Improving maternal mental health through mindfulness

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ORIGINAL

'Motherhood forces women into a new kind of self-sufficiency. Our only hope for mothering happily and wisely lies in developing inner resources to nourish ourselves.' (Napthali 2011:2).

Introduction

Becoming a mother is a momentous event during which huge physical and emotional changes take place. For many women, it is also a period of financial challenges, relationship pressure, and unmet expectations of motherhood (O'Mahen *et al* 2012). Around one in five women experiences mental health problems such as depression or anxiety in pregnancy and the first year after birth; it is believed that around half these women are not identified by health care professionals (Khan 2015). Still more women experience heightened levels of anxiety and stress but are below the threshold for treatment or support. Perinatally, women are at increased risk of both relapse of existing mental illness and presentation of new illnesses (Hogg 2013).

Perinatal mental illness is an isolating, frightening experience for women, which affects not only their interactions with their baby, but also their self-esteem and relationships with partner and family. Poor maternal mental health increases the risk of preterm birth and the resulting cognitive impairment, future behavioural issues and emotional problems of the child. In the most serious cases it can lead to suicide. Perinatal mental illness has been estimated to carry a long-term cost to UK society of £8.1 billion for each one-year cohort of births (Hogg 2013, Bauer *et al* 2014, Maternal Mental Health Alliance 2014).

There is a substantial and growing body of evidence that mindfulness interventions have a clinically significant and lasting positive effect on mental health (Hofmann *et al* 2010, Klainin-Yobas *et al* 2012, Khoury *et al* 2013, Godfrey *et al* 2015, Gong *et al* 2016). This article discusses the scale and impact of perinatal mental illness, reviews the evidence around mindfulness interventions to improve mental health and calls on midwives to consider how they can include mindfulness both in their individual practice and, more widely, how high-quality perinatal specific interventions can be developed and incorporated within the maternity system.

The scale and impact of perinatal mental illness

Improving the detection and treatment of perinatal mental illness has been identified as a crucial public health goal by the All-Party Parliamentary Group (The 1001 Critical Days 2013), the Department of Health (2014), the Royal College of General Practitioners (Khan 2015) and the National Maternity Review (NHS England 2016). It is estimated that 100–150 women per 1000 are affected by mild to moderate depressive illness and anxiety states in the perinatal period, whilst 150–300 per 1000 experience adjustment disorders and distress. Each year this equates to a total of approximately 241,000 women in England alone (Hogg 2013). Research has shown that poor maternal mental health can negatively impact the emotional, social and cognitive development of children, with the quality of early attachments affecting future relationships (Hogg 2013, Maternal Mental Health Alliance 2014).

A report by Bauer *et al* (2014), commissioned by the Maternal Mental Health Alliance, calculated that each case of perinatal depression or anxiety costs the public sector approximately £10,000 and wider society significantly more than this. Quantifiable outcomes used to calculate the cost included increased use of health and social services, productivity losses and loss of quality-adjusted life-years for mothers; and increased risk of pre-term birth and resulting cognitive impairment, emotional problems and behavioural issues for children. The researchers acknowledged that due to difficulties in quantifying significant additional costs, including the effect of perinatal mental illnesses on partners, there were unaccounted for expenditures. The researchers further propose a correlation between maternal mental health issues and poor antenatal attendance, smoking, substance misuse and poor diet.

Diagnosis and treatment of perinatal mental health problems

It is believed that around half of women experiencing mental health problems in the perinatal period are not identified by health care professionals (Khan 2015). Despite the prevalence of perinatal mental health issues, there remains a perceived stigma, and women may fear being judged negatively as a mother, or being separated from their baby; the mental health problem itself may further prevent women engaging in treatment (The National Institute for Health and Care Excellence (NICE) 2018a). Furthermore, many women believe their midwife is too busy and as a result fail to disclose mental health issues for fear of burdening them further (Royal College of Midwives (RCM) 2014). Overall, seven in ten women conceal or minimise the severity of their mental health problem (Maternal Mental Health Alliance 2014).

Midwives may also be reluctant to begin conversations around mental health; a national survey of women's experience of maternity care (Redshaw & Henderson 2015) found that one in five women had not been asked about their current emotional well-being or mental health history. Due to resourcing issues, criteria for referral to psychiatric services are extremely narrow, and there is no clear pathway of help for women with sub-threshold anxiety or depression. The *Pressure Points* report on maternal mental health, quote one mother: *'everyone asked how I was coping, but no-one had any help they could offer, so it was pointless'* (RCM 2014:12).

Perinatal mental health care has been described as a postcode lottery that focuses on pharmacological treatment rather than prevention and early intervention (Hogg 2013). The majority of mothers express negative views about antidepressants with concerns including becoming physically dependent, teratogenic effects on the fetus, a negative impact on breastfeeding, and potential drowsiness affecting their ability to parent. As a result, there is widespread non-compliance with antidepressant treatment (Battle *et al* 2013). Many women discontinue antidepressant medications abruptly, without support, with subsequent relapse. Furthermore, even persistent use of antidepressant medication does not confer absolute protection against depressive episodes (Roca *et al* 2013, Dimidjian & Goodman 2014).

NICE (2018a) highlights the risks associated with using psychotropic medication while pregnant or breastfeeding, and recommends psychological interventions where the benefits are likely to outweigh the risks of medication. However, despite the introduction of the national *Improving Access to Psychological Therapies* programme, there are considerable variations in waiting times for treatment of between six and 124 days (NHS England 2016). Moreover, therapist-supported psychological interventions are costly to run and present logistical difficulties for women to attend, particularly postnatally (Khan 2015).

Mindfulness to improve mental health

There is promising evidence that mindfulness — the deliberate practice of paying attention to the present moment — may improve mental health. Mindfulness is an established discipline with no known adverse side effects. Although rooted in Buddhist teachings, mindfulness has been described as*: 'a universal capacity of the human mind, a skill that can be learned independent of any particular religious, spiritual, or cultural tradition'* (Bardacke 2012:11).

The use of mindfulness in health care was pioneered by Kabat-Zinn (1990). His mindfulness-based stress reduction (MBSR) programme — an eight-session taught group programme which includes breath meditation, body scan and mindfulness yoga — has been shown by numerous meta-analyses to have a clinically significant and lasting positive effect not only on anxiety, depression and stress but also on

chronic pain, insomnia and eating disorders. MBSR has been shown to improve the quality of life of healthy individuals, and to have benefits for population groups as varied as medical students, prisoners and schoolchildren (Hofmann *et al* 2010, Klainin-Yobas *et al* 2012, Khoury *et al* 2013, Zenner *et al* 2014, Godfrey *et al* 2015, Khoury *et al* 2015, Gong *et al* 2016). Mindfulness-based cognitive therapy (MBCT) — which combines mindfulness with cognitive behavioural therapy and includes techniques which focus on the recognition of negative thought patterns — has also demonstrated diverse health benefits, and now forms part of the NICE guideline on preventing relapse of depression (Segal *et al* 2012, Kuyken *et al* 2016, NICE 2018b). Other mindfulness-based interventions include yoga with an integrated mindfulness element.

In recent years the impact of mindfulness during the perinatal period is beginning to be explored, with several meta-analyses showing a variety of benefits (Hall *et al* 2016, Lever Taylor *et al* 2016, Shi & Macbeth 2017). Bardacke (2012) adapted MBSR to create her ten-session mindfulness-based childbirth and parenting programme. These antenatal preparation classes include fathers/birth partner as equal participants and incorporate mindfulness into traditional antenatal and birth preparation classes. The classes were further adapted into a weekend course by Duncan *et al* (2017), who demonstrated lower rates of postpartum depression and a trend towards reduced use of opioid analgesia in labour compared with parents who had attended a standard antenatal class with no mindfulness component. Warriner *et al* (2018) piloted an adaptation of Bardacke's (2012) programme within the NHS and showed a significant positive impact on both maternal and paternal mental health, and high levels of satisfaction with the course.

Dimidjian *et al* (2016) carried out a randomised trial involving women with a history of depression. A version of MBCT which had been modified for the perinatal period was provided in small group classes over eight sessions, and participants were provided with audio and video files to use at home. The researchers asserted a substantial relapse prevention effect and high levels of interest, engagement and compliance with the programme. Woolhouse *et al* (2014) piloted a six-week mindfulness group therapy programme for women considered at risk of perinatal anxiety and depression, which showed positive outcomes. In-depth interviews with four of the participants provided an insight into their perspective of the course; the researchers noted a strong theme of recognising and changing negative behavioural patterns, and an improvement in interpersonal relationships. The course included a loving kindness meditation, which was found to be both challenging and thought-provoking — one participant commented: *'It definitely showed that you don't put much love onto yourself'*. Each of the women intended to continue using mindfulness practices after course completion.

Other researchers have studied whether yoga classes with a mindfulness element may improve maternal mental health. Newham *et al* (2014) reported that yoga significantly and persistently decreased both anxiety and fear of childbirth, while Gong *et al* (2016) carried out a systematic review and meta-analysis of yoga for antenatal depression, and found that while 'typical' yoga did not impact on depression rates, yoga which integrated mindfulness did significantly decrease depression levels. Curtis *et al* (2012) reported reduced labour duration and pain for women who undertook yoga in pregnancy, but noted the potential side effect of uterine contractions and the need to monitor the level of activity accordingly.

Although there are no known adverse effects of mindfulness, much of the research has significant limitations. Hall *et al* (2016) noted considerable variation in mindfulness interventions in terms of form, duration, and study design, which makes generalisation of results difficult; the researchers further commented on the high drop-out rates of mind-body interventions and the lack of cost benefit analyses on the use of such interventions in maternity. Shi & Macbeth (2017) observed a research bias towards Caucasian women, a higher than average education level and women in stable relationships. Lever Taylor *et al* (2016) report that many studies were underpowered and did not include a control group; further, the majority of the perinatal studies have focused on antenatal rather than postnatal populations. At present, the underlying mechanism of how mindfulness improves outcomes is unclear. The body of evidence for the benefits of mindfulness continues to develop rapidly and it is hoped that these shortcomings will be addressed by adequately powered, longitudinal randomised controlled trials, using active controls.

A move from reactive to preventative health care

Naidoo & Wills propose that:

'mental health is more than the absence of mental illness or distress. It includes emotional health, self-determination and resilience to manage and cope with the stresses and challenges of life' (2010:198).

The authors further note that strategies to promote mental health have mainly focused on the detection and treatment of mental illness, rather than wider issues of well-being. In 2016, NHS England published its *Five Year Forward View for Mental Health* which identified the need for a *'far more proactive and preventative approach'* (2016:4) to reduce the impact of mental health problems, a view echoed by the RCM (2014).

In recent years there has also been an increased emphasis on encouraging women to take an active role in their own well-being. The Nursing and

Midwifery Council's *Code of professional standards for nurses and midwives states that midwives* must:

'recognise the contribution people can make to their own well-being… encourage and empower people to share decisions about their treatment and care' (NMC 2015:2.2).

Managing stress is known to have a protective effect against the onset and escalation of mental illness symptoms; the absence of negative side effects means that, unlike pharmacology, mindfulness can be targeted at the general population (Hogg 2013). Edwards & Byrom (2007:2) note that: *'pregnancy is unique in giving a window of opportunity for making changes in lifestyle and habits'*. Midwives are experts in providing holistic care to women (Crabbe & Hemingway 2014) and mindfulness can be part of a package of good self-care including a good diet, adequate rest and strong social networks.

Incorporating mindfulness in midwifery practice

There are a number of high-quality publicly available mindfulness resources, often at low cost, which midwives can recommend to the women in their care. *Be mindful: online mindfulness course* (Wellmind Media & Mental Health Foundation 2018) is an unguided, internet-based self-help MBCT course which has been shown to have a significant and persistent positive effect on depression, anxiety, perceived stress and sleep quality, with results comparable with face-to-face mindfulness courses (Krusche *et al* 2013, Querstret *et al* 2017, Querstret *et al* 2018). The course is listed in the NHS Apps Library (NHS 2018), a selection of high-quality, safe, effective digital tools.

There are numerous mindfulness books available — often with access to audio-guided meditations — which provide a good introduction to this topic. Bardacke's *Mindful birthing* (2012) covers the content of her mindful parenting classes and contains many useful antenatal and intrapartum mindfulness techniques. It can be used by midwives to adapt their antenatal classes or use in an intrapartum setting, or by mothers at home. Influential texts not specific to the perinatal period include, Williams & Penman (2011), Segal *et al* (2012) and Kabat-Zinn (2013).

Development of perinatal-specific mindfulness interventions

Despite recommendations that psychosocial interventions should be the first-line treatment for perinatal mental health problems and calls for funding to be made available for preventative mental health projects (RCM 2014, World Health Organization 2015, NICE 2018a), there are few mindfulness interventions targeted at the perinatal period. O'Mahen *et al* (2012) propose that modifying interventions to meet the specific challenges of this time may improve acceptability and outcomes.

There are notable advantages to the development of an unguided, internet-based mindfulness resource, tailored to the perinatal period, which could be made available to women nationally free of charge. The *National Maternity Review* noted that the majority of pregnant women confidently use digital tools and that a smartphone app targeted at pregnant women, Baby Buddy, has shown impact with all ages and in particular younger women (NHS England 2016). Such a resource would reduce the significant geographical variation in service care, improve access to psychological therapies and expand provision of digital services — all goals of the *Five Year Forward View for Mental Health* (NHS England 2016). Furthermore, online resources are instantly available and can be offered alongside medication.

Dimidjian *et al* (2016) propose that mindfulness is associated with a healthy lifestyle rather than illness and is therefore less likely to engender stigma than traditional psychological therapies. Unguided mindfulness resources remove the issues of long waiting lists, difficulty in attending appointments, transport problems and a limited number of therapists. Such resources also provides a cost-effective way to offer a high-quality, national service to a large number of people; and crucially, usage of such programmes is anonymous, thus providing confidentiality to the large numbers of women who do not disclose mental health issues due to stigma or fear of separation from their baby (NICE 2018a). Midwives may be more willing to begin conversations about mental health if they have a resource available to offer, and these conversations provide an opportunity for midwives to normalise the topic of mental illness and motherhood.

The resource would be available to all women; however, mothers with risk factors for depression or anxiety, or with particularly stressful lifestyles, may find the tool particularly useful, and it could therefore be recommended by midwives who are caring for vulnerable women. Such a resource could be extended multilingually, again at low cost, available for fathers in what can also be a challenging time for them (Ly 2010) and specifically developed to address tokophobia. Rouhe *et al* undertook a large register-based retrospective study in Finland which found that: *'previous mental health problems and fear of childbirth are the strongest predictors for the need for postpartum psychiatric care'* (2011:1108).

Trusts could also consider the creation or expansion of a well-being programme, including mindfulness yoga and incorporating mindfulness in their antenatal classes. Further, the provision of a mindfulness tool to staff could be considered. Warriner *et al* (2016) noted the high level of workplace stress experienced by midwives; following an eight-week mindfulness meditation course, the researchers reported not only personal benefits for participants but an improvement in organisational culture.

Conclusion

Mindfulness resources enable all midwives to provide clear, evidence-based support for women

experiencing, or at risk of, mild depression, anxiety or stress. Whilst mindfulness is not suitable as a sole treatment for individuals with more severe symptoms of depression or anxiety, it can be offered alongside pharmacological treatment and may be a palatable alternative to women who would not otherwise disclose mental health issues or who would not comply with prescribed medication regimes.

The *National Maternity Review* (NHS England 2016) proposed that the mental and physical well-being of women is equally important. Mothers' stress, depression and anxiety levels impact upon their babies and cause huge costs to society. Equally importantly, poor mental health diminishes the joy of motherhood and detracts from the pleasures of everyday life. Mindfulness can enable women to develop the inner resources needed to better cope with the challenges of motherhood, gaining strength and autonomy. As Sarah Napthali, a writer on the Buddhist perspective on motherhood, has written:

'If we managed to rearrange our lives a little, remove some of the clutter, what might this new space bring us? We could enjoy time for silence, stillness, meditation. We might watch our children sleeping, gaze into the eyes of our baby, go for a walk, observe nature, write in a diary, enjoy a slow meal, or listen to all the sounds around us. We might do something utterly spontaneous: pick some flowers, chat to a stranger, go for a leisurely wander to explore a neighbourhood. These activities allow us to reconnect with ourselves and find energy. They also remind us that life can be lighter, more spontaneous and enjoyable' (2011:248).

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