



## Listening to the Voices of Women Suffering Perinatal Psychological Distress

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# Listening to the Voices of Women Suffering Perinatal Psychological Distress

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## Abstract

This article suggests that transactional analysis can be an effective treatment approach for women suffering from mental health conditions and the emotional and life disturbances that may occur during the perinatal period. It offers a brief introduction to perinatal psychological distress followed by a description of the use of transactional analysis psychotherapy for this condition. The article outlines a new model for a research project that aims to ascertain women's views on the helpfulness of the treatment and to gain a better understanding of the stigma often associated with perinatal mental health issues. The author argues for the necessity of qualitative research to assess the efficacy of transactional-analysis-based treatment and to increase our knowledge about the change process in transactional analysis psychotherapy with this client population as well as to inform future transactional analysis treatment protocols.

## Keywords

perinatal, antenatal, postnatal, mental health, stress, anxiety, depression, distress

Many women struggle with their mental health at some point in either the antenatal or the postnatal period. In the recent past, such mental health issues have tended to be diagnosed as one of three conditions: so-called baby blues, postnatal depression, or puerperal psychosis. These were seen as distinct and were deemed to occur postnatally, with the biomedical determinants thought to be either hormonal dysregulation or abnormalities in the hypothalamic-pituitary-adrenal (HPA) axis (Meltzer-Brody, 2011). However, this does not explain perinatal depression in fathers (Ballard, Davis, Cullen, Mohan, & Dean, 1994; Paulson & Bazemore, 2010; Paulson, Dauber, & Leiferman, 2006; Pinheiro, Magalhaes, Horta, da Silva, & Pinto, 2006; all cited in Rosenquist, 2013) or adoptive parents (Payne, Fields, Meuchel, Jaffe, & Jha, 2010; Senecky et al., 2009; all cited in Rosenquist, 2013). Postnatal depression is viewed by the medical profession as one of the most common complications of childbirth (Robertson, Celasun, & Stewart, 2003), and one of the strongest predictors of postnatal depression is depression during pregnancy (Milgrom et al., 2008; O'Hara & Swain, 1996). Women with a history of previous psychiatric illness are at most risk of mental illness during the perinatal period (Coble et al., 1994; Kendell, Chalmers, & Platz, 1987; Leight, Fitelson, Weston, & Wisner, 2010), that is, the time shortly before or after giving birth.

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Recent research is beginning to change our understanding of the depth and breadth of emotional difficulties during pregnancy and motherhood. Rather than speaking only about postnatal depression, it is more common to use the term *perinatal* to reflect the recognition that mental illness can begin in pregnancy, with many women suffering from mental health issues both before and after giving birth (Glover & O'Connor, 2002). The term *depression*, although commonly used as a blanket term for women struggling in pregnancy and postnatally, may not adequately fit the experience of many.

I prefer to use the term *perinatal psychological distress* in my work because it more closely fits the experiences of the women I see. Without exception, all of the women I have seen so far have been unwell during her pregnancy (antenatally) and through into motherhood. My clients rarely talk of depression. Instead, they speak of their distress and how much they are struggling with motherhood and life. Listening to and understanding how these women contextualize what is happening to them is, in my view, the first and fundamental step in helping them back on the path to health. However, the research to date mostly uses the terms *depression* and *anxiety* and, in particular, *postnatal depression*.

The Cochrane Database of Systematic Reviews estimates that postnatal depression affects between 10-15% of women in the United Kingdom (UK) (Dennis & Hodnett, 2007). This level appears to have remained constant for the last 10 years (see O'Hara & Swain, 1996, who suggested the figure was 13%). Statistics for anxiety and stress in the perinatal period are virtually nonexistent, although Rubertsson, Hellström, Cross, and Sydsjö (2014) found that 15% of women report anxiety in the antenatal period, whereas the figure cited for the entire perinatal period is 25-45% (Britton, 2008; Faisal-Curry & Menzes, 2007). However, these statistics only encompass those women who actually seek medical help for their distress, and thus the incidence may be considerably under-recorded. More worrying is research showing that half of all cases of perinatal depression and anxiety may be overlooked or unrecognized by health professionals and therefore left untreated (Bonari et al., 2004). This would seem to be corroborated by Glover (2014, p. 25), who also highlighted that many cases are simply not recognized. Equally, there is evidence that few women seek treatment antenatally, with only 5% of pregnant women with a mental health disorder undergoing either psychopharmacological or psychotherapeutic treatment (Andersson et al., 2003, as cited in Bittner et al., 2014). This could be due to misinterpretation of symptoms, an absence of treatment considered to be safe for mother and fetus, and possible competing medical demands such as fatigue, work, family commitments, and so on (Vesga-Lopez et al., 2008, as cited in Bittner et al., 2014).

Yet the most serious implication of this condition is the long-term effects it can have on the infant (see Agnafors, Sydsjö, Dekeyser, & Svedin, 2013; Deave, Heron, Evans, & Emond, 2008; Field, Diego, Hernandez-Reif, et al., 2010; Glover, 2014). Epigenetic research is now highlighting the possible repercussions of this disorder, with statistics showing that antenatal depression leads to a fourfold increase in the likelihood that the child will develop depression at some point in his or her life (Lester, Conratt, & Marsit, 2013, p. 556). Research also highlights other significant consequences of this condition, such as low birth weight and preterm birth (Cooper et al., 1996; Field, Diego, Dieter, et al., 2004), impaired cognitive development, symptoms of attention deficit hyperactivity disorder, emotional problems (Glover, 2014), and impaired maternal-fetal attachment (Lindgren, 2001) as well as transgenerational changes (Kaplan et al., 2013) and possible negative effects on the behavioral development of the child (Deave et al., 2008). In addition, the economic consequences involve financial costs not only to the mother and her immediate family but also in terms of the infant, with the possibility of a predisposition to lifelong mental health disorders and thus costs to society at large. In their economic research from the South London Child Development Study, Bauer et al. (2015) were the first to research and begin to attribute the long-term cost to the child of growing up with a severely depressed mother. However, there remains a significant gap in our knowledge about the true cost of perinatal mental health during a child's lifetime. This is an area

that needs research, particularly at a time when perinatal mental health budgets are being cut quite severely in the UK.

Because of the serious consequences of perinatal psychological distress for the mother (Glover & O'Connor, 2002), infant (Agnafors et al., 2013; Deave et al., 2008; Field et al., 2010; Glover, 2014), and the wider family and the possible significant economic costs (estimated at £8 billion per year in the UK, Bauer et al., 2015), research on intervention strategies other than antidepressant medication is needed. Women who seek treatment have little choice of modalities of care offered. Few women in the UK have access to psychological therapies because the National Health Service (NHS) is actively cutting such services, if indeed they existed at all. Women are often faced with difficult choices that they may perceive as harmful to either/both themselves and/or their infant. Getting women to admit to these difficulties often seems related to diagnosis, possibly because of the intense stigmatization some women feel (McLoughlin, 2013; Staneva, Bogossian, & Wittkowski, 2015). Stigmatization becomes a barrier to seeking help because it leads women to shy away from engaging in treatment. Instead, they end up isolating themselves, pretending to health professionals, friends, and family that there is nothing wrong. Intense feelings of shame effectively silence them (McLoughlin, 2013; Staneva et al., 2015).

A possible treatment option for this type of distress is psychological therapy and, in particular, psychotherapy. *Psychological therapy* is a term used to incorporate any type of psychosocial therapy, including counseling, cognitive behavioral therapy (CBT), psychoanalysis, and psychotherapy. A generic term, it can encompass therapies that are short term and not necessarily performed by professional psychiatrists, psychologists, or psychotherapists. Psychotherapy is a specific type of psychological therapy and is distinguished by the length, depth, and breadth of training for the practitioner, normally (but not always) requiring a master's degree and often a clinical psychiatric placement as well.

Psychotherapy appears to be the treatment women would prefer for postnatal depression because it does not involve the risks of medication (Fitelson, Kim, Scott Baker, & Leight, 2011; Kim et al., 2011; Pearlstein et al., 2006). This is particularly significant for women who are breastfeeding. Psychotherapy has been used effectively in the treatment of depression in adults but has not been used widely for the treatment of perinatal mental health conditions, particularly in the United Kingdom. These conditions, when they are diagnosed, are treated in the UK most often by psychopharmacotherapy through a patient's general practitioner. However, in the UK there is research showing that many women with this condition never receive any kind of treatment. According to a survey carried out by the National Society for the Prevention of Cruelty to Children (NSPCC), of Primary Care Trusts in the UK, 64% do not have a perinatal mental health strategy, 73% of maternity services do not have a specialist mental health midwife, and 50% of Mental Health Trusts in the UK do not have a perinatal mental health service with a specialist psychiatrist (Hogg, 2013).

### **The Need for Transactional Analysis Research**

As a clinical psychotherapist, I work with clients with this condition who either self-refer or are referred by a doctor or medical practitioner such as a midwife or health visitor. I find transactional analysis an effective form of treatment with these clients, but to date, there has been no research on it as a possible treatment for distress or mental health difficulty in the perinatal period. However, there is a small body of research on its use as a treatment option for depression (van Rijn, & Wild, 2013, 2016; van Rijn, Wild, & Moran, 2011, 2012; Widdowson, 2011a, 2011b, 2012a, 2012b, 2012c, 2013a, 2013b, 2014a, 2014b, 2015, 2016), which suggests that transactional analysis may also be effective for perinatal psychological distress. I am, therefore, proposing to research the use of transactional analysis with this client population. Much of the existing research (which has not included transactional analysis) with this group has focused on the postnatal period and only on

depression. There is also a significant gap in qualitative literature on psychotherapy for this condition, although there is some quantitative data.

I hope to address these gaps in research by:

- Expanding the research to include the entire perinatal period
- Expanding the mental health conditions to include stress and anxiety as well as depression in this period
- Addressing the lack of qualitative research
- Addressing the gap in transactional analysis research
- Addressing the gap in currently available treatment choices

My primary goal is to provide qualitative evidence for a treatment option for women with perinatal psychological distress that may be perceived as more appropriate and less harmful to them and/or their infants than antidepressant medication. This is especially important because antidepressants are now the first line of treatment in the perinatal period, and usage rates are increasing worldwide (Bakker, Kölling, van den Berg, De Walle, & De Jong van den Berg, 2008). There is disagreement about the effects of psychotropic drugs in both the antenatal and the postnatal periods with concerns about them passing through the placenta and also into breast milk, thereby posing possible side effects for both mother and baby (Galbally, Lewis, Lum, & Buist, 2009; Rosenquist, 2013). The literature on antenatal antidepressant effects and antidepressant usage while breastfeeding is inconclusive as to whether the antidepressants or the untreated depression is worse for the fetus/infant (Field, 2008). Yet in the United States, psychological and/or behavioral therapies are the preferred first-line treatment options for women with depression in the antenatal period (Yonkers, Vigod, & Ross, 2011; Yonkers, Wisner, Stewart, et al., 2009). In the UK, National Health Service funding for treatment other than psychotropic medication is limited, if not totally unavailable (Social Care, Local Government and Care Partnership Directorate, 2014).

## Rationale

My interest in this condition began 6 years ago during my placement in an inpatient mother and baby psychiatric unit. I learned that treatment for this condition was virtually nonexistent and seemed to be crisis led. Many of the women had been unwell for a while but had been unable or unwilling to ask for help, possibly because of a perceived sense of stigma and intense fear.

On completing my psychiatric placement, I chose to continue to offer psychotherapy for women struggling with perinatal distress. Unfortunately, most women who have this condition are unable to pay for therapy, and the NHS is unwilling to pay me for treating them. The only way I can provide this service is by offering free, long-term psychotherapy, although one or two of my clients are able to contribute something financially. I also could not find a charity or research council willing to fund me, so my research is self-funded.

Many women with perinatal psychological distress have prior mental health issues. Indeed, this is corroborated by research that shows that women with a history of previous psychiatric illness are at most risk of mental illness during the perinatal period (Coble et al., 1994; Kendell et al., 1987; Leight et al., 2010). Some women have sought help through their doctor, midwife, or health visitor only to find nothing on offer. Many have simply suffered through and continue to suffer. For some this condition continues for years after the birth of their child or children. My belief is that many of these women have something in their past that is triggered either antenatally or during the birth, thus exacerbating the stress and anxiety of what is an already stressful and anxious period of life.

Over years of treating this condition, I have noticed striking similarities in many of the women I see. Trauma in the formative years seems common. Such trauma can also be inextricably linked with

a woman's own experiences of being mothered. Often there is a distinct gap or missing element in their experience of the mother-child bond. To illustrate this, I will offer some clinical examples later in this article.

### **A Brief Overview of Treating Perinatal Psychological Distress with Transactional Analysis**

We all have intimate knowledge of what it was like to be mothered. It may have been good, it may have been bad, it may have been neglectful, it may have been overwhelming. Whatever it was like, it still resides within us. We may also be unable to give it a narrative because, of course, those early years are preverbal. I often feel when I work with women on their experiences of being mothered that the preverbal phase is the "unthought known" (Bollas, 1987). Hollway (2015, p. x), in her most recent book called *Knowing Mothers*, wrote about "the ineffable in maternal experience," ineffable having two meanings: "incapable of being expressed" and "not to be uttered." Hearing the word *mother* often brings up intense affect in my clients, who often need to keep their own mother in an idealized place. Exploring this word, its meanings, the loss of the perfect mother, and the fear of not being the perfect mother seems to allow these women to grieve in a way that appears, again, to be nonverbal in its inexplicability. The grief can often seem primitive, and the women may seem unable to put words to their loss.

Relational transactional analysis provides a context in which I can explore intimacy with these women, and we can be in the unthought known in whatever way they need. The formation of this relationship, the cocreatedness of it (Summers & Tudor, 2000; Tudor & Summers, 2014), helps to model the creating of relationship for my client with her infant. It also offers an environment rich with opportunity to explore what motherhood and the transition from being someone's child to being someone's parent actually means. I also work with stigma, guilt, shame, and loss, feelings that my clients often articulate to me along with their felt inadequacy as a mother. My clients are not alone in their feelings; women have also articulated these feelings in the context of qualitative research exploring women's experiences of perinatal mental health (Buultjens & Liamputtong, 2007; Choi, Henshaw, Baker, & Tree, 2005; Mauthner, 1999; O'Mahen et al., 2012; Wood, Thomas, Droppleman, & Meighan, 1997).

Many of these women talk about stigma (Choi et al., 2005; Mauthner, 1999; Staneva et al., 2015; Wood et al., 1997) because motherhood can bring with it an enormous sense of shame, failure, guilt, and not being good enough. There is a huge myth around motherhood, and the media often depict motherhood as an experience of intense joy and fulfilment and of happy, squeaky clean, giggling babies. For many women, this bears no resemblance to their life. They talk about how impossible it is to describe birth and/or motherhood. The NHS offers parenthood classes that appear to provide choice in terms of delivery, medication, and what to expect during the birth, but there is little on offer to help parents learn how to cope with the baby once it is born. The implication is that a woman should just know and have some genetic predisposition for mothering. Yet, if our own modeling of motherhood was dysfunctional, how are we to know what to do or how to cope? I find the depth and breadth of relational transactional analysis to be helpful when working with mothers who feel a lack in their own experience of being mothered and mothering their own child.

#### *Three Clinical Vignettes*

All the names in these vignettes have been changed to preserve confidentiality.

*Lucy* came to see me because she was unable to return to work as a police officer due to what she described as severe anxiety and "irrational" crying. In her first session, it became apparent that she was utterly terrified that her 6-month-old baby would die in her sleep. Lucy had lost her father

suddenly, from a heart attack, when she was 15, and she was shocked that this might be the cause of her terror. She related her father's death to me as if it was completely normal to wake up in the morning with no mother or father at home. Alone in the house, she got herself and her sister ready for school totally unaware that her father had just died some hours earlier. Even though she and her sister were alone in the house, she was aware that she must go to school and act as if nothing had happened so strong was her cultural script of keeping up appearances. In fact, her father was never talked about or mentioned after his death, and there were no momentos of him at home; her mother had literally silenced the whole family, not allowing him to be spoken about by anyone. Consequently, Lucy never grieved for her father. Unsurprisingly, when the grief came it was, as Lucy described, like an onslaught. Silencing was a continuous theme throughout her therapy. She felt unable to ask for help for anything or from anyone, including her mother, whom she described as continuously depressed and unavailable following her husband's death. Lucy also described feeling unable to talk to anyone about how she was feeling during her pregnancy and after the birth. Her job as a police officer played a large part in the theme of being silenced because her condition was not recognized or spoken about, and she did not feel she was given any dispensation for being unwell. It took a while before Lucy felt able to return to work without feeling judged and inadequate.

*Aniya* was originally from the Czech Republic and had two children, ages 2 and 4. She came to me distraught and saying she was unable to cope with her boys. She said she had felt stressed and anxious throughout her pregnancies and postnatally and had not received any help apart from antidepressants. Aniya described her anxiety and stress as particularly overwhelming at the time, and, in desperation, she said she had contacted me on the recommendation of a friend. Aniya described feeling terrified and unable to cope with anything. She said she knew her feelings were out of proportion to her sons' behavior, but she could not explain why she felt the way she did. In her third session, Aniya told me that she had spent 2 years in the hospital from the age of 2 to 4 years old in what was then Czechoslovakia. During those years she had apparently seen her parents for only an hour once a month. Aniya had no memory of this time, but her parents had told her they had no option but to abide by the doctors' recommendations that she stay in the hospital. The coincidence of the ages of her sons and of her own experience seemed significant to me, but Aniya was unable to see any link between that and her own distress. Once we began to explore the desperation she felt now and the parallel to how she might have felt in the hospital as a terrified child, she began to realize the horrific legacy of that time for her. Her sense of abandonment was, in her words, "engulfing and overwhelming" and triggered by many situations. Silence played an important part in her therapy because she knew so little about her hospital stay, and her mother had no physical evidence to mark those 2 years. Each time Aniya tried to discover more about that period, her mother discounted her almost to the extent of making that time seem irrelevant. Aniya talks often about her sense of her mother as being "disinterested, distant, and abandoning." We continue to work on her abandonment and fear.

*Sarah* came to me when her daughter was 3 months old. She knew she was at great risk for mental health problems because her mother had committed suicide the year before. Sarah said that her mother had suffered severe mental health difficulties for her entire life, including puerperal psychosis after the birth of Sarah's younger sister when Sarah was 2½ years old. Sarah said that she had tried to gain support from her local perinatal mental health team but was told that she was not "ill enough" to receive any kind of care. When Sarah first came to see me, she was terrified that something would happen to her baby or that she would do something to harm her, so she was not able to leave her, even for a moment, with anyone else. I saw Sarah with her baby for 6 months until she felt comfortable leaving her daughter with her husband. After that she came alone. Not surprisingly, she struggled with intense self-doubt and said she had no idea whether she was doing the right thing with her daughter, even though she thought she should instinctively know what was best. Fear,

silence, and intense shame are areas we continue to work on along with helping her to develop a sense of what good-enough mothering is and how she wants to define herself as a mother.

### **Why Qualitative Research?**

A great deal of the published literature in this area is based on quantitative techniques of data collection. That data is mainly in the form of statistics gathered from medical-type questionnaires such as the Edinburgh Postnatal Depression Scale (EPDS) (Cox, Holden, & Sagovsky, 1987) or the Generalized Anxiety Disorder Scale (GAD-7) (Spitzer, Kroenke, Williams, & Löwe, 2006). These give a snapshot view of a particular woman at a particular time. Quantitative techniques can test the outcome of the treatment option, that is, whether it works and by what percentage. This type of research is done from a biomedical perspective and measures the incidence, risk, and effects of perinatal depression. Quality and outcome of psychotherapy, on the other hand, are subjective and may be difficult to evaluate using purely quantitative techniques. Such techniques are important in highlighting the prevalence of the condition and offer justification for more in-depth qualitative research, which will enhance our understanding and provide a richer depth of knowledge about perinatal depression. Qualitative research also allows us to hear the important stories that lie behind the statistics.

In my research, I use qualitative research methods because it is important for me to understand the experiences of women affected by this condition, particularly what they found helpful and unhelpful in their psychotherapy (see Client Helpfulness Interview studies, Cooper & McLeod, 2015). My research aims to give women the chance to describe their actual experiences, and doing so may empower them by giving their voices an increased emphasis. Hearing about their lived experience allows for an increased understanding of how they perceive and value their treatment, how this type of psychotherapy can be used in treating perinatal psychological distress, and how future treatment protocols can best be developed. Qualitative data about women's experiences also contribute to the body of knowledge about perinatal mental health, in particular, our understanding of the stigmatization and silencing of women with this condition. Whereas women have rarely been asked to give voice to their experiences of treatment, this research will allow the differences in reflexivity and subjectivity of each woman to enhance therapists' understanding of the manifest and latent drivers that affect the outcome of and engagement with treatment. Because part of their experience may be ineffable, I have chosen to use the method of Free Association Narrative Interviewing (Hollway & Jefferson, 2000) informed by an object, piece of art, poetry, literature, aspect of nature, or whatever the women choose that speaks to them of their experience of this condition and the treatment for it. My hope is to access that which may not have been accessed before, apart from in therapy.

### **The Future**

My research is currently in the data collection phase. It has proven problematic for me to research my own practice because the university to which I am attached does not allow it for ethical reasons. Therefore, my research is highly dependent on finding other transactional analysis psychotherapists who also treat or have treated this condition, and by "this condition" I mean treating women with stress, anxiety, and/or depression at any stage in the perinatal period. Gaining participant data has been difficult so far. More of such data will allow me to enhance and validate the small amount of data I already have. I hope suitable therapists will contact me so that I can brief them on the requirements of the research. The requirements are not onerous.

My hope is to highlight the prevalence of this condition, the destructive and long-lasting effect it can have on families, and the serious negative effects on infants born to mothers with perinatal depression. I believe relational transactional analysis gives therapists powerful tools to use when

treating this distress, tools that are just as effective as therapies such as CBT. My hope is that my research will demonstrate that transactional analysis is an effective treatment for this condition and that it is an alternative to antidepressant medication. Psychotherapy is never going to offer a quick fix; in my experience most women need to be seen for at least a year, if not longer, to effect long-lasting change. Although this could pose a difficulty, particularly in the NHS in the UK, because of budget cuts, the costs of this condition to the UK economy are substantial and warrant the development of a more effective treatment strategy.

## Conclusion

There has been relatively little research in transactional analysis, although the gap is beginning to be filled by the *International Journal of Transactional Analysis Research (IJTAR)*. It is important that more research be done, because without practice-based evidence, transactional analysis will continue to struggle to be taken seriously by bodies such as the National Institute for Health and Social Care Excellence (NICE) and the National Health Service (NHS) in the UK as well as by similar bodies worldwide. It will also slip seriously behind other types of psychotherapy, such as cognitive behavioral therapy, psychodynamic psychotherapy, and interpersonal therapy, the practitioners of which engage in widespread research into many mental health conditions. I hope other transactional analysts will join me in adding to the research base for transactional analysis by participating in my study on TA as a treatment for perinatal depression.

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The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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