Psychiatria Danubina, 2015; Vol. 27, Suppl. 1, pp 482–485 *Conference paper*

EVALUATION OF A SPECIALISED COUNSELLING SERVICE FOR PERINATAL BEREAVEMENT

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SUMMARY

Objectives: *We aimed to evaluate the outcomes of Petals: a charitable organisation in Cambridgeshire. Petals provides counselling for women and couples who have suffered perinatal bereavement, or trauma during pregnancy or birth. This paper attempts to evaluate the effect of counseling interventions at this difficult time.*

Methods: *Outcomes were recorded in 107 patients using the CORE (Clinical Outcomes in Routine Evaluation) system. CORE was developed to assess the effectiveness of psychological therapies. CORE-OM (CORE Outcome Measure) involves a questionnaire that assesses subjective well-being, symptoms/problems, function, and risk to self and others. The CORE-OM questionnaire was completed before and after the counselling sessions.*

Results: *The CORE-OM scores were summated into a global representation of severity. Severity decreased in all patients. Symptoms of psychological pathology were also decreased in all cases.*

Conclusion: *Offering a free specialised counselling for parents suffering perinatal loss seems to be associated with an improvement in psychological outcomes. It is possible that it is more effective among a clinical population. However, we are uncertain of the natural history of the psychological problems this group of clients are experiencing. Having a control group would show how much of any natural improvement is due to the therapy; conversely, it is possible that without intervention these problems worsen with time, so a control group could actually amplify the effect.*

Key words: *perinatal bereavement - trauma in pregnancy - counselling*

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INTRODUCTION

Ever since the nineteenth-century French psychiatrist Jean-Etienne Esquirol included a chapter on conditions in women in the postpartum period in his seminal work Des Maladies Mentales, the puerperium has been recognised to be a unique and vulnerable period for mental illness (Esquirol 1838). The so-called 'baby blues' is reported to occur in as many as half of post-partum women (Chaudron 2003), while there has been extensive research into post-partum depression and psychosis (Sit 2006, Brockington 2004, Dean 1981). Moreover, schizophrenia, adjustment disorders, post-traumatic stress disorder, anxiety disorders and personality disorders have all been linked in some way to the peripartum period (Brockington 2004, Meltzer 1985, Munk-Olsen 2006, Seager 1960).

If normal birth is linked to such profound psychological distress, it seems likely that abnormal gestation and labour would be associated with at least as high levels. In the UK, rates of stillbirths and neonatal mortality are falling slowly, but as of 2009 were still 5.2 per 1000 total births and 3.2 per 1000 live births respectively (CMACE 2011).

Last year, we examined the work of a charity based in Cambridge, UK, which provides specialised counselling for parents affected by stillbirth, neonatal death, loss of pregnancy, foetal diagnosis, termination of pregnancy, trauma following delivery, miscarriage, IVF, fear of pregnancy, antenatal anxiety and phobic responses to antenatal care (Petals Charity 2014). This study looked at the outcomes of the service for 41 clients and suggested that the service was efficacious, but acknowledged the need for further data collection (Spink 2014). We have now collected data for 107 patients in total and we present this in the following paper.

METHODS

Our method has been described in detail in our previous paper (Spink 2014). In brief, we used the CORE (Clinical Outcomes in Routine Evaluation) package, which is a reliable and well validated tool for assessing the efficacy of psychological therapies (Evans 2002, Gray 2007). An overall score is given, as well as scores for 4 separate domains: well-being, problems, function and risk. Clinical and non-clinical populations differ substantially overall and for all domains other than risk (Evans 2002), allowing users to differentiate whether a client falls into a clinical or non-clinical population. The tool is administered at the start and end of therapy.

Petals offers up to six one-hour sessions free of charge to clients, who are referred from a variety of sources. These may be delivered as an individual or a couple. Counsellors are accredited by the British

Association of Counselling and Psychotherapy and undergo additional more specialist training. The CORE tool was administered at the beginning and the end of the course of counselling.

RESULTS

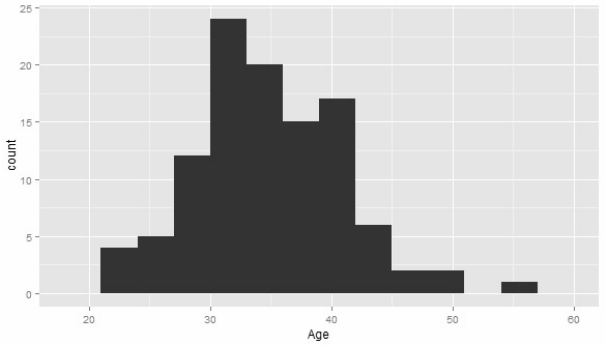
See Table 1 - 5 and Figure 1 – 3 for results.

Table 1. Population Demographics

	n	%
Sex		
Male	19	17.6
Female	89	82.4
Employment		
Full time paid employment	44	41.5
Part time paid employment	22	20.8
Houseperson	33	31.1
Student	4	3.8
Unemployed	2	1.9
Other	1	0.9
Referral source		
GP surgery	64	59.3
Psychiatrist	6	5.6
Other doctor	3	2.8
Other NHS service	5	4.6
Social Services	4	3.7
Voluntary organisation	5	4.6
Other	21	19.4

Table 2. Therapy modality

	n	%
Individual	65	60.6
Couple	42	39.3
Total	107	100.0



Mean =34.3 years; Standard deviation =6.1

Figure 1. Age of Clients

Table 3. Status of clients at start of therapy

	Pre-therapy	Post-therapy
Clinical (%)	70 (66.0)	10 (9.7)
Non-clinical (%)	36 (34.0)	93 (90.3)
Total	106	103

10 patients of the 16 were diagnosed with depression. One patient had previously had postpartum psychosis. Two patients were being seen by secondary psychiatric services (Figure 2).

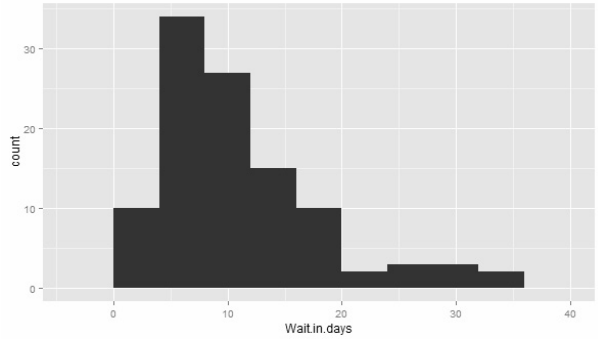


Figure 3. Waiting time for first session in days

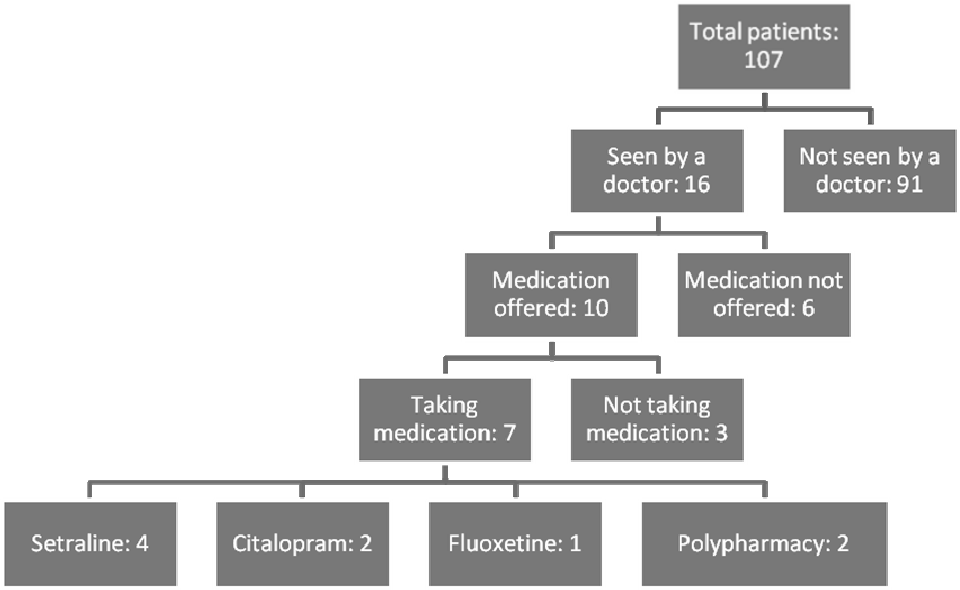


Figure 2. Psychiatric Morbidity and Medication

Table 4. Core Outcome Measure Pre- and Post-Therapy

	Pre-therapy mean	Post-therapy mean	Paired t-test p-value	Cohen's d = (mean 1 - 2)/ average of s.d.
Functioning	1.14	0.92	0.03	0.31
Problems	1.57	1.22	0.01	0.37
Risk	0.10	0.11	0.70	-0.05
Well-being	1.82	1.40	0.01	0.41
Average	1.19	0.94	0.02	0.35

Table 5. Correlation Matrix (Pearson's)

	Age	Gender	Waiting time to first session	Clinical?	Change in OM
Age	1.00	0.04	-0.01	-0.11	0.01
(p)		(0.69)	(0.92)	(0.27)	(0.94)
Gender	0.04	1.00	0.05	-0.22	0.00
(p)	(0.69)		(0.64)	(0.02)	(0.97)
Waiting time to first session	-0.01	0.05	1.00	-0.07	0.13
(p)	(0.92)	(0.64)		(0.48)	(0.19)
Clinical?	-0.11	-0.22	-0.07	1.00	-0.12
(p)	(0.27)	(0.02)	(0.48)		(0.23)
Change in OM	0.01	0.00	0.13	-0.12	1.00
(p)	(0.94)	(0.97)	(0.19)	(0.23)	

DISCUSSION

It was to be expected that men less commonly took advantage of the therapy than women, since men are less commonly affected by mental disorders following birth of a child (Munk-Olsen 2006) and men are less likely to seek professional help for health problems (Agency for Healthcare Research & Quality n.d.). Of the 19 men who did receive counselling, only 2 had individual therapy, suggesting that men are more likely to receive help with their partner than on their own.

Interestingly, the majority of referrals came from general practitioners (GPs), rather than midwives or obstetricians, suggesting that the problems these clients may experience may not arise in the acute hospital setting and may only be picked up later by a GP. Alternatively, GPs may take a more holistic view of their patients than the rest of the NHS does. Intriguingly, while 68% of referrals came from doctors, only 15% of patients had a diagnosis, suggesting that clinicians are recognising the importance of helping patients with sub-threshold problems. Among the few patients with a diagnosis, the use of sertraline is unsurprising, given its good side effect profile in pregnancy and breastfeeding. Two patients declined medication, however, stating that they did not need it as they were receiving counselling from Petals. At the other end of the diagnostic scale are the two patients who were known to secondary psychiatric services, indicating that perhaps Petals was supplementing the provision they were already receiving.

In terms of the performance of Petals, the vast majority of patients receive their first counselling session within two weeks of referral, marking a rapid response to what could be extremely distressing and urgent symptoms, since two-thirds of the population may be considered 'clinical' at referral. Post-therapy, this drops substantially to 9.7%, marking a very large improvement. This improvement is mirrored when the scores themselves are examined. The overall score and each of the individual domains with the exception of risk show a statistically significant and clinically significant improvement. The values for Cohen's d correspond to a small effect size. It is unsurprising that risk did not change significantly, since this has been shown not to differ between clinical and non-clinical populations in CORE validity studies (Evans 2002).

Our next step was to try to find what may be underpinning this change. Since there seems to be a large effect in moving patients from a clinical to a non-clinical population, we hypothesised that clinical populations would have a greater reduction in outcome measure than non-clinical populations. This turned out to be correct, but with a small effect. Conversely, having a longer wait to for the start of the therapy seems to be associated with a poorer outcome. However, it should be noted that neither of these results was statistically significant. Clients' age and gender had no effect on outcome.

CONCLUSION

Offering free specialised counselling for parents suffering perinatal loss seems to be associated with an improvement in psychological outcomes. It is possible that it is more effective among a clinical population. However, we are uncertain of the natural history of the psychological problems this group of clients are

experiencing. Having a control group would show how much of any natural improvement is due to the therapy; conversely, it is possible that without intervention these problems worsen with time, so a control group could actually amplify the effect.

Acknowledgements: None.

Conflict of interest: None to declare.

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