Journal for Prenatal and Perinatal Psychology and Health 37(2), Summer 2023

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JOURNAL FOR PRENATAL AND PERINATAL PSYCHOLOGY AND HEALTH publishes findings from the cutting edge of the rapidly growing science of prenatal and perinatal psychology and health. The journal, published quarterly from 1986 through 2023, and now triannually, is dedicated to the in-depth exploration of the dimension of human reproduction and pregnancy and the mental and emotional development of the unborn and newborn child. It provides a forum for the many disciplines involved, such as psychology, psychiatry, midwifery, nursing, obstetrics, prenatal education, perinatology, pediatrics, law, and ethology. The journal also navigates the numerous ethical and legal dilemmas that are emerging as society reevaluates its attitudes toward adoption and abortion or strives to establish moral positions on high-tech obstetrics and third-party conception. The opinions expressed in articles are those of the authors and do not imply endorsements by APPPAH, the editorial team at *JOPPPAH*, or the printer, Allen Press, Inc.

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Editorial
Special Issue: Patient Perspectives on Care

Each summer issue, the *Journal for Prenatal and Perinatal Psychology and Health* dedicates an issue to patient experiences on care. Growing research in our field supports the theory that clinicians' interactions with patients bear significant weight on not only patient mental health but the health and well-being of their child. The first two articles in our special issue posit the importance of staff interaction with pregnant or postpartum clients and patients. The researchers identified what qualities seemed most helpful to clients, from education and information about the client's condition to helping clients be more confident as new parents. As a researcher, advocate, and mental health clinician who works primarily with mothers in the postpartum period, I cannot stress enough how pivotal our role is in providing a well-informed, kind space for mothers and birthing people, validating their experiences, and providing timely and research-driven information through a trauma-informed paradigm. Both studies indicate how the care clinicians provide can shape pregnancy, birth, and beyond.

In one of the first evaluations of service users' experiences of community perinatal mental health in the UK, "An Evaluation of Perinatal Mental Health Treatment Experiences Using Patient Rated Experience and Outcome Measure (POEM)," Simone Davies, Psy.D., Rebecca Ison, Psy.D., Lucy McEntegart, MSc, and Tal Moore, Psy.D. investigated the experiences of perinatal clients in East England between 2017 and 2019. Combining quantitative and qualitative analysis with patient-rated experience measure, Davies et al revealed that of the 28% of service users' experiences gathered, perinatal mental health support was highly rated by users and valued by the patients. Consistent with the bulk of current scholarly work on supporting perinatal mental health, the researchers found that users not only used but relied on supportive staff and especially noted if the staff were friendly, approachable, caring, and more. Though the authors call for more research, this study indicates that community perinatal mental health works.

Nichole Cubbage, MS, argues in "The Deliverance of Miscarriage Information and Fetal Loss in Multiple Pregnancies and Vanishing Twin Syndrome (VTS)" that protocol regarding VTS requires a significant shift. Cubbage writes that current standards of care do not compel providers to inform patients that a miscarriage is currently or will take place, though they are required to disclose risks that may affect treatment decisions. VTS is not uncommon, and yet there is no standard protocol for informing patients of the risks of VTS with twin pregnancies. Cubbage created a proposed model for providers to follow that incorporates necessary information on VTS along with resources if VTS should occur.

In "A Unique Approach to Healing After Birth," *JOPPPAH*'s Peer Review Coordinator, Anita Horvath, MFT, interviewed Canadian Clinical Counselor Jennifer Summerfeldt on healing after birth. The discussion is frank, open, and curious—how do we show up for mothers and birthing people incorporating neuropsychology, the nervous system, and pushing back against disordered thinking? The interview dives into how personal experience can shape clinical perspectives and workshops how we as clinicians can safeguard clients' informed choices.

In this issue, we are fortunate to bring you two book reviews of a new work from Robbie Davis-Floyd, Ph.D. and Licia Claire Seaman. *JOPPPAH*'s creator, Thomas Verny, MD, DHL (Hon), DPsych, FRCPC, FAPA, reviewed Davis-Floyd's self-published book, Robbie's Reader. Verny describes Davis-Floyd's collection of stories as "undeniably compelling" and "brilliantly illuminating." *JOPPPAH*'s Book Review Editor, Stephanie Cloutman, MS, reviewed Lullaby Wisdom. Seaman's book combines interpersonal neurobiology and her expertise as a musician to help parents and caregivers utilize lullabies to soothe babies.

Lastly, it is a privilege to share "American Indian and Alaskan Native Maternal Mental Health" from Cindy Lee Herrick and Joy Burkhard of the Policy Center for Maternal Mental Health. Herrick and Burkhard summarize the disproportionate issues American Indian and Alaskan Native birthing people face, from increased maternal death to trauma, intimate partner violence, and inequities due to systemic racism. I give my thanks to Herrick, Burkhard, the Policy Center, and our Copy Editor, Christiana Rebelle, Ph.D., for this new partnership.

A year into my role as Editor in Chief, we have taken steps towards more inclusivity, gathering momentum to consider patient perspective through quantitative and qualitative means. With this vision, we present our Patient Perspectives on Care journal issue, grateful for the authors' contributions to stretching and honing our understanding of best practices of care.

If you have quantitative or qualitative research, case studies, or clinical vignettes to share, submit them to journal.editor@birthpsychology.com by our September 5th deadline to make the Fall issue. Until then, we hope this journal reaches you in good health and spirits.

Special thanks to Managing Editor Jess Kimball and Copy Editor Christiana Rebelle for countless hours spent reworking the journal format, bringing *JOPPPAH* a fresh new look.

Happy Summer,
Kate Stahl-Kovell, PhD

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An Evaluation of Perinatal Mental Health Treatment Experiences Using Patient Rated Experience and Outcome Measure (POEM)

Simone Davies, PsyD, Rebecca Ison, PsyD, Lucy McEntegart, MSc, Tal Moore, PsyD

Since 2016, policymakers in the UK have invested heavily in specialist services for women presenting with moderate to severe mental health difficulties during the perinatal period, funding new perinatal community teams. This study aimed to explore the experiences of clients, their partners, and families using a new Perinatal Community Mental Health team in the East of England between 2017-2019. Both quantitative and qualitative data from the Patient-rated Outcome and Experience Measure (POEM) were analyzed. While most service users and their families reported a positive experience of using the service, a small number reported negative experiences. The researchers used framework analysis for qualitative data and identified five themes: Containing, responsive, and attuned; Minding the gap; Let down, mis-attuned, and unsupported; Falling through the gap; Praise and gratitude—changing lives. The psychometric properties, reliability, and validity of the POEM are discussed alongside

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The authors have no conflicts of interest to report. **Simone Davies, PsyD** is a Clinical Psychologist and doctoral graduate in Clinical Psychology at the University of East Anglia. Drin the Perinatal Community Mental Health Team employed by Norfolk and Suffolk NHS Trust. **Rebecca Ison, PsyD** is an Associate Lecturer at the University of East Anglia for the Clinical Psychology Doctorate Program. **Lucy McEntegart, MSc** is a Research Assistant Psychologist employed by Norfolk and Suffolk NHS Trust**. Tal Moore, PsyD** is a Clinical Psychologist and has an independent practice in New Zealand. Correspondence concerning this article should be sent to Dr. Davies. Email: Simone.Davies@nsft.nhs.uk

the important implications for the service and future research into the service user experience of perinatal services.

Keywords: perinatal mental health, patient-rated experience measure, perinatal mental health services

Perinatal mental health problems occur during pregnancy and the first 12 months following birth and are either caused or made worse by factors related to this time. In the UK, around 20% of service users are thought to be affected (Bauer et al., 2014). If left untreated, these difficulties can have significant and long-lasting negative effects on the parent and their child and family (National Health Service [NHS] England, 2016). As well as the human cost, there is also a significant economic impact. In the UK, the cost of not treating maternal mental health problems in the perinatal period has been estimated at £8.1 billion per birth year's cohort (Bauer et al., 2014).

Those who experience perinatal mental health problems will experience mild to moderate difficulties, though some will experience more severe difficulties which cannot be treated within primary or universal services (National Institute for Health and Care Excellence [NICE], 2014). Specialist perinatal mental health services have been commissioned to respond to this need (Oates, 2014). In 2014 it was estimated that most localities within the UK (85%) either had no specialist provision or services that did not meet NICE requirements (Maternal Mental Health Alliance [MMHA], 2018). In 2016, NHS England allocated a budget of £365 million over five years to build capacity and capability within community and inpatient specialist perinatal services and provide an additional 30,000 service users with care (NHS England, 2016). In the first phase of the program, twenty new or expanded perinatal community mental health teams (PCMHTs) were commissioned in line with the service standards and guidelines set out by NICE, NHS England, the Royal College of Psychiatrists (RCPsych), and the British Psychological Society (Joint Commissioning Panel for Mental Health [JCPMH], 2012; NICE, 2014; McKenzie-McHarg et al., 2016; RCPsych, 2018a). In 2019, NHS England increased funding to 44 specialist perinatal community mental health teams with the goal of reaching 66,000 service users to access care (NHS England, 2019).

Specialist perinatal mental health teams offer psychoeducation, risk management, psychological interventions, medication management, liaison with relevant services, including midwifery, social services, and early years support, promoting secure parent-infant attachment, and discharge planning to those with moderate to severe mental health difficulties in the antenatal and up to one-year postnatal period. These teams are currently evaluated by the accreditation and peer review process of the RCPsych's Centre for Quality Improvement (CCQI) perinatal quality network (PQN). Assessing healthcare quality using routine clinical outcome measures is considered best practice within UK mental health services (Department of Health, 2010; NHS England, 2016). Studies have shown that routinely using patient-reported measures is key to improving mental health services and addressing system failures (Dormon, 2015; RCPsych, 2013; Thornicroft & Slade, 2014).

In line with this, the RCPsych (2018a) standards stipulate that services should evaluate how clients, their partners, and family members experience the care they receive and use this feedback to improve services. To this end, the RCPsych developed the Patient-rated Outcome and Experience Measure (POEM, Table II). This measure is completed by service users and their partners and families when they are discharged from services and explores mental health outcomes and experiences. Although not a validated measure, the POEM is recommended for use by perinatal community teams and inpatient Mother and Baby Units (MBUs) by the RCPsych (2018b). When this paper was written, no research evaluated perinatal mental health teams using a patient-rated outcome and experience measure (POEM).

While the service has made a significant investment in data collection, POEM data is yet to be analyzed or used to inform service improvement. Such an evaluation is particularly important because NHS England no longer commissions first-phase funded PCMHTs. Funding will come from local care commissioning groups (CCGs) and sustainability and transformation partnerships (STPs). Services will need to provide evidence of how they are performing and any gaps in provision. This paper evaluates the POEM data from one perinatal community team based in East England. This paper aims to evaluate service users' experiences who received treatment in the perinatal community team by using a patient-rated experience measure.

Methods

Participants

Eligibility criteria included service users who received treatment and were discharged from a PCMHT in Norfolk between October 2017 and October 2019 and their partners, caregivers, and family members. This service offers service users mental health treatments and consultancy and supports their families and current care team. During this period, 218 service users and their families were eligible to complete the POEM, nineteen service users were not offered the POEM as it was considered insensitive to ask for feedback (e.g., following the baby being taken into the care of social services or pregnancy loss), and 11 service users received the POEM after the time frame being considered by the researchers. Of the 188 service users who were still eligible to give feedback, 102 were contacted to complete the POEM, and of those service users, 60 completed it, and 13 service users declined to complete the POEM. In addition, six POEM questionnaires were completed by their partners/family members. The response rate of completing the POEM was 67%. Of the 66 participants, four did not leave any qualitative feedback. The POEM does not contain questions relating to identity; therefore, we could not retrieve data on the exact age and ethnicity of the 66 responses.

Inclusion criteria were:

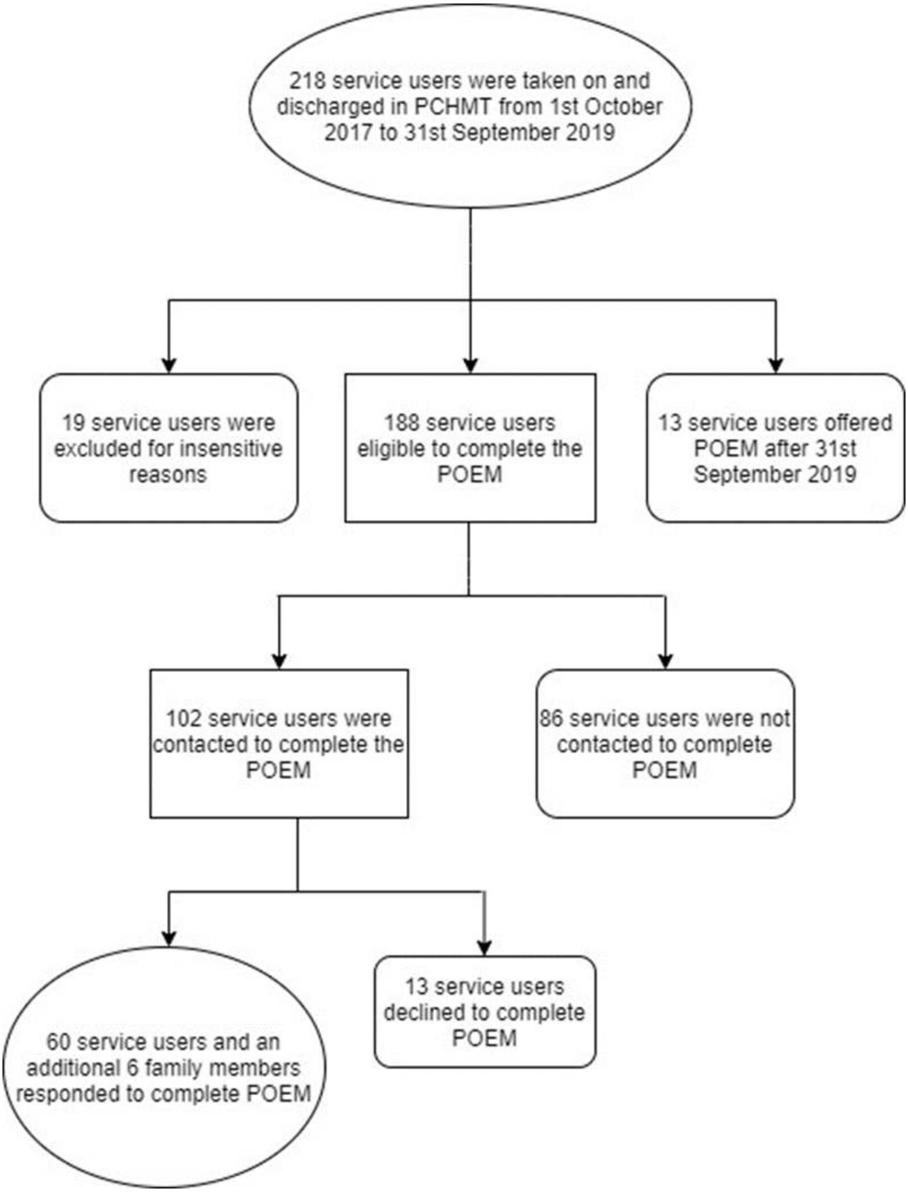
- moderate to severe perinatal-related mental health difficulties or a history of severe mental illness (although participants may have been well at the time)
- presentation during the perinatal period (conception and one year following the birth of the child)
- aged 16 years and upwards
- at least one appointment from the PCMHT following assessment

Exclusion criteria were:

- referral or assessment to the PCMHT but not then taken on for treatment
- receipt of preconception advice only

Figure 1

Flowchart of the Selection Process of Participants



Materials

The POEM (RCPsych, 2018b) is a 15-item patient-reported outcome and experience measure designed to assess service user, partner, and family member satisfaction with service experience while indicating mental health outcomes following treatment within the service (Table II). The POEM asks participants to rate their/their partners' or family member's mental health on a six-point Likert scale on entering and leaving the service and has 12 questions on a four-point Likert scale: participants are asked to rate whether they strongly agree, agree, disagree, or strongly disagree with statements about service provision, such as communication, baby care, and information provision. There is an additional open-ended question for any other feedback.

Design

The study uses a cross-sectional study design using an existing data set. The POEM is a routinely offered self-report measure used within perinatal services in England, which generates qualitative and quantitative data about women's mental health outcomes and service experiences. The data set used for this study was completed POEM measures sent to service users who were taken on and discharged from the Perinatal Community Mental Health Team between October 2017 and September 2019.

Procedure

Participants were invited to complete the POEM in one sitting following discharge in one of three ways: over the telephone with a research assistant psychologist (RAP), directly via the RCPsych online portal, or by anonymously returning a completed paper form. RAPs uploaded completed paper versions of the measures onto the RCPsych portal. Participants were told it was a tool to receive feedback on their experience of treatment in the PCHMT. Completion was optional and not a requirement for discharge from PCHMT.

Scoring and Data Analysis

Quantitative Data

The self-reported outcome ratings (questions A1 and A2) were not analyzed, as their consideration was outside the scope of the current research.

The self-reported experience ratings (questions B1 to B12) are described in Table II. Inferential statistics were not used because the measure's psychometric properties were not robust enough to extrapolate to a wider population or to enable comparison between questions (Clarke-Carter, 2019).

Qualitative Data

Free text responses from the POEM were analyzed using the Framework Method (Richie and Spencer, 1994). Framework Analysis is a thematic approach providing a flexible but structured method for analyzing qualitative data (Gale et al., 2013). It was chosen because it is particularly suited to studies with a large amount of data, a specific research focus, and a team approach to data analysis (Kiernan and Hill, 2018). The five stages of Framework Analysis (Gale et al., 2013) were followed.

Table 1

Five Stages of Framework Analysis

Stage	Description
1	Data familiarization
2	Development of framework to organize data
3	Indexing the data onto the framework
4	Charting the data: summarizing the data in a table
5	Mapping and interpretation

The researchers worked collaboratively to develop the framework, coming together to explore the patterns of meaning (Smith et al., 2009) that emerged. These patterns were further refined into themes (Li & Seale, 2007).

Results

Through quantitative and qualitative methods, the results illustrate the experiences of service users in PCHMT measured by the POEM.

Quantitative Data

For all experience questions (Figure III), most participants either agreed/strongly agreed[1] with the statements; agreement rates were between 86.6% and 97%. The service received the lowest agreement rate for question B1—communicating with others involved in care (86.6%)[2]; and the highest agreement rate for question B9—sensitivity to needs of the baby (97%). For all other questions, agreement rates were between 89.1-92.4%. On average, 90.8% of participants agreed/ strongly agreed[3] with the statements, and 9.2% disagreed/strongly disagreed[4].

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[1] Or for reverse scored items, disagreed–strongly disagreed.

[2] Or for reverse scored items, disagreed–strongly disagreed.

[3] Or for reverse scored items, disagreed–strongly disagreed.

[4] Or for reverse scored items, agreed–strongly agreed.

Table 2

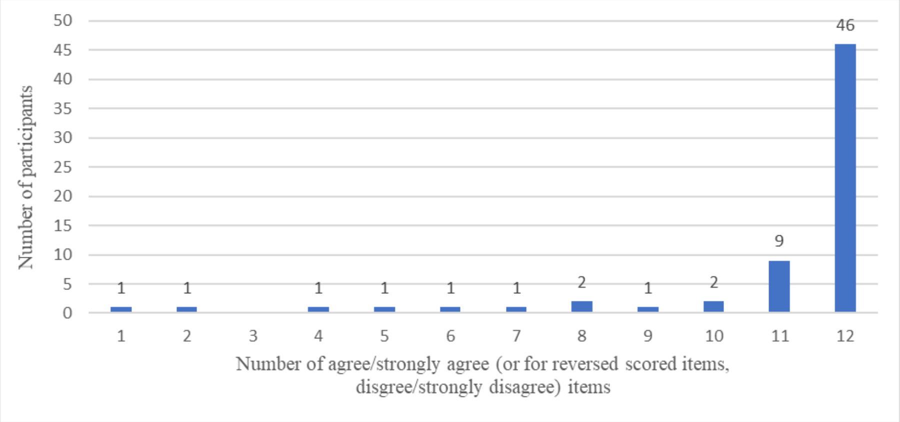
Percentage of Participants Who Strongly Agreed, Agreed, Disagreed, Strongly Disagreed with the 12 Experience of Service Statements

	Strongly agree (%)	Agree (%)	Disagree (%)	Strongly disagree (%)
QB1 Staff did not communicate with others involved in my care	6.1	7.6	34.8	51.5
QB2 Staff gave me the right amount of support and care	54.5	34.8	3.0	7.6
QB3 I did not get help quickly enough after referral	0	7.6	34.8	57.6
QB4 Staff listened to me and understood my problems	71.2	21.2	6.1	1.5
QB5 Staff did not involve me enough in my care and treatment	1.5	9.1	33.3	56.1
QB6 The service provided me with the information I needed	47.0	42.4	7.6	3.0
QB7 Staff were not very sensitive to my needs	0	9.1	21.2	69.7
QB8 Staff helped me to understand my illness/difficulties	47.0	43.9	4.5	4.5
QB9 Staff were not very sensitive to the needs of my baby	0	3.0	30.3	66.7
QB10 Staff helped me be more confident with caring for my baby	39.4	50.0	9.1	1.5

Most participants (70%) agreed/strongly agreed[5] with all 12 experience statements, and 17% disagreed/strongly disagreed[6] with only 1-2 statements. While the results show strong agreement rates, three statements had the highest disagreement rate of the survey at 10.6%: "Staff gave me the right amount of support," "The service provided me with the information I needed," "Staff helped me be more confident with caring for my baby." Additionally, 13.7% agreed with the following statement: "Staff did not communicate with others involved in my care." Therefore, these statements show the areas that require the most perinatal services improvement.

Figure 2

Statements Participants Strongly Agreed, Agreed (for Reverse Scored Items Disagreed, Strongly Disagreed)



Qualitative Data

Out of the 66 responses, four participants did not leave qualitative feedback. Of the 94% of responses analyzed, five themes were identified through framework analysis: Containing, responsive, and attuned; Let down, mis-attuned, and unsupported; Minding the gap; Falling through the gap; Praise and gratitude—changed lives. Although there are areas of overlap between the five themes, they represent distinct elements of the experience of the perinatal service.

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[5] Or for reverse scored items, disagreed–strongly disagreed.

[6] Or for reverse scored items, agreed–strongly agreed.

Theme One: Containing, Responsive, and Attuned

"I never felt alone. I always felt I had them to comfort me and fall back on. They made me understand it wasn't my fault." Most women, their partners, caregivers, and family members described experiencing the service as containing, responsive, and attuned to their needs. One of the key elements of the experience was the staff being consistent, reliable, available, and responsive: "always there if I needed them."

The personal attributes of staff were also described as important. Participants reported that the staff was "friendly," "approachable," "caring," "welcoming," "non-judgmental," "understanding," and "genuine." Women, partners, and families reported feeling listened to, understood, reassured, and validated. This attunement emerged as a key factor in participants feeling held and contained. "Listened to what I knew I needed." "You always understood me and helped me understand what was going on, didn't judge me, always considered my feelings."

Participants reported that they were treated holistically and described the importance of considering all aspects of their social situation, from their relationship with their baby, parenting with previous children, work, finances, and relationships. "[They] considered all aspects of my life—my relationship with my partner, my child's sleeping arrangements, going back to work."

Theme Two: Let Down, Mis-attuned, and Unsupported

"I was feeling extremely low and vulnerable, and missed appointments and phone calls only added to my feelings of worthlessness." A minority of women, their partners, and their family members described negative experiences using the service. Key to the difficulties described were experiences of missed and canceled appointments and broken promises, resulting in participants feeling let down. "I was promised help with bonding with my baby and to learn coping techniques, yet nothing ever materialized."

Some participants reported that services seemed overstretched and described experiencing negative impacts from staff absences and insufficient cover. They reported feeling less of a priority and concerned that the service did not have the resource to support them if they had had greater needs. "I could really tell that the service was overstretched."

Some respondents also reported that they did not feel listened to or heard. Staff members were described as "dismissive," "intimidating," and "quite formal." Participants reported not feeling included in conversations about themselves and gaps in communication.

"Felt like [they] thought [they] already knew what I was going to say so wasn't really hearing me. Meeting with someone who kept telling me how I was feeling and not listening to how I was actually feeling." The minority of participants that reported a negative experience of service also described feeling as though their needs were not met. "I asked to be discharged because I felt that the care wasn't helpful."

Theme Three: Minding the Gap

"[They] went above and beyond as [they] kept me on longer than [they] [were] meant to so that [they] could sort of bridge the gap between services." Participants described how the perinatal service supported them to access and receive help from other sources, "minding the gap" between the team and other providers. For some, this involved signposting to community resources, while for others, it involved transitions to secondary mental health services, returning to primary care, or coordinating additional support while under the care of the perinatal team. Participants described positive experiences of the service's communication and the team advocating for their needs being met. "After discharge, got lots of options and groups I could join." "Got everyone in that I needed from other teams and from your team."

Theme Four: Falling Through the Gap

"What I don't get is why there was nothing else put in place after she was discharged. I had such a fight with well-being and other people trying to get her the help she needed. It was like she was just left in limbo." A minority of participants described experiences of "falling through the gap." These experiences included difficulties transitioning to other services, including long waits for assessments and interventions and little contact or support in between, difficulties with referrers being unaware of referral routes, and the other services lacking the perinatal knowledge of mental health key to their recoveries. "I had to wait ages for my first appointment. Even my midwives said I should have been seen earlier." "Been a long wait for referral to the wellbeing service—in gap between services have been struggling."

Theme 5: Praise and Gratitude—Changing (Saving) People's Lives

"Thank you, I can't thank you enough. What you do is amazing. The team was just great. […] I'm so grateful for the work they did with me. I wouldn't have gotten better without them." Over two-thirds of respondents praised the service and clinicians, expressed gratitude, or reflected on the life-changing, sometimes life-saving, experience of using the service. "Because of the work [they] did with me, it actually gave me the confidence to study mental health myself"

Discussion

This study has enabled the researchers to develop an initial understanding of service users' experiences using a perinatal service, using data from the POEM, a patient-rated outcome measure. Analysis of the quantitative data shows that service users found the staff to be sensitive to their needs and their baby's needs, that staff listened and understood their problems, and that they would recommend the service to others. A closer analysis of the responses of participants who reported a mainly negative experience of the service suggests that even when the service is rated poorly in other areas, it is experienced as performing well in terms of communication with others involved in the person's care, getting help quickly following referral and being sensitive to the needs of the baby. This indicates that they are areas of strength for the service.

Three statements had the highest disagreement rate of the survey at 10.6%: "Staff gave me the right amount of support," "The service provided me with the information I needed," "Staff helped me be more confident with caring for my baby." Additionally, 13.7%. agreed with the following statement "Staff did not communicate with others involved in my care." Indicating the areas which require the most improvement for perinatal services.

The framework analysis of service user comments also indicated that the majority of participants had a positive experience using the service. Service users reported receiving vital support at a vulnerable time, expressed praise and gratitude towards the service, and reported how it had changed their lives. Key to these experiences was trusting therapeutic relationships attuned to the patients" perinatal needs and clinicians who considered them holistically, creating safe spaces to receive support. For the minority of participants who felt let down, unsupported, and unheard by the service, the opposite was true—they reported breakdowns in trust and communication, again pointing to the importance of building therapeutic relationships, good communication, and safe-containing spaces.

Service users from both groups reported problems with "falling through the gap" between the perinatal service and other forms of support, particularly with difficulties returning to primary mental health care services. Studies suggest that improving joint working, the development of training and education, clear care pathways, protocols and referral guidelines, and liaison services would improve service user's experiences in these areas (Coates et al., 2017; Myors et al., 2013; Rothera & Oates, 2008). Perinatal community standards (RCPsych, 2018a) set out a role for specialist services in supporting this. Since this data was collected, an effort has been made to support liaison between services, and staff roles have been created to provide assessments to help prevent service users from falling through the gap by offering assessments and referring to external agencies.

Using a four-point Likert scale, with no neutral category and the lack of specificity of some statements, calls into question the clinical credibility and utility of the quantitative data (Clarke-Carter, 2019). This was emphasized by a participant's comments: "It would be good to have a neutral category in the survey." Further research is needed to assess the validity and reliability of the POEM questionnaire. The qualitative data from the open-ended question were incomplete. Comments were not stored beyond the count of 690 characters, despite it being possible to add information indefinitely. This cut-off affected 24% of the data sets, which may have skewed the qualitative analysis. Since this research was conducted, the Royal College of Psychiatrists (RCPsych) has amended this error.

Furthermore, the POEM response only represents 28% of service users' experiences in the perinatal team between 2017 and 2019, so it may not fully represent service users accessing perinatal services. Collection methods may also have biased the responses as participants were asked to complete the POEM over the telephone with the research assistant psychologist and may have felt unable to talk about negative experiences with someone who had links to the team.

Implications and Recommendations

Although the importance of supporting mental health in the perinatal period is well documented, little is known about the health services that support them and how users experience them. The qualitative analysis in the current study increased the understanding of perinatal mental health services by exploring the characteristics that clients find valuable. Future research should focus on several different services to explore the breadth of experience of service users and their families under perinatal services across the UK.

Services need to provide adequate cover for absent clinicians and commission enough resources to meet demand. The experience of "falling through the gap" points to the need to establish more robust links with other services and for commissioners to consider whether primary and secondary mental health services are adequately funded for service users in the perinatal period (Myors et al., 2013, 2015; Rothera & Oates, 2008).

This study has highlighted several limitations of the POEM measure itself. Guidelines for scoring should be provided, and additional items exploring support with transitions to other services and interpersonal relationships with clinicians may be of benefit. Consideration needs to be given to adding a neutral category, and using the protocol used to create the VOICE Questionnaire: using a series of patient focus groups (Evans et al., 2012) may help improve the questionnaire.

Consistent with previous literature, clients who reported trusting therapeutic relationships based on clinicians being available, consistent, and responsive were key to positive experiences (Coates et al., 2017). They reported benefitting from a holistic approach and clinicians' specialist knowledge of mental health and parent-infant relationships. Therefore, it is recommended that the perinatal services continue to provide support, training, and supervision for clinicians to develop these relationships, safe spaces, and specialist knowledge safely and effectively in perinatal mental health and parent-infant relationships. This study captured how perinatal teams can meet the needs of babies and treat service users' mental health difficulties. It is recommended that perinatal services continue to receive high-quality parent-infant training to meet the baby's needs.

In summary, this study is one of the first to evaluate service users' experience in a perinatal mental health team in the UK after using the POEM. The results suggest that the perinatal service currently being evaluated provided a highly rated service. Participants reported that they particularly valued supportive therapeutic relationships in which clinicians were responsive, available, and containing. Further research is needed to validate and update the POEM questionnaire. As perinatal services continue to expand across the UK, further research is required to fully understand the experience of families and partners of service users and consider developing an alternative questionnaire that may better meet the needs of partners and family members.

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The Deliverance of Miscarriage Information and Fetal Loss in Multiple Pregnancies and Vanishing Twin Syndrome (VTS): Enhancing Patient-Provider Relationships by Improving the Patient Experience

Nichole McTurk Cubbage, MS

Enhancing patient-provider trust and relationships is more important than ever. One way to achieve this is with improved quality (e.g., informative) delivery of miscarriage information when Vanishing Twin Syndrome (VTS) occurs. Although all types of pregnancies deserve attention regarding this matter, individuals with multiple pregnancies appear to have a high propensity for not only being ill-informed of their miscarriage(s) but more likely not to be informed that fetal loss has occurred. Research illustrates there is a long-standing misconception that informing a patient who is pregnant with multiples of fetal loss (especially early in the pregnancy) may cause increased stress and anxiety when, in fact, the opposite is true. By identifying information that ought to be conveyed or could be conveyed more effectively, patients and survivors may be better equipped with information that can benefit them medically, socially, legally, and more. Moreover, by adequately informing patients of fetal loss, patients may have more trust and confidence in care providers.

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Vanishing Twin Syndrome (VTS), first identified in 1945, occurs when one or more fetuses vanish during pregnancy with multiples (Zamani & Parekh, 2021). The term *vanishing* can be misleading because there are three possible outcomes for VTS patients, none of which guarantee that the deceased fetus(es) will vanish. Depending on several factors, the deceased fetus(es) may calcify and become compressed against the growing surviving multiple(s). In other cases, the deceased fetus may be completely or partially resorbed by the surviving multiple(s).

Reabsorption presents developmental and health risks for the survivor(s) and mother, even when the loss(es) occurs as early as six weeks gestation (Davies et al., 2016; Li et al., 2022; Shinnick et al., 2017; Song et al., 2020). In many cases, women with VTS develop a blighted ovum, a sac that does not contain a living embryo (Zamani & Parekh, 2021). VTS can occur during any trimester but is most common in the first trimester (Evron et al., 2017; Sun et al., 2017). When VTS occurs later in gestation, the potential risks for harm to the surviving multiple(s) and mother are even greater compared to the first trimester (Sun et al., 2017).

Current standards of care surrounding VTS warrant a need for protocol regarding patient information, specifically mandating the conveyance that a woman may be experiencing a miscarriage in a multiple pregnancy. Hayton (2010) demonstrates the need for a policy(-ies) outlining patient miscarriage information protocol for VTS patients. According to Hayton (2010), many providers actively choose not to inform their patients with VTS that they are experiencing a miscarriage. Swanson et al. (2002) and Hayton (2010) argued that if patients are not informed of the loss that is taking place within their bodies, they may not be able to make informed decisions with medical guidance.

Depending on the time of loss in gestation, cause of death, and multiple chronicity, the mother and surviving fetus(es) may be at increased risk for developmental impacts regardless of whether the loss(es) occur during pregnancy (Davies et al., 2016; Li et al., 2022; Zamani & Parekh, 2021). Thus, it is vital that patients receive all information that could potentially impact them, their fetus(es), and any subsequent generations (Császár & Bókkon, 2019; Fjeldstad et al., 2020; Segal, 2017; Seong et al., 2020; Magnus et al., 2017; Yu et al., 2002). Moreover, with the increased use of assisted reproductive technologies and their association with increased VTS rates, the need for more policies surrounding VTS patient care will likely increase (Zamani & Parekh, 2021).

Unlike many patients with singleton pregnancies, patients with VTS may not be informed of their fetal demise, depending on whether the provider believes it will do more harm than good to inform the patient (Hayton, 2010; Swanson et al., 2002). Murray (2012) states that doctors are "required to disclose information if it is reasonable to do so. Essentially, […] a physician is now required to disclose all risks that might affect a patient's treatment decisions" (para. 7). Despite disclosure of information being required for informed consent, providers are not explicitly required to inform their patients that a miscarriage is taking place or has taken place. Most miscarriages during singleton pregnancies are obvious to the patient, but this is not always the case in multiple pregnancies, depending on when cessation of viability occurred in gestation. While pregnancies with multiples (and therefore miscarriage during multiple pregnancies) have naturally occurred throughout history, the increased use of reproductive assistance has begun to highlight this issue.

According to Zamani and Parekh (2021), "[the VTS] phenomenon occurs in about half of pregnancies with three or more gestational sacs, 36% twin pregnancies, and 20 to 30% of pregnancies achieved with assisted reproductive techniques" (para. 1). In the past 20 years, there has been a rise in the use of assisted reproductive techniques as many women are opting to have children later in life (Zamani & Parekh, 2021). If this trend continues, the rates of VTS will also continue to rise as the rate of twinning, in general, has also increased across the globe (Monden et al., 2021). Nonetheless, the numbers for this medical phenomenon's prevalence warrant attention to health policy surrounding its treatments to provide quality care. Lack of protocols for providing VTS patients with information, resources, and assistance is imperative as the negative consequences of improperly handling VTS patients can have multigenerational effects on the unborn surviving multiple(s), mothers, and possibly others (Császár & Bókkon, 2019; Fjeldstad et al., 2020; Seong et al., 2020; Swanson et al., 2002). Thus, care policies and standards surrounding VTS are related to the population's health, as these effects (e.g., psychiatric disorders) could potentially proliferate within the communities and larger populations (Song et al., 2020).

As previously denoted, protocols are needed because many providers are still becoming familiar with VTS due to its limited research. In addition, there is a need to improve general provider communication skills regarding delivering miscarriage information and infant/fetal loss (Brann et al., 2020). Because of the relative novelty of VTS, some provider providers may have misconceptions about the level of perinatal effects caused by the death of one or more multiples in the womb. Thus, in addition to potentially lacking the skills to effectively communicate the difficult topic of fetal loss in a compassionate and informative manner, providers may not see the need to inform their patients that a loss has occurred in the case of VTS.

Numerous studies have shown that more informed patients experience less stress and anxiety (Bolejko & Hagell, 2021; Fischbeck et al., 2021; Legg et al., 2015). Legg et al. (2015) also illustrated that patients who feel informed have more hope. Moreover, informed consent is exercised patients are entitled to choose what treatments may be used on their bodies (Hall et al., 2012). If patients are never adequately informed of what has occurred or is occurring within their bodies, how can they adequately know what treatments they wish or do not wish to undergo?

One example of why patients need to be fully aware and informed of the fetal loss of multiples can be seen with a mother whose twin's DNA was found to be in four locations across her body due to resorption (Yu et al., 2002). Confusion ensued when it was discovered that this mother, who had not been previously informed, could be harboring a twin's DNA, as the DNA of the children she birthed did not match hers. Harvard and the Red Cross launched a joint study where they discerned that her deceased twin was, in fact, genetically the mother of her children- making the woman what is known as a *chimeric* (Yu et al., 2002). Although chimerism occurred long before the advent of advanced reproductive technologies, the rise in the use of such technologies only increases the rates of twinning and, as a result, the rates of chimerism as well (Monden et al., 2021).

A Proposed Model for Enhanced Information Delivery Regarding Fetal Loss

Providing patients with information regarding when, how, and why a fetal loss occurred and the anticipated health impacts for both the patient and fetus(es) and offering additional resources when needed can contribute to better preparedness for health outcomes, strengthen patient-provider relationships, and enhance the overall well-being of the survivor(s).

Thus, the following is a proposed model for enhancing the deliverance of miscarriage information:

1. Inform all patients (whether pregnant with singletons or multiples) that conceptus has formed or been lost within their bodies no matter what stage conceptus may be discovered or loss occurs.
2. Provide information and resources regarding the loss. Such information could include, but not be limited to, information on the loss itself, grief resources, or resources for preserving remains (e.g., funeral homes).

   If the loss is of multiples, the following detailed information ought to be conveyed in order to help providers and patients understand chances for specific risks and equip the patient/survivor(s) with future information they may need for medical, social, legal, or other reasons, and allow patients to exercise fully informed consent:
    a. Chorionicity (i.e., type of placentation) of multiples;
    b. Cause of death in gestation if able to be identified (typically not discernable but most often believed to occur due to genetic abnormalities (Zamani & Parekh, 2021);
    c. Known or estimated timing of cessation of viability.

Limitations

Despite existing and surrounding evidence, more research is needed on the experiences of patients who experience miscarriage and fetal loss, especially those of pregnant patients with loss of multiples. The author of this text is currently undergoing review by an institutional review board for a study that analyzes the experiences of patients with Vanishing Twin Syndrome during their initial diagnosis and subsequent prognosis. However, it should be noted that research in this area can be complex. Ultrasonography, the primary means of identifying VTS, was not of mainstream use in maternal medicine in the United States until the mid-90s.

Therefore, numerous patients were born between the initial VTS discovery in 1945 and the mid-90s. As a result, many patients have been the product of a VTS pregnancy who may not be aware of their VTS status or, if they are somehow aware, they may or may not have ever received a formal medical diagnosis simply due to an absence in technology. In some cases, these VTS patients may have received a diagnosis at birth where, at times, there can be evidence of a deceased fetus or blighted ovum to indicate fetal formation/cessation of viability. Individuals falling into the older population must not be excluded simply due to this inconvenient age-related technological disparity. Good science accounts for all the data, and good clinical protocols are established by accounting for the views of all stakeholders and constituents. Accurate conclusions and inclusive policies cannot be curated when pieces of data or important points of view are missing.

To make matters slightly more complex, protocols for miscarriage information and disposal of fetal remains can vary between hospitals, states, and nations (Forster, 2003). For example, a Catholic hospital may have different protocols for what they define as *life* or *resembling life*, which may determine what type of fetal remain disposal options are presented/available to patients. A brief search on this topic will reveal a global, rather hostile landscape containing legal feuds of patients wanting to memorialize remains but legally being unable to and patients who want little or nothing to do with deceased fetal remains that are legally forced to make arrangements (Nahidi et al., 2021; Middlemiss, 2021; Morgan, 2002; Sheriar, 2020). The landscape becomes crowded with views asserting various defining points for the beginning of life. However, some may argue this is a red herring and what constitutes the definition of *life* or the *beginning point of life* on behalf of the medical system and provider is distinct from what the patient may or may not believe. Nonetheless, the *life* views of providers and the overall medical system in which the patient participates should be considered when analyzing the patient experience during the diagnosis and prognosis of fetal loss, especially in the case of multiples, as these views can have both direct and indirect ramifications that may have varying effects.

Conclusion

Such protocols and policies, as proposed above, can affect patient experiences during pregnancy, at birth, and post-partum as well as the lives and well-being of any surviving child(ren). Thus, any model for enhancing miscarriage information delivery must consider these variances and the extent of their potential impacts. Quality care must be provided for all patients who experience fetal loss, including those who experience loss of multiples, as with VTS patients. Standards of care, policies, and protocols must be established and continuously evaluated to enhance treatment.

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A Unique Approach to Healing After Birth: Blending the Worlds of Birth and Perinatal Mental Health Interview with Jennifer Summerfeldt, Canadian Clinical Counselor

Anita Horvath, MS, MFT

As a therapist passionate about physiologic birth and traditional postpartum care, I have searched for a resonant perinatal mental health approach. I first heard Jennifer on one of the Indie Birth podcasts—she was talking about birth trauma and healing in an unconventional way. What Jennifer shared seemed spiritual, scientific, deep, and comprehensive, leaving me intrigued and inspired to learn more. Jennifer embodies a rich, unique experience that includes many years of practice as a birth worker and therapist. This interview allowed me to learn more about Jennifer, how she merges the worlds of birth and therapy, and the training program she is developing.

Aside from Jennifer's professional credentials, she has over two decades of experience in maternal health and psychology. In addition to being a therapist, Jennifer has been a childbirth advocate, maternal educator, doula, midwifery apprentice, and published writer. As the founder and creator of the Healing After Birth program, Jennifer uses her expertise and pioneering voice to help advance the dialogue on motherhood, mental health, and healing. Jennifer has had many teachers along the path. Whapio has been a seventeen-year mentor and is now an elder to Jennifer. Many others have informed her work, including Bonnie Badenoch, Jane Simington, Joe Dispenza, Byron Katie, Dan Siegel, Gabor Mate, Gordon Neufeld, and Gloria Lemay. Mostly, Jennifer learns from the births she has attended and clients' healing journeys. Jennifer combines her passion for childbirth as an altered state experience with her knowledge of nervous system-informed therapy to bring about a unique approach to healing.

HORVATH: Could you please start by telling us about yourself and your background?

SUMMERFELDT: My name is Jennifer Summerfeldt. I hold a Master's degree in Counseling Psychology. I work as a Canadian Clinical Counselor. I am the founder and CEO of Ask Therapy for Moms, where I run educational training content. I am a mother of three children, two are young adult men, and my daughter is soon to be 18 and about to graduate. I'm married, partnered with a man who also raised three children. We are moving into that next phase of life where we are no longer focused primarily on raising children. It is wild to think that here I am at this stage of my life, and my children are pretty much out of the house. I loved raising my children. I loved the teen years and am loving the young adult years. I feel like our relationship just gets deeper and deeper and closer and closer. I feel very blessed.

I spent many years in the world of birth work. I have a background in traditional birth work, traditional birth attending, or midwifery. I have a background prior to that in peak performance and sports psychology. I've worn many hats, from birth advocate, childbirth educator, doula, trainer, apprentice, midwife, and traditional birth attendant. I feel like I am well-versed in the culture of birth. That is what led to my deep, intimate passion around healing from birth trauma, which is what put me on the map as an author when I wrote my first book, *Healing After Birth*, blending these two worlds—the world of birth with the world of perinatal mental health, and the intersection of all of that.

H: How do we know if birth trauma has occurred?

S: It is about the psychology of the mother. It is about the integration of the birth experience and how the mom adapts to that postpartum period. It isn't necessarily the birth outcome itself that we are measuring as to whether it was traumatic or not. Or whether we as an outsider—a birth worker or a therapist—are looking at the birth storyline and imposing whether or not we think it was a good birth or a traumatic birth, whether the story should be met with elation and ecstasy, or with a lot of grief and disappointment. We can't impose that onto that mom because it is really independent to how they integrate their experience psychologically—how they make sense of it. Also, how well it's integrated into their heart—how they experience it within their emotion center. And then also how their body took it in. That's the somatic experience of it. Those three layers have an impact on how well that mom is going to fare in the postpartum.

H: Through this lens, one can bring so much benefit as a perinatal mental health professional.

S: Correct. I believe so.

H: Why did you switch from birth work to psychotherapy?

S: I never thought that I would end up in the role I'm in today. I didn't enter the work of supporting moms in labor, thinking that I would be a perinatal therapist sometime later in my life. It's a little bit of a surprise to me, although the story, as it unfolds, makes sense. Granted, I did start with sports psychology in grad school in my early 20s—I obviously had an inclination to work toward the psychotherapy paradigm. So, in a way, it's not surprising.

There were a few major factors. I entered the world of birth work because I was extremely fascinated and passionate about understanding why moms seem to have birth experiences that are very interventive and oftentimes harmful and that we now label as traumatic. Or why the cultural norm, as we talk about birth, always includes a huge, almost emergency event that unfolds, and we've just normalized that as how birth is. My first birth experience was so radically different from that conversation—it left me feeling deeply empowered and inspired, and, as I later understood, I kept my instincts intact. The fact that those instincts were supported physiologically or neurophysiologically is a huge reason I ended up parenting the way I parented—I intuitively parented in a way that aligns with what we now know as the attachment framework.

That initial birth woke something up in me. I became very passionate about wanting to support moms in having the best birth experience, the most optimal experience they could have. I was so enamored by the oxytocin and the ecstasy I was feeling. I was like, we all need to feel this. I was young. I was 23. This happens a lot—either moms have an extremely challenging birth experience,e and they get initiated into doula work or childbirth education, or becoming a midwife, or they can enter that portal through an ecstatic birth experience. I entered it through that ecstatic birth experience paradigm and felt like I needed to stand on a soapbox and scream to the world: "There is a whole other way!"

H: Of course, you would want everyone to have this experience.

S: I did, yes. As I experienced, in time, attending births that didn't unfold in a physiological instinctive way, I was mesmerized as to why not? What was coming in the way? And oftentimes, I would internalize it—"It must have been something I did or I didn't do" or "I didn't support the mom and the family well enough so that they could have that birth experience." I've since grown from that point of view, but that motivated me a lot. I was always curious about what facilitated or got in the way of that mother having that physiological instinctive birth experience and what was the outcome of that. I realized it was not just about setting up the right birthing environment. It is what we are often taught in the birth world—if you just have the right environmental factors, if you set up the space well enough so that mom can drop into that altered state and have this instinctive physiological birth...And then moms would internalize: "What did I do wrong?"

In time, I've been peeling back the layers of looking at all the contributing factors that might impact that mom's birth experience. The environment is one of them. Of course, the attendants and the paradigm that the attendants are trained within is another one.

H: That is all external, right?

S: This is all external. What I wasn't taking into consideration at that time were some of the historical pieces of that mom's lineage, of that mom's nervous system, of that mom's psyche. So much of it ends up orienting around how much work was done internally for this mom to be prepared to enter the space of physiological instinctive birth. Granted, not all moms want to enter that space, and it's important to distinguish that. But that led me to get back to my roots of psychology because I noticed—the one thing I was always interested in was the mindset of birth and, therefore, the mindset of the postpartum.

I have had my own experiences and wrote about this in *Healing After Birth*. My third experience, which to mainstream culture would be extreme, was that I decided to have a freebirth with my daughter. Freebirth culture is exploding right now. At that time, this was not a trendy thing to engage in. It was a very personal decision to radically take responsibility for your birth experience. And it required an enormous amount of psychological preparation and physical preparation to understand what it means to enter the field of birth on your own without looking outside of yourself for an expert to take over at any moment. For many people, it would be such a radical shift in course of action. The thought of entering that space without external expertise to handle any emergency that could present is a very scary place to land when you do a deep investigation of it.

H: The preparation is useful regardless of the way you choose to give birth.

S: Right. Labor is a journey of initiation. It is a rite of passage into parenthood or into motherhood. In the Western dominant culture, we have neglected that. We have removed that from the preparation and conversation around what it means to become a parent. We get totally blown open, become completely discombobulated, and then we are left alone in the postpartum. We give birth from an altered state of consciousness in which we are not in everyday thinking, rational brainwave states. In Stan Grof's work, we call that non-ordinary states of consciousness.

So much of the birth culture interrupts the mom's experience of that and keeps them in this everyday thinking reality, making it impossible to enter into that physiological instinctive birthing plane that I was talking about earlier. What happens is we still get blown open. There's still a discombobulation of ourselves that is happening. Whether we are in that huge, expanded state of non-ordinary states of consciousness, or whether or not many interventions are being done to us at such a fast rate and our system is now in a state of survival, stress and shock - we are still being discombobulated. The result is our baby is being born. In that process, we are left to pick up these pieces.

So, you asked me the question, why did I switch gears? Well, because my third birth experience was met with both - this moment of ecstasy, huge awakening, and knowing - I had what they would call a transpersonal experience - and it was also met with terror and trauma. I didn't think you could have a freebirth, which would be met with terror and trauma. Those two paradigms didn't come together before. The belief was that if you wanted to prevent medical intervention or trauma, you would have a freebirth. It was an awakening moment for me. That's what got me deeply passionate about healing after birth. I was on my own healing journey, which got me into this world of trauma recovery, neurophysiology, and attachment theory. So much of what's being taught in the neurobiological field around trauma recovery is the same recipe as what we need for instinctive birth. I'm talking about the work of people like Peter Levine, Dan Siegel, Bessel van der Kolk, Bonnie Badenoch, and later Steven Porges and Deb Dana—all of these foundational folk who brought to the forefront what we need neurophysiologically for well-being and mental health.

So, I linked these two worlds and was, like, "Whoa! This is powerful!" We now have research and evidence in the field of psychology that confirms the need to support the neurophysiology of a mom in labor, not just the physiology. My big dream is to bring the conversation around what it means to support the neurophysiology of the mom in labor and why that's important in the postpartum, long-term health and well-being of that family unit over into the field of birth, obstetrics, and midwifery.

H: So, what does it mean to support the neurophysiology of a mom in labor, and why is it important?

S: If we are supporting a mom in labor and looking at it through the lens of just physical safety, we can intervene with procedures and protocols that, from a bird's eye view, are harmful. We have normalized them as necessary because of our death-phobic culture—safety at all costs. Safety means that the baby and the mom don't die. I am sorry, I am very blunt about this, and don't mean to do any disrespect to life. Of course, we want to support life, but this is not supporting life. It's preventing death at all costs, which means that we're intervening with harmful procedures and practices that leave the mom and the baby in a distressed, traumatized state of stuck survival stress, which then impacts the ventral vagal nerve, which is responsible for connection, bonding, and social engagement. If that mom's nervous system is not considered in preparation to and during labor and delivery, then they are at risk of having a rocky postpartum.

Speaking from the disordered lens, it's going to show up as postpartum depression, postpartum anxiety, PTSD, even postpartum psychosis. And then the mom will think, oh, there's something wrong with me. As therapists, psychologists, or psychiatrists, we meet the mom at that stage and look at the symptoms that are presenting in the postpartum. Often, we don't consider this broader context: how is this mom's nervous system doing? What were the contributing factors that might have alarmed that system throughout the childbirth continuum?

H: It can be anywhere on the continuum, right? There are women who had amazing birth experiences, but then, for example, didn't have the right support in the postpartum. And they spiraled down.

S: Correct. Yes. When I say *the childbirth continuum*, I'm referring to the time from conception or leading up to conception until that postpartum period is done—there's an argument as to when that is, but let's say at least a year. It's not like we ever go back to who we were pre-children. We are not siloed beings. We are relational beings. Therefore, what our whole lineage is carrying can show up at any point. There may not be any markers throughout the childbirth continuum; it could extend beyond that. You want to get a very comprehensive history. But, oftentimes, there are markers within the childbirth continuum that initiated something. And that can link back to historical material that maybe was nicely stored away for a while. And because of the initiating factors or the whole experience of birth, it lit up in the system.

So, to answer your question, why does it matter? Because if we understood this better and knew how to support the neurophysiology and well-being of the mom in labor, we might reduce the need for medical intervention. Because we could learn how to help that mom shift state from survival stress to what I call thriving, or, we could say, the ventral vagal state, and be able to titrate between that. We know we can't give birth from a state of survival stress. Biologically speaking, our nervous system takes that information as a potential threat, and it shuts down labor on purpose until that organism, that mammal, can go and find safety. Or, if you are about to give birth, it is going to speed it up so that there is this sudden fetal ejection reflex for the birth to complete itself, and then you can go find safety. Our system is intelligent, so let's work with our system instead of against our system. Because then the long-term benefits, I hope, would mean better mental health, better relational connection, more access to joy, and more access to supporting the health and well-being of our offspring. And we could only imagine the ripple effect of that. That's my theory.

H: You mentioned the disordered lens. What is the lens you view postpartum mental health problems from?

S: Maybe disordered is a harsh word, but I'm referring to our biomedical model of looking at mental health or mental illness through a particular lens, which we label based on the DSM.

H: They are called disorders. So, I guess it is a disordered lens.

Correct. And through that lens, we are grabbing bits and pieces of information to highlight the symptomology. Then we are going to treat the symptoms based on whatever evidence-based modality we want to choose from. That is typically how it works and can include medication.

The other lens that I see through is more holistic. It includes the nervous system and is very trauma-informed. It also includes the transpersonal and the psychospiritual. Here we are seeing through a bigger, broader lens. We are also seeing it through the systems approach, which is that we are not just siloed in our experience—it is also influenced by our environment. Taking into consideration epigenetics, for example. Ideally, first and foremost, we need to know why this mom's nervous system is trapped in a survival stress state. That is what we would call trauma—a system has not completed that survival stress response, has not completed it biologically, but maybe also psychologically. So, integration is paramount here, and integration includes the completion of those cycles, and then the reunion.

It's like weaving it all together so that this mom can make sense of that journey that they just went through. And that sense-making makes it meaningful to them. Now it wasn't just to get to the end of having a baby, but there is a deeper meaning in it. I have become something. There is purpose in that. And there is a purpose for me to become the best version of myself so that I can transmit that to my children. And this is why it is so important that integration is part of the postpartum. I see it as what is lacking for so many moms. I can go into a gazillion reasons why moms are suffering in the postpartum. But it is one of the reasons that there is a lack of care and consideration around the journey of birth, motherhood, and parenthood, and the value in that role.

H: As a psychotherapist, could you tell us more about your approach? It sounds like it is different from the more mainstream, top-down approaches. A client comes to you, and says, I am suffering. How do you go from there?

S: First, I see that mom's experience through the lens of trauma-informed care, trauma recovery, and the lens of the nervous system, what I call nervous system-informed care. I hear the story, but I do not put a lot of attention onto the story. Initially, my attention is more on how this mom's system is integrating, where it is stuck, and on getting into what might have happened and what could have contributed to this mom's experience. Why is it that they're expressing these symptoms in the postpartum? The symptoms are the tip of the iceberg. Now, moms come in because they're struggling with those symptoms, which are horrendous. So, this is not to minimize the symptoms. If the mom is coming in with intrusive, dark thoughts, suicidal ideation, deeply low self-esteem, lack of confidence, can't sleep at night, terrified that something bad is going to happen to their baby, constantly in high alert - that mom is suffering. We know that mom's experience at postpartum is a nightmare.

So, I don't want to minimize that experience for them. Of course, first and foremost, we lean in with compassion into that experience. Typically, I'll get a sense of what's happening for the mom. I'll really listen. So, going into that therapy mode of being a deep listener, being curious, lending an ear, doing reflective listening... "What I'm hearing is you struggle with..." As therapists, I hope we are good at that. The mom feels seen, the mom feels heard. And then I'll often say, look, here's a different lens. Are you interested in hearing a bit more about how your nervous system might be contributing to the symptoms that you are experiencing? And most often moms say, yes, absolutely.

H: Takes so much blame off of the mom.

S: A hundred percent. In that initial session, I'll get a good sense of what the mom is struggling with. I might ask questions about their birth, pregnancy, or conception experiences. Because there could be a story of multiple miscarriages or fertility challenges. That all plays into it. But I don't want to go deep into their story initially. I just want to get a sense if there are any markers there that could have been high-stress points or potentially traumatizing that are contributing to the experience. Once we gather that information, typically, I will introduce the nervous system-focused approach. When I lay that out through psychoeducation, immediately, the mom has an experience of relief. There is an obvious sigh. I recognize that we are not just healing the nervous system as an isolated biological marker. The nervous system is deeply interconnected to our biological experience as a mammal. But we also have consciousness, this whole field of our inner world, the psyche, however you want to call it.

So, I'll say to a mom, we are going to work with your body first. We are going to help to befriend—that is a word often used in polyvagal theory—your system, learn how to be okay with your felt experience within your biology, it is alarming you for a reason. We will work to discharge some of that extra stress that might be trapped (they are usually excited about that). I'll say, then we need to work with your heart. We need to work with the emotional material that is showing up, which is often grief, anger, frustration. So you can get to the place of love, of feeling excited and happy, joyful to receive your baby. So many moms don't feel that joy or love, and there is a reason, and it is a biological reason: they are stuck in survival stress. And survival stress means the emotions of anger, fear, despair. We want to be able to clean that out, so you can access what is right there in your system, hasn't gone anywhere, it's just a little bit on pause right now. And then you can move into that heart space, which is deeply healing.

Then we want to work with the cognitions, the mind—how you make sense of your birth, the birth story, the narrative. We bring it all in. And, depending on the mom, we can tap into the transpersonal, the spiritual, because this is a spiritual journey, however you want to call it. We can use whatever language you want, but let's not ignore that something else is happening too. Depending on the moms' spiritual beliefs, we can bring in their language, so it becomes deeply meaningful for them. So, I have mapped that out in something I call the therapy map. And it's a journey that we go through, that really taps into all those areas. It is comprehensive, humanistic, holistic, and very much geared towards the specific, unique needs of that mom.

H: You also teach students, and offer trainings to childbirth practitioners and therapists.

S: I have multiple training offerings because, as you can see, I like to think about a lot of things, and my passion truly is imparting information. I love being able to talk about this stuff. I want more people to have access to this information because not everybody is going to be a therapist and a birth worker.

H: You serve the perinatal population from childbirth, trauma, and nervous system informed paradigms. How do you weave in childbirth education into psychotherapy?

S: When I say childbirth informed, that means I understand the different paradigms of birth, of how caregivers are trained within those, of what moms are looking for, depending on the kind of paradigm that they're choosing to give birth within, and the impact that that might have on that mom. So, for example, a mom who, let's say, is planning to have a freebirth and has taken all the coursework to prepare for that and end up in the hospital with a cesarean. That's a huge leap to go from one paradigm to another. And culturally, they are still met with the imprinting of "But you should be happy that your baby is okay." That is still there.

As a care provider, as a psychotherapist, if we don't understand the paradigm of freebirth, we will come in with many assumptions and biases. We might even think that mom was crazy for making that decision. We might have unconscious thoughts or biases around it: "Well, thank goodness they went into the hospital for a cesarean section because their baby could have died. How can they not be okay with that?" And then what happens is that bias, that lens comes in between you and your client, and you are no longer walking alongside your client. It is important to become aware of your biases and how, if you have given birth, it has shaped the way you show up to be with the moms in the postpartum.

H: So much countertransference work.

S: So much! And I don't even think we have begun to talk about it. As the perinatal field is exploding, thanks to Postpartum Support International, I don't think that we give enough emphasis in this area in terms of the impact of the birth, the different paradigms in which moms and families are choosing to give birth within, and the impact all of that can have on the mom making sense out of their birth experience in the postpartum.

H: It is hard not to have biases around birth. How do you handle them? For example, someone says to you, I choose to—I want to have a cesarean. I, personally, feel triggered right away. How do I, as a therapist, with my strong biases, navigate that in the space where my client is supposed to feel safe and accepted?

S: I think you nailed it. That would have been my bias initially as well. And I had to work through unpacking my understanding of how trauma can shape our decisions and how for a mom choosing to have an elective cesarean, for example, can be incredibly empowering. So, you ask yourself how do I become conscious of my biases? First of all, I notice when I'm activated or triggered, or if I immediately want to interject something or challenge their decision-making process, or if I immediately assume they will have a certain kind of experience because of that. That could be me assuming they are going to have a challenging experience for both themselves and their newborn by having an elective cesarean, let's say, or by choosing to go in and get pitocin. I might immediately assume the kind of experience they are going to have. That would be an indicator of a bias. The flip to that would be, for example, you are with a client, and you hear them say, I'm freebirthing, and you right away think danger or immediately project onto them that there's bad things that are going to happen, and you bring that into the therapeutic space.

Let's say a mom is saying that they want to give birth in water, and you know nothing about water birth, and you assume it is unsafe. We might make assumptions about their outcome or project our own fears onto them. Please, let's not do that. As therapists, we know this already, but it is surprising how much can come up around the birth world. We are working with moms in the postpartum. It is imperative that if you want to be working with moms prenatally or postnatally, you need to do your own work. You need to heal your own experiences of birth and become aware of your biases. That doesn't mean that you have to accept it.

When we become aware of our biases, it doesn't mean that we suddenly have to be okay with freebirthing. I may not be, but I have to be aware that that is going to come into the therapeutic space. And if I can't manage that by dropping my own lens and being super curious, walking alongside my client, gathering information, entering their world, if I can't do that, then I know there is still work that needs to be dealt with. The beauty of being a therapist is that we are always doing our own work.

H: In the training program you are developing, you are going to teach about different paradigms of childbirth. Please tell us about it.

S: It is in its infancy. I want to do it justice. There's a lot of trainings out there. I want to make it so that it is a training we want to engage with, that it is very healing for us and provides us with the information that we are looking for. The childbirth side of it is gathering enough information, so that you have a good understanding of the different paradigms you are working through, your different fears and biases, that you even have an opportunity to do deeper release work around that through the cohort. That would be ideal in my world. Also, we are going to look at how to gather information, do research, what to expect through a biomedical model, and what to expect through a traditional midwifery model. We are going to understand the culture of birth to look at things like the professionalization of midwifery and what happened there.

There is so much about the politics of birth that people don't understand. We are going to look at how the birthing culture was shaped by the industrial, what we call the industrialization of medicine, and what happened in that process, how that disempowered the family, how that disempowered the woman to give birth as a rite of passage. How we suddenly shifted from knowing that we are capable of birthing to looking outside of ourselves and needing to be saved by technological advancement. We will look at it through a feminist lens—nowadays, this word might ring differently for different people—but I think we need to look at it through that lens. I think we need to look at the history of the Inquisition and the burning of the witches, the burning of the midwives, the impact that had on where we are today in the world of birth, and how all of that comes into play in that mom's postpartum experience. If we don't hold that knowledge, we can't understand the complexity of what is happening, and it can't necessarily just be treated with cognitive behavioral therapy.

H: Can you share a little bit more about what else will be in your perinatal mental health training program?

S: So, what I described is the starting point. My hope is people could do it as an offshoot if they want. What I mapped out to you as to how I orient with a client uniquely; the therapeutic map. I have broken that down into different stages, and I have teachings on each of those stages so that it becomes a frame of reference that you can start to see and orient through as a therapist. Considering all of those parts I mentioned before about the body, the heart, the mind, the psychospiritual, the transpersonal. Learning how to walk along the healing journey with this mom. It helps us be able to anchor, phase by phase. As Dan Siegel says, we know that we have integrated and healed when we have a coherent storyline that has a beginning, middle, and end. The therapeutic map takes that into consideration.

And the endpoint is what I call the celebration phase. In therapy, it's nice to mark that end even if we have multiple beginnings, middles, and ends. We can always start over, but let's at least make it digestible. Within that, I've developed my own modality called Flowing Fears. I've been working with and tweaking it over the past five years. That's embedded into it, but it's also its own thing. I'm most passionate about the Flowing Fears healing modality. I love using it, I love teaching it, and going deep into each of the ten steps. Again, it is nervous system-informed, trauma-informed, it's mindfulness-based, it's got all the goods of all the different modalities, and it was an inspired method that came through my own healing journey. So, those three components are part of the program. And then, if I were to wave my magic wand, there would be mentorship built in. As a therapist, having mentorship is so valuable.

I love moving into those spaces with other practitioners who are passionate about embodying this information, case conceptualizing, and holding space for you to go deeper into your own healing by embodying some of these tools and techniques. This is not just knowledge-based learning, it is heart-based, embodiment learning. That's what I want to do more of. I do it on a small scale right now; ideally, that's the world I want to enter.

H: This sounds amazing. Sounds like a dream come true training program.
S: Thank you. I'm still pulling pieces together. It's been a very creative process - obviously, 23 years of unfolding.

H: There is a lot to share!

S: There is a lot to share.

H: How does the baby come into all this?

S: I'm still in my infancy when it comes to the research aspect of it. I started training with Stan Grof. For those of you who don't know of Stan's work, he is very well known for holotropic breathwork but also for the perinatal matrices. The theory is, and this is based on some of the founders of Western psychology that branched away from Freudian and Jungian approaches, that we are deeply imprinted by the birth experience itself, insomuch that how we come into this world impacts much of how we think, feel and behave. That is the foundational theory behind perinatal psychology. That's very much what that whole field was about - how the environment in utero, birth experience, and immediate postpartum affect the baby and, long term, how it affects their well-being.

We know through epigenetics and some of the science of neurophysiology that when a mom is experiencing high stress or chronic stress when the baby is in utero, the baby is getting a lot of that adrenaline and other stress hormones. That is encoding the baby with what Dan Siegel talks about - their window of tolerance—the capacity to tolerate stress. We are all interconnected within the field in which we are in. This often leaves the mom feeling like they did something wrong and bad. So, I am careful about that. Within the field of perinatal psychology, it is easy to talk about the environment the baby was incubating within, the birthing experience and the impact on their well-being.

We have to remember that there are so many contributing factors to why that environment might have been stressful and that the mom didn't do anything wrong, physiologically, by being in a stress state that would have impacted their baby. That's just a biological norm. Your body is going to respond accordingly. So, I am careful with how we talk about it. But the point is that there is a symbiotic field. We could call it a psychological or an energetic soup in which that mom and that baby are one. They share a nervous system in a way. They are sharing information. They are sharing everything. For the first two years, that whole space is a shared space.

H: Some say even longer.

S: We could argue that we never stop sharing this space, of course we don't, because it is all energy and information, and that's what we are. But let's just say two years for the purpose of psychology. Therefore, we can't really look at it through the lens of a mother or baby. It is just one. It is one unit. Of course, the experience that the mom has in conception, labor and delivery impacts the experience that that baby is going to have.

H: And postpartum.

S: Exactly. I am starting to bring it into the conversation more. There are a lot of psychological modalities that came out of that lens, like family constellations and holotropic breathwork. And there are some modalities in which the idea is to go back to your primary experience of being born and relive that, so you can create a new imprint. That isn't the work I do. When I work as a perinatal therapist, I'm not doing the work of bringing people back to their primary imprint of being in utero. Although we know that through different healing modalities, we can get there, and it most likely will present, and we do encode that birth in ourselves, that embodied memory is there. Part of our healing might be going back to needing to release that because there could be trapped energy there. But if the mom and family do their healing work, it changes the vibration, it changes the frequency of that field, and therefore the child, the baby, heal in response to that. The younger the child is when you're doing it, the better, but it's never too late. Every time you as the parent shift, you will most likely see a shift in that relationship and in your child.

H: What else would you like therapists who are interested in your future training program to know?

S: I'll keep offering the free webinar.

H: Would you like to say a couple of things about it to our readers?

S: The webinar is an introduction to what I've highlighted as ten potential biases that, as a perinatal therapist, you might be bringing into the therapy space. You can always start there to get to know a bit about my point of view. On our website www.therapyformoms.ca, you can sign up for future training. You go on a waitlist, and we will be contacting you that way. You can email me if you have any questions. I would love to get a cohort together to know that there is interest. Ultimately that’s the first step. I also offer the nervous system-informed doula training for birth providers. I also offer private mentorship. I love working with therapists, and I love working with midwives, doing critical incident debriefing, for example. This is what I am really passionate about.

H: Your work is so valuable. Thank you very much.

S: Thank you for reaching out.

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Review of *Robbie's Reader: Vignettes of My Magical Life*

By Robbie Davis-Floyd, PhD
Review by Thomas R. Verny, MD

I met Robbie at the first International Congress on Pre and Perinatal Psychology in 1983 in Toronto. At that time, she was already well-known as a cultural and medical anthropologist with special interests in childbirth and midwifery. Gradually, Robbie became more active in APPPAH, lecturing at many of our congresses, joining the board for a time, and publishing several papers in JOPPPAH. She recently offered a five-week course for APPPAH students called the "Anthropology of Birth."

In her recently self-published book, *Robbie's Reader: Vignettes of My Magical Life*, we learn that her interest in studying births in different contexts and parts of the world was triggered by her birth experiences. In her academic work, Robbie has argued that midwives play important roles in safeguarding positive outcomes for childbearing people, substantiating her reasoning with scientific evidence. Birth workers, childbearing people, and academics within and outside of the humanities and social sciences have relied on her groundbreaking book, *Birth as an American Rite of Passage* (1992, 2003, 2022), and her edited collection *Birth Models that Work* (2009) to better understand how we think about and learn about birth via various cultural lenses. Since 1983, she has given over 1,000 presentations worldwide at universities and childbirth, midwifery, and obstetric conferences. She has become an icon in midwifery circles.

Robbie is not exaggerating with the subtitle of her book, *Vignettes of My Magical Life.* Her other writings have been academic, yet, she takes us on a retrospective journey through her personal life in this book. Robbie has filled this book with fascinating vignettes that include her autobiography, a chapter describing her father and another on why she loves the strength of men, her Eulogy for her mother, experiences of her two births, funny and not-so-funny stories about her son Jason, lots of good mom and bad mom stories, and descriptions of her many experiences in Mexico, where she worked with two shamans and participated in the Gurdjieff Work. Her travelogues take us to some countries where she has given talks and had magical experiences.

Of course, her life was not without disappointments and trauma. The two most painful incidents involve her divorce from her second husband, Robert Floyd, who was occasionally abusive, and the death of her daughter, Peyton, in a car accident at age 20. She tells us about her cocaine addiction and how she managed to stop using it, the fire that destroyed her cherished home of 30 years, reconciling her own internal biases, and her experiences in rehab at the famed Sierra Tucson, where she was diagnosed with and successfully treated for trauma, anxiety, and depression.

This book balances the pain and the joy that has characterized her life, yet mostly focuses on the magic that Robbie feels has permeated that life. Her writing is vivid, accessible, and clear. It is personal. While reading, you sense that she is right beside you, talking to you about her many adventures. The last chapter's title is self-explanatory, "On My Life as It Is Now, on Being Exiled from My Family, and on Healing from Breast Cancer."

This brilliantly illuminating, multilayered book presents a colorful cornucopia of personal reminiscences combined with keen intellectual observations. Undeniably compelling.

To order this book, please email Robbie at davis-floyd@outlook.com

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Review of *Lullaby Wisdom: The Stories, The Songs, and the Science of Soothing*

By Licia Claire Seaman

Review by Stephanie Cloutman, RN, BSN, CPN, CLC

Licia Claire Seaman's *Lullaby Wisdom: The Stories, The Songs, and the Science of Soothing* describes how lullabies can optimize brain development. Seaman applies her certification in interpersonal neurobiology and background as a musician to assess how the lullaby can help the health and well-being of babies. She writes that human brains are wired to defend and protect themselves for survival. By creating enough feelings of safety for the baby—e.g., through the lullaby—the caregiver can help the baby's brain move beyond defending against danger when activated to learning and wiring other capacities, such as those for more complex social and cognitive functioning. Seaman argues,

> Babies default nervous system is hunting for danger. We all have this automatic danger- detecting system for a lifetime. So the big challenge is to reduce threat, and/or feelings of danger. Being safe is more than someone telling us that we are safe, it is the feeling of safety from inside. (Seaman, 2022, p.7)

The book includes many examples of soothing and clear and accessible explanations of the neuroscience at play as a result and the impact on the developing brain. In one example, the author shares how caregivers can support the prefrontal cortex development in their baby because it is quite unfinished at birth. The degree to which this part of the brain develops depends on interaction with the outside world and other humans. Seaman writes,

> We know internally how to frame the structures (of the prefrontal cortex) in three to five years. How? Well, our needs are fairly simple, and yet not always available. We need safety. Nerve pathways are laid in with safe, warm human interactions. Imbued with love's nourishment, the prefrontal cortex grows rapidly…When Baby feels safe, they grow phenomenally quickly, setting capabilities for a whole lifetime.
> (Seaman, 2022, p. 6-7)

Warm, loving, and supportive interaction through singing is one way caregivers can bring the feeling of safety and support to both themselves and their baby. Seaman has compiled lullabies from around the world in this song-filled book. The author begins by introducing information regarding the science of soothing babies, including the impact of playing, touching, talking with, listening to, and sensitively responding to the needs of babies. The bulk of the book contains lullabies and is easily digestible because of how it is compiled.

Seaman introduces each song by sharing a short story about where it originates, followed by what is happening in the brain for the baby and caregiver, including the impact on development and capacities later in life. There is artwork in the form of watercolor illustrations by Peggy Dressel alongside each lullaby, complete with chords and a link to listen online.

This book explains to caregivers why developing and honing their capacity to support a baby lovingly is valuable. It does this by highlighting not only what is happening in the moments of soothing but also by explaining the powerful long-term benefits that loving and attentive connections have on the developing brain and the future capabilities that those neuronal connections will afford the human later in life.

The value of sharing the science and practical tools in an accessible way could be especially valuable in cultures where many do not have access to the wisdom of their ancestors and in cultures that do not overtly value intuition as a source of information. The clear and accessible education presented in this work could support humanity's maturation and contribute to developing compassionate societies.

Lullaby Wisdom is a valuable companion for anyone who loves or cares for a baby as they endeavor to support their optimal development and for those who want to receive or offer soothing through song, despite age. This book's practical application is one of its great strengths. It offers valuable information about how and why time spent connecting, playing, singing, and being soothed by a loving caregiver is important for a baby's brain development and future. The value of lullabies, with and without lyrics, some just with sounds or humming, is abundant and can be used immediately. This information can educate those outside of the scientific community and offer inspiration and motivation to support babies in effective and lasting ways.

Lullaby Wisdom: The Stories, The Songs, and the Science of Soothing (2022), by Licia Claire Seaman. Peaceful Pear Publishing. 100 pages. ISBN-978-0-578-31613-0; ISBN-13: 978-0-578-31614-7

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American Indian and Alaskan Native Maternal Mental Health

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While mothers of any race can face mental health conditions during pregnancy and after childbirth, American Indian and Alaskan Native (AI/AN)[7] women experience higher rates than the average population (Foley & Strunz, 2022). Though the body of research is still growing in the United States, initial data on the prevalence of maternal depression for AI/AN women in the United States ranges from 14-30% (Heck, 2021). Studies based on international Indigenous populations suggest that Indigenous women experience an even greater risk for maternal depression and anxiety: Indigenous women experience depression 87% more often than White women (Black et al., 2019) and experience maternal anxiety 37% more often than non-Indigenous women (Owais et al., 2019).

Maternal Death

Pregnancy-associated deaths disproportionately impact AI/AN women. Indigenous women have much higher rates of pregnancy-associated drug-related death and suicide than other racial or ethnic groups (Margerison et al., 2022). Based on a review of pregnancy-related deaths among AI/AN people, mental health conditions and hemorrhage were the most common underlying causes of death, accounting for 50% of deaths with a known underlying cause. Most pregnancy-related deaths of AI/AN people (93%) were determined to

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[7] A report from the Centers for Disease Control and Prevention (CDC) uses an approach for classifying AI/AN populations, including those who also identify as multi-racial or of Hispanic ethnicity (Trost et al., 2022).

be preventable. About 64% of deaths occurred seven days to one year after pregnancy (Trost et al., 2022).

Trauma: A Contributing Factor to Post-traumatic Stress Disorder (PTSD)

AI/AN people have almost twice the percentage of lifetime PTSD than White people (Emerson et al., 2017). This can be attributed to historical trauma from forced relocation and the prohibition of cultural and spiritual practices, leading to high levels of multigenerational psychological distress. One study found that the historical relocation of AI/A) people can elevate multigenerational risk for developing substance use disorders and increasing depression in female caretakers, perpetuating a cycle of trauma sometimes labeled as intergenerational PTSD (Walls & Whitbeck, 2012).

Intimate Partner Violence (IPV)

Research shows that AI/AN women experience the highest rates of intimate partner violence (IPV) and homicide in the US (Campbell et al., 2021). Intimate partner violence is a substantive risk factor for depression, PTSD, anxiety, and suicide (Ellsberg & Emmelin, 2014).

Inequities and Systemic Racism Lead to Stress and Adverse Outcomes

Researchers have found that racism, rather than race, increase the risk for distress, as increased stressors and the cumulative experience of historical trauma due to relocation, violence, and genocide negatively impact physical and mental health (Solomon et al., 2022). Gestational age at birth and gestational weight are two of the strongest indicators of long-term wellness or potential impairments for a newborn child. Indigenous women are 62% more likely to give birth prematurely than White women, leading to higher rates of low birth weight and developmental delays (March of Dimes, 2022).

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