Overview - Perinatal Psychology

Perinatal Clinical Psychology in Mother and Baby Units – what can it add?

National context; Current provision

- Psychology Representation Nationally
- Differences in the role of the Psychologist in Perinatal services nationally
- Clinical Psychology on MBUs – interventions
- Two cases
- Group discussion – how is Clinical Psychology doing in my service - and what could a Psychologist add to help us do better/ more effectively?

Psychology is represented in NHS England at regional and national level by BPS Lead Clinicians
- Scottish Perinatal Mental Health Forum
- Two Psychologist members of the Clinical Reference Group for Specialist Commissioning
- Royal College of Psychiatry: standards, peer reviews & accreditation network – Psychologists contribute as senior clinicians
- BPS representative Maternal Mental Health Alliance
- BPS Faculty of Perinatal Clinical Psychology – Academic and Clinical membership – includes Psychologists with CAMHS, Health Psychology, Adult Psychology and Research Backgrounds “Science Practitioners”

Although there are 18 MBUs there are only 11 Psychologists across 10 MBUs. The availability of specialist psychological intervention is a Type I Standard in the CQC quality perinatal network standards. Psychologists may a more may not be part of the MDT although a typical unit with six beds should include at least 0.5 WTE clinical psychologist.

- In Scotland there are 2 MBUs and 2 Clinical Psychologists – national policy requirements stipulate that psychologists are part of care provision.
- On 6/5/14 MBU based psychologists from across the UK met as a group for the first time at the Royal College of Psychiatry and will now continue to meet bi-annually to share expertise and improve standards.
The Clinical Psychologist is often based in different specialties, most operate from within services with differing core philosophies e.g., CAMHS, Maternity services, Early Intervention - not all are embedded within a perinatal service.

Psychologists on MBUs also differ in terms of what they provide – some offer mainly interventions for mothers (adult psychological treatment) or for the mother and infant or for the mother and family, depending on training and local expertise.

Psychologists are able to enhance and support psychological skills within the wider team. They can encourage and facilitate reflective practice and can provide supervision and training so that those providing routine care are enabled to deliver straightforward evidence based interventions.

Psychologists are able to provide tailored specialist interventions having a full psychological understanding of the maternity (antenatal) and postnatal context. They are able to work flexibly to meet women’s individual needs without relying on manualised approaches.

Psychologists are trained to deliver interventions using the main treatment modalities - Systemic, Psychodynamic, CBT, Cognitive and Behavioural therapy. They are trained in making assessments of complex difficulties and able to formulate, drawing on a diverse range of information about a person and their context as opposed to simply applying prescribed symptomology based interventions.

Clinical work includes antenatal and postnatal periods and may involve;
- Individual Therapy
- Couples Therapy
- Infant Mother Interaction/Attachment
- Family Therapy
- Parenting assessment
- Group Therapy
- Partners

Interventions encompass assessment, formulation, therapy and routine evaluation.

There are a range of therapeutic approaches used; Cognitive Behavioural Therapy, Specialist CBT with maternal OCD, Interpersonal Psychotherapy, (or other brief psychodynamic approaches), Dialectical Behavioural Therapy, Compassion Focused Therapy, Cognitive Analytical Therapy and Solution Focused Therapy.

Interventions are not always manualised, they are highly tailored to the individual.

There are a range of clinical presentations where psychological intervention can be particularly helpful e.g., Obsessive Compulsive Disorder, Personality Disorder, fear of childbirth, antenatal anxiety and post traumatic stress following a traumatic labour and delivery.

There are also specific psychological interventions for psychosis e.g. schizophrenia and Bipolar, recurrent depressive disorder, suicidal ideation.

Clinical Psychologists are able to carry out thorough risk assessments especially for those with complex presentations where there are co-morbidities through the use of individual psychological formulations.
In addition to providing individual therapy for a range of conditions, the clinical psychologist is able to:

- Facilitate psychotherapeutic groups
- Parenting assessments
- Interventions for feeding problems
- Provide infant relationship support and intervention, e.g., video interaction guidance – “seeing is believing”, to work alongside staff providing baby massage and encouraging mother and baby play and interaction where appropriate
- Provide couples and family therapy (including supporting fathers and partners)
- Carry out neuropsychological assessments
- Provide clinical supervision for other professionals applying different evidence-based approaches
- Teach other professionals; e.g., obstetrics and gynaecology, maternity, health visitors and midwives.

Antenatal Interventions

- Most of the research into perinatal difficulties focuses around postnatal depression and distress
- More recent research has identified the potential impact of antenatal depression and anxiety on infant development and the need for timely intervention in the perinatal period
- Antenatal distress has been linked to a range of disturbances in children, extending well beyond behavioural disturbance/emotional reactivity to include cognitive and neurological development.

Challenges treating difficulties antenatally:

- Some medications are considered safer than others.
- There could be withdrawal effects on the baby once born
- Psychological treatments are more acceptable to many women but not always available
- Some promising antenatal interventions e.g.:
  - Compassionate-Mind focused antenatal groups (Reading RCT)
  - ‘Click’ antenatal parenting groups (facilitating parental mind-mindedness)

- Encourage and facilitate father’s involvement
- Facilitate service user involvement
- Conduct (or support) service audits and service-related research
- Provide placements to clinical psychologists in the final year of their training and placements for honoraries and interns who wish to gain experience in the area, thereby increasing the variety of expertise available – all of which contributes to good quality patient care.
- Undertake and publish scientific research – Clinical Psychologists are ideal to take the lead due to their research expertise. This is essential in developing evidence-based practice for this population. DClinPsy. trainees are an added asset to carry out local research – however, there needs to be a strategic cross unit research programme which could appropriately be led by Clinical Psychologist.

Challenges in treating difficulties antenatally

- How safe are Psychological treatments?
- Psychodynamic psychotherapy:
  - Increased distress, difficulty focussing on issues vs maternal preoccupation.
- Exposure and response prevention:
  - Increase in adrenalin
- Clinicians dilemma is that of the impact on the mother (and fetus) if the mental illness is left untreated.
Despite the challenges highlighted above, the impact of untreated antenatal OCD, and the benefits of psychological treatment antenatally (depression, anxiety, failure to bond, tokophobia -primary and secondary and relational issues), which will persist into the postnatal period and may impact on the mother-infant relationship, means appropriate psychological interventions, implemented timely are essential to prevent most complex postnatal presentations.

NICE guidelines (APMH, 2007) recommend rapid psychological treatment before the woman reaches caseness as treatment of choice - rarely met as most perinatal services sit within secondary services

Alternative options;
- Boosting soothing system - good for mum and fetus?
- Listening to classical music and nursery rhymes for antenatal stress?
- Compassionate Mind Training?
- Building resources
- CBT or treatment as usual should be available where woman choose it.

Fear of Childbirth

Can work psychologically to alleviate tokophobia (fear of childbirth) and teach understanding of the labour and birth process.
- Identify sources of fear e.g. sexual abuse, previous incidences of being seriously out of control etc.
- Gives sense of agency, enabling a women to feel in reasonable control and thereby to have a positive participation in the process.

Postnatal interventions

Anxiety and Depression

The care of women with postnatal anxiety or depression should be the same as for anyone suffering from anxiety
- However, specific fears or worries about baby and about emotional difficulties in relation to the arrival of a baby are best assessed and addressed by psychologists who are experts in the perinatal field.
- There should be a lower threshold for psychological intervention during pregnancy and prompt access, due to potential impact on the infant including attachment difficulties and other subsequent longer term health outcomes for infants.

Maternal OCD

NICE guidelines (2007) for Maternal OCD; in which mother’s experience distressing thoughts e.g. “my baby will be damaged” or “I want to harm my baby”.
- Triggered by motherhood and new responsibilities.
- Psychologists trained in understanding maternal context.
- Negative Power of offering constant reassurance.
- Encouraging and supporting positive risk taking within MDTs.
**PTSD**

- Post Traumatic stress following childbirth (and psychotic episodes)
  - Trauma focused work
  - The baby as a constant reminder; protective factor?
  - Attentional training
  - EMDR
  - Fears around future labour and delivery can be addressed

**Personality Disorders**

- Dialectical Behavioural Therapy Groups – Winchester MBU
- Mentalisation Based Psychotherapy (MBP) – referrals for treatment in the future
- DBT skills can be used and encouraged by all members of the MDT
- Psychologists can provide support and training around this

**Attachment Interventions**

Can be provided by all staff in terms of facilitating and supporting mothers and Fathers to interact and bond with their Babies. Some mothers and babies require extra help...

**Research context**

- **DEPRESSION AND ANXIETY;**
  - Evidence that recovery from parental depression does not lead directly to recovery of the parent child relationship - or of the infant his or herself (e.g. Murray et al. 2001).

- **SEVERE MENTAL ILLNESS;**
  - Evidence of difficulties in mother-infant INTERACTIONS in some parents with severe mental illness (Wan, Goodman & Able, 1988).
  - Several studies have found deficits in parental sensitivity, in physical care, deficits in interaction, increased levels of insecure and disorganised attachments in infants of SOME mothers diagnosed with schizophrenia.
  - Some of these difficulties are associated with infant as well as parent factors.

**Attachment Findings – Brief Summary**

- Longitudinal studies of children with attachment difficulties at 12 months have been correlated with children with poorer self-esteem, difficulties with problem solving, impaired cognitive abilities, and problems with showing empathy in response to others’ distress (e.g. Milgrom et al., 1999).
- There is a significant body of research that indicates that the development of a secure mother-infant attachment relationship is often but not always impacted on by the presence of maternal postnatal depression (e.g. Murray, 1997).
Personality Disorders: BPD and EUPD

- Mothers/parents often preoccupied with their own difficulties.
- Impaired capacity to ‘mentalise’ i.e. to think about baby as a separate person with needs and preferences of their own.
- Can alternate between intrusive and neglectful parenting.
- High risk of transmitting problems to the next generation.

How do we measure attachment?

- The CARE-Index - used at the Bethlem MBU and widely used in CAMHS;
  - Developed by Crittenden to measure dyadic interaction between parent and infant
  - Measures the sensitivity of the parent to infant’s communications
  - 3 minute video of playful interaction occurring under non-threatening conditions
  - In Bethlem unit, used as a indicator of outcome done on admission and discharge, feedback to mother can be very helpful.

Dyadic Patterns (Crittenden)

Parent          Infant
- Sensitive    -> Co-operative
- Controlling  -> Difficult
- Unresponsive -> Avoidant or Passive

Global rating scales – Murray;

- Similarly a measure of maternal sensitivity
  - 3 – 5 minute videos coded on approximately 37 dimensions
  - Does not currently have dimensions in main measure which help identify interactive disturbances at the severe end – for example for mother’s with chronic psychosis

Care Index and Global Rating Scales

- Developed initially for research purposes.
- But used increasingly to screen for risk (abuse/neglect).
- Can also used as form of intervention.
- And as evaluation of an intervention
- And for research purposes

Questionnaire measures

- Mother Object Relations Scale (Oates, 2005)
- Post partum bonding questionnaire (Brockington, 2001)
- Child parent relationship scale (Pianta, 1992)
- Parent Infant Interaction observation scale (2013)
**Attachment Interventions**

- Question of what to do – what works? Review by Wan et al. (2008) which found that interventions directly focused on increasing parent-child sensitivity showed the best outcomes in terms of significantly improved numbers of securely attached children. In MBU’s this work could be part of care plan in the latter stages of treatment. There is some evidence that in mother’s diagnosed with schizophrenia, interventions are more effective when implemented after 6 months and when mothers are receiving some social support and care themselves.

- Wan et al. cited a number of studies showing evidence for video based interventions including Stein et al. (2006) who found that VIG in infants of mothers with bulimia was associated with improved outcomes in terms of infant autonomy & parent child interaction.

**Seeing is Believing – a video based intervention**

- Filming the parent and child playing or interacting for a maximum of 10 minutes – developed originally for CAMHS settings
- Editing short clips in which mutual eye contact and/or play are observed for feedback.
- Watching selected clips of good interaction with the parent in a feedback session without the child, unless they are a baby
- Filming the feedback sessions for supervision
- Short term work for a maximum of 16 weeks, with filming and feedback on alternate weeks
- Give a DVD to the parent at the end of the positive clips, as a keepsake and to refer back to

**Mindfulness based parenting Interventions & Parent-Infant Psychotherapy**

- Provide strategies to lessen the grip of ‘automaticity’ in families (Dumas, 2005).
- Emphasises ‘facilitative listening’
- Distancing
- ‘Motivated action plans’
- PARENT INFANT PSYCHOTHERAPY:
- Works on the mother-baby relationship but often includes father
- Powerful vehicle for change – no RCT’s as yet
- Provides containment and supports the development of ‘Mind-Mindedness’ in parents.

**Group Interventions**

- Example of group intervention: CFT
  - 7 members
  - 3 facilitators
  - 16 weeks
  - Reduction in anxiety
  - Increase in self compassion
  - Peer support
  - Therapeutic environment

- Increased psychology input reduced clinician care time
Case Studies

- Case study: Tina (Vanessa)
- Case Study: Siva (Fiona)

Economic Value

Patient Related Outcomes

Care Quality Improvements

The added value of having a clinical psychologist on the team

New Economic Report Launched October 2014 – huge savings to public services identified if woman receive effective care and treatment in the perinatal period:

- The health and social care system saves £989 for every patient who receives Cognitive Behavioural Therapy (CBT) due to reduced hospital admissions.
- Over a ten year period, every £1 spent on Early Intervention Services saves society £15.
- Women who have been service users often report that the psychological input has made a key difference to their progress and recovery, has enabled them to develop personally and to learn from their experiences-to the benefit of both them and their families.

Challenges

- Issues discussed in the new forum:
  - Relationship with IAPT
  - Short contacts with patients whilst in-patients
  - Language and cultural barriers- particularly for groups
  - The prevalence of the medical model
  - Professional isolation
  - Mixing adult and infant expertise “jack of all trades?”
  - The difficulties of working alone
  - Conflicts in roles and priorities: 'pressure to do and be all'
  - Time and Risk management
  - Cost cutting...
  - Meeting the expectations of ourselves and others
  - Referral criteria conflicts with service referral criteria

Discussion

Views from the units: could Psychology help improve standards of care?

Are we essential to an MBU or an add on luxury? - should we be a type 1 profession along with our medical colleagues?

Your Views are welcome
THANK YOU FOR LISTENING!

This presentation was created by Vanessa Hewitt and Fiona Seth-Smith with additional advice from Mary McGuiness.