Cheshire and Mersey
Specialist Perinatal Service

Mental healthcare for women and families

Keeping the baby in mind during Covid-19

FAQs for Specialist Perinatal Clinicians

Parents' wellbeing has a direct impact on their babies. Mental health problems already affect the lives of 10-20% of women in the perinatal period. Approximately one in ten fathers are also affected by mental illness during this period. Many perinatal mental health problems go undetected in normal circumstances.

For many babies, their parents will currently be providing them with emotional support and care through this unsettling time. But some parents will be finding it hard to give their babies the care that they need. Babies (born and unborn) are vulnerable because they are at a critical stage in their development, are totally dependent on adults for their care, and are unable to speak out or to seek help.

Babies are born vulnerable and dependent on a parent to help settle (regulate) them emotionally and physically. Parents should be supported to understand that babies will learn to do this for themselves best if they are soothed by a parent first, and that this won't make them more 'clingy' in the long run. Even as adults we can struggle to regulate our own bodies and feelings without the support of another person - especially under unusual levels of stress (having a baby, being in a pandemic for example!) and even more so if we didn't experience this containment as a child ourselves. Specialist Perinatal clinicians are a hugely important resource to help mums to regulate themselves so that in turn they are able to do so for their babies.

Vital services that would normally help to support parents and safeguard babies, such as health visiting service, are suffering from staff shortages, due to staff illness or in isolation, and because of redeployment. This is, therefore, a "perfect storm" of increased risk and decreased support for babies and their parents. It is therefore vital that all Specialist Perinatal Mental Health clinicians continue to keep all babies in mind from referral through to discharge during C-19 (and beyond).

This document is draws on resources from a range of organisations including the Parent-Infant Foundation, AVIG-UK, IHV, BPS, Alliance for the Advancement of Infant Mental Health, Robin Balbernie (Honorary Advisor AIMH (UK)) and Cheshire and Merseyside Specialist Perinatal Mental Health Services.

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Frequently Asked Questions

How do I start a conversation about parent-infant relationships?

It's important to start by exploring the relationship context and how this is impacted by C-19. You might ask none, some or many of these questions depending on your relationship with mum and what point she is at in her journey through services. You will already ask many of these questions and it is essential to link these to the parent-infant relationship and infant wellbeing – and document accordingly

1. Acknowledge that things are different and explore how:

- ✓ In normal circumstances I would have been able to sit with you / you and your baby / get down on the floor and play with you and your baby – it might feel a bit strange talking over the telephone / video
- ✓ Talk about confidentiality and privacy issues, acknowledge that might feel vulnerable, exposed (especially for any video sessions)
- ✓ How has family life changed since for you since C-19? (e.g. usual routines)
- ✓ Who would you normally see? Who normally helps you look after baby? (family, friends, neighbours, health visitor, baby group, peer support – what's different and how is this impacting?)
- ✓ Have parents experienced bereavement as a result of C-19?

2. Normalise feelings for mum, baby and family

- ✓ How have you been coping with being apart from people you would normally see? (identify coping strategies and gaps) How has your partner been coping? (identify potential for increase in relationship conflict etc)
- ✓ It's normal for adults to feel sad, angry, lonely, worried, numb or none of these things during a pandemic
- ✓ It's normal for babies to feel these things too – they show this by crying, fussing, changing their sleeping or feeding patterns etc – have you noticed any changes? What is the impact on you / your relationship?

3. Explore potential safety issues impacting mum and baby

- ✓ Is there anyone in the family with underlying health conditions or additional needs?
- ✓ Does anyone currently have symptoms of C-19?
- ✓ Do you have easy access to food /formula/basics and do you have an income? (identify if they need any urgent support)

4. Normalise talking about mother-baby relationships

Our job in the SP team is to support mum's mental health and also to support family relationships, especially parent and baby relationships. We know that lots of parents don't feel able to talk about how they really might be feeling because they can feel bad about how they are feeling, or are worried that others will think they are a bad parent. What really matters is that you are getting the support that you need from us as this is linked to better outcomes for you and for your baby.

5. The previous questions might provide a scaffold to direct exploration of mum's developing relationship with her baby (below):

Unborn baby: I'd love to hear about your pregnancy and how you've been feeling.

- ✓ How has the pregnancy been for you?
- ✓ With everything that's going on, have you noticed any thoughts or feelings towards the developing baby? (Prompt if needed – some women think a lot about the baby, some women think very little about the baby. Prompt: some women can feel anxious about the baby, some women can feel irritated by baby.)
- ✓ Do you have ideas about baby names?
- ✓ Have you ever wondered what you baby might be like as an older child, a teenager or even a grown-up?

Baby: I'd love to hear about how things are going with your baby.

- ✓ How are you finding being a mum? (Was it what you expected? How is it different?)
- ✓ How would you describe the first few weeks at home with baby? (emotional tone of the baby's entrance into family life)
- ✓ Tell me about why you chose your baby's name? (family story)
- ✓ Do you have any sense of your baby's personality? (can you choose 3 words that describe your baby's personality? Does your baby remind you of anyone?)
- ✓ What does your baby like to do? When does he seem most relaxed? What are the things that seem to stress him out? What helps him to calm down?
- ✓ What do you think your baby has noticed about the world around him during C-19 (how do you think he feels about it all?)
- ✓ What's the best bit about being a mum to baby? What's the hardest bit about being a mum to baby?
- ✓ Babies tend to cry a lot in the first few weeks and months and this can be really tough. How has this been for you? Have you noticed any patterns? Note: explore mum's response to baby crying - how difficult/easy she is coping with crying, confidence with soothing baby, strategies used and developmental appropriateness, ability to put baby safely down and take time by self if too overwhelmed)
- ✓ Just like any new relationship, it takes time to get to know someone – even your baby! Are you getting used to playing and chatting with baby? How does it all feel? (Note: look out for feelings of estrangement or incompetence as mum e.g. feelings of worthlessness, guilt, dread, loss of confidence, loss of role, wanting others to play with and care for baby

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How do I gain a more in-depth understanding about parent-infant relationships?

In SPS we use the MORS and can make a remote assessment of parent-infant interaction to gain a better understanding of the parent-infant relationship – identify what's going well and what might need extra support or intervention.

THE MORS

Introducing the MORS: The SP team use different kinds of questionnaires. Some help us to understand more about how you are feeling and others help us to understand more about your relationship with your baby.

I'd like to ask you some questions about how you feel about your baby. We have time to talk afterwards – and just remember that there are no right or wrong answers (document consent).

On completion: Did anything stand out that you would like to talk through? What did it feel like thinking about baby and answering those questions? Did it bring anything that you had not thought about before?

Feedback and follow-up: Once you've scored the MORS think about when and how you might feed this back to a parent. You can chat with one of the psychologists if you want to think about it first.

If you want to talk it through a curious approach can be helpful. Here are some examples:

- ✓ I noticed that you've scored that baby can cry a lot. That sounds really hard. What is this like for you? Have you noticed any patterns (time of day, events, number of hours per day etc. Note: explore mum's response to baby crying - how difficult/easy she is coping with crying, confidence with soothing baby, strategies used and developmental appropriateness, ability to put baby safely down and take time by self if too overwhelmed)
- ✓ I was looking at this and noticed that there are times when your baby can irritate you. I thought about how hard this might be. What do you do when you feel this way? Are there certain times this might happen or not?
- ✓ Sometimes it seems your baby can annoy you. I wanted to think about what can feel annoying and if there is anything you or we can do to help this?

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Assessment of parent-infant interactions

What do I need to think about practically and IT wise to make a remote observational assessment of parent-infant interaction?

- ✓ Audio and visual needs to be of good quality even with low band width
- ✓ Needs to work on mobile, computer, tablet, android/PC and apple
- ✓ Needs to be easy/intuitive/accessible to use particularly for families
- ✓ Families need to have access to wi-fi and suitable device to engage in assessment (remember that families experiencing poverty or with complex difficulties will be at a cumulative disadvantage here)
- ✓ Some families will respond well to video assessment and intervention, some will not
- ✓ Remember that families don't always have a private space free from other people in the household
- ✓ Consider your own situation – what's possible in terms of private space in your own home?
- ✓ If you do plan to complete an observational video assessment, please see practical guidance (below) for completing 'telehealth' appointments (from University of Melbourne). This can be easily adapted for assessment of parent-infant interactions.
- ✓ Consider how you might 'mirror' the parent e.g. get down on the floor too! This might help put parents at ease.

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Framework to guide assessment of parent-infant interactions and inform clinical decision-making				
Caregiving pattern	**Insensitive**	**Controlling**	**Under-responsive**	**Sensitive**
Infant pattern	**Compulsivity**	**Difficult**	**Passive**	**Cooperative**
Markers	Ambiguous half smiles Facial changes when looking away (mostly sad); gaze aversion Frozen watchfulness Silence; strained positive voice; stressed sounds – eg hiccups / coughing Stiff, still body or limbs; jerky body movements Behaviours with sharp beginnings or endings; bright / happy behaviours without obvious stimulus; highly aroused but still Lack of initiative; avoidance of intimacy Immediate switches to adult's interest Tolerate aversive adult behaviour without complaint	Avoidant gaze; turning head away Grimacing; tongue protrusion Vocal protests Squirmy; pushing or arching away; hitting / kicking; resisting touches Defensive sleeping; restlessness Highly aroused / irritable Tense body; refusing to engage / be comforted Refusing to respond Throwing toys; ignoring adult Frustration with the play or task; refusing adult initiatives	Lack of eye contact / smiling Expressionless face Unfocussed eyes Few vocalisations; low volume; doesn't initiate speech Floppy, poorly coordinated; still (not rigid) Low arousal; seems half asleep; no clear positive or negative affect Not initiating interpersonal turns; don't resist; lifeless play Permits manipulation of self and toys No initiation of activity; decides by self what to play – and usually very little Accepts difficult / dull activities without protest or reaction	Slowly developing smile that lingers after its peak Shared eye contact Relaxed voice tones Fluid movements Ease with physical closeness Moderate and comfortable arousal Shared peaks of joy that 'fit' Taking turns where both seem to be at ease with this Infant initiates control Adult modifies their response in response to infant's signals Developmentally challenging and satisfying activity – well targeted by adult

Parent-infant interaction and developmental considerations- What's the game?

0-3 months - Physiological Regulation

- *Can the parent enable the infant to remain in an alert and relaxed state for increasingly long periods of time? (e.g. keeps baby settled, responds promptly and sensitively to cues, able to soothe)*

3-6 months – Turn Taking

- *Can the parent help the infant to find and expect repetitive dyadic sequences in which they each have a part? (e.g. peek-a-boo, nursery rhymes, 'talking' to each other, both initiating)*

6-9 months – Playing the Game

- *Can parent and infant establish a pattern and then vary the pattern? (e.g. playing 'round-and-round-the-garden' but tickling in a different place or adding new elements*)

9-12 months - Reciprocal Communication around Joint Attention

- *Can parent and baby turn their attention away from each other and toward an object that they both enjoy? (e.g. blocks, toy, book; and incorporates language into game)*

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Identifying risks in the parent-infant relationship

Stressors on the Caregiving Relationship: A Risk / Vulnerability Analysis

This is a risk model to guide parent-infant treatment created by robin.balbernie@gmail.com It also identifies some distal points for intervention, away from the immediate family. Serious conditions that merit interventions on their own are in red in the list below. Since risks are cumulative, it is suggested that four or more less serious risks will also need attention. This guide may support clinical decision-making in Specialist Perinatal Services.

1.	**Potential Biological Vulnerability in the Infant:**	
	Mother substance abused (including alcohol) during pregnancy.	☐
	Very low birth weight / extremely premature.	☐
	Non-organic failure to thrive / malnutrition.	☐
	Extreme feeding / sleeping difficulties	.....
	Congenital problems / poor health / serious developmental delay.	.....
	Baby has a very difficult temperament / extreme crying.	.....
	Chronic maternal anxiety / stress during pregnancy.	.....
	Regulatory / sensory integration disorder / hypersensitive to stimuli.	.....
2.	**Parental Social and Emotional History and Current Functioning:**	
	All forms of mental illness, including eating disorder & PTSD.	☐
	A serious medical condition / physical disability.	☐
	Own mother was mentally ill / substance abused.	☐
	Alcohol and / or drug abuse (current or past).	☐
	History of trauma, witnessing violence, neglect, abuse or loss.	☐
	Parents seem incoherent or confused when describing relationships.	.....
	Parent was in care or adopted (often signifies maltreatment).	.....
	A serious lack of preparation during pregnancy or denial of pregnancy.	
	Learning disability / low educational achievement.	.....
	A previous child has been placed in foster care or adopted.	.....
	Mother has experienced the death of a child (including stillbirth).	.....
	A previous child has shown very difficult behaviour problems.	.....
	The presence of an acute family crisis.	.....
3.	**Interactional or Parenting Variables:**	
	A lack of sensitivity and responsiveness to the infant's cries or signals.	.....
	Signs of being physically punitive or harsh towards the child.	.....
	Lack of vocalisation to the infant, few serve and return 'conversations'.	.....
	A consistent lack, or avoidance, of eye-to-eye contact.	.....
	Regular negative attributions made towards child, even if 'jokey'.	.....
	Lacks everyday knowledge of parenting and child development.	.....
	The infant has poor care (e.g. dirty and unkempt), physical neglect.	.....
	Is unable to anticipate or encourage the child's development.	.....
	Quality of partner relationship; may be undermined or unsupported.	.....
	Infant a victim of maltreatment, emotional abuse or neglect.	☐
	Infant regularly rejects being held or touched by caregiver.	☐
	Any violence reported in the family, especially if witnessed by infant.	☐
	Infant prefers a 'stranger' to a familiar caregiver.	☐
	Negative affect / verbal abuse openly shown towards child.	☐
4.	**Socio-demographic Factors:**	
	Homelessness or housing instability.	☐
	Chronic unemployment and / or insufficient income.	.....
	Food insecurity and / or inadequate housing and hygiene.	.....
	A single teenage mother *without* family support.	.....
	Absent parent, or step-parent in family (i.e. not biologically related).	.....
	Severe family dysfunction, current and in background.	.....
	Lack of supportive relationships / social isolation.	.....
	Recent life stress (e.g. bereavement, birth trauma, racial prejudice, etc.).	.....

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How can I support parent-infant relationships from a distance?

Being held in the mind of another is especially important during times of social distancing. Agree a communication plan with mum – how often will your contacts be? By phone, video or both?

Hold and contain the parent who is frightened. When we acknowledge and validate fears and worries, we help mums who need co-regulation to feel calmer. Allow them the opportunity to talk while you listen unconditionally.

Normalise feelings. Mums will experience a range of feelings (sadness, worry, fear, anger, loneliness, frustration, numbness etc). It's important that they understand that these are normal feelings in response to a crisis.

How we are is as important as what we do. Mums can experience our empathy through consistent and responsive outreach. We can consciously settle ourselves before a visit, so our voice is strong, soothing and calm. We can share our strength with them.

Enquire about and normalise infant and toddler reactions to stress. Help mum to consider ways to help, comfort, and soothe her baby. Offer anticipatory guidance about changes in behaviour, sleeping, feeding etc that they might notice and help them put changes into context. Encourage mum to wonder if this might be baby's way of 'asking' for help to comfort the uneasiness and confusion they are feeling but can't yet understand.

Ask about crying and coping with crying: Acknowledge that it's hard to cope with crying at the best of times. Crying is the way a baby tells us what they need and it's not unusual for babies to cry from 1 to 5 hours daily. Talk to mum about whether she has done all the usual checks (hunger, thirst etc) and talk through different ideas for soothing and down-regulating (holding, singing, walking, rhythm etc). Share resource *https://ihv.org.uk/wp-content/uploads/2020/04/PT-Coping-with-a-crying-baby-during-COVID19-FINAL-VERSION-14.4.20.pdf* and consider request for remote baby massage intervention.

Encourage play: Talk to mum about baby's favourite things to do and build a bank of ideas together. Remind mum that her face is baby's favourite 'toy'! If mum is pregnant, encourage talking to bump, noticing movements and patterns. Share Perinatal team resources *'Being with your baby – becoming a mum'* and *'Staying at home pack'.*

What else can help?

The SP team offer a range of interventions that support parent-infant relationships which have been adapted for remote working.

- ✓ Baby Massage and Baby Yoga (Perinatal Support Workers)
- ✓ Cues Cards and Building Bonds (Perinatal Support Workers / SPS clinicians)
- ✓ Mentalization-based Parenting (psychology)

  [Video Interaction Guidance (psychology – guidelines in development)]

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What if the conversation brings up safeguarding concerns?

We know that lots of parents don't feel able to talk about how they really might be feeling because they are worried that others will think they are a bad parent or that social services will get involved. We also know that living with a parent who has mental health difficulties does NOT mean your baby is at risk. But what really matters is that families are getting the support that they need as this is linked to better outcomes everyone.

If significant concerns are identified consider a home visit to be carried out by a health visitor (see IHV guidance) or Perinatal clinician (follow Trust guidelines).

Please follow local trust safeguarding policies and / or seek support from line manager & Safeguarding lead nurse as appropriate.

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