Psychological Interventions in the Perinatal Period

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What will we cover?

- The role of psychological therapy in the perinatal period
- The experience of women accessing psychological therapy in the period
- Interventions for women with Personality Disorder
  - For the difficulties resulting from the personality disorder
  - To support the Mum and Baby relationship
- The different therapies that are effective for a range of mood and anxiety based difficulties
  - Depression
  - Generalised anxiety
  - Obsessive Compulsive Disorder
  - Post Traumatic Stress Disorder
- Specific Considerations for Therapy in the Perinatal Period
  - Timing
  - Priorities
  - Babies in the room
Myths about Therapy in the Perinatal Period

• It is not safe for a woman to have therapy when she is pregnant
• The pregnancy will give her a focus so she wouldn’t need therapy
• It’s not the right time to address difficulties as she needs to focus on her baby
• It’s not possible to have therapy with a baby in the room
What might it be like for women?

- The messages women receive from society, their families and friendship groups about their pregnancy and parenting their baby may influence their perceptions about accessing psychological therapy.

  ➢ What have women said to you about having therapy in the perinatal period?

- Women may feel guilty or ashamed for accessing support for their mental health particularly in the perinatal period where they may perceive that they should feel happy, excited and grateful. These feelings and ideas can sometimes get in the way of accessing psychological therapy in a timely way.

- As well as difficult feelings about accessing psychological therapy, women can often be more motivated than at other times in their lives to engage in psychological interventions, recognising the importance of optimising their mental health and/or their relationship with their baby.
What can therapy help with?

1. **Reducing distress:** Reducing suffering and distress is a primary aim of all psychological interventions. Within this, there is often a focus on short term and longer terms aims that are in line with a women’s values and hopes for herself, her baby, their relationship and the future.

2. **Facilitating the transition to motherhood:** Talking and thinking about self as a Mum. There is the opportunity to help women to start to make shifts in their thinking and emotions through talking about what becoming a mother means, what sort of mother the woman does and does not want to be and where those ideas come from (Laxton-Kane & Slade, 2002).

3. **Improving the relationship between Mum and Baby:** Psychological interventions can maximise the opportunity for mother–infant bonding. A significant number of mothers encounter struggles to bond with their infants and this can be the case during pregnancy or post-natally (Taylor et al., 2005).

4. **Improving the couple relationship:** For those women who are in a relationship, pregnancy and the arrival of a baby can lead to huge changes in the relationship between a woman and her partner. Psychological therapy can help couples for whom those changes have caused significant distress which is impacting on either the women, her partner or on their ability to parent their baby effectively.
What do the guidelines say?

• When a woman with a known or suspected mental health problem is referred in pregnancy or the postnatal period, she should be assessed for treatment within 2 weeks of referral.

• Psychological interventions should be offered and started within 1 month of initial assessment.

• Psychological and psychosocial interventions in the perinatal period should be based on the relevant treatment manual for the disorder.
  • These will give guidance around the structure and duration of the intervention.
How are therapies organised?

Mild - Low Intensity Work

- Guided self-help based on the principles of CBT
- Computerised CBT
- Short term counselling
- Up to 6 sessions

Moderate or severe High Intensity Work

- Formal CBT
- Up to 16 sessions
- Possibly twice weekly

Complex

- Relapse Prevention using CBT
- Mindfulness-based CBT for depression
- Up to 24 sessions

- Women who are accessing help for the first or second time
- Women where there are no identified risks
- Women who are generally well functioning
- Primary care settings - GP/IAPT

- Women who present as more severely distressed
- Low intensity work has not helped sufficiently
- Women with a history of mood or anxiety difficulties
- Women who’s functioning is impaired by their distress

- Women who are severely distressed and impaired by their difficulties
- Presenting with risk to self, baby or the relationship
- History of severe depression
- Secondary care settings
Depression and Low Mood

Mild - Low Intensity Work
- Guided self-help based on the principles of CBT
- Computerised CBT
- Structured group physical activity programme
- Counselling/ Brief Psychotherapy

Moderate or severe High Intensity work
- CBT (Behavioural Activation for those who present with reduced activity (either in amount or range)
- Interpersonal psychotherapy (IPT)
- Behavioural Couples Therapy

Complex
- Relapse Prevention using CBT
- Mindfulness-based CBT
- Twice weekly sessions of Behavioural Activation
Psychological Therapy for Depression

Moderate and Severe or Complex Depression

- Women who’s depression is more severe; for example she experiences severe feelings of hopelessness, her day to day functioning is very impaired and or she presents with risks to herself or others would be offered a more intensive psychological intervention.
  - CBT- individual face to face appointments of up to 24 sessions
  - Interpersonal therapy (IPT)- this is a brief therapy of 12-16 weeks that focusses on attachment and relationship patterns and sees this as underpinning the psychological distress that the woman is facing. Given the focus on relationships in the perinatal period, it can be a highly relevant therapy during this time in a woman’s life.
  - Behavioural Activation- emphasis on increasing the number and range of activities a person is engaging in each day. Designed to increase feelings of both enjoyment and competence. May be offered two sessions per week
  - Behavioural Couples Therapy- this is not a treatment for the couple relationship but rather a therapy that treats depression. It is for a person who has a regular partner and where the relationship may contribute to the development or maintenance of depression, or where involving the partner is considered to be of potential therapeutic benefit.

- The choice of intervention is influenced by; the length of time the woman has been depressed and what this might indicate about the persistence of depression without interventions; any previous periods of depression and response to treatment; the woman’s ability to engage with the treatment and any potential adverse effect and importantly the woman’s treatment preference and priorities.

- CBT has a very large evidence base, suggesting it is a very effective treatment for depression. A recent large systematic review and meta-analysis (Huang et al. 2018) suggested that CBT for perinatal depression was effective in the short and longer term at reducing symptoms and distress.
Perinatal Anxiety

• Low intensity interventions are shorter term (up to 8 sessions)
• High intensity interventions are longer term - usually up to 24 sessions but sometimes longer
• The recommended interventions are CBT or CBT with specific Guided Relaxation techniques for more severe anxiety presentations
• There are a range of specific anxiety disorders including Generalised Anxiety Disorder, Social Anxiety, Health Anxiety, Body Dysmorphic Disorder and Panic Disorder.
• The treatments have slight variations depending on the specific disorder but the recommended psychological interventions of all anxiety disorders are CBT
• **Post Traumatic Stress Disorder:**
  Psychological treatments for PTSD are organised based on whether the trauma happened as a single event (e.g. giving birth or a car accident) or is a ‘complex trauma’ happening over a period of time (e.g. being abused as a child or living in a war).

  • **Single Event Trauma** - The recommended treatments for single event trauma is CBT or Eye Movement Desensitisation Reprocessing (EMDR) of between 8 and 12 sessions. It is not uncommon for sessions for be up to 90 minutes long. The focus of the therapy is to establish a trusting relationship before talking about the traumatic event in a specific way that allows the person to process what has happened and for the memories of the event to be triggered less frequently and with less emotional intensity.

  • **Complex Trauma** - The focus of therapy for complex trauma tends to be less on a ‘traumatic event’ and more on the impact of complex or repeated trauma on belief systems, emotion regulation and interpersonal relationships. One way of thinking about this is to see that what is addressed in therapy is *less about what was done, but what it did* to a person. CBT is an approach used for complex trauma as well as some of the therapies you will read about later in this module that are offered for longer term difficulties.
Perinatal Obsessive Compulsive Disorder

The psychological treatments for OCD, as with depression, depend on the severity of the symptoms and the impact on a woman’s functioning. These are generally organised as low and high intensity treatments:

**Low Intensity**- Women who have more mild or moderate OCD and/or who’s functioning is not severely impacted would be offered up to 10 hours of CBT. Exposure Response Prevention (ERP) would also be offered to women who struggle with compulsions.

**High Intensity**- Women who have more severe OCD, or who’s difficulties don’t improve with a low intensity intervention should access a high intensity intervention. This involves more than 10 hours of CBT and ERP with a therapist with specific expertise in treating OCD. For women who’s OCD makes it very challenging to leave the home, therapy should be offered either by telephone or at home initially, with an aim to improve the difficulties enough to mean the woman can then attend a clinical setting to continue therapy.

**Perinatal Considerations**- It is important that the psychological intervention for OCD in the perinatal period also attends to the relationship between a Mum and her baby, specifically if the content of the obsessions or compulsions involve the baby. This is not because of concerns of a parent acting on intrusive thoughts.
NICE - Borderline Personality Disorder (CG78)

- NICE does not recommend one particular talking therapy. Some of the therapies highlighted are Mentalization Based Therapy (MBT), Dialectical Behaviour Therapy (DBT) and Cognitive Analytical Therapy (CAT).

- For women with borderline personality disorder for whom reducing recurrent self-harm is a priority, consider a comprehensive Dialectical Behaviour Therapy Programme.

- The use of these therapies necessitates adherence to the evidence base from which they come from. This necessitates they are offered to people in the form of full treatments.

- Do not use brief psychological interventions (of less than 3 months' duration) specifically for borderline personality disorder or for the individual symptoms of the disorder, outside a service that has the characteristics.
Approaches for women with EUPD

- Consider the person, the approach, the history and the timing

- Any individual work must have a relational focus (unless there is significant self harm
  - Schema therapy
  - Mentalisation based therapy
  - CAT

- Consider the role of an Emotional Coping Skills group programme (based on DBT) that is open to antenatal and postnatal women
Therapies: DBT

- Dialectical Behaviour Therapy (Linehan)
- EUPD as a result of emotional dysregulation that leads to harmful coping and difficulties forming and maintaining relationships
- Early environment and temperament interaction means emotional regulation means are not acquired
- DSH as a way of regulating intense emotional distress
- Therapy as a way of acquiring skills not otherwise learnt in early and adult environment
Therapies: MBT

- Mentalisation Based Treatment (Fonagy)
- Based on the idea that disorganised attachment and a difficulty understanding the needs, feelings and intentions of self and other underpin personality based difficulties
- Development of secure attachment with therapist through which mentalising becomes more possible
- Slowly understanding interactions with others and self increases the possibility for the person to know their ‘own mind’ and the ‘mind of the other’
Therapies: Schema Therapy

- Schema Therapy (Young)
- 18 early maladaptive schemas (complex patterns of thinking, feeling and relating)
- Core patterns (‘self defeating’) that keep repeating across our lives
- 5 categories of emotional needs that all have but for some are not met as a child-connection, mutuality, reciprocity, flow and autonomy
- Unhelpful coping modes block contact with feelings
- Therapy (within and outside) as a way of getting needs met and letting go of unhealthy coping modes

- http://www.schematherapysociety.org/
Therapies: CAT

- Cognitive Analytic Therapy (Ryle)
- Protocol based- either 16 or 24 sessions
- Looking at relationship patterns that have early life origins but are causing/contributing to distress in the present day
- Understanding how you learned to cope with intense/difficult feelings and how these ways may now be causing distress
- Therapeutic relationship as a means through which to better understand difficulties and find different ways of living
- [http://www.acat.me.uk/page/home](http://www.acat.me.uk/page/home)
A big part of the Perinatal Team’s role is to think with women about the relationship with their baby. There are well researched links between PD in parents and difficulties in the parent/infant attachment. Outcomes for the children of parents with PD are often less favourable.
Parents are responsible for enabling their baby to:

- Experience, express and regulate emotions
- Form close interpersonal relationships
- Explore the environment and learn

The first model of relating that a child experiences (and often the most powerful one)
Parent-Baby Focussed Work

- Parent-Infant Psychotherapy (PIP)
- Video-Feedback Intervention to Promote Positive Parenting and Sensitive Discipline (VIPP-SD)
- Circle of Security Parenting (Cos-P)
- Video interactive guidance - VIG
Circle of Security

- 8 group sessions of 1.5 hours each
- Sessions utilize dvd footage, handouts and reflective discussion
- Based on attachment theory which is used to offer a framework to comprehend children’s fundamental relationship needs
- Therapists act as safe base for group members to explore their own struggles and how these present in their relationships with their baby/child
Video Interventions

- Some women with a mental health problem may experience difficulties with the mother–baby relationship. Assess the nature of this relationship, including verbal interaction, emotional sensitivity and physical care, at all postnatal contacts. Discuss any concerns that the woman has about her relationship with her baby and provide information and treatment for the mental health problem.

- Consider further intervention to improve the mother–baby relationship if any problems in the relationship have not resolved.

- No one specific video intervention is recommended by the NICE guidance but video feedback itself is recommended to support attachment between parents and children.

- VIG, VIPP. Seeing is Believing
Seeing is Believing

- Videos are unstructured and capture moments of day to day being between parent and baby.
- The video is edited and excerpts showing successful interaction are shown to the parent and used as a basis for discussion of skills, ability, knowledge and intention, creating positive and confident stories.
- These excerpts provide parents with concrete evidence to support the idea that they are doing a good job.
- Videos watched together and new narratives of the relationship and woman as a mother are built and strengthened.
- Ideas from Narrative Therapy used to make new relationship frames possible.
Video Interaction Guidance (VIG)

- Focus on improving communication in relationships
- Families/parents are supported to think about what they would like to change before any of the interactions are filmed
- Adult-child interactions are filmed and edited to produce a short film that focuses on the positive interaction
- The clips are filmed and then reflected on by parent and clinician
- Moments of attuned/sensitive care giving are highlighted and encouraged
- The observing of this is thought to improve confidence and promote more of the same interactions
Video Interaction to Promote Positive Parenting and Sensitive Discipline (VIPP-SD)

• Video feedback to promote positive parenting. It is based on attachment theory and social learning theory.
• Home-based (Includes 7 home visits, 2-3 week intervals)
• Focused on the here and now.
• Parent is filmed in specific activities with their child and feedback is then given on this in the following session-the whole clip is watched but the clinician stops it at planned moments to give specific feedback
• Focus on the strengths and positive moments and these are reinforced
Parent-Infant Psychotherapy

• The parent-infant therapist will focus on building relationships and trust with both parent and baby with the aim of:
  • Supporting the parent to understand their baby’s needs and responding sensitively to them
  • Keeping the baby actively engaged emotionally with his/her parent
  • The relationship between client and therapists is used to a base from which the parent can explore their own relationship experiences concurrently whilst they are developing their relationship with their baby
In Summary

- Psychological therapy can be very helpful to women with personality disorder in the perinatal period.

- Therapy would almost always take place weekly and will be longer than 3 months in duration.

- There may be a focus on the difficulties associated with the personality disorder or the parent-infant relationship and often both of these.

- It is not effective to treat a singular symptom (e.g., anger) outside of a therapy that addresses the longer-term difficulties.

- If a woman is self-harming or having suicidal thoughts, these would be the priority for the beginning of treatment.

- The perinatal period may be a time where a ‘full’ treatment for the personality disorder is not possible (timing, need to focus on parent-infant relationship) so it may be a that a woman engages in therapy and is then referred on for further therapy.
Small Group Discussions

• Think and talk together in your small groups
• Consider what is in the case description and what we have covered today to help think about the following:
  • What ideas you have about psychological interventions for this woman
  • What you might consider asking her to help think about what therapy/therapies may be useful
  • What might the priorities for a psychological intervention be
Practicalities; timing

- Timing is important in therapy but is especially so in the perinatal period
- It would be usual and appropriate to have a planned break/pause around 36/7 weeks
- Therapists should generally continue to offer supportive contact around the time of birth unless there is a good reason that this would be unhelpful
- A therapeutic agreement should be made between therapist and client in conjunction with the wider MDT about when therapy will likely resume post-natally

**Trauma:**
- Where possible complete trauma focussed work post-natally
- Consider trauma focussed work early in the pregnancy (if the distress is a high as a result of the trauma)
- If the birth is less than 12 weeks away consider grounding/management strategies rather than other aspects of therapy such as re-living or exposure
Practicalities; organising priorities

- Discussion with the woman about what will likely happen if we try and work on this and what will happen if we don’t
- There is no evidence suggesting therapy shouldn’t happen in the perinatal period
- This is often a time of increased motivation; harness this but also be mindful of the bar being set too high resulting in feelings of having failed
- Consideration given to how long have these difficulties been around to plan what is feasible- there is a need to be transparent about this and discuss the likely increase in distress at the start of therapy
- What would make the most meaningful difference at this point in time. Priority often given to the Mum-baby relationship as this is often less considered in other services
Practicalities; Babies in the room

- There is a careful balance to strike having a baby in the session though it is most often both necessary and safe.
- However, the impact on both the mother and her baby must be considered and reviewed. Mum may become anxious or distressed when talking about her concerns, and this can unsettle the baby or leave him/her feeling anxious and unsafe. *Nb Consider the specific session content*
- Also consider the baby’s needs and if he/she cannot settle or sleep in the session this takes away from the time and focus on the mother and her presenting concern.
- Post nataly- women may be offered longer sessions; to allow for the need to attend to baby within the session.
- Children who are beginning to acquire language shouldn’t be present during therapy and this will have implications for women with older children and those closer to 24 months.
Perinatally Specific Considerations

- Flexibility in the work is vital and home visits may be both clinically or practically indicated - this can make it harder to hold onto the therapeutic frame but is often required.

- Women consistently feedback that having lots of paperwork is challenging - other means of recording ideas/practice is needed (rather than not doing it).

- More flexible approach to attendance but problems with attendance shouldn’t be assumed that it is related to pregnancy or being a parent.

- Sleep deprivation can impact on concentration in and out of sessions and so session length and number may need to be adjusted.
Any Questions