The Value of Art Therapy in Antenatal and Postnatal Care: A Brief Literature Review with Recommendations for Future Research

Key words: art therapy and motherhood; arts and maternal health; arts and post-natal care; birth trauma and art; maternity and art; childbirth and arts-based support.

Prof. Susan Hogan, Prof. David Sheffield & Dr. Amelia Woodward

Synopsis

There is a very small body of literature addressing the use of the arts or art therapy in antenatal and post-natal care, and much of it is qualitative, including some rich and complex data which is worthy of discussion and consideration. Overall, it points to a promising use of supportive and therapeutic arts in this area. This article presents some background on the use of the arts specifically focusing on post-natal depression and birth trauma. It then moves on to present a brief survey of literature in the field, followed by some further reflections and discussion about further research needed to establish clinical utility and economic viability.

Background: Post-natal depression (PND).

By 2020 the number of births in England is predicted to increase to 691,038 per annum. Around 87% of women give birth in hospital-based obstetric units today, whilst survey evidence suggests that the vast majority of women would rather have a homebirth or use a midwifery unit (National Maternity Review 2016 p.20). Rates of maternal mortality have fallen to around 9 deaths per 100,000 births in the UK, with a significant cause of maternal death in the UK being suicide (Cantwell et al. 2011; Oates 2013, National Maternity Review 2016). Mental ill health is acknowledged as the largest cause of disability in the UK and post-natal depression (PND) is a significant public health problem (Downey and Coyne, 1990; Almond, 2009; Oates *et al*., 2004; World Health Organisation, 2010). Conservative estimates suggest that postnatal depression in England and Wales costs the NHS at least £45 million per annum (Knapp et. al., 2011). More recent figures for perinatal depression, psychosis and anxiety, posit a much higher global figure, with long-term costs at £8.1 billion per year in the UK (Bauer et al. 2014). Of these costs, nearly three-quarters (72%) relate to adverse impacts on children; the total figure equates to around £10,000 for each birth (Bauer, 2014, p. 1). Moreover, it is estimated that about half of all cases of perinatal depression and anxiety

go undetected. Almost one in five women said that they had not been asked about their emotional and mental health state at the time of booking, nor about past mental health problems and family history (NPEU Safely delivered, 2014).[1]

Unresolved or distressing birth experiences appear to be one of a number of precipitators of post-natal depression (PND) – this is particularly troubling given that the current UK NICE guidelines for perinatal mental health suggest *not* routinely offering a birthing debrief following a traumatic birth (Gamble & Greedy 2007; Hogan 2012; NICE, *Antenatal and postnatal mental health*, 2007). There is a lack of consensus about the cause of PND, and the complexity of contributing factors is one justification for further research. It is possible to recognise a number of psychosocial risk factors for both antenatal depression and PND (Lancaster *et al*. 2010). Antenatal anxiety or depression, lack of social support, experience of domestic violence, a history of depression and stress during pregnancy all increase the likelihood of a woman experiencing significant depression in the postnatal period (Robertson *et al*. 2004; Musters, McDonald and Jones 2008; Howard *et al*. 2013; White et al. 2006). In the UK at present, almost half of pregnant women and new mothers do not have access to specialist perinatal mental health services and only 3% of clinical commissioning groups have a strategy for commissioning perinatal mental health services (Bauer et al. 2014 pp. 3-4).

Trauma

Around a quarter of women may have symptoms of psychological trauma following birth and some actually experience post-traumatic stress disorder (PTSD) (Czarnocka and Slade 2000). With reference to post-traumatic stress disorder (PTSD) associated with childbirth (Ballard *et al*. 1995), recent research suggests at least 2.5% of women may meet the criteria for full PTSD after giving birth (Ayers *et al*. 2009). Birth trauma responses and postnatal depression can co-occur (White *et al*. 2006). Ayers suggests there is no simple causal correlation between trauma and mode of birth, and cautions against assuming a clear-cut relationship between birth trauma and interventionist birthing practices (2003; 2004). However, aetiological factors related to postnatal PTSD include a traumatic birth, mode of delivery and perceived or actual low support levels during the birth itself (Ayers, 2004; Bailham and Joseph, 2003). Czarnocka and Slade (2000) suggest that ‘Perceptions of low levels of support from partner and staff,

patterns of blame and low perceived control in labour were found to be particularly related to experience of post-traumatic stress symptoms' (p.35). Unresolved trauma is *probably more wide-spread than statistics suggest* since it is not always recognised or reported or, as noted above, results in or is misinterpreted as PND. The National Maternity Review (2016) suggests that around half of all cases of perinatal depression and anxiety may go undetected (p16). Indeed, current classifications 'may not adequately address the range or combination of emotional distress experienced by mothers' (Coates et al. 2015 p.1).

Maternal Mental Health and Links to Child Development

Effects of poor maternal mental health can have an impact upon foetal, child and adolescent health (NICE, 2007). Prenatal anxiety has been strongly linked to possible later child and adolescent mental-health problems (O'Donnell et al, 2014). The National Institute for Health Care Management states:

'Pregnant women with depression are 3.4 times more likely to deliver preterm and four times as likely to deliver a baby with low birth weight than non-depressed women' (NIHCM, 2010, p. 9).

The NIHCM summarises the potential effect on babies and children:

'Maternal depression threatens a mother's emotional and physical ability to care for her child and foster a healthy relationship with her child. Research has found that a secure attachment, or healthy emotional bond, between an infant and primary caregiver is key to the future emotional development of the child... Children born to a mother who suffers from postpartum depression are more likely to lack this attachment and are therefore be at increased risk for delayed or impaired cognitive, emotional and linguistic development. Children of depressed mothers are also more likely to experience worse long-term mental health problems' (NIHCM, 2010, p. 9).

Influential and widely cited work claims links between poor maternal mental health and adverse effects on infants - Lynne Murray and Peter Cooper's 1997 writing on PND and infant development, for example, is widely cited in later works on the subject and explores links between PND and slower cognitive development, and PND and poorer

quality emotional development with infant attachment or behavioural issues. They also explored the mechanisms by which this occurred, looking at direct and casual factors (child exposure to maternal depressive symptoms or parenting difficulties) or indirect elements (such as 'environmental adversity'). More recently, pathways linking poor maternal mental health, poor child physical health and later adolescent poor mental health have been developed (Raposa et al. 2014). Furthermore, children who experience maternal depression early in life may experience lasting effects on their brain architecture and ongoing disruptions of their stress response systems. Studies of children of depressed mothers show patterns of brain activity that are similar to those found in adults with depression (Dawson et al., 1997).

Although there is a large body of research that has documented the association between maternal depression and adverse outcomes in children and reviews of this literature have been undertaken (Downey & Coyne 1990; Weissman et al. 2006; Misri and Kendrick 2008), less is known about new mothers' general sense of wellbeing and the implication of this for child development and this is a subject worthy of further enquiry. The formation of a strong bond between mother and child has been identified as crucial for more positive parenting behaviours and improved developmental outcome of a child. However, a number of factors related to a mother's wellbeing have been identified as barriers to an effective bonding process (including a traumatic birth, maternal stress, presence of maternal pain, insufficient social support, or lack of support from the woman's partner with the child (Bicking, Kinsey & Hupcey, 2013; 2014). Thus, the maternal social environment and maternal emotional availability is thought to be related to the ability to form a strong relationship with one's infant. Furthermore, a systematic review examining the relationship between maternal psychological distress and infant development demonstrated that four developmental domains in infants from birth to one year age were adversely influenced by maternal psychological distress. Postnatal distress was found to contribute to both cognitive and socio-emotional delay and all forms of maternal psychological distress (stress, anxiety, depression, psychiatric diagnoses) were implicated in poor infant development (Kingston et al., 2012). Furthermore, postnatal depression in women has been clearly identified as a risk factor for depression in male partners in an Australian study (Condon et al. 2004 p.57).

Social Support with Mothers

Social support groups - social support during the first 6 weeks post-partum is shown to have positive effects on maternal mental health (Leahy-Warren et al 2012). Timely intervention is noted as crucial to lower the risk of PTSD and can have salutary effects on personality and overall functioning (Bowman 1997). Beck noted there was limited follow-up of women after birth, lack of screening during pregnancy for vulnerability factors and understanding of PTSD (2004). Given that pregnancy and childbirth are very important factors in many women's lives, and potentially extremely destabilising, there are few routinely available support services for new mothers despite cogent research findings which show the manifest long-term potential benefits to both mother and child of such provision (Oakley 1992; Oakley, Hickey and Rajan 1996; Maselko et al. 2011) as well as guidelines which acknowledge a pressing need for further research evidence into this area (NICE *Postnatal care*). Furthermore, a qualitative systematic review, providing a meta-analysis of 59 studies from diverse cultures on the topic of postnatal depression concluded that 'the most desired treatment' by mothers was someone to offer *empathetic listening*: 'Having someone to talk to' and 'talking therapies' with health professionals if their assistance was sought were universally expressed as a treatment preference in a cross-cultural study incorporating 11 countries (Dennis and Chung-Lee 2006, p.327; italics added). The study concluded that, 'Support groups may be particularly valuable because they enable depressed mothers to offer support and to share their experiences whilst also assisting them to learn effective ways to deal with their emotions and to cope with their new roles' (p.329). This points to group approaches as of particular value.

The efficacy of individual postnatal 'debriefing' by midwives has been questioned (Ayres et al. 2006). Evidence is mixed. Creedy et al. (2005) found, in an RCT with women's experiencing psychological trauma, that a brief midwife intervention (consisting of a discussion within 72 hours of the birth and a follow-up telephone call four to six weeks post-partum) was effective and that the intervention group experienced decreased symptoms of trauma and depression and less self-blame. Bailey and Price (2008) in a small-scale qualitative study, based on a midwife led service, called Afterthoughts, identified four crucial elements noted by interviewees as helpful: 1. Caring. 2. Empathy. 3. Understanding. 4 Knowledge of childbirth.

The Family Nurse Partnership (FNP) started in England in 2007, targeting vulnerable first-time young mothers. The service, is available to mothers aged nineteen and under, offers home visits by nurses during pregnancy and until the infant is two years old. The model imported from the United States has shown positive behavioural outcomes in the U.S., such as better antenatal diet and decreased rates of smoking, reduced levels of child abuse and neglect, and improvements in life-style of mothers. Moreover, there were fewer subsequent pregnancies improved rates of employment, as well as improvements in emotional and behavioural development for the FNP cohort children (Olds 2006). Those who garnered the most benefit most from the intervention were noted to be those who were vulnerable, for example women on a low income, young and unmarried, with mental health problems, low self-efficacy or a low IQ. Initial analysis of FNP in the UK indicates that it results in increased confidence for these young mothers (Barnes et al. 2008).

However, the average age of first-time mothers in the UK is now thirty years (National Maternity Review 2016 p.19). Key ingredients across *all interventions* in a recent report (The Birth Companions Literature Review, 2015) were noted as follows:

'Across all interventions the quality of the interaction was found to be critical…. The opportunity to meet with other pregnant women was a simple but important mechanism of support.' (p.5).

Some women feel their bodily integrity is violated during the birth experience. Kitzinger suggests that unwanted medical interventions result in some new mothers being 'left to cope with feelings that are very similar to those a woman experiences after being raped, and which often persist weeks, months, and even years later' (2002, p.189). Women not necessarily diagnosed as depressed may benefit from support in ways which then have developmental significance for infants, *therefore universal provision of social-support packages should be considered*. Coates et al. (2015), in a small qualitative study involving in-depth interviews with new mothers, found that women wanted support to be on offer regardless of whether a mental-health diagnosis had been made and that the availability of post-natal support should be 'normalised' and universal. Coates et al. (2014) note that therapeutic support could explore psychological processes such as 'distancing, guilt and self-blame' across different types

of emotional difficulties. They noted breastfeeding and birth trauma as key areas with which women felt they needed more support that was not readily forthcoming.

Arts Based Interventions with Pregnant Women & New Mothers

There are a number of reviews that provide broad support for the efficacy of art therapy, which are therefore broadly relevant to this enquiry. Slayton et al. (2010) reviewed 35 studies from 1999–2007 that measured outcomes of art therapy effectiveness with a diversity of ages of clinical and nonclinical populations. Although numerous studies blend art therapy with other modalities, this review is limited to studies that isolate art therapy as the specific intervention. The results of the review suggest that there is a small body of quantifiable data to support the claim that art therapy is effective in treating a variety of symptoms, age groups, and disorders, though a lack of standardisation across studies with respect to research design and reporting understandably makes such assessment difficult. The review discusses two of the papers which will be highlighted below (Ponteri 2001 and Hosea 2006).

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A number of papers discuss art-based work with mothers, or depressed women. Ponteri (2001) describes directive group art therapy with mothers and their children interested in exploring maternal self-image and self-esteem with depressed mothers, as well as on the quality of interactions between mother and child. The mothers in this study were all described as experiencing depressive symptoms that were impacting on their caregiving capabilities. The Maternal Self-Report Inventory (MSI-SF) was used (Shea and Tronick 1988). The results showed benefits in mother's self-assurance and well-being, in relation to their improved 'self-image' and 'self-esteem'. The authors surmise that maternal self-esteem is a crucial 'pathway' which allows women to mediate other problems associated with new motherhood (p.155). An interaction rating scale was employed which illustrated that half of the population had retained the improvements after the eight-week long intervention and were illustrating more positive interactions with their children. The authors suggest anecdotally that those not showing the improvements may have been those with more severe depressive symptoms, consequently more in need of a longer-intervention (but they did not test for levels of depression in this study). Overall, the results of this study are very promising for the efficacy of brief art therapy with new mothers, but their generalizability is limited by the very small cohort (n=8).

Hosea (2006) worked with parents and their children in a small non-directive community art therapy group, though the article focuses on work with six mothers working with their children of unspecified ages. Her conclusion is that art therapy can foster 'attunement experiences' between parents and their young children, enhancing 'creative connections' (p.77-78). She notes four aspects in particular. Firstly, the act of mothers and infants painting together created intimacy and engagement – they were brought close physically and metaphorically. Secondly, that colour was important. Thirdly, that the containment provided by the art therapist was significant in enabling the process, keeping at bay the potential for overwhelming chaos. Lastly, that the art works were highly symbolic and encompassed parent's hopes. Hosea emphasises the creative and playful nature of the engagement. Art therapy has also been used with mothers who have suffered domestic violence with the aim of improving mother-child relationships. The study found art therapy to be helpful in helping children communicate and express feelings about their experiences of family violence (Buschel et al. 2006).

Perry et al. (2008) report on a small-scale qualitative study of a creative arts group for mothers with children under two years of age, who were experiencing mild to moderate postnatal anxiety or depression. This was an eight-week long intervention. The Time for Me programme was reported as having created a relaxed, safe space which was experienced as supportive by women who participated in the sessions. It is suggested that creative arts can serve as a useful complement to conventional therapies in cases which are not severe.

White et al. (2010) ran a visual arts programme on a neo-natal ward for parents, but this was facilitated by visual artists rather than by art therapists. The pilot intervention was offered because of a recognition that parents of babies admitted to a neonatal unit may be suffering from stress in addition to experiencing an interruption to the anticipated parental role. Engagement in creative arts was considered to have the potential for a significant effect on parental health. The intervention was considered to offer 'a relaxing diversion' and also as offering the potential 'for allowing the expression of fears and anxieties, difficult to express verbally, and might provide emotional support and alleviate stress', so as offering a therapeutic intervention though delivered by artists rather than art therapists (p.165). Staff responses were positive and described the intervention as having created a 'more relaxed' and less medical ambience in the unit (p.167). All participants reported that making art had relived their stress. Space was at

a premium on the unit and the report concludes that a dedicated art space would enhance results.

Or (2010) used a phenomenological approach using clay with first-time mothers, asking them to sculpt themselves with their child, and found that the task enabled most of the participants to gain insight into their mental states as mothers.[2] These were Jewish mothers with children between two and four. The study emphasises the sculpting process and the objects as revelatory – as an act of self-discovery which did not rely on verbal questioning (p.325). However, the authors also acknowledge that Israeli Jewish mothers, who place a high value on ideas of family, may be particularly receptive to consideration of themselves as mothers, so were unwilling to generalise beyond this cohort (p.326).

Demecs et al. (2011) ran an arts-based programme for pregnant women which included six two-hour sessions including singing, dancing, storytelling and 'art project' involving weaving. The authors conclude that this short intervention afforded the women social support, a sense of connection with each other and enhanced their sense of well-being; furthermore, women shared information relating to childbirth which had the effect of improving their confidence and sense of competence with respect to the forthcoming birth and transition to motherhood.

Siegel (2011) found in a case study that art therapy was useful with a mother who suffered from intense anxiety, and whose birth experience had awakened past trauma, related to her 'pathological merger' with her own mother, which prevented her from enjoyment of her infant (p. 61). The intervention was found useful in boosting her confidence. Nien-Hwa (2011) used an expressive arts intervention with victims of domestic violence in Taiwan with the aim of improving mother-child relationships. This is a structured approach aimed at 'personal transformation'. The steps include looking at positive mother-child interactions, an exploration of the trauma, a re-visioning of perceptions to 'create a new family outlook' culminating in a ritualistic ceremony. The model attempted to be culturally sensitive to local communication styles and cognisant of issues of patriarchy and hierarchy in communications.

Blomdahl et al. (2013) completed a systematic review of art therapy with clients with depression. Low homogeneity amongst papers discussed, generalisations about effectiveness are noted as problematic, then this study seeks to question what works. Therapeutic factors identified included 'self-exploration, self-expression, communication, understanding and explanation, integration, symbolic thinking, and

sensory stimulation' (p.324). Understanding and exploration was taken to include personal insight (emotional function, content of thoughts, and experience of oneself) and the authors suggest exercises facilitating understanding and explanation can also increase self-acceptance, and reduce self-criticism (p.329), noted as ameliorating other symptoms in Ponteri (2001) above. Symbolic expression, via art materials, was noted as an important means for self-understanding and comprehending existential questions. Art therapy was regarded as useful in problem solving and creativity and in helping to develop new coping strategies toward recover (p.330).

Sunnam & Kyungmin (2012) report on two groups with 6 mothers in each group (an experimental group and a control group) with children aged between 2-12. The experimental group engaged in sixteen-weeks of art therapy. The Parental Acceptance-Rejection questionnaire was applied before and after the programme and a difference between the two groups apparent in the areas of aggression and hostility (a subcategory of the rejection scale). Though not statistically significant in scale (n=6), the study points towards art therapy as potentially effective in changing the mother's child-rearing behaviours.

Arroyo and Fowler (2013) noted that most of the referrals to a mother and baby painting group were 'lacking extended support' (2014 p.101). Arroyo & Fowler also suggest that art therapy with both mothers and infants was beneficial in facilitating enhanced bonding. They conclude that participants also experienced a reduction symptoms of postnatal depression and experienced significantly improved self-esteem.

Van Lith et al. explore the evidence base for mental health recovery in a critical review (2013). Some criticism is made of the way that 'self-esteem' is defined by studies and incongruities were noted with regard to the constructs being investigated and how they are measured. One randomised control study found no significant improvements on the self-esteem measure, but significant improvements using the Attitude Toward Self Scale, for example. Concepts of empowerment, self-expression, motivation, a sense of purpose, focus and thinking were noted as easier to identify, since participants could compare their current state with former states (p. 1319). The review concludes 'that art-based practices are of high benefit to psychological and social recovery particularly in the areas of self-discovery, self-exploration, relationships and social identity' (p.1309).

Morton & Forsey (2013) reported on ongoing work, “My Time, My Space”, using an arts-based intervention to combat social isolation, and improve self-esteem for women with post-natal depression. Their findings suggest that engagement does have a positive effect on mood as indexed by the Edinburgh Postnatal Depression Scale, providing an effective alternative or additional method of treatment for postnatal depression. This is promising evidence, but was with a small group of women (n=8).

Schouten et al. (2015) have produced a systematic review looking at the effectiveness of art therapy in the treatment of adults with trauma. They examined six studies. The evidence of effectiveness was based on comparative outcome trials with a control group, demonstrating a robust methodology. (These were identified as Curry and Kaiser (2005), Henderson et a. (2007), Stok (2007) and Volker (1999)). The addition of art therapy to psychotherapy offered a larger reduction in the severity of trauma symptoms than the psychotherapy control group (in Stok) and the authors suggest that this could point to the enhanced effectiveness of art therapy in combination with other treatments. Furthermore, they suggest that the significant improvement in rates of depression in Volker (a longer intervention than that of Stok in combination with CBT) may support this supposition (p.7). The Birth Project ran two groups with new mothers (n=16), one facilitated by a contemporary installation artist and the other by an HCPC registered art therapist. The Warwick Edinburgh Mental Well-being Scale (WEMWBS) showed highly significant improvements for both groups after a twelve-week intervention. Pre and post results show a 37% variance in the WEMWBS scores for *both* of the groups (Hogan 2016 b). That there was no difference in the overall degree of improvement between the two group formats may point to the fact that generic features are at play, such as self-expression via art materials in a safe supportive space, empathy and shared experience between participants, competent facilitation and so forth. Longitudinal work would be interesting as one group was focused on the participants developing an ongoing art practice and the other was not. Although there are limitations in the number of included studies, the number of participants, the heterogeneity (diversity) of included studies and their methodological quality, the results contribute to insight into the effectiveness of art therapy in trauma treatment in reducing symptom severity (for trauma and anxiety) and form an evidence base for the urgent need for further research on art therapy and trauma treatment in relation to material wellbeing.

A National Institute of Health Research funded systematic review (Uttley et al. 2015)

examined eleven art therapy randomised control trials involving 533 patients. Art therapy was associated with significant positive changes in 7 out of 11 studies, relative to the control group regarding mental health symptoms. One of the studies examined was with depressed women, (not specifically with new mothers), but this study did not demonstrate efficacy (Thyme et al. 2007). However, there were considered to be to many confounding factors in the study, as well as a lack of information about relative use of anti-depressants in the two arms of the study, and hence it was considered to be methodologically flawed.

Maternal Wellbeing: Further Reflections

In the national maternity review, "Better Birth: Improving outcomes of maternity services in England" (2016), many women said that they received lots of care and support in the antenatal period which is not continued after birth. For some women, additional support – sometimes simply someone to talk to – particularly in the days spent in hospital after giving birth which can often be a low point for women, may prevent the onset of depression and other mental health conditions. One way this support might be obtained is through art therapy, which has the additional benefit of enabling the expression of feelings not easily articulated in words. Nora Swan-Foster has noted that women can use art therapy during pregnancy to address emotional issues concerning a bad first birth (1989, p.289). Furthermore, she notes that key relationships are often re-examined in the light of pregnancy and birth (Swan-Foster, 1989, p.289). Hogan found art-based support groups to be much appreciated by new mothers anecdotally (2003; 2008; 2012). In confidential art therapy support groups maternal anxiety can be discussed, depicted and explored. Socially unacceptable feelings of alienation from one's baby, for example, may be articulated (Hogan 1997; 2003; 2008). Because of their confidential nature, women in the art therapy support groups reported that they felt free to express feelings they were *unable to express elsewhere*. Furthermore, self-identity is bound up with what we are capable of conceptualising and remembering, so it is not surprising that extreme fatigue, which disrupts these faculties, will prove challenging and destabilising (Hogan 1997; 2012). Hogan found that the effect of exhaustion was a recurrent theme throughout the art sessions (Hogan 1997; 2003; 2012). Other key themes in the art therapy support groups were a sense of claustrophobia, disarticulation, shock, guilt, resentment and loss of self, as well as a celebration of the new baby and joy. Hogan noted the challenge of pregnancy and

childbirth to established notions of self-identity, suggesting that in the use of art materials, women are able to negotiate and articulate their new sense of self, and mourn, if necessary, their 'lost' self-identity (Hogan 2012). Hogan has produced further rich qualitative data exploring women's experiences of birth and the transition to motherhood, which should prove useful reading for those working with such populations.

In *The Birth Project* new mothers were invited to investigate their experiences of pregnancy, birth and post-natal re-adjustments using different art forms. Diverse perspectives were shared, primarily through elucidation of the art works produced. The *raison d'être* of the work has been to create dialogue between different constituents, to use the arts to interrogate discourses, to explore women's experience, including their experience of hospital protocols and how these have iatrogenic outcomes which impact on women's sense of wellbeing. One project used a participatory arts approach, with an emphasis on women building their own art practice (Hogan 2015). Another project worked with women who had been traumatised by their birth experiences and who engaged with a thematic art experience facilitated by an art therapist (Hogan et al. 2015). In both groups, feelings of guilt featured prominently for a variety of reasons: from not being able to have a calm birth as envisaged using 'hypno-birthing' techniques without other interventions (with a sense of ones-own body having malfunctioned, or disappointed, or let one down), to the example of a medical doctor feeling bad that she was overruled, when she tried to resist being induced when she was having her first baby (Hogan et al. 2015). She felt, as a medical professional, that she should have been able to have been more assertive, especially knowing that induction is often linked to further interventions (Hogan 2016). The reasons for feelings of guilt and shame were myriad. Interrogating the experiences allowed women to develop enhanced self-acceptance and self-compassion (Hogan 2015 et al.). Furthermore, the *process* of art making as a revelation and as empowering for some participants is also noted (The Birth Project, Final Report 2017). The project found that the quality of the engagement between health professionals and the birthing mother is of crucial importance to mother's experiences of well-being in childbirth. This accords with the research findings of Czarnocka and Slade 2000 (above).

Most recently Hogan (2012; 2016) has sought to challenge some of the 'mother blaming' language used in discussions of the transition to motherhood, as women are subject to

many conflicting messages and conceptualisations during pregnancy and in the transition to motherhood which are inherently undermining and disorientating and which cause distress; this needs to be kept in mind by practitioners working with pregnant women and new mothers who are troubled. Moreover, as noted above, traumatising birth experiences are often overlooked and women left unsupported with unresolved feelings expected to just get on with it. Coates et al. (2015) note that 'forms of emotional distress', other than PND, are often overlooked. Furthermore, anthropological research would seem to indicate that a healthy bond and secure base can be provided for babies by the *regular* involvement of *several* key caregivers (Blaffer Hrdy 1999; Lancy 2014); an overemphasis on a perceived need for one primary caregiver (the mother) in Western cultures may be part of what leads to PND and anxiety (Hogan 2012).

The Need for Research

To conclude, there is a small evidence-base emerging which points to the usefulness of art therapy during pregnancy and in the transition to motherhood. Social support is a crucial factor in women's ability to manage this transition and art therapy group-based interventions, in particular, have been shown to improve women's self-confidence and self-esteem in ways that allows them to meditate the other stressors associated with new motherhood. The use of art making for self-reflection leading to greater self-knowledge is highlighted by several studies and linked to reductions in self-criticism. A small number of studies report on work with mother-infant dyads and report improved relationships and self-confidence in mothers.

A recent Health Technology Assessment (HTA), consisting of a quantitative systematic review of clinical effectiveness and a systematic review of studies evaluating the cost-effectiveness of group art therapy, explored whether art therapy may be a more acceptable form of psychological therapy than standard forms of talking therapy (Uttley et al. 2015). The review examined eleven randomised controlled trials involving 533 patients and concluded that art therapy appears to have statistically positive effects compared with controls in studies with patients with nonpsychotic disorders but that studies were generally of poor quality and, accordingly are likely to be biased. The recommendations of this HTA are that further controlled trials are needed and that these

'should consider the value of non-active treatment as usual/waiting-list control arm' (p.87), to assess the importance of remission in patients who do not receive treatment. The benefit of art therapy relative to other available packages of care, such as group verbal therapy, is also suggested for multi-arm trials. It is recommended that trials subscribe to the CONSORT guidelines. Long-term follow up is also suggested. Recognition of and classifications for post-natal distress need to be more sophisticated (Coates et al. 2015).

Furthermore, qualitative evidence gathering, to provide rich data, should form part of future RCTs of art therapy efficacy (Uttley et al. 2015 p.88). Qualitative research which focuses on women's actual experiences and understanding of postnatal distress outside of diagnostic categories has been suggested to capture the complexity of women's distress (Coates et al. 2014). Uttley et al. also recommend that studies report on cost-effectiveness measures as recommended by NICE, as their review found insufficient evidence to make an informed conclusion regarding the cost-effectiveness of art therapy compared with verbal therapy. However, it is not just a question of relative cost-effectiveness which is relevant, as inchoate emotions can be captured in art in ways which are fundamentally different and differently reachable to that of a language-based approach.[3] Understanding those emotional processes and the way they impact on the wellbeing of mothers and, consequently their children, may also be a fruitful avenue for research.

Biographical Notes

Dr Susan Hogan is Professor of Cultural Studies and Art Therapy at the University of Derby and a Professorial Fellow at the Institute of Mental Health, Nottingham. For more information about The Birth Project and to see the project films and reports (AHRC grant ref. AH/K003364/1) please visit: http://www.derby.ac.uk/health-and-social-care/research/birth-project/

Dr David Sheffield is Professor of Psychology at the University of Derby where he is Associate Head of the Centre for Psychological Research. Professor Sheffield is a Chartered Psychologist and a Health Psychologist.

Dr Ameila Woodward is a researcher in the College of Health & Social Care Research Centre at the University of Derby.

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[1] The average cost to society of each case of perinatal depression is c. £74,000 (of which £23,000 relates to the mother and £51,000 relates to effects on the child). Further, each case of perinatal anxiety (when not combined with depression) is estimated at £35,000 per case, of which £21,000 relates to the mother and £14,000 to impacts on the child. For each case of perinatal psychosis, the overall costs are c. £53,000 (with costs relating to the mother at £47,000 per case, and a lack of clear evidence on the long-term costs of impacts for the child) (Bauer et al., 2014, p.2).

[2] Phenomenology is the study of subjective experience.

[3] Inchoate feelings are incipient or imperfectly formed.