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Wellbeing in Perinatal Health



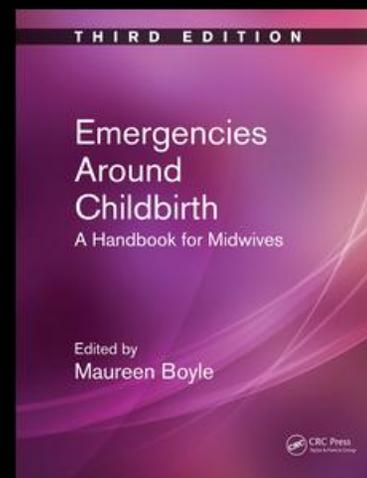
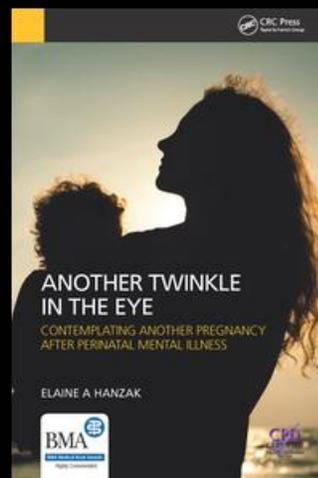
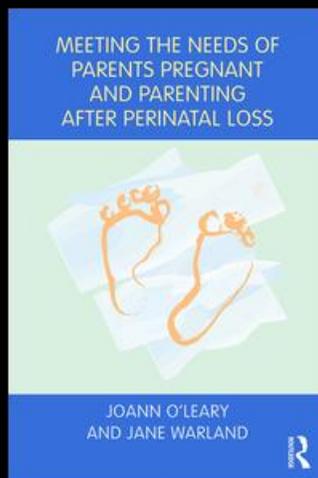
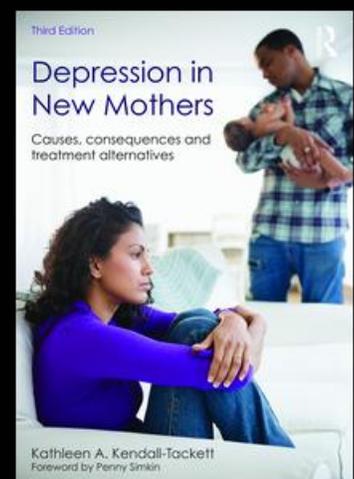
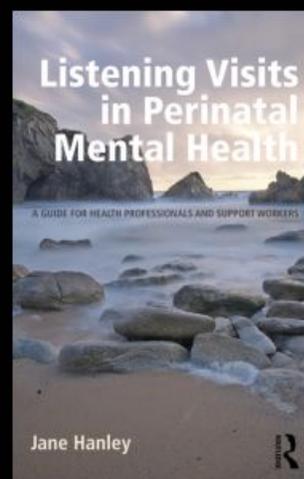
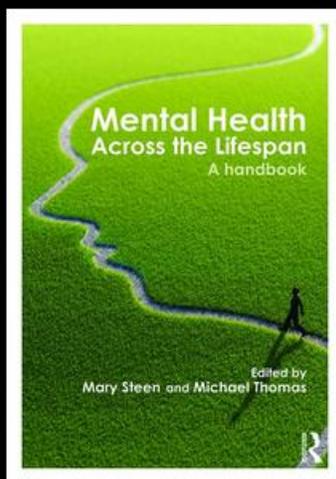
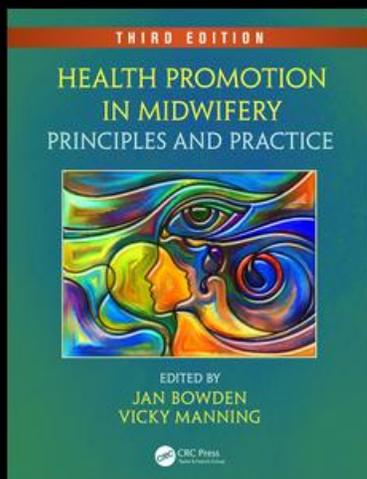
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Introduction

This book is relevant to anyone working with women and families going through pregnancy, birth and post-natal care. This could include midwives, health visitors, researchers, students, counsellors and doulas as well as families themselves.

Chapter 1 looks at mental health and mental health illnesses that can affect women experiencing pregnancy and after birth. This chapter explains how midwives can promote the mental wellbeing of all patients in their care.

Chapter 2 will focus on the needs of mothers and pregnant women who have existing mental health problems and those who are at risk of developing them. It will also look at how this can affect partners and members of the family as well as covering the pressures and influences of social expectations during pregnancy. Expanding on this, **Chapter 3** will discuss the effects on fathers and managing men's mental health needs during the perinatal period.

Drawing on a brave account from a well know celebrity **Chapter 4** explores breastfeeding and how this could impact the risk of post-natal depression, plus discussing how breastfeeding can be impacted by previous life events and trauma.

Chapter 5 looks at how parents move forward to raise their family after the loss of a child and how they can integrate their deceased child into their family.

Being written first hand by a previous patient **Chapter 6** explains how the attitudes and approach of hospital staff can impact the care and outlook of mothers suffering from a mental health illness.

Chapter 7 talks about the psychological care needed during an emergency birth, for women and their birth partners, an element often overlooked.

Note to readers: References from the original chapters have not been included in this text. For a fully-referenced version of each chapter, including footnotes, bibliographies, references and endnotes, please see the published title. Links to purchase each specific title can be found on the first page of each chapter. As you read through this FreeBook you will notice that some excerpts reference previous chapters – please note that these are references to the original text and not the Freebook.

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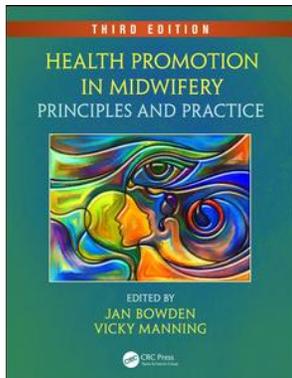


CHAPTER

1

Mental health promotion in midwifery practice

1. Mental health promotion in midwifery practice



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INTRODUCTION

This chapter aims to explore how midwives can promote the mental health of all women in their care. This includes women who have or who are at risk of mental illnesses as well as women who are mentally fit and well and who we want to help maintain or improve their psychological well-being throughout their pregnancy and labour.

In order to achieve this, we first need to explore and define mental health and mental illness to know what they are and consider how pregnancy might impact on them. The chapter will then identify the specific risks to mental health associated with pregnancy, childbirth and the postnatal period, before exploring interventions to promote maintenance of well-being and to prevent relapse in pregnant women with mental health problems. These different approaches will be broadly framed within a model of primary, secondary and tertiary illness prevention as defined by Boyce et al. (2010) in their exploration of health promotion in public health, and by an exploration of the model of mental health promotion and demotion proposed by MacDonald and O'Hara (1998) known as the Ten Elements of Mental Health.

Examples applied to practice will be used to illustrate the concepts and approaches and learning activities identified to help explore how the mental health of women in our care may be promoted or demoted. The learning outcomes for this chapter are:

- For midwives to be able to promote the mental health of all women in their care through primary, secondary and tertiary illness prevention interventions.
- For midwives to understand what bio-psycho-social factors might put a woman's mental health at risk during pregnancy.
- For midwives to consider what sociological and organisational factors, impacting both on the women in their care and on the exercise of their practice, might risk demoting women's mental health.

MENTAL HEALTH

If we are aiming to promote something, we need to know what it is. However, both mental health and mental illness are difficult concepts to define. The World Health Organization (WHO 2014) defines mental health as follows:

Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.

This is a positive definition and is meant to be inclusive and applicable globally. However, the concept of mental health is defined not as a discrete phenomenon but in relation to someone's social role, ability to cope, work and contribute to their community. Inevitably, this means that what appears to others as mentally healthy differs throughout our lives and in different cultures. It immediately illustrates one of the dilemmas faced by women who have children and chose to, or feel obliged to, return to work and for those who are able to, or chose to stay at home to, raise their children. What is considered fruitful, productive or a contribution may represent a judgement by others rather than solely the women's own values, ideas and hopes. It is perhaps this very tension between one's own desires and the expectations and values of others that is most keenly felt in pregnancy when everyone seems to have an opinion about what is the right thing to do. This tension could be viewed as a stressor in the stress–vulnerability model discussed later and illustrated in Figure 11.2.

If we compare this definition with what Keith Tudor (1996) describes as the eight elements of mental health, it is clear that there are further possible tensions. Tudor (1996) suggests that mental health is dynamic and responsive to our ability to cope; ability to manage tension and stress; self-concept or identity; self-esteem; self-development; ability to exercise autonomy; ability to adapt to change; and ability to harness support available. This flexible and fluid definition seems at odds with the WHO (2015) definition that mental health is a 'state' – something fixed and permanent in some way. For many, pregnancy and childbirth are among the biggest and most dramatic changes in their lives. It therefore has the ability to affect women's mental health both positively and negatively.

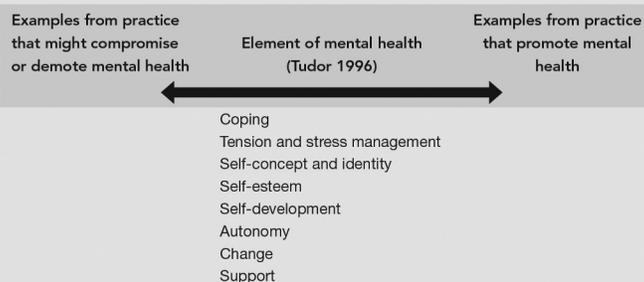
ACTIVITY

Think about women you have cared for and identify the ways in which their experience of pregnancy and childbirth may have impacted on each of Tudor's eight elements of mental health.

Try to consider how they might be affected positively and negatively.

For example, in terms of autonomy, a woman may find the choices offered to her while booking an appointment and whilst agreeing to her birth plan positive, as she gets to consider, express and agree the type of labour she would like to have and rule out things she would like to avoid. However, if these are compromised in an emergency situation and she and her partner are involved in making quick decisions that go against her values, her autonomy may feel undermined.

As with the autonomy example, there are no concrete right or wrong answers to this. In your reflection, it may be helpful to think of things on a continuum: Was the woman's experience or my practice more likely to be in the direction of promoting or demoting each of the eight elements of Tudor (1996)?





MacDonald and O'Hara (1998, 10) conclude that there is no single definition of mental health that includes the human needs and psychological constructs as well as the 'social conditions, structures, contexts and processes in which the individual's experiences are grounded'. Broadly speaking, any definition needs to include the recognition that health in any context is a balance of self, others and the environment (WHO 2004) and that mental health is more than merely the absence of mental illness. In this way, the mental health of all women in our care should be prioritised. This is both an ideal value and a professional requirement in midwifery practice.

The Nursing & Midwifery Council, in Section 3 of Prioritising People in The Code (NMC 2015), requires us to make sure that people's physical, social and psychological needs are assessed and responded to, for which one must:

- 3.1 pay special attention to promoting well-being, preventing ill health and meeting the changing health and care needs of people during all life stages...
- 3.3 act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it, and
- 3.4 act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care.

Part 3.1 of the code relates to primary prevention of mental illness and parts 3.3 and 3.4 to both secondary and tertiary prevention as outlined below.

MENTAL ILLNESS

Some models explain mental illness as the deficit or outcome of an interaction between our stressors and ability to cope with them. Albee and Ryan-Finn (1993) proposed a formula for mental illness in order to identify where there might be opportunities for mental health promotion, explaining that mental illness resulted when stress, exploitation and organic factors outweighed or exceeded our ability to cope, self-esteem and social support (Figure 11.1).

Similarly, Zubin and Spring (1977), in an attempt to explain why some people get schizophrenia and others do not, devised the stress–vulnerability model, which can in turn be used to explain other mental illnesses. They suggested that individual vulnerability to, or ability to cope with, either internal or external stressors determined whether someone was able to tolerate the stress and integrate the experience or were vulnerable to an episode of mental illness. This is illustrated in Figure 11.2.



Stress and vulnerability

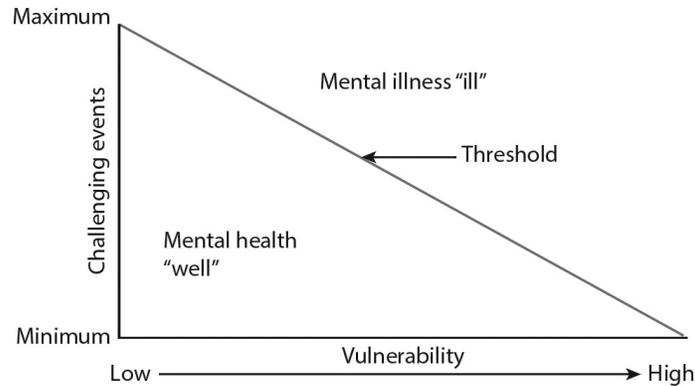


Figure 11.2 The stress–vulnerability model. (From Zubin, Joseph and Bonnie Spring. 1977. *Journal of Abnormal Psychology* 86(2):103–126.)

Zubin and Spring (1977) suggest that we all have an innate vulnerability to mental illness that could be considered low or high depending on a number of factors (Figure 11.2). Honig (1993), specifically in relation to hearing voices, identifies six factors that combine to form our vulnerability: personality traits, important life events, social isolation, physical disease, genetic disposition and early experiences. These could be considered as our ‘fixed assets’ that form who we are and how we respond to most situations from late adolescence onwards.

For example, someone who has parents with acute mental illnesses may have a genetic predisposition and have had an insecure attachment to their primary carer particularly if their mother was ill postnatally), impacting on some negative early life experiences and social isolation in adulthood. For this person, with a high vulnerability, it may only take what others might perceive as a relatively small challenging or stressful event to become mentally ill. For another person, without any family history of illness, a secure attachment and happy upbringing, who is physically well and socially engaged, their vulnerability might be low, but exposed to a high level of stress, they could still become ill.

There are limitations to this model. Many of us experience symptoms of stress that exceed either our ability to cope or the limits of our vulnerability: for example, anxiety about an observed assessment in practice or a sleepless night thinking about someone in our care. In noticing and doing something about these symptoms, we might be at, but not crossing, the imaginary threshold into illness. It is more like a zone in which the interaction of our vulnerability and stress causes concern but not necessarily mental illness.

ACTIVITY

Think about your own vulnerabilities: how might your early life experiences, physical health, social life, etc. influence the ways in which you respond to stress.

Recall a time when you have experienced the sort of stress that has challenged your ability to cope. What did you notice that might suggest your individual vulnerability risked being exceeded?

It is important to consider these models before introducing a definition of mental illness in order to try and avoid any sense that mental illness is something that happens to 'other people'. By considering what impacts on a continuum of mental health and what interactions impact on our potential to experience mental illness, it is hoped that this will convince you that it is relevant to all of us and all of the women in our care. We all have some vulnerabilities and are all exposed to stress.

The mental health charity, MIND, uses the broader term 'mental health problems' and gives an excellent plain language summary of what these might be from the point of view of the person experiencing them:

Mental health problems can affect the way you think, feel and behave. Some mental health problems are described using words that are in everyday use, for example 'depression' or 'anxiety'. This can make them seem easier to understand, but can also mean people underestimate how serious they can be.

A mental health problem feels just as bad, or worse, than any other illness – only you cannot see it. Although mental health problems are very common – affecting around one in four people in Britain – there is still stigma and discrimination towards people with mental health problems, as well as many myths about what different diagnoses mean.

There are also a lot of different ideas about the way mental health problems are diagnosed, what causes them and which treatments are most effective. However, despite these challenges, it is possible to recover from a mental health problem and live a productive and fulfilling life. It is important to remember that, if you have a mental health problem, it is not a sign of weakness.

MIND (2015)

One of the difficulties in defining mental illness is whether to describe it from the personal, subjective experience of living with the illness; from the perspective of the clinician in terms of which diagnostic criteria it meets; or from the point of view of the family, carers or wider society on whom the illness impacts. The WHO (2014) definition focusses on a symptomatic approach:

Mental disorders comprise a broad range of problems, with different symptoms. However, they are generally characterized by some combination of abnormal

thoughts, emotions, behaviour and relationships with others. Examples are schizophrenia, depression, intellectual disabilities and disorders due to drug abuse. Most of these disorders can be successfully treated.

Both of these definitions overlook to some degree the social process and the impact of environment and culture. MacDonald and O'Mara incorporated these into their 10 elements of mental health, each of which offers a continuum of factors that promote or demote mental health. Mental health and illness are often described as polar opposites on a continuum, and sometimes on dual continua of mental illness and mental well-being (e.g. Westerhof & Keyes 2010). However, as Tudor (1996) points out, these continua are mistakenly described on a plane, whereas he views the continuum more as a slide:

This suggests that it is easier to maintain than to regain mental health (Figure 11.3). Whilst many people make a full recovery, learn from it and integrate their experience of mental illness, others find it has a profound impact on their relationships, social function, employment, housing, all putting them at risk of social exclusion (Repper & Perkins 2003) which is why mental health promotion and mental illness prevention are so important.

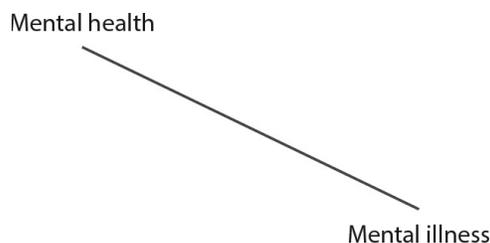


Figure 11.3 Continuum of mental health and mental illness as a slide.

In midwifery, perinatal mental health problems affect up to 20% of women, and only 50% of those experiencing perinatal anxiety or depression are identified in spite of regular contact and screening (Khan 2015) (Figure 11.4). The NICE guidelines are clear that many mental illnesses present in the same way during pregnancy as at any other time, but that there are also specific risks to women's mental health in the perinatal period (NICE 2014):

- Increased rate of relapse of bipolar affective disorder (postnatal)
- Increased rate of first presentation of bipolar affective disorder (postnatal)
- Normal changes in appetite during pregnancy might mask changes that are a symptom of mental illness

Furthermore, treatment during and after pregnancy often has to differ because of possible impacts of the treatment on the mother and the baby:



- Taking psychotropic medications during pregnancy and whilst breastfeeding is problematic. None is safe or licenced for use during pregnancy, but there are also risks to the mother's mental health of stopping medication treating an existing mental illness.
- Women who stop their psychotropic medication during pregnancy have an increased risk of post-partum psychosis.
- Depression and anxiety are the most common mental health problems during pregnancy, with around 12% of women experiencing depression and 13% experiencing anxiety at some point; many women will experience both.
- Depression and anxiety also affect 15%–20% of women in the first year after childbirth.
- During pregnancy and the postnatal period, anxiety disorders, including panic disorder, generalised anxiety disorder (GAD), obsessive–compulsive disorder (OCD), posttraumatic stress disorder (PTSD) and tokophobia (an extreme fear of childbirth), can occur on their own or can coexist with depression.
- Psychosis can re-emerge or be exacerbated during pregnancy and the postnatal period. Post-partum psychosis affects between 1 and 2 in 1,000 women who have given birth. Women with bipolar I disorder are at particular risk, but post-partum psychosis can occur in women with no previous psychiatric history.
- Changes to body shape, including weight gain, in pregnancy and after childbirth may be a concern for women with an eating disorder. Although the prevalence of anorexia nervosa and bulimia nervosa is lower in pregnant women, the prevalence of binge eating disorder is higher.

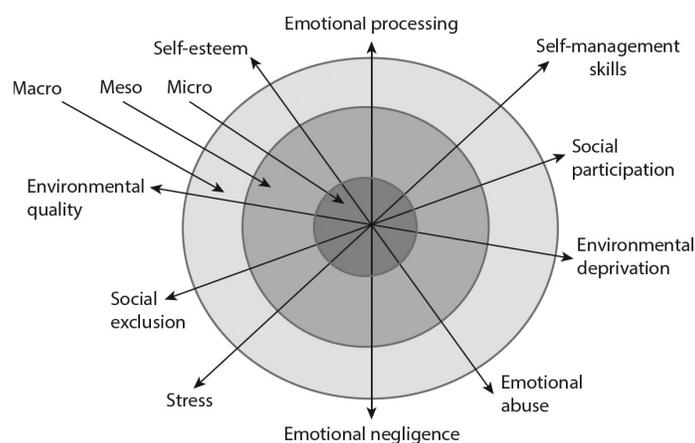


Figure 11.4 The 10 elements of mental health promotion and demotion. (From MacDonald, Glenn, and Kate O'Hara. 1998. *Ten Elements of Mental Health, Its Promotion and Demotion: Implications for Practice*. London: Society of Health Education & Health Promotion Specialists.)

- Smoking and the use of illicit drugs and alcohol in pregnancy are common, and prematurity, intrauterine growth restriction and fetal compromise are more common in women who use these substances, particularly women who smoke (NICE 2014).

In terms of management of mental illness, the NICE guidelines outline core principles that have to be applied to the care of all women (Table 11.1). The recommendations are structured over time from women of childbearing potential, those planning pregnancy, through pregnancy and the postnatal period, and consider interventions for traumatic experiences or stillbirths and organisational responses to the management of mental illness in pregnancy (NICE 2014).

MENTAL HEALTH PROMOTION IN MIDWIFERY

All of the NICE guideline recommendations focus on tertiary prevention strategies. They are meant to minimise the risk of relapse and reduce the incapacity or injury caused in the group of women who have mental health problems. However, The Royal College of Midwives (RCM) is clear that all women should have their emotional well-being assessed and that screening for post partum depression should be routine (RCM 2014). These are primary and secondary prevention strategies aimed at promoting the mental health of all.

The different types of prevention are defined and illustrated with examples in Table 11.2.

As a minimum standard for postnatal care, the RCM (2014) state that all women should have their emotional well-being and emotional attachment to the child assessed at each postnatal visit, that transient low mood or anxiety that does not resolve within 10–14 days should be formally assessed for mental health problems and that parents and primary carers who are identified as having attachment problems should receive services and support to improve their relationship with the baby.

NICE core recommendation	Detail	Examples in practice
Considerations for women of childbearing potential	<p>Discuss with all women of childbearing potential who have a new, existing or past mental health problem:</p> <ul style="list-style-type: none"> The use of contraception and any plans for a pregnancy; how pregnancy and childbirth might affect a mental health problem, including the risk of relapse; how a mental health problem and its treatment might affect the woman, the fetus and the baby; how a mental health problem and its treatment might affect parenting. Do not offer valproate for acute or long-term treatment of a mental health problem in women of childbearing potential. 	<p>Community midwife liaison with:</p> <ul style="list-style-type: none"> Mental health services GP practices Primary care Health education for women of childbearing potential Mental health service-user and advocacy groups
Principles of care in pregnancy and the postnatal period	<p>Develop an integrated care plan for a woman with a mental health problem in pregnancy and the postnatal period.</p>	<p>Integrated care plans should set out:</p> <ul style="list-style-type: none"> The care and treatment for the mental health problem The roles of all health care professionals, including who is responsible for: <ul style="list-style-type: none"> Coordinating the integrated care plan, the schedule of monitoring Providing the interventions and agreeing on the outcomes with the woman
Treatment decisions, advice and monitoring for women who are planning a pregnancy, pregnant or in the postnatal period	<p>Mental health professionals providing detailed advice about the possible risks of mental health problems or the benefits and harms of treatment in pregnancy and the postnatal period should include discussion of the following, depending on individual circumstances:</p> <ul style="list-style-type: none"> The uncertainty about the benefits, risks and harms of treatments for mental health problems in pregnancy and the postnatal period and the likely benefits of each treatment, taking into account; The severity of the mental health problem The woman's response to any previous treatment The background risk of harm to the woman and the fetus or the baby associated with the mental health problem 	<p>Providing information and advice and liaising with specialists, for example:</p> <ul style="list-style-type: none"> Mental health pharmacists Obstetricians Psychiatrists Specialist mental health midwives <p>Acting as an advocate for women to ensure their voice is heard in the multi-disciplinary discussions</p>
NICE core recommendation	Detail	Examples in practice
Recognising mental health problems in pregnancy and the postnatal period and referral	<ul style="list-style-type: none"> The risk to mental health and parenting associated with no treatment The possibility of the sudden onset of symptoms of mental health problems in pregnancy and the postnatal period The risks or harms to the woman and the fetus or the baby associated with each treatment option The need for prompt treatment because of the potential effect of an untreated mental health problem on the fetus or the baby The risk or harms to the woman and the fetus or the baby associated with stopping or changing a treatment <p>At a woman's first contact with primary care or her booking visit, and during the early postnatal period, consider asking the depression identification questions in the column on the right as part of a general discussion about a woman's mental health and well-being</p>	<p>Ask the following screening questions:</p> <ul style="list-style-type: none"> During the past month, have you often been bothered by feeling down, depressed or hopeless? During the past month, have you often been bothered by having little interest or pleasure in doing things? <p>Also, consider asking about anxiety using the 2-item Generalised Anxiety Disorder (GAD-2) scale:</p> <ul style="list-style-type: none"> Over the past 2 weeks, how often have you been bothered by feeling nervous, anxious or on edge? Over the past 2 weeks, how often have you been bothered by not being able to stop or control worrying?
Providing interventions in pregnancy and the postnatal period	<p>All health care professionals providing assessment and interventions for mental health problems in pregnancy and the postnatal period should understand the variations in their presentation and course at these times, how these variations affect treatment, and the context in which they are assessed and treated</p>	<p>Organise inter-professional education and professional development with maternity services, health visiting and mental health services</p>

Table 11.1 Summary of the NICE guidelines for antenatal and postnatal mental health



NICE core recommendation	Detail	Examples in practice
Considerations for women and their babies in the postnatal period	Discuss with a woman whose baby is stillborn or dies soon after birth, and her partner and family, the option of one or more of the following: <ul style="list-style-type: none"> • Seeing a photograph of the baby • Having mementos of the baby • Seeing the baby • Holding the baby 	This should be facilitated by an experienced practitioner and the woman and her partner and family should be offered a follow-up appointment in primary or secondary care. If it is known that the baby has died in utero, this discussion should take place before the delivery, and continue after delivery, if needed.
The organisation of services	Clinical networks should be established for perinatal mental health services, managed by a coordinating board of health care professionals, commissioners, managers, and service users and carers	A specialist multi-disciplinary perinatal service in each locality, which provides direct services, consultation and advice to maternity services, and other mental health services and community services. In areas of high morbidity, these services may be provided by separate specialist perinatal teams with access to specialist expert advice on the risks and benefits of psychotropic medication during pregnancy and breastfeeding. Clear referral and management protocols for services across all levels of the existing stepped-care frameworks for mental health problems, to ensure effective transfer of information and continuity of care.

Table 11.1 (Continued) Summary of the NICE guidelines for antenatal and postnatal mental health

Definition in Boyce et al. (2010)	Examples of application to midwifery practice in the context of mental health promotion
<p>Primary prevention</p> <p>This comprises activities designed to reduce the instances of an illness in a population and thus to reduce (as far as possible) the risk of new cases appearing, and to reduce their duration</p>	<ul style="list-style-type: none"> • Consideration of the stress–vulnerability model • Promoting a woman’s autonomy, self-esteem, coping mechanisms, adaptability to change, transitions of identity and ensuring support is available • Sensitive and thorough history taking exploring mental illness, self-harm, drug and alcohol use and any experience of partner violence at the time of booking
<p>Secondary prevention</p> <p>This comprises activities aimed at detecting and treating pre-symptomatic disease</p>	<ul style="list-style-type: none"> • Screening during pregnancy using the depression and anxiety screening questions (During the past month, have you often been bothered by feeling down, depressed or hopeless? During the past month, have you often been bothered by having little interest or pleasure in doing things?) • Postnatal screening using the above questions and a structured tool such as the Edinburgh Postnatal Depression Scale (EPDS). For further details, see NICE (2014)
<p>Tertiary prevention</p> <p>These are activities aimed at reducing the incidence of chronic incapacity or recurrences in a population, and thus to reduce the functional consequences of an illness, including therapy, rehabilitation techniques or interventions designed to help the patient to return to educational, family, professional, social and cultural life</p>	<ul style="list-style-type: none"> • All of the recommendations in the NICE guidelines (NICE 2014) • Information and advice giving • Planned pregnancy • Specialist liaison midwife role linking with pharmacists, obstetricians, psychiatrists, community drug and alcohol teams, primary care and service-user groups • Lobbying for specialist post-registration training and specialist service development

Table 11.2 Primary, secondary and tertiary prevention

MENTAL HEALTH PROMOTION FOR ALL

There remains a risk that mental health promotion is seen as something we only need



to do for women who either have a mental illness or are at obvious risk of developing one during or after pregnancy. However, if we use the model of 10 elements of mental health proposed by MacDonald and O'Hara (1998), we could consider that for every interaction at a micro-, meso- and macro-level (Tones & Tilford 2001), there are opportunities, thereby a choice to either promote or demote the mental health of the woman in our care. The micro-level is primarily concerned with the relationship, interactions and interventions between the individual midwife and the woman, her supporters and family and the immediate team. Meso-level interventions are those around the organisation of service delivery, inter-professional liaison and availability of services, for example, and at the macro-level we are concerned with maternal health care funding, priority within the NHS, social trends and issues such as stigma that effect whole populations' views around mental health and mental illness.

The 10 elements of the mental health model attempt to integrate the personal experience of mental health and illness, the impact on family and friends as well as the causal factors of illness in an integrated bio-psycho-social approach. It builds on the work cited above by Albee and Ryan-Finn (1993) and expands the six components of their equation to include environmental, social and self-management/emotional intelligence and maps these across the micro-, meso- and macro-levels.

At the micro, or personal interaction, level, the way in which we care for women can promote their health if we demonstrate woman-centred care and empathy (Figure 11.4). These are not just abstract concepts but the skills we use to make the promoting (rather than demoting) choices. In order to promote a woman's self-esteem, emotional processing and social participation, for example, we need to demonstrate Warmth, Acceptance, Genuineness and Empathy (WAGE) (Rungapadiachy 2008): warmth towards the women, her partner or other family and friends; acceptance of her choices and values; genuineness in your care of her; and empathic responses showing that you have understood, or are attempting to understand, both the content and meaning of what she says and does.

In order to demonstrate empathy, we need not have had the same experience as the woman in our care but be able to imagine what primary emotion she is feeling (fear, happiness, sadness or anger) and be open to knowing what that feels like. We then need to demonstrate that we have understood that emotion. Wiseman (1996) summarises this process as:

- Perspective taking – trying to see things from the woman's point of view
- Staying out of judgement – even when her values seem very different from yours
- Recognising emotion in others and communicating it
- Feeling with – making a connection with the woman that acknowledges what she is experiencing

ACTIVITY

Read through the following case study and answer the questions below which should guide you through the principles of applying the 10 elements of mental health in a practical way.

Agnita is a 21-year-old woman who moved to England from Poland with her partner, Gregor, 3 years ago. They both work full-time in a bar owned by Gregor's cousin.

Agnita is expecting her first baby, which was not planned, but they are happy to be pregnant and Gregor has attended both the GP appointments and her first appointment with you as her midwife at about 12 weeks into her pregnancy.

During the appointment, you notice some old scars on Agnita's wrist and when you ask about them briefly, she dismisses them saying 'they are just old childish things', but you think that she seemed uncomfortable talking about them. The rest of the booking is unremarkable and when asked, Agnita states she has no history of physical or mental illness. She has occasionally had too much alcohol in the past but nothing since she thought she might be pregnant. She has never used illicit drugs. Her partner, Gregor, answers a number of the questions for her and corrects her answers on occasion. He is keen to be involved throughout.

Gregor has also asked for your help to give them proof that she is pregnant as they are currently on a waiting list for a housing association flat and need to move out of their flat share where they have one room, but share with four other young people who won't want a baby in the house.

1. First, identify what issues you might want to follow-up with Agnita in order to assess and promote her mental health.
2. Now consider each of the continua within MacDonald and O'Hara's model to plan how you would go about doing this in a way that promotes rather than demotes Agnita's mental health. For example, you may want to ask to see her on her own so that she can answer questions without being interrupted, but how might this impact on her social support or self-esteem. Try to identify an approach for each continuum:

Emotional processing	←————→	Emotional negligence
Self-esteem	←————→	Emotional abuse
Environmental quality	←————→	Environmental deprivation
Social participation	←————→	Social exclusion
Self-management skills	←————→	Stress

3. Finally, think about the organisation in which you work or have been on placement. How will you raise these issues on a micro (interpersonal) level with Agnita and with colleagues; what meso or organisational barriers might there be to promoting Agnita's mental health; and at the macro-level, what policies might inform your decision making in practice?

It might be easier to identify the interventions at an individual and organisational level, and in terms of primary promotion of mental health, there are no right or wrong answers to the above exercise. The only thing that is clear from both the NMC (2015) and RCM (2014) is that mental health and psychological well-being must be assessed and promoted. At a macro-level, Khan (2015) makes several recommendations to policy makers and commissioners. Although the report addresses maternal mental health in primary care, they are just as relevant to midwives who are in a position to lobby



service managers and commissioners. These include:

- Full implementation of the NICE guidelines on perinatal mental health
- Reducing pressure on workloads in order to allow longer consultations
- Work to reduce stigma around perinatal mental health problems
- Promoting effective liaison between maternity and health visiting services to ensure ongoing assessment of maternal health and attachment
- Fund and provide specialist training around perinatal mental health
- Multi-agency liaison by the various commissioning groups

SUMMARY

This chapter has explored the concepts of mental health and mental illness in order to consider the role of the midwife in promoting mental health and preventing mental illness in women before, during and after pregnancy.

- The NICE guidelines focus on secondary and tertiary prevention of illness and relapse in women who have or are at risk of mental illness, but it is also important for midwives to promote the mental health of all women in their care.
- This can be achieved by reflecting on the impact of pregnancy on the various elements and concepts that challenge all of our vulnerabilities.
- This may often present a balancing act between the needs and pressures of the services in which we work and the individual needs of the women in our care, but the cost of not assessing, screening and promoting perinatal mental health is far too great a risk to both the mother and her child in the long term.
- Both the NMC and RCM are clear that mental health promotion is the responsibility of all midwives.

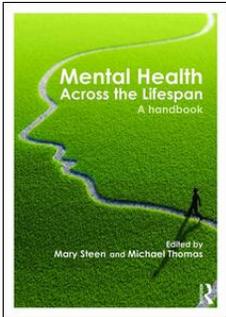


CHAPTER

2

Mental health during pregnancy and early parenthood

2. Mental health during pregnancy and early childhood



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Introduction

During pregnancy and the first year following childbirth, anxiety and stress are a common phenomenon and can stand alone or present as co-morbidities and predispose women to other mental health problems (Steen and Steen 2014). Pregnant women and new mothers throughout the world are susceptible to mental health problems that can have adverse effects on their physical health and also be detrimental to the health and well-being of their infant, which can lead to bonding and attachment issues (Steen et al. 2013). Women who suffer from an existing mental health illness are at an increased risk of relapse during pregnancy. Birth trauma can also be a trigger for a mental health problem and some women can develop anxiety and stress, and suffer post-traumatic stress disorder (PTSD), which may lead to maternal exhaustion and depression. In severe cases mental health problems can lead to maternal suicide and even infanticide (CMACE 2011).

This chapter will focus on highlighting the needs of pregnant women and mothers who are at risk of developing or have an existing mental health problem. The chapter will be introduced by a brief exploration of how a pregnant woman's or new mother's background, life style, environment and fear of being judged and perceived by society as a 'bad mother' can affect her general health and well-being and contribute to mental health problems. This will be followed by a discussion regarding the evidence and recognition of mild to moderate mental health problems such as anxiety and stress, phobias, panic symptoms, baby blues, antenatal depression, postnatal depression (including paternal), eating disorders, links with alcohol and substance use; and then more severe mental health conditions such as puerperal psychosis, schizophrenia and bipolar disorder will be covered. The implications of taking prescribed medication during pregnancy and when breast feeding will be considered. In addition, building resilience as a preventative measure and the benefits of social support and psychological therapies will be discussed. Disguised real life case scenarios will be included to give the reader an insight into some pregnant women's and mothers' experiences of mental health problems and the care and support given to help these women to develop coping strategies and improve their mental health and well-being.

This chapter will consider:

- The risks of mental health problems during pregnancy, childbirth and in the first year following birth;
 - The evidence and recognition of mild, moderate and severe mental health problems;
 - The care and support needs of women who are at risk of developing or have an existing mental health problem during the childbirth continuum;
 - How mental health problems during pregnancy and the transition to motherhood can affect partners and other members of the family;
 - The increased risks of mental health problems for fathers during this time period;
 - The influence of social determinants and expectations during pregnancy and when becoming a mother.
-

Mental health and motherhood

Socio-economic and life events

There are several socio-economic and life events that can have an impact on a pregnant woman's health and well-being status. Childhood experiences, relationships with family members, friends and own peer group can affect how a woman perceives herself. Her personality and life style behaviours also play a part as do personal relationships with a partner. Family violence, sexual abuse and poverty are known risk factors that can trigger mental health issues and being a single mother and a teenager can increase the risk further (Steen et al. 2013). Young deprived mothers are more likely to misuse drugs and alcohol and have safeguarding issues to contend with (National Treatment Agency for Substance Misuse 2010). Many of these pregnant women live stressful and disorganised lives. During pregnancy they may conceal or minimise their alcohol and drug use, often fearing that their baby will be placed in care, which often is the outcome. CMACE (2011) reported a case where a young mother who was a substance user committed suicide shortly after her baby was placed in care. Guilt, shame, loss and being judged contributed to her poor mental health state.

Mental health intervention

It is noteworthy that up to 16 per cent of women may require a mental health intervention during the antenatal and postnatal period (NICE 2008). There is some evidence that women who are substance users and who attend treatment programmes are likely to have better antenatal care and better general health than those who do not (National Treatment Agency for Substance Misuse 2010). NICE (2007a) recommend that a stepped care level of treatment is adopted and this be



incorporated in a mental health care pathway, which facilitates referral to appropriate services. Psychological therapies have been demonstrated to be effective in the treatment of mild to moderate mental health problems (NICE 2007a) but the Improving Access to Psychological Therapies (IAPT) strategy indicates a lower threshold for access to women in pregnancy (IAPT 2009). Many vulnerable women will not attend for antenatal care. It is, therefore, vitally important that maternity services work closely and share information with the woman's General Practitioner and addiction services to identify these at risk women and then involve the mental health team to address associated mental health problems.

Motherhood

In today's society mothers are increasingly expected to invest heavily to enhance their child's physical, social, intellectual and emotional development; balancing their time, energy, finances and own physical and emotional health can take its toll (Kingdon 2009). Fear of being judged and perceived by society as a 'bad mother' can contribute to a woman's belief in her ability to mother. Second-wave feminist research during the 1960s and 1970s highlighted and advanced understanding of the linkages between gender and mental health, with women much more likely than men to suffer from anxiety and depression (Busfield 2010). In particular, Gavron (1968) identified how the gender division of labour, where women are principally associated with the domestic sphere, impacts on women's mental health. Around the same time, Oakley (1979), in her seminal study of first time mothers, demonstrated the disjuncture between women's expectations of motherhood and their actual experiences. More recent research by Gattrell (2005) and Miller (2007) highlights the persistence of this disjunction, the realities of mothers' continued engagement in the labour force and their increasing agency in challenging how childbirth and motherhood should be, for example, medical discourse, natural childbirth discourse, the ideology of motherhood and intensive mothering discourse, in order to maintain their 'sanity'.

Some mothers from culturally and linguistically diverse (CALD) backgrounds are at increased risk of becoming socially isolated when not residing in their country of origin. Language barriers, lack of opportunities to integrate with local communities and different cultural and traditional aspects of motherhood can all play a part in predisposing these women to mental health problems. Mental health problems are often hidden and a taboo subject in many cultures around the globe. Stigma and shame is associated with mental health and this can contribute to pregnant women and new mothers not seeking help and support (Steen and Jones 2013). It is, however, noteworthy that a recent review has reported that similar patterns of mental illness are prevalent in pregnant women and mothers residing in East Asia when compared with





rates reported in Western countries (Schatz et al. 2012).

Balancing family life and work commitments can take its toll and affect general health and well-being and exacerbate mental health problems. That said, many women from various backgrounds can develop good coping strategies to maintain a good level of health and well-being regardless of what life throws at them; they take on the caretaker role of the family and adjust to motherhood without too many problems. There is emerging evidence that demonstrates that when a mother has good family support this helps her remain mentally well (Gjerdingen et al. 2009;

Stapleton et al. 2012). When family support is lacking she is vulnerable and can be susceptible to mental health problems. A recent study of low-income Mexican American families examined cortisol reactivity in infants born to mothers who had experienced stress during pregnancy and found an association between higher cortisol reactivity in infants and lower partner support during the pregnancy (Luecken et al. 2013).

Pregnancy, birth and becoming a mother are major life events that require good support and care for a woman to sustain good health and well-being status. CMAACE (2011) recommend pre-conceptual counselling and care for women with a history of a mental health problems so that planning for adjustments can be made for pregnancy and following birth. There is also emerging evidence that a befriending approach and social support is beneficial (Darcy et al. 2011; Robinson et al. 2014). Steen (2007) reported that pregnant women and mothers who attended a maternal health and well-being community programme highly valued the opportunity of meeting others and the social support they received. There is evidence that local community peer support, sometimes referred to as 'community mothers' can be beneficial (Johnson et al. 2000; Molloy 2007). These local mothers are able to befriend and support other mothers who are feeling alone and isolated. Trust is developed and they are seen to be non-judgemental, approachable and know the reality of living in the local community. This is confirmed by further evidence reported by Robinson et al. (2014) who have demonstrated clear benefits to show how befriending and peer support help women to stay mentally well.

Women and mental health during the childbirth continuum

Anxiety and stress during pregnancy

Even though pregnancy is associated with a happy life event which is often planned but sometimes not, women can suffer from varying degrees of anxiety and stress. Fear of the unknown, past life events, current life events, changes to personal relationships,



work related stress and a dissatisfaction with changing body image can contribute to some women having what can be classified as mild, moderate or severe anxiety and stress (Bergman et al. 2007; Lavender 2007; NICE 2007a). Prevalence rates may be under-estimated and variations have been reported to be between 8 and 24 per cent (Rubertsson et al. 2003; van Bussell et al. 2006),

Pregnant women in Western societies who suffer severe anxiety and stress are usually identified and referred to the specialist mental health team. In the UK, women who suffer mild to moderate anxiety and stress are usually cared for by a community midwife and the primary care team. These women are more difficult to identify and therefore it is vitally important that woman during their pregnancy have continuity of care and carer. Furber et al. (2009) conducted an exploratory study and interviewed pregnant women and three emerging themes were identified. The three themes that emerged were the cause of, and the impact of, ways of controlling their self-reported mild to moderate distress. This study demonstrated that past life events, previous childbirth experiences and current pregnancy worries contributed to anxiety and stress. Mild to moderate anxiety and stress often took over the women's lives and they used both positive and negative coping strategies to try and manage their anxiety and stress.

Midwives and other health professionals need to be alert to women's emotional and psycho-social well-being during pregnancy and will need to watch for signs and symptoms of anxiety and stress. The link between mental health and physical symptoms needs to be recognised. Anxiety and stress are associated with several cognitive, behavioural and autonomic symptoms (Steen and Steen 2014). Palpitations, headaches, dizziness, restlessness, insomnia, gastric problems, urinary frequency and muscular tension and pain are often present and may be overlooked. Distinguishing between the normal transition of physical and emotional/psychological changes that occur during pregnancy and following birth and recognising episodes of anxiety and mild to moderate levels of depression is a challenge for health professionals (Robertson et al. 2004). In addition, raised cortisol levels in pregnancy due to anxiety and stress can increase the risk of hypertension, pre-eclampsia, premature labour and intra-uterine growth restriction (Field et al. 2010; Yu et al. 2013).

Routinely enquiring about how a woman is coping with her pregnancy and her support mechanisms will assist to identify women at risk of anxiety and stress and create an opportunity to offer additional care and support to meet their individual needs.

Building resilience for better maternal mental health

Local community support groups can help pregnant women to build confidence and

resilience and this local support can continue following birth. The mental health charities Mind and the Mental Health Foundation in the UK recently developed a resilience triad model to help people remain mentally well. Recently, this resilience model has been piloted with pregnant women and vulnerable mothers who are at risk of developing mental health problems (Robinson et al. 2014). The evaluation report clearly demonstrates improved maternal mental health and well-being when the resilience triad model is used to facilitate local community care and support for pregnant women and new mothers. This triad model focuses on building resilience to mental health problems by assisting people to acquire a range of coping strategies, build self-esteem and confidence in

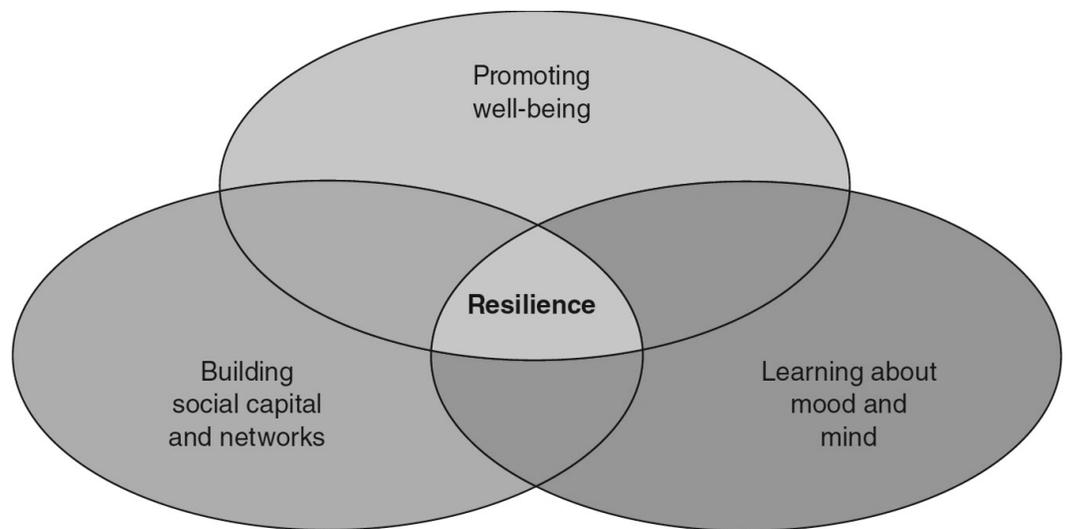


Figure 4.1 Striving for better maternal mental health

relation to a triad model which encompasses well-being, psychological therapies and social capital (Holloway 2013). Positive activities are advocated, such as exercising outdoors (for example, pram walks), building social networks (befriending) and increasing awareness of how to manage anxiety and stress based on principles of low intensity cognitive behavioural therapy (CBT) and mindfulness (Figure 4.1). Holloway (2013) describes how 'resilience is not an inherent quality with which you are born and ... not simply an ability to "bounce back"'. Resilience involves being able to face challenging circumstances whilst also maintaining a positive mental health status; it is an important life skill that enables a person to cope with the highs and lows of life and is closely associated to how confident a person is and their level of self-esteem. Developing skills and coping strategies to be resilient during pregnancy and when becoming a mother is essential for maintaining maternal mental health.

Agoraphobia and panic attacks

Agoraphobic behaviour is frequently associated with panic attacks (Bandelow et al 2006; Ramnero and Ost 2007) and has been linked to anxiety and stress during pregnancy (Furber et al. 2009). Panic attacks are intense episodes of anxiety associated with a variety of bodily symptoms such as palpitations, dizziness, tremor, sweating, hyperventilation and dry mouth. Sufferers may feel they are about to die and be extremely frightened. They may last 1–10 minutes until intervention, or until the person develops some form of self-control. A woman can achieve better control if she learns about the biological basis of her symptoms of panic disorder or is helped to generate her own model of how to cope with panic, maybe by teaching her how to employ easy relaxation techniques. In Figure 4.2

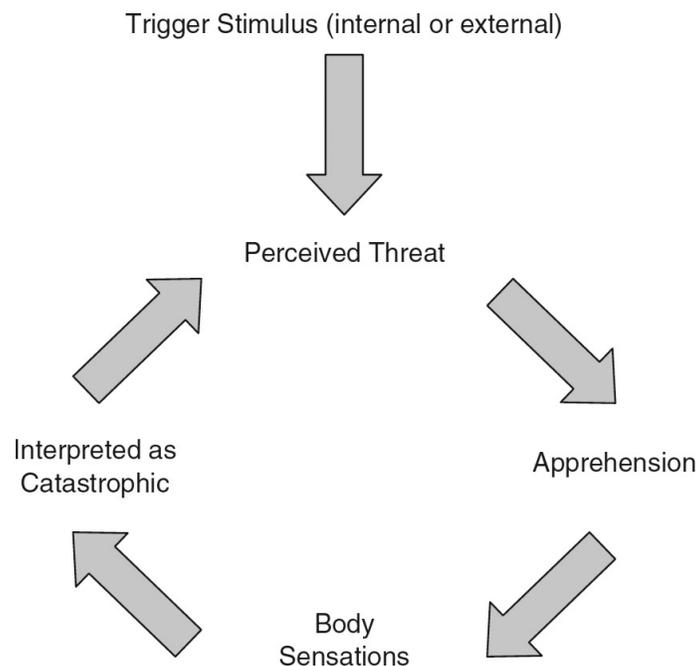


Figure 4.2 Cognitive model of panic disorder

we see how the cycle of panic develops. Interventions such as explanations of bodily symptoms lead to the person no longer interpreting them as necessarily catastrophic, and relaxation methods can inhibit the cycle too. Women with panic attacks may become dependent on alcohol or other substances, or come to rely on anxiolytic drugs like benzodiazepines. There is sometimes an overlap with other mental health problems, such as depression or PTSD. It is, therefore, vital to exclude hormonal and physical health problems, for example hyperthyroidism, before diagnosing a panic disorder. In addition, a psychiatric label can sometimes cause a physical problem to be



overlooked and this can lead to a fatal outcome, for example, a pulmonary embolism.

Antenatal depression

Pregnancy was always generally thought to have an uplifting effect on mood and women were seen as more or less protected against depression. Even amongst midwives knowledge about the condition is limited. Nevertheless, for some women depressed mood is a problem during pregnancy. Antenatal depression has become more recognised in recent years and has been linked with poor partner and family support (Schatz et al. 2012).

There is some suggestion that it is linked to adult depression and life circumstances and then linked to postnatal depression following birth (Robertson et al. 2004). There is also growing evidence that antenatal depression is associated with several risk factors, such as increased levels of anxiety and stress suffered when a woman has a complicated pregnancy and is at increased risk of a difficult birth (Andersson et al. 2004). This can result in a premature or intra-uterine growth restricted baby (Field et al. 2010), which is then linked to post-partum depression (van Bussell et al. 2006). In addition, impaired maternal–fetal attachment is also linked to antenatal depression (Lindgren 2001) and developmental problems in the infant (Deave et al. 2008).

Researchers exploring women’s experiences of antenatal depression have reported emotional loneliness (Bennett et al. 2007; Raymond 2009). It is worth noting that antenatal domestic violence is highly associated with antenatal depression in women (Flach et al. 2011) and is correlated with later childhood behavioural problems (probably mediated through maternal depression). Practitioners need to be mindful to seek out and eliminate underlying causes of depression. Research suggests that intervention antenatally to treat symptoms of depression may prevent more severe postnatal depression later (Clatworthy 2012). Levels of distress, antenatal depression and stress about the parenting role are reduced by help-seeking behaviour in women and antenatal interventions to treat depression improve engagement and well-being (Milgrom et al. 2011).

Where there is a history of depression in fathers (Areias et al. 1996), this is linked to an increased risk of a father also susceptible to anxiety and stress during pregnancy and antenatal depression (Ramchandani et al. 2008).

Eating disorders

Eating disorders (ED) can affect the health and well-being of some pregnant women and new mothers. An eating disorder is a complex compulsion to eat in a way which



Figure 4.3 Maternal-fetal attachment

disturbs physical, social, emotional and psychological health (NICE 2004). See the Glossary of mental health terms for a description of common types of eating disorders. Eating disorders appear to be more common in young women, and dysfunctional eating behaviours if not recognised and treated can develop into an addiction (Wolfe 2005). There is often a history of psycho-social problems and some form of abuse within the young woman's life (Little and Lowkes 2000). Mitchell and Bulik (2006) have highlighted that women living with an eating disorder are at risk of their dysfunctional eating behaviour exacerbating during pregnancy and after giving birth. In addition, those women who have previously experienced such disorders may be at risk of a recurrence during pregnancy because of significant issues around change in body image, weight gain and major life transition.

Gielegum et al. (2002) raised concerns that even though women with an eating disorder are at increased risk of poor maternal and fetal outcomes, disclosure by them seldom occurs. Therefore, health professionals need to be alert to possible physical, emotional, psychological and behavioural indicators to detect an eating disorder and offer supportive care. Body Mass Index (BMI) may be an indicator to a possible eating disorder. For instance, a BMI <18.5 is associated with Anorexia Nervosa and a BMI >40 is associated with Bulimia Nervosa (Hudson et al. 2007). Specifically relating to pregnancy, there may be a history of difficulties in conceiving and poor pregnancy outcomes such as miscarriage, stillbirth, intra-uterine growth restriction (IUGR), premature birth and congenital abnormalities. Other physical indicators such as tooth decay, a persistent sore throat, digestive problems such as heartburn, difficulty swallowing and constipation are possible indicators of an eating disorder.



Complaints of general malaise, persistent backache and leg cramps (they are more at risk of mineral loss from their bones and osteoporosis), signs of dehydration and frequent complaints about urinary and bowel problems may also be indicators. A pregnant woman with previous or current eating disorders may demonstrate signs of anxiety and stress, low self-esteem, feelings of guilt and being ashamed, poor body image and a history of mental health problems where she has self-harmed or even attempted suicide. In general she appears to be struggling to cope with life and the pregnancy. She has poor family support and there may be a history of taking prescribed drugs such as antidepressants and slimming pills. During pregnancy she may be reluctant to discuss dietary intake and may deny having any eating problems. She may also be very anxious about weight increase during pregnancy and can appear obsessive about losing weight in the immediate postnatal period. If she has children, they may have eating problems such as overeating or food refusal (Little and Lowkes 2000).

Asking questions about eating habits and patterns needs to be undertaken very sensitively. Initially, general questions about how she is feeling, how she is coping with her pregnancy, her family life and what social support she has may give an opportunity to then ask more direct questions about her eating habits, patterns, likes and dislikes of food types (Steen 2009). Documenting concerns is paramount, as is also discussing with the woman a referral to the local mental health team who can offer additional care and support from an eating disorder specialist. There is evidence that women with an eating disorder can positively modify their eating behaviours whilst pregnant as they want to provide a good nutritional intake for their developing baby, but they may go back to their dysfunctional eating behaviour following birth and are at increased risk of postnatal depression (Mitchell and Bulik 2006; NICE 2004, 2007a).

Long term follow up with an eating disorder specialist is often necessary to prevent the woman from relapsing. The most common treatments for eating disorders are cognitive and other behavioural therapies and these have been reported to help many women but this takes time and women may need several years of therapy (NICE 2004, 2007a). An eating disorder specialist will aim to focus the woman on her negative thoughts towards food and weight, then support the woman to enable her to recognise 'triggers' and then replace the negative thoughts with more positive ones that are rational and healthy. Often other mental health problems will also need to be worked through (Steen 2009).

Eating Disorder: a case scenario

Helen booked late for antenatal care. She arrived unexpectedly at the clinic when she was



approximately 28 weeks gestation. The midwife knew her from a previous pregnancy and was aware that she had several social issues and little family support. The clinic was busy and the midwife was running late with the appointments as there had been some other social problems to sort out with a few of the women attending. Therefore, she could not book Helen at the clinic but arranged to go visit her at home later in the day. The midwife's first impression of Helen was that she looked tired and very pale. She reflected and remembered that she had a history of miscarriage and intra-uterine growth restriction (IUGR). The midwife arrived at Helen's home around 4 pm and Helen's little girl was present. Whilst taking her booking history, the midwife noticed that Helen was coughing a lot and complained of a sore throat. Helen put it down to being 'run down and not looking after herself'. When the midwife asked her about her diet, Helen disclosed that she had little appetite and was suffering from constipation. The midwife was aware that there had been some concern in her last pregnancy about domestic violence and she had a history of self-harming as a teenager, although Helen never disclosed this. She appeared generally unwell and possibly dehydrated as she was constipated and also complained of general aches and pains in particular, affecting her lower back and legs. The midwife was concerned about Helen's mental health state as she was not happy about being pregnant and when gently asked how she was coping she showed signs of being upset. Her partner had left her and she was struggling to cope with life in general. The midwife referred her to the mental health team and arranged to visit her weekly. During the weeks that followed there was a concern that Helen's baby was not growing and developing as well as expected and a growth scan confirmed this. Helen's pregnancy was monitored closely and she attended the consultant-led unit. Helen's sister agreed to care for her little girl when she went into labour at term. She gave birth to a baby boy who weighed 2300 g and showed physical signs of IUGR. He fed well in the postnatal period which pleased Helen. During this time she disclosed to her midwife how she felt guilty for not eating properly during her pregnancy. When sensitively questioned about this she discussed how she had struggled to eat properly for a few years and it was particularly a problem when she was stressed and had relationship problems. In addition, her little girl's eating habits were a concern to her health visitor and she was underweight. This alerted the midwife to the possibility of an eating disorder and this was discussed with her general practitioner and the mental health team.

Long term follow up with an eating disorder specialist was arranged to help her to focus on her negative thoughts towards food and then support her to recognise 'triggers' and then replace these negative thoughts with positive thoughts to eat healthier. The mental health team continued to support her and she was coping fairly well with her new baby and she had her sister and some friends to support her.

Existing mental health conditions

Women with existing mental illness such as schizophrenia and bipolar disorder may develop relapses of their condition during pregnancy, especially if compliance with maintenance medication is lost (NICE 2007a). Close working relationships between health professionals is essential and regular meetings for advance care planning for various contingencies is vital. In these cases specialist midwives with mental health expertise are extremely valuable in formulating birth plans and supporting women. The situation can become difficult to manage if women are adamant they will not take medication 'for the baby's sake'. In Western societies admission to an all-female Psychiatric Intensive Care Unit (PICU) during pregnancy may be justified in such cases, with liaison with the local Mother and Baby Unit to see if attempting to keep mother and baby together following birth is at all feasible. A pregnant woman with schizophrenia may also need to be admitted to a PICU. There is some evidence that a pregnant woman with schizophrenia is at an increased risk of poor pregnancy and neonatal outcomes (Nilsson et al. 2002). There may be a denial of the pregnancy even though physical changes are occurring and this can lead to not receiving the care and support she desperately needs. Following birth, specialist care and support is essential as the new mother is also at increased risk of failing to bond with her baby and this leads to a poor mother–infant attachment. During episodes of bipolar disorder, the risk of suicide increases. Judgement may be impaired during mania and, due to elation and dis-inhibition, a woman may make unwise decisions such as overspending or being promiscuous, increasing her risk of acquiring a sexually transmitted disease (STD) or becoming pregnant. The various mood stabilisers (such as valproate and lithium) are associated with cardiovascular and neural tube birth defects. Pregnancies in bipolar women need to be carefully planned with adjustments to medication. Misuse of alcohol during hypomania may increase the risk of fetal alcohol syndrome and a family history of bipolar disorder has been shown to increase the risk of a woman developing puerperal psychosis following childbirth (NICE 2007a). In the UK, a recent landmark case which was referred to the courts highlighted how ethically challenging the area of severe mental illness can be in the context of pregnancy. A woman referred to as Miss B (to safeguard her anonymity) was given the right to an abortion, despite an NHS hospital trust ruling that claimed she was not of sound mind and therefore incapable of making a decision. Suffering from bipolar disorder, the pregnant woman claimed that having the baby would likely result in her suicide and killing the baby. The judge ruled in favour of Miss B on the grounds that denying her an abortion would be a 'total affront to her autonomy' and he didn't accept the claim that she was lacking in capacity (Ensor 2013). It is, therefore, imperative that pregnant women with severe mental health problems are listened to and their wishes respected.





There is some evidence to suggest that an increase of obsessive compulsive behaviours may occur perinatally (Chaudron and Nirodi 2010), such as intrusive ideation in the mothers about the baby's health or safety, coupled with, say, washing compulsions or cleaning rituals. Difficulties in pregnancy such as oedema and prolonged labour have been proposed as potential risk factors for further study (Vasconcelos et al. 2007). In patients who attended a mental health obsessive compulsive disorder (OCD) clinic, out of the 78 women in the ever being pregnant group (ever pregnant group), 32.1 per cent (n = 24) had OCD onset in the perinatal period (perinatal-related group), 15.4 per cent in pregnancy, 14.1 per cent at postpartum, and 1.3 per cent after miscarriage (Forray et al. 2010). This indicates that for females suffering from OCD, the perinatal period is a time when symptoms are highly likely to reveal themselves. Some specific scales such as the perinatal obsessive compulsive scale (POCS) have been developed to measure perinatal OCD (Lord et al. 2011).

The possibility of a woman remaining in her own home, supported by a health care team, will be considered if the woman's mental health state is assessed as being not severe enough to warrant admission as an in-patient. If she is deemed at risk of harming herself or her baby then admission to the nearest Mother and Baby Unit may be necessary. Women with existing mental health illness are at risk of relapses and psychotic episodes following birth and every case needs to be assessed on its own merits.

Drug use and pregnancy

Mothers using substances are statistically more likely to have infections such as Hepatitis B Virus (HBV) and Human Immunodeficiency Virus (HIV), have an increased incidence mental illness and be prone to poor social support and thus require a deal of proactive planning and care (APA 2012). Mothers using cocaine are at increased risk of hypertension and pneumothorax. Underlying mental health conditions are associated with illicit drug misuse – conditions such as PTSD, personality disorder, psychosis and alcoholism. Increased risks to the fetus include fetal alcohol syndrome, infection, malnutrition, and neonatal withdrawal from drugs such as opiates. Neonates may have low birth weight, increased developmental abnormalities and be born prematurely.

Grandey et al. (2002) found that 1 per cent of mothers using maternity services were substance users and a third of their babies were in withdrawal and required special care units. Various studies have found that these mothers were more likely to be victims of violence, to present late in pregnancy, have less antenatal care, increased mental health morbidity and neglect social roles (Thompson and Kingree 1998; Hans

1999).

Medication and the fetus

Approximately 7 per cent of mothers in their childbearing years suffer from a mental illness (NICE 2007a). This, combined with the fact that many pregnancies are generally 'unplanned', means that there is a significant risk that the developing fetus might be exposed to psychotropic drugs. First trimester exposure is associated with abnormal organ formation and third trimester exposure is linked to withdrawal effects in the neonate. For instance, neonatal withdrawal symptoms can be seen with some antidepressant and antipsychotic drugs. As no drug can be deemed wholly safe, the policy of avoiding drugs during pregnancy (especially in the first trimester) is the wisest course. This is only counterbalanced if the risk, for example, of suicide or severe relapse of psychosis, is a serious concern. Of all the many drugs that the developing fetus might be exposed to the so-called tricyclic antidepressants are relatively safe in terms of any risk of malformations, but if used in the third trimester can lead to withdrawal symptoms in the neonate. There is less certainty about the serotonin re-uptake inhibitors (SSRIs) and malformations. Of the antipsychotics the older style phenothiazines, like chlorpromazine, are associated with a small risk of malformations. Haloperidol is thought to be relatively safe as is olanzapine, a newer antipsychotic drug. The outlook for women, say with a bipolar disorder, taking mood stabilisers is of more concern and careful advice about contraception and planning pregnancies needs to be given on initial prescription and repeated thereafter. Of the various mood stabilisers lithium is definitely associated with fetal cardiac abnormalities, for example Fallot's tetralogy, while sodium valproate and carbamazepine are associated with neural tube defects and phenytoin is associated with facial cleft defects.

Care and support Problems with motivation may make pregnant women and newly delivered mothers with severe mental health conditions less likely to engage proactively with health professionals and this may impair compliance with health advice. This in turn may affect a pregnant woman or mother's ability to cope with everyday life activities, therefore necessitating careful planning with mental health services, their family, social services and community support.

It is vitally important to involve the woman's family to support her. Living with a mental health condition has its challenges and living with someone who has a mental health condition can also be very difficult. Fear of not being able to cope will be a strong emotion for some women and their family members. There is still an element of stigma and shame attached to mental illness and a woman and her family will be fearful of how other people in society will react to her and to some extent to her family



as a whole (Steen and Jones 2014). A woman-focused and family-included approach to care and support is required as this will benefit all concerned.

Childbirth and mental health The medicalisation of childbirth Traditionally throughout history, birth has been a social event that takes place within the nurturing setting of the home and a communal celebration. During the 1970s and 1980s a technocratic approach to birth gained momentum with the growing use of biomedicine and the power of obstetrics within the health service (Harris 2012). The assumption that being in a hospital was a safer environment to give birth rather than the home led to the majority of women giving birth in hospital with the use of machinery and being treated as a patient. Birth became a medical event rather than a social event and this has had a major impact on how birth is viewed by society as a whole. There is evidence emerging that this technocratic approach to birth is having detrimental effects on some women's health and well-being (Emerson 1998; Murphy 2003; Newnham 2014). This approach has had an effect on women's confidence and ability to give birth normally. A growing phenomenon of the 'fear of birth' continues to affect many women's views of childbirth: some become very anxious, even depressed and fretful during pregnancy (Melender 2002; Steen and Jones 2012). Sudden unexpected interventions and events during labour and birth can lead to tokophobia (morbid fear of childbirth). In severe cases mental health problems may lead to maternal suicide (CMACE 2011).

Fear of childbirth Fear can be acquired by suggestion or association and can manifest itself in dread and dismay, even terror, depending on the nature of the stimulus and a person's personality (Tucker 2003). The bible teachings have instilled a generic fear of childbirth and the 'Curse of Eve' has given women a reason to fear birth. Genesis 3:16 quotes '*Unto the woman he said, I will greatly multiply thy sorrow and thy conception; in sorrow thou shalt bring forth children . . .*'

For many women over the centuries this has been the case until the great advances of science and living conditions played their role in improving the health and well-being of women (Steen and Jones 2012). There is no doubt that great advances in the care of expectant mothers and their babies have contributed to better maternal and fetal outcomes, but *medicalisation* and more recently the *media's* portrayal of birth have contributed to this generic fear of childbirth. Fear of childbirth has had an effect on women's confidence and ability to give birth normally. This fear continues to affect many women's views of childbirth, and may lead to maternal request for caesarean section.

Tokophobia is a complex but rare condition where women need to be supported by a





range of healthcare professionals, including midwives, obstetricians and occasionally perinatal mental health specialists. This collaborative approach can help a woman to be less anxious and understand the normal physiological process of birth and prepare for birth feeling supported. The most appropriate choice of birth environment and how to give birth to meet her individual needs is vitally important in her care and being actively listened too and counselling can also help (NICE 2007b; RCOG 2011).

Post-traumatic stress disorder (PTSD) For most mothers birth is a happy, rewarding and life-affirming milestone in their lives. However, in Western countries it is estimated that around 1.5 per cent to 6 per cent of mothers experience PTSD following childbirth complications which, whether due to inherent pathology or clinical negligence, mean that the mother's life or the child's life can be threatened or serious injury may result (Andersen et al. 2012). However, social and cultural differences between countries and different assessment scales used to identify women with PTSD following birth may influence the reporting of prevalence rates. For example, a higher rate of prevalence (17 per cent) for PTSD following birth in a study undertaken in Iran has recently reported by Shaban et al. (2013).

The researchers reported a strong relationship between anxiety and depression and the mother's occupation. In addition, it is now acknowledged that women can develop PTSD following birth involving unexpected obstetric procedures and complications and in some women symptoms can last for several months (Ayers and Pickering 2001; Beck 2004; Leeds and Hargreaves 2008). PTSD is associated with high trait anxiety, pre-existing fear of childbirth, other physical and/or mental health problems during pregnancy and a previous traumatic birth experience and history of child sexual abuse (Ayers and Pickering 2001; Bailham and Joseph 2003; Soet et al. 2003).

During birth trauma heightened states of arousal and fear can engender PTSD, a moderately severe psychiatric disorder encompassing nightmares, anxiety and panic, flashbacks (intrusive thoughts) and avoidance behaviour. Depending on the outcome of such traumatic injuries chronic ill health may lead to adjustment disorder (or secondary depression) which can be treated by antidepressants or cognitive behavioural therapy (CBT). Loss of the baby and loss of future reproductive ability are both bereavements and are sometimes complicated by depression, again treatable by antidepressants or CBT with the addition of elements of grief therapy.

Just as with couple depression (this is where one partner in a couple is depressed and there is a heightened risk of depression in the other), there is often a sharing of PTSD symptoms across the mother-father dyad – where trauma symptoms are experienced

by one these are correlated with trauma symptoms in the other (Iles et al. 2011). Staff attitudes can contribute to the development of PTSD, with disinterested or nervous midwives adding to fear levels during emergency caesarean procedures (Tham et al. 2010).

Post-traumatic stress disorder: a case scenario

A 30 year old primigravida who had opted for active management of the third stage of labour had difficulties delivering the placenta. It became apparent that the placenta was abnormally attached. Following IM injection with syntometrine and cord-controlled traction (CCT) by a newly qualified midwife the placenta was not delivered. This was uncomfortable to the point of pain for the woman. A senior midwife was summoned who again repeated CCT, but with greater force, leading to more severe pain, anxiety and stress and tending to panic for the woman. Finally a junior doctor was called who removed the placenta manually by dividing the placenta from the uterine wall with her fingers bit by bit until eventually the placenta came away. No anaesthetic was involved and subsequently the woman developed a heavy blood loss and infection as complications of the procedure. The woman said that she had been screaming and in great pain throughout the procedure. Thereafter, she had nightmares from which she awoke in a panicky, sweaty state. Her sleep was poor, and she felt low in mood. She chose to avoid hospitals, doctors and midwives because of the reminder of feelings of panic and fear experienced in their presence. She could not be driven past the hospital where her baby was delivered. Her libido was absent even six months after the delivery. She felt constantly on edge, was irritable and easily startled. She suffered intrusive memories of the doctor's angry face shouting at her not to 'be stupid' and the feeling of the doctor's hand inside her uterus. A diagnosis of post-traumatic stress disorder (PTSD) was made and there was some response to antidepressants and CBT, but the woman was very clear with her therapist that she would 'never' contemplate having another baby.

Care and support It is important in promoting the normality of birth and even when complications occur that the woman and her partner are fully informed and consent is given to the interventions and care necessary. The woman and her partner must be supported in a caring and compassionate way to reduce fear and anxiety.

Mental health following birth Transient psychological disorder (baby blues) A transient psychological disorder commonly referred to as the baby blues is relatively common, being experienced by about 1 in 3 mothers (Steen 2011). Baby blues refer to transient feelings of weepiness or pessimism occurring within days of birth and lasting just hours or days, and certainly no more than a week postnatally. The lowered mood is typically relatively mild in nature and may be accompanied by tiredness and insomnia. The causes may include a psychological reaction to apprehension or anxiety about the

birth, physiological reaction and the genuine physical exhaustion felt, or a sociological reaction and the realisation that a life event has finally occurred. Other causes may include a biological switch in hormone levels with withdrawal from previously high levels of progesterone and oestrogen. Whatever the cause the symptoms of baby blues usually disappear with support and some reassurance and without the need for specialist intervention.

Baby blues: a case scenario

A first time mother on her 3rd postnatal day: felt weepy, didn't know why, just started to cry, very emotional, query anti-climax following the pregnancy and birth, over tired, not had much sleep, feels hormonal, breasts engorged and aching, baby not fixing on properly, perineum hurting from stitches, house a mess. Midwife arrived to undertake a postnatal visit and recognised baby blues, she sat and listened to the woman's concerns and reassured her that she appeared to have the baby blues which many women have after giving birth but it would subside with help and support. It was decided that the woman's partner would take their new-born out for a stroll in the pram and the woman would take herself off to bed and get some very needed sleep. The woman had the midwife's contact details if she needed a chat later in the day and another visit was arranged for the next day. The next day was much better, the woman had had some sleep and felt able to cope, her breasts were not as engorged and her baby was able to fix on and feed well, stitches were still causing some pain but bathing, cool packs and analgesia were helping to alleviate this, her own mother had come around and tidied up. She was going to take another nap in the afternoon and was gaining confidence in her ability to be a 'mother'.

4.5.2 Postnatal depression This is also sometimes called postpartum depression; postnatal depression (PND) is defined as a depressive illness within a year of birth. Symptoms include excessive low mood, poor sleep, poor concentration, altered appetite, increased tiredness, low self-esteem, social withdrawal, lack of interest or pleasure, increased irritability and reduced sex drive. In more severe forms suicidal ideation and plans can form and be accompanied by psychotic features such as delusions of guilt or worthlessness and auditory hallucinations. In different studies PND can affect between 5 and 25 per cent of mothers (Gaynes et al. 2005). A recent study in Spain found depression in 9.3 per cent and 4.4 per cent of mothers at 3 and 12 months postpartum respectively (Escriba-Aguir and Artazcoz 2011). However, there is some evidence that PND prevalence may be higher in some developing countries (Fisher et al. 2012). A cross-section study undertaken in Karnataka, South India screened a sample of 123 women who attended a rural maternity hospital and reported rates of PND to be around 45 per cent in the immediate post birth period and then at 6–8 weeks following birth (Johnson et al. 2015). PND was associated with mood swings during pregnancy, being stressed, having a low-esteem, staying with maternal family and being





away from their husbands. In Indian societies, risk factors such as low income, lack of education, multiparity, congenital malformations, disappointment that infant is female, husband's use of alcohol, difficult relationship with mother-in-law and history of depression within the family have been found to be associated with PND (Hegde et al. 2012).

There is debate as to whether PND is a separate illness confined to the postnatal period or to be seen as a depressive episode that is likely to be part of a recurrent affective disorder and also linked to antenatal depression. The prevalence of depression in parents postnatally is not that different from the prevalence of depression in adults. Risk factors include a past psychiatric history of depression, poor relationship with partner, adverse temperament in the infant, lack of support, being a single parent, being a smoker, amongst others (Beck 2001). Recent studies have additional factors: being a younger mother, being less educated and being impoverished (Darcy et al. 2011) and intimate partner violence (IPV) (Valentine et al. 2011 and Garabedian et al. 2011), and having suffered previous miscarriages/stillbirths (Blackmore et al. 2011). Causes of PND are not well understood –hypothetical causes may include sleep deprivation and exhaustion (perhaps due to infant temperament problems or colic), hormonal shifts (Soares and Zitek 2008), iron deficiency (Beard et al. 2005) and socioeconomic factors.

Midwives and doctors are advised to enquire early in the pregnancy about any family and personal history of serious mental illness so referrals and specialised expertise can be arranged (NICE 2008). However, screening for mental health problems during pregnancy is much debated. There are a number of validated screening tools for depression (Sanders 2006) and the Edinburgh Postnatal Depression Scale (EPDS) is a well recognised ten-question scale used to screen for postnatal depression (Cox et al. 1987). NICE (2008) do not recommend using the scale antenatally.

PND is associated with poorer quality of life for mother and child at follow up over a year later (Darcy et al. 2011). Social support is a necessary adjunct, with deployment of the full resources of the multi-disciplinary team being helpful. At times admission to an inpatient unit may be necessary particularly where there are issues of suicide risk and third party risks to the baby whether through neglect or depression-driven delusional action. Effective treatments include antidepressants, inter- personal therapy and CBT (Sockol et al. 2011). In the UK, recent work has focused on training health visitors with additional cognitive behavioural and person-centred therapy skills to deploy in helping women with PND (Morrell et al. 2011). In the UK, Australia and New Zealand, specialist midwife posts have been created to specifically focus on women with mental health

issues and to promote a care pathway that encourages a joint up teamwork approach.

PND: a case scenario

Mary was a 24 year old single mother who lived with her mother. She had been tearful and withdrawn before the birth of her daughter Ann. This was observed and documented by her midwife and a GP referral was made. Mary's mood improved transiently following the baby's arrival. On transfer of care to the health visitor, the community midwife discussed Mary's health and well-being during her pregnancy and then following the birth of her baby. At six weeks, the health visitor made a home visit and found Mary to be very withdrawn and almost silent. On questioning she became tearful and said that Ann was waking her every hour or so at night and that she felt exhausted. Mary said that although her Mum had been looking after Ann in her bedroom at night for the past week to give Mary some sleep, Mary said she thought she had no future and that the world would be better off without her, and Ann. Mary was referred to the mental health team. In-patient admission was deemed not necessary and community care was given. PND is treatable and Mary's mental health improved with, initially, antidepressants, then cognitive therapy and by attending local support groups and home visits from a volunteer befriender.

Paternal mental health The issue of paternal mental health around the time of childbirth is only now being taken relatively seriously. For many years the mental health of fathers has either been neglected or been the target of sexist humour. The twentieth century's popular view of the subject can be encapsulated in the ribald humour of the film *Carry On Doctor* (1967) where Charles Hawtrey played a husband who shared his wife's pregnancy and symptoms. Hawtrey's fictional case was probably a depiction of *Couvade syndrome* (or sympathetic pregnancy, long recognised in the medical literature since antiquity as a rare male psychological reaction to pregnancy). The focus on adult mental health around pregnancy has always been firmly placed on maternal mental health until recently.

Paternal postnatal depression In the last decade or so, there have been various papers describing serious researches into paternal postnatal depression. Firstly, there have been researches into the scope of the problem. Skari et al. (2002) 'clinically important psychological distress' a few days after childbirth in some 13 per cent of fathers with 2 per cent of fathers having 'severe intrusive stress symptoms'. However, after six weeks they found that these levels of distress fell to a level found in the general population. However, this return to normal cannot always be guaranteed. Paulson et al. (2009) found that 10 per cent of fathers were depressed at 9 months. Sherr et al. (2006) identified depression in 12 per cent and anxiety in 30 per cent of the fathers of children aged 6 years and under in North London. Infant crying and sleep problems



seem to particularly correlate with depression – where these problems are present up to 30 per cent of fathers have abnormal depression scores (as measured on the Edinburgh Postnatal Depression Scale) (Smart and Hiscock 2007). A Spanish study found depression in 9.3 per cent and 4.4 per cent of mothers and 3.4 per cent and 4.0 per cent of fathers at 3 and 12 months post-partum respectively, (Escriba-Aguir and Artazcoz, 2011).

Paternal depression also has effects on child development. Ramchandani et al. (2008) looked at the development of child psychopathology in association with male postnatal depression. They followed 10,975 fathers and their children for seven years and found that postnatal paternal depression (measured by the Edinburgh Postnatal Depression Scale) was associated with psychiatric disorder in the children seven years later – these mainly being oppositional defiant/conduct disorders. This association appears to be independent of maternal postnatal depression. (Ramchandani et al. 2008). An earlier study of Ramchandani's on a similarly large cohort of 12,884 fathers found an association between male postnatal depression and adverse emotional and behavioural outcomes in their children at 3.5 years old, with conduct disorders in boys (Ramchandani et al. 2005). Postnatal male depression may be a major predictor for impaired parental competence during the first months after birth (Ferketich and Mercer, 1995). Paternal depression at 9 months post childbirth has also been linked to a reduced tendency to read to the child and impaired development of the child's vocabulary (Paulson et al. 2009).

There are various risk factors that might predict which fathers might develop male postnatal depression. These risk factors include a past psychiatric history of depression in fathers (Areias et al. 1996), higher prenatal depression and anxiety scores (Ramchandani et al. 2008), being the father of twins (Vilksa et al. 2009), early infant crying and sleeping problems (Smart and Hiscock 2007), excessive crying in the infant (van den Berg et al. 2009) and maternal post-natal depression (Edhborg et al. 2005). Amongst father of twins conceived through assisted reproduction treatment (ART) they show no difference in terms of depression rates compared to fathers of singletons during pregnancy. However, at two months and one year after delivery fathers of twins (both ART and normally conceived) show significantly more symptoms of depression than fathers of singletons (Vilksa et al. 2009). Excessive infant crying (using Wessel's criteria i.e. crying >3 hours for >3 days in the last week) is associated with paternal depressive symptoms (van den Berg et al. 2009). Couple depression is a repeated finding in various studies such that where one partner is depressed there is a heightened risk of depression in the other (Areias et al, 1996, Edhborg et al, 2005, Field et al, 2010). Goodman (2004) found that the prevalence of paternal depression ranged





from 1.2 per cent to 25 per cent in various community samples, but that the rates increased from 24 per cent to 50 per cent amongst men whose partners had postpartum depression.

There has also been research into potential interventions. Where infant crying has been a causative factor then Smart and Hiscock (2007) found that education about normal infant behaviours and management strategies helped maternal and paternal mental health. Other recognized interventions might encompass CBT, antidepressants, interpersonal therapy and group therapy.

With regard to other potential mental health problems, the issue of male bereavement is probably under-researched. Bereavement is generally held to be a huge risk factor for depression, but in modern times males may witness traumatic scenes in hospital such as the attempted resuscitation of a newborn or a cherished partner. The risk of these scenarios may be expected by health staff, but to emotionally involved partners and relatives these scenes where highly valued lives are threatened may form the kernels of PTSD memories that are re-experienced for many years or complicated bereavement reactions. The undoubted advantages and disadvantages of allowing relatives to witness such resuscitations and the ethical issues involved are outside the scope of this chapter.

Puerperal psychosis Postpartum psychosis (or puerperal psychosis) is a rare occurrence affecting less than 1 in 1,000 women (Terp and Mortensen 1998). The psychosis develops within days of giving birth. It is important to exclude and treat physical causes such as uterine infection, chest infection, or urinary tract infection, which might be accompanied by fever, rigors and signs of physical illness. Presentations may include mania or schizophreniform psychosis, with hallucinations and delusions. Once physical causes have been excluded treatment would be dictated by the severity of the condition and any risks of suicide or danger to the infant. Admission could be considered, if necessary requiring detention under a Mental Health Act, such as the UK Mental Health Act (2007). As presentations are relatively early and often seen after first pregnancies there may be a chance that these are present and detected in the maternity unit. If so a hospital liaison psychiatrist may be asked to assess the woman. In the UK, the community midwife or health visitor would need to alert the GP to access secondary care. In some areas a direct referral to community mental health care may be possible if the facility is available. Mother and Baby units are, in this day and age, still depressingly scarce (approx. 12 in the UK) leading to the trauma of separation of mother and family whilst mental illness is resolving with treatment. Treatments may include antipsychotic drugs (such as quetiapine) or mood stabilisers (such as valproate),

with due care and attention as to whether the mother is still breast feeding. The mother and baby unit should be able to make an assessment of any current and on-going risks to the baby and hopefully work towards fostering and strengthening the relationship between mother and baby as the mother's illness resolves. In addition, a family-centred care approach in which fathers and other family members are involved is encouraged once the mother's illness is improving. This form of psychosis is a more likely scenario than an all-new sudden psychosis postpartum. See psychosis case scenario below.

Psychosis: a case scenario

Gill had a history of schizoaffective disorder. She was 28 and had been intermittently ill since the age of 18 when she had run away to London and worked for a time in the sex industry. She had been diagnosed with a 'drug-induced psychosis' when she was 20, but since then had been admitted three times under section 3 of the Mental Health Act. Over the past eight years she had been out of hospital for only three. For the last two years she had been living in a flat and had a boyfriend staying with her, who was also a service user. She had been maintained on depot injections of risperidone and on oral sodium valproate. She had wanted a child, however, and stopped her medication. A few months later she became pregnant. She was managing off medication for six months when her partner left her; thereafter she started to become chaotic in her behaviour, dancing in the street in the early hours of the morning and singing songs about the Virgin Mary. Gill was admitted to a mixed acute psychiatric ward, on another section 3 but was assaulted by a male and felt intimidated and fearful for her baby, which she insisted was an 'immaculate conception'. She said she was hearing the voices of the Virgin Mary and of her husband Joseph talking to her (second person auditory hallucinations) and that they told her to be 'joyous' and 'to stay awake and refuse the devil's medication' (command hallucinations). She became agitated and upset when staff challenged her ideas, and when a member of staff tried to give her some diazepam to calm her she assaulted the nurse with a chair, breaking her jaw. Gill was subsequently admitted to an all-female psychiatric intensive care unit. Initially, staff attempted to manage her without medication, but Gill was highly disturbed and not sleeping. There was discussion about the risks posed by any rapid tranquilisation or regular antipsychotic to the baby (in the second trimester now), but it was felt that the mother's mental health needs and physical risks to the baby of violence outweighed these risks and medication was administered. There was a gradual response over the next few weeks, but Gill's insight was so poor that she was adamant she would discontinue medication as soon as she was discharged. As Gill approached the delivery date the consultant psychiatrist, key nurse and community care co-ordinator from the psychiatric team met with Gill's consultant obstetrician, hospital midwife and the specialist mental health midwife to formulate a birth plan with Gill as a team. The consultant psychiatrist began work with the Mother and Baby



Unit consultant to see whether Gill might be considered for a place following the birth of her baby. This follow up care was agreed. Gill remained in the Mother & Baby Unit (MBU) for 8 weeks and was then supported by the community mental health care team and a specialist Health Visitor.

Medication and breastfeeding We also need to bear in mind that following birth, babies may encounter any drugs that are secreted in breast milk. Manufacturers usually suggest that women taking psychotropic medication should avoid breastfeeding, and gathering research evidence on medication from breastfeeding mothers is difficult. Recent reviews have suggested that some SSRI antidepressants (but not fluoxetine) and Nortriptyline (a tricyclic antidepressant) may be relatively safe in breastfeeding mothers (Devanzo et al. 2011). However, lithium, nefazodone and doxepin should be avoided.

Conclusions

Most women experience pregnancy, childbirth and early motherhood without mental health problems. However, there is evidence to suggest that approximately one in seven women will experience a mental health problem in pregnancy or following birth. It is vitally important to meet the needs of these expectant and newly delivered mothers who either already have on-going mental health issues or are at risk of developing and experiencing them during pregnancy, childbirth and following birth. There is good evidence that a befriending approach and social support is beneficial to both pregnant women and newly delivered mothers. Local peer support is highly valued and appears to be a buffer against developing poor mental health. Trusting relationships are developed and this type of local support encourages and enables pregnant women and mothers to disclose their anxieties and fears. This also reduces the risk of feeling alone and being isolated within the local community. Health professionals need to work alongside these local community befrienders and offer support and help when the need arises.

Women who have an existing mental illness are at increased risk of relapse during pregnancy and after giving birth, therefore, pre-conceptual counselling and care is recommended. Health professionals need to be alert and continually assess these at-risk women and work collaboratively with the mental health team and other professionals to meet the needs of individual women. The recognition of mild to moderate mental health problems such as, anxiety and stress, panic symptoms, baby blues, antenatal depression, postnatal depression (including paternal), eating disorders, substance misuse and severe mental health conditions such as puerperal psychosis,





schizophrenia and bipolar disorder should be included in continual professional education.

Health professionals can help alleviate postnatal family mental health morbidity by addressing the issue of paternal depression. Recognising depression in fathers and enquiring about their own past history of depression and current symptoms may be worthwhile. In view of the repeated finding regarding couple or dyadic depression it would be good practice to screen the father for depression as well. For whatever reasons, including ignorance or overt sexism, male postnatal depression has been neglected in terms of recognition, treatment and research. It is time to address this neglected area to reduce morbidity in fathers and to prevent any adverse impact on the couple's relationship and their child's development. This will assist to tackle the novel concept of 'couple depression'.

Improved communication between health professionals and others is essential to meet the needs of women with mental health issues. Referrals and requests for support and specialised care must be followed up to ensure that women's needs are addressed effectively.

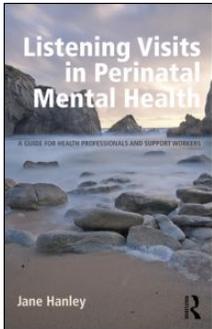


CHAPTER

3

Fathers and perinatal mental health

3. Fathers and perinatal mental health



The following is excerpted from *Listening Visits in Perinatal Health* by Jane Hanley. © 2015 Taylor & Francis Group. All rights reserved.

To purchase a copy, [click here](#).

Her: 'You never listen to me!'
Him: 'Yes I do'
Her: 'No you don't!'
Him: 'Yes I do!'
Her: 'No you don't!'
Him: 'Yes I do!!!'
Her: 'You never listen, so shut up!'

As this is a comparatively new area of research, there is limited data of the effects of paternal depression on the cognitive, motor, and socio-emotional development of infants. Some studies have highlighted the impact it may have and in Hong Kong, Koh (2014) found that the role of the father coupled with traditionalism–modernity could moderate the relationship between marital dissatisfaction and paternal anxiety and depression. Traditional fathers who were dissatisfied with their marriage were more susceptible to paternal anxiety and depression in late pregnancy and at six weeks postnatally. Studies in rural Vietnam found that although domestic violence is a crime, young women were still subjected to it and, as in the United Kingdom, it is associated with an increased risk of ante- and postnatal common mental health disorders. Fisher *et al.* (2013) and other researchers have advocated that as a result of these findings there should be community-based violence reduction strategies, which would concentrate on awareness and skills to reduce the incidence. This stresses the importance of the ability to access help in order to sustain and maintain good quality relationships throughout the perinatal period.

Managing men's mental health needs is somewhat different from managing those of women, as fathers who are depressed tend to direct their feelings towards anger, conflict and/or hostility. Their overall responsibilities in caring and childcare have often been marginalised by health workers and it is often evident that fathers tend not to seek help, but prefer to avoid contact or withdraw into escapist activities by overworking, indulging in sport, or self- medication, using alcohol or drugs (Veskrna 2010, Hanley 2013). Accepting this reactive behaviour can be difficult; nevertheless, Mark Williams, who has worked with men for several years, offers the following advice:

The importance of good communication skills cannot be overestimated when talking with fathers as men do not tend to be as communicative about distressful events as women. One of the main openings for a conversation is body language with non-verbal cues. The first fifteen seconds may be the difference between



creating an instant rapport with the father or creating a barrier. Talking with any father who is struggling to assimilate his thoughts can be difficult and therefore the health worker must have a certain level of knowledge and control. For many fathers it may be the first time that they are able to unload their problems, so it is important that their voice is heard.

ENVIRONMENT

There are several issues to consider before embarking on a listening visit with a father. The venue is important and ideally should be free of noise and distractions. If the room is full of other people, access to a quiet space or room is preferable. If in the family home and family members are anxious to take part in the conversation, ensure people sit in a triangular format to enable everyone to be seen and join in.

PERSONAL SPACE

When first introducing yourself it is essential to be aware of the space between you and the father, as some fathers may be uncomfortable having their space invaded by a stranger. Sitting opposite and at slight angle is normally the easiest way. Awareness of body language and the messages this conveys is significant, for example, folding your arms when talking to the father suggests that you are holding yourself back and being defensive. Avoiding eye contact or making no eye contact can make communication difficult for the father and suggest to him that you are disinterested in what he has to say. This can be evident with technology, as it is easy to be distracted by an iPhone or laptop computer. That momentary lapse of concentration and contact can have a significant impact on the father, particularly if he is feeling vulnerable, and any excuse which might indicate you are not listening will persuade him to shut down.

The tone of voice is crucial, both in one-to-one conversations and group discussions and can make a difference to the reaction of the father. Saying 'How are you?' with soft tones can come across differently from saying it in a brusque or harsh voice. When talking to fathers never search for something to say, as this can make the situation uncomfortable.

Talking and using body language are important to allow the father to gain trust. An acknowledgment of how the father is feeling can be as simple as a nod of the head. When talking to fathers it is important that they feel you understand their frustration. This can be as simple as 'I remember a friend going through a similar situation...'



Fathers need to convey how they are feeling, and will appreciate the use of open questioning, starting sentences with 'how?', 'when?', 'why?', 'where?', 'what?' and 'who?' will allow the father to feel he can reply. Non-verbal communication represents two-thirds of communication with fathers. First encounters or interactions with the father strongly affect his perception. When absorbing the message, they are focused on the entire environment using all five senses during the interaction: 83 per cent sight, 11 per cent hearing, 3 per cent smell, 2 per cent touch and 1 per cent taste. This is useful if there is a silent pause:

- 'What kind of support do you have from your family?' Pause ... eye contact. ...
- 'Where is the mother now?' Pause ... eye contact. ...
- 'How are you coping with all this?' Pause ... eye contact. ...

When talking to fathers, it is important to take into account how they acquire information. When trying to explain certain situations, some fathers would rather see it written down. It is important to ensure that the father has full view of what is being written, to give him the confidence to know that it is being interpreted correctly.

Listening skills are more necessary than talking skills. If a young father is telling you something that has just happened and you start talking over him, that conversation may be the last open and truthful conversation. If he does not think that you are fully listening then you will miss the underlying issues that are causing his distress. The father should feel that he is able to talk freely. One of the hardest things about fathers opening up about perinatal mental illness in the family is often the lack of education about the illness. The mother may ask the father not to discuss their family issues with anyone, to avoid social services being informed.

Studies have shown that it is positive to experience some anxiety, as a part of the body's make-up. It is okay to feel like that and there is little need to worry about feeling that way. Fathers who have never experienced anxiety before cannot understand why they should experience this, as having a newborn baby in the family should ideally be a happy time. There is often the feeling that anxiety is associated with terrible situations, but it is normal for the father to feel a little anxious, as this is something he truly cares about, the baby and the mother.

COPING SKILLS

In some cases, the fathers have developed negative coping skills and feel they are unable to cope. The provision of stories about personal situations can enable fathers to see similarities in their own lives. Many fathers feel isolated and that they are the only





ones who have experienced this. They need to understand that other fathers have had similar experiences. Nearly half of the fathers who have been in contact have developed negative coping skills within a few months of the mother developing perinatal mental health problems. It is helpful to provide the father with positive thoughts to which he can relate, for example from past experiences of helping others.

FURTHER VISITS

The essential messages should be at the beginning and the end of the conversation, ensuring the most important parts are at the end. The father is more likely to take in the last five minutes of the conversation than the middle part. The father should be aware that if he does not want to make the next appointment he must phone to cancel, and there should be a time limit for the cancellation period. Ensure they are aware how valuable (and free) the visit is, as often they may feel that it is less importance to cancel because it is free. It is important to consider a follow-up appointment and direct questioning will give you control. For example:

‘So John, I can come and meet you on either Thursday or Friday?’ . . . Pause . . . Wait until he answers.

GROUPS

When working with groups of fathers, ground rules should be set at the beginning. It is more relaxed sitting in a circle where everyone is able to be seen. The chair of the facilitator (health worker) should be slightly to the front to enable all the fathers to be seen and to assist with communication. Group confidentiality must be ensured before each meeting, as this will provide fathers with the confidence to open up about their true feelings. Protocols should be enforced about the use of social media and the importance of not divulging any information about the group or individual fathers. The group should be made aware of their safety risks as sometimes there may be more underlying issues than just perinatal mental health in the family and it must be reinforced that the support you are giving is only for their mental well-being.

Open discussions can be begun by anyone in the group. Not all fathers in the group will talk openly, so it's good practice to offer one-to-one support either before the next meeting or at the end. Sometimes a father may monopolise the group, talking longer than necessary about his family's problems. Giving the father a pen to hold as an indication that he is the only father who has a right to talk normally stops others talking over and among themselves. Dress is important. Prior to convening a fathers' support group, consideration should be given to what is worn as this can make an



impact. Casual smart appears to be the more acceptable. If the group feels the health worker is inappropriately dressed, this will determine how they will react, which can sometimes be in a negative way.

Fathers like to see their concerns listed on paper and during each group session each concern is discussed within a certain time scale. Coping skills such as mindfulness and cognitive behavioural therapy help them to understand that there is an avenue for extra help.

Group sessions and support for the facilitator

It is useful to bring in another health worker to the group who can also be involved in the duty of care to the fathers. Some fathers have struggled with a lack of support and this can come across in group sessions. Fathers can bring negative issues revolving around coping skills. Fathers can be signposted to the support they need for problems with alcohol or severe social anxiety.

Sub-groups

The fathers are welcome to form sub-groups outside of the main group, while ensuring the strict group rules are applied and enforced. Anecdotal evidence has suggested that men, unlike women, prefer to discuss their more intimate thoughts while they are occupied and situated side by side. For example, two men together digging up the road, or sharing a game of football, where they feel the environment is safe and secure. In recognition of this behaviour, several groups are adapting this idea by forming 'men sheds'. This initiative copies the idea of a shed, but is larger, where men can feel safe and pursue their practical interests. Groups of men are able to share the tools and resources necessary to work on the projects they choose to work on. It provides a friendly, inclusive atmosphere which allows men to talk openly and freely about issues or problems which have been a source of distress (UK Men's Sheds).

TELEPHONE LISTENING

Listening allows fathers to unburden their worries. When talking to fathers over the telephone it is worth ascertaining if it is appropriate to phone them back on the telephone they are currently using.

Talking to fathers over the telephone can be difficult as facial expressions cannot be seen. This is important if something is said which triggers a negative reaction. Ensure a note pad is available to take notes, and make sure the father is aware of what you are doing. Always clarify what has been said as sometimes the father may be worried,



anxious or feel low, making him difficult to understand.

If the father is expressing suicidal thoughts, he must be directed to a helpline telephone number and advised that he must phone this at the end of your phone call, and ensure he attends the next support group. Personal mobile phone numbers should never be revealed to either fathers or families, as, for instance, if the father is expressing suicidal ideation and is unable to contact you, he may leave a suicide note as a text.

Creating a rapport with the father enables him to connect with you. Although this is a technological age people still need to connect with people. It should feel as if you are selling him a wonderful service which will get the right results. A confident pace and tone of voice will assure the father you can deliver the right messages and understand the problems he faces. Ensure the last few phrases of your conversation are assuring. For example:

- 'John, I'm going to find out what debt advisors are really helpful in your area.'
- 'John, I know you're finding it hard to cope at the moment, but I am able to help you to put something in place.'
- 'John, I'm going to meet up with you next week, what time is best?'
- 'John, where shall we meet next week?'

EXERCISE 5.1

Ten top tips for fathers

- Educate yourself about this illness; there are so many sites on perinatal mental health.
- Talk to family and friends; tell them how you are really feeling. Educate them too.
- Exercise and eat healthily.
- Look for support and for other fathers going through this illness ... Don't isolate yourself.
- Support you partner and keep assuring her you will both get through this together.
- Interact with your newborn and children as much as you can ... both walks and fresh air are good.
- Look at coping skills like relaxation classes; avoid using alcohol to cope with stress.



- 
- If you're feeling low make sure your first call is your GP, and seek other advice if your GP does not understand.
 - Remember in the next ten years 1 million families in the UK will experience this illness.
 - Remember this is an illness, like any other illness. Don't suffer in silence.

Top 10 tips for health workers

- Ask the father how he is coping.
- Provide the father with information about perinatal mental health.
- Ask him if there is support from family and friends.
- Let the father talk, and listen.
- Empathy and the assurance that many other fathers have the same experience is vital.
- Due to timescale for health visitors, it is important to have some preparation on coping skills, websites on perinatal mental health and support groups in the area.
- Never make promises you can't keep; be honest, this will help to develop the rapport.
- Encourage the family to go for walks and interact with the newborn/children.
- Ensure the family knows that thousands of families go through this illness and the quicker the help, the quicker the recovery.
- Make a point that it is important that both parents are included in this care.

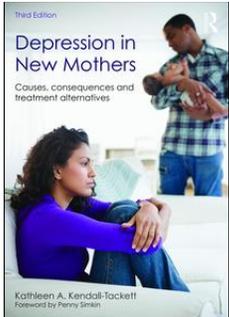


CHAPTER

4

Breastfeeding and mother–infant sleep

4. Breastfeeding and mother–infant sleep



The following is excerpted from *Depression in new mothers* by Kathleen A. Kendall-Tackett. © 2016 Taylor & Francis Group. All rights reserved.

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Unfortunately, some postpartum depression advocates consider breastfeeding a risk factor for depression. Based on this belief, mothers are often urged to quit in order to recover. Some of these same providers argue that even if mothers say they want to continue, what we really need to do is give them “permission” to quit. When actress Brooke Shields experienced postpartum depression, her family strongly urged her to stop breast-feeding. She adamantly refused because she felt that breastfeeding was the one thing that was helping her to hang on to her sanity.

Both my mother-in-law and my mother suggested that I stop breastfeeding to give myself a break. In fact, the consensus seemed to be that I give up the baby on the breast and move past that added pressure. But what nobody understood was that the breastfeeding was my only real connection to the baby. If I were to eliminate that, I might have no hope of coming through this nightmare. I was hanging on to breastfeeding as my lifeline. It was the only thing that made me unique in terms of caring for her ... Without it, she might be lost to me forever. (Brooke Shields, 2005, pp. 80–81)

While advice about weaning is usually well-intended, the evidence does not support it. So the question we need to ask is whether women need to wean in order to recover from depression. When providers urge mothers who want to continue to quit, breastfeeding can become a barrier to treatment. Mothers may delay or avoid seeking treatment because they believe that they will be told to wean. In my experience, this fear is realistic: practitioners often do tell mothers to wean.

What these practitioners often fail to realize is that breastfeeding actually protects maternal mental health. If women want to continue, and it is always their choice, we should support them because it will aid in their recovery.

Breastfeeding confers survival advantage by protecting mothers’ mental health

Previous studies have found that breastfeeding mothers actually have lower rates of depression than their non-breastfeeding counterparts (Dennis & McQueen, 2009; Groer, Davis, & Hemphill, 2002). Breastfeeding protects maternal mental health because it down regulates the stress response. This down regulation confers a survival advantage by protecting the breastfeeding mother and directing her toward milk production, conservation of energy, and nurturing behaviors (Groer et al., 2002). Hormones related to lactation, such as oxytocin and prolactin, have both antidepressant and anxiolytic



effects (Mezzacappa & Endicott, 2007).

A more recent review from Brazil noted that we now better understand the processes by which breastfeeding protects mothers' mental health. They described possible mechanisms by which breastfeeding might protect maternal health in more detail:

1. by promoting hormonal processes that attenuate the cortisol response to stress (particularly the effects of prolactin and oxytocin),
2. by regulating sleep for mother and child,
3. by increasing mother's self-efficacy and emotional connection with her baby,
4. by reducing difficulties related to child temperament, and
5. by promoting better mother–infant interaction

(Figueiredo, Dias, Brandao, Canario, & Nunes-Costa, 2013)

In addition, depressed, breastfeeding mothers are less likely to have babies with highly reactive temperaments, compared with depressed, bottle-feeding mothers. Further, breastfeeding mothers have more physical contact and positive play with their infants, and vocalize more than their bottle-feeding counterparts (Figueiredo et al., 2013).

A study of 137 women from the United Arab Emirates found that formula-feeding mothers had more depressive symptoms at 2 and 4 months postpartum than their breast-feeding counterparts (Hamdan & Tamim, 2011). The researchers found that women had lower scores on the EPDS if they were “breastfeeding at all,” and breastfeeding at the time of the assessment. Further, the more frequently that a woman breastfed, the lower her scores on the EPDS.

Similarly, a study of 2,072 women from Malaysia also examined the relationship between exclusive breastfeeding and postpartum depression at 1 and 3 months postpartum (Yusuff, Tang, Binns, & Lee, 2016). In this study, mothers were assessed with the EPDS. Approximately 46 percent of the mothers were exclusively breastfeeding at 3 months. The exclusively breastfeeding mothers had significantly lower EPDS scores at both time points than mothers who never breastfed, or who were not exclusively breast-feeding. This relationship remained significant even after controlling for covariates.

In a sample of 209 women from Oklahoma, researchers examined risk factors associated with a score >13 on the EPDS (McCoy, Beal, Shipman, Payton, & Watson, 2006). Formula-feeding doubled the risk of depression. Other significant risk factors included a history of depression, and cigarette smoking. Breastfeeding is associated



with a significantly lower occurrence of postpartum depression. Approximately 39 percent of this sample had an EPDS score in the depressive range, possibly due to the high percentage of women living in poverty in this sample.

A prospective study of 205 pregnant women found that women who breastfed more frequently at 3 months postpartum had significantly lower depressive symptoms by 24 months (Hahn-Holbrook, Haselton, Schetter, & Glynn, 2013). Depression was measured at 5 points during pregnancy with the CES-D, and at 3, 6, 12, and 24 months with the EPDS, with a cutoff of >10. They also found that women who were depressed during pregnancy were significantly less likely to breastfeed than their non-depressed counterparts. They asked about “any” breastfeeding, number of feeds per day, the percentage of breast milk that made up the baby’s diet, and the percentage of breast milk that was pumped. Mothers who breastfed at least nine times a day had significantly lower rates of depression than mothers who breastfed less than four times a day. This relationship was still true, even after controlling for possible confounding variables, such as age, income, education, social support, and employment status. Mothers who were depressed weaned their babies an average of 2.3 months earlier than mothers who were not depressed.

Breastfeeding and the stress response

A study of 43 breastfeeding women found that both breastfeeding, and holding their babies without breastfeeding, significantly decreased ACTH, plasma cortisol, and salivary-free cortisol (Heinrichs et al., 2001). Breastfeeding and holding the infant led to significantly decreased anxiety, whereas mood and calmness improved only after the baby was at the breast. In response to an induced stressor, breastfeeding suppressed the HPA axis, and provided a short-term suppression of the stress response. The researchers argued that this short-term suppression provided several evolutionary and biological advantages: it isolated the mother from distracting stimuli, facilitated her immune response, protected the baby from high cortisol in the milk, and prevented stress-related inhibition of lactation.

Groër and Morgan (2007) found, in a study of 200 women at 4–6 weeks postpartum, that depressed women were significantly less likely to breastfeed, had significantly lower serum prolactin levels, and had more life stress and anxiety. A more recent study of 63 primiparous mothers at 2 days postpartum had similar findings (Handlin et al., 2009). In this study, both ACTH and cortisol were measured. They found that breastfeeding lowered ACTH and cortisol, and that skin-to-skin contact contributed to these effects. ACTH was negatively correlated with duration sucking, but cortisol decreased in relation to skin-to-skin contact that proceeds breastfeeding. The longer





the skin-to-skin contact went on, the lower the cortisol levels. Oxytocin also plays an important role in reducing ACTH and cortisol during breastfeeding.

One-hundred nineteen women were recruited during pregnancy, and followed through 6 months postpartum (Ahn & Corwin, 2015). They were assessed during the third trimester of pregnancy, on days 7 and 14 postpartum, and at 1, 2, 3, and 6 months. Pro- and anti-inflammatory cytokines were measured, as were depression and self-reported breastfeeding. The rates of breastfeeding “most of the time” were 92 percent at day 7, and 71 percent at 6 months—well over the national averages in the US. The researchers found that depression, or perceived stress, did not significantly differ for breastfeeding vs. bottle-feeding mothers at 6 months, possibly because the rates of breastfeeding were so high. However, salivary cortisol levels at 8 a.m. and 8:30 a.m. were higher (indicating that the HPA axis was functioning well), and IL-6 was lower, for the mothers predominantly breastfeeding at 6 months. One factor that may have made a difference in this study was their measure of breastfeeding. “Predominant breastfeeding” is not the same as exclusive breastfeeding from a physiological standpoint. Previous studies have found that supplementing exclusive breastfeeding lessens breastfeeding’s stress-reduction effects (Kendall- Tackett, Cong, & Hale, 2011).

Breastfeeding’s downregulation of the stress response appears to have long-term effects, and it likely explains another set of recent findings regarding cardiovascular disease (Schwartz et al., 2009). This study included 139,681 postmenopausal women (mean age = 63 years). The researchers found that women with a lifetime history of breastfeeding for more than 12 months were less likely to have hypertension, diabetes, hyperlipidemia, or cardiovascular disease than women who never breastfed. This was a dose–response relationship: the longer women lactated, the lower their cardiovascular risk. The authors noted that lactation improves glucose tolerance, lipid metabolism, and CRP.

Similarly, Stuebe and colleagues (2011) found that women who breastfed their first child ≥ 12 months were less likely to develop hypertension, and women who never breast-fed were more likely to develop hypertension than women who breastfed 6 months or longer. Their sample was 55,636 women from the US Nurses’ Health Study II. They concluded that 6 months of exclusive breastfeeding, or >12 months of total breastfeeding per child, reduced the risk of hypertension.

Because stress is related to the onset of depression, Mezzacappa and Endicott (2007) examined the impact of parity and whether it mediated the effect of feeding method on maternal stress. This study compared primiparae who were breast- or



bottle-feeding, and multiparae who were breast- or bottle-feeding. Breastfeeding had greater stress-reducing effects, and oxytocin levels were higher, on multiparous women than primiparous women. For primiparas women, 35 percent of bottle-feeding and 16 percent of breastfeeding mothers were depressed. Among multiparas women, 37 percent of the bottle-feeding and 12 percent of breastfeeding women were depressed. The authors indicated that parity was a critical factor mediating the effect of lactation on depression.

Breastfeeding appears to also influence infants' emotional development, and less exclusive breastfeeding (EBF) may bias them toward more negative information processing, which could make the infants more vulnerable to stress and depression. In a recent study of 28 8-month-olds, exclusive breastfeeding had an impact on infant brain development (Krol, Rajhans, Missana, & Grossman, 2015). Half of the infants were classed as low exclusive breastfeeding (12–152 days), and half were high exclusive breastfeeding (167–252 days). The results indicated that amount of exclusive breastfeeding was related to infants' neural processing of images of happiness or fear. Babies who exclusively breastfed longer paid more attention to happy stimuli than those with shorter duration of EBF. In contrast, infants with shorter EBF showed a negativity bias, responding more to the fear stimuli and less to the happy stimuli. The authors speculated that EBF affects central oxytocin levels in infants, and thereby impacts emotional processing. Breastfeeding plays a role in infants' socioemotional development and biases them towards either positive or negative information.

Another recent study highlights why it is important to address depression and anxiety promptly. This study examined the relationship between depression and anxiety in 81 breastfeeding mothers, and how those conditions affected the immune qualities of breast milk (Kawano & Emori, 2015). Negative mood states, such as depression and anxiety, lowered secretory IgA (SIgA) levels in breast milk, but positive mental state did not influence it. They recommended that mothers with depression or anxiety receive support, and did not suggest that they wean.

Depression and breastfeeding cessation

Women who encounter breastfeeding problems are at increased risk for depression. Conversely, depression increases the risk for breastfeeding cessation. A review by Field (2010) found that depression impaired a wide range of caregiving practices, including breastfeeding, sleep routines, well-child visits and vaccinations, and safety practices.

Breastfeeding cessation in depressed mothers may also have a physiological basis. A study from Japan conducted an *in vitro* study on the effects of the three



proinflammatory cytokines most commonly seen in depression—IL-1b, IL-6, and TNF-a—on mice mammary epithelial cells (MECs) (Kobayashi, Kuki, Oyama, & Kumara, 2016). They found that TNF-a downregulates lactose synthesis, IL-1b caused degradation of glucose transporter 1 from the membranes of the MECs, and IL-6 both upregulated and downregulated expression of lactose synthesis-related genes of the MECs. Each of these cytokines influences the lactose synthesis pathways, but in different ways. In other words, depression may have a negative impact on milk supply.

A study of 168 women in south eastern Brazil found that depressed women were more likely to stop exclusively breastfeeding at 2 months postpartum (Machado et al., 2014). The sample was assessed at 1, 2, and 4 months postpartum, and the EPDS was used at 1 and 2 months, with a cutoff ≥ 12 . Depressive symptoms and traumatic deliveries both predicted lack of exclusive breastfeeding at 2 months.

A study of 226 women from Barbados also showed a relationship between depression and breastfeeding cessation (Galler, Harrison, Ramsey, Chawla, & Taylor, 2006). This study assessed women's feeding practices and attitudes in the first 6 months postpartum. If women believed that breastfeeding was better than bottle-feeding, they had lower rates of depression at 7 weeks and 6 months postpartum. Mothers with depressive symptoms were less likely to believe that breastfeeding was better for infants, and more likely to believe that breastfeeding was private and restrictive. Even after controlling for maternal feeding attitude, maternal mood at 7 weeks was still significantly associated with infant feeding practices at 6 months.

A Turkish study showed similar results (Akman et al., 2008b). In this study, 60 mothers of newborns were enrolled prospectively. Mothers and babies were assessed at 1 and 4 months postpartum. The percentage of mothers exclusively breastfeeding was high: 91 percent at 1 month and 68 percent at 4 months. Mothers with higher EPDS scores at Time 1 were less likely to be breastfeeding at Time 2.

A study from Pakistan produced results that were consistent with the other studies (Taj & Sikander, 2003). This sample included 100 women with breastfeeding-age children ranging from 2 months to 2 years. Thirty-eight percent of these women had stopped breastfeeding, and their average scores on the Urdu version of the Hospital Anxiety and Depression Scale (HADS) were 19.66, compared with 3.27 for the breastfeeding women. Of the women who had stopped breastfeeding, 37 percent reported that their depression had preceded breastfeeding cessation. The authors concluded that maternal depression caused mothers to stop breastfeeding.





Women were assessed for depression with the EPDS at 6 and 12 weeks postpartum ($N = 185$) in another study (Hatton et al., 2005). At 6 weeks, depressive symptoms were related to lower rates of breastfeeding. This relationship persisted even after controlling for prior history of depression, life stress, and current antidepressant use. There was no relationship between breastfeeding and depressive symptoms at 12 weeks postpartum. The authors concluded that depressive symptoms in early postpartum may lead to early breastfeeding cessation. They offered several possible explanations for their findings, including that depressed women may not have initiated breastfeeding, or that early depression impacted milk production or let down. They also noted that stressful life events can have a negative impact on breastfeeding, and are also predisposing factors for postpartum depression.

In a qualitative study of 12 women from Ghana, and three focus groups with new mothers, fathers, and grandmothers, the impact of depression on breastfeeding was universally acknowledged (Scorza et al., 2015). The study participants often described depression as “thinking too much” to reflect the ruminations that are common in depression. One woman described the impact on breastfeeding: “she thinks too much, the child doesn’t get breast milk to suck because breast milk is not available.” Grandmothers reported that women without happiness cannot, or will not, breastfeed their babies. Babies may also refuse to feed if “a woman has not happiness, her baby can see that her mother is sad by looking at the mother’s face, in which case the baby would not breastfeed.” Fathers also described this link by noting that depressed women become withdrawn and do not eat. If they do not eat well, they cannot produce enough milk for breastfeeding.

A US nationally representative sample of 1,271 mothers, who were part of the Infant Feeding Practices Study II, found that 31 percent met criteria for mild depressive symptoms (Bascom & Napolitano, 2016). The researchers found that women with depressive symptoms had significantly shorter overall breastfeeding, and shorter EBF. Depression was measured using the EPDS >9 . Sixty-nine percent stopped breastfeeding before 6 months, with “too many household duties” cited as the most common reason. Sore nipples were also more common in the depressed mothers.

A study from Canada had similar results (Dennis & McQueen, 2007). This sample included 594 community women who were surveyed at 1, 4, and 8 weeks postpartum. The women were surveyed about their feeding method and depressive symptoms on the EPDS. The researchers found no relationship between maternal mental health and feeding method at 1 week postpartum. However, mothers with an EPDS score of >12 at 1 week postpartum were significantly less likely to be breastfeeding at 4 and 8 weeks.



They were also more likely to be unsatisfied with their infant feeding method, experience serious breastfeeding problems, and report lower levels of breastfeeding self-efficacy. Mothers who thought breastfeeding was “progressing terribly” at week 1 were more likely to develop depressive symptoms. However, when depression was removed from this analysis, the effects disappeared. The authors felt these findings reflected depressed mothers’ moods and cognitions, rather than objective problems. They concluded that early identification of mothers with depressive symptoms can both halt morbidity associated with depression, and increase breastfeeding duration.

One factor that might contribute to the link between breastfeeding cessation and depression is epidural anesthesia. In our study of 6,410 new mothers, women who had had an epidural had higher rates of depressive symptoms, even after controlling for other risk factors for depression (such as other birth interventions, and history of depression or sexual assault) (Kendall-Tackett, Cong, & Hale, 2015). (Our study is described in more detail in Chapter 8.) We also found that women who had had epidurals were significantly less likely to be exclusively breastfeeding.

A prospective study of 1,280 women from Australia had similar results (Torvaldsen, Roberts, Simpson, Thompson, & Ellwood, 2006). They found that women who had an epidural were more likely to be partially breastfeeding, and have breastfeeding difficulties in the first week, than women who did not have an epidural. The results of these two studies indicate a possible link between epidurals and lower rates of breastfeeding, which increases the risk of depression. Further studies will need to examine possible causal links.

Mothers’ intention to breastfeed

Intention to breastfeed has also been the focus of recent studies. Mothers in the Avon Longitudinal Study of Parents and Children in the UK indicated that intention to breastfeed was an important risk factor in postpartum depression (Borra, Iacovou, & Sevilla, 2015). Depression was measured during pregnancy with the EPDS ≥ 14 , and postpartum EPDS ≥ 12 . In this longitudinal study of 14,000 mother–infant pairs, mothers who were not depressed during pregnancy had the lowest risk of depression if they planned to breastfeed their babies, and actually were able to do it. The mothers at highest risk were those who planned to breastfeeding and could not. They also found that mothers who had not intended to breastfeed, but actually did, were at increased risk of depression. The authors noted that depression is mediated both by breastfeeding intentions and mothers’ mental health during pregnancy. They recommended that mothers be given access to skilled breastfeeding support, and mothers who intended



to breastfeed, but could not, be given compassionate care. A recent study from the US also found that mothers' expectations about breastfeeding made a difference with regard to depression. In this study, 1,501 mothers from the Infant Feeding Practices Study II were included if they intended to exclusively breastfeed (Gregory, Butz, Ghazarian, Gross, & Johnson, 2015). Only 39 percent were able to exclusively breastfeed, and 23 percent had depressive symptoms (EPDS ≥ 10). The researchers found that mothers who met their prenatal expectations had fewer PPD symptoms than mothers who did not. Interestingly, this was only true for the middle- and upper-income mothers, but not for the lower-income mothers. Breastfeeding pain in the first 2 weeks was also related to depression.

Nipple pain, depression, and breastfeeding cessation

A study from Melbourne, Australia found that nipple pain was relatively common in the first 8 weeks postpartum (Buck, Amir, Cullinane, Donath, & the CASTLE Study Team, 2014). This study included 340 primiparous women that were part of the prospective cohort study. After hospital discharge, 79 percent reported nipple pain. During the 8-week study, 58 percent reported nipple damage, and 20 percent reported vasospasm. By 8 weeks, the situation had improved for most of the mothers, with only 8 percent reporting nipple damage and 20 percent reporting pain. Surprisingly, despite this high rate of nipple pain, 94 percent were continuing to breastfeed.

In a study of 2,586 women who reported “ever breastfeeding,” 9 percent had an EPDS score ≥ 13 at 2 months postpartum (Watkins, Meltzer-Brody, Zolnoun, & Stuebe, 2011). Women who disliked breastfeeding at 1 week were more likely to be depressed at 2 months. In addition, women who experienced breastfeeding pain on day 1, week 1, or week 2 were more likely to be depressed at 2 months. Severe pain doubled the odds of postpartum depression. Women who were depressed at 2 months were significantly less likely to still be breastfeeding. However, breastfeeding help appeared to protect women's mental health when the women had moderate to severe pain. The authors concluded that women who had negative early breastfeeding experiences were more likely to have depressive symptoms at 2 months postpartum, but that breastfeeding helps attenuate those effects.

Anxiety and breastfeeding cessation

Postpartum anxiety can also impact breastfeeding initiation and duration (Britton, 2007). In a study of mothers at discharge and 1-month postpartum, pre-discharge anxiety was inversely related to breastfeeding confidence. Mothers who were high in post-discharge anxiety were less likely to be fully or exclusively breastfeeding, and





were more likely to have stopped breastfeeding at 1 month.

A study of 852 pregnant women in Brazil (Rondo & Souza, 2007) found that distress and worry about breastfeeding, concern about body changes, and work outside the home were negatively related to intention to breastfeed. However, depression and anxiety scores were not related to intention to breastfeed.

A study from India found significant levels of anxiety and depression in their sample of 85 new mothers measured by the HADS (Arinfunhera et al., 2015). The researchers found the HADS depression score, low birthweight, and lower income were all independent predictors of poorer attitudes towards breastfeeding. Anxiety did not emerge as an independent predictor of breastfeeding attitudes.

One hundred twenty-two depressed women described their breastfeeding experiences (McCarter-Spaulding & Horowitz, 2007). The researchers collected data during three home visits. They noted that in this sample, severity of depression was not related to breastfeeding, but older maternal age, living with a partner, and higher income were. Maternal education was the most important predictor of exclusive breastfeeding, and combination feeding. Depression was most severe at the 4- to 6-week assessment, dropping off after that. By 14–18 weeks postpartum, 78 percent had EPDS scores below the cutoff. All of the women were encouraged to seek outside care for their depression, but only 11–12 percent had gone to psychotherapy, and 3–6 percent had used medications.

In terms of breastfeeding patterns, by 14–18 weeks, EBF had dropped from 34 percent to 22 percent. At 14–18 weeks, 33 percent were using a combination of feeding methods, and 45 percent were exclusively formula-feeding. They noted that their findings of high breastfeeding rates, despite severity of their postpartum depressive symptoms, are consistent with previous research that suggests a link between depression and early weaning. What depression seemed to affect was EBF, which was lower than in the larger sample from which they were drawn (McCarter-Spaulding & Horowitz, 2007).

In a qualitative review of 49 articles that specifically examined the link between depression and breastfeeding, Dennis and McQueen (2009) found that in early postpartum, depressive symptoms decreased breastfeeding duration, increased breastfeeding difficulties, and decreased breastfeeding self-efficacy. Further, depressed women may be less likely to initiate breastfeeding, and to breastfeed exclusively. Mothers with depressive symptoms were more likely to discontinue breastfeeding



earlier than non-depressed mothers. Depressive symptomatology was related to lower breastfeeding self-efficacy, demonstrating that depressed mothers were less confident in their ability to breastfeed.

Stuebe and colleagues hypothesized that perinatal depression and lactation failure may share common neuroendocrine mechanisms (Stuebe, Grewen, Pedersen, Propper, & Meltzer-Brody, 2012). Possible physiological mechanisms include estrogen and progesterone; oxytocin and prolactin; hormones related to stress reactivity, such as CRH, ACTH, and cortisol; pain perception; thyroid; and infant development, such as temperament and oromotor development, which can affect ability to latch. They recommended that future studies address the overlap between maternal depression and breastfeeding difficulties, understanding that they may come from the same underlying etiology.

Sleep, feeding method, and maternal mental health

As described in the previous chapter, sleep has a major impact on maternal well-being. For example, in a study of 245 pregnant women, sleep problems were the strongest predictor of poorer health-related quality of life (Da Costa et al., 2010). Depressed mood was associated with more bodily pain, and poorer general health, vitality, social functioning, and emotional health. Sleep problems also predict new-onset depression and anxiety disorders. In a non-postpartum sample of 9,683 young women from Australia, researchers found that sleep problems at Time 1 predicted that depression was two to four times more likely 3–9 years later. Anxiety risk also doubled 6–9 years later (Jackson, Sztendur, Diamond, Byles, & Bruck, 2014).

Amount of sleep also makes a difference. In a prospective study of 112 couples recruited during the third trimester of pregnancy, sleeping <4 hours between midnight and 6 a.m., spending more than 2 hours awake during that time, and napping <60 minutes during the day increased the risk of depression at 3 months postpartum (D. Goyal, Gay, & Lee, 2009). Depression was assessed with the CES-D ≥ 16 . Twenty-eight percent had depressive symptoms. Infant temperament did affect mothers' sleep, but was not associated with depression. In addition, variables such as maternal age, income, education, sex of the infant, feeding method, delivery type, and satisfaction with their relationship with their partners accounted for 15 percent of the variance in depression.

Another longitudinal cohort study of 1,840 women from Norway followed the mothers from week 32 of pregnancy to year 2 postpartum (Sivertsen, Hysing, Dorheim, &



Eberhard-Gran, 2015). The rate of insomnia was 60 percent at 32 weeks gestation and at 8 weeks postpartum, and dropped to 41 percent at year 2. Sleep duration ranged from 6 h 30 min to 7 h 16 min. Maternal depression did not explain the stability of sleep problems in these new mothers. The researchers noted that sleep problems in this sample appeared to be largely independent of comorbid postpartum depression, despite the close inter-relationship of these conditions.

Sleep characteristics of depressed mothers

Ross et al. noted that several factors suggest a relationship between sleep problems and depression in postpartum women (Ross, Murray, & Steiner, 2005). These are as follows:

1. Insomnia is a significant risk for new-onset depression.
2. Sleep disturbances are common in most psychiatric disorders.
3. Treatments that manipulate sleep and circadian rhythms can be used to treat mood disorders.

In a review of polysomnographic studies of postpartum women, Ross et al. (2005) noted that sleep differed in some distinct ways for women at risk for postpartum depression, or who have current postpartum depression—reduced REM latency, increased total sleep time during pregnancy, and decreased total sleep time postpartum for the women who are depressed. REM latency refers to the time during the night when REM sleep becomes the predominant pattern. A pattern of reduced REM latency means that REM occurs earlier in the nightly sleep cycle, and is a symptom of depression. As a result of these sleep disturbances, women are more fatigued during the day, and they also have more bodily pain. The authors noted that these changes may represent an underlying vulnerability to depression as they do with non-postpartum populations. They also noted that women with a history of affective disorders may be more sensitive to the normal physiologic changes of pregnancy.

A study with 425 mothers from Canada found that mothers with postpartum major depression reported substantially poorer sleep than their non-depressed counterparts at 4–8 weeks postpartum (Dennis & Ross, 2005). The mothers were assessed for depression at 1 week postpartum, and women who were depressed at that time point were excluded from the study to eliminate pre-existing depression as a cause of sleep problems. Mothers with an EPDS >13 at 1 week were more likely to report that their babies cried often, that they were woken 3 or more times a night, and that they received less than 6 hours sleep in a 24-hour period. Further, they were more likely to report that their babies did not sleep well, and that their babies' sleep pattern did not allow



them to get a reasonable amount of sleep. Infant temperament mediated the relationship between infant sleep and maternal fatigue, with fussy babies sleeping less.

A Taiwanese study of 163 first-time mothers found that 50 percent were depressed at 13–20 weeks postpartum (Huang, Carter, & Guo, 2004). Depressed mothers had poorer sleep than non-depressed mothers. Half reported that their sleep quality was either “fairly bad” or “bad.” The average time it took for mothers to fall asleep was 26 minutes vs. 20 minutes for non-depressed mothers. Depressed mothers had overall poorer sleep quality, took more time to fall asleep, had a shorter sleep duration, and reported more daytime dysfunctions.

In a study of 46 mothers at 6–26 weeks postpartum, data were collected via questionnaire and wrist actigraphy for 7 days (Posmontier, 2008b). Half of the mothers were depressed. Postpartum depression was measured via the Postpartum Depression Screening Scale. The author found that women with postpartum depression had substantially poorer sleep quality than non-depressed women, and that as depressive symptoms increased, so did the sleep problems. Women with postpartum depression took longer to go to sleep (longer sleep latency), were more likely to wake after sleep onset, and had poorer sleep efficiency. She concluded that for women with postpartum depression, night time breastfeeding demands, high-needs infants, and little night time support may negatively impact sleep quality, and further exacerbate depressive symptoms. This was true, even though the non-depressed group was breastfeeding and had fewer night time wakings than the non-depressed group.

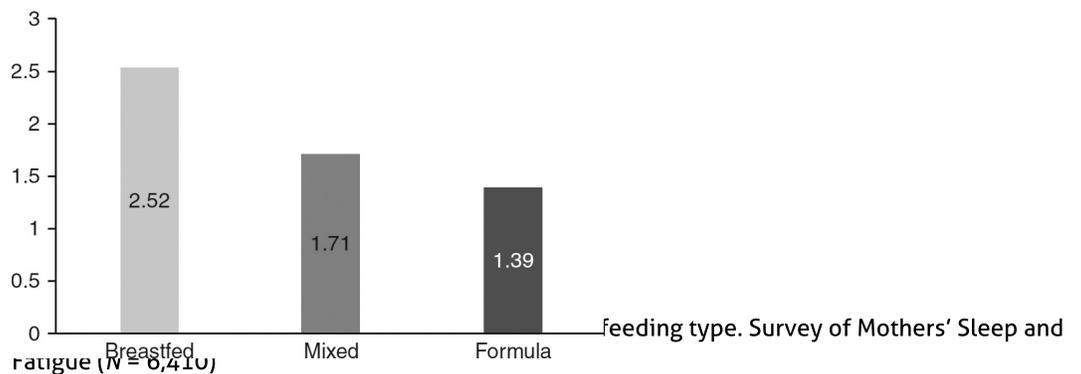
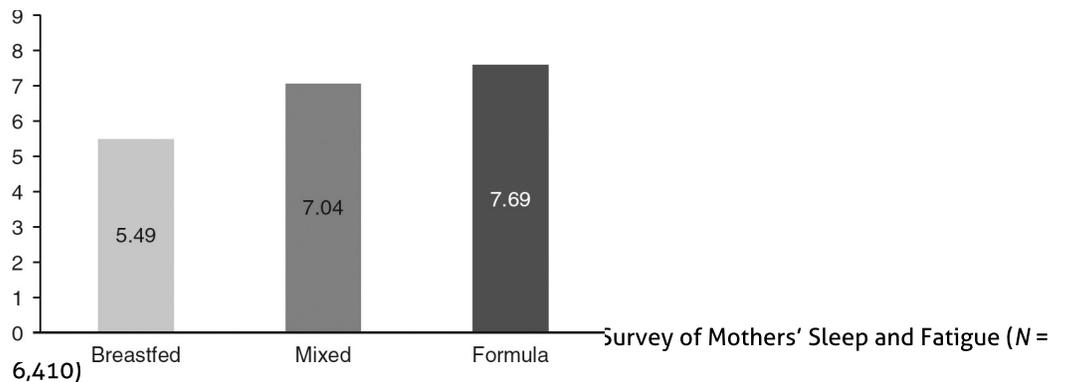
A longitudinal study of 124 primiparous women collected data during the last trimester, and at 1, 2, and 3 months postpartum (Goyal, Gay, & Lee, 2007). At Time 1, 26 percent had clinically high depressive symptoms. Depressed women had more sleep disturbance, trouble falling asleep, daytime sleepiness, and early awakening than women who were not depressed. The mothers who had the highest depression scores reported the most difficulty falling asleep. The author concluded that delayed sleep onset may be the most relevant clinical screening question to assess risk of postpartum depression.

Sleep, depression, and feeding method

Feeding method is yet another variable that we must consider in order to understand the complex relationship between depression and sleep problems. If mothers are breastfeeding, and they have any symptoms of depression, they are frequently told to supplement at night and eliminate night time breastfeeding so they can get more



sleep. This advice is more and more common in postpartum depression treatment programs and books written for



new mothers, but is this good advice? At first glance, it may seem to be. Because breast milk is lower in fat and protein than formula, we might assume that breastfeeding mothers sleep less than their formula-feeding counterparts, especially when you look at data like these from the Survey of Mothers' Sleep and Fatigue (Kendall-Tackett et al., 2011). You see something similar when examining the number of night time awakenings. Babies wake more often when they are breastfed. Looking at data like these, one could surmise that breastfeeding mothers get less sleep. However, recent research has revealed the opposite: that breastfeeding mothers actually get more sleep—particularly when the baby was in proximity to the mother.

Breastfeeding and maternal fatigue

The sleep patterns of 72 couples were compared from pregnancy to the first month postpartum via sleep diaries and wrist actigraphy (Gay, Lee, & Lee, 2004). Most of the mothers were at least partially breastfeeding (94 percent), and 80 percent were exclusively breastfeeding. Most of the babies slept in their parents' room, and 51 percent regularly slept in their parents' beds. Sleep and fatigue outcomes were not associated with type of birth, parent–infant bedsharing, or baby's age. Mothers who were exclusively breastfeeding had a greater number of night time wakings compared with mothers who were not breastfeeding exclusively, but slept approximately 20 minutes longer than mothers not exclusively breastfeeding. In a study of mothers and fathers at 3 months postpartum, data were collected via wrist actigraphy and sleep diaries (Doan, Gardiner, Gay, & Lee, 2007). The study compared the sleep of exclusively breastfed infants vs. those supplemented with formula. In this sample, 67 percent were fed exclusively with breast milk, 23 percent were fed a combination of breast milk and formula, and 10 percent were exclusively formula-fed. Mothers who exclusively breastfed slept an average of 40 minutes longer than mothers who supplemented. Parents of infants who were breastfed during the night slept an average of 40–45 minutes more than parents of infants given formula. Parents of formula-fed infants had more sleep disturbances. The researchers concluded that parents who are supplementing with formula under the assumption that they are going to get more sleep should be encouraged to breastfeed so they will get an extra 30 minutes of sleep per night. Dorheim and colleagues (2009) prospectively studied a group of 2,830 mothers at 7 weeks postpartum. They confirmed that poor sleep was a risk factor for depression. When examining the risk factors for poor sleep, they identified “not exclusively breast-feeding” as one of the risk factors. In other words, if mothers supplement, they get less sleep. The other factors associated with poor sleep included depression, previous sleep problems, primiparity, and having a younger or male infant.

A key question you can ask to find how a mother is doing is “How many minutes does it take for you to get to sleep?” If it takes her longer than 25 minutes, it could indicate that she is depressed. Asking about minutes to get to sleep (known as “sleep latency” in the sleep literature) is a non-intrusive way to ask about a mother’s mental well-being, and will give you a good deal of information about how she is actually feeling.

The key to understanding why breastfeeding makes a difference is understanding the two variables that make a difference in terms of mothers' risk for depression: minutes to get to sleep and total hours mothers report that they sleep. Three recent studies found that new mothers' perception of their sleep was a better predictor of fatigue and depression than objective sleep measures. For example, women were significantly more likely to report fatigue if they perceived that their sleep quality was poor, and their

sleep time was short, compared with women who were less fatigued in a sample of 109 postpartum mothers (Rychnovsky & Hunter, 2009).

Another study included 45 new mothers from Melbourne, Australia who were at low risk for postpartum depression (Bei, Milgrom, Ericksen, & Trinder, 2010). The researchers found that perceived sleep quality was more strongly related to postpartum depression than actual sleep time. Similarly, Caldwell and Redeker (2009) found that self-reported sleep was a better predictor of psychological distress than sleep measured objectively in 115 inner-city women from New Haven, Connecticut. A recent study of 25 new mothers in North Carolina had similar results (Park, Meltzer-Brody, & Stickgold, 2013). In this study, mothers completed self-report measures on sleep, and also measured sleep via actigraph (a more objective measure). They found that self-report measures highly predicted EPDS scores. Actigraph measures also predicted depression, but not as well as the mothers' self-report. The authors concluded that the subjective measures were by far the most accurate predictors of EPDS score. They also noted that disturbed sleep did contribute to postpartum depression.

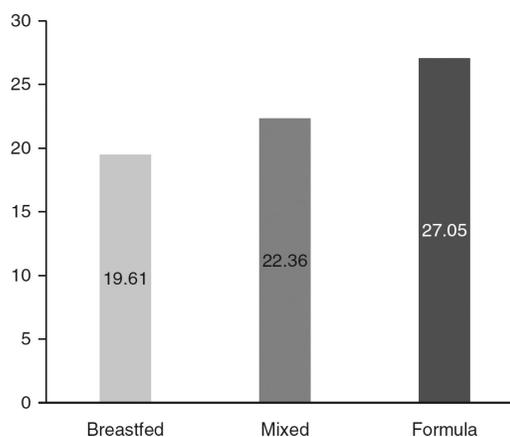


FIGURE 7.3 Minutes to fall asleep from the Survey of Mothers' Sleep and Fatigue ($N = 6,410$)

In our study, the Survey of Mothers' Sleep and Fatigue, 6,410 mothers in 59 countries completed an online survey about sleep location and behaviors, and maternal well-being. Minutes to get to sleep and total sleep hours are the two best predictors of maternal mental health. Exclusively breastfeeding women do significantly better on both indicators. For example, in minutes to get to sleep, exclusively breastfeeding mothers are under 20 minutes, the time associated with better mental health. In contrast, 25 minutes or longer is associated with depression (Goyal et al., 2007; Huang et al., 2004).



On the second key variable—mothers' report of the number of hours they sleep—breastfeeding mothers also do well. They sleep significantly longer than their mixed- or formula-feeding counterparts (Kendall-Tackett et al., 2011). These findings run counter to the advice mothers are often given, which is to supplement so they can sleep more. Our findings, as well as those of Doan et al. and Dorheim et al., suggest that once a mother supplements, she actually gets less sleep, not more (Doan et al., 2007; Dorheim et al., 2009; Kendall-Tackett et al., 2011).

Doan and colleagues (2007) noted the following with regard to sleep and breastfeeding.

Using supplementation as a coping strategy for minimizing sleep loss can actually be detrimental because of its impact on prolactin hormone production and secretion ... Maintenance of breastfeeding as well as deep restorative sleep stages may be greatly compromised for new mothers who cope with infant feedings by supplementing in an effort to get more sleep time. (p. 201)

Sleep quality may also be better for mothers who exclusively breastfeed. Blyton et al.'s sleep study compared 12 exclusively breastfeeding women, 12 age-matched control

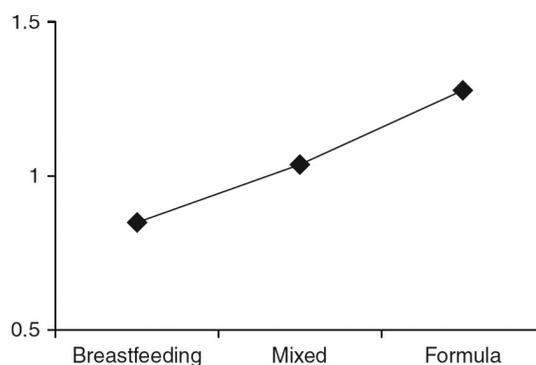


FIGURE 7.4 Exclusively breastfeeding mothers have lower depressive symptoms than their mixed- or formula-feeding counterparts (Kendall-Tackett et al., 2011)

women, and 7 women who were exclusively bottle-feeding (Blyton, Sullivan, & Edwards, 2002). They found that total sleep time and REM sleep time were similar in the three groups of women. The marked difference between the groups was in the amount of slow-wave sleep (SWS). The breastfeeding mothers got an average of 182 minutes of SWS. Women in the control group had an average of 86 minutes, and the exclusively bottle-feeding women had an average of 63 minutes. Among the breastfeeding women,

there was a compensatory reduction in light, non-REM sleep.

Inflammation and sleep

Sleep disturbances and fatigue are also related to cytokine levels. Both chronic and acute sleep deprivation alter cellular and immune function (Berk et al., 2013; Kiecolt-Glaser et al., 2015). Interleukin-1 β (IL-1 β) was related to fatigue in postpartum women (Corwin, Bozoky, Pugh, & Johnston, 2003). Corwin et al. collected measures of fatigue, and urinary excretion of IL-1 β over 4 weeks postpartum. The authors found that IL-1 β is elevated during the postpartum period, and that this elevation has a significant, though delayed, relationship to postpartum fatigue.

In a study of women 4–6 weeks postpartum, Groër and colleagues (2005) found that mothers' fatigue levels correlated with their levels of stress and depression. They also found that fatigue, stress, and depression increased the risk of infection for both mother and baby. Interestingly, this same study also found that mothers who were stressed, depressed, and fatigued had lower levels of prolactin in both their serum and milk. These same mothers also had higher levels of melatonin in their milk, the hormone that regulates circadian rhythms (Groer, 2005).

Possible interventions for fatigued new mothers

Breastfeeding mothers get more sleep and are less fatigued than mothers who supplement or wean. However, breastfeeding mothers can still be quite fatigued and may need some additional intervention to help prevent or treat depression.

Some approaches you might suggest

- Brainstorm with the mother on some strategies to help her cope with fatigue (e.g., encourage her to accept offers of help or access new sources of support).
- Treat depression.
- Use cognitive-behavioral sleep interventions.
- Use medications.
- If taking sleep medications, mothers should not bedshare with their infants.
- If mother has a trauma history, *The Post-Traumatic Insomnia Workbook* will likely be a helpful resource.

Rule out physical conditions

Severe fatigue may also be caused by an underlying physical condition. To rule out physical conditions, the following tests may be helpful.

- Blood work to rule out hypothyroidism, anemia, autoimmune disease, low-grade infection, or vitamin D deficiency.
- TSH, T3, T4, CBC, ESR (Sed rate), vitamin D.
- Possible sleep study to rule out sleep-breathing and sleep-movement disorders if other tests are negative and the mother's fatigue level has not improved.

If limiting feedings does become necessary, a stretch of 4–5 hours will meet mental health goals and be less disruptive of breastfeeding.

Reprinted with permission from Kendall-Tackett et al. (2011).

In another study of 200 women at 4–6 weeks postpartum, Groër and Morgan (2007) found that depressed mothers reported more fatigue and daytime sleepiness than non-depressed mothers. The depressed mothers had abnormally low levels of cortisol, which may also cause their fatigue. The authors describe how chronic fatigue syndrome, various chronic pain syndromes, and PTSD are also associated with low cortisol levels. The depressed mothers also had more health problems since the baby was born, and had more health-related events, such as sprains, dental pain, and allergies. They had higher levels of perceived stress, anxiety, and more negative life events. The serum IL-6 levels were three times higher in the depressed mothers, but this was not a significant difference because of measurement variability.

A study of 479 women at 6 months and 1 year postpartum found that mothers averaged 6.7 hours of sleep a night (Taveras, Rifas-Shiman, Rich-Edwards, & Mantzoros, 2011b). They found that sleep duration ≤ 5 hours per night in the first year post-partum predicted elevated IL-6 at 3 years postpartum.

In a study of 634 pregnant women from Peru, a history of childhood abuse increased the risk of stress-related sleep quality, and doubled the odds of poor sleep quality in early pregnancy, compared to non-abused women (Gelaye et al., 2015). Women who experienced both physical and sexual abuse during childhood had 2.43 times more risk of poor sleep quality and stress-related sleep disturbance in early pregnancy. These effects were only partially explained by ante-natal depression. The more abuse experiences a woman had, the worse her sleep.

Summary

Sleep disturbances and fatigue are physical stressors that increase the risk of depression. The relationship between sleep problems and proinflammatory cytokines appears to be bidirectional: sleep disturbances increase cytokines and cytokines increase sleep disturbance by delaying sleep onset, increasing daytime fatigue, and perpetuating the cycle of disturbed sleep and inflammation.

Breastfeeding, sleep location, and maternal well-being

From previous studies, we know that feeding method makes a difference in terms of how much a mother sleeps and her overall well-being. However, looking into this topic further, we recognize that where a baby sleeps is also important and could interact with feeding method. We also know that a high percentage of mothers around the world sleep with their babies at least part of the night. In the US sample from the Survey of Mothers' Sleep and Fatigue ($n = 4,789$), we found that nearly 60 percent of





mothers sleep with their babies at least part of the night (Kendall-Tackett, Cong, & Hale, 2010). When these mothers were asked “Where does your baby usually sleep?” only about 40 percent indicated that their babies slept with them. However, when asked “Where does your baby end the night?” 60 percent revealed that their babies slept with them. So sleep location has the potential to play a large role in the relation between feeding method and mothers’ sleep and well-being.

In a study of 33 mothers at 4 weeks postpartum, Quillin and Glenn (2004) found that mothers who were breastfeeding slept more than mothers who were bottle-feeding. Data were collected via questionnaire that recorded 5 days of mother and newborn sleep. When comparing whether bedsharing made a difference in total sleep, they found that bedsharing, breastfeeding mothers got the most sleep and breastfeeding mothers who were not bedsharing got the least amount of sleep. Mothers who were bottle-feeding got the same amount of sleep whether their babies were with them or in another room.

A recent study examined the impact of both feeding method and infant sleep location with data from the Survey of Mothers’ Sleep and Fatigue ($N = 6,410$) (Kendall-Tackett, Cong, & Hale, 2016, in press-b). Mixed- and formula-feeding were combined after previous analyses revealed no significant difference between the two (Kendall-Tackett et al., 2011). The findings reveal the complex relationship between breastfeeding, sleep location, and maternal well-being. As found in previous studies, bedsharing helped sustain breastfeeding (Kendall-Tackett, Cong, & Hale, 2016, in press-a). The data revealed a main effect of feeding method (exclusive breastfeeding vs. not exclusively breastfeeding). In most cases, the exclusively breastfeeding mother has lower scores on the PHQ-2 than the non-EBF mother on most variables, especially if she is bedsharing. For example, the EBF-bedsharing mothers get more total sleep, and take less time to get to sleep than their non-EBF/non-bedsharing counterparts (Kendall-Tackett et al., 2016, in press-b).

The sleep variables are also reflected in the mothers’ depressive symptoms. Overall, the EBF mothers have lower depressive symptoms regardless of sleep location, but the bedsharing-EBF mothers have the lowest rates of all.

Does taking the baby away help?

To help mothers who are very tired and/or depressed, a common suggestion is to have the baby sleep apart from the mother so she can get uninterrupted sleep. This is a suggestion that sounds reasonable, at least at first glance, but the research does not

support it. To consider whether it would be helpful, we can examine studies where the babies are not with their mothers to see if it helps.

Sleep disturbances can occur in depressed mothers even when the baby is absent, or even before the baby is born. For example, we can examine the sleep of depressed mothers during pregnancy. The baby is not “there,” yet the depression itself is what disturbs the sleep. In a study of 253 pregnant women, depressed women had more sleep disturbances 6.3 and higher depression, anxiety, and anger scores during the second and third trimester than their pregnant, non-depressed counterparts (Field et al., 2007). The newborns of depressed mothers also had more sleep disturbance. They spent less time in deep sleep, and more time in disorganized sleep. The babies of depressed mothers also spent significantly time more fussing and crying.

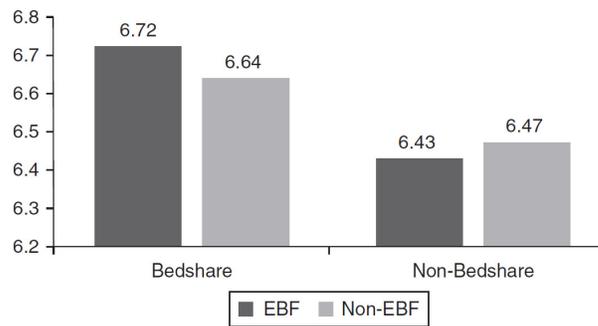


FIGURE 7.5 Sleep location by feeding mother for total hours mothers sleep (Kendall- Tackett et al., 2016, in press-b)

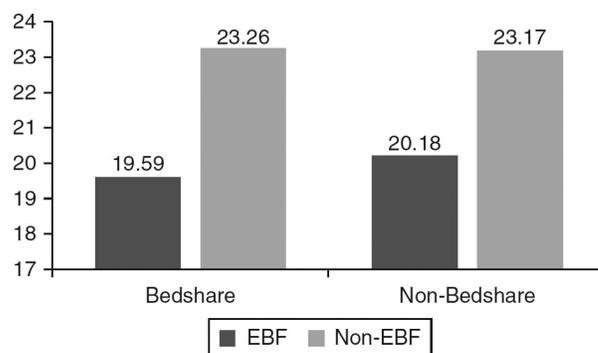


FIGURE 7.6 Sleep location by feeding method for minutes to fall asleep (Kendall-Tackett et al., 2016, in press-b)

In a review of the literature on PTSD and sleep, Spoormaker and Montgomery (2008) noted some specific abnormalities in the sleep of patients with PTSD. They have more stage 1 sleep, less SWS, and higher REM density. Sleep disturbances are a core feature of PTSD, and insomnia is common in people with PTSD, ranging from 40 percent to 50

percent. Conversely, disturbed sleep is a risk factor for developing PTSD. They also reported that sleep disturbances often do not respond to treatments for PTSD, and may persist even after the other symptoms have been alleviated. However, addressing sleep problems lessens PTSD symptoms. Their findings suggest that sleep disturbances may need to be addressed separately in women who have experienced PTSD in pregnancy and the postpartum period.

A study of mothers and fathers of infants in the NICU found that sleep was disturbed for both (Lee, Lee, Rankin, Weiss, & Alkon, 2007). Sleep disturbance was high for both mothers and fathers: 93 percent of mothers and 60 percent of fathers reported disturbed sleep. Mothers had longer sleep latency, more night time wakings, and more subjective fatigue than fathers. Data were collected via wrist actigraphy and sleep diary. The total minutes of sleep were significantly lower for mothers than fathers, and mothers reported more morning and daytime fatigue.

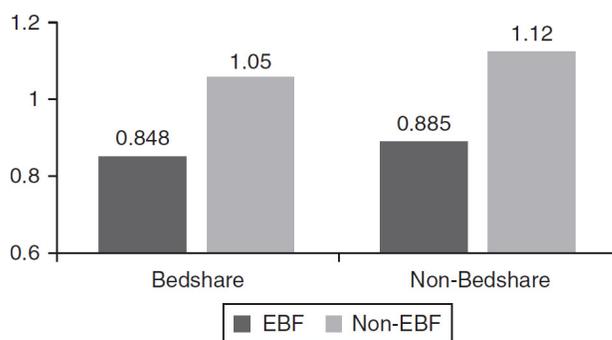


FIGURE 7.7 Sleep location by feeding method for maternal mental health (Kendall- Tackett et al., 2016, in press-b)

Breastfeeding, sleep, and trauma

Mothers with a history of childhood abuse often feel as though they do not have the tools they need to successfully parent their own children. They may wonder whether they will perpetuate the cycle of violence. Impaired sleep can be an important trigger to the intergenerational transmission of abuse. Babies of mothers with depression or PTSD are more likely to have sleep difficulties, possibly because of mothers' elevated stress hormone levels that the babies were exposed to *in utero* (Field et al., 2007).

Intergenerational transmission of trauma is an ongoing concern. In one recent study, researchers included a group of 184 first-time mothers: 83 had a history of childhood abuse and PTSD (PTSD+); 38 had a history of childhood abuse and no PTSD (PTSD-);





and 63 had no history of abuse nor any maternal pathology (control) (Hairston et al., 2011). The mothers who were PTSD+ had higher rates of both depression and infant sleep disturbance symptoms. There were two variables that predicted impaired mother–infant bonding: infant sleep difficulties and maternal depression, which predicted infant behavior problems at 18 months. The PTSD+ mothers also had more sleep impairment than the other two groups. The researchers noted that it was the maternal depression, not the mother’s PTSD, that predicted the degree of mother–infant bonding impairment in the PTSD+ mothers. All of these lead to the intergenerational transmission of trauma.

Breastfeeding can have a positive effect on both maternal depression, and infant and mother sleep problems, thereby lowering the potential risk of a new mother maltreating her own children. In Strathearn, Mamun, Najman, & O’Callaghan’s (2009) 15-year longitudinal study of 7,223 Australian mother–infant pairs, breastfeeding substantially lowered the risk of maternal-perpetrated child maltreatment. There were over 500 substantiated cases of maternal-perpetrated child maltreatment (abuse and neglect). Non-breastfeeding mothers were 2.6 times more likely to be physically abusive and 3.8 times more likely to neglect their children compared to mothers who breastfed for at least 4 months.

The results of our recent study may help explain why this is so. In our sample of 6,410 new mothers, 994 women reported previous sexual assault (Kendall-Tackett, Cong, & Hale, 2013). As predicted, sexual assault had a pervasive, negative effect on mothers’ sleep, physical well-being, and mental health. The sexually assaulted mothers’ sleep was poor overall, the mothers were more tired, they were more anxious and angry, and they had more depression. However, when we added feeding method to our analyses (feeding method × sexual assault status), we found that breastfeeding attenuated the effects of sexual assault and downregulated the stress response. There was no significant difference between mixed- and exclusively formula-feeding mothers on any of the variables in a previous study, so these two groups were combined (Kendall-Tackett et al., 2011). The rate of exclusive breastfeeding in our study was the same for sexually assaulted and non-assaulted women (78 percent for both groups). This is in line with an earlier US nationally representative sample of 1,220 mothers with children under the age of 3 (Prentice, Lu, Lange, & Halfon, 2002). In our study, exclusively breastfeeding mothers got more total sleep, took fewer minutes to get to sleep, and had more daily energy than sexually assaulted women who mixed- or formula-fed. They had less anxiety, depression, and anger. There was still an effect of the past sexual assault on the variables, but it was significantly lessened (Kendall-Tackett et al., 2013). See Figures 7.8–7.10. The effect on anger, in particular,



was striking, and this might explain Strathearn and colleagues' (2009) findings about maternal-perpetrated child maltreatment cited earlier.

Although breastfeeding can be helpful in terms of lessening trauma symptoms, and lowering the risk of depression, depressed abuse survivors may be less likely to breastfeed than their non-abused counterparts, especially if they have violent partners. One large study found that women with a history of current or past abuse may breastfeed at lower rates (Sorbo, Lukasse, Brantsaeter, & Grimstad, 2015). This study included 53,934 mothers who had given birth between 1999 and 2006 in Norway. Women who experienced physical, sexual, and emotional abuse as adults were 40 percent more likely to stop breastfeeding than were non-abused women. These women also had much higher rates of postpartum depression (33 percent) than their non-abused counterparts (11 percent). Women who had experienced childhood abuse were also at high risk. The authors noted that women with a history for abuse were a high risk for early breastfeeding cessation. They only included this as a confounding variable, but found that it exerted an independent effect on breastfeeding cessation at 4 months. Childhood sexual abuse had the strongest effect.

A study from Hong Kong indicated that intimate partner violence (IPV) during pregnancy and early postpartum depression may influence breastfeeding initiation rates (Lau & Chan, 2007). This study included 1,200 Chinese mothers. Women who had no experience of IPV during pregnancy were significantly more likely to initiate breastfeeding than women who had experienced IPV, even after adjusting for demographic, SES, and obstetric variables. Early postpartum depression was not associated with breastfeeding initiation in a logistic regression model.

Mothers' experiences of breastfeeding after sexual abuse

The subjective experiences of abuse survivors who breastfeed vary quite a bit. For some, it can be quite healing. For others, it can be extremely difficult. Below are two accounts of women's experiences. In the first account, abuse survivor Beth Dubois (2003) describes how she was nervous about giving birth and breastfeeding her son. The theme of low self-efficacy is evident, but she also describes how breastfeeding was healing and empowering for her.

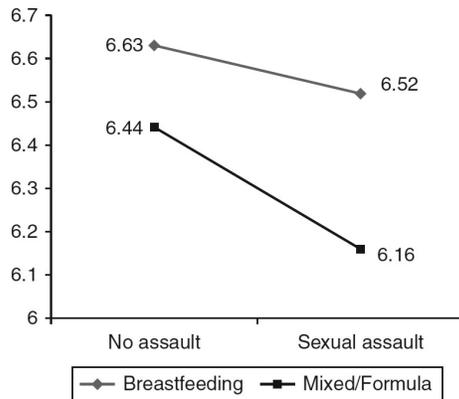


FIGURE 7.8 EBF attenuates the effects of sexual assault on hours mothers sleep (Kendall-Tackett et al., 2013)

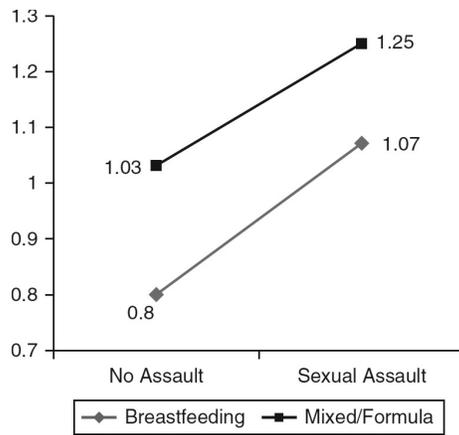
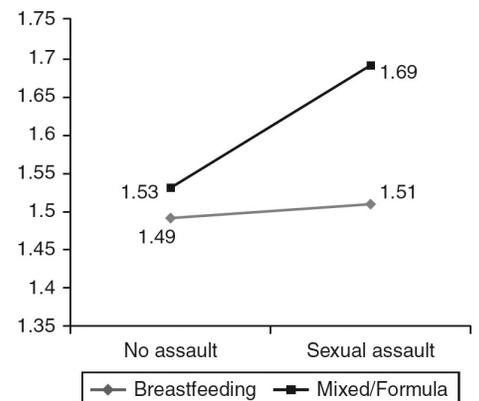


FIGURE 7.9 Sexually assaulted women had increased risk of depression, but EBF attenuated that effect

As the time of my son’s birth approached, my worries about breastfeeding came into sharp focus. I knew the benefits of breastfeeding, and had plenty of book knowledge on the subject. I knew I wanted to breastfeed. I had been sexually abused when I was a child, however, and I was concerned. I worried that I would not be able to maintain the constant physical closeness breastfeeding would require and that breastfeeding might trigger memories of the abuse. I was especially distraught because I believed that I would be failing my child and myself if I were not able to breastfeed...

FIGURE 7.10 EBF had a dramatic effect on sexually assaulted women’s anger and irritability





After describing her experiences of pregnancy, labor and delivery, she describes the positive impact breastfeeding has had on her.

... I now see that not only has breastfeeding been possible for me, a survivor of childhood sexual abuse, it has been immensely healing. My desire to have a fulfilling breastfeeding relationship forced me to face emotional territory I would probably have otherwise avoided. One wound left by the abuse is an underlying sense of “I can’t do it. It’s not even worth trying.” Birthing and breastfeeding Theodore has helped to replace this with a very real sense of capability and confidence. Also, the heightened sensitivity to both myself and my son, which I gained through our breastfeeding relationship, serves us in other ways, especially now that Theodore is in the “terrific twos.”

(pp. 50–51)

Unfortunately, it would be negligent to only report positive findings regarding breastfeeding after abuse. Some abuse survivors struggle immensely to breastfeed, and may get to the point where they cannot continue. In a detailed case study, Beck (2009) presents the story of a woman with a history of childhood sexual abuse and rape as an adult. During Marilyn’s birth, she dissociated and had a flashback to her abuse experience.

A haze of hospital labor room, nakedness, vulnerability, pain. Silence, stretching, breathing, pain terror, and then I found myself 7 years old again, and sitting outside my parents’ house in the car of a family acquaintance, being digitally raped ... my birth experience did not look traumatic at all—because the trauma physically took place 23 years before and only in my mind not the labor room.

(Beck, 2009, pp. e4–e5)

After birth, her milk never came in, possibly due to the trauma of her birth or her pre-eclampsia. She felt that inability to breastfeed only compounded her sense of shame and inadequacy. What she remembered most about her postpartum experience was an incredible feeling of numbness. She felt that she could not connect with her baby, husband, life, or anything. She describes her breastfeeding experience as follows:

Of course, I couldn’t tell anyone what was really going on in my head when I tried to breastfeed. When I placed my baby to the breast, I experienced panic attacks, spaced out and dissociated. It triggered flashbacks of the abuse and a sick feeling



in my stomach. I hated the physical feeling of breastfeeding. I hated having to offer my body to my child, who felt like a stranger. Whenever I put her to breast, I wanted to scream and vomit at the same time. My body recoiled at the thought of placing my baby to my breast. The thought of breastfeeding made my skin crawl. The very act of breastfeeding, which was sustaining my baby, was forcing me to relive the abuse. I resented her for needing to breastfeed ... I did actually experience some relief when I expressed, rather than breastfeeding directly; however, my supply was so poor that for an hour's effort expressing, I'd only have about 10 mm of milk to give my daughter ... At the moment I gave myself permission to give up on breastfeeding, things started to look up. I slowly started to feel a sense of connection with my baby, and with my life, and I even began to feel a bit like my old self again.

(Beck, 2009, p. e6)

Breastfeeding can be strongly positive or strongly negative for individual abuse survivors. Even the mother in the above case illustration got to the point where she “kind of liked” breastfeeding with a second baby. Some mothers have shared with me that they never got to the point where they liked breastfeeding, but they got to the point where they could tolerate it, and that was an important goal for them. As care providers, it is important that we be open to the whole range of reactions that mothers may have and support them in their decisions to breastfeed, to pump and bottle-feed, or to simply bottle-feed.

Conclusions

Fatigue and sleep deprivation can be important signs, or even triggers for postpartum depression and psychosis. While most new mothers are tired, those who seem exceptionally tired and unable to cope may be depressed, or are at risk for depression. Sleeplessness not related to baby care can be a particularly ominous sign that requires close monitoring.

Clinical Implications

1. Because depression is a major risk factor for breastfeeding cessation, lactation specialists should screen for it.
2. Maternal stress and fatigue reduce prolactin levels, and may lead to breastfeeding cessation. High levels of cortisol can delay lactogenesis II.
3. Breastfeeding difficulties, especially nipple pain, can lead to depression and need to be addressed promptly (see Chapter 6).

- 
4. Breastfeeding mothers actually get more sleep than their formula-feeding counterparts. When mothers try supplementing with formula at night to get more sleep, they may encounter the opposite effect.
 5. Depressed mothers should be encouraged to continue breastfeeding because it protects infants from the harmful effects of maternal depression (see Chapter 7).

Regarding the role of healthcare providers caring for women who are breastfeeding and depressed, McCarter-Spaulding and Horowitz noted the following.

Nurses caring for women who are at-risk, or struggling with PPD, also may feel that breastfeeding is perhaps an unnecessary burden that should be discontinued.

Although nurses might expect that mothers with depression may not want to continue, or may not be able to maintain breastfeeding, such assumptions may not be accurate.

(McCarter-Spaulding & Horowitz, 2007, p. 10)



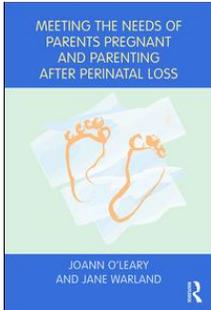


CHAPTER

5

Bereaved parents raising children

5. Bereaved parents raising children



The following is excerpted from *Meeting the Needs of Parents After Perinatal Loss* by Joann O'Leary and Jane Warland. © 2016 Taylor & Francis Group. All rights reserved.

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Regardless of how the loss occurred, this chapter explores the challenges parents face in rebuilding trust in the world as they move forward and raise their children. The chapter also explores ways in which the experience of loss can change parenting behaviors and how parents integrate their deceased child into their family.

Little research has addressed parenting after a perinatal loss. Historically what has been written has not necessarily been helpful. Often called the “replacement” (Grout & Romanoff 1999) or “vulnerable child,” under the influence of a “Ghost” or “penumbra baby,” the children may be seen as subject to increased risk of psychopathology, including attachment disorders (Cain & Cain 1964; Heller & Zeanah 1999; Kempson et al. 2008; Powell 1995; Poznanski 1972). Indeed, the long-term effects of the parents’ heightened anxiety and fear during pregnancy have been found to affect the mental health needs of the subsequent child (O’Leary & Gaziano 2011). In a study assessing the mother–child attachment relationship with one-year-old children born after a loss, 45 percent of the infants had disorganized attachments compared with 15 percent in the “normal” non-bereaved population (Heller & Zeanah 1999). It is important to note that this study was undertaken with bereaved parents who were not necessarily offered supportive intervention at the time of loss or in the pregnancy that followed.

Protective parenting: rebuilding trust

When parents have lost a child through whatever cause, it is understandable that they exhibit overprotective behaviors raising subsequent children (Buckle & Fleming 2011; Lamb 2002; Pantke & Slade 2006; Rosenblatt 2000a). This is why parents continue to need support in dealing with the fear that this baby could also die (Armstrong et al. 2009; Côté-Arsenault & O’Leary 2015; O’Leary 2005). The fear, anxiety, and stress experienced during nine months of pregnancy take time to resolve. Parents also need time to truly believe they have a healthy baby. Anxiety levels can decrease but the symptoms of posttraumatic stress can remain in the moderate range at eight months (Armstrong et al. 2009) and even 16 months (Theut et al. 1992) after birth for some parents. Although no information was given on bereavement care for mothers who chose elective termination, one study found relational disharmony between the mother and subsequent child (Alexander et al. 2015) speculated to be the result of the mother’s inability to resolve the grief associated with her decision, especially if the death occurred late in pregnancy. These parents have lost their sense of naivety and strive to do everything to avoid having to endure again the pain that results from the death of a child.

I was so very overprotective. I remember when he turned once and I was like, “Oh my



God, I've been holding my breath waiting for him to die."

I think we are maybe much more concerned about situations, a little bit more scared in the world than other people would be. Both of us make sure that all the safety rules are followed; you wear your helmet when you're doing this, be careful about that. I don't know if it stops us from doing stuff but it certainly colors the way we do those things; crossing the street, going sledding, whatever, so I think we're far more cautious.

The reason for overprotectiveness is valid but the behavior is not. Overprotective parenting style and poor parent-child affectional bonds can impact children's later mental health (Armstrong & Hutti 1998; O'Leary & Gaziano 2011). Therefore bereaved parents must try harder than most to allow their children to be children. It can be helpful for parents to assess their overprotective behavior by comparing it to that of non-bereaved friends who they think are doing a good job in raising their children (O'Leary & Warland 2011).

There is something to be gained from having friends who have never experienced loss and are sort of skipping through the tulips, as I used to say. I can tone down to some degree the overprotectiveness. But I really think it's more of an emotional thing and it's our connecting with our kids.

Overprotective behavior can understandably make it difficult for parents to leave their child in someone else's care. Leaving their child for the first time when they return to work can be a difficult and overwhelming experience for some parents because this situation evokes memories of leaving the hospital without their baby who died.

Actually the first time I left her she was nine months old and I just had a lot of panic attacks.

Dropping him off the first day, saying goodbye at a new daycare place, I would feel really sad as I left, maybe also a little guilty.

These parents need more reassurance that their child is safe, and thus often only ask a close family member to babysit.

They had their first babysitter when [my oldest daughter] was five, probably four and a half. We had [their grandmother]. I was comfortable with that so I could do that. But she was about the only person because she just lived really close and she was always there.



Ten years after their loss these parents were still rarely away from their three subsequent children:

We never wanted to leave him [first subsequent child], which in hindsight was terrible for our [the parents'] relationship. Even now we rarely do. I think a lot of it is still, something could happen to them. We just need to do as much as we can because there is so much we can't control. That's why I stay home with the kids because ... life is so short.

As the above quotation illustrates, parents do need to regain their relationship as a couple. Care providers need to encourage parents not to wait until their children are older before they start doing things for themselves. This humorous account demonstrates why:

When I did get a babysitter and went out, the kids were just shocked that I looked good. They like, almost fell over. They were like mom! I was wearing a skirt and jacket and they said, "Are those your real legs?" Then I thought, maybe I need to go out more often.

Teachers need to be aware that protective behavior on the part of previously bereaved parents can continue throughout their children's schooling:

I can't leave the boys with a neighborhood babysitter. I'm hiring a nanny for the summer and she has a Master's in child psych and is a middle school teacher, pretty high credentials. I've interviewed some other people; they might do a fine job but I just want them to have CPR, want to be of a more mature level and I need to know where they are. If I can't get a hold of them I just go crazy. I do let my mom take care of them and my nephew, who is in his twenties. That's about it. I feel safe with family. They go to private school now and I feel safe with them there.

Just as they learned to advocate during their pregnancy (O'Leary & Warland 2012), these parents continue to need concrete, specific reassurance from those caring for their children. Parents should be encouraged to share their family story with those who look after their children because it explains why they are anxious and may stop them from being viewed as overprotective (ibid). Those looking after their children can ameliorate overprotective behavior by seeking more information from the parents and listening carefully to identify their needs:

The daycare providers helped to make it easier. They were really supportive and validated what we needed to do. It was very personalized and it was a very good experience.





Similar to the reasoning behind parents' choice of health care provider for their pregnancy, this parent did not choose a particular day care provider because she was unclear of their expectations regarding children in the classroom:

They didn't provide us with much information. When we asked questions, they seemed to think we were questioning their ability to do their job instead of finding out just what's going on in the classroom. She was pretty upset with us for even asking the question. It wasn't very long after that that we pulled him out of that situation because we couldn't count on how things were being handled there. The kids in that class were probably three and four year olds and I think you need to know a whole lot about the behavior expectations at that age.

Parents may continue to worry about the physical health of their subsequent child or children (Theut et al. 1992). It is perfectly normal to worry about sickness in this way. Finding a pediatrician who will be sensitive to their history is important:

I've been very pro-active. I only see certain pediatricians now. I said, you should just put this on the front of my file, that this is my history and that you need to probably do a little more with me than you would an average parent. Dr. Smith has been our primary and he's just great. I've encountered a couple of other doctors who will say, "Lady, what's your problem?" and now I just won't see them. I say, put it on there so they read that so they know I'm just not your average parent waiting in here.

Loss changes the family landscape forever (Buckle & Fleming 2011), both for parents and the deceased baby's siblings. Worrying about sickness is not confined to the subsequent baby, nor bereaved parents. This family found that their older child who also experienced the loss of the baby lives with concerns too:

This fear is not confined to us, as our children also feel anxious when there is sickness. Recently when Sarah was quite sick with a high temperature, Gregory said, "She looks pale like Emma, is she going to die too?"

Some parents are aware they need help to not be overprotective and this should be noted by professionals:

I definitely would have benefited from more emotional support through parenting children after a loss. I kind of look back, I was so scared and I had so much anxiety that I think I realize it more now than when I was going through it. I was just so determined to have a healthy child that maybe I didn't deal with some things in pursuit of

parenthood.

Intentional parenting

Rather than describing parents' behavior as overprotective, it may be helpful to reframe it in a more positive light, as intentional parenting (O'Leary & Warland 2012). In this context, "intentional" means parents prefer a parenting style whereby spontaneity is avoided and deliberation, intent, and planning valued. Especially in regard to discipline, parents report that it is helpful when they are clear about rules:

I have rules but I always hear the children out. I don't do any physical disciplining whatsoever. I try and follow the love and logic type of parenting.

I'm trying to find a balance which I realize is healthier for the boys, as I work on issues and let go a little bit. I have made a really conscious effort to keep myself in check about that. I really make a specific effort not to go overboard with them.

Parents need to resume a healthy lifestyle too, trusting that their children will be safe even if they are not hovering over them:

I'm working really hard on trying to enjoy life and being a little bit more light-hearted about things, but it's definitely a challenge for me.

A paradoxical parenting style

Realizing how lucky they are to be parents coupled with their understanding of the reality that children can die, leaves parents feeling vulnerable. One study reported that parents feel as though these children do not completely belong to them but are simply on loan (Green & Solnit 1964). These parents know things can happen that they have little or no control over. Similar to parents who have lost older children, the post-death approach to child-rearing of these parents can make them feel powerless to prevent harm (Buckle & Fleming 2011). Warland et al. (2011b) describe a "paradoxical" parenting style in parents raising children after a loss; that is, they are simultaneously *in control but out of control*, as this example demonstrates:

I remember not even turning the monitor on. My friends would ask why I wasn't afraid of SIDS [sudden infant death syndrome], and I think I didn't feel that way because I felt like if it was gonna happen, it was gonna happen. I am not going to be able to do anything about it. I am not going to like hear her last breath and know that it is her last breath. Do I want it to happen, NO, I try to do everything in my power to prevent it but beyond that if it is going to happen I am powerless to stop it. It is up to nature.



Although this mother let her children experiment to help her let go of overprotective behavior, she also prepared herself for the worst:

I always did have pictures [in my mind] of them dying and being in a casket, and how I would plan the funeral. No one in the family did that. I was living the practical side, if they die, what will I do? Who will I call?

Sharing the story of a deceased baby with the subsequent child

Parents may wonder when they should tell the subsequent child about the sibling before them. During a relationship-based parenting intervention in a subsequent pregnancy, parents naturally share the story of their deceased baby with the fetus. To avoid their children feeling that they were carrying a “burden” regarding being born after a loss, one family honored this as part of their story (O’Leary & Thorwick 2006):

Our subsequent children have known grief from conception onward, because losing Micah changed who we are and how we’ve parented our daughters. We actually think it is a gift—especially in a culture that is so afraid of grief. We feel like our daughters got a healthier start at a spiritual level, because Micah’s life and death have always been a part of their being. It’s a natural part of their being, not something they have to learn to cope with or manage or run away from.

My subsequent child is now two and has seen pictures of her big brother. She’s asked, “Who’s that?” We told her that her brother died and is with the angels. She’s been to the cemetery many times. She now talks about her brother on occasion. Out of the blue she’ll say, “Ben died, Mommy.” Or, “This is Ben’s toy.” She accepts the idea on her level of understanding, and I like that he’s become a part of her idea of our family.

Another mother saved the gifts that were given to her first child, who died, and gave one to each of his siblings as a gift from Bailey.

Madeline got a little blanket, Max got a couple little stuffed animals, and Isabelle got a little bunny. So they now have them in their room and that’s their presents from their big brother.

For other parents, sharing the information can take time and need guidance from a professional. Some children realize they may not have been born if their sibling had not died (Jonas-Simpson et al. 2014; Warland et al. 2011a). *We don’t know if we would have been born, my brother and I.* One wise mother describes her response to her 12-year-old son’s question:





“Mom, if she hadn’t died, would I be here? ”You could just see the profound meaning at that very moment in time. It just drained all energy from him. And I just put my arm around him and said, “You know, I don’t know how all of this works but I really believe that you were meant to be a part of our family. I don’t know if you would have been born a year later or if you would have been born at another time but I truly believe you were meant to be with us.”

Memory building: keeping the deceased baby in the family

How the family keeps the memory of their deceased baby alive is a personal choice, and an important goal for all family members (Fanos et al. 2009). Just as parents have a continued bond with and attachment to the deceased baby, so do children *continue their sibling relationship to him* (Erlandsson et al. 2010; Jonas-Simpson et al. 2015; Packman et al. 2006;Thompson et al. 2011).

Children often become the memory keepers for the missing sibling (Kempson & Murdock 2010; Jonas-Simpson et al. 2015; Limbo & Kobler 2009). In the preschool years children follow the lead of their parents. Art has been found to be a useful tool for helping children integrate a sibling into their lives and letting others know they have a missing brother or sister (Jonas-Simpson, et al. 2015). It is quite common for children from bereaved families to include their baby in pictures as a continued member of the family:

When my daughter and her little friend draw pictures of their family, her little friend will say, “Remember to draw Connor.” They’ll have conversations about her brother Connor, that he’s in heaven, how he died, and these little four- and five-year-old girls will have conversations about death and her brother in heaven.

Responses to grief are very individual for children as well as adults. It is important for professionals to be mindful that how parents respond to their children’s requests for more information needs to be tailored to the language around death they already use (Limbo & Kolber 2009). Some bereaved siblings rely on their faith/belief system as a source of comfort (Thompson et al. 2011):

I remember Darby drawing a picture of the family and she drew three. It wasn’t elaborate, it was like sticks; it was mom and dad drawn and then there were three kids. Why are there three kids? You only have a brother. And she said, I have an angel.

He will correct me if I say I have three children in front of other people. And I’m at least partially responsible for that because he had so many questions early on about Connor. The best way that I could describe it is to say, “He’s your brother and he’s an angel and

he's looking out for you; he's your guardian angel. He's with us, he's with you all the time." So that must have impressed upon him that he's always got somebody behind him. He draws pictures of our family with Connor floating with wings above us. Often he will tell me things like, "If Connor were here he'd do this."

Keeping the memory of the deceased child within the family should not overtake family life:

You can't ignore the fact that you had a child who passed away. But you can't make your house a memorial to that child either because then the other children suffer. You have to find a balance.

I generally remind myself how blessed I am to have them, how fragile life is. You just forget sometimes. I think that's made a difference in how we try to treat them respectfully and not take them for granted too much. We try to make it known that Sydney is part of our family but not have it impact our everyday life too much.



FIGURE 13.1



Losing Matthew still affects me every single day. There's really not a day that it doesn't cross my mind, some times in a positive way but it's not always fear based. I've thought a lot about, one of the coolest things about subsequent children is you just think they were in the same space, and I always wonder if they knew that somebody else was living in there. I think they do. That's why it's important for me to let them know that Matthew was there, that he's their brother, and to celebrate his birthday, that it is a significant day and we recognize it.

Children's view of their parents' parenting

Children can also link the way they were parented to the loss of their sibling, some understanding why their parents were overprotective, Yeah probably a bit overprotective. I know it is for a reason, and others feeling the opposite, I found that they were very open to us having adventures and kind of being confident and independent. Most adolescents in one study felt neither overprotected nor that they were a replacement (Warland et al. 2011a), and the researchers speculated that that was the case because their parents had undertaken professional counseling and/or peer support in the early years following their loss. This intervention may have assisted the parents to deal appropriately with their loss, thus enabling them to provide appropriate parenting to their subsequent child. Others whose parents did not have support described being held at a distance or feeling invisible (O'Leary et al. 2006c, 2011b).

Parents' altered view of self

Some parents recognize that their experience has had a positive effect on their parenting and their appreciation of the value of life (O'Leary et al. 2011):

This experience has fundamentally changed who I am. It's changed how I parent. It's changed everything—how I understand what life is about and how I live my life.

Parents today are very aware of research demonstrating the effect of maternal stress on the unborn baby, and some may continue to worry that their continued anxiety about safety can be transferred to their children:

The kids definitely pick up on your anxiety and I realized it's important for me to work through this, to not hand this off to them too and that they respond. I have a lot of guilt about the anxiety I felt while they were in utero. I wonder how that affected them.

They already were hearing so they knew what the anxiety was about. I do think as they





get older I'm doing better, I'm more comfortable. I realize it's their job to separate from me more.

It is important to focus on the positive gifts that can eventually result from the experience of losing a child:

I think I'm a better person, I think I'm much more sensitive, I think I have a lot more compassion. I think I'm more present in all my relationships with people, having that vulnerability. I know people would say, everything happens for a reason. At the time that's not real comforting but I do feel like this is my path, doing the Faith's Lodge1 thing and that everybody that comes through gets a quilt. And the letters I've gotten from families talking about when they got home, being able to wrap themselves in something is a real comfort. It's a mission in my life to be able to provide comfort to families who walk through the same path. I think I'm instilling that in the boys.

Twelve years after the loss of their first baby, this mother describes her continuing grief for her first son after birthing two healthy subsequent children: [It's] maybe a journey of always moving towards learning to live with that grief in your life and to share it with the people who care about you and are concerned about you. The continued bond with and attachment to a deceased child remains, as it should, part of the family story.

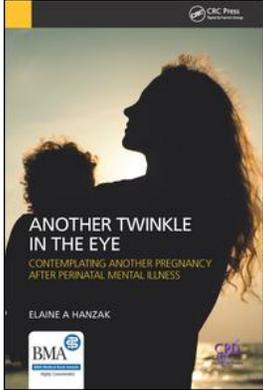
Summary

This chapter has addressed how parents move forward in raising children after a perinatal loss. They have experienced the worst possible outcome for parents, which subsequently changes their life view and how they parent other children. They understand that keeping the memory of their deceased baby alive is important for the family. They are naturally more protective of their surviving children but there is still little research on other aspects of parenting after a perinatal loss, especially the long-term impact on the mental health of all family members.



The role of healthcare professionals: what can you, as an HCP, do?

6. The role of healthcare professionals: what can you, as an HCP, do?



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A doctor who cannot take a good history and a patient who cannot give one are in danger of giving and receiving bad treatment.

Author unknown

I am eternally grateful for the services I received from the NHS professionals who cared for me and ultimately enabled me to make a full recovery from puerperal psychosis. When I vowed to speak and write further about maternal mental health as a former patient, I did so through a desire to make the journey of new parenthood easier for others. I also wanted to help the people treating them feel encouraged to do so with their present and future families in distress. I have found that this is common amongst those of us who have suffered poor mental health around a pregnancy. One of the mothers who responded to my survey illustrates this beautifully with this paragraph:

- Remember YOU have the power to make a massive difference to someone's life. Out there somewhere is a health visitor, a GP and a mental health nurse who at one time each saved my life for one more day. I will never forget them and the gifts they gave me with their compassion and care. You might feel like a drop in the ocean but you can be the drop that makes the difference to that person. The most important gift you can give anyone in that place is Hope.

This will be a message I shall continue to highlight. So often people working in a large organisation can feel demoralised and that their actions will make no difference. Take confidence and inspiration from being or becoming the 'drop' described above!

I have had some great care from some individuals, as have many of the people who responded to my survey. What is evident is the lack of consistency in care and services and amongst the different health professionals involved. The good practice outlined by the NICE guidelines,¹ does not appear to be followed in many cases, with very little networking around care being carried out. Considering we have a 'national' health service in the UK this is alarming. For example:

- Community Midwife – very good. GPs – first 3 useless, final one brilliant (that's how many I had to see to find one who would listen!). Health Visitor – first one AWFUL. Second one (after I sacked the first one!) – amazing. Life saving.

In the summer of 2014 the Maternal Mental Health Alliance² published a map of the UK showing the huge gaps that exist. The stories that I have heard would certainly back up this postcode lottery of care. This has to be one of the main drivers in the UK to ensure that we have a national system for specialist perinatal mental health. Imagine if



you broke your leg only to be told that you needed a four-hour journey to find a specialist?

This has impacted upon the decision of one lady dramatically:

- I have been lucky to live in Australia during my second pregnancy, where I could pay privately for affordable access to a psychiatrist who is a specialist in perinatal mental health, and an obstetrician, who allowed me to have full control over my labour. If I was relying on the NHS, I would not have had another baby in the UK because the quality of care you receive is a matter of pot luck. I couldn't afford to take that risk again.

In November 2014 the Maternal Mental Health Alliance was able to commission an economic review on perinatal mental health by the London School of Economics and the Centre for Mental Health. They highlighted the costs of undiagnosed or untreated perinatal mental health problems as including:

1. **avoidable suffering:** perinatal mental illness can cause intense, debilitating, isolating and often frightening suffering for women
2. **damage to families:** perinatal mental illness can have a long-term impact on a woman's self-esteem and relationships with partners and family members
3. **impact on children:** perinatal mental illness can have an adverse impact on the interaction between a mother and her baby, affecting the child's emotional, social and cognitive development
4. **death or serious injury:** in severe cases, perinatal mental illness can be life-threatening; suicide is one of the leading causes of death for women in the UK during the perinatal period
5. **economic costs:** the economic cost to society of not effectively treating perinatal mental illness far outweighs the cost of providing appropriate services.

From a review of the literature on perinatal depression, the estimates imply that only 3% of all cases of perinatal depression end up achieving full recovery (p. 22 of the report). The conclusion was 'If perinatal mental health problems were identified and treated quickly and effectively, all of these serious and often life-changing human and economic costs could be avoided.'

As a healthcare professional, your first step could be to ensure that those who have the influence to channel funding into perinatal mental health are aware of the need and its impact. A useful tool to share with commissioners is the Guidance for Commissioners of Perinatal Mental Health Services by the Joint Commissioning Panel for Mental Health.⁵ It has been written to assist specialised commissioners, as well as Clinical Commissioning Groups and Health and Wellbeing Boards. Send it to all the influential



people – if you get no response, resend until you do! It will also be of use to provider organisations, service users, patients, carers, and the voluntary sector.

One of my teaching friends makes the point:

I always think that what the Government could get better is investment in prevention instead of having to fund additional services to ‘pick up the pieces’, e.g. instead of having a midwife with MH expertise they then need to fund psychiatric support services, hospital stays etc; instead of investing more into early numeracy and literacy they have to spend more in services like teaching in prisons!

Remember that as an individual within a healthcare profession, you can make a difference as an individual. Even if faced with tight budgets, if you have the will and determination to make a difference to people’s lives, it can be done. Kathryn Gutteridge set up a postnatal support group in 1997 simply by finding a vacant room in Tamworth. It has since helped over 1000 women.

The NICE Guidelines stress the need for networks of professionals to work together – as perinatal mental health covers several, it takes just one person to arrange a meeting with a representative from each discipline. For example in Barking, Havering and Redbridge University Hospitals NHS Trust, Dr Farida Bano, Consultant Obstetrician and Gynaecologist, is also the perinatal mental health lead. She and her colleagues have set up a service for perinatal mental health with a joint obstetric and psychiatric clinic. This kind of system may even be possible without needing extra funding.

Another good example of a service is in Oxford Health NHS Foundation Trust. Gerry Byrne is clinical lead for the Family Assessment and Safeguarding Service (FASS) and the Infant Parent Perinatal Service (IPPS). Their award- winning service is described in their BMJ article.

I believe that there is a growing interest within the government on perinatal mental health. They now award prizes via the All-Party Parliamentary Group on Maternity.⁷ For example, the Perinatal Mental Service led by Nigel Perks from Lewisham and Greenwich NHS has just been recognised. They stress the need for ‘identification through communication’ and how professionals need to be aware of picking up the signals to access the mental state of a new parent. Also you may like to get involved with the First 1001 Critical Days,⁸ a cross-party manifesto, looking at the importance of conception to age 2.

Again I encourage healthcare professionals to believe that they *can* make a difference. As Dalai Lama XIV said, ‘If you think you are too small to make a difference, try sleeping with a mosquito.’

Let me remind you that from the ward to the board you have a role to play. I used to





believe that I was not in a leadership role because I am self-employed. I now accept this quote by John Quincy Adams:

If your actions inspire others to dream more; learn more; do more and become more, you are a leader.

We all cast a shadow by our thoughts, words and deeds – what is the impact of yours and what can you do to improve perinatal mental health?

I have already mentioned the financial aspects above that tend to be one of the initial reasons people use to say they ‘can’t’ do anything. The other challenge I am often given is time. You may find it helpful to look at some of the tips I included in the chapter about the mother who is in employment, e.g. ‘the do, ditch and delegate’ principle. Another approach I find useful is Parkinson’s time law that states ‘work expands to fill the time available for completion’. Think about how much you actually achieve in 15 minutes before you have to leave on a work day. How much longer does it take you to do the same chores when it is a day off? Set yourself scheduled times into a diary rather than making a list. You may find that you achieve more in a shorter time.

I know that often healthcare professionals tell me that the time they get with patients is too short. Let me share this story with you. My sister is 10 years younger than me. When she announced her engagement I was delighted that she asked me to go looking for a wedding dress with her. We arrived in the first shop – stunning premises, designer gowns everywhere you looked. The assistant appeared, dressed extremely elegantly. She looked at me, back at my sister and asked, ‘When is your daughter getting married?’ We left. We go into the second shop. This one had a commercial radio station playing loudly, with special offer stickers everywhere. The assistant appeared, wearing slippers and slurping her coffee. ‘Yeah?’ she asked. My sister politely answered: ‘I’d like a wedding dress – one with sleeves.’ ‘Oh, we don’t have any of those – they’re old-fashioned.’ We left.

We went into the third shop, this time with our mum. As we entered, a smiling assistant appeared, making eye contact with each of us. Her first question was ‘Who is the bride?’ Once that was established, she complimented Claire on her engagement ring, the time of year she was getting married and told us that one of her other customers had just had a wonderful time at the venue we were going to. Guess where we got the dress? How long did it take us to decide where we wanted to shop?

You too can have that same impact on the people in your care. If you have 60 seconds or 60 minutes for contact, my message is make it count! Especially where mental health is concerned. Let me remind you again about the marathon runner – he does not run 26 miles – he runs a mile 26 times by putting one foot in front of the other. What small step can you do today to make perinatal mental health services better for those

in your care? What if you did one small thing each day or week? What could that lead to or prevent? For example, in the case of this mother:

- In hindsight, the signs were all there even when I was pregnant but I can put on a good front. I think healthcare professionals would have been able to see through the front if they'd spent even a few minutes with me.

I would also like to encourage you using the Six Cs of enduring values and behaviours that underpin Compassion in Practice by the NHS. I believe that whatever your role is working with young families, these are vital.

1. CARE

In the previous chapter I gave you many examples of what happened with poor care; additional trauma during births, for example. With an additional child, aspects of care are crucial to avoid anxiety of the parents. If you make people feel special, I strongly suggest that they will feel that you are. What do people do for you that makes you feel special? How can you apply this to others? Even a smile can make a difference, and simply acknowledging someone is there. Use names and 'be present' with the people you are with. One mum told me how her health visitor always used to jangle her car keys in her pocket during a visit – it made her feel like she was in a rush so there was no point in saying how she was really feeling. Remember this quote:

Too often we underestimate the power of a touch, a smile, a kind word, a listening ear, an honest compliment, or the smallest act of caring, all of which have the potential to turn a life around.

Leo Buscaglia

Think about the use of sensory stimulation to make yourself and others feel good. A blast of your favourite song in the car before a meeting can improve your mindset before seeing someone, for example, so that you can be at your best for them.

2. COMPASSION

I have mentioned at many stages about giving reassurance, 'being there' and hope in situations, no matter what treatment may be used.

Drugs are not always necessary. Belief in recovery always is.

Norman Cousins

You may need to draw on additional skills where loss is an issue. Ensure that you know the best ways to respond by looking at the advice by organisations such as Sands¹⁰ and Child Bereavement UK.¹¹ If you are aware that you may face situations where you feel that you will not know what to say, research it. Did you know that the best public



speakers, who appear to be so quick-witted in reply to hecklers in the audience, have actually thought out the likely comments and have rehearsed replies? Preparation is the key. Sometime patients need you to be their advocate and view their situation from their perspective. This may be by being aware of when 'the system' may overwhelm them, as demonstrated by this mum:

Beware the dangers of overwhelming mums with too many healthcare visitors – please monitor and liaise. I remember a real low ebb where the phone and doorbell were constantly ringing at home with friends, family, flower deliveries, etc. Then on top of that was a stream of other people, I don't remember who, but could have been doctors, midwives, CPN, health visitors, social worker etc. The CPN arrived and I had to take myself upstairs to lie down. It was just too much to deal with.

3. COMPETENCE

When you are competent you instil faith and confidence in those that are seeking assistance from you. It helps ease their fears and worries. You have the ability to reduce perinatal mental anxiety in this way. Share your knowledge. Consider the different aspects in the book. What do you need to learn more about? For example, have you already looked at the Marcé Society website resources page? There is a Marcé Resource Pack that can be used by groups or as self-training guide to update your knowledge and practice should this be of interest to you. Are there some new methods that you could use, e.g. text-messaging? Could you become involved in the Quality Network for Perinatal Mental Health Services and their forum? What can you learn from past reports on maternal deaths?

From your knowledge then consider what you can ACT on:

A – apply

C – change

T – teach

Always remember to keep patients informed about their condition, care and treatment. It really does make a difference.

4. COMMUNICATION

I would highly recommend that you re-read my chapter on communication (see Chapter 9) and decide what you will 'ACT' on in both your internal and external dialogue. Remember about the need to reframe and use positive words about what you want to happen, as opposed to avoiding, e.g. 'hold the cup tightly with two hands' as opposed to 'don't spill the drink'. 'Remember' rather than 'Don't forget'. Think about the words and phrases you use and what their impact may be on those who are vulnerable. A key





element throughout is for healthcare professionals to 'be there' for new parents. As one summed up – 'I knew I was ill. No one listened.' Always appreciate the need for 'someone to talk to' even if you are unable to 'fix' it. I love this quote by Alison Stuebe:

We need to listen to the individual mother in front of us without judgement. We need to ask her what her goals are for her relationship with her baby, and find out how we can help her accomplish them.

Always remember that it is about how you say things as well as what, as in this example, provided by one of the mothers in my survey:

- For health carers, it is absolutely imperative the way they speak, introduce themselves and conduct themselves generally. I remember returning to hospital day 6 post-partum with suspected PP and in need of blood transfusion. I wasn't really psychotic, just spaced out and very, very unwell. A terribly clumsy locum psychiatrist entered the side room where I was with my husband and I do not recall any introduction, names etc. All I recall is her launching into questions starting with 'have you had any thoughts on harming yourself or your baby'. I hadn't, didn't and was shocked and horrified. I believe this pushed me over the edge from being unwell into paranoia and a slide into psychosis. Care, reassurance, politeness, sensitivity and time to build rapport, could have stopped this happening. My husband is very easy going but had an argument with her. I could not deal with the questions so simply turned my back on her and sat silently on the edge of the bed – it had all become too much. She then addressed my husband and asked why I was ignoring her?????!!! (I needed him to be my advocate.) He explained to her that I didn't know who she was or why she was asking me these questions. She could have approached me so differently and had a much more positive outcome for all concerned. So much can be learnt from this – it's not the 'what', but the 'how'!

5. COURAGE

As a healthcare professional I ask you to listen to your instinctive inner voice at times if you feel something could be better with a patient. I often wonder how the healthcare professional who drove away from a mother who said 'Please take me with you' felt the following day, when that mother's body was scraped up from a railway line? Have the strength and determination to act on your instinct. When a patient responds to the question 'how are you?' with 'I'm fine' and you have that gut feeling that they are not, what is the worst that can happen if you look them in the eye and simply ask, 'Are you really?' Our society tends to be so rushed today that people are worried about answering that question honestly. One mum said 'fine' stands for 'I'm Fed-up, Insecure, Neurotic and Emotional!' Get beyond the 'Fine' and ask more questions.

I have been told that some healthcare professionals are reluctant to ask because either they do not know how to respond if they really admit their thoughts and feelings and/or they do not know where to refer. Find out!

I have also suggested to parents that if they are not comfortable with some- one who is supposed to be caring for them, to ask to change to someone else. I also encourage you to do the same. If you have a 'clash' for no other reason than that not all human beings connect, ask if you can swap with someone else. It may be that your skills are much better suited to someone who is currently having a clash too! Your courage at being honest could be the difference in a life being saved or at least improved.

6. COMMITMENT

The 6 Cs are meaningless unless you apply them. Embrace them. Choose and decide what knowledge you need to acquire to make your good practice great. Silence the inner critic (remember 'Shut the duck up') and investigate and apply what you *can* do.

We are all aware of why perinatal mental health is so important. We know how we can make it better. We simply need to identify what it is as individuals, groups and health and care organisations we can do to make a difference.

What if we all played our part in making a future pregnancy, birth and early parenthood better for those who previously were mentally unwell?

TOP TIPS FOR HEALTHCARE PROFESSIONALS

1. Listen to the parents and take their concerns seriously.
2. Be proactive in getting swift and correct referral or treatment as necessary.
3. Provide appropriate support and time at each stage of their journey.
4. Have relevant training in perinatal health.
5. Work towards a consistent national specialist perinatal mental health service in the UK.
6. Be compassionate and empathetic as opposed to judgemental.
7. Remember that with correct support and treatment, a positive outcome can be possible for an additional pregnancy.
8. Apply the 6Cs of Care, Compassion, Competence, Communication, Courage and Commitment to your role.
9. Believe that as an individual you can be instrumental in building a perinatal team to support many.

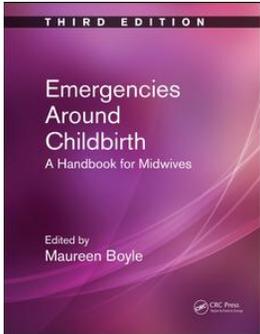


CHAPTER

7

Psychological considerations for emergencies around childbirth

7. Psychological considerations for emergencies around childbirth



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INTRODUCTION

Psychological care of the woman and her birth partner during a birth emergency is an important element of the management of a birth emergency. The previous chapters have focused on life-saving measures and professional considerations. The physical well-being of the woman and her baby is paramount, as is professional competence. The psychological well-being of the woman and her partner may not seem as crucial at the time of a birth emergency but occurrence of an emergency can result in long-lasting adverse effects, including flashbacks and nightmares, panic attacks and disrupted relationships with baby and partner. Emotional support needs to be provided during and after a birth emergency, as evidenced by the following quotes from qualitative research.

Two months after experiencing a significant postpartum haemorrhage, ‘...the staff and care me and the babies received were excellent. Just the emotional side of the labour and birth still bothers me’... they do what is easiest to save your life but the care of the mind is not looked at, at all.

In addition, there has been concern that use of manikins for emergency skills training does not consider the patient’s viewpoint. Research clearly indicates that this area of care needs to be addressed. Postnatal depression (PND) and post-traumatic stress disorder (PTSD) (see Box 14.1 for definitions) have been shown to be more common in women following a difficult birth such as emergency caesarean section (EmCS) or operative vaginal birth. A traumatic birth event can also result in PTSD in fathers. Depression and post-traumatic stress (PTS) have been shown to co-occur, and pre-existing depression, anxiety disorder and/or social isolation can increase susceptibility to PTS following a birth that is perceived as a traumatic event. The two disorders share some features including diminished interest, feelings of detachment, and difficulties with sleep and concentration.^{13,14} Verreault et al.¹⁵ state that the risk factors for postpartum PTSD symptoms ‘can be categorised into vulnerability-related, trauma related, and postpartum factors’ (p. 257). Awareness of these psychological disorders should be used to inform postnatal psychological care following a birth emergency/traumatic birth.

Factors during a birth emergency shown to benefit psychological well-being and recovery following a traumatic birth should be implemented as part of the emergency management. Midwives should also take into account the body of evidence showing there is a relationship between antenatal and postnatal psychological well-being. This is reflected in the National Institute for Clinical Excellence (NICE) guidelines.¹⁹ The guidelines, in addition to recommendations relating to specific care for those

BOX 14.1: Definitions

- *Postnatal (postpartum) Depression (PND)* refers to depression identified by the Edinburgh Postnatal Depression Scale¹⁶ or a modified version of the Beck Depression Inventory¹⁷ to take into account ante/postnatal factors.
- *Postnatal Stress* refers to symptoms of postnatal distress where all the criteria for postnatal stress disorder may not have been measured or met. Only a small percentage of women are likely to experience all the criteria.
- *Postnatal Stress Disorder* refers to the disorder reflecting the criteria in the American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (*DSM-IV*)¹³ and 5th edition (*DSM-V*).¹⁴ The symptoms are mostly the same in the two editions, apart from the removal of an individual's response to the event being intense fear, helplessness or horror in *DSM-V*. Much of the literature refers to *DSM-IV*.
- PTS and PTSD are used somewhat interchangeably. In the literature and research there is no standardised scale used for PTSD across studies.¹⁸

women receiving treatment for a mental health problem, advocate routine screening of all women at their antenatal booking visit for depression and anxiety. NICE also provides guidelines for the postnatal period.

It is clear that psychological care needs to be addressed by those providing maternity care commencing with the first contact and continued throughout the whole childbirth experience. Midwives have a particular responsibility in labour, as failure to address the woman's psychological well-being during labour and a birth emergency could have long-term ramifications for the woman and her family. White et al. suggest that symptoms of PTSD can persist for as long as 40 years after the event.

The main aim of this chapter is to equip midwives with knowledge of the factors shown by research to promote the psychological

well-being of the woman and her partner when there has been an emergency during the birth of their baby. It is hoped that by implementing the recommendations indicated by research findings, women and their partners will be better able to cope with a traumatic birth and be able to enjoy parenthood. Psychological disorders associated with childbirth are also discussed to enhance midwives' knowledge.

PSYCHOLOGICAL HEALTH AND CHILDBIRTH: AN OVERVIEW

Early descriptions of psychological disturbances following childbirth were associated with physical problems. Hippocrates, in his description of 'milk fever', mentioned symptoms of weeping and hysteria. Louis Victor Marce (1828–1864), a Parisian physician, was one of the first to recognise the existence of mental distress specifically relating to childbirth; however, toxemia and sepsis were common causes of puerperal psychoses around this time. Fears of complications of childbirth in the nineteenth and



early twentieth century also led to maternal apprehension and depression. Shorter, in his chapter on pain and death in childbirth, includes a quote from a working class woman around 1914: 'I always prepared myself to die, and I think this awful depression is common to most at this time' (p. 70). Recognition in the 1930s that women may have psychological problems associated with childbirth and lactation was acknowledged by the Infanticide Acts of 1922 and 1938. These Acts considered that a woman who caused the death of her baby (up to 1 year) was deemed to have diminished responsibility as a result of her mind being disturbed. Altered mental states following child-birth were largely thought to be a result of the reproductive process; women were at the mercy of their problematic biology. Oakley suggests menstruation and childbirth are beyond the understanding of men and this resulted in medical psychiatric diagnoses of premenstrual tension and PND. Thus unhappiness after childbirth, frequently a result of a defective social structure,²³ became more or less universally labeled as PND. Postnatal mental health needs to be considered in the social context rather than being seen as an individual psychological or biological problem, as may be the case in a biomedical approach, where 'the women's feelings are reduced to a matter of hormonal imbalance' The positive effect of social support has been shown in studies of postnatal well-being.

The main psychological problems associated with childbirth are PND, anxiety disorders and PTSD. Mild and moderate PND has been considered largely to have its roots in the biophysical and psychosocial domains and has been accepted as a postnatal illness since 1968, when it was described by Pitt.^{27,28} PND is relatively common, with an incidence of 8%–15%.²⁸ When it is transient, lasting no longer than a few days following childbirth, it is referred to as postpartum depression (or 'baby blues'). If it lasts beyond a week and results in impairment in the woman's ability to function it is known as PND. Postnatal depression may also occur in fathers and is estimated by Beck and Driscoll to affect 10%–28%. The onset of postpartum depression appears to occur later in the postpartum period in fathers, and studies have shown it to be significantly correlated to postpartum depression in their partner/spouse.

Postnatal psychosis is often considered with PND but it is much more severe and rare, affecting about 1:1000 new mothers. Unlike depression, it is a psychotic disorder involving delusions, hallucinations and gross impairment in functioning usually requiring inpatient treatment.

Postnatal anxiety may accompany PND. Mild and self-limiting anxiety symptoms are common- place in the first few weeks after delivery,³² but these symptoms can be the early signs of something more serious such as PTSD in some women. NICE¹⁹ uses the term *anxiety disorders* to include 'generalised anxiety disorder, panic disorder, obsessive-compulsive disorder, phobias, post-traumatic stress disorder and social anxiety disorder'



(p. 4). In *DSM-V*,¹⁴ PTSD has been moved into a new class of 'trauma and stress related disorders' to include conditions that require exposure to a stressful or traumatic event as a diagnostic criterion.

Unlike PND, PTSD was not accepted as result of childbirth until recently. This in part seems to be because the symptoms associated with PTSD in men were interpreted differently when seen in women. Women having these symptoms were at risk of being labelled emotional and/or neurotic; alternatively, the symptoms were seen as an adjunct to PND. This is discussed later when the evidence that PTSD can occur as a result of childbirth is examined. Another issue was that the *DSM* diagnosis and criteria for PTSD (prior to 1994) was more restricted and could less easily be applied to birth trauma.

PTSD was outlined following World Wars I and II. It was often described as 'shell shock' and the description of it in *DSM-I* (1952) and *DSM-II* (1968) was as reactions to traumatic events which were seen as temporary and having an endogenous aetiology.³³ As knowledge of the disorder increased, the diagnosis and criteria for PTSD included more stressors, and a more general picture of post-trauma anxiety appeared.³³ This meant that in *DSM-III-R*³⁴ the stressors extended more widely from military combat to include stressors such as rape, but there was still controversy about the stressors which could lead to a diagnosis of PTSD. The diagnostic criteria were restricted to events 'outside the range of usual human experience', and childbirth did not fit comfortably with this. Even with further modifications in *DSM-IV*, which took into account that PTSD may occur in individuals who were not exposed to an unusual event or even to an acute stressor, controversy continued. However, this change was an important one in that it recognised that an individual's perception of a threat and response to an event can affect the subsequent development of PTSD. The broadening of the diagnostic criteria has enabled consideration of PTSD as a consequence of childbirth by researchers and clinicians.³⁵ Subsequently this has been further endorsed by *DSM-V*, which includes exposure to actual or threatened death, serious injury or sexual violation as triggers for PTSD. (See Box 14.2 for diagnostic criteria.)

Ideas relating to the psychological sequelae of childbirth have moved from the perception that any problems were endogenous, being a result of the woman's biology, to being largely a result of outside factors, which can be mediated to improve women's postnatal psychological well-being. Thus midwives have a key mediation role to help facilitate an environment which promotes women's mental health in childbirth. In order to do this, midwives also need to consider that the psychological effects of childbirth, as with any psychological response, are affected by numerous variables. Those relating to childbirth include:

- The psychological type or personality of the individual

- Previous life experiences and mental health
- Social support available
- Expectations of birth and becoming a parent
- Antenatal well-being
- The birth experience
- Postnatal well-being and experience

These variables interact, with the result that women and their partners will respond differently to experiences the midwife may feel are similar.

BOX 14.2: DSM-V diagnostic criteria for PTSD as applied to childbirth¹⁴

- A. The person has been exposed to a traumatic event, i.e. childbirth, which involved threatened or actual death, or serious injury, or violation to the woman or her baby. The exposure may be direct experience, witnessing or by learning of the event involving a close family member or friend.
- B. Following the traumatic birth one or more of the following intrusive symptoms are present: recurrent, involuntary distressing memories. Recurrent distressing dreams related to the birth event; dissociative reactions such as flashbacks in which the mother or relative/friend relives the traumatic birth; intense or prolonged psychological distress on exposure to cues such as sexual intercourse and anniversary of the birth; marked psychological reactions to internal or external cues that symbolise or resemble an aspect of the traumatic birth.
- C. Persistent avoidance of stimuli relating to the birth and including one or both of the following: efforts to avoid memories, thoughts or feelings associated with the traumatic birth; efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts or feelings about, or closely associated with, the traumatic birth, which may result in avoiding a subsequent pregnancy.
- D. The beginning or worsening of negative alterations and mood associated with the traumatic birth, such as inability to remember an important aspect of the trauma, negative beliefs or expectations, distorted beliefs about the cause or consequences of the trauma, negative emotional state such as fear, horror, anger, guilt or shame about the experience, marked diminished interest or participation in significant activities, feeling of detachment or estrangement from others, restricted range of feelings, sense of foreshortened future. All these criteria may affect the parents' relationship and bonding with their baby.
- E. Persistent symptoms of increased arousal and reactivity such as angry outbursts and aggression, reckless behaviour, hypervigilance (of baby), exaggerated startle response, problems with concentration, sleep disturbances.
- F. Duration of criteria B, C, D and E is more than 1 month.
- G. The disturbance causes significant distress or impairment in social, occupational or other areas of functioning such as parenting.
- H. The disturbance is not attributable to the effects of substances (such as medication or alcohol) or another medical condition.

For example, Ryding et al.,³⁶ in their study of 25 women's experiences of EmCS, found that positive expectations turning into disappointment resulted in the highest prevalence (two-thirds of the women) of post-traumatic intrusive stress reactions 6 weeks after the birth. In this study women identified as confident whatever happened had no signs of PTS, whereas women who had fears that were realised all perceived the



birth as traumatic, and one third had signs of PTSD. The research of O'Donovan et al. exploring predictors of PTSD after birth concluded that helping women – especially those with a history of previous PTSD and affective disorders such as depression – develop realistic expectations may help them to not view their birth experience as traumatic and thereby reduce the incidence of postnatal PTSD.

For the midwife to understand why women respond differently, risk factors for PTSD and depression after birth need to be explored. The variables suggested above may provide some clues and will be considered further. These factors relate to what has happened before the pregnancy as well as what happens during the pregnancy and childbirth, thus providing a holistic view.

ANTENATAL CARE AND PRE- EXISTING PSYCHOLOGICAL FACTORS

Pre-existing factors which have been found to increase the risk of PTSD following childbirth include

- Depression in (early) pregnancy
- Fear of childbirth (severe)
- Pre-traumatic stress
- Anxiety disorders
- Low stress coping (low self-esteem and self-efficacy)
- Previous psychological problems
- History of psychological counselling related to childbirth

Previous psychosocial problems such as domestic violence and sexual abuse are examples of factors that result in women being more vulnerable to further psychological problems. In a study undertaken by Menage almost one third of women found to have diagnostic criteria for PTSD following obstetric and/or gynaecological experiences gave a prior history of sexual abuse or rape. Lev-Wiesel et al.³⁸ likewise found that childhood sexual abuse increased the risk of PTSD following childbirth. There is also a suggestion that people have different thresholds for trauma in the same way as people are thought to have for pain.³⁹ This may partly explain why women who appear similar respond differently to what appear to be similar situations. Midwives caring for women during birth emergencies should be aware that by providing evidence-based psychological care they may be able to reduce the incidence of adverse psychological sequelae but not eliminate it, due to the severity of the birth emergency, the woman's psychosocial background and the woman's threshold for trauma.

The importance of identifying mental health and psychosocial factors has been recognised as a key issue following findings of maternal mortality reports, which have shown that suicide is a leading cause of maternal death (although the rates are similar





to the general female population). These findings have indicated that more attention needs to be paid to mental health issues when providing maternity care. The number of suicides during pregnancy up to and including 6 months postnatal was 29 in 2006–2008.³² Four of these were during pregnancy and 25 were postnatal. These deaths provide an indication to the prevalence of postnatal mental distress. Of these women, 66% had a previous psychiatric history. Midwives therefore need to be alert to all signs of maternal distress including PND and PTSD. If mental health problems are identified antenatally, informed efforts could be made to provide appropriate care throughout the maternity experience and potentially improve psychological well-being should a birth emergency occur. The strongest predictor for PND has been identified as prenatal depression.

The 2011 CEMACE³² report noted a non-significant increase in maternal suicide. As has been previously recommended by CEMACE's earlier reports, this report re-emphasised that all women should be routinely asked, at their antenatal booking visit, about a previous history of mental illness as well as their current mental health. These recommendations are reflected in NICE guidelines that provide guidance for recognising mental health problems in pregnancy and the postnatal period, and the importance of referral. They recommend that all healthcare professionals communicate information on any past or present mental health problems when referring a woman to a maternity service, and that the range and prevalence of anxiety disorders and depression are recognised. The guidelines suggest that depression identification questions and two-item Generalised Anxiety Disorder scale (GAD-2) questions are asked as part of a general discussion about a woman's mental health and well-being (see Box 14.3) at booking. These questions should be repeated during the early postnatal period, and all health professionals should consider asking these questions at all contacts with the woman during pregnancy and postnatally. If a woman responds positively to the depression identification questions or scores three or more on the GAD-2 scale there should be further assessment and referral to the general practitioner or mental health professional. All interventions for mental health symptoms should be delivered by competent practitioners. The guidelines include treatment for specific mental health problems such as tokophobia. The guidance for postnatal support following a traumatic birth will be considered later.

The issues of mental illness and pre-existing psychosocial problems are largely beyond the scope of this chapter except where they have a direct impact on the woman's ability to cope with a traumatic birth. Women with a mental illness require specialist care, however, the principles of effective psychological care should be applied to all women and their partners. If women do have depression or PTSD following a previous traumatic birth and this has not been addressed it may have an adverse effect on any

BOX 14.3: Antenatal mental health screening questions¹⁹

DEPRESSION IDENTIFICATION QUESTIONS

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

TWO-ITEM GENERALISED ANXIETY DISORDER SCALE¹⁹

- During the past month, have you been feeling nervous, anxious or on edge?
- During the past month have you not been able to stop or control worrying?

subsequent pregnancy. Midwives therefore need to be aware of care that supports women following a birth emergency and understand how to promote antenatal psychological well-being.

Pre-traumatic stress, general anxiety and fear of childbirth have been shown to be the factors most strongly related to PTSD and depression one month after the birth.^{4,10} These antenatal factors may in some cases, as indicated above, be related to previous births. Zar et al.,⁴³ in a study on anxiety disorder and fear of childbirth in late pregnancy, found all six

multiparous women with PTSD in their study had a previous birth as the traumatic event. These women had a phobic fear of childbirth. This symptom of PTSD may not be identified until a subsequent pregnancy when the woman expresses her fear of childbirth. A subsequent pregnancy can lead to panic and terror. Some of these women request an elective caesarean section (CS). As well as having a negative impact on subsequent pregnancies, fear of childbirth has also been shown to cause some women and/or their partners to avoid having subsequent children. Choosing not to have further children after a near-miss event (where the woman nearly lost her life) may be a normal response, but in some circumstances it may be related to inadequate support provided around and subsequent to the event.

In addition to pre-existing factors, midwives also need to be mindful of antenatal preparation that can assist a woman to cope mentally with a birth that does not go according to plan. As identified by Ryding et al.,³⁶ positive expectations turning into disappointment appears to be strongly associated with postnatal PTSD. Women in a study by Somera et al. 6 of women's experience of EmCS clearly indicated that women were not prepared for their birth to not be a normal or 'beautiful experience'.

I didn't prepare myself for the possibility of a c-section. I didn't expect it at all.

It ended up being a medical emergency rather than this idyllic beautiful experience. It certainly wasn't what I had pictured.



Antenatal preparation should also be considered for women's partners to enable them to have realistic expectations and assist their ability to support women during labour and birth.⁴⁸ A survey of 140 fathers in New Zealand found that 100% valued a separate 'dads group' during the antenatal course and to be able to talk with 'dads' who had gone through the experience to prepare them for the birth.⁴⁹ Experiences of traumatic birth discussed later demonstrate that antenatal preparation can be expected to assist both pregnant women and their partners in coping with a traumatic birth and avoid descriptions of being 'totally unprepared'.

THE PSYCHOLOGICAL IMPACT OF A TRAUMATIC BIRTH

The woman's perception of her birth being traumatic could be expected to lead to negative psychological repercussions. However, perceptions and the ability to deal with traumatic experiences are affected by variables (such as depression and anxiety) identified earlier. Midwives and others who provide care need to acknowledge that their perception of what happened may not be the same as the woman or her partner's perception. For example, some aspects of labour care such as artificial rupture of membranes (ARM), or the 'pulling' involved in a LSCS when the baby is delivered, both considered routine by a midwife, can constitute a traumatic experience.⁵⁰ Also, hospital staff may view a 'near miss' as a positive outcome and not consider the perception by the woman and her close family of the potential for negative outcomes.⁹ Lack of awareness can lead midwives to be dismissive of such concerns. By being mindful of this, and by avoiding factors that have been identified as contributing to women's psychological problems, midwives can make a positive contribution to the psychological well-being of the women for whom they provide care.

In the United Kingdom, providing care that promotes a positive birth experience has been highlighted in government policy for maternity care. Reports state that midwives and others providing care should work in partnership with women. A national strategy launched in 2012 introduced the six 'Cs' (care, compassion, competence, communication, courage and commitment; see Chapter 1), in relation to psychological care; compassion and communication are particularly of note. Midwifery 2020 indicates that midwives are responsible for providing both a physically and emotionally safe service. Sadly, literature and research into PTSD indicates that some cases of PTSD may be wholly or partially a result of these government policies not being followed. The experience of undergoing a birth emergency could be expected to be traumatic for a woman and as such will create challenges for the team providing care to promote a positive experience. While their priorities are to the physical well-being of the mother and baby, a bit more consideration of the mother as a person may make a big difference to her and her partner.





Awareness of women's traumatic experiences of childbirth and the resulting psychological problems increased when campaigners from organisations such as the Association for Improvement of Maternity Services (AIMS) and National Childbirth Trust (NCT) addressed women's experiences. An example of this awareness is a letter written in 1985 by Beech and Robinson⁵⁶ to the editor of the *British Journal of Psychiatry*, concerning women suffering 'severe nightmares' a year or more following childbirth. The term PTSD was not used, but the symptom of 'severe nightmares' is one associated with PTSD. They also identified mediating factors including 'excessively painful and traumatic deliveries', 'unsympathetic staff', experience of 'technological rape' and the 'impossibility to discuss criticism of previous care'. Several authors, including Kitzinger, describe quality of care factors such as poor communication and lack of control, causing subsequent distress. She provides graphic examples in quotes from women: 'They didn't speak to me. Only about me'. '... felt like an oven-trussed turkey'. Poor communication and lack of control are described as key issues leading to PTS after childbirth. More recent studies echo these findings.

Harris and Ayres, in a survey of intrapartum 'hot spots' for traumatic labour and birth, concluded that interpersonal issues such as 'being ignored, lack of support, [and] poor communication' were the most common 'hot spots' identified. These were followed by obstetric events and pain, and then by events concerning the baby. An example of being ignored is provided by Beck⁶⁰: 'The hospital discussed my baby's possible death in front of me and argued in front of me just as if I weren't there'

Inhumane treatment is further described in a meta-ethnographic study,¹ together with other themes relating to women's experiences of a traumatic birth. Women used phrases such as 'barbaric', 'horrific' and 'degrading' to describe their treatment by health professionals. They had thoughts of death to make their ordeal of pain and trauma end. Sadly, such examples of care associated with traumatic births occur all too frequently. Ayres et al., when discussing narratives relating to traumatic birth, state 'The importance of negative interaction with staff is consistent with a large amount of research showing that interpersonal traumas, such as abuse are more pathogenic than non interpersonal traumas'. Ayres et al. also state that meta-analyses have shown that lack of support is associated with PTSD.

The importance of relationship with the staff is also shown in a study of 825 women's experiences of childbirth undertaken by Green et al. which explored women's expectations and identified both positive and negative experiences. The issues they identified affecting women's overall satisfaction with birth included the women's feelings about major/minor interventions, pain and pain relief, control, relationship with the staff, amount and accuracy of information, and ability to get into a comfortable position. When assessing 'emotional well-being' following birth, a relationship was



found with having or not having interventions. This was not so much to do with whether they had the intervention but the context in which the decision was made. The woman's perception of the 'rightness' of the intervention was seen to be more important for her emotional well-being than the intervention itself. Women who felt the right decision had been made were significantly happier. This again reflects the importance of good communication and involvement of women with their care. A body of psychological research has provided further information and evidence regarding PTSD following a woman's traumatic experience of child-birth. This research should increase knowledge and understanding to assist health professionals in developing interpersonal skills that support women and their partners, particularly when an emergency occurs.

The incidence of PTSD and PTS as a result of childbirth varies throughout studies depending on the methods used and whether all the DSM-IV criteria are met. Rates between 1% and 7% are described by Soderquist et al. A study undertaken by Alcorn et al. using all the *DSM-IV* criteria found 3.1% of women had PTSD at 6 months after birth after controlling for previous traumatic events and clinically significant antenatal anxiety and depression. The number of women identifying aspect(s) of their birth as a traumatic event is much higher than this, at around 33%⁶⁴–45.5%,⁶³ but the majority of these women do not develop PTSD. The prevalence of a PTSD profile appears to be fairly stable over the first year, leading researchers to conclude women with PTSD do not all recover spontaneously.^{11,62} Although studies show some variation in research methods and findings, they consistently indicate that PTSD can occur as a result of childbirth and that it may not resolve spontaneously. However, there is some evidence that a larger proportion of women do spontaneously recover from postnatal PTSD compared with women experiencing PTSD after other traumatic events such as rape.

PTSD may also occur in fathers witnessing a traumatic birth involving their partner and/or baby. In Western society there is an expectation by partners, friends and family that the father attends the birth of his children, and while many fathers do this willingly, some are ambivalent and nervous. In a meta-synthesis of fathers' experiences, midwives were identified as best placed to make a significant difference in how the fathers perceived labour and birth. The key conclusions of this study indicated that while being committed to being involved, the men expressed overwhelming feelings and inadequacy. They often felt vulnerable, so being prepared and supported were essential elements of a positive experience and being able to support their labouring partner. For some fathers, being present at the birth can be 'distressing and distasteful' even if there are no complications. Ayers et al.'s study of PTSD in couples after birth showed that 5% of men and women had severe symptoms of PTSD, other studies have shown rates for men to be approximately half that for women. The symptoms were found to be strongly associated within couples, and related to similar birth factors.

White investigated the experience of fathers witnessing a traumatic birth. All the participants had been distressed by their experience and had bad memories, although not all described symptoms of PTSD. Descriptions from the fathers included:

Our birthing experience was a traumatic one.

My single worst experience...

Took three days to get over the scene, shock, did not take it in I was a dad...I can describe everything in the room, smells, sounds, colours. I can still see the images...causes headaches... clinical smells get you going. I resigned from my hospital laboratory job.

These findings clearly show that partners can experience similar negative psychological outcomes as mothers following a traumatic birth.

In addition to PTSD, the incidence of PND may also increase as a result of a traumatic birth. PND has been reported to be present in a significant number of women with PTSD after childbirth. This has also been shown to be true with fathers. The consistent findings of a high comorbidity of PND and PTSD appear to be associated with risk factors the two conditions share, and they show that pre-existing depression increases the risk of PTSD.¹⁰ It is important that the diagnosis is correct for appropriate treatment to be provided. White et al.¹¹ suggest that if there is a high degree of overlap between PND and PTSD, PTSD may be missed. They cite cases of women who experienced a traumatic birth and subsequent upsetting thoughts being diagnosed with PND by their general practitioners. Joseph and Bailham point out that only routinely screening for PND can mean that PTSD is missed, and the treatment for these two conditions is different. Drug treatments may help PND, but psychological therapies are thought to be more appropriate for PTSD. This situation may improve if the guidelines introduced in the United Kingdom in 2014 are implemented and if women are also routinely screened for anxiety disorders (see Box 14.3).

BOX 14.4: Summary of potential birth traumas

Stillbirth/infant death	Postpartum haemorrhage/manual removal of placenta
Emergency caesarean section/fetal distress/fear for baby's life	Forceps/vacuum extraction
Fear for own life (maternal collapse/cardiac arrest)	Severe pre-eclampsia/eclampsia
Inadequate medical care/felt that staff did not know what they were doing	Premature birth
Fear of epidural/felt coerced into having an epidural	Separation from infant in neonatal intensive care unit (NICU)
Inadequate pain relief	Prolonged, painful labour
	Rapid delivery
	Degrading experience/unsympathetic staff



CHILDBIRTH RISK FACTORS FOR PTSD

As identified earlier, it is the woman's perception of childbirth and the support she receives that are important for her psychological well-being. After investigating 40 women's experiences of traumatic births, Beck concluded a traumatic birth was 'in the eye of the beholder'. From the women's descriptions of their births Beck identified four main themes. These related to care, communication, trust and price of the outcome. She also listed the birth traumas identified by the 40 women in her sample. The traumas she identified are largely similar to those identified in other studies. (See Box 14.4 for a summary of potential birth traumas.) Women's experiences of birth trauma include aspects of childbirth which may not have been recognised by midwives and other carers, for example 'inadequate medical care' and 'degrading experience'. Ayers et al. point out that research shows that subjective factors such as perceived support and control may be more important than objective factors such as type of delivery for the development of postnatal PTSD. Ayres et al.⁵⁰ state that a body of evidence shows interpersonal trauma during birth to be more pathogenic than non-interpersonal trauma. Subjective factors (involving interpersonal care) as well as having a negative impact may also alleviate the effects of a complicated birth. In a study of the effects of EmCS, a woman was quoted concerning her experience of a second EmCS:

I really feel as though I was given every possible chance to achieve what I wanted. Nobody forced anything on me. I can only look back positively. Even though I ended up with an emergency caesarean section it was absolutely the right decision.

Creedy et al. also found that women experiencing a high level of obstetric intervention were less likely to develop PTSD if they perceived their intrapartum care to have been adequate. Similarly, Boorman et al., in a study of 890 Australian women, found that only one third of those who had an EmCS reported a traumatic birth. Their findings indicated that factors such as a sense of control around decision making and adequate information from staff were protective. Another study found that 'support during birth was shown to be particularly important for women with a history of prior trauma or having a high levels of interventions during birth' to protect against the development of PTS symptoms.

As indicated earlier, the incidence of PTSD has been shown to be higher where birth complications/interventions have occurred. Many of the birth traumas listed in Box 14.4 are associated with emergencies around childbirth. The majority of psychological research focuses on the prevalence of PTSD and the factors that are associated with it, and although this provides valuable information, the detail that may assist midwives and other carers is not always provided. A study that does provide detail in respect to obstetric emergencies is one undertaken by two research midwives. They studied 10



women's experiences of obstetric emergencies that included cord prolapse, placental abruption, shoulder dystocia, uterine scar rupture, severe pre-eclampsia, and major obstetric haemorrhage. The interviews in their study highlight practice issues that need to be considered to improve the woman's experience and recollection of the event.

The findings of Mapp and Hudson³ are directly related to emergencies around childbirth. The significant themes they identify include communication and the need to make sense of what happened. In regard to communication, the women were very aware of nonverbal cues such as fear being expressed in the facial expressions of the healthcare professionals. This was also expressed by women in the study by Thompson et al.² The women were aware that something was wrong without being told, and were frightened when they did not know what was happening. The women also commented on being reassured by receiving a smile. Touch was also identified as being important as it made the woman feel she was a human being. This contrasted with staff communicating with each other and ignoring the woman.

Information given during an emergency situation may not be understood and explanations may be required later. A mother illustrates this in a study undertaken by Calam et al.:

I had fulminating toxæmia. They took the trouble to explain everything. What they'd do, how they'd make the incision. Another doctor explained about premature babies and their chances. I felt supported. Even the anaesthetist bothered to see me. I was a person.

Did you understand?

No. I was too upset and involved.

The women in Mapp and Hudson's³ study appreciated that the staff were probably shocked by the situation too, and needed to manage the emergency. They identified a variety of experiences. Positives included anaesthetists and midwives providing explanations and support. There were comments regarding communication with their partners, with instances of women thinking there was a problem relating to them when their partner was called aside to change out of theatre clothing. The positioning of the partner in theatre and the 'green sheet' impaired communication. They felt disorientated and restricted in theatre. The women recalled experiences such as staff running down a corridor and the air blowing on their face, inexplicable pain, drifting off and then feeling better when blood transfusions were up. In most cases the women felt the situation was in the medical domain and recognised they did not have the knowledge to influence the management or outcome.

The women felt fearful for their baby's mortality but appeared to trust the healthcare



professionals would help them, despite lack of explanations. They viewed continuity of carers and familiar faces positively, and felt secure when staff showed concern. However, there were instances described where the women did not feel listened to and false reassurances did not validate their situation and how they felt. The women were concerned that their partners were looked after and kept informed. They looked to their partners for support such as holding their hand and reassurance, but recognised that they would be frightened too.

The study by Thompson et al. indicated similar findings in relation to women's experiences, but it focused more on the negative aspects of interpersonal care. It sought to identify sources of distress for the women including gaps in the service and meeting informational needs following a significant primary postpartum haemorrhage (PPH). The study included a cohort of 204 women recruited from 17 major hospitals in Australasia. Quotes from the women provide graphic examples of inadequate information to help them understand what had happened, and lack of supportive care. One woman stated 'I was incredibly frightened and I didn't get any reassurance' (p. 330). As identified in other studies, 59,75 staff did not speak directly to the women at the time. Thompson et al. provide statistics showing satisfaction of care following a PPH. These show that overall satisfaction is high – 96% were either very or somewhat satisfied. This figure may reflect that the women were relieved to have survived a significant PPH.

When women were asked about the information they were given about their physical recovery, 62% said they had adequate information, and regarding their emotional recovery only 48% thought they had adequate information. Emotional support is discussed further in relation to postnatal care.

Further insight of women's experiences is provided by a meta-ethnography of women's perceptions and experiences of a traumatic birth in which 10 qualitative studies were examined.¹ The studies identified six major themes:

- feeling invisible and out of control
- to be treated humanely
- feeling trapped: the reoccurring nightmare of my childbirth experience
- a rollercoaster of emotions
- disrupted relationships
- strength of purpose: a way to succeed as a mother

The issues raised for midwives and other healthcare professionals include taking notice of women's opinions and not making authoritarian decisions, not being 'too busy' to explain procedures and what is happening.





Further suggestions for midwives and other birth attendants are identified in research undertaken by Ayres. Ayres' study aimed to explore issues that might be important in the development of PTS. It compared women with and without PTS following similar birth experiences. The sample had a high incidence of birth complications, due to this being the case for women with PTS, and those without PTS being matched. Twenty-five women in each group were interviewed about their experiences 3 months after giving birth to examine their thoughts and emotions during birth and their subsequent cognitive processing. Some themes identified from the interviews were common – for example poor understanding and feeling scared. Those with PTS felt more panicky, helpless, angry and discouraged, and had more thoughts of death, mental defeat and dissociation. The thoughts of death were not always in response to a life-threatening situation, showing that women can fear death without a medical reason or trigger. Midwives and other carers need to be sensitive to women's fears and reassure women and their partners by preventing or minimising the perception of a threat to life as appropriate.

The theme of anger may relate to not being listened to and not being happy about the care given. However, in some cases, it may be due to the birth not going to plan despite the best efforts of the birth attendants. Anger appears to exacerbate and perpetuate PTS symptoms. Steps should be taken to recognise negative emotions to avoid mental defeat and dissociation, and when negative emotions are evident the woman should be supported as much as possible.

In the study of 'hot spots' undertaken by Harris and Ayres interpersonal difficulties and obstetric complications were associated with a higher incidence of PTSD than complications with the baby. They suggested a reason for this could be that women receive more support from hospital staff, friends and family, recognising the upset involved with having a sick baby. This reinforces the importance of communication and support to reduce the risk of PTSD following all birth complications.

The experiences of fathers during birth emergencies also warrant consideration as they may be sidelined, with the focus being on the woman and her baby. The themes identified as encapsulating fathers' traumatic experiences in White's study related to being a spectator, not being included, feeling sexually scarred and having to 'tough it out'. Fathers are under pressure to witness the birth of their baby but their role is not always clear. They are expected to be a support, a fetcher and carrier, and a spectator but not necessarily a participant. They felt alienated, excluded and disregarded. The following quotes from the study⁷ illustrate these feelings:

felt like an appendage in the way not being given any information

I was rushed to the corner of the delivery suite and told not to interfere...it's like

you don't count

evidence of midwife only working with the mother

These quotes clearly indicate that the fathers were not given information and support. Lack of support is further shown in the theme 'toughing it out', where fathers describe being fearful of losing their wife and unborn child, and coping by breaking down in private. They felt disempowered and unable to help their wife. The fathers in the study were all keen to be involved but the pressure to witness led a few to experience sexual scarring, affecting their ability to resume a sexual relationship with their partner. Three fathers declared they would never have any more children.

Further information of partners witnessing birth is provided by a qualitative study of 10 male partners' and one lesbian partner's experiences of life-threatening experiences in pregnancy undertaken by Hinton et al.⁹ Such experiences could be expected to be shocking and distressing. Their findings also showed that the partners' experiences were characterised by powerlessness and exclusion. For example, Sally describes being asked to leave the room when her partner had a haemorrhage. She was left alone and no one provided any explanation while the emergency was being managed. Similarly, John was left for hours with no news of his wife's condition when she haemorrhaged and doctors had to perform a hysterectomy to save her life. One husband recalled waiting without news and twice being told to go away when he approached the operating theatre doors. Another husband whose wife was taken to intensive care misunderstood the situation and thought his wife was dead. When he was taken to see her on a life support machine he stood with her for about an hour stroking her hand. No one explained to him that she would recover. Two other husbands described being shocked when seeing their critically ill partners, and no one provided information to assist their understanding.

Support from both family and staff was very important. Personal touches from individual staff have been shown to make a real difference in how partners cope. One husband whose baby was still-born after his wife had an antepartum haemorrhage was comforted by a kind anaesthetist's act of support. A year later he recalled when his wife was 'out for the count' and he was holding his daughter, the anaesthetist putting her arm around him and stroking his wife's hair.

Communication from medical staff that was clear and honest was highly valued. Partners appreciated it was difficult to communicate while dealing with an emergency. However, how well staff communicated during or after the emergency was important. One husband whose wife developed HELLP syndrome 11 weeks later stated, 'I think they did a wonderful job of trying to explain it in a way that a medical dummy like me could sort of understand things'.

Feelings such as being scared, fearful, helpless and angry were common to mothers and fathers experiencing PTS. Both mothers and fathers have shown awareness and concern about the support given to their partner during a birth emergency. A woman in Mapp and Hudson's study commented about her partner's experience, 'He had a midwife with him making sure he was kept up to date'. It is important that psychological care during childbirth is provided for both the woman and her partner. Fathers as well as mothers need to be psychologically supported for good postnatal outcomes. All the men in White's⁷ study experienced subsequent marital difficulties. If midwives focus exclusively on 'being with woman' the outcome for the couple will not be optimal. NICE⁷⁹ advocates involvement of partners throughout pregnancy and childbirth, and there is evidence that involvement during labour and support postnatally have a positive effect on the subsequent health of the mother and baby.

BOX 14.5: Strategies to minimise emotional trauma during a birth emergency

Communicate with the woman and her partner. If the doctors do not communicate directly, convey what they are saying to the woman and her partner.
Provide simple explanations of what is happening to both the woman and her partner and rationale for decisions.
Encourage the woman and her partner to express their feelings and ask questions when appropriate to the situation.
Listen and respond to anything the woman and/or her partner say.
Ensure adequate pain relief.
Avoid false reassurance.
Avoid inconsiderate comments, e.g. suggesting the baby is causing problems to the parents.
Encourage parents by focusing on positive aspects such as imminent birth of baby where appropriate and enhance any perception of control.
Use touch to support the woman and her partner if appropriate.
Position the partner where he/she can communicate with the woman where possible.
Positively acknowledge any support the partner provides.
Be aware of facial expression; try to show encouragement and that you care.
Try to provide continuity of carer.
Introduce staff to the woman and her partner.

There is some evidence that worries and fears related to childbirth are more prevalent in women from different cultures. Redshaw and Heikkilä found that compared with white women, twice as many ethnic minority women worried about pain and discomfort, length of labour, possible medical interventions and embarrassment. The research of Ternström et al. had similar findings. Their results showed foreign-born women were almost three times more likely to be fearful. Sociocultural factors related to emergencies around childbirth are not specifically discussed in the literature and research, but if women from different cultures have increased antenatal anxiety, it is



likely that they will be more at risk of postnatal mental health problems should an emergency occur. Also, if a language barrier impairs communication, this may have a negative impact on the already traumatic experience of a birth emergency. For these women and their partners, nonverbal communication and continuity of carer are important strategies to reduce the emotional trauma of the situation. Interpreters should be used where possible.

The literature shows that midwives have a key role in minimising emotional trauma during a birth emergency. (See Box 14.5 for strategies.)

BOX 14.6: Postnatal care following a birth emergency

Promote parental–baby bonding as appropriate.
Encourage and facilitate breastfeeding as desired by the mother.
Avoid leaving the woman alone in the initial period.
Ensure effective postnatal analgesia is provided for women experiencing pain.
Offer simple explanations and information as desired by the mother and father.
Offer sympathy and apologies where appropriate, do not justify or defend care given.
Take into account that women may not want too much information initially, but give information that is needed to facilitate recovery.
Routine ‘debriefing’ is not advised and if felt beneficial should be used with caution.
Provide opportunities and support for women wishing to talk about their experience, encourage use of support from family and friends.
Consider the effect on the partner and include in postnatal care.
Refer parents for specialist support, e.g. psychologist or bereavement counsellor when required.
Provide information concerning ongoing support available so parents can make contact when they want to.

POSTNATAL SUPPORT AND CARE FOLLOWING A BIRTH EMERGENCY

See Box 14.6 for a summary of postnatal care following a birth emergency.

Following a birth emergency, where possible and appropriate, skin-to-skin contact with the newborn baby and early breastfeeding should be encouraged and facilitated to promote parental–infant attachment, newborn thermoregulation and successful breastfeeding. Breastfeeding has been shown to empower the new mother and benefit mental as well as physical health in women choosing to breast-feed. For some women breastfeeding provides an opportunity to overcome a birth trauma, and it can be a way of compensating for not having the birth they would have chosen. The close proximity of the baby can assist women in healing from their ordeal and promote their satisfaction and confidence. It is therefore particularly important that women experiencing a birth emergency should receive all the support they need to enable them to successfully breastfeed their babies. There are some reports of women choosing not to breastfeed to protect their equilibrium and avoid breastfeeding



difficulties. There are also reports of women feeling alienated from their baby due to their experience and as a result are not keen to breastfeed. Midwives need to be particularly mindful and empathetic with regard to women's preferences after a traumatic birth, so that their support aids emotional recovery and does not add to the trauma.

If the mother is unwell, the baby's skin-to-skin contact may be with the father if desired. Parents with infants requiring intensive or special care will require additional support to promote parental bonding and cope with anxieties regarding the well-being of their baby, and these issues are addressed elsewhere.

The experience of a traumatic birth can result in women feeling disconnected from their baby. This inability to feel a closeness and develop a bond may be short-lived, but it can persist. Studies of women with postnatal psychopathology including PTSD have shown that the mother–infant bond may be impaired, resulting in the mother either avoiding the baby or being overvigilant. PND can also have a negative impact on the maternal–infant relationship. Beck and Driscoll and Green et al. found that women's descriptions of their babies were more negative if they had poor 'emotional well-being' postnatally. Midwives should support and encourage parents in getting to know their baby and in caring for their baby.

Mapp analysed women's feelings following a birth emergency using evidence from 10 women interviewed for a study of their feelings and fears during a birth emergency. The women felt 'shell shocked' and emotional; they experienced night-mares and were frightened to be alone in the initial postnatal period. They were unable to process what had happened to them and lacked understanding of why the emergency had happened. This lack of understanding led two of the women not to be aware of how ill they had been and take appropriate care of their health postpartum. In the initial period the women felt 'in a fog' and were unsure of the amount of information they would have been able to take in. Thus midwives need to ensure any information given has been understood and repeat as required.

Postnatal factors such as additional stress, support and the meanings attached to birth events may influence the development of PTSD. Postnatal support by the midwife should include the care recommended in NICE guidelines for postnatal care and respond to individual needs to avoid any additional stress. For example, women experiencing a birth emergency may have had interventions resulting in postnatal pain, so midwives need to ensure analgesia is provided and effective. The experience of postnatal pain can be overwhelming and it has been shown to contribute to PTSD symptoms. As for all women, communication is important, but women who have experienced a birth emergency may require additional information and explanations to assist understanding. In a study by Thompson et al., a woman at 4 months



postpartum said she had not been given any details about why she haemorrhaged or what was done to stop the bleeding. Another woman 2 months postpartum said she was not informed about the extra time it would take for her to recover after losing a lot of blood, she felt she was not coping compared with other women.

A way of assisting women to understand and come to terms with their birth experience may be by providing postnatal 'debriefing'. NICE guidelines state that women should be asked at each postnatal contact about their emotional well-being and support they have. They should be encouraged to report any concerns and health professionals should be aware of signs and symptoms such as unexplained sleeping difficulties. NICE also state that 'women should be offered an opportunity to talk about their birth experiences and to ask questions about the care they received during labour'. NICE do not recommend formal debriefing of the birth, as there is a lack of evidence to support the practice.

Ayers et al. identified that 94% of hospitals in the United Kingdom provided postnatal services for women who have had a difficult birth. Of these services 65% were debriefing services, and 13% 'birth afterthoughts' programmes provided by midwives, midwife-counsellors or doctors. The other 22% were psychotherapy (14%) and service based on individual needs (8%). It was reported that 5% of services were provided in response to research evidence and the remaining 95% in response to women's perceived needs. It is possible that some services have been implemented as a damage limitation measure in response to concerns relating to litigation in obstetrics.

The term *debriefing* is frequently used, but it is a broad term that has caused some confusion in literature and research. Baxter et al. identified two main types, structured and unstructured, the former relating to more formal psychoanalytical forms and the latter to sessions commonly undertaken by midwives, but they comment that the type of service provided was not always clear in the studies. The need for clarity of terms has been identified by Alexander⁹⁵ and Rowan et al.⁹⁶ who concluded that the provision of a postnatal child-birth discussion as part of good midwifery care should be differentiated from a formal debriefing, which is not recommended (see Box 14.7).

There is little evidence that formal debriefing interventions are beneficial in improving mental health, and there is some evidence that such interventions could possibly increase the risk of developing PTSD and depression.^{97–101} However, it should be noted that despite no measurable benefit, women generally reported it to be helpful. The recent critical review of the literature by Baxter et al.⁹⁴ relating to current practice in offering a postpartum 'debriefing' (both structured and unstructured) service to women reached similar conclusions from examination of 20 papers – that women's responses to the service were generally positive and the women valued the service, but there was no evidence that it reduced morbidity.



BOX 14.7: Postnatal interventions intended to reduce PTSD and PND

Counselling is an intervention intended to help the woman understand the cognitive processes that link the (birth) event with trauma reactions, with the intention of reducing her distress following a traumatic birth experience. Specialist training is required for this.

Debriefing is the most common term used and usually consists of one session within 4 weeks of a traumatic birth. The individual is encouraged to talk about his or her experience in order to promote emotional processing and understanding. The types of debriefing are as follows.

Psychological debriefing is a type of counselling.

Medical debriefing is provided by a midwife or doctor and may focus more on the medical events and explanations, and involves going through their notes.

Informal debriefing is similar to the interventions below.

Defusing is a term used by Alexander⁹⁵ to describe midwives giving women the opportunity to talk about their birth during the postnatal period.

Post-childbirth discussion as referred to in the literature is similar to 'defusing', or a listening and information service.

Listening service is similar to defusing and discussion but the emphasis is on listening. A listening and information service may be one that women can access to discuss unresolved issues in an unlimited time period postpartum.

'*Birth Afterthoughts*' programmes are where women meet with a midwife or midwife counsellor to go over the obstetric events of their birth and express their feelings. These programmes may be similar to listening and information services.

There is evidence that women who have had a traumatic birth experience welcome the opportunity to talk about their birth experience with a supportive health professional, feeling it facilitated their postnatal recovery and adjustment. NICE advises offering advice and support to women who wish to talk about their experience and encouraging the woman and her partner to accept support from family and friends. Gamble and Creedy developed a counselling model for postpartum women after a traumatic birth. The results of their study suggest that women are more able to process events surrounding birth at 4–6 weeks postpartum rather than immediately, and that counselling offered too soon may interfere with the woman's ability to process her experience. They identify key elements for counselling support that can be used by midwives, including showing kindness, listening with encouragement/ prompting, clarifying misunderstandings, not justifying or defending care, gently challenging any self-blame, and identifying ways to enhance social support.

The problems related to ascertaining the effectiveness of debriefing and counselling may be due to inconsistency in the approaches used and the personal nature of this type of intervention. The research tends to focus on the provision of a specific session or sessions rather than providing opportunities for women to talk about their experience and have questions answered. Being able to recount what has happened to a sympathetic person has been shown to promote understanding and regaining of psychological equilibrium. A formal session may result in women revisiting their experience at an inappropriate time and/or being provided with more information than



they can cope with.

The opportunity for women to talk about their birth experience and gain the information they need may be provided during routine postnatal care or arranged later when the woman requests it. Women's views of postnatal care have identified that they are frequently not encouraged to ask questions about their birth experience and how they felt about it, and that emotional support was often not provided. Therefore midwives need to ensure they ask women if they have any concerns or questions regarding what happened during the birth of their baby and offer emotional support. Discussion should be led by the woman to avoid providing more information than she can take in, while providing information that will assist the mother in helping herself to recover. In this way women will be able to access the information they need when they want it. The 6-week postnatal check may be a more appropriate time for some women to discuss their birth, when they have sufficiently recovered from the emergency they experienced. However, only two out of the ten women in Mapp and Hudson's study understood what had happened to them after their 6-week post-natal check with their general practitioner. For this reason Mapp suggests that it may be more appropriate for women who have experienced a birth emergency to have their appointment with a healthcare professional who had an understanding of the events.

Partners should also be included in postnatal care and provided with support and information. The woman and her partner may both develop PTSD, or less frequently only the partner. Partners are expected to provide support, understanding and consideration of the woman's needs. However, a traumatic birth can sometimes negatively affect marital relationships and result in relationship breakdown. The couple may have difficulty in expressing their feelings and emotions, resulting in a lack of understanding and inability to provide each other with affection and support. Women who feel violated by their experience may blame their partner and avoid intimacy. Also, women may avoid sex, fearing a subsequent pregnancy. The woman may feel guilty about not meeting the expectations of her partner. Partners have reported feeling rejected and frustrated, and they are often reluctant to seek help, as childbirth is viewed as a female event.⁹ If health professionals do not include them when providing care their emotional needs may be neglected.

If a woman or her partner show any signs of PTSD or PND it is important that they are referred for diagnosis and treatment. Cognitive behaviour therapy (CBT) has been shown to be effective for PTSD,⁶⁵ though it is not useful for all cases. Peeler et al.¹⁸ suggest that face-to-face counselling or structured writing (written emotional disclosure) may be used to reduce PTSD symptoms. NICE¹⁹ advises offering CBT or eye movement desensitisation and reprocessing (EMDR) for PTSD. In the case of PND, CBT and/or anti-depressant medication can be used according to the

woman's preference and condition.

CONCLUSION

PTSD and PND are more common in women and their partners when a birth emergency occurs, and psychological considerations are an essential part of midwifery care at such a time. Some women are more at risk of PTSD and PND due to factors other than the birth emergency, and these need to be taken into consideration. Information from women and their partners indicates that professionals may focus on the birth emergency and physical care, whereby the woman and her partner may not be listened to and not informed of what is happening, resulting in emotions such as anger, fear and loss of control, which in turn increase poor psychological outcomes. Working in partnership with the woman and including her partner may provide the support needed to help the couple cope psychologically when an emergency occurs. The risk of PTSD and PND is increased when women and their partners do not feel supported and have a poor relationship with those providing care. A traumatic birth is 'in the eye of the beholder'⁶⁰ and information from parents clearly shows that it is important that caregivers communicate and show that they care. Feeling the care provided at the time was appropriate and 'the right thing was done' improves the experience of the woman and her partner and facilitates a good psychological outcome.

Following a birth emergency it is important that psychological care is continued to support parent/infant bonding and assist the couple in coming to terms with what has happened. The couple may initially feel 'shell shocked' so information needs to be provided when they are physically and emotionally able to take it in. Information may need to be repeated with additional explanations to assist understanding and avoid unresolved issues.

Strategies need to be incorporated in emergency skills training so they can be rehearsed and implemented. Midwives have a key role in providing emotional support and consequently can make a big difference to a woman and her partner's experience and memories of childbirth.

SUMMARY OF MIDWIFERY RESPONSIBILITIES

- Antenatal considerations
 - Identify women with or at risk of mental ill health.
 - Ensure women requiring specialist care are appropriately referred and followed up.
 - Provide antenatal information that prepares women and their partners for birth 'not going to plan'.



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- Provide care that supports the woman emotionally as well as her physical health.
 - Labour considerations
 - Use all appropriate strategies (see Box 14.5) to minimise emotional trauma during a birth emergency.
 - Ensure effective communication at all times (including non-verbal).
 - Include and support partners as appropriate.
 - Ensure appropriate pain relief.
 - Maintain continuity of caregivers wherever possible.
 - Postnatal considerations
 - Promote parental/baby bonding.
 - Ensure appropriate pain relief.
 - Provide opportunities and support for women wishing to talk about their experiences, following their lead as to the amount and sort of information which is appropriate.
 - Refer women for specialist support as necessary.