Preparing for birth and beyond

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Preparing for birth and beyond

This autumn 2015 issue of Perspective contains two new sections. The first covers Training opportunities for practitioners working with parents. The second is the Interview, featuring individuals whose work is helping to shape the experience of parents before and after the birth of their baby.

Our theme is pregnancy, birth and beyond, and focuses very much on parents’ preparedness for, and confidence about, what lies ahead. We cover how practitioners can introduce practical baby care skills, during antenatal classes, and also make sure that parents fully understand the range of choices available on place of birth, and what to expect during the third stage of labour. Pregnancy and the transition to parenthood can be particularly challenging for young mums, but there are inspiring examples of how teenage mums (and dads) can be helped to overcome difficulties and enjoy becoming parents - as revealed through the work of the Family Nurse Partnership. Any mum can experience stress and anxiety during pregnancy, whether due to everyday events or following extreme experiences including sexual abuse in childhood. We review research on the effects that stress in pregnancy may have on unborn babies, with some impacts potentially lasting well into childhood, and on the effectiveness of talking therapies for reducing stress in pregnancy.

Julie Clayton

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Editorial team
Principal editor Cathy Ashwin, NCT/MIDIRS
Editor Julie Clayton
Graphic design NCT Design Team

We welcome contributions to Perspective, so please send us your ideas. Contact the editor Julie Clayton, by email at julie.clayton@nct.org.uk

Perspective is published by NCT, Alexandra House, Oldham Terrace, London, W3 6NH
Helpline: 0300 330 0700 Fax: 0844 243 6000 Websites: www.nct.org.uk www.nctshop.co.uk

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NCT Access to NCT training course

Fancy a career change? Interested in becoming an NCT practitioner but do not meet the criteria? Need evidence of recent study? NCT tutor and antenatal and postnatal leader Linda Doyle describes how the NCT’s access course can get you off to a new start.

Were you aware that NCT runs its very own access course? Like other access courses it has been designed for people who want to undertake our NCT training, an HE qualification or a new job and who don’t currently meet Level 3 entry requirements.

The course started life in 2011 as the NCT Birth Companions (doula) Orientation Programme, and was designed as an introduction for 15 potential doula students who had not already trained with NCT. In 2012 we had 10 students, four of whom went on to train to become NCT Doulas; two used the course as proof of recent study and went on to midwifery. However in 2013 we had only seven students.

Clearly the course needed revamping, and NCT tutor and access course leader Jane

“...The access course was a brilliant introduction to both NCT and the world of childbirth/parenting in general. The course gave me the confidence to know that I could work in this field and enough information to make an informed choice about further training with the NCT/future career steps. Completing the course has allowed me to train as an NCT Doula and in a few years it will fulfil the requirement for recent training/education when applying for a midwifery degree. The course itself is brilliant value for money, offering a very in depth introduction before committing yourself to any more expensive/time consuming training. The course tutors are incredibly supportive and create a friendly and welcoming group atmosphere during the training days. I feel I will remain firm friends with the rest of my group even though we are all taking different paths; we shared just a great experience which has changed life for many of us.

Miriam Scofield
perspective

I was thrilled when I found that I could do an NCT access course if I wanted to do further studies with NCT rather than follow the traditional Access to HE route. Our group bonded immediately. We all came from different backgrounds/situations but had a huge common interest with our love of all things related to birth and beyond. Our tutors, Jane and Linda, had their work cut out at times stopping us chatting too much and going off on a tangent. The two day residential weekend in Worcester was great and bound us together even more as a group. The communication route was really good with comments/suggestions being flagged which made amendments to essays etc. very doable. I’d do it again in a heartbeat.

Jo Blythe

Franks proposed that it be broadened in scope and serve as a point of access to the wide range of NCT practitioner training courses available (e.g. antenatal teacher, breastfeeding counsellor, postnatal practitioner, yoga for pregnancy, baby massage practitioner, etc.) It meant re-validating the course with OCN London and changing the qualification to 21 credits at Level 3.

Thus the NCT access course was born, enabling students who complete the course to apply to do the Level 4 Certificate of Higher Education NCT Birth and Beyond (CertHE NCT BB) course. Completion of the CertHE course enables students to apply to train at Level 5 as an NCT practitioner, including as an NCT Doula. Of course the training also opens doors to other training courses or qualifications as well as to new jobs or career changes which require evidence of recent study.

Of the next cohort of students to complete the programme, two moved onto the CertHE NCT BB training and have applied to do Level 5 next year. Other students applied for NCT Doula training or midwifery degrees. In 2015 a second tutor joined the course with the hope that there will be enough applicants in 2016 for NCT to run the course twice, or run it in different locations.

A broad introduction

The course aims to provide an introduction to all key aspects of NCT practitioner training, and is therefore structured in a similar way to the modular style of the NCT CertHE. Six contact days each focus on one of the different modules: reflective practice, developing baby, giving birth, and the new family. Topics explored are:

• Understanding NCT philosophy
• Anatomy and physiology of labour
• Birth and the first few hours after birth – the ‘golden’ hour
• Active birth skills such as use of different positions, massage, breathing patterns and relaxation
• Supporting new families
• Study skills
• Speaking and listening
• Introduction to counselling skills.

Course details

If the subjects of pregnancy, birth and early parenthood are of interest to you and you are contemplating studying, or just want to stretch your brain cells following maternity or paternity leave, this may well be the course for you!

The cost of the course is £450 payable in three monthly instalments, with £150 paid one month before the course commences. The six days are currently divided between London and Worcester, but the locations for the 2016 intake are still to be confirmed. There will be an ‘expression of interest day’ in October/November 2016 for prospective students to visit and find out if this course is for them.

For more information or to apply, please check out the NCT website: www.nct.org.uk/nct-college/courses/nct-access-training or contact jane.franks@nct.org.uk or linda.doyle@nct.org.uk
INTERVIEW WITH VIRGINIA CAMPBELL

Virginia Campbell, NCT College Operations Manager, tells Julie Clayton about her career and research on yoga for pregnancy. Her recent paper explores what it is that teachers of yoga for pregnancy are trying to achieve.

How did you become involved with NCT?

I joined with the birth of my first child in 1989. I took maternity leave and hired a nanny so I could return to work. I didn’t really want to go back but knew we needed the money. When I had my daughter it was love at first sight and I desperately didn’t want somebody else to see her first steps, hear her first words. I just loved being a mother. I feel hugely lucky that I then got made redundant on my first day back - the money enabled me to stay at home.

I trained as an NCT antenatal teacher and qualified in 1991, which allowed me to look after my daughter and earn some money at the same time. I became an assessor in 1997 and a tutor in 2005 following the death of my local tutor Fiona Cowell. I was very fond of her.

How did you find being a tutor?

Being a tutor is such a privilege. It’s lovely to be able to work with the students who are so passionate and see them grow through the training. The reflective practice element of the course means that it is transformative for the students while they learn to work with parents. NCT practitioners are parent-centred and non-judgemental. Part of being reflective means practitioners try to be aware of their biases and not put them across to parents. For example, if you are somebody who is passionate about natural birth you don’t walk into a group of parents and say, ‘Well I breastfed my baby and had a natural labour. That’s the best thing for everyone to do.’ As part of the training you work through your own experience and beliefs so that you can be parent-led and help parents to do whatever they want to.
perspective

What made you decide to teach yoga for pregnancy?
When I was expecting my second child I wanted to have a home birth. A lot of people said, "How brave. How can you do that?" which was hard to hear as it felt like a criticism. I wanted people to just accept my choice as I knew it was the right one for my family and me. I went to a 'yoga for pregnancy' class (NCT didn't do them then). When I said I was having a home birth everyone just said 'OK'. It was lovely to be with a group of women who accepted who I was. I thought NCT should run yoga groups where women could prepare for the birth, as well as support each other and feel accepted.

In 1992 the yoga teacher left for Australia and as I had already done yoga for about 15 years I took over her class, combining yoga for pregnancy with a bit of NCT stuff about informed choice. It then took about five years to set up the first NCT yoga for pregnancy teacher training course, with Charlotte Whitehead who still tutors on it.

What did you feel was the benefit of yoga during pregnancy?
Everything that comes from doing yoga. The fitness and flexibility, the relaxation and meditation and the mindfulness element. Finding that space to be quiet and still and [focus on] the physicality of birth. There is something lovely about having that time-out for you and the baby and thinking, "Wow I'm pregnant! Hello baby, we’re in this journey together! How do I feel about mothering and the birth?" It's invaluable.

Why did you decide to do research on yoga for pregnancy?
When I was first teaching yoga for pregnancy I noticed that women who did the class tended to have easier births than the ones in my antenatal couples classes. It could be argued that women who go to yoga for pregnancy classes are more likely to have a nice birth, and that they also tended to feel better about the birth even if it didn’t go the way they’d hoped. Over 23 years about 2000 women came to my yoga for pregnancy class. A high percentage had home births, and there were very low intervention rates.

It’s probably the only time they get where they just nurture themselves... Those who have already got children; they admit they spend very little time thinking about the current pregnancy... It allows them to think about how their own body works, their own body’s needs...

I’ve been trying to unpick the evidence for years. Although a randomised controlled trial would be the best form of evidence it’s very hard to do with yoga for pregnancy. But I was lucky to be able to apply to the University of Worcester to do a PhD research study on how yoga affected self-efficacy.

The question was, ‘Does yoga make a difference?’ Does it help women to have the birth that they would like to have? Or is it just that the women who tend to do yoga tend to have different labours?

How would you define self-efficacy?
Self-efficacy is about helping people to behave in a way that will enable them to reach their goals. It’s about enabling them to start and then persist with the behaviours that will help them. For example if somebody wants to birth their baby naturally, it would help them if they felt more confident about how they manage the pain of contractions because then they would be more likely to start and persist with pain-management techniques. Or if they chose a birthplace where they are more likely to have their baby naturally, for example a midwife-led unit or at home. It may help them if they had a female birth attendant, a doula. It's about giving everybody the best opportunity to have what they want to achieve. So does yoga affect women's self-efficacy? Does it affect confidence? Does it affect women's feeling of control, or where they choose to have their baby?

This study was based on asking yoga for pregnancy teachers, ‘What are you aiming for?’ And ‘What do you think you are doing that might increase women’s self-efficacy?’ The second [ongoing] part of the study is speaking to women before they do yoga, and then after they have their babies, to ask what they felt the yoga did, if anything, to affect their self-efficacy.

What is grounded theory?
It’s a research methodology where you start from the ground and build up – you don’t start with a hypothesis but go in with a question and an open mind. You’re seeing what evolves from what people say. There’s a lot of debate about whether anyone can really go in with an open mind but I think that all the reflective practice in NCT allows you to acknowledge this and to be very open about your ‘place’ in the study.

[Give] them the space to be pregnant and to be with other pregnant women... Women need to get together and talk to other women and that’s how they learn about being a mother.
I’m not pretending that I’m not a yoga teacher, but every conclusion in the study emerges from the interviews and quotes from the participants. Grounded theory methodology is strict about ensuring that other people are involved with creating the themes. All the yoga teachers were sent first drafts to ensure I was representing what they said honestly and fairly.

**Of the key themes in your study, how important is the sisterhood-like environment?**

The teachers felt it was really important that the classes were women-only so that everyone had a shared experience. The teachers all taught NCT couples courses too and remarked on the difference in atmosphere in the yoga group.

**What about previous studies that have attempted to look at the effect of yoga on stress in pregnancy?**

There are many trials that conclude that yoga is beneficial to things such as anxiety, perceived stress, depression and labour experience, but only about ten are robust, and even they are either very small or have other flaws. None of them has passed Cochrane review standards yet but most found that yoga does make a positive difference. The latest one by Newham et al shows a reduction in anxiety and is one of the more robust quantitative trials.

**What’s next in your research?**

Thanks to the three yoga teachers from the first part of the trial, I am speaking to 22 women before and after they had their babies, using grounded theory analysis to see what they found most useful and how yoga has affected their self-efficacy, if at all.

**Any surprises so far?**

Yes. Coming through very strongly is how much they appreciate being taught the breathing and birth positions week after week, and also the time-out and relaxation. It could be simply that looking after themselves prepares them better for birth - they feel more relaxed and in the right frame of mind. But it’s still very early days. I expect to have the results available in 2016.
Baths, Bottoms and Beyond!

Demand is high from parents wishing to know more about practical baby care skills before their baby is born. Lynn Thompson, NCT tutor and CPD manager, reveals how a new study day is helping practitioners consider how best to meet this challenge, and shares her own approach.

Overall, feedback from parents attending our NCT antenatal courses in 2014/15 reveals high levels of satisfaction, but many say they would have liked more time spent on practical baby care skills: 31% of those attending NCT Signature courses, and 44% on Essentials courses, expressed this desire. To help practitioners in exploring the challenge of how to meet this need, I have commissioned NCT’s new study day called ‘Baths, Bottoms & Beyond’. The ‘Beyond’ part refers to how parents can support their baby’s development alongside caring for their practical needs.

Benefits of learning baby care skills

Parents attending my recent reunions and Early Days courses have revealed why they valued covering baby care skills antenatally:

- “It helped me feel more confident about caring for my baby in the early weeks - I felt relieved afterwards as it meant one less thing to panic about in late pregnancy.”
- “I felt more reassured that my partner had a clearer picture of how he could support me with our baby once we came home from hospital, especially as I’m spending a lot of time breastfeeding.”
- “We genuinely had no idea about baby care prior to our antenatal course. We had never held a new baby and were completely immersed in our careers, social life and building our home together.”
- “It prompted us to get on and prepare for the reality of bringing home our baby from the hospital – what equipment we would need, how it worked, where we would set it up, etc. For me it was the most useful and exciting part of the course!”

I facilitate NCT Signature antenatal and Early Days postnatal courses in Chester, in addition to more condensed antenatal courses at the Countess of Chester hospital. Typically, half of the parents attending my antenatal courses choose to prioritise preparation for birth, but just as many prioritise preparation for life after birth. This includes baby feeding, supporting the baby developmentally and practically, and exploring the joys and challenges of new parenthood.
As NCT practitioners we know that all babies are unique in what they need and when, and that parents experience hormonal changes which help prepare them to be able to satisfy these demands. We also know that most practical baby care skills are very straightforward. However whilst some parents are relaxed and take practical baby care in their stride, others lack confidence and are looking for additional preparation. There are undoubtedly many reasons why parents differ in their needs, but the challenge for antenatal teachers is to aim to get the balance right so that there is sufficient time to cover both birth and postnatal topics. It is for each practitioner to reflect on how she successfully achieves this, and to seek support from colleagues where needed.

Group sharing and learning

In my antenatal classes I have to think very carefully about using the time available to best advantage. I consider the unique course agenda set by each group, and prioritise covering both their antenatal and postnatal requests. It helps to use layered learning techniques, and more signposting where time is limited.

For years I used to set up practical baby care stations, one for bathing, one for nappy changing, one for settling a baby and safe sleeping, and one for transport items. The parents visited each station in small groups. Whilst this activity had merit and the parents enjoyed it, they often wanted to ask for clarification about certain matters but I found it impossible to attend all four stations when required. One commented that in my absence it felt like ‘the blind leading the blind’, and that they had booked onto the course to hear my guidance. Whilst my aim is to empower parents to explore and make decisions that are right for them, I realised that some needed me a little more to point them in the right direction.

Hands-on activities

I take items including a weighted doll, and as many dressed, soft-bodied dolls as there are unborn babies on the course, as well as baby cue photos, nappy change items, a variety of sheets and blankets, a muslin cloth, and a collection of nursery rhyme CDs and first baby books for book sharing.

I usually begin by passing around a weighted doll to raise awareness of what it can feel like to hold a new baby, and then ask parents to choose a soft-bodied doll and a baby ‘cue’ photo. After describing their baby’s ‘cue’ to everyone, it seems to work best if I lead a nappy changing demo first to model to the parents what I’d like each of them to do when we look at their piece of baby equipment.

I am careful not to be the expert, and have already empowered parents in asking them to bring their own nappy of choice. I have a selection of wipes and cotton wool pleats/balls/pads, and ask them to change their doll in the position most comfortable for them. I ask one parent to pour water onto a spare nappy and pass it around so that they can all identify what a full nappy feels like. Another fetches from the kitchen a small bowl of water which feels like the right temperature, and passes it around for all to dip their hand in.

I take a very relaxed approach, encouraging parents to chat in pairs, with neighbours...
or with the whole group, whilst practising these kinaesthetic learning opportunities. I often throw questions out to the group and encourage them to see that often there is no right or wrong way to care for a baby, and that their skills and decision preferences will evolve over time. I also weave in other postnatal topics where it seems timely, such as asking why chatting to their baby whilst nappy changing supports their development, or discussing strategies for managing tiredness, postnatal depression and the impact of baby on the couple relationship.

Once the nappies are changed I hand over the reins to the group asking parents to share information about their item of equipment and give a demo, inviting others to join in where possible. I’m often really impressed by how much the parents are able to get across in just a few minutes, while I take on the backseat role of ‘phone a friend’. I keep an eye on the pace and time, and may ask an open question to prompt deeper discussion if needed, or alternatively summarise what one couple has just shared and move the focus to another couple so that all have an opportunity to be ‘in the spotlight’ with their piece of equipment. I instigate a change of dynamic when I notice parents are ready for a re-energiser. I may ask the parents with the car seat to take everyone into the car park to show how it attaches in their car. Another option is for the parents with the sterilizer or baby bath to do a demo in the kitchen, and whilst they set it up everyone can grab a cuppa and then gather round to watch and discuss.

I always end this session with a round robin ‘closer’, maybe asking each parent to share either a top tip they’ve heard about for new parents, or what stands out for them having completed this activity. All usually leave seeming very satisfied, and happily I now no longer need to cram the larger pieces of baby equipment into my car!

Reference

1. NCT Signature and Essentials course feedback 2014/15 from an internal survey conducted by NCT’s Research Department.

Sign up!

NCT practitioners can sign up for a ‘Baths, Bottoms and Beyond’ study day via the internal NCT study day booking system, or look out for the workshop at the babble livel 2015 conference. You can also find other study days covering postnatal topics.
Helping parents choose place of birth

NCT antenatal teacher and tutor Jane Franks considers how to help parents as they decide where to give birth

Having reached the stage of feeling almost like a grandmother within NCT (after 22 years as an antenatal teacher) I frequently have the feeling of *deja vu* on issues associated with the miraculous thing called birth... one of which is the place of birth.

Every time a major new report or guideline appears about place of birth I jump on it eagerly, hoping to find the elusive answer on how best to help women realise the importance of their decision about where to birth their baby. They don’t have to give birth in an obstetric unit (OU); birthing instead at a midwifery-led unit or at home can be absolutely amazing. However, I am constantly disappointed that there seems to be very little that is new in these reports. As a colleague said recently: ‘We have known this for years!’

Two exceptions are the much-lauded recent report by Australia-based general practitioner Sarah Buckley,1 and the updated NICE Intrapartum Care guideline.2 Buckley’s report provides an extensive review of the role of hormones in childbirth. It supports the notion that women should choose the birth environment that will enable them to have as close to a natural, undisturbed birth as possible.

And as Gill Gyte, Research associate at Cochrane Pregnancy & Childbirth Group, notes, “After all our years of fighting for choice of place of birth for women, at last NICE has backed that choice with strong words and with evidence on safety from the large impressive Birthplace research study. This is strong ammunition for parents wanting out of OU births.” (personal communication)

Many of us now live in areas where women — particularly those at low risk - do have a choice of a home birth (HB), or birth in a freestanding midwife-led unit (FMU), an alongside midwife-led unit (AMU), or an OU.

…when I enquire about how parents have chosen where to give birth, they often reply that they are following recommendations from friends and family, or opting for their nearest hospital.

My concern, however, is what do women and their partners really understand about these options? The NICE guidelines recommend that midwives should explain all the options and support women in their choice.2 But during the first session of an antenatal course, when I enquire about how parents have chosen where to give birth, they often reply that they are following recommendations from friends and family, or opting for their nearest hospital. I frequently then discover that the midwife does not seem to have explained fully the differences. Sometimes it is the GP rather than the midwife who has handled the question. One woman told me recently that her GP’s first question was, ‘Had I decided where I wanted to give birth?’ — apparently with no explanation about the options.

My impressions may be different to those of other practitioners — I live in a densely populated area where there is a shortage of midwives. Elsewhere, midwives are spending time discussing place of birth with pregnant women. Many of my clients say that they never see the same midwife twice,
or that there is no time to share concerns or discuss options. So what do women really understand about the differences between place of birth options, other than they cannot have an epidural at the midwife-led unit?

**Issues around women’s choices**

At a recent conference on the future of midwifery and nursing, Lesley Page, president of the Royal College of Midwives (RCM), quoted statistics that in 2012, 87% of all women gave birth in an NHS OU, 9% in an AMU, 2% in an FMU and 2% had home births. The reason that so many women choose an OU is to do with the perception of risk and, following the Peel Report 1970, the rhetoric (without any evidence in support), that out-of-hospital birth was unsafe. The Peel Report stated “We consider that the resources of modern medicine should be available to all mothers and babies, and we think that sufficient facilities should be provided to allow for 100% hospital delivery. The greater safety of hospital confinement for mother and child justifies this objective.” And yet there was no evidence to support this. Since then the number of births in OUs has increased dramatically and has remained high over many years. Now we have excellent evidence on the safety of out-of-hospital birth in the Birthplace study and NICE, based on this evidence, recommends choice of place of birth for women saying: “Explain to both multiparous and nulliparous women that they may choose any birth setting.”

Many women and their partners choose a hospital birth because they want to feel ‘safe’ – hence the current trend for the medical model of birth. However, this model undermines women’s belief in their innate ability to birth their babies. NICE guidelines say that for women at low risk of complications, choosing to give birth at an AMU or FMU, ‘...the outcome for the baby is no different compared with an obstetric unit’. Planning a home birth, FMU or AMU birth, gives women a greater chance of having a spontaneous vaginal birth. The media picked up on the issue that for a first baby a home birth has a small increased risk of an adverse outcome for the baby (four more babies per 1,000). However the mother is still safer giving birth at home.

The reason that so many women choose an OU is to do with the perception of risk and, following the Peel Report 1970, the rhetoric (without any evidence in support), that out-of-hospital birth was unsafe.

These concerns about safety compound my belief that if women received detailed information earlier and had time to consider the differences then maybe we would see a dramatic shift towards choosing midwife-led care (at least, in relation to low risk mothers). At NCT College, tutors (including myself) work hard to give new teachers of the NCT Signature antenatal courses all the detailed medical information they need to be knowledgeable and informed about place of birth. There is a strong underlying thread that centres on the idea of an undisturbed birth. Once students fully understand this they engage really well with clients, who certainly GET IT about place of birth.

Hannah Crawford chose home births for both her daughter Isla (now aged 3.5 years) and Esther (11 months).

My mum had my youngest brother and sister at home so that’s why it was first on my radar. Unless you know someone who’s done it you just assume you’re going to go to hospital because that’s what everybody does. I remember my sister being born when I was eight. I woke up and I could go straight into my parent’s room and see her straight away. I remember it being a positive thing.

I’ve never been in hospital so for me it’s not a natural or comfortable place – it’s where you go when you’re sick. I really wanted to have a natural birth. I thought that if I was in hospital and somebody offered me pain relief I could easily say yes in the moment and not really mean it. They can offer you all sorts of things and once you’ve gone onto that path then you can end up having more interventions. [At home] if I wanted to be transferred that would be an easy option.

I was really lucky because my community midwife was supportive of home births. She delivered Isla... it went completely smoothly so why would I do anything different for Esther? One of the best things was being in my own home and tucked up in my own bed.

If I had another I would still have it at home but I think I would be more aware that things can go wrong. Even having heard other people’s stories I’d still rather be at home.
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As practitioners working with parents, what can we do about place of birth?

We know that hormones orchestrate key processes from the moment of conception and throughout pregnancy and birth.7 The magical golden hour immediately after birth is another significant time, when hormones assist with the initiation of breastfeeding. Ideally, these events slip effortlessly into undisturbed parenting. So during a session with parents, antenatal practitioners should never lose an opportunity to inform parents about the conditions that may facilitate release of the fabulous hormone oxytocin: being a ‘shy’ hormone its release may depend on the woman feeling safe, secure and protected A stressful environment can slow a woman’s labour, which may involve the inhibition of oxytocin.1,8

In antenatal classes, discussions around hormones can lead naturally into the topic of birth environment. There are a number of ways of leading such discussions. For example:

- **Date night.** Parents could have a ‘date night’ (romantic night in!!) activity, in which they separate into two groups, with mothers drawing a picture of the ideal birth environment, and partners drawing the perfect date night in. Getting clients to draw is often a mood changer! The two pictures are then brought together to compare.

- **Pictures of different birth environments.** Try distributing pictures of the various types of birth environments and get parents to work out which environment may help the release of oxytocin. Or show a YouTube clip of hospital-based versus a home birth and consider which setting appears the most calm and serene?

- **A gingerbread woman.** In groups, parents can also explore the topic of hormones by drawing either a gingerbread woman who is completely relaxed, and potentially releasing lots of oxytocin or her ‘sister’ gingerbread woman who is fearful, stressed and definitely not relaxed. How do they look? What is going on physiologically? The groups can compare and contrast the pictures and then work out which environment or place of birth fits which picture the most. Who would they most like to resemble during labour?

- **Using water for pain relief.** It is also good to explore with parents the benefits of using a birthing pool to manage pain during labour, and the impact a water birth can have on a woman’s perception of discomfort. Although a recent Cochrane review found no link between immersion in water during labour and birth and a reduction in the incidence of perineal damage,9 there is some evidence to suggest that women should be offered the application of warm compresses in the second stage of labour. This is recommended in the RCM guidelines on perineal care10 and is more likely to be offered on a relaxed MLU than a busy OU.

- **Birthing positions.** As antenatal facilitators we know the importance of encouraging parents to practise birthing positions frequently and of re-enforcing the message of ‘upright forward and open’ positions as often as possible.11

Katie Parrington and her husband Tom chose the Bracken Centre (a midwife-led alongside unit) at Musgrove Park Hospital, Taunton, for the birth of their first child.

I was born there and we felt it was quite a nice link for having our baby. I found out about the options including the Bracken Centre through my midwife or GP, and it came up during [NCT antenatal] classes. It takes us half an hour to get there. We didn’t want a stand-alone birth centre – especially with the first baby we wanted to have the actual maternity ward nearby. It’s joined through a corridor so you can be wheeled from the Birth Centre to the maternity ward should anything else be needed – you have that peace of mind as a backup. We didn’t ever consider a homebirth but wanted to have as relaxing and calm environment as possible. As the hospital was big and busy, we felt it would be quieter and calmer in the Birth Centre. It has calm colours including purple, lots of space, and also essential oils and candles. The beds don’t look like hospital beds – they’re at a lower level. It’s more of a home from home.

Although my husband can’t stay the night they are quite flexible about him being around a bit more which is obviously important for him as well. It’s not everybody’s cup of tea. You can have the pool and gas and air, but women can’t have higher level pain relief there.
By asking couples to bring with them pillows, cushions, and rugs or mats we can encourage parents to build their own comfortable 'birth nest' and ask in which setting they would feel more able to recreate this environment. They may then realise that this is more likely to occur in an FMU or AMU and of course at home.

- **Sharing birth stories.** Sharing positive birth stories with parents is also an effective way of demonstrating the significance of place of birth, because these are about real people with whom clients can identify.

Using such ideas we can hope to help parents make the right choice for them about where to give birth. But can we bring about a swing away from 87% of births taking place in an OU?

How about taking your group for a tour of the local midwifery-led unit? It is amazing how positively staff greet parents and laugh hopefully about seeing them soon. In the birthing pool room you can recap on the ways that women can cope with labour, and lead a standing relaxation activity, encouraging mothers to imagine themselves in the room in a few weeks’ time. We have done this locally for many years and found it to be a very positive aspect of an antenatal course and greatly appreciated by clients. We often go on a Sunday afternoon or early evening and only rarely get turned away because the unit is too busy.

Practitioners could also consider talking early by telephone to clients before their antenatal courses begin, to discuss the available choices about place of birth. They may also like to take a look at links and resources available on the NCT website about place of birth, including the Which? Birth Choice tool and the Birthplace study, which contains critical evidence around the safety of out-of-hospital births. The latter hopefully would make more sense following a discussion.

Practitioners can contact local midwives and offer to be available during clinics to talk to women about place of birth.

Finally, the Maternity Services Review was launched in March 2015 to examine maternity care in the UK and how to improve it. This will look at midwife-led care, support women in their choices and support staff to provide responsive care. So yet another review! But what I would like to say is, get the low risk women to the right places and make it the choice that enables them to have a calm, relaxed, positive birth whilst at the same time saving costs to the NHS. Surely this makes sense?

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**Suzie Rae chose a home birth for each of her three of her children (now aged eight, five and two).**

Quite a few people said, "You can’t do that!", but I thought I could try. It wasn’t a really big decision process [for my first baby]. It was almost my first instinct. The midwives were amazingly supportive of homebirths. They really actively encouraged them and had a very high rate of home births, which made me feel so much more at ease. I did active birth yoga. My teacher gave me a lot of confidence in my body’s ability to do without a huge amount of intervention. I really didn’t like the idea of being in a hospital. I hated it that my husband would be sent home a few hours after we’d had the baby – just when it was so important to us to be the family. He was very happy to support my decision partly because he really doesn’t like the medical environment either. With my second child, my daughter, I had planned a home delivery and although my midwife was on her way, I had such a fast labour that my husband had to deliver her.

It was so lovely the third time not having to confirm what would happen to my children. They were just asleep upstairs in bed. We heard them coming down the stairs at 7 o’clock. I hid round the corner and then showed them their brother!

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**Further resources for parents**

- **NCT. Hormones in labour and birth.** Available from: [www.nct.org.uk/birth/hormones-labour](http://www.nct.org.uk/birth/hormones-labour)

References


BREAKING THE CYCLE OF DISADVANTAGE

Julie Clayton explores how the Family Nurse Partnership is making a difference in helping young mothers to develop positive parenting skills.

Teenage mums can face a tough time during their pregnancies and after their babies are born. They may feel negatively judged and criticised for becoming pregnant so young, and, if they are from disadvantaged backgrounds, they may also lack the education and resources they need to make a positive impact on their babies’ lives.

Without intervention, the result can be a cycle of disadvantages that persist from one generation to the next, including poor social and emotional development, low educational achievement, and more. The Family Nurse Partnership (FNP) is trying to tackle this negative cycle by providing support to young mums, many from disadvantaged backgrounds, with the support they need to develop more effective parenting skills.

The FNP programme is an evidence-based psychoeducational programme offering assistance to young mums – and often fathers - during the crucial period of pregnancy and the first two years of their child’s life.

CAN THE SAME INTERVENTION WORK IN DIFFERENT SETTINGS?

Started in 2007 to improve prospects for the babies of teenage mothers, FNP has offered 16,000 places in 135 local authorities across England since April 2015, supported by the Department of Health. It is also available in Scotland and across Northern Ireland, but not yet operating in Wales. It is licensed and follows strictly the format of a similar approach pioneered in the USA more than 35 years ago by Professor David Olds from the University of Colorado (Nurse-Family Partnership). His research, including three randomised controlled trials, has demonstrated that the intervention works in improving a whole range of developmental, educational and future job prospects for babies born into poverty to young mothers, and provides a cost-saving to the state and society as a whole through reduction in child abuse, neglect and crime. It is also underway in Canada, Australia and The Netherlands.
The key question was, ‘can such a programme translate to the UK setting?’ Unlike in the USA, all mothers in the UK have free access to midwives, GPs and health visitors. Despite this, many young mums were not getting the help and resources they needed.

“Everybody was clear that for the very small proportion of families with multiple challenges on an intergenerational basis that what we were currently doing was not helping them to move away from this,” says Ann Rowe, former nurse, health visitor, and Clinical Director of the FNP, and now a consultant for NFP International, who took part in the initial discussions.

Building trust and motivation

FNP offers more intensive individual support than mothers would normally receive. It begins with a referral, usually from a GP or midwife, in which eligible clients can enrol in the programme if they are under the age of 19 and less than 28 weeks into their first pregnancy. Many are highly vulnerable. “Most of them are young and pregnant because of difficult life circumstances. Many have been in care and have had a number of caregivers. They often don’t have permanent addresses and are facing lots of difficulties in their families, or friendship networks or gangs,” Rowe explains.

Added to these circumstances, is their sense of being judged, according to FNP nurse supervisor Sarah Tyndall, who is based at the Fulford Family Centre in Withywood, Bristol, from where she supervises a team of Family nurses across Bristol and North Somerset and also sees some clients herself. “We often hear that young mothers feel judged by professionals, who assume that they can’t do a good job, or that they’re irresponsible in some way. That can be quite a barrier. But for some of them that can be quite a motivator for mums to try to prove them wrong. If you can tap into that motivation that can be really helpful.”

They often feel pretty suspicious of services, so the nurse has to show that she is trustworthy as someone the client can invest in over a long period of time - someone who won’t let them down.

At their first meeting a Family nurse explains to a client what the programme entails and makes it clear that the client has the choice of whether or not to enrol. Beyond providing information, it is the beginning of a new relationship based on trust. This can be quite challenging for clients who may have seen many professionals and carers come and go. “They often feel pretty suspicious of services, so the nurse has to show that she is trustworthy as someone the client can invest in over a long period of time - someone who won’t let them down,” says Rowe. Clients may display various testing behaviours – for example, not showing up or playing on their mobile phone during meetings, refusing to have eye contact. Family nurses are trained to deal with challenging behaviour and use a variety of skills in order to gain trust and keep clients engaged. They draw from a range of methods and tools including motivational interviewing and the use of practical visual props including life-size dolls with which to demonstrate positive parenting behaviour.

Positive role models

The use of life-size dolls enables Family nurses to model positive parenting behaviours that clients can copy and practise with their babies in order to understand better their baby’s emotional states and cues and to respond appropriately.

For most [clients] that’s a completely novel idea, that a small baby will be trying to reach out and communicate with them. But they are fascinated. They love to learn these things. Ann Rowe

Family nurses use parenting methods helping clients to explore issues such as attachment and the need to soothe a baby when crying in order to promote a sense of security and positive attachment. The Family nurse’s own behaviour towards the client is also a form of modelling that clients can adopt with their infants, for example, showing that they are trustworthy and understanding.
belief in the client’s capacity for change. “We have a lot of tools to work on building positive attachment, supporting child development - things that we know are really important and which a lot of other services know are important too but they don’t really have the consistency and intensity to deliver over the same sort of time period. For me it’s about the therapeutic relationship. If you haven’t got that, however good, your tools are, they’re not going to have the impact because it’s within that relationship that the growth can happen and the client can take on and work on some of those issues,” says Tyndall.

**An intense relationship**

The programme involves regular one-to-one visits from the same Family nurse until ‘graduation’ upon the child’s second birthday. The visits are weekly for the first four weeks, then fortnightly, as a supplement to midwife-led antenatal care. The Family nurse then visits weekly for the first six weeks following the birth, then fortnightly and gradually less frequently as the child nears the age of two years. This frequency and length of contact foster a strong and sometimes emotionally intense relationship. “We have that in-depth relationship which has the potential for huge positive change but it does mean that we find out here lots of things that maybe they haven’t shared with anybody else... if they’ve experienced abuse, neglect, poor attachment relationships themselves. The point at which they have their babies is the point at which some of those things can surface again. What this programme offers is an opportunity to work with that and to really help.”

There is a defined framework of topic areas that the Family nurse must cover in order to be true to the original programme design and to ensure consistency, but nurses also tailor information and support to the individual client’s needs. They start with the topic of healthy pregnancy. “That’s the point of powerful motivation for a lot of young people to make big changes in order to do the best for their baby. We focus on the aim of healthy pregnancy. “That’s the point of powerful motivation for a lot of young people to make big changes in order to do the best for their baby. We focus on the topic of healthy pregnancy.” That’s the point of powerful motivation for a lot of young people to make big changes in order to do the best for their baby. We focus on the topic of healthy pregnancy.”

After the birth, Family nurses observe the interactions between clients and their babies and give clients feedback about the positive aspects in order to encourage them to be sensitive and responsive parents. The programme also covers the client’s own health and relationships, future aspirations, education and training.

The past eight years of FNP in England has enabled considerable organisational learning to take place, which is facilitated through its support structure. Each Family nurse has a caseload of up to 25 clients, and meets regularly with their supervisor who also has a small caseload. Each supervisor looks after up to 8 Family nurses, and is in turn supported through regional meetings with other supervisors, so that any major issues and best practice lessons are fed upwards and across the organisation. One especially useful lesson has been the need to support nurses in setting boundaries over personal

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I was 15 when I became pregnant. Life was really hard and I had a bad relationship with my mum. I lost a lot of friends when I found out I was having a baby and I felt scared and alone.

I didn’t like telling people about my background because they tried to tell me what to do. People were always coming in and saying I was doing things wrong and I found it hard to trust anyone. When I joined FNP, I thought it would be the same but when I met Rachel, my family nurse, and I knew she was going to keep coming back even through the bad stuff, it was easy to tell her things and I looked forward to her visits. I didn’t feel judged and she helped me to stop shutting down and being defensive. She listened to me, and she’s helped me do it my way. Rachel taught me to understand things like how my hormones could affect my moods swings and what smoking could do to my unborn baby. It always felt like people expected me to fail so I was surprised when Rachel told me how well I was doing. She’s taught me a lot about how to care for Lucas, my baby, and I’m proud of how I managed to breastfeed even though it was really hard to start with. It’s been nearly two years now and Rachel has taught me everything I needed to know. Not only do I understand what my baby needs, but I realise how my behaviour can affect hers too.

Sometimes my social worker comes with Rachel now and the three of us talk about my plans for the future. It’s feels like I can make better decisions for me as well as for Lucas, because of Rachel’s advice. If I hadn’t had the family nurse partnership I don’t know what I would have done. Rachel has given me the confidence to be the person I am today and to make sure my son has a good positive future.

**FNP client**
perspective

Breastfeeding Marshall has been the best thing I have done as a parent. I really enjoy this special time with him, I think it helps me to be tuned into what he needs and so we have a great bond. FNP has been really helpful as I found that most other information is aimed at mums who are older than me. My family nurse has helped me overcome my own challenges.

Venka

involvement with clients. “We’ve learned a lot about supervision. It allows them the space to talk about the emotional impact of the work.”

The intense relationship between Family nurses and clients can reveal issues that pose a risk to the child’s safety, and nurses may require referral to other professional services, including child protection services—a possibility that clients are aware of from the start. Despite the vulnerabilities and risks, however, Tyndall perceives a strong desire for change among clients. “These young people have phenomenal capacity to do well if they’re given the right support. That’s one of the challenges—we know that given the right support, if we get it right then a lot of them can make incredibly positive changes and be really, really good parents and potentially break that intergenerational cycle of poor parenting that they’ve experienced. They are astounding.”

Saying goodbye

When the partnership ends on the child’s second birthday, the aim is for clients to be equipped with the skills they need to move on, and seek for themselves other support services and networks they may need, including through children’s centres and other community networks. “There won’t be many other professionals if any they’re seeing as regularly or intensively. Therefore part of it has to be to ensure that they are able to interact with other professionals and seek the different services they need from others.”

However, not every client reaches that stage by the child’s second birthday. “Some clients have enduring mental health problems and will need ongoing specialist support but helping them be able to transition into those services well is really important,” says Rowe.

As the partnership draws to an end, clients are congratulated for completing the programme, and presented with certificates. The way this is handled itself becomes a significant life lesson in managing relationships.

“Some clients haven’t ever experienced someone who’s shown them that you can leave, have a relationship end, and still feel positively about that relationship and look back on it with fondness and appreciation and feel it’s finished. Working on that is probably the last gift that the Family nurses give to these young people” says Rowe.

Results of the first independent randomised controlled trial of FNP intervention in the UK are due to be reported in the autumn of 2015, looking at the benefits of FNP intervention for children up to the age of two. This involved recruitment from 18 sites including Birmingham, Cornwall, Cumbria and Lambeth, between June 2009 and June 2010, to compare the impact of FNP intervention with standard care for infants up to the age of two. Rowe cautions that the impact for mothers and babies who participate in the programme may not be as marked as in the USA, where health and social services are more patchily distributed than in the UK. The US research also shows that any impact seen at the age of two could become more pronounced with time, as children go through a range of developmental and educational milestones to adulthood, and start becoming parents themselves.

References

1. Family Nurse Partnership. www.fnp.nhs.uk
2. Nurse Family Partnership. www.nursefamilypartnership.org/about/Program-history
The first study I have chosen to highlight involves research on the feelings of fathers recruited from NCT antenatal groups in Oxford. Although a small study with only 15 participants, it raises issues of interest to us all.

The fathers gave their views through questionnaires and interviews, from seven months of gestation to six months after the birth of their baby. Among the findings during both the antenatal and postnatal period, the dads particularly reported feeling unsupported by health professionals. One father commented that he felt a lack of a ‘dads’ network’ or father-focussed support during his first few months as a new dad. I wonder if there is more that NCT practitioners could do to encourage fathers in our groups to see each other as that support network? Although the study participants felt better supported by health professionals during the birth, they also reported feeling helpless and anxious. Although most of the fathers held their babies immediately after birth, two thirds stated that the baby was wrapped in a blanket. Could we encourage more skin-to-skin contact, for example, by having photos of this practice on display during classes? Study participants were asked to choose three words describing their emotions at various points. The words given about leaving partners and babies in hospital after birth are particularly stark: ‘frightened’, ‘excluded’, ‘anxious’, ‘nervous’, ‘distressed’ and ‘powerless’ being common. Perhaps NCT could encourage more birthing units to enable fathers to stay in hospital after the birth, and maybe our classes should include discussion of dads’ feelings about hospital stays. The study revealed a common theme to be the balancing of participants’ perceptions that they would ‘co-parent’ and the difficulties in achieving this. Participants found that breastfeeding and the strength of the bond between babies and mothers (in all cases the primary caregiver) made it harder than anticipated for fathers to
bond with their babies, although they did adopt behaviours to promote bonding. The participants also felt that financial demands left them struggling with work-home life balance, particularly with partners on maternity leave. They therefore felt that recent changes to parental leave were not a real option, and that society as a whole did not support them in their new role. Fathers experienced many ups and downs in their transition to fatherhood, but even so they chose positive words to express their emotions around becoming a father, with ‘proud’, ‘happy’ and ‘joyous’ being the most common. What is clear is that fathers’ experiences are distinctly different from those of new mothers and we need to ensure we are doing all we can to prepare and support them.

**Fathers’ experience of home birth**

My second research highlight is about the experiences of fathers in Ireland whose partners had planned home births – a rarely considered perspective in ‘place of birth’ studies.


Through interviews conducted postnatally, the study found that the majority of fathers were initially against the suggestion of a home birth - which in all cases came from their partners. Much emphasis is given to the joint fact-finding that couples did, with all the fathers reporting feeling involved in decisionmaking. Many of the fathers described the birth using the term ‘our’, and felt actively involved in the process. There are mentions of the difference it made to be in their own home environment for the birth rather than in hospital (which some had experienced previously). I was left wondering if the continuity of care from midwives during these home births had also made a difference to the fathers, in the way that other research has shown for mothers. The fathers described their feelings immediately after the birth, with words such as ‘amazing’, ‘ecstatic’ and ‘fantastic’ (quite a contrast from words used after hospital births in the research by Machin, outlined above).

The birth experience has had lasting effects on the fathers: confirming their belief in natural birth, strengthening relationships with partners and in some cases changing their outlook on life - leaving them more open to new ideas and ‘natural’ approaches.

The study is small in size (eight fathers), and as the authors acknowledge only includes planned home births that went ahead, without requiring transfers into hospital. Their experiences are framed within the Irish system (where self-employed community midwives offer a limited home birth service), but it remains hugely valuable to hear directly fathers’ own voices.

**About the author, Jenny Barrett**

Jenny has been an NCT Antenatal Teacher for 12 years, and is a mentor to other NCT practitioners. Her special interest in supporting dads antenatally inspired her to create the Mantenatal course, held initially through her local Children’s Centre in St Neots, Cambridgeshire, and now being piloted as a stand-alone NCT workshop in Cambridge. Jenny includes a dads-only session within her NCT Signature antenatal courses, runs NCT Mother and Baby Yoga sessions and co-ordinates her local NCT Bumps and Babies group.

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**Tips and Tools for New Parents**

NCT has launched a brand new postnatal Tips and Tools for New Parents course offering parents the opportunity to explore and share their thoughts and feelings with other recent parents, in an open and friendly environment. This relaxed and friendly course centres around four key themes:

1. Being the parent you want to be
2. Understanding baby/child behaviour
3. Assessing the needs and tensions within the family
4. Recognising the impact of those around you.

For more details see [www.nct.org.uk/courses/postnatal/tips-and-tools-for-new-parents](http://www.nct.org.uk/courses/postnatal/tips-and-tools-for-new-parents)
The maternity needs of women who were sexually abused in childhood

The rarely heard voices of women who were sexually abused in childhood are brought to the fore by Elsa Montgomery, Lecturer and Head of the Department of Midwifery at King’s College London.

Introduction

This article addresses a subject which remains taboo despite recent media attention. It presents some findings from a study on the maternity care experiences of women who were sexually abused in childhood and considers how practitioners can provide sensitive care to these women. Nine women spoke in depth about their experiences as part of the study. Their words are powerful and it is important that they are heard. The names used are pseudonyms chosen by the women.

The prevalence of childhood sexual abuse

Childhood sexual abuse (CSA) is very common. Determining prevalence is difficult and there is considerable variation across studies. However, it is generally accepted that approximately one in five women have experienced CSA. As it is so common all practitioners will meet women with a history of abuse. A sensitive approach to these women is important in facilitating their journey through pregnancy, birth and into motherhood.

The impact of childhood sexual abuse

As few women choose to disclose abuse their history is unlikely to be known by those caring for them. The maternity care experiences of women with a history of CSA can be characterised by ‘silence’ and this creates challenges for practitioners working with them. There are significant long term physical and mental health effects of CSA. These include depression, substance misuse, eating disorders, risky sexual behaviour, problems with the gastro-intestinal tract, gynaecological problems and chronic pain. There is also an association between the common complaints of pregnancy (e.g. heartburn, backache, tiredness and constipation) and a history of abuse. Published personal accounts reveal how being pregnant and having a baby can be traumatic for these women and how the situation may be made worse by care providers. The research reported here confirmed those accounts.

Why don’t women disclose?

Women who have experienced CSA can feel guilt and shame. They often grow up thinking what happened to them was their fault. Linda had believed for 30 years that she was to blame for ‘encouraging’ her stepfather to abuse her:

I felt that I must have been in some way provocative, encouraging, some sort of Lolita-type figure... (Linda)

Consequently it was not something she would ever have shared with her midwife even though she found her ‘absolutely fantastic’. Women fear that they will be judged if people find out. Elizabeth struggled...
with flashbacks throughout her pregnancy and desperately wanted to be able to tell someone how bad it was but she didn’t think anyone would support her:

*I thought that everyone would just hate me and think I was a terrible person and that I didn’t deserve to have this baby.*

(Elizabeth)

So women hide their true feelings, try to fit in and appear ‘normal’. For Sue this meant curling up and being ‘part of the wallpaper’ but even so, like several of the other women in the study, she felt different and ‘a little bit odd’:

*...because in antenatal class and postnatal class I, I almost felt like I had a... banner on me and although I didn’t and it’s perhaps a bit stupid saying it, it’s how I felt...* (Sue)

It is therefore not surprising that women are reluctant to divulge their abuse. But there is an even greater fear haunting many – that their babies will be taken away if anyone was to find out about it. For example, Sam’s view was:

*I can’t afford to tell you [healthcare professionals] because you’ll take my kid away; you know, if you really knew how bad...* (Sam)

There is also concern that ‘the abused becomes the abuser’ and it scares women. Elizabeth’s mother had been implicated in her abuse and she was frightened she would be the same:

*And all the way through my pregnancy with [my first son] I had, I, I, I had this image of this... a monster being in me that was gonna make me into this horrible person and make me hurt my son.* (Elizabeth)

Although evidence is lacking, this view is prevalent and Linda recognised that:

*...unless we can take away this awful cliché that the abused become the abusers. Then, I don’t know if anybody will ever be really free of fear enough to talk.* (Linda)

### Pregnancy, birth and beyond for survivors of childhood sexual abuse

Becoming a mother can be challenging for any woman but for those with a history of CSA there are particular issues that can potentially heighten the challenge. These include the fear, shame and secrecy discussed above. On a physical level, having a baby involves intimate procedures and the invasion of personal space. These aspects can remind women of their abuse and are frightening as a result. But it is not only physical aspects of care that can trigger memories of abuse. CSA is fundamentally about power and control. Any situation that leads to loss of control for women can leave them feeling very vulnerable. Women want to feel safe when they are having a baby. For these women that means not being reminded of their abuse. It is not always possible for women to predict what will trigger memories. It depends on the context, how they are feeling at the time and the relationship they have with care-givers. Even sensitive care doesn’t always prevent the experience from being traumatic. However with hindsight the experience can be healing.

Breastfeeding provides a useful example. For Elizabeth and Linda choosing to breastfeed was part of proving they were good mothers. Women varied in their experience of establishing breastfeeding. Sue had no problem with it but appreciated the fact that her midwife and health visitor did not insist on checking her nipples – something she would have found challenging. For Sam breastfeeding was difficult on a number of levels. Not being able to ‘escape from it’ reminded her of how she felt as a child:

*...it’s like being it’s like it’s happening again because you are being controlled by another person.* (Sam)

Sam was very sensitive about her breasts so the ‘help’ she received to latch her baby was problematic:

*And then all of a sudden they’re trying to get you to whip it all out and stuff it in this baby’s mouth.* (Sam)

The brutality of the help given to breastfeeding women and lack of respect for bodily integrity is recognised elsewhere. Sam felt huge relief when she decided to give up breastfeeding. On the other hand Elizabeth was determined to do it and the time that a community midwife spent helping her to establish breastfeeding was very validating. It suggested that the midwife believed in her. Ultimately it was healing for Elizabeth:

*...that made me feel so much better about myself, that my body could be actually used for some good, and could make this beautiful baby and that I could feed this beautiful baby for so long...* (Elizabeth)

### Meeting women’s needs

The issues with breastfeeding demonstrate some of the factors that need to be considered in caring for women with histories of CSA. However, if we cannot expect to know who these women are, how can we meet their needs? As they will be hidden in apparently ordinary situations encountered daily, the answer lies in ’making
perspective

changes for many to protect a few.\textsuperscript{3} Control is really important in helping women to feel safe. This includes both self-control and control over what is being done to them.\textsuperscript{1} For some women lack of control over their body during labour is difficult:

I just felt totally out of control. This was all happening to me and you can’t stop your body from having contractions… (Helen)

Attempts to retain control may be seen in very detailed birth plans. For some women epidurals can be helpful, but for others they are counter-productive:

…I had asked for an epidural, which did help with the pain, but then you’re just on this bed and you can’t move… (Elizabeth)

The fact that sitting epidurals often requires women to have their back to the door can also be difficult. Not knowing who is about to come through the door leaves women feeling very vulnerable. These issues can be helped by the sharing of information so that they are fully informed and are prepared for what might happen. However, listening is also important. Even though they are a silent population and won’t necessarily speak out, these women want to be heard:

I hoped that somebody would just … just say one thing and make me think they actually will want to listen… (Elizabeth)

Picking up cues and responding to unspoken messages (like requests for a caesarean section or concern over male staff) become key aspects of care. Trust is also important and that can be promoted when women develop good relationships with practitioners. Getting to know a woman enables cues of distress to be noticed and a sensitive response to be given. For as Garratt says ‘the most useful guide to providing appropriate care for a woman with a history of abuse is the woman herself’\textsuperscript{13}

Awareness of CSA as a widespread issue, compassion during times when women appear uncomfortable, acknowledgement of their distress without attempting to name a cause, sensitivity to their body boundaries and ensuring that they are able to retain control over what happens all help to meet women’s needs. If their needs are met, rather than feeling like ‘it is happening all over again’ more women will enter motherhood feeling ‘so much better’ about themselves.

References


Educational resource

\textbf{Voicing the Silence} animation reflects the words and experience of a woman who survived childhood sexual abuse.

www.kcl.ac.uk/cultural/culturalinstitute/showcase/current/kei/voicingthesilence/index.aspx
Third stage of labour

Labour and birth together form a continuous process which is often referred to as a series of separate events. Even once the baby is born, the process is not complete until the placenta is outside of the mother’s uterus. This latter part of labour is referred to as the third stage. NCT Bank tutor and antenatal teacher Denise Stanford-Bell outlines the different routes the third stage can take and the evidence base, focusing on key questions that parents may have rather than being an exhaustive review.

What is physiological third stage?

With no medical interventions, and with or without a short break in her contractions, the mother will be able to push her placenta out, preferably with her baby held skin-to-skin and still attached to the umbilical cord. Before this expulsion of the placenta, whilst the placenta is still attached to the uterine wall, the cord will continue to pulsate for a few minutes, if left undisturbed. As a midwife, I have occasionally observed it to pulsate for 20 minutes or more. It continues to supply oxygenated blood to the baby until she starts to breathe on her own. The cord and placenta system will still contain about one third of the baby’s blood, whilst the remaining two thirds is in the baby. At this point, the cord is thick and rubbery and the uterus, under the influence of natural oxytocin, contracts the ‘living ligatures’, stemming blood loss. From observation this process can take from between a few minutes to an hour. The midwife will then check the placenta, to ensure that it is complete and none is left inside the mother. This approach often entails slightly more blood loss immediately after the birth compared with active management of third stage, but this should not present a problem for fit and healthy mothers with a good haemoglobin level.
What does active management entail?

The midwife or doctor will give a uterotonic drug, generally syntocinon or syntometrine, by injection at the top of the thigh, soon after the baby is born. Syntocinon can also be given intravenously if the mother is already on a drip, perhaps for an epidural or if she is in the operating theatre. The cord is then clamped and cut, by the partner if desired. The uterotonic drug makes the smooth muscle of the uterus contract, which normally causes the placenta to quickly detach from the wall of the uterus – which will be accompanied by a visible lengthening of the cord and increased blood loss at the vagina. The midwife will put her hand on the fundus, the top of the uterus, to check that the placenta has come away. Then the midwife may gently pull the placenta out ('controlled cord traction'), whilst guarding the uterus to stop inversion. This usually takes 10-20 minutes.

The updated National Institute for Health and Care Excellence (NICE) guideline recommends for healthy women:

**Third stage of labour**

After administering oxytocin, clamp and cut the cord.

- Do not clamp the cord earlier than 1 minute from the birth of the baby unless there is concern about the integrity of the cord or the baby has a heartbeat below 60 beats/minute that is not getting faster.
- Clamp the cord before 5 minutes in order to perform controlled cord traction as part of active management.
- If the woman requests that the cord is clamped and cut later than 5 minutes, support her in her choice.

NICE also recommends syntocinon as the choice of uterotonic drug. Some NHS Trusts still choose syntometrine although this has possible side effects including nausea, sickness and and headache, so it is good to check what is used locally.

What happens to the umbilical cord?

If the cord is very short or wrapped tightly around the baby’s neck, health professionals may attempt to free the cord using the ‘somersault manoeuvre’ or rotation of the baby at the perineum. If this is not possible then the cord may need to be cut immediately. For most babies the cord is cut after the birth after first placing two clamps on the cord, the first about 3-4cm from the baby’s navel, and the second a few centimetres further on. The cord is cut between the two clamps, leaving a stump about 2-3cm long at the umbilicus, which will become the baby’s belly button. Cutting does not cause pain as there are no nerves in the cord. The mother may continue to feel contractions, like period or labour pains, which are often stronger with second and subsequent babies. The midwife should ask consent to examine the mother’s perineum and vagina, to see if the skin and/or muscle has torn and requires stitches.

What are the benefits of ‘delayed cord’ clamping?

The Cochrane review: **Effects of timing of umbilical cord clamping of term infants on maternal and neonatal outcomes** states some important advantages of delayed cord clamping for healthy term infants, such as a higher birthweight, early peak haemoglobin concentration, and increased iron reserves for up to six months after birth. Delayed cord clamping does not seem to increase the risk of haemorrhage or other complications for ‘low risk’ mothers.
though it does appear to be associated with an increased incidence of neonatal jaundice. The Cochrane review suggests, however, that the latter can be managed with a liberal approach so long as phototherapy treatment is available. For preterm babies delayed cord clamping seems to be associated with less need for transfusion, better circulatory stability, less intraventricular haemorrhage and lower risk of necrotising enterocolitis.\(^5\)

Retired obstetrician David Hutchon writes that as there is is no sudden change in neonatal circulation at birth and the baby has her own circulation to support the transfer from womb to world, allowing a minimum of two minutes will give the baby an increased blood volume of up to 100mls.\(^6\)

In newborn lambs born by caesarean, deferring cord clamping until the neonatal circulation is established seems to reduce the need for resuscitation, and supports circulation.\(^7\) Some human societies practise the method of ‘cord milking’ - pushing the cord blood towards the baby at the time of birth, in order to protect term and preterm babies when delayed cord clamping is not possible. Further research is needed, however, to see if cord milking has overall benefits for babies. We also need more research on the optimal timing for delayed cord clamping, for mother and baby. Across the UK teams are developing the skills for using alongside resuscitation equipment for newborn babies whilst keeping the cord intact.\(^8\) At a home birth, a flat hard surface will suffice.

**What facilitates the third stage of labour?**

The following strategies will support a physiological third stage, and might also help a slow managed third stage: keep the mother in an upright position to take advantage of gravity; encourage her to hold the baby skin-to-skin; breastfeeding, in order to increase her oxytocin levels and promote contractions of the uterus; ensure that she has an empty bladder (a full bladder may ‘block’ the way out); and keep the mother warm and as relaxed as possible.

**Why would some mothers need an actively managed third stage?**

The mother may be at risk of heavy bleeding (more than 500 mls of blood) if she has had any medical interventions including forceps or ventouse, a very quick or a very long labour, twins or multiple births (resulting in a bigger placental site). In maternity service settings, the midwife or doctor will want to reduce the risk of haemorrhage by recommending an actively managed third stage, with delayed cord clamping wherever possible. Anecdotally, delayed cord clamping is also occurring in theatre at an elective caesarean.
Rhesus negative mothers

Mothers who have the Rhesus negative blood group may wish to have the option of an injection with anti-D immunoglobulin, to prevent her becoming sensitised to any of the baby’s blood cells that may have entered her bloodstream during the birth. She can still have delayed cord clamping and/or a physiological third stage. The midwife can take a blood sample from the cord during the process in order to check whether the baby is Rhesus positive or Rhesus negative. Currently, in the NHS, cord blood is not routinely taken and stored at birth except when there is a known family history of haematological conditions (e.g. leukaemia or haemophilia). However, cord blood can be taken and donated.9

Blood loss after birth and retained placenta

A blood loss of up to 500 mls is generally considered normal.10 Above this it is considered a post-partum haemorrhage (PPH). If blood loss continues then extra uterotonics drugs and other interventions may be employed to safeguard the mother’s wellbeing. Rarely, surgery or hysterectomy may be considered. In about 3% of births, the placenta is still retained within the uterus after either a physiological or managed third stage.11 This requires surgical removal in an operating theatre under spinal anaesthesia if the use of all other oxytocics has failed. The definition of retained placenta depends on the time period used – for example, whether it has not been expelled within one hour of birth. Some settings use a threshold of just 30 minutes, but according to WHO there is no evidence to support this definition.12

Teaching ideas

One idea for working with parents is to engage them with a card-sorting activity. To help parents remember more information, divide a series of statements in two, each on a different card, and ask them to read the cards and try matching pairs of cards to form the correct statements. Visual aids such as placenta and umbilical cord fashioned from material such as wool, and photos or drawings, are helpful to explain the process of labour and birth. For deeper learning in a small group setting, offer different levels of information ranging from the most recent Cochrane reviews, NICE summaries and other journal articles, to NCT fact sheets, information from Babycentre, or Wikipedia. Ask clients to read these for 10 minutes then focus on a topic or set of questions. A conversation around the new NICE guidance and benefits of delayed cord clamping may be the most useful to focus on, so that wishes are carried out at birth, particularly when combined with skills around decision making.

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The impact of stress in pregnancy

Vivette Glover and Jane Barlow review the evidence for the lasting effects of stress and anxiety during pregnancy

Introduction


A happy and trouble-free pregnancy is something that all parents and practitioners might hope for, but for many couples this is not the reality and many women can experience anxiety and/or depression at some point during their pregnancy. This article outlines the immediate and long-term effects that may be experienced by some but not all babies as a result of such problems, and highlights the need for interventions aimed at reducing anxiety and depression before and during the transition to parenthood.

Anxiety – a state of fearfulness about what may happen in the future – is relatively common in pregnancy, affecting 12 - 20% of women.¹ Depression – a set of symptoms including negative thoughts and feelings about the present – can affect a similar number of women both in the antenatal and postnatal period.² Both anxiety and depression in pregnancy are associated with postnatal depression.² Many women also experience other problems in pregnancy that are strongly associated with both anxiety and depression. For example, around 30% of domestic abuse starts during pregnancy,³ and around 9% of women are being abused during pregnancy or after giving birth.⁴ Around 1% of pregnancies in the UK (20,000 women per year) involve a drug dependent mother,⁵ and such drug dependency co-exists with a range of other difficulties including mental health problems.⁶,⁷

Types of stress in pregnancy that can affect the developing baby

A range of stress-inducing circumstances may adversely affect the future health of the baby. These can vary from very severe stress caused, for example, by the death of an older child or other bereavement (Khashan et al., 2008), to quite mild stresses, such as daily hassles.⁸ Other types of stress that have been found to have an impact on the baby include relationship problems...
perspective

with the partner,9 as well as exposure to acute external disasters such as 9/11,10 Chernobyl,11 a Louisiana hurricane,12 and war.13 Both anxiety14,15,16,17,18 and depression14,19 have also been found to have an impact on the developing fetus and baby.

Impact of adverse mental health

Adverse prenatal mental health of the type described above is associated with a wide range of outcomes both in the short (i.e. immediately following birth) and longer term (i.e. through to adolescence and adulthood). Very severe stress in the first trimester such as the death of an older child has been shown to be associated with an increase in congenital malformations.20 Less severe forms of stress are associated with somewhat lower birthweight and reduced gestational age21,22 and an altered sex ratio, with fewer males to females being born than in an unstressed population.23,24

Beyond these immediately obvious effects at birth, other longer-term consequences for the baby have also been identified in a number of studies. Examples in young children include the neurodevelopmental functioning of newborns;25 and the behaviour of infants and toddlers (e.g. difficult temperament,15,26 sleep problems,27 and lower cognitive performance and increased fearfulness.9

Studies on older children, aged 3 to 16, have shown an association between prenatal stress and neurodevelopmental outcomes, including an increased risk (usually about double) of child emotional problems, especially anxiety and depression, and symptoms of ADHD and conduct disorder.14,15,21,28,30,31 Other studies have shown a reduction in cognitive performance.17,32

Two studies have found an increased risk of schizophrenia in adults born to mothers who experienced stress during pregnancy including the death of a relative,33 and exposure to the invasion of the Netherlands in 1940.13

A further set of studies on both animals and humans have shown associations between prenatal stress and a range of altered physical and physiological outcomes. These include reductions in brain grey matter density,29 which may be associated with neurodevelopmental and psychiatric disorders as well as cognitive and intellectual impairment. Several studies have shown that prenatal stress is associated with an altered diurnal pattern or altered function of the HPA axis, although the pattern of alteration is quite complex.36

Critical periods of sensitivity in pregnancy

There is little consistency in the literature regarding the most critical time in pregnancy for the influence of prenatal stress, and there are different times of sensitivity dependent on the outcome studied, and the stage of development of the relevant brain or other structures. The two studies of schizophrenia, for example, found the most critical period to be the first trimester, when neuronal cells are migrating to their eventual site in brain, a process previously suggested to be disrupted in schizophrenia.13,33 In contrast, two studies of conduct disorder, or antisocial behaviour, found the greatest associations with stress in later pregnancy.14,36

Mechanisms involved

The mechanisms by which prenatal stress affects the developing baby are not fully understood, but seem to involve changes in the environment in utero during specific critical periods, which may then alter key processes in the baby’s development, with long-term consequences. One of the key mechanisms identified in humans is the overexposure of the fetus to glucocorticoids (i.e. the stress hormone cortisol) as a result of the impact of stress on placental functioning.37 Stress appears to affect the barrier enzyme, which converts cortisol to the inactive cortisone. Increased maternal stress or anxiety reduces the level of this enzyme in the placenta, thus potentially allowing more cortisol to pass through to the fetus.37

The neurotransmitter serotonin is another possible mediator of prenatal stress-induced effects on the baby’s neurocognitive and behavioural development. During gestation serotonin regulates cell division, differentiation and synaptogenesis. Animal studies have shown that increased serotonin exposure during gestation is associated with alterations in many neuronal processes and subsequent changes in offspring behavior. Recent work has identified an endogenous serotonin biosynthetic pathway in the human placenta,38 suggesting a possible role for alterations in placental serotonin in human fetal programming.

Prenatal stress has also been shown to cause changes to the DNA of experimental animals – known as epigenetic changes – for example, in the DNA that codes for the receptor for cortisone39. In humans, stress during pregnancy caused by violence from the partner has been shown to cause epigenetic changes in the DNA for this same receptor, in the blood of their adolescent children.40
The importance of improving maternal psychological wellbeing in pregnancy

The studies outlined here provide a strong indication of the importance of intervening during pregnancy to reduce the risk of adverse maternal mental health and its impact on child development.

The newly updated National Institute for Health and Care Excellence (2014) guideline on ante and postnatal mental health provides clear guidance about screening for common mental health problems in pregnancy such as anxiety and depression, using the two Whooley questions (i.e. ‘During the past month, have you often been bothered by feeling down, depressed or hopeless?’; ‘How often have you often been bothered by having little interest or pleasure in doing things?’, and the two-item Generalised Anxiety Disorder scale (GAD-2) (i.e. ‘During the past month, have you been feeling nervous, anxious or on edge?’; ‘Have you not been able to stop or control worrying?’).

The guidelines recommend that if a woman responds positively to either of the depression identification questions or is at risk of developing a mental health problem, or there is clinical concern, the practitioner should consider: using the Edinburgh Postnatal Depression Scale (EPDS) or the Patient Health Questionnaire (PHQ-9) as part of a full assessment or referring the woman to her GP or, if a severe mental health problem is suspected, to a mental health professional. They also recommend that if a woman scores three or more on the GAD-2 scale, consider using the GAD-7 scale for further assessment or referring the woman to her GP or, if a severe mental health problem is suspected, to a mental health professional. If a woman scores less than 3 on the GAD-2 scale, but you are still concerned she may have an anxiety disorder, you should ask the following question: ‘Do you find yourself avoiding places or activities and does this cause you problems?’ If she responds positively, you should consider using the GAD-7 scale for further assessment or referring the woman to her GP or, if a severe mental health problem is suspected, to a mental health professional. It is also important to find out if the woman is experiencing any other form of major stress, such as domestic abuse, and if so to institute appropriate help.

Evidence-based methods of intervening to support women experiencing moderate problems include Guided self-help; computerized CBT or exercise; non-directive counselling (e.g. listening visits); brief CBT or IPT (Interpersonal Psychotherapy). Women experiencing more severe problems will require specialist support from a psychiatrist and possibly medication.

Summary of implications for policy and practice

• The psychological wellbeing of women in pregnancy can have long-term effects on the child, especially in terms of their later emotional and behavioural adjustment.
• This evidence points to the importance of intervening during pregnancy to provide support that is aimed at reducing stress, anxiety and depression, and promoting reflective function.
• A number of evidence-based methods of working to promote the mental wellbeing of women during pregnancy are currently available, and should be implemented.
• More still needs to be done to ensure that the treatment of common mental health problems in pregnancy is routinely addressed.
References


Talking therapies for mild perinatal anxiety and depression

As highlighted in the previous article (The impact of stress in pregnancy), perinatal mental illness is not uncommon and can have adverse effects on both mother and baby. The evidence reviewed clearly highlights the importance of intervening during the perinatal period. In this article Abigail Easter, Hedie Howells and Susan Pawlby review the evidence for interventions aimed at preventing or reducing mild perinatal anxiety or depression.

Abigail Easter is Research and Evaluation Manager, NCT; Hedie Howells (Research Assistant) and Susan Pawlby (Lecturer in Perinatal Psychiatry) are at the Institute of Psychiatry, King’s College London.

What interventions are available?

There is increasing recognition of the significance of perinatal mental illness and increasing focus on the importance of early intervention, which is reflected in recent government and National Institute for Health and Care Excellence (NICE) guidelines.1,2 A wide range of interventions for the treatment of perinatal mental illness exist, with varying degrees of empirical evidence to support their use. These range from ‘light touch’ interventions, including alternative and complementary approaches (e.g. acupuncture and yoga), community support programmes and educational interventions (e.g. peer support), psychological interventions and talking therapies (e.g. cognitive behavioural therapies), through to pharmaceutical treatments and more intensive interventions such as those delivered in mother-and-baby units. Here we take a closer look at what talking therapies are available and whether they are effective in reducing perinatal anxiety and depression. Interventions to treat and alleviate anxiety have been researched to a lesser degree than those used in the treatment of depression; therefore, the research is combined throughout this review.

This review summarises the findings from a recent report from researchers at the Institute of Psychiatry, Psychology and Neuroscience at King’s College London, commissioned by the NSPCC.3 It included
interventions that have, to some degree, been empirically demonstrated as effective. The focus of the review is on talking therapies for mild perinatal anxiety and depression, which can be delivered by non-psychological interventions or treatments in which individuals are provided with a safe and supportive environment to explore problems that they may be experiencing. Talking therapies provide the opportunity to explore thoughts and feelings and the effect they have on behaviour and mood. The key principle of most talking therapies is that the process of describing thoughts, feelings and behaviours can help individuals to develop positive coping strategies or notice any patterns which it may be helpful to change.

In the following sections the evidence for the efficacy of cognitive behavioural therapy interventions, interpersonal therapy and mindfulness interventions for the treatment of mild perinatal anxiety and depression will be discussed.

Cognitive-based therapy interventions

What is cognitive-behavioural therapy?
Cognitive-based therapy (CBT) is a well-established intervention for individuals experiencing anxiety or depression. It is based on a combination of cognitive and behavioural theories of human behaviour. The key premise is that emotional distress is maintained by maladaptive ways of thinking and processing information (cognitions and schemas), which are driven by individuals’ experiences and beliefs. CBT guides and supports people to evaluate and alter maladaptive ways of thinking, leading to changes in emotional state and behaviour, in this way reducing symptoms of anxiety and depression. Since the introduction of CBT in the 1960s it has been adapted to meet the needs of a wide variety of populations and health conditions and a range of CBT interventions now exist.

How is cognitive-behavioural therapy delivered?
CBT can be delivered not only on a one-to-one basis but also to groups and in self-help format (e.g. self-help books and computerised CBT). Group administration is particularly useful in areas with little access to facilitators and resources. However, the evidence-base supporting individual CBT is currently more extensive than the research regarding group CBT.

Group administration of interventions for mild perinatal anxiety and depression has, in general, been shown to be more cost-effective than CBT delivered on an individual basis, due to the reduced demand for trained facilitators.

Cognitive behavioural therapy for perinatal anxiety and depression
There is a growing evidence-base to support the use of CBT as a treatment for mental illness, including during the perinatal period.

Adaptations to CBT interventions for perinatal mental illness are well demonstrated by the 'Mothers and Babies' course, which was originally developed by researchers and clinicians at the University of California for low-income Latino families. The course utilises a cognitive behavioural framework, and incorporates social learning concepts, attachment theory, and is tailored to address socio-cultural issues. It was designed to be delivered as an antenatal course, with the aim of preventing postnatal depression. The 'Mothers and Babies' course is facilitated by trained professionals and teaches various principles such as, how to modify maladaptive thoughts and benefit from social contact.

'Mothers and babies' has demonstrated efficacy in preventing perinatal depression in Black and Hispanic women and one study investigated its effect when adapted for use with perinatal African-American women in Baltimore City, USA. This study reported that mood regulation, which is hypothesised to prevent depression, increased by 16% after completion of the course.

A small Korean study (27 women) of CBT interventions delivered in late pregnancy also found significantly lower depression scores following treatment, and a French study with a group of 241 pregnant women found beneficial effects post-intervention. However, in the latter study only one intensive CBT intervention session was provided.

As outlined above the majority of studies suggest a beneficial effect of CBT interventions on mild perinatal anxiety and depression. Furthermore, CBT is currently endorsed by NICE guidelines as a treatment for perinatal depression. However, contradictory findings do exist, and some studies have found no difference in anxiety or depression symptoms following a CBT intervention. It is possible that the lack of differences in these studies may be explained by a natural remission of mild-range mental illnesses, or alternatively by a ‘therapeutic’ effect of the control group (e.g. in one study CBT was compared to an information booklet containing information about perinatal anxiety and depression).
Computerised CBT

Despite the strong evidence-base for CBT, issues of availability exist and access across the UK is often limited, meaning that many individuals with mild perinatal anxiety or depression do not receive it.

Computerised and online formats of CBT can improve access as they reduce therapist resources. One study noted a 73% reduction in clinician time when treatment was computer-based as opposed to entirely clinician-led.14 Furthermore, these approaches allow individuals to be virtual and anonymous, and provide the potential to improve access among those who are concerned about accessing mental health services due to concerns about stigma.

A meta-review of 12 systematic reviews of computerized CBT (cCBT) for depression (with and without anxiety), concluded that the treatment demonstrated clinical efficacy and had positive effects on depressive symptoms.15 Nevertheless, the review did not identify any specific studies that included cCBT for antenatal or postnatal mental illness, therefore its efficacy for individuals with mild perinatal anxiety or depression remains largely unknown.

Computerised therapies, however, have high non-completion rates, which much be considered when assessing their efficacy.16,17 One study reported that only around half (56%) of people completed a full online CBT course,17 and completion rates were just 39% in another study.16 However, it is thought that this may in part be due to curiosity accounting for the uptake and subsequent withdrawal, as opposed to low acceptance of the therapy.16

Mindfulness-based cognitive therapy

What is mindfulness-based cognitive therapy?

Mindfulness-based therapies are becoming increasingly popular interventions, particularly for the prevention and alleviation of mental illness. Mindfulness-based cognitive therapy (MBCT) was originally developed as an eight week course, which combines mindful meditation with cognitive therapy, for individuals with relapsing depression.18 It aims to reduce symptoms of anxiety and depression by supporting individuals to reflect on and modify maladaptive evaluation styles, encouraging themes such as ‘living in the moment’, ‘adopting an accepting attitude’,19 and ‘promoting cognitive flexibility’, which reduces anxious and depressive symptoms.20

As with CBT the intervention can be implemented in a group setting, delivered one-to-one or self-taught with no requirement for a professional to be present.21

Is mindfulness-based cognitive therapy effective?

Findings from a meta-analysis of the effectiveness of MBCT in general clinical populations indicate that it is a promising intervention for reducing anxiety and depression.4 However, few studies have investigated its application during the perinatal period.

A recent pilot study of MBCT delivered to women during pregnancy reported a reduction in depression, stress and anxiety compared to a control group who had not completed the therapy.20 Moreover, its benefits to general cognitive styles appear to be long-lasting and applicable to various challenging situations throughout the perinatal period and long after childbirth.20

Further evidence for the effects of the intervention on anxiety during pregnancy comes from feedback from the ‘Coping with Anxiety through Living Mindfully’ project (CALM Pregnancy), which used an adaptation of MBCT specifically designed for women in pregnancy.22 This study found a reduction in the number of women meeting diagnostic criteria for generalised anxiety disorder (GAD) before and after treatment (from 17 women to one) and statistically significant reductions in anxiety as well as depressive symptoms. However, the findings among antenatal populations are currently derived from small, non-representative pilot studies and the reliability of these findings requires further confirmation.

Reports from women participating in MBCT intervention during pregnancy have been largely positive. Qualitative analysis of the above studies reported:

“Every participant spoke of the benefits they experienced from learning these skills.” 20

“Participants regarded their experience in the intervention to be overwhelmingly positive.” 22

However, there is some concern about the practical accessibility of out-of-home interventions since various factors such as feeding and nap times, transport and childcare costs and the mother’s own mobility can present barriers to the uptake of these interventions.7,16,23 Offering out-of-home groups at different times of the day, and reimbursing travel costs might help to improve engagement in such interventions.23
Interpersonal therapy

What is interpersonal therapy and how does it work?

Interpersonal therapy (IPT) is a brief structured therapy originally designed to treat major depressive disorders in adults, but is typically delivered to individuals with mild to moderate depression. A central premise of IPT is that symptoms of mental illness, such as depressed mood, can be understood as a response to current difficulties in everyday interactions with others. Depressed mood can, in turn, affect the quality of these interactions, creating a vicious cycle. Therefore, the principal focus of IPT is remedying maladaptive interpersonal relationships that are considered fundamental to mood and therefore, depression and anxiety. IPT typically focuses on the following relationship areas: relationship conflict, life changes affecting how you feel about yourself and others, grief and loss, and difficulty in starting or keeping relationships going.

Is IPT effective for treating perinatal anxiety and depression?

Theoretically the use of IPT as an intervention for perinatal mental illness is appealing since partner conflict and lack of support are two key risk factors. Furthermore, empirical studies of the effectiveness of IPT have, in general, been supportive of its use in preventing and reducing mild perinatal anxiety and depression.

Antenatally, the preventative and reductive effects of IPT on mild perinatal depression and anxiety are empirically supported by some studies, whilst others were found to be methodologically weak. Two randomised studies by Zlotnick and colleagues in America found that IPT delivered during the antenatal period in a group setting was effective in preventing depressive disorder three months post-birth, compared to standard antenatal care.

Postnatally, IPT has been found to be effective as both a preventative therapy, as established in a review of five separate trials, as well as a reductive intervention for mild perinatal anxiety and depression.

In terms of acceptability, IPT does not require a significant amount of ‘home-work’, as for example, CBT interventions do, and this may be particularly acceptable for new parents during the perinatal period. IPT can also be implemented in a group setting, or individually and in this way is flexible and may be particularly good for the mother-father dyad. There is preliminary evidence to suggest beneficial effects, albeit mixed, when implemented with both groups and individuals.

Socio-cultural considerations

When discussing the appropriateness and effectiveness of talking therapies during the perinatal period there are several socio-cultural factors that need to be taken into consideration.

Ideas of maternal and paternal roles, as well as perceptions of mental illness, differ considerably cross-culturally, and it is important to be aware of and sensitive to differences when discussing and referring individuals to an intervention. Moreover, it is crucial that interventions for perinatal mental illness are designed to be flexible enough to account for cross-cultural differences. Language can also be a barrier to treatment for some communities, and lack of ethnic diversity among healthcare professions may exacerbate this problem.

Conclusions and practice points

In conclusion, talking therapies, overall, benefit from different implementation methods and are each well suited to different needs. Interpersonal therapy improves partner support and works on the mother-father dyad, whereas MBCT and CBT interventions are flexible and can be self-administered, offering convenience and cost-efficacy. Although there is good evidence for the efficacy of talking or psychological therapies for anxiety and depression, evidence regarding their effectiveness in pregnancy and how these interventions might be adapted for use in pregnant women is more limited, with CBT interventions providing the strongest evidence-base to date. All can be delivered during the antenatal or postnatal period; however talking therapies are most effective when delivered early in pregnancy.
Key points

• A wide range of interventions for the treatment of perinatal mental illness exist, with varying degrees of empirical evidence to support their use.
• Talking therapies is an umbrella term for psychological interventions or treatments where individuals are provided with a safe and supportive environment to explore their feelings.
• Three main forms of talking therapies have been used in the treatment of mild perinatal anxiety and depression: cognitive-behavioural therapy interventions, interpersonal therapy and mindfulness interventions.
• Although there is good evidence for the efficacy of talking therapies, evidence regarding their effectiveness in pregnancy and during the postnatal period is more limited.
• Talking therapies are most effective when delivered early in pregnancy.
• Currently, cognitive-behavioural interventions have the strongest evidence-base for the prevention and treatment of mild perinatal anxiety and depression.

References


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