Committee to a person who is thought to have made an outstanding contribution to either the clinical care or research activities in the field of perinatal mental health. The first recipient was James Hamilton, the second Channi Kumar."*

James Hamilton	1990 (given by Channi Kumar)
Channi Kumar	1992 (given by Margaret Gates)
Robert Kendell	1994 (given by Gene Paykel)
John Cox	1996 (given by Brice Pitt)
George Winokur	1998 (given by Michael O'Hara)
Lynne Murray	2000 (given by Louis Appleby)
Michael O'Hara	2002 (given by Philip Boyce)
Vivette Glover	2004 (given by Lynne Murray)
Margaret Oates	2006 (given by Carol Henshaw)
Philip Boyce	2008 (given by Bryanne Barnett)
Ian Jones	2010 (given by Kathie Wisner)
Kathie Wisner	2112 (given by Nine Glangeaud)

Channi Kumar Lecture

Vivette Glover gave the first Channi Kumar lecture in 2004 at the Oxford Biennial Meeting.

David Rubinow from the National Institutes of Mental Health, USA gave the Channi Kumar Memorial Lecture at the Biennial Conference, held in September 2006 at Keele University, UK and in 2008 Nine Glangeaud-Freudenthal was very honored to give it at the Biennial Conference in Sydney.

CONTENTS

Unit 4 [Page 114]
In practice

- Screening for and recognising disorders
- EPDS
- Managing disorders and referring
- Roles of other professionals

Unit 1 Emotions and feelings

Introduction

Around the time of childbirth women need both physical and emotional support from health professionals. This course focuses on the support women need to deal with their emotions and feelings.

In the first unit we look at pregnancy and childbirth as a transition phase for parents, and the needs which emerge from this viewpoint. We consider why it is important to understand women's feelings and emotions and their consequent needs. We consider both the common emotional changes associated with each stage, and factors which influence the enormous variety of emotional responses from individual women. We also look at groups of women with special needs. Throughout the unit we ask you to consider how far you distance your own feelings from the emotional responses of women you care for.

Working through this unit will help you review and refresh current knowledge and awareness about the emotions and feelings which surround childbirth, and also put the rest of the course into context. If the ideas are new to you we suggest you work through the unit and its activities in detail. On the other hand if you find the content of the unit is familiar ground it may be more helpful to skim through the unit as a reminder, or to dip into those sections which introduce new ideas for you.

Objectives

By the end of this unit you will be able to:

- Explain the emotional effects of pregnancy, childbirth and the puerperium as a transitional phase

- Give reasons why it is important to understand women's emotional changes during pregnancy, childbirth and the puerperium

- Describe the common emotional changes that occur during each stage, and the range of women's feelings and needs

- List factors which may contribute to the ways women respond emotionally to pregnancy and the puerperium

- Identify women likely to have special needs.

1 Childbirth as a transitional phase

As a woman and her partner progress through a first pregnancy and puerperium they move through the transition to parenthood and, in the words of one woman, 'all is changed, changed utterly ... ‘ These changes include:

- Change from dyad to triad
- Change from person centredness to responsibility
- Change of quality of relationship with partner and others; for example partner starts to relate to woman as ‘mother’, and this relationship may be affected by his relationship with his own mother – change in status
- Change in demands
- Change in roles
- Change in coping resources, for example less income, entering a job she is not
  trained for new stressors, new relationships, new priorities.

After the birth of a second child, which for many couples is the move to a ‘complete’ family, parents may expect the changes to be less marked, while in fact they can be just as powerful. They may feel ‘We’ve been through this before, we know what we are doing this time’, whereas the emotional responses of each member of the family may be quite different, and there may be the additional complication of sibling rivalry.

Overall the woman and her partner find themselves on 'a journey into the unknown', and for the woman this journey takes place at a time of physical and emotional vulnerability.

We look briefly at one explanation of this transitional phase, and then at ways in which different societies mark the transition in order to help cope with it.

The developmental crisis

Erikson (1963) suggests that people go through separate stages of development in their lives. Before transition to the next stage they need to resolve a dilemma or 'crisis' which is important at that time of life. If an issue is not resolved positively, the person will be psychologically troubled and less able to cope effectively with subsequent crises. How each individual deals with the issue involved at each transitional stage is influenced by their relationships with people who are important to them, and the outcome is reflected in their subsequent self-confidence.

Erikson's model of the transitional phase as a developmental crisis is helpful because it explains:

- That the emotional turbulence and discomfort are both essential and normal
- The need for trusting and supportive relationships from family and society
- The need for Carers to anticipate areas of difficulty for women with special needs, for example, the adolescent mother and others whose essential needs are not being met.

The importance of the transitional phase from woman to mother is reflected throughout the world in rituals, or rites of passage, undertaken by the woman and her close society around the time of childbirth.

For example in some rural societies women are secluded away from the village with older women for the first six weeks after birth. During this time 'female wisdom' is

passed on, breast feeding is established and there are no domestic demands on the new mother. In many Asian societies women have a number of female attendants during the birth, and do not breast feed immediately, because the colostrum is not believed to be good for the baby. For Muslims the first words a baby should hear should be prayers from a religious man. In Sweden paternity leave is usual, acknowledging the father's need for time to adjust to his new role. In many western societies there are few rituals, with perhaps the main ones being physical preparation for the baby (clothing, equipment and the room), visitors and presents for the new baby, and the christening service.

While the rituals in different communities are many and varied a common theme among them is to meet the mother's need for support and advice and in particular to protect her from everyday responsibilities for a short while after the birth.

Such rituals help both the woman and her community to adapt to and accept her new status. They are one way of acknowledging and responding to a woman's physical and emotional needs.

If midwives are unaware of the rituals they may misunderstand the needs of women. For example a midwife who is unaware of customs in communities from the Indian subcontinent may feel resentful when an Asian mother rejects having the baby delivered on to her stomach (whereas the woman is perpetuating the custom of not starting to feed until the colostrum has been expressed); or think the new mother is lazy when she stays in bed expecting others to care for the baby (whereas the Asian custom is for the new mother to be responsible only for breast feeding, with female relatives taking on all other domestic duties and care of the baby).

It is helpful to be aware that the transition to parenthood is marked by varying rituals in different societies, so that you can recognise and respond to possible variations in the needs of women from different communities.

Activity 1.1

This activity will help you to identify some rituals associated with childbirth. Remember, if you are already familiar with the content of this unit you may wish to select only those activities which will be most productive for you to work through.

If possible, find three women from very different backgrounds and ask them what kind of things their family and community do to mark the transition to parenthood. (You could, for example, talk to women of different religions or from different cultural backgrounds.)

If you have little contact with women from minority communities, talk to three women of different ages (for example, to a grandmother or to a teenage mother) or from different social classes about how they would mark the transition to parenthood.

	Background	***Rituals to mark the transition to parenthood***
1		
2		
3		

This activity will give you some idea of the variations in rituals that are used in different communities, different age groups or different social classes to mark this period of transition. We have already mentioned a number of rituals associated with different cultures and communities. An example of a tradition which older Christian mothers may have mentioned is ‘churching’ (the first public appearance of a woman at church to give thanks after childbirth) which has now more or less died out.

At the same time, it is unwise to assume that an individual woman from a particular background will automatically follow the general pattern. Each individual has her own needs and wishes, and these should always be elicited.

Childbirth, then, is seen as a transitional phase – a time of emotional upheaval. We will now focus on some feelings and emotions that might be experienced and how they might be acknowledged.

2. Feelings and emotions

This is what Laura told her mother on the evening after her first visit to the antenatal clinic.

> *"I found the clinic all right but it felt strange having to talk to the woman through a glass partition. The woman who spoke to me had a label on which said she was a records clerk. She was quite nice and I was pleased that she didn't call me Mrs. or Miss; she just referred to me as Laura Brown. She sent me round a corner and a friendly woman in a brown overall asked me to do a 'mid stream specimen'. I didn't know what she meant and I didn't like to ask. Anyway one of the other women in the queue told me what to do, I hope I did it right.*
>
> *Then I had to sit in a queue, there were an awful lot of pregnant women there and some of them looked very big. Someone said I had to have a 'booking interview'. A pretty nurse came. She said her name was Jane and that she was a midwife. Mum, what is a midwife? What does she do? I didn't like to ask. Anyway she was very nice. She took me into a little room and had a folder with my name on it. She asked me a lot of questions and she was filling in the answers in the folder. I didn't like it when she asked me who the baby's father was, but she wasn't cross when I said that Tim had left me. She asked me how I had felt when I first found out I was pregnant. I came over all hot when I remembered how upset I had been and that I had wanted to get rid of the baby. I told her about that and she didn't seem shocked, she just asked how I felt now. She also asked if I wanted to see the social worker.*
>
> *She asked me a lot of questions about illnesses that I had had and that you and Dad had had. I hope I told her the right answers. I felt exhausted when all this questioning was over. After that I had to go and sit in another queue. I was told I had to see the consultant. I was called into a room with a long narrow bed in it. There was a paper sheet on the bed. Another nurse (or was she a midwife as well?) told me to get up on the bed as Dr Green would be in in a minute. It seemed ages before a man in a white coat came, I don't know if he was Dr Green. He looked at the folder which had my name on and then asked me a lot of the questions that Jane had asked me. He looked quite cross at times and altered some of the things that Jane had written down. I wonder if I had given him different answers. He kept asking me if I was sure of my dates but I was glad he didn't ask me about Tim again. He examined me like the doctor used to do at school and then he did what he called an 'internal'. It wasn't very nice and I was very embarrassed. He told me I had to have a smear, what did he mean?*
>
> *When this was all over I had to go and sit in another queue to have some blood taken. Then I was sent to the X-ray to have a scan. Yes, there was another queue here, but it was lovely to see the baby. The lady showed me the baby's head, and I saw the heart beating and she showed me an arm and a leg. I felt awful when I realised I had thought about killing the baby. When*

the scan was over I was sent back to the clinic to see Sister. She told me that I had to go back to the clinic in four weeks time.

I left the clinic at ten past twelve; I'd got there at nine. I hope it doesn't take so long next time. I'm not really sure if it was all necessary but it was nice to meet other pregnant women, and look at all these leaflets they gave me – it'll take me all my pregnancy to read them".

Activity 1.2

This activity will help you to identify the emotions Laura expressed, and assess how well they were dealt with by her carers.

Make a list of the emotions and feelings Laura experienced during her booking visit:

Put a cross by those emotions and feelings which you feel the staff at the booking clinic did not understand or acknowledge.

Overall, how far do you think Laura's emotions and feelings were understood by the staff at the booking clinic? Circle one of the following responses.

Very well Well Adequately Not very well Not at all

How would it help Laura if her feelings were understood and acknowledged?

Here is our response to the activity

The Xs in the left column indicate emotions which we feel we are not acknowledged or understood.

	Emotions and feelings Laura experienced
X	Strange feeling for Laura to talk through the glass partition.
X	Laura was pleased to be called Laura Brown.
X	Laura did not want to say she didn't know what a 'mid stream specimen' was.
X	Laura did not like to ask what a midwife was.
X	Relief when the midwife did not 'judge' Laura about the father.
X	Relief at the midwife's reaction to Laura's initial desire to get rid of the baby.
X	Impression that there are 'right answers' about illnesses, etc.
X	Exhaustion after the questioning.
X	Laura was unclear who the consultant was.
X	Relief the consultant did not ask about Tim again.
X	Embarrassed about the internal examination.
X	Pleasure seeing the baby during the scan.
X	Feeling bad about initial ideas of killing the baby.
X	Time the clinic took and feeling some of it was unnecessary.
X	Pleasure in meeting other pregnant women.

Overall we would argue that the staff did not respond very well to Laura's emotions and feelings.

Laura's story is one woman's account of her emotional reactions to the booking visit and you may recognise some responses which are experienced by many women. But each woman's story of her feelings at each stage is unique. So why is it important for carers to sort their way through the maze of varying emotional responses?

Here are some reasons why it is important to understand women's feelings and emotions:

- **To help women respond positively to emotional changes, and make a successful adjustment to parenthood**

  By understanding the changes each woman experiences and her consequent emotional needs, you can help her to have a positive experience of pregnancy, childbirth and the puerperium. These positive experiences form a major contribution to the successful adjustment to parenthood, and also to the physical and emotional wellbeing of mother, child and family.

- **To help other carers to meet women's emotional needs**

  As well as giving the woman direct help, you can assist other carers to understand and meet the woman's emotional needs. Such carers include the woman herself, her partner and family.

- **To help women build up positive memories**

  The way each woman is treated during each stage, and her memories of this, will leave deep impressions for the rest of her life. Women have a right to expect that this experience should be dignified and meaningful

- **To respond to women with special needs**

  By understanding the particular needs of women with difficulties such as previous reproductive problems or a disadvantaged background you will be better placed to help them.

- **To recognise abnormal emotional responses quickly**

  Familiarity with the range of common emotional behavioural changes enables a swifter recognition of those women who are ill. It also enables you to educate women themselves to be able to recognise abnormal responses and seek appropriate support or help.

Activity 1.3

This activity will help you to identify the feelings and emotions of one woman you know, and consider why it is important to recognise them. (Activities 1.4 and 1.6 will build on this activity, so you may want to look briefly at those activities before identifying an appropriate woman.)

Part 1 Identifying feelings and emotions

Think of a woman you have accompanied during some part of her antenatal or postnatal care. For example you could choose:

- The antenatal booking visit
- Your first visit to the woman on the ward after delivery
- The first postnatal home visit
- The six-week check

Imagine you are the woman later that evening when she tells her partner/mother/friend about her experiences. Note down briefly what you think she would say about the experience and the emotions and feelings she felt.

It is more than likely that your story, like Laura's, includes a variety of feelings and emotions.

Part 2 The importance of understanding these feelings and emotions

Using the reasons we listed above and your own knowledge of the woman you described in Part 1, make a list of reasons why you need to be aware of and understand her feelings and emotions.

You may have identified other reasons than the ones we gave – perhaps more specific reasons, or perhaps quite different ones.

When you noted in Part 1 how you thought the woman would respond to the experience, you may have found yourself thinking about your own reactions to her response. For example, you may have sympathised with her or you may have felt she was being over-anxious or unrealistic. But in order to help women understand and cope with their responses it is important to:

- Separate and distance your own response from the woman's response
- Accept that each woman's response is valid for her (even if it is not for you)
- Avoid 'judging' the woman's response.

If you fail to separate your own feelings from those of the woman, you may identify so strongly with her situation that you are only able to see it from her viewpoint. When you keep your own feelings separate, you are in a better position to take an overview of the situation and help her consider ways of dealing with it.

Distancing yourself from the woman's feelings does not mean that you are unable to identify with her and we look at the skill of empathising with women in Unit 3.

Activity 1.4

This activity will help you see how far you distance your own feelings from the emotional responses of a woman you care for.

Remind yourself of the account you gave of the woman in the last activity, and answer the following questions. Mark your answer at the appropriate point on the scale below.

1 How did your feelings compare with those of the woman?

Mainly different |_____| Much the same

2 To what extent did you keep your own feelings distanced from those of the woman?

Well distanced |_____| Tangled up

If you do tend to mix up your feelings with those of the woman you are caring for you could practise separating your feelings from hers. You could do this by taking a recent conversation you had with a woman (either the same woman as in previous activities or a different one) and writing down two lists: 1) her feelings; 2) your feelings about the situation. Then try to keep these two sets of feelings separate. We explore the skills of non-directive counselling which will help you keep your feelings distanced from those of the women you care for in Unit 3, 'Skills and attitudes'.

3 Emotional changes and needs during pregnancy, childbirth and the puerperium

As we have suggested each woman's emotional response is different. Nevertheless there are some common responses which are experienced by many women which we will explore in this section. (We look at responses which lead to emotional problems in Unit 2, 'Psychiatric illnesses and emotional disorders'.) The following list gives some of the varied common responses at each stage.

During pregnancy

No standard, distinctive psychological state is experienced by all pregnant women. However, in general, pregnant women are more prone to anxiety and worry, and are more emotionally vulnerable.

First trimester

- Pleasure (or dismay) on confirmation of pregnancy
- Ambivalent feelings about the pregnancy; for example, the joy of pregnancy versus what having a baby will mean. Am I really ready for this?
- Confirmation of femininity
- Tiredness, nausea and weeping.

Second trimester

- Increased attachment to foetus, particularly after the scan or ‘quickening’
- Feeling of relative wellbeing
- Feeling of social acceptance by other mothers
- Increasing detachment from work commitments
- A need to prepare for the birth.

Third trimester

- Anxiety about delivery, especially pain, and health/abnormality of foetus
- Need to establish relationships with other mothers
- Increasing attachment to own mother

- Increased vulnerability to life events such as moving house, bereavement or Financial instability
- Physical discomfort
- Loss of interest in sex.

With an understanding of these common responses, antenatal carers can help those women they care for by:

- Listening
- Respecting their responses
- Suggesting options
- Counselling decisions.

We explore these skills in Unit 3, ‘Skills and attitudes’

During labour and delivery

The emotional responses of women during delivery are extremely varied. They may include:

- Fear of the unknown
- Fear of death
- Fear of loss of control of self
- Fear of loss of control of events
- Fear of technology
- Fear for the wellbeing of the baby, and sometimes partner
- Excitement
- Helplessness
- Embarrassment
- Depersonalisation
- Hypersensitivity

- Need for a companion/spokesperson
- Need for a supportive midwife
- Need to talk through the birth afterwards.

Pain in childbirth is a common source of anxiety for mothers. The vast majority of women do experience significant pain, and for a substantial proportion it is the most intense pain they have ever experienced. CS Research demonstrates that midwives, obstetricians and other health professionals tend to underestimate the intensity of levels of pain and the coping ability any person in pain or discomfort is experiencing. Educating the mother and her supporter about her choice of managing pain in labour by encouraging a birth plan to be made allows for discussion and questions to be answered prior to labour commencing. Respecting the plan and discussing the possible causes of deviating from it with effective support by midwives in labour has increased the mother's sense of being in control and reduces the pharmaceutical intervention rate, as does the continuity of care((Hodnett 2001). Higher levels of labour pain are associated with:

Physical factors

• Primiparity
• Rapidly dilating cervix
• Size and position of the baby
• Continuous back pain
• Sudden changes in contraction pattern, for example following acceleration of labor
• Induction with syntocinon.

Psychological factors

• Undesired pregnancy
• Unrealistic expectations of birth
• Previous bad birth experience
• Lack of social support.

Women's responses to pain vary. For example, they may:

- Want no pain and want to use epidural analgesia, for instance
- Plan to cope with the anticipated pain through a range of techniques
- Be willing to endure intense pain because they wish a birth free from pain-killing drugs

Women have the right to choose their own response to pain and this needs to be recognised by their carers. We look at ways midwives can help women cope with pain in Unit 4.

While midwives carry out many deliveries a week, each woman may experience only one or two in a lifetime. The support from experienced carers is therefore crucial. But this support means helping women to make their own choices. The 1992 House of Commons Health Committee Report on Maternity Services strongly endorses the need to provide choices in labour.

There is evidence to show that continuous social and emotional support from the midwife (or other person dedicated to her emotional needs) during the antenatal period, labour and after delivery can influence the physical as well as psychological outcome for both mother and child. For example, parents are usually grateful to be 'debriefed' on labour and delivery. On the other hand adverse management, for example by taking over from the woman, using more technology than necessary or using technology without proper explanation, can lead to both emotional and physical problems (See Unit 2, 'Psychiatric illnesses and emotional disorders'.)

Perhaps because women experience only a few deliveries while their carers carry out many a woman's perceptions of the delivery and her carers' perceptions may well be different. The woman's feelings are not always acknowledged.

Activity 1.5

This activity will help you to become aware of the difference between the carer's perception of a woman's feelings and the woman's real feelings.

1 Think of a situation where you observe, and perhaps record a woman's feelings during her antenatal, labour or postnatal care. This might be:

– The antenatal booking visit
– The delivery
– Your first visit to the woman on the ward after delivery
– The first postnatal home visit
– The six-week check.

Choose three women you have accompanied in your chosen situation, taking care for postnatal situations that they have healthy babies.

Explain to the women that you want to learn more about the feelings and emotions about childbirth, and ask them if they would be willing to share their feelings with you. Explain that the discussion will be confidential. Record their feelings in the first column in (4) below.

2 Look up the notes you have of the situation.

3 Were the woman's feelings recorded?

a) Yes [ ] No [ ]
b) Yes [ ] No [ ]
c) Yes [ ] No [ ]

4 If yes, note in the second column whether the feelings are consistent with the notes, or seem to represent quite different perceptions.

	Relation between feelings and notes	
Each woman's feelings…	*Seem consistent*	*Seem different*
a)		
b)		
c)		

It is more than likely that one or more of the women told you about some feelings which were not recorded in the notes or even seem at odds with them. Being aware of the woman's feelings helps you as a carer to meet her needs and a record of these feelings may be helpful in understanding any later illness. It is therefore important that your notes represent women's feelings as well as the physical events. If you have found important differences between a woman's perceptions and her notes, you may find it useful to think about what, with hindsight, you would have recorded in her notes at the time.

Immediate post-delivery phase

After delivery women may experience a range of both positive and negative feelings.

Positive feelings	***Negative feelings***
Elation	Exhaustion
Satisfaction	Detachment
Relief	Disinterest in baby
Closeness to partner	Disappointment at lack of partner/family support
Sense of being a family	Anxiety about feeding
Need for female support	Disappointment in sex/appearance of baby
Instant love for baby	Fear of hospitals
Gradual 'falling in love' (bonding) with baby	Helplessness
Development of maternal feelings	Awe at the responsibility for such a vulnerable being
Protectiveness	Ambivalence towards baby
Sense of achievement or fulfillment	Fear of not living up to society's expectations

The provision of care during this phase should facilitate bonding between mother and baby, and the subsequent establishment of successful (PB) feeding. We consider how to provide such care in Unit 4.

The puerperium (42 days following the birth – the fourth trimester)

The varied responses in this phase can include:

- Tiredness
- Increased emotionality
- Specific anxieties, for example about feeding, health and welfare of the baby,
- Weight gain
- Vulnerability
- The 'blues'
- Decisions about feeding
- Pain – perineal, nipples, etc.
- Loss of interest in sex, painful intercourse
- Change in marital relationship – now mother and father
- Increased anxiety about everyday decisions, fear of losing control of daily routine, trying to 'catch up'.

We have summarised the most usual responses that women experience at each stage. But women may experience other feelings, not listed in this section.

Activity 1.6

This activity asks you to distinguish between ‘common’ and 'other' feelings.
Look back to the feelings and emotions you identified for the woman in Activity 1.3.
Make two lists below, distinguishing between 'common' and 'other' feelings.

Common feelings	***'Other' feelings***

The 'other' feelings you identified are not necessarily 'abnormal' (though statistically they may be uncommon), they may merely be the individual's own unique way of responding. The next section explores the factors which affect the way each woman responds.

4 Factors which can affect an individual woman's emotional response

There are many factors which may affect a particular woman's emotional response during the various stages of the transition. For example, problems with housing or financial insecurity may lead to anxiety about buying clothing, prams and all the other baby equipment, while nearby relatives or friends with young families may make the woman feel secure that experienced help will be on hand. Screening can raise many anxieties and difficult dilemmas with positive results.

Some factors are two-sided, with the possibility of either a negative or positive response by the woman. For example, the attitude of family, friends and health professionals to the mother's state of health can work either way. Regarding the woman as ill (i.e. 'a patient') may adversely affect the woman's emotional response, whereas treating the woman as a healthy person going through a particular physiological process can help her to feel good about herself and her pregnancy. The House of Commons Health Committee Report states that ‘becoming a mother is not an illness’, and goes on to say that it is in fact a manifestation of good health.

The next activity asks you to identify potential positive and negative influences on women's emotional responses to their pregnancy. It is, however, vital not to prejudge any individual woman’s circumstances as positive or negative but instead to listen for the woman’s own perception of her situation.

Activity 1.7 This activity asks you to identify potential negative and positive influences on women's emotional responses.Under each heading below, note any negative and positive influences you can think of. We have given an example under the first heading. It will make the activity more realistic if you are able to think about individual women you have cared for recently.

How family, friends and health professionals view pregnancy

Negative influences	***Positive influences***
Pregnancy seen as illness, e.g. woman addressed as 'patient'	*Pregnancy seen as healthy woman passing through physiological and psychosocial process*

The woman's socio-economic circumstances

Negative influences	***Positive influences***

How conception was achieved

Negative influences	***Positive influences***

Feelings when the pregnancy is confirmed

Negative influences	***Positive influences***

Here are some of the negative and positive influences we thought of:

- **How family, friends and health professionals view pregnancy**

Negative influences	***Positive influences***
Pregnancy seen as an illness, e.g. pregnant women addressed as 'patient'	Pregnancy seen as a healthy state with the woman passing through a physiological and psychosocial process
Pregnancy disapproved of because of social circumstances	The extended family welcomes the pregnancy

- **The woman's socio-economic circumstances**

Negative influences	***Positive influences***
Shortage of money	Comfortable financial and housing situation
No extended family nearby to give support	Support from extended family or peers
Mothers may feel their lives will become restricted	Woman has ‘made it’ in her career and is happy to divert all her energies to the baby

- **How conception was achieved**

Negative influences	***Positive influences***
Conception from a 'one night stand'/rape/incest	Conception within a loving caring relationship
Conception unintended	Conception after trying a long time

- **Feelings when the pregnancy is confirmed**

Negative influences	***Positive influences***
The woman feels a baby will adversely affect her lifestyle/career	The woman feels pleased/overjoyed, etc.
The woman is unsure if she will be able to cope with a baby	The woman’s partner and family share the pleasure
The baby is not wanted by the woman/her partner	Motherhood an acceptable ‘way out’ of an unpleasant job

High expectations, e.g. 'the baby will be good, and easy to care for' may lead to negative influences since reality fails to meet these high expectations	Sense of confirming femininity
Fear that the foetus may be abnormal – heightened for women who opt for non-routine tests such as AFP	

This list is by no means exhaustive, and you probably thought of other examples. We have emphasised the importance of listening for a woman's own perception of her situation, rather than making your own assumptions about whether the circumstances of the pregnancy are positive or negative. You may also need to distinguish her first response, which may prove to be a view imposed by others, from how she really feels about her situation. It also highlights the importance of good communication between the health professionals

Activity 1.8

This activity asks you to compare other women's feelings about pregnancy with your own expectations.

If you were a pregnant woman what would be your answers to the following two questions:

- What is the best thing and the worst thing about being pregnant?
- How did seeing the baby on the scan/feeling the baby move affect your attachment to it?

Write your response in the table below.

Ask five mothers the same two questions and write their response below. (For example, these might be five women attending a postnatal support group or individual women whom you care for. If this proves difficult, you could ask friends or colleagues who have had a baby.)

	Best thing	**Worst thing**	**Effect of scan/feeling baby move**
You:			
Others:			
1			
2			
3			
4			
	Now circle any of the feelings above which differ from your own expectations of each situation.		

You have probably identified a wide range of responses, and almost certainly some of the feelings will be at odds with your own. As we emphasised earlier it is important to keep your own feelings separate from those of the women you care for. This includes your view of how **you** would feel given **her** circumstances.

5 Women with special needs

In addition to the common emotional needs experienced by women, there are some women who have special needs because of their circumstances or previous experiences.

The following table lists the various groups of women and one example of a special need for each group.

Group	**Example of special emotional need**
The young, single and unsupported	Worries about housing, finance, etc.

Older mothers, long marriages and successful careers	Fear that the baby will completely disrupt a settled lifestyle
Women who have had an emergency caesarian section	Feeling inadequate because she did not manage a ‘natural birth’
Women with a sick or handicapped baby	Fears about the future wellbeing of the baby
Women who have had a previous bad birth experience	Fears that the bad experience will be repeated
Women without a birth companion.	Feeling of being ‘different’ and alone
Women with the ‘precious baby syndrome’	Fear that something will go wrong for the baby
Women who have had a termination of pregnancy	Anxiety that the termination may affect the success of this pregnancy
Women who have had a miscarriage	Fear the woman may not be able to have a baby in the future
Women who have had a stillbirth	Regret that she did not hold the baby
Women who have had a neonatal death	Feelings that if something had been done differently the baby would have survived
Disabled women	Fear of being seen and treated as ‘different’ from the norm
Women from ethnic minorities	How to balance traditional birth rituals with western customs/hospital practice
PB-Women with a history of sexual abuse	Fear of internal examinations

Women with problematic past relationships	Anxiety about partnership
Women who were looked after children	No role model
Women with positive results on screening test	Anxiety about decision to terminate pregnancy or not

We consider the needs of some of these groups in more detail below.

The young, single and unsupported

The pregnancy rate in British teenagers is one of the highest in Europe. Teenagers often face socio-economic disadvantages, such as low income and housing difficulties. Adverse outcomes are high for teenage pregnancies, for example the very high rates of post-neonatal mortality, and teenage mothers are more likely to have psychiatric disorders (Maskey, 1991). Common needs are:

- Help in deciding whether or not to continue with the pregnancy
- Emotional support in coping with reactions from partner and family
- Emotional support for practical problems associated with finance, housing, etc.

Women who lose their babies

Women, their partners and the rest of their families who lose their babies through miscarriage, stillbirth or neonatal death face one of life's greatest traumas. They have special needs both during their loss, and coming to terms with it afterwards. Needs common to all three groups of women include:

- Having someone to listen to them recount their experiences
- Resolving fears that the woman was somehow responsible for the loss of the baby
- Wanting to know what went 'wrong'
- Wanting to know whether a future pregnancy is likely to be more 'successful'.

Other needs of women who experience **miscarriage** may include:

- Support in dealing with an emotional loss that is often not recognised by others
- Support in deciding when to try to conceive again.

Other needs of women who experience **late miscarriage or stillbirth** may include:

- Support in deciding whether to see/hold the baby
- support in collecting mementoes of the baby, for example foot or hand print, or lock of hair
- Privacy for the parents and the baby for some time after the birth
- Respect and gentle handling of the dead baby.

Other needs of women who experience **neonatal death** may include:

- Support in deciding whether or not to stay with the baby
- Privacy to stay with the baby while it is dying, and afterwards
- Support in caring for the baby while it dies
- Support in deciding whether to involve other members of the family,

Women from ethnic minority communities

Women from ethnic minority communities relate, in part at least, to the traditions of their culture. Increasingly, ethnic minority women of childbearing age are British-born and educated. Some women may, however, choose to actively maintain the social and cultural traditions of their community or country of origin, while others may adopt certain aspects of 'western' patterns of living, such going out to work and bottle feeding, but not others.

In Britain the largest ethnic minority group is the population which originates from the Indian subcontinent, which, at around 1.4 million, represents just over half the ethnic minority population. People of Afro-Caribbean and African origin make up a further quarter of the ethnic minority population.

Around 50% of the ethnic minority population are British born, but the size and origins of minority communities differ from area to area, and the number of women within each community who are British born will depend on the length of time the community has been established here.

A prime difficulty for carers is to communicate, and establish a relationship with women who find it difficult to speak or understand English. These difficulties can lead to misunderstanding and prejudice, and midwives and other carers may come across unhelpful generalisations about ethnic minority women. You may, for example, hear people say that they:

- Communicate badly
- Make a fuss about nothing
- Have a low pain threshold
- Abuse the maternity services (for example by having 'too many children')
- Lack normal maternal instincts.

Various studies have shown that these stereotypes are 'untrue' and unhelpful to the women concerned

The needs of specific ethnic minority communities and the needs of individual women from within each community will vary widely. You should find out about the communities you deal with and try wherever possible to find out about the needs and wishes of the individual woman you are caring for, preferably through a trained interpreter if communication is difficult.

Here is a list of general needs of women from ethnic minorities:

- Not to be stereotyped
- Sufficient time to communicate and establish a relationship
- Awareness and respect for customs, for example
    - Who normally attends the birth?
    - What is the usual way of feeding the baby?

        - What are the customs for new mothers, such as rest with few responsibilities?

    - How long do mothers usually breast feed for?

- Support in deciding if it is feasible to follow traditions, for example, is there enough family support for initial resting after the birth?

Activity 1.9

This activity will help you to:

- identify the groups of women you care for with special emotional needs
- list the special emotional needs of some women you have cared for.

Tick below the groups of women with special emotional needs that you care for

	The young, single and unsupported		Women with the 'precious baby syndrome'
	Older mothers, long marriages and successful careers		Women who experience a miscarriage
	Women who experience an emergency section		Women who experience a stillbirth
	Women with a sick or handicapped baby		Women who experience neonatal death
	Women who experience a previous bad birth experience		Disabled women
	Women without a birth companion.		Women from ethnic minorities
	Other group, please specify:		

Note down three women you have cared for/are caring for who have special needs.

In the second column note down their special emotional needs.

Women	***Their special emotional needs***
1	
2	
3	

An awareness of groups of women with special needs will help you to recognise and respond to the possibility of particular needs in individuals that you care for.

Summary

This unit has outlined some of the common emotional changes associated with pregnancy and the puerperium and stressed the importance of meeting emotional as well as physical needs. Unit 2 looks at the emotional illnesses and disorders which women may experience, Unit 3 introduces the key skill of non-directive counselling, and Unit 4 will help you put your skills into practice to help women deal with their emotions more effectively.

Key points we have introduced in this unit are:

- Women's emotional responses and needs in the childbearing phase of their lives are as important as their physical needs.

- There are some key responses which are commonly experienced at each stage.

- However, there is a wide variety of responses, and each woman's individual response should be respected.

- Becoming a parent is an important transition. If it is not resolved positively it may contribute to disorders. Every social group has its rituals to help parents work through the transition.

- Certain groups of women are likely to have special needs.

- Understanding and responding to women's emotional needs is likely to lead to a better outcome for both mother and baby.

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Unit 2: Psychiatric illnesses and emotional disorders

Introduction

For most women, the first few weeks following childbirth is a time of heightened and sometimes turbulent emotions. More than half will suffer during the first week from 'the blues', a common, transient and normal condition. At least 10% of all women delivered will become mentally ill during the first year, with illnesses ranging in severity from mild postnatal depression to puerperal psychosis. Over one third of pregnant women suffer from a mental disorder. Some will experience a recurrence of a previous illness, while others will suffer from a new onset condition. Conception rates in women with most disorders (with the exception of anorexia nervosa, severe learning disability and possibly schizophrenia) are the same as women in the general population. In addition, pregnancy is a multifactor stressor and life event which may render women with a history of psychiatric problems who may be well when they conceive, vulnerable to relapse during pregnancy or postpartum.

Many women will suffer from emotional difficulties, sometimes related to their personal experiences and sometimes to difficulties with their baby or adjusting to motherhood. Despite the fact that emotional problems, unhappiness, psychiatric disorder, and in particular severe mental illness, are so common to childbirth, very little of this morbidity is presented for help or treatment. The majority of women with mild disorders recover spontaneously, but a significant minority does not, and their illnesses and problems can become chronic, persisting well into the second year of their child's life.

Much of the research on perinatal mental health has been undertaken in economically advantaged countries, although studies are now appearing from low income countries. It is not clear whether the risk profile is the same in disadvantaged societies, or whether treatments would be equally effective. In western society emotional problems and postnatal mental illness are the greatest cause of avoidable morbidity in the puerperium. More effective detection, earlier treatment, and the possibility of prevention will have a major impact on both maternal health and the health of the children, partners and families. Longstanding, untreated perinatal problems have frequently been implicated in physical, emotional

and psychiatric childhood ill health. The early detection and effective treatment of these perinatal conditions are therefore important for the child as well as the mother.

This unit will help you to recognize the symptoms of the illnesses and emotional problems and understand the factors which contribute to them. Understanding the problems, together with an awareness of the available treatments, will put you in a better position to help the women you care for yourself, or to refer them on as appropriate. While we briefly introduce methods of prevention and treatment in this unit they are treated more fully in Unit 4 'In practice'.

The unit summarizes a lot of technical information. You may wish to skim through the headings first to see what is covered, and then plan to work through the three sections at separate times.

Objectives

By the end of this unit you will be able to:

- describe the psychiatric disorders associated with pregnancy and childbirth (puerperal psychosis, antenatal and postnatal depression)
- describe the range of severities of psychiatric disorders associated with pregnancy and childbirth
- identify women likely to be at risk of developing these illnesses and explain the treatment of the psychiatric disorders and the possibility of preventative measures
- understand the use of the Edinburgh Postnatal Depression Scale (EPDS) to detect women with low mood
- explain how to recognize 'the blues' and how to help women deal with it
- describe the other emotional disorders that may be associated with childbirth
- explain the difference between psychiatric illnesses and states of emotional distress, including 'the blues'.

1 Postnatal psychiatric illness

Everybody gets upset, worried, distressed or anxious at some time in their life, particularly in the first few weeks after childbirth, so how can you tell the difference between a normal and understandable reaction to stress, and the symptoms of a mental illness? Ordinary distress is usually clearly related to a cause and passes in a few hours, or a few days. As long as it does not last longer than this or interferes with bodily functions and the ability to cope with everyday life, such states of distress are regarded as normal and are a part of ordinary life. However, if they do not clear up quickly and if physical and psychological symptoms appear in a persistent and constant way, then a person is said by psychiatrists to be ill. These symptoms can interfere with a person's ability to think, concentrate, sleep and eat, to take care of themselves and others, and may distort the way in which they see both the outside world and themselves. In some illnesses the symptoms are similar to ordinary reactions to stress, but are present to a much greater and more disabling degree. In other illnesses, there are symptoms which are not often found in ordinary life, which can be very strange and frightening and which may have greater reality for the patient than the real world.

There is substantial psychiatric morbidity associated with childbirth. At least 10% of all women experience sufficient problems to meet criteria for mental illness in the year following childbirth. The majority of these illnesses are mood disorders (affective disorders) and the majority of these are depressive. However, the whole range of psychiatric illnesses can occur following childbirth, although less commonly. Less severe cases of depressive illness are very common in the general population. However, the risk of a woman suffering from a serious mental illness (severe depressive illness and affective psychosis) is greatest in the first three months after the birth of a child. She is more likely to be admitted to a psychiatric hospital and to be referred to a psychiatrist than at other times in her life.

The term 'postnatal depression' is now well known. It is used to refer to depression diagnosed during the postnatal period. It has also been used to refer to depressive symptomatology measured by questionnaires, which may not reach the threshold for

a diagnosis. Even above diagnostic threshold depressive episodes can be of varying severity and we will therefore describe to you three conditions of differing severity:

- Puerperal psychosis
- Severe or major postnatal depression
- Mild to moderate postnatal depression.

The clinical descriptions that follow are of the most typical cases in each of the groups. It is important to realize that these conditions represent a spectrum of severity rather than distinctively separate conditions. However, it is also important to try and match your patient most closely to these three groups, because there are different risk factors associated with them and different implications for the future.

1.1 Puerperal psychosis

Definition

This is a clinical term used to describe a group of severe illnesses which occur suddenly in close relationship with childbirth and which are hallmarked by any or all of the following psychotic symptoms:

- Delusions
- Hallucinations
- Impaired perception of reality.

The majority of puerperal psychoses are affective; manic or depressive psychoses. The minority are schizophrenia-like conditions. Although true or chronic schizophrenia arising for the first time in the puerperium is very uncommon, some women with chronic schizophrenia will experience acute exacerbations particularly if medication has been discontinued. Puerperal psychosis is the most rare and most severe form of postnatal disorder, resulting in the admission to a psychiatric hospital of two out of every 1,000 mothers delivered although probably as many again are not admitted.

Clinical presentation

The majority of the manic and schizophrenia-like illnesses and a third of all the depressive psychoses present very abruptly, between the 3rd and 14th post partum day. A woman may become psychotic while still on the postnatal ward, or while the

community midwife is still visiting.

Some women will have had no mental health problems in the past, (while others will have a past history). Women with no previous mental health problems become acutely disturbed and for the first few days the picture is one of perplexity, confusion, fear and distress, restlessness and insomnia. The woman looks physically unwell and may be unable to care for herself and her baby.

For the first few days her mental state may be very variable, interspersed with phases of apparent normality and it may be difficult to make a specific psychiatric diagnosis.

Within a few days of the onset of the condition, the symptoms usually settle into a clearly recognizable psychiatric illness. Up to a third may be manic, with increased restlessness and activity, insomnia, over-talkativeness, a euphoric or irritable mood, marked impatience with others and delusions of grandeur.

More commonly the illness is a depressive psychosis where the mood is pathologically lowered, and the patient may be slowed up both physically and mentally. A woman may have delusions that she has done something dreadfully wrong, or that some harm is coming to her or her child.

Many patients, both manic and depressive, may have bizarre and frightening experiences and beliefs. All will have great difficulty in caring for themselves and their child and may therefore have problems with hygiene, nutrition and hydration. Over 90% of all puerperal psychoses are affective psychoses.

Aetiology and risk factors

Puerperal psychosis is commonest in women having their first baby. The most important risk factor is a previous serious psychiatric disorder, particularly an affective disorder (bipolar disorder or manic depressive illness). This may have occurred before childbearing, or may have been associated with a previous baby. If a woman has had a previous bipolar illness her risk of having a puerperal psychosis

is at least 1:2. However, the majority of these women will be having their first ever psychiatric illness.

A family history of bipolar disorder or puerperal psychosis in a first degree relative also confers a high degree of risk. These two risk factors are so important that information on them should always be gathered at booking clinic.

Other risk factors are a caesarian section, or delivery complications, particularly in the first pregnancy, and being older than the average when having a first baby. However, it is important to note that puerperal psychosis can happen to anybody from any walk of life and that in general these patients do not appear different from other obstetric patients.

Hormones

At the moment there is little evidence to suggest that the hormonal status of women suffering from puerperal psychosis is different from other women who have just delivered. However, it may be that these women are abnormally sensitive to the dramatic change of hormone levels that come after childbirth, particularly to the fall of oestrogens and that this triggers off the illness to which they have an underlying predisposition.

Management

The most important aspect is swift detection and the early instigation of treatment. The treatment would usually take place in a psychiatric inpatient or day unit, but it is probably better for mother and baby to be admitted together to a hospital mother and baby unit where specialist nursing skills are available to care for the mother - infant pair.

As women with puerperal psychosis are so severely disturbed, these patients will require medication to reduce their fear and perplexity, make them safely containable and allow for adequate hydration and nutrition. It is often necessary in the early phase for the nursing staff to assist, or take over, the care of the baby. Medication will usually be an antipsychotic, such as a phenothiazine, e.g. chlorpromazine or a

butyrophenone, e.g. haloperidol, or one of the 'atypical' antipsychotics e.g. risperidone, olanzapine, quetiapine or aripiprazole. For women with depressive psychoses, antidepressants will be used as well, but because they need between 10 and 14 days to take effect, the most severely disturbed may require electro-convulsive therapy (ECT) which produces a very rapid improvement. Medication will need to be continued beyond the resolution of the acute phase because of the high risk of relapse and will often need to be continued for three months at least.

If a patient is suffering from a manic depressive relapse, treatment with lithium or another mood stabilizer such as divalproex semisodium or carbamazepine may be considered.

All psychotropic drugs pass into breast milk. Lithium and clozapine should be avoided due to the risk of toxicity (lithium) and neutropenia (clozapine). Other drugs are excreted in breast milk in varying amounts and as this is a field where the evidence base changes rapidly, information and guidance should be sought from drug information services. Bear in mind that guidance assumes that the baby is full term and well. Preterm and sick infants are less able to metabolize drugs and additional caution is required.

Prognosis

The immediate prognosis of these illnesses is very good. Manic patients in particular often recover from the worst of their illness within two weeks, depressive psychoses within four to six weeks and the rest within six to eight weeks. However, for the manic illnesses in particular, the risk of relapse is high and medication will need to be continued, albeit at a lower dosage, for at least three months.

Long term prognosis

The risk of a woman suffering from a similar illness which will tend to occur at the same time and in the same way following any subsequent child is 1:2. A woman with a postnatal bipolar episode is at high risk, 95% of suffering from a further episode after another delivery and 62% of having a later non-puerperal episode.

Almost all women admitted with a postnatal episode of schizophrenia will experience another episode at another time of her life.

Self-check

This self-check will help you check your understanding of puerperal psychosis. Circle the words and phrases in the following list which best describe puerperal psychosis.

Palpitations	Difficulty getting to sleep	Tearfulness
Confusion	Difficulty caring for self/baby	Lowered mood
Delusions	Feels better in company	Require medication
Feel worse in the morning	Variable mental state initially	Often associated with previous psychiatric disorder

The following words and phrases typically describe puerperal psychosis: confusion; delusions; difficulty caring for self; variable mental state initially; lowered mood; require medication; often associated with previous psychiatric disorder. If you did not circle these words, check back over this section.

1.2 Postnatal depressive illness

This is the commonest form of postnatal psychiatric disorder, affecting around 10% of women and varies in severity from severe or major postnatal depression through to minor or mild postnatal depression. Patients tend to present along a spectrum of severity, but in general approximately 3% of women will tend towards the description below of severe postnatal depression and approximately 7% of women will tend towards the description of mild to moderate postnatal depression.

Severe (major) postnatal depressive illness

Definition

This is a term used to describe women suffering from a depressive illness which involves a profound and consistent lowering of mood as well as an alteration in thinking, physical symptoms of depression, and slowing of psychomotor functioning. Whilst they do not have hallucinations and delusions, and to some extent remain in touch with reality, their internal world is still more real to them than the external one, and they are profoundly ill and disabled. The symptoms of this illness are not just those which are found in ordinary states of unhappiness and distress.

Clinical presentation

This illness too often begins in the first two weeks after delivery, but develops more gradually than puerperal psychosis. One third of these women will present within the first four weeks post partum and two-thirds later, between 10 and 14 weeks. Those that present earliest tend to have the most profound and obvious illnesses, whilst those that present later are sadly often missed because their symptoms may be hidden.

The classical physical (biological and psychological) symptoms of a severe depressive illness are:

- Difficulty in sleeping
- waking through the night and early morning wakening
- slowing of physical and mental functioning
- feeling much worse in the morning (diurnal variation of mood)
- Fatigue
- feeling ill
- Loss of appetite and weight
- marked difficulty in thinking
- impaired concentration
- Indecisiveness and slowing of thinking
- An alteration in perception of self and others
- Feelings of guilt, inadequacy and unworthiness

- Hopelessness and despair which may reach very severe proportions
- The loss of the ability to feel pleasure or enjoyment, particularly focused on the baby

  Feel incompetent as a mother
- A distressing feeling that everybody may be better off without them and that suicide is the only answer.

Some women may be weepy and tearful and some may be very irritable. Some may feel angry and bitter, others empty and hollow.

Women who present later may be able to maintain a good social facade and conceal their distress from family and health care professionals. They may be able to care for their babies well, but derive little pleasure or spontaneous enjoyment from them. This profound lowering of mood tends to be present constantly from day to day and is not easily distracted by pleasurable events. They often withdraw socially and avoid contact.

Aetiology and risk factors

A previous history of severe depressive illness either associated with childbirth or occurring before reproduction is also a risk factor, as is a family history of severe depressive illness in first degree relatives. However, many of these women will be experiencing their first ever psychiatric illness. Other factors may include:

- Previous obstetric loss, such as perinatal death, repeated miscarriage, etc.
- Investigations for infertility, assisted reproduction (the 'precious baby syndrome')
- Stressful 'life events' particularly in the weeks before and after delivery
- Hormonal factors. There is no evidence that the hormonal status of women suffering from severe postnatal depression is different from that of other women. However, some women may have an abnormal sensitivity to the hormonal changes which predispose them to developing the condition.
- Marital problems and/or lack of social support from partner and families
- Social isolation, history of sexual abuse and being a very young mother

Women who have been previously hospitalized for a psychiatric illness, substance misuse disorder or a dual diagnosis (both a mental illness and substance misuse) are at increased risk of postpartum suicide attempts.

Those who are seeking political asylum, refugees and recent migrants often have additional risk factors such as trauma, separation from and loss of relatives, exposure to conflict and war, poverty and social exclusion. In addition, some pregnancies in this group are the result or rape and women may also suffer from communicable diseases such as tuberculosis, hepatitis B and C and HIV. The needs of this group are many and complex.

Management

Early detection and swift instigation of treatment are most important. The majority of women can be managed at home, but the most severely ill, particularly women who have ideas of suicide, or who have stopped eating and drinking, will require admission to hospital, preferably to a specialized mother and baby inpatient or day unit.

Antidepressants such as imipramine, lofepramine, fluoxetine, paroxetine, sertraline, citalopram, venlafaxine and newer drugs such as duloxetine and escitalopram are very effective provided they are given in full therapeutic dose. However, they take between 10 and 14 days to have effect and the most severely ill may require ECT and/or antipsychotic medication to produce a more speedy improvement.

Oestrogen skin patches have produced encouraging results in one trial for prolonged postnatal depression, so may be worthy of further research. Progestogens are associated with a higher risk of developing depressive symptoms and neither progesterone nor oestrogen has been rigorously evaluated in the prevention of postnatal depression.

Some antidepressants can safely be prescribed to breast feeding mothers. These patients require a great deal of emotional support and practical assistance,

particularly in the early phases of their illness. Care must be taken to ensure that the needs of the child are met, particularly when a mother is too ill to do so herself. Additional counseling or psychotherapy is often needed to repair the damage to self-esteem.

Prognosis

The immediate prognosis is good. The majority of women respond within four to six weeks to the first choice of antidepressant, with full recovery within three months. However, a minority will require a change in treatment and may progress more slowly.

Untreated, one third of women will still be ill at one year post partum and a small, but significant, minority is still ill at two years post partum.

There is also a risk of women suffering from a non-puerperal depressive illness later on in life, approximately 6:4 of another episode over 20 years. The risk is lower for unipolar than bipolar disorder, especially if onset was within the first month of a first birth.

Self-check

This self-check will help you check your understanding of severe postnatal depressive illness. Circle the words and phrases in the following list which best describe severe postnatal depressive illness.

Delusions	Suicidal feelings	Common in women having second babies
Slowed mental/physical functioning	Loss of appetite, but no loss of weight	Can usually be treated at home
Feel worse in the morning	Tearfulness	Recovery likely in 6–12 weeks
Abrupt onset	Feelings of guilt/inadequacy	Recovery spontaneous

The following words and phrases typically describe severe postnatal depressive

illness: slowed mental/physical functioning; feel worse in the morning; suicidal feelings; feelings of guilt/inadequacy, can usually be treated at home. If you did not circle these words, check back over this section.

Minor postnatal depression

Definition

This term is used to describe a very common group of depressive illnesses, where the symptoms and signs vary only in quantity from those which are part of the normal reactions to stress and unhappiness. Both the timing and symptoms of the illness are usually understandable as a result of the interaction of the personality with stress. The symptoms may be very distressing and disabling, but there is not usually any impairment in the patient's perception of reality. Symptoms of emotional turbulence, tearfulness, unhappiness and anxiety tend to predominate. Such illnesses are very common in the general population and may not in fact be any commoner following childbirth than at other times. New onsets appear to be more common in the first three postnatal months than antenatally. Or later in the postpartum More importantly, it is particularly distressing and disabling to suffer from such a condition when one has a new baby.

Clinical presentation

Although many of these illnesses have an insidious onset within the first few weeks after delivery, they frequently present after three months postpartum and are often missed by health professionals. The physical and psychological symptoms of minor depressive illness are usually those of:

- Anxiety and depressed mood
- Palpitations
- churning in the tummy
- Headache
- Tiredness
- feeling shaky, nervous and fearful
- sleep disturbance, usually difficulty getting off to sleep

- Appetite is often decreased, but there is no weight loss
- The mood is usually tearful and distressed, but is often variable with good days and bad days
- Often feeling better in company and worse when alone
- Often irritable, anxious and fearful of going out
- feeling particularly tense and irritable with the baby and other children.

Aetiology and risk factors

Although this condition can happen to anybody, women with a previous history of depressive episodes are particularly at risk as are, those with chronic life difficulties, financial, marital and relationship problems, lack of a confiding female friend or relative.

Other factors which can make women more vulnerable than usual are:

- previous termination of pregnancy, previous miscarriages
- poor childhood experiences
- antenatal admission to hospital in the last trimester
- life events or stressful happenings, before or shortly after the delivery
- finding infant difficult to manage
- infant health problems
- prior involvement with social services
- An unwanted pregnancy.
- history of sexual abuse
- domestic violence

Treatment

The most severe minor postnatal depressive illnesses may require antidepressants, but the most important treatments are social and psychological. This group of illnesses respond particularly well to non-directive counseling, practical support and social and emotional contact. These simple interventions provided by primary care professionals appear to be as effective as various types of psychotherapy or anti depressants. However, approximately one third of women will not recover with these interventions and so will require referral to specialist psychotherapy or

psychiatric services.

Prognosis

With appropriate help the prognosis is good, with most mothers recovering. However, without such help, approximately 30% of these illnesses will persist into the second year of the child's life and beyond, and may therefore have a profound effect both on the mother/baby relationship, older children and on the marital relationship.

Self-check

This self-check will help you check your understanding of minor postnatal depressive illness. Circle the words and phrases in the following list which best describe minor postnatal depressive illness.

Present around three months post partum	Loss of appetite and weight	Women with chronic life difficulties at risk
Palpitations	Hallucinations	Women with previous psychiatric problems at risk
Variable mood from day to day	Difficulty caring for self/baby	Responds well to counseling
Feel worse when alone	Suicidal thoughts	Most women require antidepressants

The following words and phrases typically describe minor postnatal depressive illness: present around three months post partum; palpitations; variable mood from day to day; feel worse when alone; women with chronic life difficulties at risk; responds well to counseling. If you did not circle these words, check back over this section.

1.3 Effects on the child

The research on the effects of postnatal depression on relationships and child

development is now widely known. It is important to remember, however, that postnatal depression in the mother does not inevitably lead to a damaged child. Depression increases the risk that difficulties will arise, but many factors determine what, if any, difficulties arise for an individual child. One unsurprising factor is the duration of depression. Early remission, whether as a result of formal treatment, informal help or 'spontaneous recovery' reduces the impact on the child.

Other factors influencing the type, probability or extent of effect on the child appear to be:

- type of disorder
- infant health and behavioral style
- gender of child
- quality of parenting by father and other caregivers
- relationship between parents
- parental educational level

It is not yet clear what mechanisms lead to the effect of maternal depression on the child. Preliminary research suggests that the difficulty depressed mothers may have in responding to the infant's communication may mean that the infant's ability to concentrate and notice connections between events in the environment are not fostered, disadvantaging intellectual development. Depressed mothers can sometimes feel hostility towards their infant which can lead to longer term conflictual interactions and later emotional and conduct problems.

1.4 Prevention

Primary prevention of the most severe postnatal psychiatric disorders (puerperal psychosis and severe postnatal depression) may not be possible with our current state of knowledge. However, much can be done to identify those at risk by virtue of previous personal or family histories of psychiatric disorders, and to alert health care professionals - and even the woman herself - to ensure the earliest possible diagnosis and treatment of the condition. A woman who has had postnatal depression has a 41% risk of having it after subsequent deliveries and therefore consideration should be given to the need for prevention. Studies have shown that although many psychosocial interventions do not prevent recurrence of postnatal

depression, intensive postpartum support from nurses or midwives, peer telephone support or antidepressants commenced after delivery can be effective.

For the less severe forms of postnatal depression it may be possible to reduce the vulnerability of women to this condition by antenatal counseling; antenatal education on the realities of parenting; helping women to avoid extra stress before and after delivery; increasing women's awareness of the need for social and emotional support; and giving specific counseling and practical help to those identified as being in difficulties during pregnancy and after delivery. The psychological aspects of routine care during pregnancy and afterwards have improved over the past two decades in countries such as the UK, so it is not clear whether additional services could make any further gains. In circumstances of severe deprivation more radical interventions may be required.

1.5 Recognizing the illnesses

The case studies below and the activity which follows should help you to recognize some of the illnesses we have described.

Case study 1

Ann is a 29-year-old school teacher, who is married to a minister of religion. She gave up work and moved to a new town when seven months pregnant because her husband had just obtained a new position. Although previously competent and with no previous history of psychiatric illness she had always been rather shy and found it difficult to make friends. Her mother and her maternal grandfather had been hospitalized for severe depressive illness. She had three years treatment for infertility before becoming pregnant and had hoped for a natural childbirth in her local community maternity home. She was transferred in labor to a large maternity unit because of failure to progress and had an emergency caesarian section under general anesthetic because of fetal distress. On the second post partum day she was transferred back to her local midwifery-run unit. Four days after delivery she became agitated and restless and could not sleep. Over the next few days she became increasingly frightened that the midwives were not who they appeared to be

and were going to harm her. She felt that she was being closely monitored because she was a bad mother and believed that her child would be taken away from her. She felt that everybody knew she had stolen some sweets as a child and even her baby did not like her and would not feed from her. She stopped eating and drinking because she was concerned that the hospital food was poisoned.

Case study 2

Nasreen is a 31-year-old full time housewife with three children who had previously worked as an administrative assistant. She is married to an accountant and lives in comfortable circumstances. She had an extensive social network of family and friends and had no personal or family history of psychiatric illness.

During her last pregnancy, her second child had febrile convulsions and was hospitalized at a time when she was having a threatened miscarriage. She was very concerned about his long term future and at 18 weeks of pregnancy developed physical symptoms of anxiety which spontaneously resolved when his physical health was confirmed. At eight months of pregnancy her husband was made redundant. Normally a supportive man who enjoyed a good relationship with his wife, he became moody and preoccupied. She had a full term normal delivery and left hospital within 24 hours because of her desire to return to her two older children. She found establishing breast feeding unexpectedly difficult this time because of the demands on her attention of the two older children and missed the support that her mother had given her previously because she was visiting an older sister in America. She was preoccupied with worries about her financial security and concerns for her husband's wellbeing. By the time of her postnatal check she was waking early in the morning, even if the baby did not need feeding, felt uncharacteristically exhausted, irritable and tearful, and avoided her friends and invitations to go out. She found herself unable to plan the simplest meal and although caring for her children physically did not have the energy to play with them and became guilty that she was leaving the baby in his cot instead of stimulating him. She became frightened for the safety of the children and found herself checking them when asleep to make sure that they were still breathing.

Case study 3

Kirsty aged 19 is an unemployed single mother. Her parents divorced when she was young and her mother remarried. She never got on with her stepfather and left home at the age of 16 to live with her boyfriend. He too is 19 and came from a broken home. Neither of them had been in paid employment since leaving school. Their parents, although kindly, were preoccupied with their own lives and Kirsty had always wanted a baby and a home of her own. She became pregnant by accident, but was determined to keep the baby. She found the antenatal clinic frightening and unfriendly and missed many of her antenatal appointments. She was admitted at 36 weeks of pregnancy because of concern about retarded inter-uterine growth and had an induced delivery at 39 weeks. Her boyfriend was present during the delivery which she found long and distressing. The baby was small for dates and was kept in the neonatal intensive care unit for three days. On returning home Kirsty's boyfriend was initially supportive, but after two weeks started going out with his friends leaving her alone in their flat. She felt lonely and isolated, tearful and anxious, particularly when the baby cried and she found herself wanting to scream, particularly in the middle of the night. She spent most of her time out of the house, visiting friends and relatives and was therefore never in when the health visitor called. By the time her baby was four months old she plucked up the courage to go to the baby clinic and tearfully told the health visitor that she was frightened that she might slap the baby when it would not settle at night.

Activity 2.1

This activity will help you identify the characteristics and risk factors of psychiatric illnesses.

1 List any symptoms which made you feel concerned about the emotional state of the women in the case studies above

2 What, if any, disorder do you think each woman has?

3 What are the predisposing factors for any disorder you identified?

	symptoms	**disorder**	**predisposing factors**
Ann			
Nasreen			
Kirsty			

1 ***These are the symptoms which we feel you should have recognized:***

Ann	Agitation
	Insomnia
	Delusions of guilt
	Paranoid delusions
	Ideas of reference
	Not eating/drinking
Nasreen	Early morning wakening
	Preoccupation with worry
	Irritability and tearfulness
	Avoiding company
	Impaired concentration, energy and interests
	Indecisiveness
	Anxiety
Kirsty	Anxiety
	Irritability
	Tension
	Loss of confidence
	Fear of losing control
	Tearfulness
	Missing antenatal appointments/appointments with health visitor

2 ***These are the disorders which we feel the women were suffering from:***

Ann	Puerperal psychosis (depressive)
Nasreen	Severe (major) postnatal depressive illness
Kirsty	Mild postnatal depressive illness

3 *These are the predisposing factors we feel these women had:*

Ann	Elderly primipara
	Infertility
	Family history
	Moving house and town during pregnancy
	Being moved during labor
	Emergency caesarian section
	Being moved after delivery
Nasreen	Worries and problems during pregnancy
	Anxiety state during pregnancy
	Difficulty in breast feeding
	Missing the support of her mother
Kirsty	Difficulties in childhood
	Young and single
	Antenatal admission
	Preterm baby - baby in neonatal intensive care
	Relationship problems
	Lack of social support and a female confidante
	Social isolation
	Inability to use professional support.

2 The blues

Definition

The blues, also known as the three-day or five-day blues or baby blues, is a transient state of tearfulness and emotional lability, often associated with other symptoms, which occurs between the third and tenth post partum day. The most common time for the 'peaking' of symptoms is day 5. It is usually a benign and self-limiting condition which usually resolves between 24 and 48 hours, but may recur off and on for at least two weeks. It is very common; occurring in at least half of all

women and in most women is best regarded as normal. However, if blues is severe, it is a risk factor for postnatal depression.

Clinical presentation

The most common symptoms are tearfulness and emotional lability, the mood changing from happiness to sadness, either for no good reason or triggered off by a chance remark. The tearfulness is often associated with brief feelings of incompetence, inability to cope and worry. Other common symptoms include tension and restlessness, irritability, difficulty sleeping, excessive sensitivity to the remarks of others, a tendency to make 'mountains out of molehills', a tendency to excessive worry particularly about the child, and sometimes difficulty in concentration, forgetfulness and feeling muddled. Blues may vary in its severity and while some women only experience a few of these symptoms, others may experience many. Although the symptoms tend to 'peak' in intensity around day 5, for some women it may be over very quickly while for others, it may take a few days to resolve. It is fairly common for some of these symptoms to recur off and on over the next few weeks following childbirth, particularly when the mother is tired.

The blues often occurs at the same time as the mother is trying to establish breast feeding and it may coincide with problems with her perineum. She may therefore react in a tearful way to both of these situations.

Importance of the blues

Although getting the blues is normal and most women and their partners are educated about the blues in antenatal classes, it can still come as a great surprise and can upset and distress women. It is therefore very important that mothers, their partners and families and also health care professionals are educated about this very common event. When it does happen it should be handled with further reassurance that it is common and valid and treated with comfort and sympathy so that the distress may be minimized. Severe blues increase the risk of depression by 3 times and a woman who has a past history of depression and severe blues is nearly 7 times more likely to develop postnatal depression.

Causes

The blues is probably related to the changes in hormones (oestrogen, progesterone and prolactin) that occur at this time. It may also represent an inevitable reaction to the strain and excitement of delivery and the first two to three days afterwards.

Differential diagnosis

For a woman who is known to be at risk of developing a postnatal mental illness it may be difficult for the women herself and her caregivers to tell the difference between the blues and the beginning of an illness. Careful and sensitive monitoring should distinguish between the two, as the blues will tend to resolve as the days pass. Women with a high risk of puerperal psychosis should be referred antenatally so that the appropriate monitoring could be in place after the birth.

2.1 Recognizing the blues

Maria was at home on the fifth day following the delivery of her first child. For the first four days she had been feeling fine, but today had been a bad day. The baby was crying and unsettled and kept falling asleep at the breast. Her episiotomy was hurting. The house seemed in a terrible mess and her hair looked dreadful. Her friend came round to see her, picked up the baby, who immediately stopped crying. Maria burst into tears saying that she was no good as a mother, was fat and ugly and would never be the same again.

Each woman's symptoms vary, so you may identify different symptoms from those we described above, and that the symptoms for each woman were different.

3 Other psychiatric disorders

Although the commonest mental illnesses following childbirth are mood disorders (affective disorders), it is important to remember that other psychiatric conditions can occur for the first time during pregnancy or following childbirth. Women with pre-existing mental illnesses may get pregnant and have babies. Illnesses such as:

- Schizophrenia
- Obsessive compulsive disorder
- Anxiety states

may therefore occur before conception, or new episodes may arise after delivery.

3.1 Schizophrenia

Women with chronic schizophrenia maybe in remission or have their symptoms controlled by medication at the time when they become pregnant. Alternatively, as many pregnancies are unplanned, they may be acutely unwell. Providing that their medication is judiciously controlled during pregnancy and after delivery, they are probably not at increased risk of a relapse following delivery. The issue will be their ability to care for themselves and their baby and in many cases, this will require careful assessment. It will be largely determined by the quality and length of their remission, their ability to function and care for themselves when well, and the degree of family and social support as well as their attitude towards their illness.

3.2 Anxiety states/phobic anxiety states/Obsessive compulsive disorder

These conditions may occur as illnesses in their own right or as symptoms in a depressive illness. A woman may have suffered from such a condition before and the condition may have been present during pregnancy.

Anxiety states

These are very common conditions in the general population, but in recently delivered women the anxiety may be focused on the child. Symptoms include feelings of fearfulness, apprehension and nervousness, accompanied by the well known physical symptoms of anxiety, such as palpitations, butterflies and churning in the tummy, tension headaches and a feeling of dizziness and unreality. Not surprisingly many mothers become frightened that they are physically ill and this fear increases the anxiety, so that a vicious circle may be set up. Sometimes the anxiety occurs in acute bouts, known as a panic attack, which is often associated with over-breathing (hyperventilation) and a fear of impending collapse, or even death. Although anxiety can occur in a pure form as an illness in its own right, it is also very commonly the dominant feature of a depressive illness and care should be taken to detect the presence of additional depressive symptoms as outlined in

Section 1.2 on postnatal depressive illness.

Treatment

If the woman has associated symptoms of a severe depressive illness, then she should receive antidepressants. In addition, she will benefit from therapy such as cognitive behavior therapy, anxiety management techniques and relaxation exercises. If the condition is a pure anxiety state, such psychological strategies will be the main treatment.

Phobic anxiety states

In a phobic anxiety state, the extreme anxiety is felt in particular situations and leads to avoidance of those situations. Most commonly the feared situation is going out of the house and into crowded spaces, such as supermarkets (agoraphobia). However, it may be experienced in the face of insects, animals and other specific situations (specific phobias). Again care should be taken to elicit the presence of any depressive symptoms. If a woman is suffering from a pure phobic anxiety state then systematic desensitization (behavior therapy) and anxiety management techniques will be helpful. If she has a depressive illness she will also need antidepressants.

Panic Disorder

Panic disorder is diagnosed if panic attacks are recurrent and accompanied by persistent fear of further attacks. If untreated, this can lead to further problems such as avoidance leading to agoraphobia. Co morbid depression is not unusual. It is usually treated by a combination of antidepressants and cognitive behavior therapy.

Obsessive compulsive disorder

This is a condition where the woman experiences distressing intrusive thoughts, images or feelings which are unwelcomed and resisted, and which are often accompanied by an overwhelming need to carry out certain actions (compulsions). The content of the thoughts is usually very unpleasant and common themes are dirt, contamination, obscenity, diseases and harm coming to the child. They are usually paradoxical and the opposite of the woman's true self. For example, religious

women may have blasphemous thoughts, kindly and caring women thoughts of violence, etc. The compulsive actions may either be yielding and trivial, for example, hand washing and checking, or they may be controlling, for example, tapping fingers or counting. The obsessional thoughts and compulsive actions can be very time consuming and extremely distressing. Although the compulsive behavior rarely, if ever, poses any risk to the mother, her child or her family, most of these women are very frightened by their experiences and fear losing control.

Obsessional compulsive symptoms may exist as an illness in their own right, particularly if a woman has had this condition before her pregnancy, or during it. However, obsessional symptoms most commonly occur as part of a depressive illness and it is particularly important when obsessional symptoms are present to elicit any depressive symptoms.

Treatment

If the obsessional compulsive symptoms are part of a depressive illness (usually severe), antidepressants are a very important part of treatment. If, with antidepressant treatment, the obsessional symptoms do not resolve quickly, or if the illness is a pure obsessional compulsive illness, then Cognitive Behavior Therapy will be an effective treatment for most women. This, however, will require referral to a specialist, either a psychologist or a behavior nurse therapist.

4 Other emotional problems

Childbirth, particularly first time childbirth, is an emotional time for most women. For many women there will be additional experiences or problems which bring about their own emotional reactions (for example, personal illness, sickness, death or disability in the child, etc.). The list of emotional variations is almost endless. However, there are two emotional problems which are sufficiently common and cause sufficient concern to health care professionals to warrant a mention.

4.1 Persistent distress at the birth experience

Intrusive memories and visual images of the birth experience are very common in the days and weeks following childbirth. It is common for many women to talk about them and be preoccupied by them, particularly in the early days. However, some women experience these intrusive memories in a very distressing way and they may persist for many weeks, or even months. This can occur after an apparently normal delivery, as well as after a frightening or unusual experience. The memories may intrude in an unwelcome fashion and may be associated with distress, emotional and physical feelings of anxiety, nightmares and feelings of anger and humiliation. Sometimes it may be so severe as to resemble the condition of post-traumatic stress disorder and may sometimes be associated with depressive symptoms.

Psychological Debriefing

For all women, whether or not the condition is associated with another psychiatric disorder, 'psychological debriefing' is necessary. This involves a health care professional, preferably the one who was involved during the delivery, going over the experience with the woman, allowing her to express her feelings, explaining to her what has happened and validating her emotions. It is important to elicit any symptoms of depression that may be present as in these cases, treatment for a depressive illness would also be necessary. It is likely that emotional and social support during labor, clear explanation and reassurance about any procedures being carried out, and the routine of psychological debriefing after delivery could do much to prevent this unpleasant emotional problem from occurring. If problems persist over a month then referral for Cognitive Behavior Therapy, preferably to a specialist traumatic stress clinic should be considered. However, it is worthy of note that psychological debriefing can have a negative impact on some women.

4.2 'Bonding' difficulties

'Bonding' is a shorthand term for the complex process of maternal/infant attachment which develops during the hours, days and weeks after birth. Most people believe that the minute a baby is born they will experience an immediate, strong, positive feeling towards their baby – 'falling in love' on sight. Whilst this experience is

undoubtedly very common, a large minority of women do not feel like this when their babies are born. Many will feel flat, numb and neutral towards their children and a minority will feel active distaste or dislike.

Neutral or negative feelings may occur when a woman has had a particularly long or distressing labor, has been anesthetized during a caesarian section or other procedure, or when the baby has had to be removed immediately to a special care baby unit. High levels of anxiety during pregnancy or delivery, or concerns about maternal or fetal health may also contribute to this phenomenon.

Although neutral or negative feelings towards a newborn baby are not uncommon, the absence of the expected warm and instant attachment or the presence of strong and negative feelings can cause intense distress and guilt, which can last for a long time and spoil the mother's enjoyment of her child, or even contribute to the development of depressive illness. It is important therefore to discuss the range of feelings that may be experienced immediately after delivery in antenatal classes.

If such an emotional reaction should occur following delivery, it should be dealt with sensitively, with comfort and reassurance and explanations that love often grows slowly, but strongly over a period of time, rather than instantly. In most cases the feelings will gradually resolve over a period of a few days. If they should persist it is important to elicit any other symptoms of a depressive illness and to treat it accordingly. If the problems remain, particularly if they become associated with irritability, negative behavior towards the child or strongly expressed concerns on the part of the mother, then specialist help should be sought, for example, from a child and family therapist, or a psychiatrist or psychologist with special experience in this field

Activity 2.3

This activity will help you explore how long it takes women to bond with their babies.

Talk to six mothers with babies or children who are more than three months old. Ask each of them how long it took to 'fall in love' with their babies. (Talk to colleagues or friends who have babies if it is not possible to do this with women you care for.)

Mother	Approximate Time taken	Mother	Approximate Time taken
1		4	
2		5	
3		6	

The time for mothers to bond with their babies varies from those who fall in love with their babies at first sight to those who gradually attach over a number of days, or even weeks.

Impact of postnatal mental health problems on parenting and child development

Just as our knowledge and understanding of perinatal mental health problems has increased, so has the evidence base relating to the impact of parental mental health problems on parenting and child development. While for most parents, the birth of a child is a welcome and joyful time, for others, this important life event leads to increased stress and anxiety. Even mild anxiety, stress and depression can impact on a child's well-being in addition to more severe mental disorders. In order to address these problems close collaboration between children's and adult health professionals is required.

Summary

Here is a review of key points covered in this unit

- Psychiatric illnesses are experienced by at least 10% of women who deliver each year.
- Postnatal depression of varying degrees of severity is the commonest illness and is often not recognized. Caregivers can do much to help women by early detection and treatment and by engaging in a range of activities explored further in Unit 4.
- Puerperal psychosis is a severe, but very treatable condition with an onset soon after delivery. Much can be done to identify risk factors in certain women and to ensure prompt and appropriate specialist treatment.
- Childbirth is an emotional time and 'the blues' affects the majority of women. It is a benign and self-limiting condition, but caregivers can reduce distress by appropriate comfort and reassurance and empathic listening so that it does not turn into a longer episode of depression.
- There are specific steps caregivers can take to avoid or minimize problems that mothers may have with distressing birth experiences and unexpected attitudes and feelings towards their new babies.

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Unit 3 Skills and attitudes

Introduction

Units 1 and 2 helped you to understand the emotional changes women experience around the time of childbirth. One of your main jobs as a health professional is to help women to express their feelings and cope with them, by making time to listen to their experiences, validate their feelings and help them find their own solutions to problems.

Such support is needed by women working through the normal ups and downs of pregnancy, childbirth, and adjusting to motherhood, as well as by women suffering from one of the disorders outlined in Unit 2. Prime responsibility for women with severe disorders will almost certainly lie with other professionals such as the GP or a psychiatrist, but you have an important contribution to make as well through your caring skills.

A range of techniques can be used to help you relate well to the women you care for. In this unit we look at the person-centred approach or 'non-directive counselling' which is relatively easy to understand and pick up. This makes it the ideal first therapeutic approach to learn, with a low likelihood of being misapplied with potential harm. Various therapeutic approaches have been shown to be equally effective for minor and moderate depressions in primary care, including postnatal depression.

As a health professional it is likely that you will already have developed a range of counselling skills, so you may be familiar with some of the content of this unit. You will be able to develop your skills further in the context of 'person-centred' counselling.

The activities in this unit give some opportunities to develop your skills. However you will need group work and practice to make real progress. You may need to ask your tutor to arrange some group work activities facilitated by an experienced person-centred counsellor or mental health professional with a therapy qualification.

In any case, a programme of screening and 'counselling' should not be introduced until such training and long term supervision/mental health liaison are in place.

Activities in this unit have been largely adapted from material in Scottish Health Education Group, 1989, *Sharing counselling skills: a guide to running courses for nurses, midwives, health visitors*, SHEG, Edinburgh.

Objectives

By the end of this unit you will be able to:

- describe what is involved in the person-centred approach
- identify your blocks to communication
- develop the following skills for active listening
    - Getting started
    - Empathising
    - Accepting and validating
    - Using non-verbal communication
    - Reflecting
    - Using questions.

Introduction to the person-centred approach

As a health professional, and probably in your personal life too, you already counsel people. 'Counselling' is an umbrella term covering a range of type of help you give people. At one end is expert advice giving, or 'directive counselling', where you tell the woman what to do. At the other is person-centred'non-directive counselling' where you help the woman to resolve her own situation for herself.

The diagram below shows these two types of counselling as extreme ends of a spectrum of types of counselling activities.

Directive counselling involves an expert and a client, with the expert largely suggesting what the client should do. This approach might be appropriate, for example, when showing a mother how to change her baby's nappy.

In the person-centred approach the helper and client are equals, and the helper's role is to help the woman to make her own informed decisions, which she will be able to live with. This type of non-directive counselling would be appropriate, for example, when helping a woman decide what to do about an unwanted pregnancy.

These extreme types of counselling, and the variations which come in between are all valid helping tools. The skill is to be able to select and use the appropriate type of counselling for a particular situation.

Expert professional	***Person-centred approach***
Directive counselling	*Non-directive counselling*
Giving advice	helping the woman understand her situation
Giving information	Helping her explore possible options and their implications
Showing how to do something	
Taking action for someone	Encouraging her to make her own decisions

The two types of counselling are not mutually exclusive. For example, if a woman says she is frightened at the prospect of having twins it would be appropriate to give some directive counselling, i.e. information about the local Twins Club, as well as non-directive counselling to help her explore the implications of having twins.

Activity 3.1

This activity will help you to identify the type of counselling you would use in particular situations.

For each situation listed below, tick the type(s) of counselling you feel would be most appropriate.

Situation	Expert Advice Directive counselling	Person-centred Non-directive counselling
A woman wants to know how to get rid of cradle cap.		
A woman is exhausted and feeling emotionally shocked after a difficult birth		
A woman says she is thinking of having her baby adopted.		
A father says he no longer gets attention from his partner.		
A woman says she is not sure how long to keep working before the birth.		
A woman has had a miscarriage.		

There are no right or wrong answers to the activity, and indeed you probably feel you need to know more about the situation to make a decision. However, here is our response.

A woman wants to know how to get rid of cradle cap

Directive advice about shampoos and use of oil would seem appropriate.

A woman is physically exhausted and feeling emotionally shocked after a difficult birth

Directive advice and action, for example, tea and toast, is needed immediately to give the woman physical and emotional comfort and help her focus her feelings on her baby. (Later she may need non-directive counselling to understand why she felt in a state of shock.)

A woman says she is thinking of having her baby adopted

Since the woman has not decided yet, non-directive counselling is needed to help her explore her reasons for considering adoption, and consider the options available to her and their likely consequences.

A father says he no longer gets attention from his partner

The father needs non-directive counselling to explore his feelings, and their consequences, and what action he will take.

A woman says she is not sure how long to keep working before the birth

Non-directive counselling will help the woman look at the options available to her, and make a decision she feels comfortable with. She will need directive advice about Department of Social Security regulations governing maternity benefits if she is not aware of these.

A woman has had a miscarriage

This woman is likely to need a mix of both types of counselling. She will probably have questions she wants answered, such as what to do about the bleeding, and what caused the miscarriage, which can be met through directive counselling. On

the other hand feelings such as guilt, sadness, relief are best responded to through non-directive counselling where the helper assists her to explore these feelings and their implications.

Many people find it easier to use directive counselling, because it puts them comfortably into the position of the expert. But an expert cannot know better than the person being counselled how she is feeling and the best way for her personally to resolve an issue. So when helping women cope with emotions and feelings non-directive counselling is usually more appropriate. The rest of this unit will help you to develop your skills of non-directive counselling.

Distinguishing non-directive counselling from routine midwifery, nursing and health visiting activities

The non-directive approach to counselling means listening without offering opinions or advice. It is based on the work of Carl Rogers who found that the process of talking to an understanding 'person-centred' professional helps clients to:

- Find new insights into their problems
- Work out their own solutions
- Become stronger and more confident in the process.

The value of listening is again highlighted in the following quotation.

'As we tell our story we know that our life has significance, at least in our own eyes and the eyes of the person who listens.'
Dorothy Rowe, *Depression. The Way Out Of Your Prison*

Being an effective counsellor means being able to:

- relate entirely to the woman's situation, while keeping your own feelings distanced
- believe and endorse the woman's experiences
- avoid making judgements.

But though you may want to take a non-directive person-centred approach, it is not always easy. A nursing training may result in an approach of more active intervention, where specific activities are used to alleviate discomfort and speed recovery. The nurse may be seen by the patient as the expert, so the relationship is not one of equals, and the patient may come to depend on the nurse for solutions. The nurse's expertise may seem to be a barrier to talking about feelings which the patient feels unsure about. Furthermore nurses may not have the time to sit and listen to their patients' feelings and experiences.

Activity 3.2

This activity will help you to distinguish between what you actually do and how you would ideally like to counsel your clients. You may also find it useful to discuss this activity with colleagues to find out how others see you.

1 Mark with a cross where you feel your counselling activities actually lie in practice on the helping spectrum.

2 Mark with a circle where you feel your counselling activities would ideally lie.

<---------->

Directive help e.g. giving advice

Non-directive help i.e. counselling

3 Now try to give reasons for any difference between the two points you marked on the spectrum

Here are some reasons for differences between what you do in practice and what you would like to do:

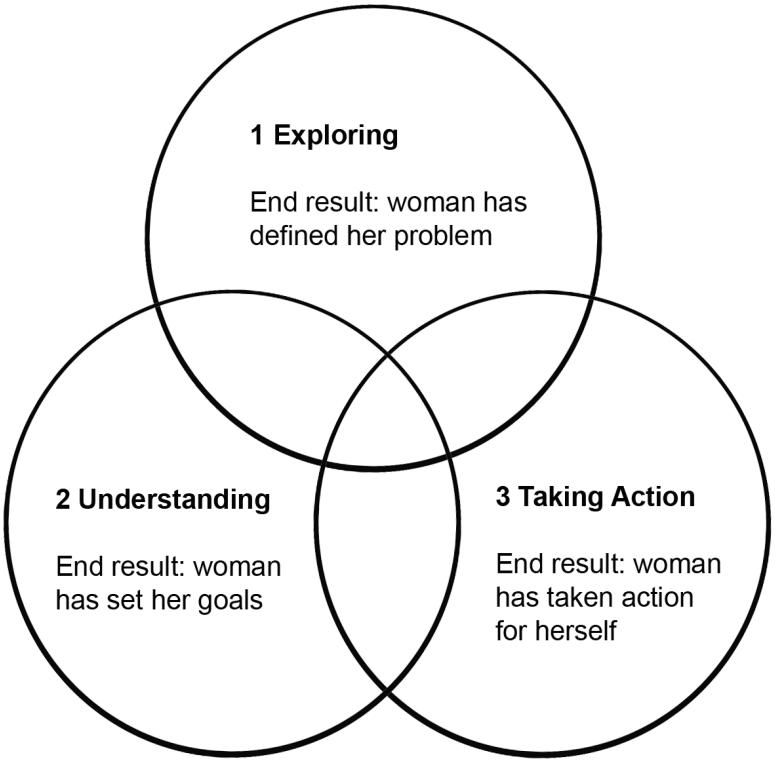
- Your past training
- The way your superiors/colleagues expect you to work
- Not enough time to devote to non-directive counselling
- feeling hesitant about the idea of non-directive counselling
  - How it works in practice
  - Cared about not being so much in control
- Feeling you do not have the skills needed for non-directive counselling
- Feeling you might do harm if you get in too deep
- Feeling that non-directive counselling is ‘a bit of a cop-out’ (in fact it is probably harder work than giving advice!).

The rest of this unit will help you to understand what is involved in non-directive counselling and develop appropriate skills.

A model for non-directive counselling

This section describing a model for non-directive counselling is adapted from Egan G, 1986, *The skilled helper,* Brooks/Cole, California, USA.

Egan developed a model of counselling in three stages, each of which has its own end results:



1 Exploring

In this first stage the counsellor builds a trusting relationship with the client, and helps her to explore her thoughts, feelings and behaviour. By the end of this stage the client is able to focus on her problem and define it.

Rhona sees her problem as the feelings of guilt she experiences because her partner no longer gets much of her attention.

The counsellor uses the following skills:

• Beginning a relationship
• Attentive listening, and using non-verbal communication
• Pacing and handling silence
• Reflecting and being empathetic
• Accepting
• Using questions
• Focusing, summarising and moving forward.

2 Understanding

In this stage the counsellor helps the client to gain a clearer understanding of her problem situation, and helps her move forward to set some goals which will help her solve the problem.

Rhona sets herself the goals of: spending more time talking through her feelings with the counsellor; and finding out how her partner feels about the situation.

The counsellor uses the following additional skills:

• sharing information
• establishing deeper empathy
• confronting issues and feelings
• Self-disclosure
• imagining
• setting goals

3 Taking action

Here the counsellor helps the woman to use her strengths to cope with the problem by making decisions or planning action.

Rhona plans to organise a babysitter so she and her partner can have a night out once a week, and decides to try to share feelings with her partner as they arise rather than when they become a problem.

The counsellor needs the following additional skills:
• brainstorming
• sorting
• identifying pros and cons
• teaching
• making contracts.

In practice the three stages do not follow a linear sequence, which is why the model is represented by the three overlapping circles. The way people think is not compartmentalised into stages, rather they move backwards and forwards within the three stages.

Rhona realises quite early on that talking to her partner about her feelings, and his, will be an important action to take, but then she needs to go back to the second stage to explore other aspects of the problem.

There are three more skills which may be needed at any stage:

Evaluation: 'How are we progressing?'
Referral: 'I feel your GP is best placed to help you think about contraceptives.'
Ending: Rhona feels that she has defined her problem with the health visitor and now wants to sort out the problem on her own.

It may take only one or two counselling sessions to go through these three stages, when the problem is simple. When problems are complex or deep-seated the counselling process may take months or years so women would need to be referred to appropriately resourced services..

2 Developing skills for the person-centred approach

The list of skills detailed in the three stages may seem long, but it should not be daunting because you will already have developed many of these skills through your personal, social and working lives. This section addresses the key skills needed for the person-centred approach, which can be grouped under the umbrella heading of good communication. But good communication in this context does not mean talking fluently. It means being open and receptive to the person you are communicating with, recognising her needs and helping the person express herself and reflect on what she is saying. Such communication skills are also known as active listening. They are the most important skills you will need to develop to help women, and cover some, but not all, of the skills listed in Egan's model.

We shall look first at communication blocks and then look in some detail at active listening skills.

Recognising communication blocks

To make your communications as effective as possible you need to be sure you are not setting up blocks to sending and receiving messages. A common block for many listeners – in any context – is that they 'switch off', perhaps because they have something else on their mind, or do not find what the person is saying interesting. When this happens the listeners are failing to give the other person their undivided attention.

Similarly, many people introduce blocks when they are talking with someone, for example by having rehearsed what they want to say in advance rather than by reacting to what the person says at the time.

We often introduce such communication blocks without realising what we are doing.

Activity 3.3

This activity will help you to recognise communication blocks you use in active counselling.

1 Read through the list of communication blocks and tick those which you recognise that you use yourself.

2 For each tick note down a situation where the communication block occurred.

3 For each communication block you identify, suggest the likely effects of the block.

As a listener, do you:	**Blocks I use**	**Likely effects of the block**
Switch off while the other person talks	✓	*Lose track of what the woman is saying. Make the woman feel that what she says is not important.*
Dismiss ideas which are new to you?		
Make fun of ideas which are new to you?		
Let your mind wander, e.g. to look at what the woman is wearing?		
Think about aspects of your own life, e.g. the shopping or the rota?		
Introduce physical 'barriers' eg folded arms?		
In dialogue, do you:	**Blocks I use**	**Likely effects of the block**
Rehearse what you will say in advance?		
Order a client to do something?		
Threaten a client, e.g. by warning of negative consequences if she does not do what you want?		

Moralise by telling a client what to do?		
Advise by telling a woman how she should tackle her problem?		
Use logic to persuade when a woman's emotional response is more relevant than reasoned argument?		
Question to collect information so that you can solve a client's problem?		
Judge your client's values, actions or attitudes?		
Diagnose why a woman is behaving in a particular way?		
Reassure a woman, so that she stops experiencing her present feelings?		
Divert a woman from her problem?		

All these attitudes and actions are likely to diminish the value of your counselling activities. If you don't give a woman your full attention, or if you in some way tell her what to do, or if you undermine her self-worth by making fun of her ideas she will feel less in control of her situation, and less able to work through it.

To start to overcome your blocks you could identify the three you use most frequently, and bear them in mind in your future dealings with clients. If you have the opportunity to do some role- play it is useful to practise avoiding using the blocks. Once you have got rid of these three blocks you can move on to others. If you try to tackle too many at once you may get confused or even introduce a new block by spending too much time thinking about your existing ones.

Active listening

Other parts of your training will have introduced you to the key skill of listening in your interactions with clients and the importance of 'active listening' where you really try to see things from the other person's point of view. When you are helping a woman through the person-centred approach there is a slight shift of emphasis so that you keep quiet more, and let go of your own thoughts and ideas about what should be done.

The main aim of active listening is to help a woman talk about her situation and particularly her feelings. This means minimising the talking you do, and using a number of techniques which will help her to feel at ease, and keep talking. It also means avoiding giving advice or your point of view.

3. Techniques for the person-centred approach

Below we introduce some techniques for the person-centred approach under a series of headings:

- Developing empathy
- Getting started
- Accepting and validating
- Using non-verbal signals
- Reflecting
- Using questions.

In reality these headings are artificial as the techniques overlap and merge into each other. For example, accepting and validating a woman's feelings is a necessary part of empathising.

Developing empathy

This means developing a relationship with the woman you care for so that she feels comfortable with you, you understand her situation and feelings, and she feels free to talk. As Rogers, 1980, put it, you need to be able to 'temporarily enter their private world and feel at home in it'. You should be genuine and show non-judgemental warmth.

Here are some things you can do to convey warmth, acceptance and empathy:

- Give all your attention to the woman.
- Show you accept her feelings (see 'Accepting and validating' below).
- Sit at a comfortable distance (too near and you intrude, too far and you distance yourself).
- Adopt an open posture (arms and legs uncrossed).
- Make reasonable eye contact – too much is intimidating, too little and you seem uninterested. However be aware that depressed women may find eye contact threatening, so be guided by her reactions until you have established a trusting relationship.
- Allow warmth to show in your voice.
- Adjust the volume of your voice (too soft and she will have to concentrate on hearing, too loud and you will sound aggressive).

We look in more detail at many of these techniques below but it is important not to become focussed on techniques. If you are genuinely interested and concerned to facilitate her developing her own understanding and problem solving this will show on how you sit and speak.

Getting started

Sometimes it is difficult to know what to say to help a woman start talking to you. After a cheerful greeting a useful technique is to ask an open ended question. An open-ended question is one which cannot be answered with 'yes' or 'no', so it

encourages the woman to talk. For example 'Where did it happen?' is an open-ended question whereas 'Did it happen at home?' is a closed question.

Activity 3.4

This activity will help you to think what to say to encourage a client to talk.

Write down three open questions you might ask to help a woman start talking about herself.

1

2

3

Here are our ideas:

- 'How are things going?'
- 'Tell me, how are you feeling today?'
- 'How have things been this last week?'

If, on the other hand, you ask 'Are you feeling better today?' you may simply receive the answer 'No' in which case you have to ask further questions.

Accepting and validating

Accepting a woman's feelings and her interpretations of them sounds deceptively simple. In practice it means avoiding making any judgements about the woman, her feelings or her behaviour. You can do this by:

- Genuinely keeping your mind open
- Suppressing your own opinion of the woman's situation
- putting yourself in the woman's shoes (empathising).

Validating means showing the woman you accept what she is saying, for example by:

- Sitting quietly while the woman talks
- Nodding as she talks
- Making encouraging noises like ‘Mmm’, or statements like ‘How did that feel?’
- Reflecting back what she has said – ‘So you’re feeling pretty fed up at the moment ...’ (see 'Reflecting' below)
- Keeping your posture and expressions open (avoiding frowning, or crossing your arms emphatically)
- Avoiding any dramatic reactions to what she says
- Accepting and being comfortable with silences, crying or expressions of extreme feelings such as anger and pain
- Recognising and accepting the hidden meaning.

We shall look at some of these points in more detail.

Coping with silence

Many people feel uncomfortable with silence in a conversation, and will quickly take steps to fill it. There may be good reasons why your client chooses to stop talking. For example she may well be collecting her thoughts about what she is saying, or she may need some time to think things through.

To accept the silence you could continue to sit passively keeping your thoughts with the woman. Accepting her silence is a very powerful way of being accepting and non-judgmental.

Coping with crying

Similarly, crying is not generally socially acceptable, often because those in attendance feel disturbed by it. However, if you see things from the woman’s point of view she has come to a point where intense emotions need to be released. If you

try to get her to stop crying by saying something like ‘Now wipe away those tears, there’s no need to cry’, you are putting your need to stop the crying in front of her need to express her emotions.

As with silences you can accept crying by sitting with a quiet but empathic presence and help the woman emerge from her expression of her emotions with dignity. While offering a hankie or a cuddle may sometimes be appropriate, in other cases they may be interpreted as signals to the woman to stop crying. You have to judge whether physical comfort is for her sake or yours, and whether or not it will be intrusive to the woman.

Coping with other people’s pain

In listening to another person’s story, we are in effect bearing witness to that person’s existence, courage, and pain. We open ourselves to the anguish of witnessing another person’s suffering.

Dorothy Rowe, Depression *The way out of your prison.*

Our instinctive response to another person’s pain may be to offer comfort, and say that things aren’t as bad as they seem, and that they will soon feel better. Like coping with crying you may try to deal with the pain quickly because it disturbs you. The woman may feel you don’t understand her, or that she needs to pull herself together to make you feel all right. To accept and validate her pain you need to share it with a quiet presence and help the woman to face her unhappy feelings in the safety of your presence.

Recognising the hidden meaning

People communicate on a number of levels, and what they say may not always be what they mean. For example if a woman says:

"I feel really stupid about this".

You might be tempted to say 'Oh, I don't think you're stupid at all'. This is bringing judgement into your reaction. A more helpful approach may be to encourage the woman to continue with her train of thought to find out why she feels stupid. You can do this by simply repeating the last word in the form of a question:

'Stupid?'

By thinking further she might realise her feeling of stupidity is based on what she imagines other people think, rather than how she really sees herself.

Activity 3.5 Imagine you are listening to the woman talking below. Then write down what you would say to her to accept and validate her feelings and thoughts.	
Young mother whose baby recently died: *"Other women get pregnant with no trouble, I had five miscarriages before I had Sean and spent three anxious months in bed at the end of my pregnancy."*	
Your response:	
"People give me queer looks. I know what they are thinking and although I know they are wrong I feel guilty. Then I get angry with myself for feeling guilty. If I wasn't such a failure I would face people and tell them."	
Your response:	

There is of course no right or wrong answer to this activity. The main thing is to avoid judging the woman, whatever your feelings about the matter. Here is one suggested response:

'It's a difficult time, but remember it is OK to talk about all your bad feelings. We can look at each of your feelings and the thoughts about what is happening that lead to those feelings?'

Using non-verbal signals

We have already mentioned the use of posture, and eye contact as important elements of empathising, accepting and validating. Your feelings are also reflected in your facial expressions, which you should keep 'open', but not so relaxed that you

appear bored or disinterested. Mannerisms such as scratching your nose or playing with your hair or a ring are distracting to the other person.

Activity 3.6

This activity will help you to identify things you can do to improve your use of non-verbal communication.

Consider the following aspects of non-verbal communication, and write down what you do well, and the improvements you could make.

You might want to ask a colleague, supervisor or client to help you with this activity. If you have the opportunity to video yourself at work you can see yourself as others see you, which is usually rather different from your own perceptions.

Good things I do *Improvements I could make*

Seating
• a comfortable distance between you (heads about five feet apart)
• Seats at the same level
• Seats at an angle to each other

Your posture
Is it open?
• Shoulders down and open
• Arms and legs uncrossed
• Trunk slightly inclined to the woman
• Head up, etc.

Your expressions
Are they open, and interested?
• Forehead relaxed (not frowning)
• Lips relaxed (not pursed)
• Eyes interested (not bored, judgmental)
• Smiles where appropriate, etc.

Your gestures
Are they warm and embracing?
Palms open
Turned towards the woman
Not touching her (unless clearly appropriate)
Your mannerisms
Are they occasional and non-distracting?

The ease with which you adopt relaxed, open non-verbal communication depends in part on your own sense of confidence and ease in the counselling situation. However, you can influence your emotions with your body language, so if you do not feel at ease, adopting relaxed and open non-verbal communication can help you feel more confident.

It is well worthwhile checking your non-verbal signals from time to time, preferably through someone else, because they change as you yourself develop as a person.

You also need to be aware of changes in your body engendered by what your client says. For example, if you feel your face and neck muscles tensing you could ask yourself what is causing this reaction? It could be that you feel some anger, in which case it is important to recognise this as being caused by unresolved issues in your own life, and put it to one side so that you can return to listening to your client.

As well as reinforcing your own messages with appropriate body language, you can pick up clues about how the woman is feeling from her body language. If the woman's non-verbal communication accords with what she says then she is confirming her feelings. So, for example, if she grimaces, shakes her head and groans as she says 'I feel terrible' then it is very clear that this is what she means.

If on the other hand she says 'I feel OK about the actual delivery', while frowning and raising her shoulders she is giving you two conflicting messages, and you can help her by encouraging to explore her feelings at the delivery, by saying something like 'Tell me some more about the delivery' .

If the woman is feeling defensive or shy or embarrassed these feelings will show through her body language, and once you have recognised this you can take steps to make her feel more at ease.

To recap, you can use non-verbal communication to reinforce your active listening, and you can read clients' non-verbal communication to pick up whether they are confirming or denying what they say. But do not go overboard in interpreting non-

verbal signals on their own – the reason for the crossing of arms might be that the woman is feeling cold rather than becoming defensive. Any non-verbal communication has to be interpreted in the context of the whole person and the conversation, not taken in isolation.

Reflecting

This section on reflecting is largely adapted from Nelson-Jones R, 1988, *Practical counselling and helping skills*, Cassell, London.

We have already said that in non-directive counselling you spend most of your time listening to the woman, and so it is important that you communicate to her that you are taking in what she is saying. This is done by 'reflecting' back or mirroring to the woman what she has said to you. We've already seen an example of this: 'I feel stupid'; 'Stupid?'

The benefits of reflection

For the client, reflecting:

• Tells her she is being listened to, understood and accepted on her own terms
• Gives her the opportunity to correct any misunderstandings
• Helps increase her awareness of her feelings
• Helps her explore her problem.

For the counsellor, reflecting:

• Helps her check she has understood what the woman is saying
• Helps her to structure the information in her mind and explore the problem
• Gives pauses and thinking space.

How to reflect

The counsellor periodically reflects back to the client, perhaps as the client pauses, or perhaps when the counsellor feels she needs to check over what has been said so far. The counsellor can do this by:

• Simple restatement of the last thing the client said
• Paraphrasing – repeating what the woman said in your own words.

Client*: 'I used to have so much energy, and be active at work and at home. Now I don't seem to have time to do anything but change nappies and give feeds. Not that I mind changing and feeding, but I sometimes feel that I'm using so much energy with no real results.'*

Counsellor using simple restatement: '*You feel you're using so much energy with no real results?'*

Counsellor using paraphrasing: '*You used to have lots of energy and a busy life at home and work. At the moment you feel there's no time for anything else but changing and feeding. You don't mind doing these things, but they use up a lot of your energy, and you feel they don't achieve much.'*
'Have I understood that properly?'

Reflecting feelings

When you help women to sort out the emotional effects of pregnancy and childbirth it is particularly important to make sure you reflect their feelings as well as the facts of what they are saying. In the example below the feelings are underlined.

'I feel so <u>helpless</u> since this all began. I used to be on top of everything – the house and my job, and now here I <u>can't even decide</u> what to make for dinner – it's <u>pathetic</u>, but I feel like I'm <u>swimming in porridge</u> – I just <u>wish I could get out</u> of this mess.'

To reflect the feelings the counsellor rephrases what the woman said in her own words, concentrating on the feelings. Here are the counsellor's own words for the feelings the woman expressed:

Helpless	– unable
Can't decide	– can't make up your mind
Pathetic	– pitiable
Swimming	– aimless
Wish I could get out	– escape

This is how the counsellor reflects back to the woman:

'You feel unable to do things. You can't make up your mind about everyday things like what to cook, and feel this is pitiful and aimless. You wish you could escape from the disorder.'
'Have I understood that properly?'

Clearly, you could be wrong in what you understand her to be meaning. This should therefore be offered tentatively giving her the opportunity to correct any misunderstandings.

Activity 3.7

This activity will help you to reflect a client's feelings.

Follow the steps in the example above:

1. Underline the feelings being expressed.
2. Write down your own words for the feelings.
3. Write down your reflection of the feelings.

Woman who had a stillborn baby:	*"I suppose it's my fault – and now I feel so guilty. I should have remembered the breathing exercises. It was stupid to forget them, and they might just have made things easier for the baby instead of me giving in to pain relievers. I'll never forgive myself for this. If only I could have the last month over again."*
Pregnant woman who no longer wants her baby:	*"I feel really bad about starting this whole thing off. I suppose it was curiosity, but we hadn't really thought it through, and now I don't want a baby to take over my life with its constant demands. I want to keep living my own life. Not that I'll do anything to harm the baby now, but I'm not sure if we will keep it."*

Each person will have used their own words to reflect the feelings in the above activity. Here is one person's response.
Woman who had a stillborn baby

Her feelings:	*My own words for the feelings*
My fault	Caused
Guilt	Guilt
Should have remembered	Recall
I was stupid	Silly
Never forgive myself	Let yourself off the hook
If only I could have	Do it again

Reflection

'*You feel you caused the situation and that makes you feel guilty. You think if you'd recalled the exercises things might have been better for the baby. You feel silly you forgot the exercises, and that you'll never let yourself off the hook for this. You'd like to be able to do it all again.'*

Pregnant woman who no longer wants her baby

Her feelings:	*My own words for the feelings*
Feel really bad	Guilty
Now I don't want a baby	Rather not have
Want my own life	Want your freedom
Not sure if we'll keep the baby	Undecided about keeping the baby

Reflection

'You feel really bad this all began. You hadn't considered the consequences of having a baby, and now you want your freedom, not the continual work of a baby. You'll take care of the baby, but you're undecided about keeping it.'

Clarifying and summing up

When women are talking about things which are confusing, painful or hurtful it is not surprising if they do not always express themselves clearly, or you do not quite pick up what they are saying. As the listener you may find it difficult to follow the woman through her maze of emotions and feelings. To clarify the woman's message you can reflect a remark which takes you both back a few steps.

You can start by interjecting with a remark like:

‘As you see it then ...’
‘Have I got this right? ...’
‘Let me make sure I’ve got this clear ...’
‘Let me see if I’ve understood you ...’
‘You seem to be saying ... Is that right?’

and then paraphrase what you think the woman has been saying for the last few minutes.

Even when you are clear what the woman has been saying it helps her if you reflect this back by summing up what has been said so far. Summing up means condensing down what the woman has been saying in the last few minutes into a short statement. For example:

‘You seem to be saying that although you love your partner, you are finding it hard to show this at the moment.’

At the end of a counselling session it is helpful if you briefly sum up what the woman has said. For example:

‘Let me try to sum up what you’ve told me today. You feel angry that you’re not getting any time to yourself, and you think your partner could help more. You’re having some arguments, and although you still love him, you find it hard to show at the moment. You think you may try talking to him about how you feel.’

Reflecting anger

Anger is a very common emotion, and one which is often buried because it is not socially accepted. When a woman expresses anger it is important to reflect it back to her – she may not be aware she is angry. As you reflect her anger you need to be careful not to react to it, remembering your role is to avoid making judgements.

Sometimes the woman's anger will be directed at you, and you may need to remind yourself to remain non-judgmental and not to become defensive.

Woman at the postnatal clinic: '*You're not even helping me - all you do is say 'yes', why don't you tell me what to do?*'

Health visitor: '*As you see it, because so far I've just listened to you, you don't think I'm able to help you?'*

Activity 3.8

This activity will help you to reflect hostile feelings back to your client.

For the following situations, write down what you would say to the woman to reflect her hostile feelings back to her.

	Your response
Pregnant woman to midwife: '*I've been thinking what you said last week and I'm very annoyed. Who do you think you are to criticise me?'*	
Anxious mother: '*What's the matter with you? I've told you I don't know what to do, but you don't seem to believe me. If I knew what to do I wouldn't be here would I?'*	

Here are our responses; yours may use different words to convey the same message.

Pregnant woman to midwife	***Response***
'I've been thinking about what you said last week and I'm very annoyed.	'Let me see if I've got this right. You Feel annoyed because you feel what

Who do you think you are to criticise me?	I sail last time was criticising you. Could you tell me which part of what i said seemed critical?

Anxious mother	***Response***
'*What's the matter with you? I've told you I don't know what to do, but you don't seem to believe me. If I knew what to do I wouldn't be here would I?'*	*'You feel I don't believe you, and you want me to tell you what to do?'*

Using questions

We have already highlighted the difference between open questions which encourage the woman to talk, and closed questions which can usually be answered by 'yes' or 'no'. In the context of active listening you will almost always use open questions to encourage her to explore further the theme that she has already introduced. However, there are some specific questions may be appropriate to help the woman if the situation appears stuck.

In this section we look at situations where you can use simple questions to help a woman to explore her feelings in more depth.

Getting in touch with the past

For some women talking about the past may help gain an understanding of present feelings and needs. For example you could ask:

'Who comforted you as a child?'

'What did that feel like?'

You need to be prepared for possible torrents of emotions if feelings about the past have been bottled up for years.

Support in the present

Women who are emotionally upset need support to recover. It may be helpful to the woman to look at possible sources of support by asking questions like:

'*Who helps you when you need support?'*
'Who can you talk to?'
'Whose shoulder can you cry on?'
'Who can you laugh with?'
'Do you find it difficult to ask for help?'

A magic wand for the future

Women may find it almost impossible to think things through to solve their problems. A useful tool is to encourage them to move the future into the realms of fantasy where it seems less threatening, and ask a question like:

'If you had a magic wand and could change your life, what would you most like to happen?'

Most people find this an interesting challenge to respond to, and an imagination game can bring the freedom of a new perspective.

The reflected question

You may find some clients are not used to having someone to listen to them, and expect you to give them advice and generally guide them about what to do.
Although this may seem tempting, particularly if you think you know what she should

do, in the long term it is more productive for the woman to work out her own decisions and solutions. You can do this by reflecting her question back to her.

Woman: *'What do you think I should do to sort all this out?'*
Counsellor: 'I am not sure that what I think is what is important here?'

Encouraging the woman to think things out for herself will strengthen her own resources, and lessen her dependence on the 'experts'.

Activity 3.9

This activity will help you to practise using questions.

Choose a convenient time to have a conversation with a person you know well – a colleague, relative or friend. Tell the person you will be practising a counselling skill, and ask them to talk about themselves, for example how they are feeling at the moment.

As you listen, use some questions to keep the other person talking and encourage him/her to open up more. Afterwards ask your partner to tell you how well you listened.

While it is useful to focus on each technique for practice, in reality you need to select from the range of non-directive listening techniques and use the most appropriate for a particular point in a conversation. Becoming confident with the techniques will increase your confidence in supporting the women you care for.

4. Other therapies

In research studies various brief therapies such as Interpersonal Psychotherapy, Cognitive Behaviour Therapy, counselling based on Cognitive Behaviour Therapy and dynamic approaches focussed on the mother and child relationship have also been shown to be effective. It is important to remember that these were provided by

experienced therapists or by experienced primary care professionals supervised by experienced therapists. In research; diagnoses and the decision to treat have been made by the research psychiatrists who also reassess post treatment and refer if necessary. If maternity or primary care staff are considering introducing the provision of brief therapeutic interventions the following should be considered

- What basic skills are required before specialist training e.g. screening, making the decision-to-treat, listening skills?
- What training will be provided?
- What level of supervision is required by this approach?
- Who will make the decision if the approach is appropriate for each woman?
- What systems are in place for referring on those not helped by this approach?
- In line with the principle 'first do no harm', how likely is harm from unskilled use of this approach?
- How acceptable is the approach in the primary care context?
- Are the therapeutic skills useful for enhancing other aspects of your professional practice?

Summary

These are the key points covered in this unit:

- Person-centred counselling helps women by encouraging them to explore their feelings in a safe, non-judgmental presence.

- Person-centred active listening is different from more directive forms of help such as giving advice and routine nursing activities.

- You already have a range of listening skills from your personal, social and working lives.

- Your attitude and behaviour can help or hinder communication with your clients; being aware of and developing non-verbal communication skills can help you to build up a supportive relationship.

- Egan's model of counselling includes three stages: exploring, understanding and action planning, each requiring a set of skills.

- Active listening is the key skill, and encompasses the following skills, all of which can be learned or developed:
  – getting started
  – empathising
  – Accepting and validating
  – using non-verbal communication
  – reflecting
  – using questions.

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Unit 4 – In Practice

Introduction

The first three units have helped you to become aware of the usual emotional changes associated with childbirth; to recognise the variations and disorders which may arise; and to develop key active listening skills. This unit will help you to explore ways of adjusting your routine practices so that you can help women deal more effectively with their emotional responses.

There is some evidence that support and education can help prevent emotional disorders from developing. This can be achieved through continuity of care, active listening and a person-centred supportive approach. Using a planned programme / pathway of care you need to be able to recognise when a disorder is present and provide initial support, again mainly through active listening. To give women effective support you need to be aware of your own limitations, and know the roles of other health professionals and how the referral system operates. Finally, developing skills to help women with emotional disorders is an ongoing process of personal development, so you may find it helpful to prepare an action plan for further learning.

It is important to recognize that any mother's sense of well-being is inextricably linked to her feelings and her power to care for the baby. Pregnancy, childbirth and getting to know a new baby are all parts of a time in a woman's life when she needs to find new capacities in herself and support in other people. The developing relationship with the baby is crucial to the mental health of both mother and child. Effective care and support for the mother will also require health professionals to keep the baby, and the baby's father in mind. As you go through this Unit, think about how you might support the mother/ father /baby relationship.

Objectives

By the end of this unit you will be able to:

- Identify ways in which you can help to prevent emotional disorders arising
- Help women to deal with emotional disorders
- Support the developing mother-infant relationship
- Acknowledge the role of the father
- Describe how your role fits in with other professionals and know when to refer on
- Develop an action plan for further learning.

1. Helping to prevent emotional disorders

There is evidence that education and support can help to prevent some types of depression and prevent the deterioration of the mother's mental health

There is a whole range of help that health professionals can give women through the various stages of pregnancy, birth and early motherhood, and we introduce some of them under the headings below. As we highlighted earlier, when dealing with emotions and feelings it is important to remember that the wellbeing of mothers, babies and the whole family is linked together. The role of the health professional is to help women to help themselves and participate in decisions. Good decision-making is assisted by keeping women's particular social and family relationships in mind. At the organisational level continuity of care is a key factor, while at the individual level a key strategy to help women is support and listening.

Providing continuity of care

The advantages of continuity of care are:

- The woman gets to know and trust the person who is helping her
- The care provider gets to build a therapeutic alliance with the woman
- The care provider gets to know the woman's particular circumstances and needs
- There is a recognized pathway of care.

An example of continuity of care is the DOMINO scheme where the community midwife, whom the woman has come to know during her antenatal care, attends her during labour and birth. This idea has been taken a stage further with the Know Your Midwife scheme where a small team of four to six midwives care for the woman through the antenatal, delivery and postnatal stages. Research has shown that when women have continuity of care they are significantly more likely to be able to discuss anxieties during pregnancy. These practices are in contrast to the hospital delivery where the woman is attended by the midwife on duty, whom she has quite probably never met before.

Activity 4.1

This activity will help you to review continuity of care where you work.

1. Note down those (e.g. midwife, GP, health visitor) who could help women through each of the three stages below.

Parent-Infant Relationship		
Antenatal care	Labour and birth	Postnatal care

2. In the above table highlight anyone who operates in more than one stage.

3. Write down any suggestions you have for providing more continuity of care?

Caring for women's emotional needs around the time of childbirth calls for: liaison between hospital and community; communication within the primary care team; and close links with community health teams, psychiatric or psychology services. Many of these practices do, of course, require decisions to be made at senior management level. But there may be opportunities for you to voice your ideas, for example at staff meetings.

Antenatal care

During pregnancy, women are growing the idea of the new baby in their mind, just as the baby itself is growing inside her body.

‘Prevention is better than cure’ is a useful adage, and helping women to deal with their emotions during pregnancy can help them to move positively through the stages, rather than bottle up unresolved emotions which may later emerge as a disorder.

There is evidence that many women with postnatal depression experienced antenatal anxiety. The EPDS has been shown to be effective in screening for antenatal anxiety or depression, and should be built into routine care. Encouraging women and their partners to think about their pregnancy and the coming baby and to reflect on the changes it will bring can make a difference As an example, Elliott *et al.* (2000) carried out a controlled trial in which pregnant women were invited to informal groups designed to discuss the realities of parenthood, and to give mothers peer group support as well as professional support. The group met during pregnancy and after the baby was born. First time mothers invited to these groups showed only half the prevalence of postnatal depression found in mothers who were not invited.

Broadly speaking, the main things you can do are to encourage both the mother and the father to express their feelings and emotions, and provide an opportunity for them to discuss their expectations what parenthood involves. Such activities do not need to take up vast amounts of time, or be costly. We look at these helping activities in more detail below.

Make early contact

First time mothers in particular may be largely unaware of what pregnancy involves, and of what roles the health professionals will have. Making early contact with the woman soon after confirmation of pregnancy provides an early opportunity to provide information and answer her various questions. Ideally, those responsible for her postnatal care will meet her at least once antenatally to build a relationship.

Encourage women to confide their feelings

Women may feel inhibited from expressing their feelings for a number of reasons, for example:

- They are busy (as most women work through pregnancy)
- They are angry at having been kept waiting, for example in the antenatal clinic.
- They think their feelings are private and they should be able to deal with them

- They are not used to expressing their feelings to health professionals
- They think you are there to deal with physical things only

Therefore you may need to work hard to make it easy for women to express what they are feeling by using the techniques we outlined in Unit 3. To recap, some of the key things you can do are to:

- Build a trusting relationship
- Make it clear you have time to listen, and avoid distractions
- Listen in an active and non-directive way so the woman stays in control of her life.

Encourage women to confide their feelings to others

Inevitably professionals will only see a woman periodically, so it is likely to be important for her to share her feelings with those close to her such as her partner, relatives and friends. Of course she may already do this, but if she does not you could encourage her to do so by, for example:

- Encouraging the woman's partner/supporter to attend some antenatal appointments
- Encouraging her to ask her own mother or close friends how they felt during pregnancy

Encourage women to /join self-help support groups

If women are in contact with other pregnant women or women with children, they have opportunities to share their joys, worries and fears and to exchange ideas and information. The main benefit of support groups is that women feel tremendously relieved to find that others have similar feelings and problems.

Alternatively, mothers may set up their own self-help support groups, perhaps through friends or perhaps through contacts made during antenatal care. For example, a mother who had experienced and recovered from mild postnatal depression set up weekly meetings in her house, alternating afternoons for mothers and babies with evenings for mothers and fathers.

Activity 4.2

This activity will help you to identify the support groups operating in your area. (You may need to consult your colleagues, local health bodies or specialist support groups)

1. Make a list of support groups you could refer women to in your area.

2. Make a list of the self-help support groups operating in your area.

[See the Unit for general areas of support]

Help parents prepare realistically for parenthood

The main formal sources of education are antenatal and parenting education classes variously provided by hospitals, health centres and voluntary organizations. Such classes usually concentrate on the physical aspects of pregnancy, birth and early parenting. However, as we stress throughout these units, the woman's feelings are of equal importance, and the development of a close and secure bond between mother and infant is fundamental to the well-being of both. If we are to help the 'whole' woman, antenatal classes should also give information, advice and opportunities to discuss feelings and relationships.

Activity 4.3

This activity will help you to identify topics you may wish to add to your existing antenatal educational classes.

If you are not involved in antenatal classes find out what is covered, so you can prepare to talk to women about topics not covered. Tick/check the appropriate boxes.

Topic	Already covered	Could be added / you should raise
Recognising the changes in your body and mood		
Understanding the value of the mother-baby relationship for infant psychological and emotional growth		
Recognising and understanding what causes you stress		
What happens if you feel sad, anxious or depressed?		
The benefits of exercise and pampering yourself.		
Looking at nutrition – what are the right foods and right amounts.		
The importance of making social contacts with your neighbours and friends.		
The advantages of confiding in your partner or a friend		
Sexual relationships after the baby – have I got one, do I want one and how do I feel good about myself?		
Where to get help		

For the topics you have ticked in the right-hand column, you can prepare yourself by:

- Finding out any relevant information

- Finding out how women usually react to the topic (from your experience or from your colleagues)
- Preparing some questions to ask to get a discussion going.

Labour

Emotional support during delivery can lead to enhanced satisfaction, fulfilment and emotional wellbeing for women. These feelings in turn help prevent the blues, reduce the length of labour, reduce the need for intervention, reduce complications for mother and baby, enhance mother–baby relationships and reduce postnatal depression.

- Providing continuity of care through labour and birth
- Allowing parents 'centre stage'
- Empathising with the woman
- Listening to her needs and responses
- Remembering she has heightened perceptions and may remember casual comments
- Respecting her previous experiences
- Offering choices and acting on preferences
- Involving her (and her partner) in all decisions
- Keeping her fully informed about what is happening
- Avoiding talking 'over' the woman
- Giving her some time alone with her partner
- Maintaining respect for the woman if she becomes helpless or loses control, then helping her to regain control
- Not intruding at the moment of the birth
- Allowing time for mother and baby to get to know each other

To help women deal with pain, you can:

- Recognise when the woman is experiencing pain (pain is often underestimated by midwives and obstetricians)

- Respect her choice of strategies for dealing with pain (see unit 1)
- Know how to use the following methods of pain reduction:
- Increasing feelings of personal control through a good midwife/nurse/doula–mother relationship
- Social support through companionship, encouragement, physical and emotional support
- Comforting from the woman's birth companion
- Helping the woman and her partner to understand what helps to deal with pain
- Helping the woman increase her control of pain, relaxation, positive images, for example:

❖ psychoprophylactic techniques, e.g. relaxation, and structured breathing techniques
❖ hydrotherapy
❖ analgesic drugs
❖ epidural analgesia
❖ TENS (transcutaneous electrical nerve stimulation)

Activity 4.4

This activity will help you to review a delivery you attended and suggest how you could extend the emotional support you give.

If appropriate you could choose a delivery that you can talk to the mother about.

If you have not recently attended a delivery, you could either discuss this activity with a colleague who has, or find a woman you care for who is willing to talk to you about how she experienced the stages of her labour and delivery, and what else she feels would have helped her.

1. Think about a recent delivery and if necessary get the notes on it as a reminder.
2. For each stage write down in the second column below what you did to help the woman:
   – participate in decisions
   – express her feelings and emotions.
3. For each stage write down in the last column below, with the benefit of hindsight and if possible with the benefit of the woman's views, what else you could have done.

Stages	What I did to help	What else I could have done?
Preparation		
First stage		
Second stage		
Third stage		
Immediate post-delivery		

This activity should have helped you identify ways of improving what you can do to help women to retain control over what happens during labour and birth, and to encourage them to express their feelings and emotions.

4.5 Case Studies

Mary and her partner have had varied postnatal experiences. The birth of their first child was traumatic, and while she coped well, her partner is reluctant to attend any future delivery because he still feels traumatised by that birth. Apart from Mary and a friend no one talked through the birth with him.

Subsequently Mary had a miscarriage, and was very disappointed as this was a very much a wanted baby as a brother or sister for Andrew. She was happy with the way she was treated at hospital – everything was handled quickly so it did not involve an overnight stay; afterwards she was put on an empty ward away from the babies; she was given a leaflet 'We're sorry you've had a miscarriage' which answered a lot of her questions; and two midwives, and the parentcraft teacher whom she knew all dropped in to talk to her. However she has no real explanation for what had gone wrong. Gradually by looking back over the past few weeks, and talking to two friends who had had miscarriages she realised that her hormones had been changing for a while. She started to write these things down – the nausea had stopped, her breasts had shrunk, she had spots as in puberty and as when she stopped breast feeding her first child. Eventually she came to terms with the fact that the fetus had probably died some weeks before the miscarriage, and when she took this explanation to her GP to check, he confirmed that she had probably had a 'missed abortion'. Having rationalised the situation Mary felt she could leave it and get back to the rest of her life.

Mary is now pregnant again, and unsure whether or not to encourage her partner to attend the birth. While Mary was given good postnatal support after the miscarriage, the lack of support for her partner after their first delivery may carry forward to any future pregnancy, making it difficult for him to provide adequate support for her. As you read on, consider the points at which you might be able to identify problems a woman's partner is experiencing relating to the pregnancy or impending birth, and also think about how you might intervene. Remember that the mental well-being of mother and father are linked together.

During the days after birth women experience intense and changing emotions associated with rapid hormone changes and reactions to their baby. The nature and intensity of feelings vary from woman to woman, and many will experience the blues as a day of low mood which resolves itself quickly.

During this phase it is helpful for the woman and her partner to express their feelings so they do not get bottled up and emerge later as disorders. By listening and using observation you can identify women who are experiencing problems, and perhaps help them prevent a later depression. It is also important to be sensitive to the feelings of her partner.

Things to do at this stage are:

- Offer the assistance of a midwife or office nurse
- Allow the mother, with or without partner, time alone to assimilate her change in status
- Encourage parents to talk fully about their experience of the birth
- Observe the woman's emotional responses
- Encourage her and her partner to express their feelings, and show that you have time to listen
- Give the mother at least as much attention as the baby
- Let the parents know it is OK to have negative feelings
- Talk about the blues, and monitor women who experience them, or have problems relating to their baby
- Do not trivialise anxieties – what seems everyday routine on the ward to you may be the mother's first experience
- Advise or empathise on the importance of rest; and not having too many visitors in hospital, and particularly at home
- Use sensible multiparous women in discussions, making use of their experiences
- Allow mothers to set their own pace in taking responsibility for various aspects of care of the newborn baby

- As far as medically possible fulfil the mother's chosen birth plan/ hospital stay requirements
- Help women with their chosen method of feeding
- Tell mothers about postnatal support groups
- Help mothers solve practical problems.

Feeding

When a mother feeds her baby, whether by breast or bottle, she is providing love and protection as well as nutrition. You can help her by:

- Accepting her chosen method of feeding
- Not expressing doubts about her ability to do it properly
- Not showing disapproval if it is not your preferred method
- Not expressing doubts about her ability to do it properly.

Women who fully breast feed their babies are more likely to suffer from low mood and exhaustion. You can help them by:

- Listen to their concerns and offer extra support – by visiting more frequently and sharing concerns with other health professionals
- Suggesting they consider extra rest and relaxation; help with housework or 'healthy neglect' of unnecessary tasks
- Discussing sexual activity after childbirth (for example, with breast feeding they may not feel ready to restart a sexual relationship very early or that KY jelly may help if they suffer painful intercourse as a result of vaginal dryness due to low oestrogen levels).

Helping mothers get access to social support

Many mothers now lack the support previously given by the extended family. This arises when mothers live away from their immediate families, or grandparents are still working themselves and have limited time to offer, but there are a number of groups which can provide support. There are several sites on the World Wide Web which are specifically designed for mothers and fathers. [*See appendix]*

New mothers inevitably face a range of problems such as colic, feeding, crying, sleeping, and there are a variety of ways of dealing with these situations. To help the woman remain in control of her life you can:

- Encourage her to suggest her own solutions
- Offer possible solutions as a 'menu' for her to consider
- Help her explore the consequences of each possible solution for her
- Give the mother a chance to discuss her birth experience
- Try to make the home visit mother-orientated rather than baby-orientated, and pay attention to the developing mother-infant relationship.
- Help the mother to raise issues concerning her. Remember mothers feel inhibited by a series of questions

Helping mothers build a happy and secure relationship with their baby

- Support the mother's sense of competence by observing out loud some of the positive things you see her doing for her baby
- If initiating conversation with the mother is difficult, ask who the baby is named after and why or who the mother thinks the baby looks like and why

- Support the mother's awareness of her importance to her baby by observing out loud some of the baby's efforts to look at her or communicate with her
- Encourage her to see that the baby is able to feel safe and build competence when interacting with the world because of her support
- Avoid making negative remarks about the baby, even if they are meant in a supportive way – mothers take the remarks of professionals very seriously: for example, a remark that the baby is 'demanding' or 'trying it on' can make her feel that her baby's expression of his needs is unreasonable compared to other babies.
- When mothers don't seem to be enjoying motherhood, encourage them to talk – sometimes there are hidden anxieties, such as a traumatic delivery, or difficulties in the transition from career to motherhood.
- Increase your support to women who don't seem to be enjoying motherhood, and refer early to specialist services.

Helping women who lose their baby

A small proportion of women lose their baby through miscarriage, stillbirth or neonatal death, and they and their partners are likely to be particularly in need of emotional support. Unit 1 lists the emotional needs of these three groups of women. While the grief experienced in each situation is the same, the practicalities, and hence the need for emotional support, are different for these three situations.

Health professionals need to be aware that:

- Parents may be in shock
- They need time to sort out their feelings
- They should be given plenty of time to make decisions, for example whether they want to cuddle the baby
- They may need ongoing counselling.

Things you can do to help all women who have lost a baby

Be there, and provide emotional support:

- Provide continuity of care before, during and after the birth
- Create an atmosphere of trust
- Help parents express their feelings, particularly fears
- Talk with both parents, trying to face them both, so the mother is not burdened with all the grief
- Be aware that either may express anger, and help him or her move through this to grieve
- Explain what had been done to save the baby and answer their questions about whether anything else could have been done
- Be prepared to talk through likely consequences of future pregnancies
- Empathise with the parents, but don't get so involved that they have to feel concerned about you.

Give information:

- ask parents what they know, and do not assume they know more than they do.
- provide explanations where appropriate to help them understand what has happened
- provide relevant written information, but only after sympathetic discussion - for example leaflets like 'We're sorry you've had a miscarriage' answer the common questions about miscarriage - and put parents in touch with relevant support groups (see the list at the end of this unit).

Look after yourself:

- Recognise that you, the carer, may have painful feelings, and may need someone to talk to about the experience; it is easy to feel very involved when a

woman loses her baby, and you may need support to get your own feelings in perspective.

For women who experience miscarriage

During or after the miscarriage health professionals can:

- Explain that miscarriages are common - the chances of a pregnancy ending in miscarriage are about 1:3 also explain that we often don't know why they happen, women may feel guilty/it's something they've done or not done
- Recognise that parents may experience intense grief, however early the miscarriage, and help them to acknowledge these feelings.

For women who experience late miscarriage, stillbirth or neonatal death

Health professionals can help women to get to know their baby in the brief time they have together. This will help the parents to remember the death as a real event, and not just a dream, and can deeply affect their mental wellbeing in the years to come.

Before and during the birth health professionals can:

- Discuss with the woman her wishes for the baby, for example:
  – does she want to have her baby delivered into her arms?
  – does she wish to cuddle her baby while he/she is still warm from her body warmth?
  – has she chosen a name so that the baby can be greeted by name at birth?
- Help a woman express and manage her feelings when she knows before the birth that the baby is dead
- Treat the baby tenderly at the birth, for example wrap him/her in warm blankets.

After the birth health professionals can:

- Offer to show parents (and other members of the family if they wish) their stillborn baby, and help them cuddle the baby if they wish
- Support parents in deciding whether to stay with a dying baby, and help them care for the baby if they want to
- Give parents privacy with their baby for as long as they want after delivery – put a bereavement notice on the door
- Help parents to obtain photographs and other mementoes, such as a foot or hand print or lock of hair, if this is what they want
- Tell parents where their baby has been taken in case they want to see him or her again
- Provide facilities for the couple to stay together in hospital, if appropriate
- Explain if there will be a post mortem, and about funeral and administrative procedures.

Seeing care from the woman's point of view

The preceding pages should have given you some ideas for improving the emotional support you give women. The next activity will help you see the care you give from a woman's point of view.

Activity 4.5

This activity will help you find out from a client how they think you could improve their care.

Choose a relevant situation from the list below. (Avoid choosing a sensitive situation if you are not confident that you have the skills to deal with the feelings and emotions that may arise.)

- A pregnant woman receiving antenatal care
- A pregnant woman who goes to antenatal classes
- A woman who has recently given birth
- A woman who recently had a miscarriage/stillbirth
- A woman who is receiving postnatal care

Ask the woman:

- What is/was useful about the care?

- What is/was not useful?

- How does she think the care could be improved for the future?

This activity may have reinforced the point we made in Unit 1, that the mother's perspective and hence her feelings and responses will probably be quite different from your own.

In Unit 2 you looked at the various emotional disorders which may arise, and the characteristics and predisposing factors to watch for. However, as we emphasised, each woman expresses her feelings in her own unique way, so it can be difficult to recognise an emotional disorder. It is not your responsibility to diagnose disorders, but you need to be aware of the possible symptoms to help you detect signals of a problem or potential problem, which you may well need to refer on to other professionals. You should also remember that a woman may have emotional problems which do not fit into the categories of disorders discussed in Unit 2.

The Edinburgh Postnatal Depression Scale (EPDS) or the Whooley Questions (now used in the UK) are useful tools for helping to detect mothers with low mood post partum, and it also gives the mother an opportunity to talk about her feelings and her health professionals an opportunity to listen to her. This should be based on an assessment of the mother's mood. You should help the woman explore the situation if you suspect there is a problem even if you have no real 'evidence' of symptoms.

Dealing with disorders

Once again the key skill in helping women to deal with disorders is to give them opportunities to talk about their feelings, and to listen to them in a non-directive way as discussed in Unit 3. Of course where a disorder is severe or complex the woman should be referred on to other specialists.
There are a number of benefits in giving support to depressed women:

- Knowing that someone understands, and that other women have similar experiences helps a woman to be less self critical and self doubting. The mother is assured that she is NOT alone

- An explicitly 'mother-baby oriented' rather than 'baby-oriented' approach gives women confidence in their ability to make decisions about the care of their baby.

- Being encouraged to talk about her feelings without advice or interpretation helps the woman think more clearly about her situation.

- A contract between the health professional and the mother means that the regular appointments will enable the mother to prepare for the visit and think of things she wants to discuss.

Visiting in the home

The following guidelines are helpful in setting up listening or home visits:

- The EPDS may be offered for the woman to complete.

- Ideally offer to make four, weekly visits in which you will:
  – give her the chance to talk about **her** feelings: 'I will come so you can talk about how **you** feel, we can talk about the baby at the clinic'
  – Mostly listen rather than talk or offer information. This is really important as there is often the urge to be prescriptive and to offer solutions before the mother has been 'heard'. Ideally both you and she should be able to explore the situation. The mother should be allowed to identify her own problems. This can be achieved by listing them and then ranking them in order of importance. The 'most important' problem may then be tackled. As an example, the worst and best case scenarios could be presented and the most appropriate solutions suggested by the mother and 'endorsed' by you.
  – Explain that what she says is confidential and that information will only be passed on to her GP or your supervisor with her permission or when necessary for her or the baby's safety and keep what she says confidential to yourself and the primary care team.

- Establish a regular time for visits,

- Allow an hour for each visit, and aim to spend the time in empathic listening.

- Encourage the woman to tell her partner/friend about the visits, and include him in at least one visit if possible

- Explain that these listening-type visits may evoke changes which do not seem positive at first, but these may help prevent further problems later.

- Ask the woman's permission before referring her on, if this is necessary

- Inform/consult her doctor about the visits.

- Decide a policy for record keeping which strikes a balance between her need for privacy and your need to keep track of and communicate progress for example
  – Dates EPDS completed
  – Date visits offered, and whether accepted
  – Date and time of visits
  – Whether the meeting took place
  – Dates of further visits
  – Whether, at the fourth 'review meeting' you recommended the woman to seek further help or made a referral.

Using the Edinburgh Postnatal Depression Scale (EPDS)

Early recognition of women with low mood may give opportunities to help them prevent the downward spiral into depression. The EPDS is a simple tool to detect low mood in the postnatal period and hence identify women who are at a high risk of suffering from postnatal depression. It checks for 10 symptoms of depression and anxiety and is easy to complete and score.

More importantly it provides a structured way of encouraging women to express their feelings, and the reassurance that they are not alone. Although the EPDS picks up depression very well, it is not a diagnostic tool. Women with high scores do not all have depression – they may have temporary low mood and need support, or they may have depression as part of another illness which requires referral. All high

scoring women need the opportunity to talk about their feelings so that decisions can be made about whether future treatment is needed. The EPDS can be used routinely from six weeks at home or in a clinic. It has not been validated for use in the first postnatal week, and so is not often used on the postnatal ward.

A screening tool, the Postpartum Depression Screening Scale (PDSS) was originally developed and validated in a North American population but has now also been translated and validated in Spanish, Turkish, Brazilian Portuguese and Thai. Screening tools for health professional interventions will not be appropriate in all cultures. Depression may not even be a meaningful concept in some cultures. Do not start by translating one of these scales, instead explore how maternal distress and misery is expressed in the cultural groups that you provide a service to.

The EPDS has been translated into several different languages and validated in some of these (some translations can be found in Cox & Holden (2003) and a list of those translated and validated is in Henshaw & Elliott (2005). In addition, Sobowale & Adams (2005) have developed picture booklet versions of the EPDS entitled 'How are you Feeling' (which are available from the Community Practitioners' and Health Visitors' Association – see Resource section) in Arabic, Bengali, Chinese, English, Somali and Urdu.

Professional contacts with mothers often focus on physical rather than emotional wellbeing, and one of the most useful functions of the EPDS is to enable women to talk about emotional aspects, giving women 'permission to talk' about their feelings and professionals 'permission to listen'. Routine use of EPDS raises professionals' alertness to women's feelings, and women quickly learn from each other that it is being used. Knowing that it is acceptable to talk more about feelings may in itself help prevent emotional disorders.

The EPDS is being used routinely by health visitors with positive results, although concerns have been expressed about the use of checklist screens. There are a number of things to bear in mind before deciding whether to use the EPDS.

- It should only be used where a full range of follow-up help is available, e.g. counseling and mental health services.

- A system for referring on seriously depressed women should exist.

- Women should fill it in individually and quickly without thinking about each question too much.

- Care should be taken with the context in which women completed it and the information available to enable them to make an informed decision to complete it

- One high score may only indicate temporary low mood, you need a discussion with her determine if she has an enduring problem requiring further help.

- Being labeled as depressed may be counterproductive for some women.

- Although most depressed women are relieved to be asked about their feelings, some may find it intimidating.

You should have been trained before using the EPDS. Then, set up a group of colleagues who meet regularly with a local mental health professional who can assist with referral decisions as well as facilitate the support group.

The Edinburgh Postnatal Depression Scale (EPDS)

How to use the EPDS

The EPDS can be reproduced, but the content and layout of questions and items should not be altered. For copyright reasons the correct title and full reference

should also appear. The demographic data section at the top can be altered to suit your own needs, ethics committee requirements and confidentiality issues.

1 Ask the woman to underline the response that comes closest to how she has felt during the previous seven days.
2 All 10 items should be completed.
3 The woman should complete the EPDS herself, unless she has difficulty with reading, and should not discuss her answers when completing the scale.
4 The EPDS can be used routinely to screen for postnatal depression.
5 Six to eight weeks after birth is a good time for the first administration of the EPDS although not every woman who scores high at this early stage will need active treatment. Discussing her feelings may be enough.
6 Scores should **not** replace clinical judgment. Women scoring 12 or more should be further assessed before deciding on treatment.
7 As descriptions of depressive symptoms may have a different meaning in other cultures, translations should be revalidated before use.

Edinburgh Postnatal Depression Scale

Health Visitor/ Health Professional .....Number .....

Today's date ..... Baby's age .....

Baby's date of birth ..... Male/female .....

How are you feeling?
As you have recently had a baby, we would like to know how you are feeling now. Please underline the answer which comes closest to how you have felt in the past 7 days, not just how you feel today.

Here is an example already completed:

I have felt happy:

Yes, most of the time
Yes, some of the time
Not very often
No, never

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

In the past seven days

1 I have been able to laugh and see the funny side of things:

As much as I always could
Not quite so much now
Definitely not so much now
Not at all

2 I have looked forward with enjoyment to things:

As much as I ever did
Rather less than I used to
Definitely less than I used to
Hardly at all

3 I have blamed myself unnecessarily when things went wrong:

Yes, most of the time
Yes, some of the time
Not very often
No, never

/continued

4 I have felt worried and anxious for no very good reason:

No, not at all
Hardly ever
Yes, sometimes
Yes, very often

5 I have felt scared or panicky for no very good reason:

Yes, quite a lot
Yes, sometimes
No, not much
No, not at all

6 Things have been getting on top of me:

Yes, most of the time I haven't been able to cope at all
Yes, sometimes I haven't been coping as well as usual
No, most of the time I have copes quite well
No, I have been coping as well as ever

7 I have been so unhappy that I have had difficulty sleeping:

Yes, most of the time
Yes, some of the time
Not very often
No, not at all

8 I have felt sad or miserable:

Yes, most of the time
Yes, some of the time
Not very often
No, not at all

9 I have been so unhappy that I have been crying:

Yes, most of the time
Yes, quite often
Only occasionally
No, never

10 The thought of harming myself has occurred to me:
Yes, quite often
Sometimes
Hardly ever
Never

Cox J L, Holden J M, Sagovsky R, 1987. Detection of postnatal depression, development of the 10 item postnatal depression scale, *Br. J. Psychiatry*, 150, 782–86.

Edinburgh Postnatal Depression Scale: Scoring Sheet

1	I have been able to laugh and see the funny side of things:	
	As much as I always could	0
	Not quite so much now	1
	Definitely not so much now	2
	Not at all	3
2	I have looked forward with enjoyment to things:	
	As much as I ever did	0
	Rather less than I used to	1
	Definitely less than I used to	2
	Hardly at all	3
3	I have blamed myself unnecessarily when things went wrong:	
	Yes, most of the time	3
	Yes, some of the time	2
	Not very often	1
	No, never	0
4	I have felt worried and anxious for no very good reason:	
	No, not at all	0
	Hardly ever	1
	Yes, sometimes	2
	Yes, very often	3
5	I have felt scared or panicky for no very good reason:	
	Yes, quite a lot	3
	Yes, sometimes	2
	No, not much	1
	No, not at all	0
6	Things have been getting on top of me:	
	Yes, most of the time I haven't been able to cope at all	3
	Yes, sometimes I haven't been coping as well as usual	2
	No, most of the time I have copes quite well	1
	No, I have been coping as well as ever	0
7	I have been so unhappy that I have had difficulty sleeping:	
	Yes, most of the time	3
	Yes, some of the time	2
	Not very often	1
	No, not at all	0
8	I have felt sad or miserable:	
	Yes, most of the time	3
	Yes, some of the time	2

	Not very often	1
	No, not at all	0
9	I have been so unhappy that I have been crying:	
	Yes, most of the time	3
	Yes, quite often	2
	Only occasionally	1
	No, never	0
10	The thought of harming myself has occurred to me:	
	Yes, quite often	3
	Sometimes	2
	Hardly ever	1
	Never	0

Activity 2.2
This activity asks you to try out the EPDS on yourself and an antenatal or postnatal mother.

Part 1 Administering the EPDS on yourself

1 Make two copies of the EPDS sheet at the end of this unit.

2 Read the instructions carefully.

3 Fill in the EPDS yourself.

Part 2 Administering the EPDS on a woman you care for

Only do this part of the activity with the approval of your supervisor and if there is a support and referral system for women with postnatal depression.

1 Ask a woman who is pregnant, or has a baby aged between six weeks and six months to complete an EPDS.

2 Ask her how she felt about completing it

3 If she indicated any negative feelings ask her to explain more about how she felt

Explain that women who score 13 or more may be depressed. Ask if she feels her score gives a reasonable clue to how she is feeling.

If her score was 13 or above and she feels depressed, what action do you think she (or you) could take?

If, having carried out the activity, you feel the woman may be suffering from postnatal depression you should suggest to the woman that she talk to her GP, midwife or health visitor to discuss the possibility of further help.

Some problems with the EPDS

Cultural issues

Although The EPDS has been translated into several languages other than English, it is not always appropriate or possible to use it in the language of the client who is non-English speaking. In some cultures there is no direct translation for the term ‘depression’ or in some cases it may be equated with madness. There is also the possibility that the woman herself, or indeed even her family, may be ostracised from the community if she is labeled with a diagnosis of depression.

It is important therefore to be sensitive when introducing the subject of depression if you are unsure of the cultural practices of the woman. Instead of using the word depression it might be useful to talk about "mood" or “feeling" as these terms may be more acceptable. It may be possible to take advice from a health professional from the same cultural background before an assessment is undertaken. If there is a language barrier it is preferable to get someone to translate who is not a family member or close relative of the woman.

Misinterpretation of the EPDS

It is inevitable that occasionally a question will be understood by the mother to mean something different from that intended.
Here are some common misunderstandings -

Qs 4&5. Sometimes the phrase '*for no good reason'* may cause confusion.

It can be difficult to determine what is a 'good' reason – and can vary for different women at different times. The question is asking is if there is an overwhelming desires or obsessive response for no particular reason.

Q7. Many mothers have difficulty sleeping - the emphasis here is on 'when you have the time to do so or when the baby is not demanding your time'

Q10. Self-harm can sometimes be misinterpreted to mean harming the baby, harming herself, indulging in alcohol, smoking, taking illicit substances or a previous suicide attempt.

NICE 45 recommends EPDS (or HADS, PHQ9) be used AFTER screen questions - up to you to make local decisions within your Guidelines.

The first 2 questions (A and B) are "Screeners" - and equate to NICE recommended routine enquiry

Woolley Questions

1. *During the past month, have you often been bothered by feeling down, depressed or hopeless?*

2. *During the past month, have you often been bothered by having little interest or pleasure in doing things?*

The third question NICE recommends is:

Is this something you feel you need or want help with?

If the person clearly is enjoying life, looking forward to things with pleasure and is not low in mood then she is most unlikely to be depressed. There is no need to enquire further.

Confidentiality

The subject of what is, and what is not, confidential has to be addressed at some point in your professional relationship. The earlier this is done the better, and most authorities suggest this is done at the first meeting/interview.

When to refer to the General Practitioner (GP)

It is good and expected practice to inform the GP if a woman is depressed. Preferably with her permission, but on occasion it may be without it, but should always be with her knowledge.

There are particular features of the presenting mental state which would indicate that a referral should be made.

Clearly, exercising clinical judgment is important, but in the main such a referral would be cued by the following:

1. Indications of a puerperal psychosis
2. Evidence of suicidal ideation
3. Signs of significant retardation

Of course should the GP prescribe medication, there is no reason why home visiting should not be initiated as a suitable adjunct.

Synopsis of the Use of the EPDS

1 Introduce the idea to mother as soon as practically possible that, in addition to the baby, you are interested in her well-being also.

2. To that end you will be bringing a questionnaire at a later date that is given to all mothers. This helps you both to focus, together, on how the mother is getting on with her experience of motherhood, and then it will be hers to keep. Tell her that at that visit you will need privacy.

3. Has she any questions?

4. At the ***planned visit***, again reiterate as above and make it clear this questionnaire is for her to keep if she wishes. Try to only use this in private. Some partners, mothers etc. may be helpful to include, but others very definitely are not – use your judgment.

   N.B. this may be a particular problem in some Asian families.

5 Before giving it to the mother, it is worth telling her that it may bring up some issues that she would like to discuss in detail. In that case you will do that with her after you have both discussed the questionnaire itself. (I.e. the clinical interview).

6 Present the EPDS to the mother, with a pen. Explain it is asking how she has been feeling in herself over the last week - not just one bad day or one good day but how the week has been in general. Ask her to tick which of the 4 options best reflects her experience.

7 Wait for the mother to complete it. Try not to interfere in any way. Exceptions are if the mother is illiterate (you may read it for her, but make no further comment), or doesn't understand English (interpreters who preferably are not family members are allowed, and they must deal with the EPDS in the way

described above). If she asks questions, be as brief as possible. What you really want is HER personal responses to the 10 items.

8 Be prepared to spend at least 10 minutes going through the questionnaire with the mother. Is there anything of special importance for her from the EPDS? Double check the first 2 items (which are very similar to the Whooley questions. Try to encourage her to say more about any items she has scored on, or those that you feel she might benefit from further discussion. During this discussion ask the additional questions from the Clinical Interview you need to confirm or otherwise the presence of depression especially the ***persistence*** and ***pervasiveness*** of her symptoms.

9 Keep the focus…., conversational style.

Scoring on item 10*

Always check the answers for Q10 – on self-harm. Suicide is the leading cause of death in women in the first year following childbirth (CEMD, 2009). Failure to ask about suicidal ideation when administering the EPDS may communicate to the woman a lack of interest or suggest that this subject is taboo and further add to a sense of shame and isolation.

Suicidal thoughts are common and it is not unusual for people to experience them at some stage in their lives when encountering difficulties, which at the time seem insurmountable. The problem is in assessing the risk that the person will act on these thoughts. Approximately 15% of women with severe depressive illness end their lives.

Some health professionals may believe they lack the necessary skills for discussing suicidal feelings, or in making a risk assessment. However, most women who are

willing to admit to suicidal ideation are so desolate, that being able to disclose such feelings relieves some of that burden.

Talking to someone who validates her feelings in a non –judgmental way may not only be therapeutic in itself, but also be preventative. It is, however, important to clarify with the woman the extent of her suicidal ideation in order to decide on a relevant course of action.

It is possible for health visitors/nurses to spend a good deal of extra time with these mothers, as they are often very concerned about women they suspect to be depressed. Having a more structured approach can actually save time in the long run. If a woman scores on item 10 (especially when combined with a high overall score) it must be discussed immediately with her- this is one reason that the EPDS be given privately, with time for feedback. Do not be tempted to leave this discussion to a later meeting.

A high level of symptomatology throughout the EPDS but nothing on Q10 may indicate the woman needs permission to own up to her suicidal thoughts.

What to do if a woman scores on item 10* - Risk Assessment

Firstly – check out her understanding of the question.

She may have misinterpreted it e.g. thinking about an episode of self harm many years ago, or just wanting to be away from the children for a little while.

However, any mother putting a positive answer to this question is saying that she wants to talk about it. Explore with her just what she has been thinking or planning and for how much of the time i.e. are these fleeting thoughts or is she brooding over them? Consideration may need to be given, with the mother, as to where to take any potentially serious information.

Ask for more information

'*Can you tell me more about this?*

She might just require a break or there may be real suicidal ideation. If it is established that she **does** have suicidal thoughts, it is necessary to find out how serious these are.

(Handy way to remember: I**,I,P,P - Ideas, Intentions, Plans, Previous attempts**)

IDEAS

- What exactly has she has been thinking of in relation to self-harm/suicide?
- Are these fleeting, occasional thoughts?
- Has she been dwelling on them for prolonged periods of time?
- Are her thoughts on suicide vague?

❖ Wishing to go to sleep and not wake up?
❖ .....Or more defined, for example, wanting to deliberately crash the car whilst out driving?

INTENTIONS

- Has she any current plans to attempt suicide?

    - If so, has she thought about the method; how she might do it?
    - If so, has she got the means? (e.g. firearm, living near a river or drugs)
    - Are these likely to be effective?

- What has she got to live for (children, a close loving family)?

- What support if any has she at home or within her extended family network?

PLANS

- Has she confided in anyone about her feelings? If she has, are they in a position to provide the necessary emotional and practical support in a non-judgmental manner?

PREVIOUS ATTEMPTS

- Has she made a suicide attempt during her present episode of low mood or at any time in the past?

- If a woman's cumulative score is very high but is negative for Q 10 this needs further inquiry as she may have difficulty in answering this question for any number of reasons.

- It might be useful to ask sensitively something like the following –

- *"Given that you are feeling pretty miserable right now, it is rather surprising that on occasions you have not had thoughts that life is not worth living....."*

- Pause and allow the woman some time to respond to this statement – it might just be enough to give her permission to admit to these feelings. She may still answer in the negative, which may indicate that indeed she is not suicidal. However if she is suicidal, she may be more likely to admit to it in the future if the question has been handled in a sensitive non-judgmental manner.

Consideration should be given within the Primary Care team as to what action needs to be taken if there is a positive response to Q.10. A protocol should be in place so that all health professionals are clear about their role in these circumstances.

If, after a risk assessment, the woman is believed to be at risk of suicide or self-harm, her doctor **must** be informed. Ideally this should be with the woman's

consent. However, given that she may not be in a rational state of mind to give permission, it may need to be without it but should always be with her knowledge.

Regular support contract

Where a mother is not able to function well, either through her depressed mood or severe anxiety or panic, then other forms of support and / or treatment should be offered.

What are the options?

Whatever form of support /treatment /therapy the mother can be offered will have to be negotiated in consultation with her and her general practitioner. As being involved in her choice of treatment can improve the chances of recovery.

However, it is well established now that (in mild to moderate depression) a planned, focused, brief supportive intervention can be very effective in alleviating the mother's distressing symptoms, and perhaps preventing a decline into deeper depression.

Where depression is marked and pharmacological therapy is indicated, supportive listening (and/or CBC) is a suitable adjunct.

In this form of treatment it is expected that a mother will receive extra support visits for counseling / listening / cognitive work over a maximum of 2 months. It is usual to agree 4, weekly sessions and then review progress, consider referring on or continuing for another 4 weeks. The contact should be weekly, at least where possible. It is important to agree this quite firmly before you start and stick to your plan (high days and holidays notwithstanding).

This type of "contract" has been shown to be therapeutic even before the visiting begins. Clients need to know what time they can reliably count on - and will often pace themselves accordingly (both in frequency and length of time of the sessions).

Cognitive Behavioural Therapy

This type of therapy is recognised as one of the more successful and has positive effects for both mother and infant. A common 'situation' is identified which might be a single event or something that is foremost in the mothers mind, and the thoughts and emotions which surround it, are discussed. An physical feelings which are present, for example nausea, are identified and a reason sought as to why these feelings occurred, the impact they have had and what actions may be done to reduce the problem to make it more manageable

Parent-infant psychotherapy

There are a number of therapeutic approaches that are effective in supporting a healthy emotional relationship between mother and infant. The Anna Freud Centre and the Tavistock Clinic both offer parent-infant psychotherapy in London. These centres also offer professional training.

The Circle of Security (www.circleofsecurity.org) is a model that can be used for psycho-education as well as psychotherapy. Find out what services are available near you, and don't be slow to refer parents and their infants for help.

Self-help groups

In the early stages of depression women may find it threatening to attend groups, and need the safety of a one-to-one relationship. However in later stages it may be helpful for mothers to be in touch with others who have had similar experiences.

Case examples

Activity 4.6

This activity will help you to discover how you would react to some situations you might encounter during your work. Even if the nature of your work does not bring you directly into contact with the sorts of situations described here, the activity will nevertheless help to increase your awareness.

Read through the following case studies, and answer the questions which follow. There is no right or wrong answer.

MOTHER A

The house is a bit untidy with surface clutter. The mother talks about some of the changes in her life since baby arrive. The birth had been rather longer than she has expected and she had been quite tearful for a few days in the postnatal ward. She feels she has underestimated the extent of upheaval in her life and misses, on occasion, the chances to go out and socialize. She has some contact with her friends from her workplace but would like to see more of them. Gradually, she is feeling more her old self and feels more rested. She is not as sexually active with her partner as she feels should be but acknowledges that her mood is improving. On balance, she is enjoying being a mother and is looking forward to spending time with her infant.

1 What is your immediate impression of the mother's condition?

2 Are there any things about the mother which make you concerned about her condition? If so, list up to five things.

1

2

3

4

5

3 How you think she feels and what would be the clinical diagnosis?

4. What care and support would you provide?

MOTHER B

The mother complains that she is constantly weary however much sleep she obtains; everything is an effort and she often sits and cries for no reason. Her husband finds it difficult to manage her moods and often retaliates by shouting at her. She says she loves her baby and her husband but feels guilty at not being able to get it together to look after them properly; often she leaves the baby to cry in the crib. She says that sometimes she thinks the family would be better off without her. She has little appetite and will only eat biscuits and drink coffee. Several friends from her past active social life have called but she has pretended not to be at home because she cannot summon up enough energy to see them.

1 What is your immediate impression of the mother's condition?

2 Are there any things about the mother which make you concerned about her condition? If so, list up to five things.

1

2

3

4

5

3 How you think she feels and what would be the clinical diagnosis?

4. What care and support would you provide?

MOTHER C

The mother attends mother and baby clinic religiously every week and often phones in the meantime with some query about her six-week-old baby's welfare. In your opinion, baby is always well cared for to the point where mother even brings along several changes of clothes on clinic days.

You visit on the off-chance and find her talking on the telephone. The mother is wearing a long sleeved cardigan but as she reaches out for something she exposed her arms. The mother is aware you have noticed the scratches and cuts on her arm and explains why they are there. She says that she self harms but cannot help it. She wishes she could stop but the pain she inflicts on herself is less painful than her 'inner' pain. She is obsessive about to do keeping the house clean and tidy, but sometimes feels so low that she would be better off dead.

1 What is your immediate impression of the mother's condition?

2 Are there any things about the mother which make you concerned about her condition? If so, list up to five things.

1

2

3

4

5

3 How you think she feels and what would be the clinical diagnosis?

4 What care and support would you provide?

MOTHER D

You receive a frantic phone call from the father asking you to visit immediately because he is concerned about the condition of his wife and their week old baby. You arrive at the house to find the mother sitting with a knife in her hand, which she is scraping along the table. She She has been in bed until 2pm usually silent and withdrawn but has started chanting about God and the devil. She refuses to pick up, touch or feed the baby. She accuses her husband of being the devil and that he will cast a spell on her if he looks at or touches her. Then suddenly she turns and accuses you of being in league with her husband and son and plotting to kill her.

1 What is your immediate impression of the mother's condition?

2 Are there any things about the mother which make you concerned about her condition? If so, list up to five things.

1

2

3

4

5

3 How you think she feels and what would be the clinical diagnosis?

4. What care and support would you provide?

Here are our responses to the activity. As we said earlier there are no right or wrong answers, and you may have interpreted the situations a little differently.

Mother A

Mother's condition

Coping well with adjustment to postnatal state.

Concerns

- Her lack of social contact could lead to isolation and depression later if not addressed.
- Her relationship with her husband. Is she trying to say that he or both of them are concerned about their lack of sexual activity?

Clinical diagnosis

The blues on the postnatal ward. Adjustment reaction. (This is a mild or transient disorder which is often situation specific.)

Care

- Encourage the mother to reacquaint herself with her social contacts and encourage new ones by joining a mother and baby group or other self help group.

- Reassure her about the normality of her reactions, and of the normal loss of libido during the postnatal period. Encourage her to discuss her feelings with her partner.

MOTHER B

Mother's condition

She is clearly depressed, and unable to cope with everyday living.
(Her symptoms include; fatigue, tearfulness, low mood; speaking as if in a dream, loss of appetite, avoidance of social contact, inability to respond to the baby; lack of energy and motivation to care for herself. See Unit 2 if you were unsure of her condition.)

Concerns

• Poor nutrition may lead to increased exhaustion.
• She probably has suicidal thoughts/plans.
• Probable lack of interaction with the baby
• She may not adequately care for the baby
• The husband appears not to fully understand her condition

Clinical diagnosis

Severe postnatal depression.

Care

- Arrange a home visit from the doctor and/or a mental health professional.
- Arrange for practical help from relatives, friends or social services
- Discuss the situation with both the mother and the infant's father to explain the mother's condition and suggest how he may help
- Offer assurance about eventual improvement.
- Offer phone contact on an emergency basis.
- Arrange for a friend to offer telephone contact.
- Organise regular home visits for listening support
- Introduce her to mother's therapy group or mother and baby group.

MOTHER C

Condition

She appears to be suffering from anxiety and self harm, possibly from being subjected to domestic abuse

Concerns

- Effect of the self harm on her physical and mental health
- Possible effects of her unstable mood on the baby – does she have sufficient physical contact with the baby?
- The poor relationship with her partner – he is failing to provide support and understanding
- Possibility of underlying depression
- There may be safety issues around the care of the infant

Clinical diagnosis

Self harm and depressive illness with anxiety features.

Care

- Discussion about their relationship and where to seek help for harm reduction
- Refer to her doctor and/or the mental health team
- Regular counseling, CBT and social support.
- Introduce relaxation techniques
- Practical advice for example on developing routines with the baby.

MOTHER D

Condition

The mother is suffering from a psychotic illness, and in need of urgent attention from a psychiatrist. (Symptoms may also include: delusions, hallucinations – visual and auditory, inability to care for herself or the baby.)

Concerns

- She presents with delusions and fixed ideas about the devil and God being present.
- Is she planning to harm the baby, herself or her husband?
- The means are available – she has a knife
- She shows no interaction with either her infant or husband
- She has no awareness of her condition

Clinical diagnosis

Puerperal psychosis.

Care

- Refer to her doctor immediately, asking him to arrange a psychiatric assessment, if necessary.
- She will probably need to be admitted to hospital for specialist care. In the United Kingdom, if she refuses go to hospital then Section 2 of the Mental Health Act (1985) may be invoked
- Stay with the mother until medical assistance arrives
- Ask the partner to remain with you to ensure your and the mother's safety

The sections on preventing and dealing with disorders have introduced a whole range of suggestions and ideas for action, some of which you probably use, whereas others will probably be new to you. The following activity gives you the opportunity to identify priority changes you will make to your care in the future.

Activity 4.7

This activity will help you to identify changes you will make to your care in future.

1. Look back over this unit, and tick or highlight the suggestions which you feel would improve your care of women around childbirth.

2. Make a list of suggestions you will use to help women prevent emotional disorders arising.

3. Make a list of suggestions you will use to help women deal with antenatal or postnatal disorders. (Midwives do not generally see women long enough to be involved with postnatal conditions other than puerperal psychosis, but awareness of the symptoms of psychosis will enable the midwife to make an early referral to the GP.)

4. In each list tick the three suggestions you feel will be most effective, and which you will start to use immediately.

It takes some time to adopt new techniques and habits, so you need to work through your action list a little at a time. Keep it somewhere where you can refer to it.

3 How your role relates to other professionals

When to refer on

Whenever you feel that a problem or potential problem is outside your responsibility or capability you should consult the family doctor or a mental health professional about referring on. Do not feel that this reflects in any way on your competence, or that you should be able to deal with every eventuality except for psychosis. Indeed a key skill in professional activity is recognising your boundaries and referring on appropriately.

No harm will be done if the doctor assesses the case and establishes that the problem is not as serious as you feared, whereas struggling on with a client who feels too difficult for you will cause you stress, and may be unhelpful for the client.

The role of other professionals

This section describes professional roles in the UK in general terms, but roles and referral systems inevitably vary from area to area. In some areas, for example, it is the midwife and in others the health visitor who initiates antenatal home visits. In some areas midwives can refer a client directly to a community psychiatric nurse, but in others this must be done through the GP.

General Practitioner (GP)

GPs are likely to have good knowledge of the woman's family and degree of community support. S/he may therefore be able to intervene during the antenatal period with vulnerable women, and is in a good position to detect early signs of antenatal or postpartum depression. If it is felt appropriate to prescribe medication the GP is able to monitor the mother's progress. S/he may refer the woman to a consultant psychiatrist if improvement does not occur.

Midwife

The midwife provides care for women experiencing normal pregnancy, labour and delivery and puerperium. By law she can provide care for between ten days and one month post delivery, but this period is subject to local variations. The midwife can diagnose when abnormalities occur at any stage of the childbirth continuum and will refer the woman to the appropriate professional. The midwife refers the woman and her infant on to the health visitor when the midwife's care in the puerperium ends.

Health visitor

The health visitor works closely with the midwife in the antenatal period providing parent-education classes. For those unable to attend she initiates home visits. Topics covered aim to prepare parents for the emotional changes of parenthood and the altered family dynamics as well as giving practical information on such topics as nutrition, home safety and immunisation. Health visitors set up postnatal support groups for all mothers and their infants and provide clinics, home visits and telephone advice to all families with pre-school children. The health visitor has local knowledge of statutory and voluntary support organisations

Community psychiatric nurse (CPN)

The CPN provides care to women who experience antenatal or postpartum mental health problems (most commonly postpartum depression, but also puerperal psychosis). S/he forms part of a specialist service accepting referrals from GPs, consultant psychiatrists, midwives and health visitors. The CPN offers a range of therapies to the woman depending on the outcome of a mental health assessment. These may include counselling and marital work, and/or behavioural cognitive approaches. A consideration of the child's care and safety is part of the management, and liaison with the other professionals is ongoing throughout the duration of care.

Psychologist

Clinical psychologists may be called upon by, for example, GPs, midwives or health visitors at any stage of pregnancy or during the puerperium when there may be cause for concern about a mother's ability to cope emotionally with the prospect or reality of a newborn baby. Clinical psychologists can provide therapy for a variety of problems, including treatment for any ongoing psychological difficulties that may affect a prospective or new mother's ability to cope adequately with her new responsibilities. In addition they may be able to provide teaching or training to other professionals. Many practices now have Primary Care Psychologists who see patients at the surgery and provide liaison and support services for the primary care team. If the primary problem appears to be in the relationship with the child referral to a child psychologist may be more appropriate.

Psychiatrist

The psychiatrist has expertise in the causes and treatment of mental illness, whether pre-existing or pregnancy or childbirth-related. S/he should be able to make a full assessment of the woman's mental state and of her relationship with other people significant in her life, most importantly her child. There should be access via the psychiatrist to suitable support and treatment, including practical help, individual or group therapy, and/or medication and physical treatments.

The psychiatrist is responsible for advising the GP about management of the client in the community and should have access to facilities for admitting the mother and child together if community treatment is no longer appropriate or effective.

Psychotherapist

The psychotherapist may be involved when the effects of childbirth give rise to a depression in the mother. S/he can also help the mother work through the emotional chaos the birth has evoked, and to own up to and face the 'problem' she feels she has in being a mother. Cognitive behavioural therapy may be used her. The woman may also be helped to explore her own experience of being mothered in

childhood, her interpersonal relationships both past and present, and her reuse of autonomy.

Social worker

The social worker can assess and provide social and financial support for pregnant women and mothers and babies. If necessary domiciliary support, such as family aides, crèches, child minders can be initiated and referrals can be made for statutory resources, such as family centres, or voluntary resources as necessary. Practical help with financial benefits may also be given.

4 Developing an action plan for further learning

Developing the skills to support women through the various emotional ups and downs of childbirth is an ongoing process of personal development. Hopefully these units have taken you a few steps further and you can build on this through experience in the future. In many ways we have only scratched the surface of this important area of women's lives. You can make your support more effective by continuing to learn about the emotional effects of childbirth and the skills involved in helping women to deal with these. The following action plan gives a framework for further learning. Use it in whatever way will be most helpful to you. For example you may want to link it in with a broader course you are working through.

Action plan

You may want to skim over the four units and any groupwork notes you have made as you develop your action plan.

1 Read through the topics below, and tick those which you need to find out more about/develop further.

2 For those you have ticked number your top six priorities, and discuss this list with your manager.

3 Find out what you can do to progress these topics.

Likely sources of further learning include:

– Books and references (see further reading at the end of each unit)
– Other self-study courses like this one
– Courses and workshops you could attend: find out about these from GPs or surgery noticeboard, the local library, the Community Health Council.

Topics	***Need to***	***Priorities***	***Action***

Summary

Key points from this unit are:

- Various forms of support have been shown to help women prevent and deal with emotional disorders.

- Key techniques for prevention include:
  – Continuity of care
  – Antenatal support including early contact, opportunities for women to express their feelings, encouraging women to confide in others, self-help groups and education on the realities of parenting
  – Emotional support during labour

  – Postnatal support including recognising signs of disorders, encouraging women to express their feelings, providing non-judgmental support for feeding, helping mothers access social support and helping women to solve their practical problems.

- Key techniques for helping women deal with emotional disorders include:
  – being aware of signs of disorders
  – listening for signs of disorders
  – screening questionnaires such as EPDS /Whooley question
  - Assessing maternal mood
  – providing listening visits
  – encouraging women to join self-help groups

- Always seek advice from other health professionals when a problem or potential problem is outside your capability or responsibility.

- Develop your knowledge of the roles of other professionals and the help they can offer.

- Developing your skills to help women deal with their emotional disorders is an ongoing process so you need to plan for further learning.

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Useful contacts

www.postpartum.net

www.janehonikman.com

Resources

Antenatal and postnatal mental health: clinical management and service guidance (2007)

www.nice.org.uk/CG45

This should be read along with the NICE Guidance for each psychiatric disorder

Saving Mothers' Lives 2003-2005
www.cmace.org.uk/Publications/CEMACH-Publications/Maternal-and-Perinatal-Health.aspx

The Royal College of Psychiatrists' leaflet on postnatal depression is available to download free from:

http://www.rcpsych.ac.uk/mentalhealthinfoforall/problems/postnatalmentalhealth/postnataldepression.aspx

It is available in Chinese, Greek, Polish and Welsh in addition to English. There is also a link to a leaflet on mental illness after childbirth which is available in Chinese, Arabic and Greek:

http://www.rcpsych.ac.uk/mentalhealthinformation/mentalhealthproblems/postnatalmentalhealth/afterchildbirth.aspx

The 'How are you Feeling?' booklets can be ordered from the Community Practitioners and Health Visitors Association:
www.cairnsbookshop.co.uk/index.php?app=gbu0&ns=prodshow&ref=CPHVA-0020
And the associated training pack
www.cairnsbookshop.co.uk/index.php?app=gbu0&ns=prodshow&ref=CPHVA-0023

The Postpartum Depression Screening Scale is available from Western Psychological Services:
www.portal.wpspublish.com/portal/page?_pageid=53,70428&_dad=portal&_schema=PORTAL

ORGANISATIONS IN THE UK

The organisations listed here may be able to offer information, advice or support to women or to the professional carers who work with them. We have given brief information about what these organisations offer, but it may be essential to find out more before you decide whether it is appropriate to put someone in touch with a specific organisation.

Active Birth Centre
25 Bickerton Road
London N19 5JT
Telephone: 020 7281 6760
www.activebirthcentre.com

Support for women and their partners desiring an active natural birth, including a range of classes.

The Association for Post-Natal Illness
145 Dawes Road
London SW6 7 EB
Telephone: 020 7386 0868
www.apni.org

Telephone support for women with postnatal depression.

Bliss
9 Holyrood Street
London bridge
London SE1 2EL
Telephone Family support helpline 0500 618 140
www.bliss.org.uk

Support and care for premature and sick babies.

British Agency for Adoption and Fostering (BAAF)
Saffron House
6-10 Kirby Street
London EC1N 8TS
Telephone 020 7421 2600
www.baaf.org.uk

Professional association for those concerned with adoption and fostering, offers advice and information.

Brook Advisory Centre
421 Highgate Studios
53-79 Highgate Road
London NW5 1TL
Telephone Helpline : 0808 802 1234
www.brook.org.uk

Sexual health and contraceptive advice for the under 25s

Caesarean Support Network
55 Cooil Drive
Douglas
Isle of Man IM2 2HF
Telephone: 01624 661269
www.ican-online.org

Service for women who are anticipating or have experienced a caesarian birth.

Compassionate Friends
53 North Street
Bristol BS3 1EN
Telephone helpline 0845 123 2304
www.tcf.org.uk

Organisation for bereaved parents and families with local groups.

Cruse Bereavement Care
PO Box 800
Richmond
Surrey TW9 1RG
Telephone Helpline 0844 477 9400
www.crusebereavementcare.org.uk

Counselling service and information for all bereaved people throughout the UK.

CRY-SIS
BM Cry-sis
London WC1N 3XX
Telephone Helpline 08451 228 669
www.cry-sis.org.uk

Support for families with excessively crying, sleepless or demanding babies.

Down's Syndrome Association
Langdon Down Centre
2a Langdon Park
Teddington TW11 9PS
Telephone: 0845 230 0372
www.downs-syndrome.org.uk

Advice, support and information for families with a child who has Down's syndrome, and for the professionals who work with them.

Depression UK
c/o Self Help Nottingham
Ormiston House
32-36 Pelham Street
Nottingham
NG1 2EG
Email: info@depressionuk.org
www.depressionuk.org

Support for anyone suffering from depression and their carers.

Family Welfare Association
Family Welfare Association
501-505
London E8 4AU
Tel: 020 7254 6251
www.newpin.org.uk

Support network and drop in centre for vulnerable families with young children or new babies. Offers a process of personal growth through counselling, group therapy and training

The Foundation for the Study of Infant Deaths (Cot Death Research and Support)
Artillery House
11-19 Artillery Row
London SW1P 1RT
Telephone Helpline 020 7233 2090
Admin 020 7222 8001
www.sids.org.uk/fsid/

Support and information for bereaved parents.

Foundation Years

'All you need to know to support families in the foundation years'

www.foundationyears.org.uk

Gingerbread
307 Borough High Street
London SE1 1JH
Telephone: 0800 018 4318
www.gingerbread.org.uk

Self help association for one parent families. Local groups offer support, information and practical help.

Home-start UK
2 Salisbury Road
Leicester LE1 7QR
Telephone : 0116 233 9955
www.home-start.org.uk

Volunteers offer support, friendship and practical help to young families experiencing difficulties, visiting them at home. Local schemes.

Hyperactive Children's Support Group
Dept W, The Hyperactive Children's Support Group
71 Whyke Lane
Chichester
West Sussex PO19 7PD
Telephone :01234 539966
www.hacsg.org.uk

Information, help and support for hyperactive children and their families.

In Touch Trust
10 Norman Road
Sale
Cheshire M33 3DF
Telephone: 0161 905 2440
www.touch-trust.org

Information for parents of children with special needs.

Keele Perinatal Mental Health Education Unit
Educational programmes and special topic study days
Training for trainer teams on the management of postnatal depression in primary care

Living with Reflux

www.livingwithreflux.org

La Leche League
PO Box 29
West Bridgeford
Nottingham
NG2 7NP
Telephone Helpline : 0845 120 2918
www.laleche.org.uk

Help and information for women who want to breastfeed, including personal counselling. Local groups.

Marriage Care
1 Blythe Mews
Blythe Road
London W14 0NW
Telephone: 020 7371 1341
www.marriagecare.org.uk

Preparation for marriage and relationship counselling

Meet-a-Mum Association (MAMA)
54 Lillington Road
Radstock BA3 3NR
Telephone Helpline: 0845 120 3746
www.mama.org.uk

Support and help for women with postnatal depression, or who feel lonely and isolated.

Miscarriage Association
c/o Clayton Hospital
Northgate
Wakefield
West Yorkshire WF1 3JS
Telephone Helpline 01924 200799
www.miscarriageassociation.org.uk

Motherisk

www.motherisk.org/prof/index.jsp Tel: 00 1 416 813 6780

For support and information

National Childbirth Trust
Alexandra House
Oldham Terrace
London W3 6NH
Telephone: 0870 444 8707
www.nct.org.uk

Help, support and advice for mothers including antenatal classes, breastfeeding counselling and postnatal support groups.

National Council for One Parent Families
255 Kentish Town Road
London NW5 2LX
Telephone: 0800 018 5026
www.oneparentfamilies.org.uk

Confidential advice and help on practical or emotional problems to lone parents and single pregnant women.

National Women's Register
9 Bank Plain
Norwich
Norfolk NR2 4SL
Telephone; 0845 450 0287 or 01603 406767 (office hours)
www.nwr.org.uk

Advice and information for women on a wide range of topics.

National Council for One Parent Families
255 Kentish Town Road
London NW5 2LX
Telephone: 0800 0185 026
www.oneparentfamilies.org.uk

Confidential information for one-parent families on financial, housing and legal problems.

Netmums
www.netmums.com

Mumsnet
www.mumsnet.com

Information and support for parents

Post natal illness website
www.pni.org.uk

Aims to support women who have, or have had, postnatal health problems

Parentline Plus
520 Highgate Studios
53-79 Highgate Road
London NW5 1TL
Telephone Helpline:0800 800 2222
www.parentlineplus.org.uk

Confidential helpline for parents.

Pregnancy Advisory Service
13 Charlotte Street
London W1P 1HD
Telephone: 071 637 8962
www.bpas.org

Very early pregancy testing, counselling and medical help for women with an unwanted pregnancy.

Relate: National Marriage Guidance
Herbert Gray College
Little Church Street
Rugby
Warwickshire CV21 3AP
Telephone: 0788 573241
www.relate.org.uk

Confidential counselling on relationship problems of any kind, not only marriage – local branch is listed in the phone book

Parentline Plus
520 Highgate Studios,
53-79 Highgate Road,
Kentish Town,
London,
NW5 1TL
Telephone: 0808 800 2222
www.parentlineplus.org.uk

Support for troubled parents in times of stress or crisis. Confidential anonymous helpline.

British Pregnancy Advisory Service
www.bpas.org.uk

Very early pregnancy testing, counselling and medical help for women with an unwanted pregnancy.

Samaritans
PO Box 90
Stirling
FK8 2SA
Telephone: 08457 90 90 90
www.smaritans.org.uk

24 hour confidential service for people who are in despair - local office is listed in the phone book.

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Stillbirth and Neonatal Death Society (SANDS)
www.uk-sands.or.uk
Telephone: Helpline: 020 7436 5881

Information and national network of support groups for bereaved parents.

Sure Start
www.surestart.gov.uk

Information on childcare, improving the health and emotional development of young children and supporting parents.

Twins and Multiple Births Association

2 The Willows
Gardner Road
Guildford
Surrey
GU1 4PG

Tel: 01483 304442
www.tamba.org.uk

Advice and support for parents.

Working Families Organisation
www.workingfamilies.org,

Telephone Helpline: 0800 013 0313
Offer advice and support to parents who work, or wish to work – and on rights at work, benefits, and how to apply for flexible working.

Women's Health
www.womens-health.co.uk

Information and support on many aspects of women's health.

Women's Health Concern
www.womens-health-concern.org.uk

Health information for women

The United Kingdom Teratology Information Service

www.uktis.org Tel: + 44 (0) 844 892 0909

Organization of Teratology Information Specialists - US

www.otispregnancy.org/hm/ Tel: 00 1 866 626 6847

Training courses

Postnatal Depression Training
www.pndtraining.co.uk

Provides training in the detection and management of Postnatal Depression to Health Visitors and other health professionals.