Taking a prevention lens to the challenges of becoming a parent

Dr Camilla Rosan, Perinatal Infant Clinical Psychologist

Dr Freya Corfield, Trainee Clinical Psychologist
Who are we?

Dr. Camilla Rosan

crosan@mentalhealth.org.uk

@camillarosan

◦ A mum
◦ Perinatal and Infant Clinical Psychologist
◦ Public Mental Health Programme Lead - Families, Children, and Young People Mental Health Foundation
  ◦ Mums and Babies in Mind project (MMHA)
  ◦ Young Mums Together
  ◦ Linking Loss
◦ Clinical Academic, Imperial College London

Dr. Freya Corfield

◦ Third year Trainee Clinical Psychologist
◦ Placement at the Mental Health Foundation
◦ Research Psychologist
Our talk

- The transition to parenthood and perinatal depression
- Who is at risk?
- What are the different kinds of prevention?
- What is the evidence-base for preventing perinatal depression?
- What is the role of the couple relationship?
- Questions and reflections
The transition to parenthood
Ghosts and Angels in the Nursery
The parental brain emerges

- Decreases in grey matter volume for women who have never been pregnant and for men whose partners were pregnant.
- Decreases in grey matter volume for women pregnant with their first baby.
- Reduction in grey matter volume predicts quality of postnatal attachment.

Fatherhood

◦ What is the role of father?

◦ Fatherhood has a long-term positive and protective effect on men's health

◦ Patterns of stress increase across pregnancy
  ◦ negative feelings about the pregnancy
  ◦ role restrictions related to becoming a father
  ◦ fear of childbirth
  ◦ feelings of incompetence related to infant care.


Fathers engage with their children differently from mothers:

- More stimulating physical play
- More encouragement of the child to open to the outside world – positive engagement - associated with:
  - Fewer behavioural problems
  - Fewer psychological problems
  - Enhanced cognitive development (Sarkadi et al. 2008)
  - Enhanced socio-emotional development (Cabrera et al. 2000)
  - Strong predictor of attachment security (Newland et al. 2008)
- More directive and at times intrusive interactions
- More discipline (setting the proper limits to their safety)
Perinatal depression is common

- 1 in 7 new Mothers
- 1 in 20 new Dads


What happens to depression symptoms over the course of pregnancy?

Context of disadvantage

Table 3
Adjusted pooled prevalence stratified by variables of interest and income level.

<table>
<thead>
<tr>
<th>Perinatal period</th>
<th>High income</th>
<th>Low and middle income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal</td>
<td>9.2 (8.4–10.0)</td>
<td>19.2 (18.0–20.5)</td>
</tr>
<tr>
<td>Postnatal</td>
<td>9.5 (8.9–10.1)</td>
<td>18.7 (17.8–19.7)</td>
</tr>
</tbody>
</table>

Pooled prevalence of perinatal depression was 11.9%.

Impact

What are the risk factors?
Risk factors during pregnancy

Review article

Identifying the women at risk of antenatal anxiety and depression: A systematic review

Alessandra Biaggi a,*, Susan Conroy b, Susan Pawlby b, Carmine M. Pariante b

a PO63 Section of Perinatal Psychiatry, Department of Psychosis Studies, Institute of Psychiatry, Psychology & Neuroscience, King's College London, De Crespigny Park, London SE5 8AF, United Kingdom
b Section of Perinatal Psychiatry, Department of Psychological Medicine, Institute of Psychiatry Psychology & Neuroscience, King's College London, London, United Kingdom
NUMBER 1 RISK FACTOR

- Previous history of mental health difficulties:
  - 30% chance of antenatal depression/anxiety
  - 50% chance of postnatal depression/anxiety
Previous loss

- Anxiety (d = 0.69)
- Depression (d = 0.22)
- Stress (d = -0.002)

Unplanned pregnancy

**Risk Factors**

**Poor Relationships**

- Low partner and social support
- **Couple relationship conflict**
- Single mother/Partner not cohabiting
- Short-term relationship

Relationship satisfaction after having children

![Graph showing relationship satisfaction over months from birth for those with no children and new parents.](image-url)
The prevalence of antenatal and postnatal depression ranged 15-65% and 5-35% among women who experienced intimate partner violence.

Suicidal ideation ranged 5-11% during pregnancy and 2-22% during the postpartum.

Risk Factors

Socio-demographic & economic factors

- Young age (especially adolescence)
- Low income/financial hardship
- Minority ethnic group/living in a deprived area
- Low level of education
- Unemployment/ Housewives
Risk Factors
Adverse childhood experiences (ACES)
What can we do to prevent perinatal depression?

Identification and intervention
What does this mean for conducting a psychosocial assessment?

• Ask about:
  ◦ **Family and personal MH history**
  ◦ Childhood histories
  ◦ Fertility
  ◦ Method of conception
  ◦ Planned v unplanned
  ◦ Loss
  ◦ Social support
  ◦ Couple relationship quality and domestic abuse
  ◦ Meaning of pregnancy, representations of baby etc.
  ◦ Money, housing, work stress

• The **Antenatal Psychosocial Health Assessment (ALPHA) form** provides a useful framework

Childhood abuse question

**ASK & Normalise**

‘I ask everyone this question’

‘You do not have to tell me now but you can let me know at any point if you wanted help in talking to your midwife about it’

‘It is totally normal that pregnancy might bring up memories from our childhoods’
### Identification of maternal depression

#### Pregnancy
- **50%** are identified in clinical settings
- **14%** access treatment
- **9%** receive adequate treatment
- **5%** achieve remission.

#### Postnatal
- **31%** are identified in clinical settings
- **16%** access treatment
- **6%** receive adequate treatment
- **3%** achieve remission.

---

Public Mental Health

Prevention before occurrence

Universal ‘Primary Prevention’

Targeted ‘Secondary Prevention’

Prevention of recurrence ‘Tertiary Prevention’

Mental Health difficulties

Prevention of impairment

Long term outcomes
Universal prevention

- HV applying psychological based techniques early on in pregnancy reduces likelihood of developing depression into 18 months following birth compared to TAU

- Most women we in their late twenties, having their first or second child, were not living alone, and over a third had experience of a major life adversity

Targeted prevention

- Likelihood of developing postpartum depression fell from 20% to 4%

Indicated prevention

- Towards Parenthood Intervention
  - For both depressed and non-depressed expectant mothers and fathers
  - Self-help workbook and telephone support to reduce parents' vulnerability to postnatal depression, anxiety, and stress.
  - Significant reductions in depression, anxiety, stress and a trend in couple decreased couple relationship difficulty

- Been adapted and evaluated in an RCT in the UK by Imperial College London


What kind of care works?

No strong evidence

- perinatal education classes
- postnatal lay-based home visits
- early postnatal follow-up
- continuity of care models
- in-hospital psychological debriefing
- cognitive behavioural therapy

Evidence

- professionally-based home visits
  - intensive nursing home visits
  - flexible midwife postnatal care
- postnatal peer-based telephone support,
- interpersonal psychotherapy.

*Interventions targeting an indicated, at-risk group have better outcomes and more feasible than universal programmes*

Targeting risk mechanisms

Look beyond mothers alone - involvement of both partners?
<table>
<thead>
<tr>
<th>First Author</th>
<th>Intervention</th>
<th>Impact on depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buist (1999)</td>
<td>Antenatal education, one session on partner’s role</td>
<td><img src="false" alt="X" /></td>
</tr>
<tr>
<td>Elliott (2000)</td>
<td>Group classes: inc. improve social support, normalise mood, reduce stress etc.</td>
<td>![?]</td>
</tr>
<tr>
<td>Gao (2010)</td>
<td>Brief interpersonal psychotherapy-oriented psycho-education, targeted martial relationship</td>
<td><img src="true" alt="✓" /></td>
</tr>
<tr>
<td>Lara (2010)</td>
<td>Antenatal classes: inc. role of partner, depression etc.</td>
<td>![?]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>First Author</th>
<th>Intervention</th>
<th>Impact on depression</th>
<th>Included fathers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feinberg (2008)</td>
<td>8 classes, focused on co-parenting</td>
<td>Larger decrease, but not significant</td>
<td>Fathers reported positive co-parenting ✓</td>
</tr>
<tr>
<td>Matthey (2008)</td>
<td>Quiz to develop communication</td>
<td>Improved satisfaction with partner support</td>
<td></td>
</tr>
<tr>
<td>Fisher (2010)</td>
<td>Couples intervention focused on MH postpartum</td>
<td>Reduced risk</td>
<td></td>
</tr>
<tr>
<td>Gambrel (2014)</td>
<td>Group-based sessions, relationship education and mindfulness</td>
<td>✗</td>
<td>Fathers relationship satisfaction after 1 week ✓</td>
</tr>
</tbody>
</table>

The couple relationship as a modifiable risk factor

Partner-inclusive interventions for preventing postnatal depression

- Interventions worked best when they targeted these factors:
  - Emotional closeness
  - Clear open communication
  - Low levels of conflict
  - High support (emotional, relationship and instrumental support)
  - Global support

A theoretical framework for treating perinatal depression using couple-based interventions.

Any questions?

Thank-you