

What are the barriers and facilitators for parents accessing local clinical psychology services, when experiencing psychological distress relating to parenthood?

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Abstract

Despite many parents experiencing psychological distress within their child's first year, only a small proportion of them access specialist treatment. Previous research has highlighted facilitators and barriers to generic healthcare services for low mood in parenthood, but this has not been specific to mental health services. As such this study adopted a qualitative methodology in order to explore parents' perceptions of barriers and facilitators to clinical psychology. Seven women took part in the study. A thematic analysis suggested six key themes in relation to the research question: 'the importance of connecting', 'pressing the danger button', 'I'm not mad', 'more round care', 'psychological distress as barrier', and, 'making space, making sense'. These will be presented and their clinical implications discussed.

119 words

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What are the barriers and facilitators for parents accessing local clinical psychology services, when experiencing psychological distress?

The transition to parenthood can evoke an array of adjustment responses, positive and negative, and it is not uncommon for parents to experience some degree of psychological distress within their baby's first year (Petch and Halford, 2008). However, significant distress is experienced by up to 30 percent of mothers (Miller, Pallant and Negri, 2006) and 20 percent of fathers (Medical Research Council, 2010), which may be diagnostically labelled as postnatal depression (PND) or anxiety (Stuart, Couser, Schilder, O'Hara and Gorman, 1998).

This distress may affect parents' daily functioning, their view of themselves or their future. In addition, a number of research studies have linked maternal depression with the development of insecure attachment between parent and child (e.g. Murray, 1992). Some vulnerability factors to psychological distress include low socioeconomic status (Abrams, Dornig and Curran, 2009) and being a younger parent (Lanzi, Bert, and Jacobs, 2009). In addition, parents may be affected by a mismatch between reality and their previous expectations of being a parent (Temmentie, Paavilainen, Astedt-Kurki, and Tarkka, 2004).

Despite the prevalence of psychological difficulties after having a baby, few parents actually access or receive treatment from healthcare services (Smith, Rosenheck and Cavaleri, 2004). Furthermore, despite recommendations for both psychosocial and medical intervention (NICE, 2007) there are still significant barriers for parents accessing the clinical psychology services available (Flynn, Henshaw, O'Mahen, and Forman, 2010). Since little research exists around these barriers, and from the subjective experiences of parents themselves, this study appears timely.

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This study therefore explored parents' perceptions of accessing local services when experiencing psychological distress after having their baby. In particular, it focussed on their impressions of clinical psychology and the barriers and facilitators which may have influenced their access to these services.

Method

Recruitment focused on a culturally and socioeconomically diverse, urban region in the UK. Potential participants were invited to take part via posters placed in local community clinics, a free newsletter and on parenting websites. Despite the recruitment being open to both mothers and fathers, all the eventual participants were mothers ($n = 7$). Demographic characteristics are presented in TABLE 1, as defined by the participants. The inclusion criteria comprised being a parent, aged 18 or over, and having experience of psychological distress relating to parenthood within the last two years.

A qualitative design was used in order to best address the research question, and data gathered by semi-structured individual interviews. Thematic analysis was selected as the most appropriate method and a published framework was used to inform the process (Braun and Clarke, 2006). As such, the seven interviews were transcribed verbatim, systematically coded by the lead researcher (SC) and finally collated into distinct themes. The lead researcher used a reflexive approach throughout the analysis so that her own interpretations and assumptions were made transparent in the process. However cross-validity was also achieved by comparing theme interpretation between two authors (SC and IS) to ensure there was appropriate 'data fit' (Miles and Huberman, 1994).

Research ethics approval was given from both Lancaster University Division of Health Research and the NHS Research Ethics Committee

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Table 1

Demographic characteristics of seven participants (all women)

Characteristics		<i>n</i>
Age	20-25	4
	26-30	2
	31-40	0
	41-50	1
Ethnicity	Black British	1
	Mixed (White and Black African)	2
	White British	4
Relationship status	Single	6
	Living with partner	1
First time parent	Yes	5
	No	2
Which services received for emotional distress?¹	Clinical Psychology	1
	Mental Health Crisis Team	1
	Local Authority Outreach	6
	Primary Care Services	2

This relates to services accessed during the recent experience of psychological distress after having child. Some parents had accessed multiple sources of healthcare support.

Findings

The analysis identified barriers and facilitators to clinical psychology services which were grouped into six, key themes. Data extracts are included with pseudonyms, in order to enhance the ‘trustworthiness’ of the findings.

The Importance of Connecting

The data suggested it was important for parents to first sense a personal ‘connection’ with frontline health professionals (e.g. health visitors, midwives, GP), before being able to discuss their emotional difficulties. In order for a referral to clinical psychology to take place, this ‘disclosure’ of distress was first needed. Conversely, where the opposite of disconnection was sensed with the health professional, this formed a barrier to open discussions.

Many of the participants had developed at least one relationship with a professional in which they felt ‘connected’. Firstly, in order for this connection to occur, parents had to feel as if the relationship was equal and without hierarchy. It did not appear that the relationship attributes were influenced by any particular professional role but by the individual themselves and their own values, skills and behaviour. What appeared important to the parents was the perceived removal of boundaries, for instance in the professional seeming available to the participants when needed, either through home visits or the telephone. In addition, where the professional appeared to offer something of ‘themselves’ by showing emotion and talking about day-to-day things, this appeared to facilitate a positive, open relationship.

“She goes if you need anything I’m always here, and she just talked to me like a friend.”(P6)

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Professional boundaries within these relationships were maintained but viewed as more flexible. Some participants talked positively about interactions in which they had felt listened to, and responded to.

Conversely some of the parents interviewed talked about feeling disconnected from health professionals, which then prevented them from opening up about their feelings.

“I didn’t want to show my emotions to her. I think it was a bit of fear about how she would have reacted, you know if she got really upset about something.” (P2).

For some parents this disconnection was fuelled by a sense of social hierarchy and powerlessness, which silenced them within professional encounters. However, parents could also feel disconnected from the health system at large, particularly when care was seen as impersonal or inflexible and not tailored to their individual needs.

“Pressing the Danger Button”: A Perceived Focus on Risk

These parents had often perceived there to be a dominance of risk assessment, of harm to self or to child, within their interactions with health professionals. Such risk assessments appeared to be conducted in both explicit and implicit (e.g. note-taking) ways and any lack of transparency further increased parents’ anxiety. However, the perceived focus on risk could both prevent and encourage openness around emotional difficulties, depending on the individual and context. For instance, some participants felt that health professionals would only respond to their emotional needs if they believed they or their child were at serious risk:

“You shouldn’t have to press that danger button of (.) I’m gonna self harm or I’m gonna hurt my children, for someone to help you” (P1)

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Conversely, some parents had feared that if they ‘disclosed’ their distress professionals would see this as an indication they were not coping, which could result in their child being removed. This indicated an interpretation that negative judgements would be made by professionals in response to a disclosure of psychological distress:

“So that’s what really freaked me out about it, you know like talking to like the health visitor. Because I don’t want them to think that I’m not coping, and they might take my baby off me there. So I just tried to cope with it myself to check if I can do it myself.” (P6)

This perceived dominance of ‘risk’ also surrounded the advice given to parents about looking after their baby. For example, the guidance given to one parent about her baby’s sleeping routine led her to feel anxious that she was not offering her child ‘perfect parenting.’ This alluded again to the culture of blame which parents may perceive around healthcare services.

The data suggested that all health professionals need to be more transparent in their risk assessment practice, as certain behaviours (e.g. note-taking) may be mistrusted by parents. Similarly, it seems that professionals need to work harder to normalise parental experiences of psychological distress in order to promote openness and honesty from parents, and to work collaboratively even where increased risk exists. In summary, a culture of blame and of risk focus seemed to be identifiable within both professional and parental discourse, and the power of this discourse could both facilitate and deter help-seeking.

“I’m not mad”: Dissociation from Mental Health Problems

There was some variation in how the parents had defined their difficulties and whether they associated them with ‘a mental health problem’. This definition then seemed to influence their impression of accessing clinical psychology services. More commonly these

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parents held the view that their difficulties were not aligned with mental health, and their views also indicated a prevalence of stigma around this:

“[Psychologists] are just there for (.) like *Stacey Slater* type of mental health, something really bad” (P3)

“I’m not mad though (.) It’s me.” (P4)

These quotes indicate how some parents viewed mental health problems as pertaining something more serious or permanent than what they were experiencing. More commonly they attributed their emotional difficulties to physical health or social isolation. Perhaps for this reason the support offered to them by other parents was seen to be most effective at this difficult time, as it provided social contact and normalisation. However, some parents appeared to more readily accept psychological support when it was offered in an indirect, multidisciplinary setting.

This highlights the validity of clinical psychology services offering parent interventions which are based on psychosocial models, integrating the peer support which parents clearly find to be beneficial. It would also seem that generic health services may still need to work harder at reducing societal stigma associated with mental health problems, as this may deter some parents from accessing appropriate care.

“More Round Care”: The Desire for More Holistic Care for Both Mother and Baby

This theme centred on parents’ perception that the primary health care offered to them had been limited to their physical needs or those of their baby. This had then given parents the message that their emotional wellbeing was not part of the remit of the health professional, which prevented them from raising the issue themselves. This suggests a

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tangible barrier to clinical psychology referrals, since the original screening process was not always implemented.

“I thought that the care would be more round care as opposed to just being about my baby’s weight, which is basically all it’s ever been about” (P1)

The participants instead expressed their desire for care to integrate both physical and emotional aspects of wellbeing. In the few cases where this had taken place, parents had found this to be effective in promoting acceptance around how they were feeling. When some of the parents had been asked facilitating questions (e.g. “how do you feel?”) they had then felt able to openly talk about their emotional distress:

“...and she asked how I was. As soon as she said it, you know how you feeling, I just cried.” (P5)

However, not all the participants had wanted professionals to ask them directly about their emotional health but to pick up on their distress through their altered behaviour or presentation. Since multiple barriers may surround parents’ communication of emotional distress, this makes it even more vital for professionals to actively facilitate these discussions.

Psychological Distress as Barrier

Some of the participants had found that feeling distressed in itself acted as a barrier to accessing support. Therefore all healthcare professionals (of both specialist and primary care services) need to consider the parents’ ability to access appropriate help at any given time. In the first instance the timing of support may be crucial. For example, depression needed to ‘lift’ slightly before parents could accept help, even if it was regularly being offered. This indicates a paradox between being more in need but yet too unwell to break out of these psychological constraints:

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“I wasn’t ready to...you know begin to get better” (P2)

This inability to access help from professionals could also be associated with a sense of hopelessness around treatment effectiveness, which might have been influenced by previous experiences and/or with a current negative view of the world. In addition, the data did not indicate that there was a singular shift into a different stage of ability, but of cycling between these stages:

“...it just depends what mood I’m in on the day...that’s the thing...” (P7)

There was a practical element to accessing support around which the emotional distress caused some disability. For example, some participants’ described feeling unable to leave the house at this time, due to a lack of energy or depleted self-confidence.

“Sometimes it kills me to just go school to drop (my son) off” (P4).

Attending clinics, even with childcare available, could become a challenging task due to the social demands it made on them at this time. Instead the parents talked about finding alternative means of support through internet chat rooms which were more accessible at this time. This suggests a number of ways in which services need to align to the needs of parents at this time: in being flexible around missed appointments, in offering home or internet-based support and in providing information about specialist resources at the antenatal stage.

Making Space, Making Sense

Once aware of what they were feeling, some of the parents talked about first needing time and space to try and understand why they might be experiencing this psychological distress. Indeed parents attributed it with a number of factors, such as negative childhood experiences, relationship breakdowns, housing problems or physical health problems after

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childbirth. In some cases having this time and space was perceived as more important than accessing external support:

“What’s making you feel so upset is it about your background or things like that? I mean you find have to find out yourself first...before you can get that help” (P6)

The data suggested that engagement to clinical psychology would be promoted when the intervention was based on the parents’ own formulation of their difficulties. Indeed for some parents simply facilitating some brief ‘time-out’ with crèche facilities may also be more beneficial than a structured therapeutic intervention.

Discussion & Recommendations

Previous research supports the idea that the relationship between parent and health or social care professional is a factor in whether conversations around emotional health take place. However these findings give more concrete examples of how professionals can foster these positive connections with parents, in a way which helps parents feel respected and equal. The professionals (e.g. health visitors, GPs, clinical psychologists) who were warm, open and flexible in their approach, and who listened and responded accordingly, tended to be the ones who connected most with parents. Interestingly, professionals may not always value the power of their relationship with service users, nor may they feel able to offer consistent, frequent visits because of increasing service pressures and depleting resources (Chew-Graham et al, 2008). As primary care or outreach staff may often be parents’ first contact with services, all healthcare professionals in contact with this client group will need to consider the impact of their behaviour and approach.

The principles of promoting an open and collaborative relationship can also be applied to the area of risk assessment and management. The findings suggest that health

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professionals may be viewed by parents as overly focused on risk of self or child harm.

Previous research indicates that parents may deter from disclosing their emotional distress out of fear, of being labelled an ‘unfit’ parent (McCarthy and McMahon, 2008) or having their child removed from their care (Flynn, Henshaw, O’Mahen, and Forman, 2010). However the data here suggest how some parents feel healthcare is disingenuous and only responsive to their needs if there is an element of risk involved. Therefore professionals need to be more explicit about why particular activities are occurring (e.g. clinical note taking) in order to reduce parents’ suspicion or sense of being negatively judged. Furthermore, enhanced and effective information-sharing between all professionals working with young families should reduce the likelihood of duplicating risk assessments. Clearly risk assessment is paramount and is part of the community practitioner remit (Department of Health, 2004); however a more collaborative and positive approach may help parents feel better able to be open with professionals.

The findings suggest that parents are not always asked about their emotional health, with care perceived to be limited to their physical health or baby’s needs. Indeed Chew-Graham *et al.* (2008) found that health professionals can be reluctant to ask such questions for fear of labelling or ‘medicalising’ problems. However, a limited care focus does not align with national guidance around “women-focussed care” (Section 3; Department of Health, 2007) and universal screening of maternal emotional difficulties in the child’s first year (NICE, 2007). When these parents had simply been asked: “how are you feeling?” by their midwife or health visitor, this appeared to instantly facilitate important discussions around psychological wellbeing and coping, whilst also normalising these parents’ experiences. Once these difficulties have been recognised, specialist support can then be accessed according to each person’s individual wishes.

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Since clinical psychologists are often reliant on postnatal emotional wellbeing screening for subsequent referrals, they also need to take a greater role in fostering improved multi-professional relationships and offering further training for colleagues around the importance of 'more round care'. Within such training clinical psychologists can further demonstrate the potential therapeutic gains to be made outside of a medical diagnostic model for parents who would like to pursue psychological intervention.

Despite the professional barriers suggested, individual clinical psychology input may not always be what parents' desire at this time. Participants here illuminated the benefits of peer support, which they felt had the potential to reduce their social isolation and also normalise their experiences. This would align with the benefits of group interventions already offered by clinical psychologists in many UK services. However, the data suggest that clinical psychology as a label can evoke strong reactions from parents, due in part to mental health stigma or misunderstanding about clinical psychologists' roles. This highlights the necessity for community-wide services to work collaboratively to normalise mental health services and promote the importance of emotional wellbeing for parents and children. The psychosocial element of interventions available (e.g. parent groups) should also be more strongly emphasised, since social isolation may be what parents 'feel' most. Similarly, clinical psychologists may need to be more accessible through everyday resources (i.e. children's centres, health visitor clinics), working indirectly through frontline professionals to offer integrated psychosocial packages. This consultation model of practice seemed to align most with what these parents wanted at the time of their distress.

Limitations

The recruitment of fathers to research around parenting can be challenging due to 'maternal gate-keeping' and accessibility (Mitchell et al., 2007), and this factor may have effected this

study recruitment. A recent study highlights how depression is a common experience for new fathers (MRC, 2010), and therefore understanding paternal barriers to help-seeking will be an important future study.

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