The Role of the Clinical Psychologist in Perinatal Mental Health Services: A Critical Review of the Evidence

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Abstract

Perinatal mental health problems can have devastating effects on the mother, child and wider family, thus prevention, early detection and early intervention are critical. Specialist perinatal mental health services were developed to aid with this process. Such teams are multi-disciplinary in nature, consisting of clinical psychologists, psychiatrists, nurses, social workers and childcare practitioners. A review of the literature suggests that the clinical psychologists role within this team is multi-factorial. There is an evidence-base to support clinical psychologist-delivered psychological interventions such as cognitive-behavioural therapy and interpersonal psychotherapy in ameliorating and preventing perinatal mental health problems, particularly antenatal and postnatal depression and anxiety. There is also evidence to support the clinical psychologists role in delivering training, supervision and support to the wider multi-disciplinary team, enabling non-psychology colleagues to deliver psychological interventions such as those mentioned and person-centred counselling. Drawing from community psychology approaches the clinical psychologist may also adopt a scholar-activist position, drawing on psychological theories and knowledge to inform policy and service provision to maximise prevention efforts and enhance wellbeing. Further, a review of the literature identified significant gaps in the evidence-base, therefore it is indicated that future research be undertaken to inform evidence-based practice. Clinical psychologists, working as a scientist-practitioner, would be well placed to undertake such research. It is plausible and supported by the evidence reviewed that the clinical psychologist could maximise their time and ensure more mothers access psychological therapies by drawing from a stepped-care model of care.

Introduction

The perinatal period, the period immediately preceding and following childbirth, is a time of major emotional and physical change for the mother. During this time, mothers are at increased vulnerability to developing mental health problems (Carter and Kostara, 2005) or to the recurrence of pre-existing problems (Austin and Priest, 2005). Commonly presenting perinatal mental health problems (PMHPs) include postnatal depression (PND), psychosis and anxiety disorders such as PTSD following a traumatic and complicated birth, obsessive-compulsive disorder (OCD) and generalized anxiety disorder (GAD). There is evidence to suggest that mothers are at increased risk of relapse of bipolar disorder and psychotic disorders where there is a history (Carter and Kostaras, 2005).

The impact of PMHPs on the mother, infant and wider family is frequently documented. There is evidence that PND disturbs the mother-infant bond, which in turn has an adverse effect on the infants cognitive and emotional development (Cooper and Murray, 1998). PMHPs can predispose the child to later-life depression and behavioural disorders and there is an increased risk of the child requiring long-term mental health support and entering the criminal justice system (Beck, 1999). PMHPs can also result in marital conflict and divorce (Holden, 1991; Boyce and Stubbs, 1994).

Considering the impact of PMHPs, early and specialist intervention that addresses the specific needs of this client group is paramount to the long-term health and wellbeing of the mother, child and wider family as well as to reducing downstream societal costs. Indeed, it is argued that early diagnosis and intervention lead to improved health outcomes (Austin and Lumley, 2003) and for this reason perinatal mental health multi-disciplinary teams (MDTs) with specific knowledge and expertise in assessment, diagnosis and treatment of the mother and infant are emerging as sub-specialist teams (Galbally, Blankley, Power and Snellen, 2013). The National Institute of Clinical Excellence (NICE) advocates for the inclusion of clinical psychologists (CPs), psychiatrists, nurses, occupational therapists, social workers and childcare practitioners within these MDTs and suggests their role is to assess for, treat and prevent PMHPs (NICE, 2007).

Assessment

Routine assessment of past or current PMHPs is endorsed by the NICE guidelines to facilitate early detection and therefore intervention. Tools to assist with detecting PMHPs include the Whooley screening questions (Whooley, Avins, Miranda and Browner, 1998), the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock and Erbaugh, 1961), the Beck Anxiety Inventory (BAI; Beck, Epstein, Brown and Steer, 1988) and the Hamilton Anxiety and Depression Scale (HADS; Hamilton, 1960). Whilst recommended by NICE, these inventories have not been validated for PMHPs and are not normed for common somatic experiences in the perinatal period such as change in appetite, sleep and libido (Henshaw, 2012). Therefore the Edinburgh Postnatal Depression Scale (EPDS) was developed to aid clinical assessment (Cox, Holden, Sagovsky, 1987). This tool is validated for use during pregnancy in addition to the postpartum period and is sensitive to picking up even early signs of PND and anxiety, which is crucial considering the identified value of early intervention.

It is not feasible for mental health specialists such as CPs to assess every expectant or new mother, thus it is recommended that assessment be built into routine consultations with members of the MDT such as nurses, midwives, health visitors and

GPs. To enable non-specialist MDT clinicians to detect and assess PMHPs, it is suggested that they should receive training and ongoing support and supervision from specialist mental health professionals (Henshaw, 2012). It is plausible to assume CPs are well placed to deliver such training in the delivery of psychological assessments and ongoing supervision considering their extensive training (New Ways of Working for Applied Psychologists [NWW], 2007).

It is important to note that assessment and detection of PMHPs are made complicated by the fears of mothers, who may fear the consequences of disclosing PMHPs such as removal of the child. Mothers frequently fail to disclose PMHPs to healthcare professionals, especially when they experience negative interactions with professionals (Franko and Spurrell, 2000). This may be further complicated by a lack of awareness and knowledge on the part of the MDT. Indeed PMHPs are commonly missed by NHS teams (Cooper and Murray, 1998). The CPs role here may reflect teaching basic counselling skills to the MDT and normalising, promoting awareness and understanding of PMHPs. Indeed evidence suggests that such training enhances awareness and detection, without increased inappropriate referrals (Morrell, Ricketts, Tudor, Williams, Curran et al., 2011).

Treatment

Whilst the aetiology of PMHPs is poorly understood, several factors advocate for a psychosocial conceptualization of PMHPs, particularly PND. Consistently identified risk factors for PND include interpersonal conflicts in marital and family relationships, social isolation and reduced social support, stressful life events, unemployment, financial difficulties, inadequate housing and being of lower socio-economic status (Hobfoll, Ritter, Lavin, Hulsizer and Cameron, 1995; Murray and Cooper, 1998; Spinelli and Endicott, 2003; Seguin Potvin, St Denis and Loiselle, 1995). Considering this and the limited evidence for a biological basis of PMHPs (Murray and Cooper, 1998), psychological approaches may be appropriate for managing PMHPs. Further, psychological rather than pharmacological treatments may be favoured due to the fear of transmission of chemicals through breast milk (Dennis and Chung-Lee, 2006). A review of the literature suggests that interpersonal psychotherapy (IPT), person-centred counselling (PCC) and cognitive behavioural therapy (CBT) are the most widely studied psychological interventions for PMHPs.

IPT

A review by Grigoriadis and Ravitz (2007) concluded that IPT is a suitable intervention for PMHPs, particularly PND, due to its brief nature and specific focus on the areas demonstrated to contribute to PND including role transitions and interpersonal disputes that accompany the many interpersonal stressors arising during the perinatal period. Indeed, an RCT conducted by O’Hara, Stuart, Gorman and Wenzel (2000) demonstrated the superiority of CP-delivered one-to-one IPT (IPT-I) sessions over a waitlist group in a large sample of mothers experiencing major depressive disorder (MDD), classified as PND. IPT-I yielded statistically and clinically significant reductions on the BDI and the HADS, which, although not validated for this population, were supported by significant improvements in the Postpartum Adjustment Questionnaire and Social Adjustment Scale. Whilst encouraging, the findings are difficult to generalise to a more diverse population owing to the Caucasian, married, well-educated and ‘less complex’ sample drawn upon.

Supporting and extending these findings, Clark, Tluczek and Wenzel (2003), included a more diverse sample of mothers of mixed marital status, of lower socio-economic status and from a mix of cultural and ethnic backgrounds. In addition to reduced maternal depressive symptoms, Clark et al. found improved mother-infant engagement, although mothers frequently attended sessions with their baby potentially accounting for the additional finding. This study suffered from a high dropout rate, which could be attributed to the inclusive entry criteria and low acceptability of the intervention in diverse populations.

Indeed an RCT conducted with bilingual, Latino and Spanish expectant mothers in an urban setting found promising results despite high dropout rates and difficulties following-up participants. Spinelli and Endicott (2003) found that culturally-adapted IPT delivered by MDT clinicians resulted in clinically significant improvements in mothers with PND as measured by the BDI, the HADS (both adjusted to account for perinatal issues), and the EPDS. These results were further supported by an RCT (Grote, Swartz, Geibel, Zuckoff, Houck et al. (2009), which found that culturally-adapted IPT delivered by trainee and qualified CPs ameliorated antenatal depression and prevented depressive relapse compared with TAU. Whilst both studies are limited by their small sample size, the diverse nature of the sample builds on previous findings with postpartum mothers and potentially supports the wider generalizability of IPT with diverse sample of mothers across the perinatal period when adaptations are made.

That IPT ameliorates antenatal depression and prevents PND is an important clinical finding considering the consequences of PMHPs on the mother, infant and wider family. Whilst future research is required to conclusively establish the acceptability and efficacy within diverse populations, these studies indicate that IPT-I, delivered by CPs and members of the MDT who are suitably trained and supervised by CPs, is an efficacious intervention for PND and can be adapted to meet cultural and diverse needs. Future research determining who would benefit most from IPT would help to effectively allocate limited psychology resources within publically funded healthcare services such as the NHS, maximising cost-effectiveness.

A further way to enhance cost-effectiveness and access to psychological therapies is to offer it within group format. Indeed group-delivered IPT (IPT-G) has shown potential. Two preliminary pilot studies evaluating the effectiveness of IPT-G in mothers with PND found a significantly reduction in depression scores. Further, these gains were maintained at three (Reay, Fisher, Robertson, Adams, Owen et al., 2006) and six months (Klier, Muzik, Rosenbaum and Lonz, 2001). However the lack of control condition in each of these studies restricts the attributions of these findings to the treatment itself; it is plausible that life events, natural remission of symptoms or the social support received from the group accounted for the findings. Further, participants in both studies continued to receive TAU, including anti-depressants and intensive home and GP visits, thus other treatment factors such as therapist attention could explain the findings.

Whilst these initial pilot studies suggest the potential efficacy of IPT-G, the limitations identified restrict wider conclusions from being drawn. However Mulchay, Reay, Wilkinson and Owen (2010) replicated Reay et al.'s findings, finding a clinically and statistically significant reduction in depression scores. Whilst the TAU group also displayed significant improvements in depression scores, the IPT-G improved significantly more with treatment, continued to improve during the follow-up period and reported significant improvements in marital functioning and mother-infant engagement, supporting the earlier findings of studies exploring individually-delivered IPT (Clark et al., 2003).

A longer-term follow-up of Mulchay et al.'s study revealed that mothers who received IPT-G improved more rapidly in the short-term and were less likely to develop depressive symptoms in the long-term (Reay, Owen, Shadbolt, Raphael, Mulcahy et al., 2012). Whilst the self-report questionnaires used to assess mothers' wellbeing at follow-up may have invited bias, the nature of these questionnaires reflects subjective experience and support the findings of Grote et al. (2009) and Spinelli and Endicott (2003) with regards to the preventative nature of IPT. Although the Australian and New Zealand, Caucasian sample of highly educated, cohabitating mothers restricts the applicability of these findings with more diverse groups of mothers, drawing on prior research exploring the efficacy of IPT-I it is plausible to assume that culturally-adapted IPT may be of benefit.

Whilst the findings regarding IPT-I and IPT-G appear encouraging, the limitations of these studies hinder firm conclusions regarding the active components of the intervention. It should be noted that adaptations were made, for example transport and crèche services were provided and standard IPT was adapted to consider role transitions specific to perinatal issues, to include partner's sessions and to accommodate infants in the sessions. These adaptations may account for the improved marital and mother-infant relationships. Also, by their very nature, group interventions may have enhanced social support thus reducing social isolation, an identified risk factor for PND. However Mulcahy et al.'s findings of continued improvement post-treatment indicate that the techniques acquired in IPT-G provided ongoing tools mothers could utilise post-treatment, rather than support being the active mechanism. It should also be noted that many mothers continued to receive TAU consisting of pharmacological treatments, intensive home visits and healthcare practitioner support. However, the same was true for those in the control group and thus the additive effects are plausibly attributable to IPT.

Despite the limitations, the findings of these studies, together with the demonstrated efficacy of IPT within the general MDD population (van Hees, Rotter, Ellerman and Evers, 2013), suggest that IPT, adapted for PMHPs, appears to be a plausible ameliorative and preventative intervention for depression in the perinatal period. Further, the evidence suggests that IPT-I and IPT-G can be delivered by many MDT clincians without compromising efficacy.

CBT

CBT may also be an effective treatment for PMHPs, offering mothers skills to manage their internal reactions to common stressful events during the perinatal period through helping them to challenge and modify unhelpful cognitions and behaviours. An RCT conducted in an urban NHS primary care service found six sessions of CBT, delivered by health visitors trained by CPs, to be as effective as fluoxetine at reducing depressive symptoms in new mothers diagnosed with minor or MDD as measured by the EPDS and a standardised clinical interview (Appleby, Warner, Whitton and Faragher, 1997). It is interesting to note that mothers made significant improvements within one week of entering the trial, which may reflect an increased perception of social support and therefore a reduction in a sense of social isolation. This may reflect the true mechanism of action rather than the techniques taught, although an absence of longer-term follow-up restricts firm conclusions. Further, the small sample size and stringent exclusion criteria of breast-feeding mothers restricts wider generalizability.

Addressing these limitations and exploring the intervention in the modern day NHS, Milgrom, Holt, Gemmill, Ericksen, Leigh et al. (2011) found that GP management of PND augmented by nurse or psychologist-delivered CBT was superior to GP management alone in reducing depression and anxiety scores. However all treatment groups yielded significant reductions in scores, although this may reflect the CBT training GPs undertook prior to the study.

A further RCT exploring the efficacy of nurse-delivered CBT found the intervention to be equally as effective as TAU for alleviating PND symptoms (Prendergast and Austin, 2001), although many of the nurses reported drawing on CBT techniques such as problem-solving and activity-scheduling in their standard practice, suggesting TAU may reflect a similar intervention. However they found CBT to be more effective in the long-term, potentially advocating the implicit teaching of skills that can be drawn upon in the long-term and concluded that CBT, delivered by nurses who received training and supervision from CPs, is an effective intervention for mild to moderate PND.

A preliminary evaluative study found group-based CBT (CBT-G), delivered by charity volunteers and MDT clinicians and incorporating principles from compassion-focused work (Gilbert, 2006) effective for reducing symptoms of PND, although no formal statistical analysis was undertaken (Alexander, 2013). Qualitative analysis revealed that mothers acquired long-term coping strategies and skills and found the intervention highly acceptable. Whilst further controlled studies are paramount to establishing the interventions efficacy, these preliminary findings suggest CBT-G has potential for alleviating PND when delivered more informally whilst receiving support from NHS CPs.

Two further evaluation studies demonstrated the efficacy of CBT-G in reducing postnatal adjustment and mental health difficulties. Both studies revealed statistically and clinically significant reductions in depressive and anxiety symptoms, as well as irritability (Marrs, 2013) and attitudes towards mothering (Griffiths and Barker-Collo, 2008). However inferences regarding active mechanisms should be made with caution due to a lack of control group, the inclusion of 'baby and me' and partner's sessions and adaptations made. Further, generalizability of the results to routine NHS practice is limited due to the provision of transport and crèche facilities, which may have enhanced acceptability and adherence, and the lack of formal diagnoses and the small, restrictive, voluntary sample.

Nevertheless, these findings are supported by RCTs that address these limitations. Milgrom, Negri, Gemmill, McNeil and Martin (2005) reported CBT-G, adapted to meet the needs of a large sample of community-dwelling mothers with moderate to severe PND, resulted in clinically and statistically significant reductions in PND and anxiety symptoms compared to TAU. These findings support an earlier pilot RCT (Meagram and Milgrom, 1996). However it should be noted that distress was measured utilising the BDI, which, as discussed, is not validated for use with this population and could reflect a reduction in somatic symptoms over time. However mothers were assessed using a standardised psychiatric interview and the EPDS by blind and independent assessors, who concluded that mothers were experiencing moderately severe PND, diagnosed using the criteria for major depressive disorder (MDD).

CBT-G has also demonstrated efficacy in the antenatal period. A brief CP-delivered CBT-G intervention within an NHS primary care setting demonstrated significant improvements in perinatal depression and anxiety symptoms in a large sample of expectant mothers (Austin, Frilingos, Lumley, Hadzi-Pavlovic, Roncolato et al., 2007), although it is difficult to detect the true effects of the intervention due to the equal effectiveness of the control condition. It is plausible that the active nature of the control condition (a self-help information booklet) offered therapeutic value. It is worth noting that despite the stringent exclusion criteria excluding mothers who were not deemed eligible for CBT, there was a high drop out rate and non-uptake rate, although this was the same for both conditions.

These encouraging findings advocate the inclusion of CBT-based interventions delivered by CPs and MDT clinicians, supported by CPs, in the management of perinatal anxiety and depression. However future research would benefit from addressing some of the limitations including unclear diagnostic entry criteria and active control groups to enhance an understanding of the efficacy and transferability of CBT-based interventions.

Counselling

In addition to CBT and IPT, NICE guidance advocates counselling as a treatment for PND and postnatal anxiety. Whilst not clearly defined, it is plausible to assume that this refers to Rogerian PCC on the basis of a recent Cochrane review (Dennis and Hodnett, 2009), which advocates non-directive counselling as an efficacious PND treatment, although they concluded that the methodological strength of the few studies available was weak and thus limits interpretation of these studies.

Holden, Sagovsky and Cox (1989) found that health visitor-delivered PCC was clinically and statistically superior to TAU in alleviating PND as diagnosed by a standardised psychiatric interview amended for perinatal somatic symptoms and the EPDS. The diverse sample comprised UK mothers of varied social class, martial status, PND severity and psychiatric history, extending generalizability of these findings to other services across the UK. Whilst participants did not differ according to these variables, a significant number of mothers in the treatment group experienced delivery complications. It is plausible that the enhanced recovery status in the treatment group is attributable to the active factors of the intervention, enabling mothers to process and work through any birth-related trauma. A review of the qualitative findings supports this assumption, with mothers describing the therapeutic role of counselling aligned to a PCC approach.

It should be noted that many mothers were prescribed pharmacological treatments for depression and, whilst GP reports suggest the dosage was not therapeutic, may have contributed to recovery status. However these findings were replicated in a diverse sample of Swedish mothers who were not prescribed anti-depressants (Wickberg and Hwan, 1996). Six sessions of PCC delivered by nurses was superior to TAU in producing clinically significant changes in PND status. Although the small sample size and Swedish healthcare setting limit wider generalizability of the findings to a UK-based healthcare service and population, the findings offer support to Holden et al.'s UK-based study.

The lack of long-term follow-up restricts knowledge of the long-term implications and efficacy of PCC. Further, the datedness and small sample sizes of these studies limit generalizability to the modern day NHS. A more recent pragmatic RCT (Morrell et al., 2011) explored the impact of training health visitors in a person-centred approach to counselling in a large inclusive sample of mothers across 29 UK primary care trusts. Adopting a person-centred approach to patient care significantly reduced the number of at-risk mothers at 6 months postpartum, although the effect size was small. This effect was maintained at one year postpartum. Further, the intervention was found to be cost-effective when delivered within the NHS and acceptable to both health visitors and mothers (Slade, Morrell, Rigby, Ricci, Spittlehouse et al. 2010), which is crucial for implementation and engagement.

Whilst health visitors were not trained in full PCC, the person-centred approach described is similar to the PCC described in prior studies, offering further support for PCC based on non-judgemental, empathic, warm and person-centred principles as a viable intervention for ameliorating and preventing PND. The research to date suggests that PCC is effective when delivered by MDT clinician's whilst receiving training and supervision from CPs, reflecting an embedded approach that strives to enhance continuity of care and to be non-stigmatising and normalising. Such an approach may enhance engagement with this population and is also likely to be cost-effective and time-effective.

These findings suggest a potential value of incorporating PCC training into MDT professional registration training prior to qualification, although it should be noted that these studies were undertaken with experienced MDT clinicians who volunteered to receive additional training and were thus potentially more skilled, knowledgeable and accepting of PMHP and psychological approaches. Indeed many had previously undertaken counselling training, which may have enhanced their skills and competence, thus enhancing the effectiveness of the interventions delivered. Nevertheless, providing education and training regarding PMHPs and brief psychological interventions may enhance detection and treatment rates. The leadership role advocating for psychological approaches would be crucial here, linking in with university departments and professional training programmes as well as the MDT service they work within.

Taken together, studies exploring the efficacy of psychological interventions suggest multiple roles for the CP in perinatal mental health services. CPs receive extensive training in psychological therapies, particularly CBT (White, 2012) and therefore are well placed to deliver such interventions, as supported by the evidence reviewed. However, many NHS services have limited access to clinical psychology services (Thomas, Thomas, Kersten, Jones, Green et al., 2013; Scope, Booth and Sutcliffe, 2012) therefore waiting lists can accumulate. By virtue of their training, competencies and experience, CPs can lead and manage teams, while supervising more junior staff (NWW, 2007), therefore they are also well placed to train, supervise and support MDT clinicians to deliver such interventions, which is also supported by the evidence reviewed. Working within a stepped-care model such as this would enable CPs to work with more complex clients, whilst supervising the MDT to work with less complex clients. This would maximise access to evidence-based interventions within resource-constrained NHS services, enabling more mothers with PMHPs to be seen in a timely fashion, which, considering the consequences for the mother, infant and wider family, is crucial.

The evidence reviewed also supports the group delivery of such interventions. MDT and CP-led groups appear efficacious for supporting mothers experiencing PMHPs such as adjustment, PND and anxiety difficulties, and can support a stepped-care way of working, maximising clinician time. When co-delivered by CPs and MDT clinicians, they also offer additive benefits of promoting psychological thinking amongst MDT staff and providing an opportunity to learn psychological knowledge, tools and skills ‘on the job’. It should be noted that the research findings reviewed report mixed acceptability of groups. Due to study limitations, it is unclear who may benefit from, or has a preference for, groups, therefore they should be offered amongst alternatives, promoting choice and person-centred care for mothers.

Another limitation of the studies reviewed is the significant gaps in the literature, such as limited exploration of the long-term efficacy and familial outcomes of psychological interventions, the sole use of outpatient samples, a bias towards individual-based interventions such as CBT, and PND diagnoses. To this authors' knowledge, there is no evidence exploring psychological management of other commonly presenting PMHPs such as eating disorders, psychosis, bipolar disorder, anxiety-specific disorders or axis II disorders. Whilst NICE recommends consulting the generic guidelines for these disorders, there is evidence to suggest that PMHPs present with their own needs and therefore limits generalizability from generic populations to new mothers (Dennis, 2004). Considering these significant gaps in the literature and the emphasis on evidence-based practice to ensure effective allocation of constrained resources in the NHS, the CP, working as a scientist-practitioner, is well positioned to undertake practice-based research to inform gaps in the literature. Working within a stepped-care model would also afford the CP more time to undertake such research.

Also, it is worth noting that the evidence regarding effective psychological interventions for PMHPs is mostly generated from high-income countries such as Australia, UK and USA. Low and middle-income countries such as India, China, Pakistan, and South Africa are largely underrepresented in samples and research. Considering the increasing diversity within the UK, it is important that the interventions offered for PMHPs are culturally-relevant and acceptable, as well as efficacious for diverse populations.

Two recent reviews of a small number of studies found support for culturally-adapted CBT, IPT, psychoeducational groups and support groups when compared to public health interventions and TAU, although the effect sizes were small (Rahman, Fisher, Bower, Luchters, Tran et al., 2013; Clarke, King and Prost, 2013). Whilst the diverse interventions examined, high statistical heterogeneity and unclear classification of PMHPs complicate an understanding of the findings and restrict firm conclusions from being made, this emerging evidence suggests that culturally-adapted psychological interventions, delivered individually and in groups, may be effective in alleviating PMHPs in non-Western populations. It is important to note that the interventions were delivered by lay and non-specialist health workers who integrated the interventions into TAU. This may have helped to overcome stigma fears and improve access to needed interventions and indicates service adaptations when delivered in UK health services. Again, the CPs role as a leader and their training in diverse needs equips them to promote the needs of minority groups within MDTs, to consider service development needs as well as to promote links with local cultural groups and communities.

Prevention

A limitation of individually-focused psychological interventions is that they are reactive to emerging distress. NICE guidance advocates for prevention strategies that reduce the risk of PMHPs. Further, individually-focused interventions can inadvertently locate wider social and economic problems in the individual, removing focus away from potentially harmful government policies and legislation. As discussed, chronic stressors such as poverty, unemployment, financial and housing problems, marital conflict and inadequate social support have consistently been demonstrated as risk factors for PMHPs. These risk factors are macro level issues, thus requiring macro level interventions such as modification and enhancement of local and national policies, service provision and community resources.

Drawing from community psychology approaches (Rappaport and Seidman, 2000) and their leadership skills (NWW, 2007), the CP's role may incorporate a scholar-activist approach, lobbying for national policy change such as fairer working conditions and benefits for parents. Indeed evidence suggests that policies focusing on parental health are more likely to impact on the child than those focusing on childhood poverty alone (Waylen and Stewart-Brown, 2010). Linking in with the emerging Evidence Information Service that aims to facilitate rapid communication between research professionals and political communities to enhance evidence-based policy would be another way to contribute to policy development.

The role may also incorporate linking in with health and wellbeing boards at local government level to promote equal and fair allocation of resources to lower socio-economic areas that may experience higher levels of inequality and disadvantage. CPs, drawing on their privileged, knowledgeable and powerful position and their collaborative and team-working skills (NWW, 2007), are well positioned to develop a link role with local public sector services and charities, supporting and advocating their work, facilitating conversations with the local public to enhance awareness and reduce the stigma of PMHPs and to support any activist work undertaken, for example campaigning against the closure of local children's centres. Many of these charities offer interventions, alleviating some of the pressures on NHS services. The CPs may be in a position to support these charities through offering training and supervision, perhaps negotiating an exchange of services in return, for example referring low-risk and less complex cases. Indeed there is emerging evidence of such a service model (Alexander, 2013). Further still, the CPs role could include developing such services where there are gaps in provision, or empowering local mothers and communities to develop such services.

Whilst there is scarce evidence to support working in this way, a significant example of the lobbying and scholar-activist role of CPs, amongst other social researchers, is the Sure Start Initiative (SSI). Addressing many of the identified risk factors for PMHPs, the SSI was implemented across England with the aim of improving access to childcare, education, family and parenting support, employment support and financial support. SSI children's centres, located in disadvantaged areas, offer mother and baby groups, parenting information, health information, childcare services and stimulating learning environments with the aim of enhancing child and parent health. The SSI is driven by social research and as such is considered evidence-based practice and policy (Johnson, 2011). Whilst SSI continues to experience difficulties evaluating the success of the initiative due to a lack of RCTs, which hinders the ability to afford causal inferences, the evaluation concluded that the SSI has beneficial effects on family functioning, maternal well-being and life satisfaction (Melhuish, Belsky and Leyland, 2012).

Conclusion

It is clear that the consequences of PMHPs can be devastating for the mother, child and wider family therefore prevention, early identification and intervention are paramount. Drawing on the evidence, perinatal mental health MDT's were developed to assist with this task. A review of the evidence advocates for a multimodal role for the CPs role within this team including therapist, trainer, supervisor and scholar-activist. The CPs training equips them with leadership skills to promote psychological thinking and approaches with the wider MDT and to promote and support the inclusion of psychological skills in their everyday practice.

The literature limitations suggest that future research is required to strengthen the evidence-base and clarify the efficacy and acceptability of psychological interventions for diverse populations, including non-Western and in-patient populations, the long-term impact of these interventions and the active mechanisms of these interventions. The CP, as a scientist-practitioner, potentially has a role in furthering this evidence-base, undertaking practice-based research to address gaps in the literature. Future research would benefit from comparing the efficacy of IPT, PCC and IPT, exploring the efficacy of systemic and macro level interventions, investigating other PMHPs besides PND, and an enhancement of study methodologies such as larger sample sizes, increased control of study inclusion and diagnostic criteria and non-active comparison groups.

Despite the limitations of the literature, there is evidence and support for the CPs role in supporting those experiencing PMHPs. Such a role is evidenced to alleviate and prevent PMHPs, particularly PND, which potentially has wider implications for the child, family and wider society.

References

Alexander, P. (2013). CBT-based support groups for postnatal depression. *Nursing Times*, *109*(41), 12-14

Appleby, L., Warner, R., Whitton, A., and Faragher, B. (1997). A controlled study of fluoxetine and cognitive-behavioral counselling in the treatment of postnatal depression. *British Medical Journal, 314*, 932–936.

Austin, M.P. and Priest, S.R. (2005). Clinical issues in perinatal mental health: new developments in the detection and treatment of perinatal mood and anxiety disorders. *Acta Psychaitrica Scandivanica, 112*(2), 97-104. doi: 10.1111/j.1600-0447.2005.00549.x.

Austin, M.P. and Lumley, J. (2003). Antenatal screening for postnatal depression: a systematic review. *Acta Psychaitrica Scandivanica, 110*(1), 10-17. doi: 10.1002/14651858

Austin, M.P., Frilingos, M., Lumley, J., Hadzi-Pavlovic, D., Roncolato, W., Acland, S., Saint, K., Segal, N. and Parker, G. (2007). Brief antenatal cognitive behaviour therapy group for the prevention of postnatal depression and anxiety: a randomised controlled trial. *Journal of Affective Disorders*, *105*, 35–44 doi: 10.1016/j.jad. 2007.04.001

Beck, A.T., Epstein, N., Brown, G. and Steer, R. A. (1988). An inventory for measuring clinical anxiety: Psychometric properties. *Journal of Consulting and Clinical Psychology, 56*(6), 893-897. doi: 10.1037/0022-006X.56.6.893

Beck, A.T., Ward, C.H., Mendelson, M., Mock, J., and Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry, 4,* 561- 571. doi:10.1001/archpsyc.1961.01710120031004

Beck, C.T. (1999). Maternal depression and child behaviour problems: A meta-analysis. *Journal of Advances in Nursing, 29*, 623–629

Boyce, P.M. and Stubbs, J.M. (1994). The importance of postnatal depression. *The Medical Journal of Australia, 161*(8), 471-472

British Psychological Society (2007). New Ways of Working for Applied Psychologists. New Ways of Working for Applied Psychologists. Available at: http://www.wiltshirepsychology.co.uk/Working%20Psychologically%20in%20Teams.pdf

Carter, D. and Kostaras, X. (2005). Psychiatry disorders in pregnancy. *BC Medical*

Journal, 47(2), 96-99

Clarke, K., King, M. and Prost, A. (2013). Psychosocial Interventions for Perinatal Common Mental Disorders Delivered by Providers Who Are Not Mental Health Specialists in Low- and Middle-Income Countries: A Systematic Review and Meta-Analysis. *Plos medicine, 10*(10). doi: 10.1371/journal.pmed.1001541

Clark, R., Wenzel, A., & Tluczek, A. (2003). Psychotherapy for postpartum depression: A preliminary report. *American Journal of Orthopsychiatry, 73*, 441–454. doi :10.1037/0002-9432.73.4.441

Cooper, P.J. and Murray, L. (1998). Postnatal depression. *British Medical Journal, 316*, 1884-1886

Cox, J.L., Holden, J.M., and Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry, 150*, 782–786

Dennis, C.L. (2004). Treatment of postpartum depression, Part 2: A critical review of nonbiological interventions. *Journal of Clinical Psychiatry, 65*, 1252–1265. doi: 10.1097/PSY.0b013e318190d7ca

Dennis, C.L. and Chung-Lee, L. (2006). Postpartum depression help-seeking barriers and maternal treatment preferences: A qualitative systematic review. *Birth, 33*(4), 323-331. doi: 10.1111/j.1523-536X.2006.00130.x

Dennis, C.L. and Hodnett, E.D. (2009). Psychosocial and psychological interventions for postpartum depression. *Cochrane Database of Systematic Reviews* (4). doi: 10.1002/14651858.CD001134.pub3

Franko, D. and Spurrell, E. (2000). Detection and management of eating disorders in pregnancy. *Obstetrics and Gynecology, 95*, 942-6. doi: 10.1016/S0029-7844(00)00792-4

Galbally, Blankley, Power and Snellen, (2013). Perinatal mental health services: what are they and why do we need them? *Australasian Psychiatry, 21*(2), 165-70. doi: 10.1177/1039856213476924.

Gilbert, P. (2006). *Psychotherapy and counselling for depression*. London: Sage.

Griffiths, P. and Barker-Collo, S. (2008). Study of a group treatment program for postnatal adjustment difficulties. *Archives of Women's Mental Health 11*(1), 33-41. doi: 10.1007/s00737-008-0220-5

Grigoriadis, S. and Ravitz, P. (2007). An approach to interpersonal psychotherapy for postpartum depression: focusing on interpersonal changes. *Canadian Family Physician, 53*(9), 1469-75

Grote, N.K., Swartz, H.A., Geiberl, S.L., Zuckoff, A., Houck, P.R. and Frank, E. (2009). A randomized controlled trial of culturally relevant, brief interpersonal psychotherapy for perinatal depression. *Psychiatric Services, 60*(3):313-21. doi: 10.1176/appi.ps.60.3.313.

Hamilton, M. (1960). A rating scale for depression. *Journal of Neurology, Neurosurgery and Psychiatry, 23,* 56-62 doi:10.1136/jnnp.23.1.56

Henshaw, C. (2012). Major depressive disorder. In Martin, C.R. (Ed.), *Perinatal Mental Health : A Clinical Guide* (pp. 15-24). United Kingdom: M&K Update Ltd

Hobfoll, S.E., Ritter, C., Lavin, J., Hulsizer, M.R. and Cameron, R. (1995). Depression prevalence and incidence among inner-city pregnant and postpartum women. *Journal of Consulting and Clinical Psychology, 63*, 445–453. doi: 10.1037/0022- 006X.63.3.445

Holden, J.M. (1991). Postnatal depression: Its nature, effects, and identification using the Edinburgh Postnatal Depression Scale. *Birth, 18*, 211–221. doi:10.1111/j.1523-536X.1991.tb00104.x

Holden, J.M., Sagovsky, R., and Cox, J.L. (1989). Counselling in a general practice setting: Controlled study of health visitor intervention in treatment of postnatal depression. *British Medical Journal, 29*8, 223–226. doi: http://dx.doi.org/10.1136/bmj.298.6668.223

Johnson, S. (2011). Sure Start case study. Available at: http://www.esrc.ac.uk/_images/sure_start_final_report_tcm8-20116.pdf

Klier, C.M., Muzik, M., Rosenblum, K.L. and Lenz, G. (2001). Interpersonal Psychotherapy Adapted for the Group Setting in the Treatment of Postpartum Depression. *Journal of Psychotherapy Practice and Research, 10*(2), 124-31

Marrs, J. (2013). Evaluation of the impact of a CBT-based group on maternal postnatal mental health difficulties. *Journal of Reproductive and Infant Psychology, 31*(1), 72-80. doi:10.1080/02646838.2012.747676

Meager, I., and Milgrom, J. (1996). Group treatment for postpartum depression: A pilot study. *Australian and New Zealand Journal of Psychiatry, 30*, 852–860

Melhuish, E., Belsky, J. and Leyland, A. (2012). **The impact of Sure Start Local Programmes on seven year olds and their families.** Available at: http://www.ness.bbk.ac.uk/impact/documents/DFE-RR220.pdf

Milgrom, J., Negri, L.M., Gemmill, A.W., McNeil, M., and Martin, P.R. (2005). A randomized controlled trial of psychological interventions for postnatal depression. *British Journal of Psychology, 44*, 529–542. doi: 10.1348/014466505X34200

Milgrom, J., Holt, C., Gemmill, A.W., Ericksen, J., Leigh, B., Buist, A. and Schembri, C. (2011). Treating Postnatal Depressive Symptoms in primary care: A randomised controlled trial of GP management, with and without adjunctive counselling. *BMC Psychiatry*, 11, 95. doi:10.1186/1471-244X-11-95

Morrell, C.J., Ricketts, T., Tudor, K., Williams, C., Curran, J., and Barkham, M. (2011). Training health visitors in cognitive behavioural and person-centred approaches for depression in postnatal women as part of a cluster randomised trial and economic evaluation in primary care: the PoNDER trial. *Primary healthcare research and development, 12*(1),11-20 doi: 10.1017/S1463423610000344.

Mulcahy, R., Reay, R.E., Wilkinson, R.B. and Owen, C. (2010). A randomised control trial for the effectiveness of group Interpersonal Psychotherapy for postnatal depression. *Archives of Womens Mental Health, 13*(2), 125-139. doi: 10.1007/s00737-009-0101-6.

National Institute of Clinical Excellence (2007). *Antenatal and postnatal mental health: Clinical management and service guidance. CG45*. Available at: www.nice.org.uk/CG45

O'Hara, M.W., Stuart, S., Gorman, L.L., and Wenzel, A. (2000). Efficacy of interpersonal psychotherapy for postpartum depression. *Archives of General Psychiatry, 57*, 1039–1045

Prendergast, J., and Austin, M.P. (2001). Early childhood nurse-delivered cognitive behavioural counselling for post-natal depression. *Australasian Psychiatry, 9,* 255–259. doi: 10.1046/j.1440-1665.2001.00330.

Rahman, A., Fisher, J., Bower, P., Luchters, S., Tran, T., Yasamy, M.T., Saxena, S. and Waheed, W. (2013). Interventions for common perinatal mental disorders in women in low- and middle-income countries: a systematic review and meta-analysis. *Bulletin of the World Health Organisation 91*, 593–601. doi: 10.1371/journal.pmed.1001678

Rappaport, J., and Seidman, E. (2000). *Handbook of Community Psychology*. New York: Plenum/Kluwer.

Reay, R., Fisher, Y., Robertson, M., Adams, E., Owen, C. and Kumar, R. (2006). Group interpersonal psychotherapy for postnatal depression: a pilot study. *Archives of Womens Mental Health, 9*(1), 31-9. doi: 10.1007/s00737-006-0120-5

Reay, R.E., Owen, C., Shadbolt, B., Raphael, B., Mulcahy, R. & Wilkinson, R.B. (2012). Trajectories of long-term outcomes for postnatally depressed mothers treated with group interpersonal psychotherapy. *Archives of women's mental health, 15*(3), 217-28. doi: 10.1111/j.1744-6163.2012.00350.x.

Scope, A., Booth, A., Sutcliffe, P. (2012). Womens perceptions and experiences of group cognitive behaviour therapy and other group interventions for postnatal depression: a qualitative synthesis. *Journal Of Advanced Nursing,* 68(9), 1909-1919. doi: 10.1111/j.1365-2648.2012.05954.x.

Seguin, H., Potvin, L., St Denis, M., and Loiselle, J. (1995). Chronic stressors, social support, and depression during pregnancy. *Journal of Obstetrics and Gynecology, 85*, 583–589. doi: 10.1016/0029-7844(94)00449-N

Slade, P., Morrell, C.J., Brugha, T., Rigby, A., Ricci, K. and Spittlehouse, J. (2010). Postnatal women's experiences of management of depressive symptoms: a qualitative study. *British Journal of General Practice, 60,* 829-836. doi: 10.3399/bjgp10X532611

Spinelli, M.G. and Endicott, J. (2013). Controlled clinical trial of interpersonal psychotherapy versus parenting education program for depressed pregnant women. *American Journal of Psychiatry, 160*(3), 555-62. doi: 10.4088/JCP.12m07909

Thomas, S., Thomas, P.W., Kersten, P., Jones, R., Green, C., Nock, A., Slingsby, V., Davies Smith, A., Baker, R., Galvin, K., and Hillier, C. (2013). A pragmatic parallel arm multi-centre randomised controlled trial to assess the effectiveness and cost-effectiveness of a group-based fatigue management programme (FACETS) for people with multiple sclerosis. *Journal of Neurology, Neurosurgery and Psychiatry, 84*(10), 1092-1099. doi: 10.1136/jnnp-2012-303816

van Hees, V.L.J.M., Rotter, T., Ellermann, T. and Evers, S.M.A.A. (2013). The effectiveness of individual interpersonal psychotherapy as a treatment for major depressive disorder in adult outpatients: a systematic review. *BMC Psychiatry, 13*, 22. doi:10.1186/1471-244X-13-22

Waylen, A., & Stewart-Brown, S. (2010). Factors influencing parenting in early childhood: a prospective longitudinal study focusing on change. *Child; care health and development*, *36*, 198 - 207. doi: 10.1111/j.1365-2214.2009.01037.x

Whooley, Avins, Miranda and Browner, (1997). Case-finding instruments for depression. Two questions are as good as many. *Journal of General Internal Medicine, 12*(7), 439-445. doi: 10.1046/j.1525-1497.1997.00076.x

White, C. A. (2012). Cognitive-behavioural therapy. In Martin, C.R. (Ed.), *Perinatal Mental Health: A Clinical Guide* (pp. 343-354). United Kingdom: M&K Update Ltd

Wickberg, B. and Hwang, C.P. (1996). Counselling of postnatal depression: A controlled study on a population based Swedish sample. *Journal of Affective Disorders, 39,* 209–216. doi: 10.1016/0165-0327(96)00034-1