

MINDING THE BABY:

Research, practice developments and early interventions during the perinatal period

Special Interest Group in Perinatal Psychology conference 2007



I attended this conference on Nov 6th and 7th and thought I'd let you know about some highlights. Some of it might be familiar to many of you, but if you'd like to know more about anything I've briefly described here then please feel free to contact me (details on the back).

Helen Jones, Clinical Health Psychologist, Liaison Mental Health

Mind Mindedness

Dr. Elizabeth Meins, Sr Psychology Lecturer, Univ of Durham

Liz Meins coined the terms 'Mind Mindedness' in 1997. She is an advocate for the use of Attachment Theory as a model to understand a number of things, but is also concerned that it shouldn't be over used to somehow explain everything about a child's development and thus lose its robustness. One of its limitations is understanding what happens before an attachment relationship is formed. 'Mind-mindedness' is a concept she developed from Ainsworth et al's concept of 'maternal sensitivity.' It refers to the notion of the caregiver's tendency to treat the child as an individual with a mind. The sensitive caregiver is 'capable of perceiving things from the child's point of view'. The insensitive mother or caregiver tries to 'socialize with the baby when he is hungry, play with him when he is tired, and feed him when he is trying to initiate social interaction'

Mind-mindedness is measured by the number of appropriate or inappropriate mind-related comments as a proportion of total maternal language. For example, when asked in an open-ended way to describe their young child, a mother described as being more mind-minded would recount more things about the child's personality ('she's quite wilful at times but enjoys a real giggle') compared to descriptions used by mothers judged as less mind-minded such as 'he's got lovely brown eyes and is tall'.

These latter mothers often continue to use such descriptions even when directly asked about their child's character.

Thus, mind-mindedness in the first year of life is a matter of asking:

- Can mothers read their babies' minds?
- Do they talk about what their babies might be thinking or feeling, or about their likes, dislikes and interests?
- If they do, do they seem to get it right?

A number of Dr. Meins studies (along with colleagues) have demonstrated that children whose mothers were more mind-minded during the first year of life are more likely to:

- be securely attached (e.g. Meins et al., 2007)
- have superior language and play abilities at 24 months (Meins et al., *in prep*)
- show a better understanding of *other people's* minds at age 4 (Meins et al., 2002). This latter so-called 'theory of mind' is judged to be very important for making and keeping friends, and negotiating disputes successfully.

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Mothering Orientation and the transition into parenthood

Dr. Helen Sharp, *Sr Lecturer in Clinical Psychology, University of Liverpool*

Joan Raphael-Leff's psychoanalytic ideas about mothering orientation are Dr. Sharp's starting point for her interesting research. She has been examining whether 3 of Raphael-Leff's different styles (see inset box) are valid and whether they make any significant difference to predicting mothers' response to pregnancy and the postnatal period. Raphael-Leff contends that postpartum distress is a function of 'interpersonal, physical, economic or socio-cultural factors, conspiring to prevent each mother from fulfilling her own specific expectations of motherhood'. Different factors might precipitate depression in 'Facilitators' and 'Regulators' by threatening identity as a 'mother' or as a 'person', respectively. It is the *meaning* of events to the mother that is important. It is suggested that Regulators would be at higher risk of distress in the early postnatal period (with greater disruption to other roles and routines), whilst Facilitators might be more vulnerable later in the infant's life.



'FACILITATOR': pregnancy is the culmination of my feminine identity; being a mother is the most important and fulfilling role I can have; feed on demand; baby is sociable and dependent on me; I can intuitively communicate with my baby even in the womb; household adapts to the baby; baby knows best.

'REGULATOR': pregnancy is a tedious means of getting a baby; maternal devotion is over rated; motherhood is just one role amongst others I play; infant is demanding, separate but not yet sociable; feed by schedule; baby should adapt to the household routine; mother knows best

'RECIPROCATOR': engages in both types of behaviour but with a constant pattern of negotiation rather than facilitation or regulation; neither mother nor baby knows best but both can find out

(NB: These are descriptions of orientation NOT individual traits that never change)

Sharp, H.M & Bramwell, R. (2004) *An empirical evaluation of a psychoanalytic theory of mothering orientation: implications for the antenatal prediction of postnatal depression*
J. of Reproductive and Infant Psychology, 22, 71-89

Family Nurse Partnership

P.O. Svanberg *Psychology Lead, Health Led Parenting Project, Dept of Education & Skills*

The Family Nurse Partnership is a new initiative based on the importance of 'investing in prevention' and the emerging knowledge of neurological development which tells us that early interactions directly affect the way the brain is wired, and early relationships set the 'thermometer' for later control of stress responses.

P.O. Svanberg's introduction to this project reminded us that parenting begins at conception, and that pregnancy and the first 3 years are vital to child development, life choices and future achievement. Pregnancy and the birth of a child is also a 'magic moment' of opportunity when parents are uniquely receptive to support.

The FMP was created by David Olds and colleagues in Denver, USA, and has now 30 years of development and 3 large scale trials evaluating it. It has shown impressive results on a dazzling array of measures including criminal behaviour,

school conduct, maternal employment, experience of domestic violence, and reducing childhood deaths from preventable causes, as well as children's general development. Pilot sites in the UK now include Derby, Manchester, Walsall, Barnsley, as well as about 6 others.

It has a clear theoretical base:

- Human ecology theory (the client's social and material context)
- Attachment
- Self-efficacy (the ability to change behaviour by building on strengths and successes)

The scheme is for first time parents only (typically under 20 years old), and targeted at low income, 'hard to reach' parents. Staff (health visitors and midwives mostly recruited) have extensive training, and regular

supervision from psychologists.

There is an intensive schedule of contact (often weekly) which begins in pregnancy and continues until the child is 2 years. It is a heavily manualized programme with each visit always covering 6 domains (personal health, environmental health, life course development, maternal role, family & friends, health & human services).

Psychology also plays a role in providing organisational consultancy, training, and support to PCTs in adopting antenatal/perinatal guidelines, in particular developing community perinatal mental health teams.



Noticeable success in involving fathers

www.nursefamilypartnership.org/index.cfm?fuseaction=home

Maternal Severe Mental Illness and the impact on children's health & development

Dr. Susan Pawlby, *Institute of Psychiatry, Mother & Baby Unit, King's College*

Quiz

Within a few weeks, babies often lead and imitate interactions **True/False**

Amount of crying in the first few months is not related to parenting practice or parental handling **True/False**

Babies' tongue, mouth, face, body, arm and leg movements are controlled by social cues **True/False**

Babies recognise their mother's face from the first day **True/False**

Timing of adult responses to babies' cues is very critical to babies' continued attention **True/False**

Answers at bottom of page



By presenting her quiz, Dr. Pawlby tuned us in to how important it is to so many aspects of children's development that mothers are able to be responsive right from the beginning to their baby. Parenthood can present a particular challenge to mothers experiencing severe psychiatric/psychological problems such as psychosis or severe depression. Around half of mothers diagnosed with 'schizophrenia' receiving in-patient psychiatric care (shortly after having their babies), sadly do not retain custody of their children. This is partly because of the difficulty of interacting with their babies that these women are *perceived* to have. Dr Pawlby and colleagues have been involved with a

number of studies exploring infant-mother interactions with mothers with diagnosed severe mental illness. Amongst a number of important findings, they demonstrated in one key study that mothers' diagnosed with schizophrenia DO NOT lack maternal mind-mindedness (see front page) and in some respects were **more** sensitive to the thoughts and needs of their babies than many 'healthy' mothers, or depressed mothers. The babies were no more withdrawn than babies of 'healthy mothers'.

Based on research findings so far, the long term adverse effects on children's development of very depressed mothers, however, are often very concerning,

CHIP Project: A programme of early psychological interventions in families where infants have been born with severe congenital heart disease

Dr. Chris McCusker, *Consultant Clinical Psychologist, Royal Hospitals, Belfast*

Aims of the Project:

1. To examine outcomes (physical, psychological and social) for children and families, and chart risk and protective factors.
2. To test whether a new programme of early psychological interventions can promote better adjustment and reduce negative outcomes

The project has 2 studies: one New Born study (which this report is about) and one school age study. It included children born with Down's Syndrome, who often have heart problems.

Psychosocial outcomes for CHD generally highlight neuro-developmental delays, emotional-behavioural problems and attachment difficulties for the child, with emotional distress (particularly

worry) and social isolation for the parents. Current intervention research into psychosocial outcomes for CHD are limited, often poorly described or not grounded in psychological theory, and tend to only have a disease management focus.

The CHIP project's ethos includes that adjustment is a 'family affair'. The CHIP intervention (in the first couple of months after the infant is diagnosed and is attending hospital) includes the use of a DVD of parents stories, advice and 'coaching', 'problem prevention therapy' ideas, and 'emotional ventilation and the construction of meaning' i.e. talking directly about fears and negative beliefs perhaps about the future (which is generally unusual at this stage of diagnosis compared to simply supporting someone's 'survival' skills).

In general, the results so far are very good for parental knowledge of the condition, breastfeeding rates, less difficulty introducing solids, reduced levels of anxiety and maternal worry. There were no gains in areas such as psychomotor problems and times of feeds, and the social impact on the family.

BY THE WAY....

Their well-made DVD of service users' experiences and views was only £15,000 to produce, which struck me as a hugely cost-effective and accessible way of providing information and support for many people



Local Clinical Perinatal Network

A new Clinical Perinatal Network was set up in Shropshire in September this year, to include representatives from service users, maternity services, midwifery, health visiting, community adult mental health services, liaison mental health services, and CAMHS. Those who have attended meetings so far include: Angela Hughes (Lead Midwife for mental health), Dr. David Redford (Cons Obs & Gynae), Cathy Smith (W&C Service Manager), Dr. Catherine Thompson (Staffs Mother & Baby Unit), Julie Lloyd Roberts (AMH Service Manager), Dr. Lorna Stewart (CAMHS), Jane Hambleton (CMHT team manager), Elaine Gough (HV coordinator), Jan Latham (Senior Midwife Inpatient services), Dr. Rosemary Corke and myself (Liaison MH).

Contact Details:

Helen Jones,
Clinical Health Psychologist,
Liaison Mental Health,
Chaddeslode House,
130 Abbey Foregate,
Shrewsbury

Helen.jones@shropshirepct.nhs.uk

01743 341914

How NICE are you?

The National Institute for Health & Clinical Excellence (NICE) issued guidelines for antenatal and postnatal mental health in February (reissued April) 2007 (Guideline No 45).

- ◆ Amongst the guidelines, it states that pregnant and postnatal women requiring psychological treatment should be seen normally within 1 month of initial assessment, and no longer than 3 months afterwards.

- ◆ At a woman's first contact with primary care, at her booking visit and postnatally, healthcare professionals such as the GP, midwife, or health visitor, are advised to ask 2 questions to identify possible depression: "During the past month, have you often been bothered by feeling down, depressed or hopeless?" and "During the past month, have you often been bothered by having little interest or pleasure in doing things?" If the answer is 'yes' to either, they are advised to then ask "Is this something you want help with?"

The Special Interest Group

The Perinatal Psychology Special Interest Group who hosted this conference is under the auspices of the Division of Clinical Psychology. Its aims are:

- To provide a forum primarily for clinical psychologists who work with women who are pregnant, in labour, or in the postnatal period and their partners, children and extended family.

- To provide support for this group of professional colleagues who span specialties (e.g. Health Psychology, Mental Health) and client groups (Adult, Child)
- To support the expansion of a knowledge base in perinatal psychology
- To develop links with other professional groups and service user groups who share an interest in the perinatal care of women and their families.

- To advise and respond on a local and national level to the development of policy impacting upon our client group

