Perinatal Mental Health Care in New Zealand: The Promise of Beginnings

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Pregnancy and the postnatal year represent a critical time in the health and development of families, and a time when psychologists can play an important role in the primary health care team. This paper discusses some key issues of interest in perinatal mental health care, encouraging clinicians and researchers to broaden the focus beyond postnatal depression to perinatal emotional disorders, and to become informed and involved in promoting recognition of, and appropriate treatment for, parents who are struggling with psychological distress.

Pregnancy and postnatal health and mental health represent a nexus of risk and opportunity, a point where biological, social, and psychological factors weave together, and both child and parents are in flux. The perinatal period—the time during pregnancy and through the child's first year—is a turning point between adult and child mental health, where the mother's and father's care of themselves, each other, and their child build the foundations for the life of the family. Providing services and support at this juncture can be critical for the wellbeing of the family, and often involves collaboration among primary health care, maternity care, social services, mental health services, and a variety of community and informal social support systems. The skills and perspectives that psychologists offer can add significantly to maternal and family mental health care in New Zealand. This paper will provide background on some current issues in perinatal mental health care, discuss research and service delivery questions pertinent to the New Zealand environment, and propose some things psychologists can do to prepare themselves to play an active and constructive role in the promotion of mental health for new families. This is not a comprehensive review of the literature on perinatal depression, anxiety, or psychological treatment, though reference will be made to resources that provide that information. It is intended as an introduction to the area of perinatal mental health care, to stimulate interest and promote awareness of these issues as they apply to families in New Zealand.

"Postnatal Depression" to "Perinatal Emotional Disorders"

Over the last two decades, evidence of the effects of the mother's perinatal depression, anxiety, and stress on the wellbeing of her child has burgeoned. Early on, studies focused mainly on the effects of postnatal depression on the mother-child relationship and the child's subsequent development, finding that children of mothers with postnatal depression were at increased risk of social, emotional, behavioral, and learning problems (Murray & Cooper, 1997; Halligan, Murray, Martins, & Cooper, 2007).

There has been increasing recognition in the last decade that the focus on depression, while important, may be overly narrow, in that many women experience severe dysfunction related to anxiety symptoms, either alone or comorbid with depression. These anxiety symptoms may include intrusive thoughts of harming the baby, and can be very distressing and isolating when women are ashamed or afraid to reveal them to others (Humenik & Fingerhut, 2007). In fact, the perinatal period may be a time of increased risk for obsessive-compulsive disorder (Abramowitz, Schwartz, Moore, & Luenzmann, 2003). The content of obsessions is influenced by the context, and often does include thoughts of harming the baby (Abramowitz et al., 2003; Humenik & Fingerhut, 2007).

Intrusive thoughts and images may also be symptoms of Post-traumatic Stress Disorder (PTSD). For some women, the experience of birth constitutes a trauma, where they fear that their own or the baby's life is at risk, and medical interventions are frightening and intrusive. Some of these women struggle with PTSD symptoms in the postnatal period (Zaers, Waschke, & Ehlert, 2008; Fairbrother & Woody, 2007). In addition, women who have a history of trauma, particularly child sexual abuse, may have an emergence or exacerbation of PTSD symptoms around pregnancy, childbirth and/or parenting (Kendall-Tackett, 2007; Lev-Weisel & Daphna-Tekoa, 2007; Seng, 2008).

In fact, a variety of preexisting or incipient psychological disorders may emerge during the perinatal period, and it is important not to forget the needs and issues of women with major

mental illnesses such as schizophrenia and bipolar disorder, whose own and family's lives may be greatly disrupted by the added stress of pregnancy and parenting (Boyce, 2008; Luskin, Pundiak, & Habib, 2007). It has become clear, then, that broadening the scope from a narrow focus on depression to a wider recognition of experiences of anxiety, depression, and other emotional and behavioural symptoms during the transition to parenthood would enable us to recognise and serve more women and families.

In recent years, the importance of the *ante*natal period has been recognised in maternal mental health, as it became clear that many women struggle with depression and anxiety during pregnancy as well as afterward (Faisal-Curry & Menezes, 2007; Grant, McMahon, & Austin, 2008). Prenatal stress and anxiety have been found to be associated with significant risks to the baby, including preterm labour and low birth weight (Talge, Neal, & Glover, 2007) and behavioural and emotional problems in the child (Weinstock, 2008). The mechanism for these associations is probably multifaceted, including the effect of psychological distress on maternal self-care (Bullock, Wells, Duff, & Hornblow, 1995) as well as the more direct impact of the maternal stress hormones on the child's developing brain, particularly the stress response system (Merlot, Couret, & Otten, 2008; Talge et al., 2007). Many women who are identified as having postnatal depression actually had symptoms of depression prenatally, and it is becoming more widely recognized that pregnancy is an important time to screen for, and treat, both depressive and anxiety symptoms (Luskin, Pundiak, & Habib, 2007).

The evidence is convincing, then, that maternal mental health is important, and has implications for family health, mental health, and child development. It is not, however, only mothers and children whose well-being is at stake. In recent years it has become clear that fathers, also, suffer from perinatal emotional disorders, both in terms of their own experiences of depression and anxiety, and in terms of the stress and burden associated with caring for a partner who is distressed at the same time as caring for a new infant (Bielawska-Batorowicz & Kossakowska-Petrycka, 2006; Roberts, Bushnell, Collings, & Purdie, 2006). The toll this may take on father's health, work, relationships, and quality of life has not yet been well-studied, and the difficulties discussed below with respect to screening for and identifying depression and anxiety in mothers are even more complicated with fathers. This is an area that is ripe for research and development of new approaches to services and supports for developing families.

The epidemiology of all this is a work in progress; rates vary widely based on methodologies and populations studied, as well as the timing of the assessment and the disorders included. The best-studied disorder is maternal depression, and rates are generally estimated at 13-14% prenatally and postnatally (Lusskin, Pundiak, & Habib, 2007; O'Hara & Swain, 1996). In New Zealand, one study found that 16% of postnatal Pakeha women scored above a screening cut-off for depression (Thio, Oakley Browne, Coverdale, & Argyle, 2006), and a separate study found that 16% of Pacific mothers had probable depression, though rates for specific subpopulations varied considerably, with 31% of Tongans scoring above the cut-off (Abbot & Williams, 2006). Very little is known about the prevalence of postnatal anxiety disorders, though a recent Australian study found that 2% of women had significant symptoms of PTSD six weeks postnatally (White, Matthey, Boyd, & Barnett, 2006), and 6% of a Swiss postnatal sample (Zaers, Waschke, & Elhlert, 2008), and 7.9% of an American sample of pregnant women had current PTSD (Seng, 2008). Taking into account the range of depressive and anxiety disorders, it seems likely that at least one in five women in the perinatal period experience significant distress and dysfunction, and their partners, and new fathers in general, are also at substantial risk (Condon, Boyce, & Corkindale, 2004).

Identification and Access to Care in New Zealand

The challenges of screening, evaluation, and treatment of perinatal emotional disorders bring into sharp focus the many psychological, cultural, social, economic, and political factors that come together when we talk about mothers and babies. How to ask, who should ask, when to ask, what to ask, and what to do about it are all questions actively debated, and acutely relevant to the task of primary health care.

How to Ask: Screening for Perinatal Emotional Disorders (PNED)

There are two basic approaches to screening for PNED: questionnaires, and oral questions in the course of a health care visit. Within the psychology discipline, and also within nursing and public health practice, the psychometric approach—giving a standardised questionnaire—is most often used. Within this area, the Edinburgh Postnatal Depression Scale (EPDS; Cox, Holden, & Sagovsky, 1987), a 10-item screening tool, is far and away the most commonly used questionnaire. It has been used across a variety of cultural and national groups (e.g., Small, Lumley, Yelland, & Brown, 2007) during pregnancy as well as postnatally (e.g., Jomeen & Martin, 2007), and has also been used with fathers (e.g., Condon, Boyce, & Corkindale, 2004). There is some variation in recommendations regarding cut-off scores for screening in various populations and purposes (Lusskin, Pundiak, & Habib, 2007; Nylen, Segre, & O'Hara, 2005), but it is a simple measure to administer and score, and has been incorporated into use in a variety of health care and social service settings. In New Zealand, it has been used with a variety of ethnic groups (Abbott & Williams, 2006; Roberts, Bushnell, Collings, & Purdie, 2006; Thio et al., 2006), and appears to be well-accepted and useful, although there are no specific New Zealand norms or validation studies.

The second approach to screening is more rooted in the primary care tradition, and involves asking general screening questions in the context of a medical or maternity visit. For example, the New Zealand Guidelines Group recommends asking two basic questions about depression routinely at several points during a pregnant and postnatal woman's care (New Zealand Guidelines Group, 2008). Very little is known about the validity of this kind of screening in perinatal women; it

has been studied more generally for depression in primary care settings (New Zealand Guidelines Group, 2008). However, it has been argued that the cultural and social expectations that mothers carry may make it particularly difficult for them to acknowledge how miserable and inadequate they feel when they are depressed (Ferguson, 2007; Thio et al., 2006), and this may make it especially difficult for them to admit to depression in response to this kind of brief, general screening question. The interpersonal distance of the paper-and-pencil questionnaire, as well as the specificity of the questions asked, may make it easier for some women to admit to distress on an instrument such as the EPDS. For others, especially those who do have an ongoing, supportive relationship with their primary care provider (Ferguson, 2007), being asked about their feelings in a direct, caring relationship may be the most effective bridge to treatment. It is important to recognise that either method is a first step. Neither is a comprehensive evaluation, but each may open the door to treatment for women who are reluctant to broach the topic of their mood, or who are so mired in fatigue and misery that they do not recognise that they are struggling with an emotional disorder. Psychologists in primary care can bring their expertise with psychometrics into practice, not to supplant the personal relationship and conversation between patient and clinician, but to provide another method and opportunity to recognise and treat distress.

Who should ask, and when?

In an ideal world, a woman has a network of professional and personal supports, any of whom might pick up on signs of anxiety or depression. However, too often the services women receive are fragmented, uncoordinated, and sparse, and their social networks are disrupted by the seismic shifts of parenting. The system of maternity care in New Zealand has shifted from one that is centred on a medical model to one that sees pregnancy and childbirth as normative developmental tasks (Sharma, 2007). In theory, each woman has a Lead Maternity Carer (LMC) who is available through the pregnancy and into the first weeks of postnatal care. This LMC, who is most often a midwife (Health Services Consumer Research for the Ministry of Health, 2008), provides education, support, and perinatal health care, and would be a natural person to monitor and screen for perinatal emotional disorders. However, in many areas there is a shortage of LMC's (Health Services Consumer Research for the Ministry of Health, 2008), and midwives vary widely in their interest in and knowledge of mental health care. There is no broadly-agreed-upon guideline for screening for emotional disorders, and practice varies across individual carers. In addition, the final maternity visit typically takes place 4-6 weeks following birth; at this point, it can be difficult to distinguish normal-range adjustment problems from more serious distress, particularly in the context of the ending of a significant caregiving relationship, as the midwife finishes her task just as the mother's begins.

Sometime in the weeks just following childbirth, the responsibility for oversight of the health care needs of the new family shifts more solidly to the primary care system, and most women who seek treatment for perinatal distress see their general practitioner as a first port of call (Thio et al., 2006). There is also evidence that women who are struggling with depression may bring their babies for more frequent non-routine visits to their health care provider (Chee et al., 2008), so these women may present for multiple reasons to their primary care provider. A family doctor who is alert to signs of distress, and has the time and skill to probe for emotional symptoms, is in an excellent position to pick up PNED. However, the often rushed, somatically-focused context of a medical visit may combine with the woman's own ambivalence and shame to lead both women and their doctors to dismiss distress as normal.

Another major point of contact for many New Zealand mothers is well-child services, provided mainly by the Plunket Society. In either home visits or office-based visits, these nurses provide information on child health and development, but are also generally aware of issues of maternal mental health, and make referrals when they recognize a need. However, again, individual practitioners vary widely in their style of guidance and support, and particularly when a woman is feeling depressed and vulnerable to criticism, the Plunket nurse can sometimes be cast in a role as a rigid dispenser of advice (Barber, 2008; Bryder, 2002), and this may undermine the possibility of communication around the tangle of guilt, anxiety, and self-doubt that festers in PNED.

There are a variety of other services and agencies that support families during this period, including Parent Centres, Family Centres, lactation consultants, birthing centres, antenatal and postnatal education providers, child care providers, and spiritual and pastoral care from religious communities. Their support can be crucial in helping young families, and many of the people who provide these services are knowledgeable and compassionate regarding mental health issues. However, very few of these services provide any systematic screening for mental health issues, or have the capacity to provide comprehensive evaluation or treatment. They represent a patchwork which may come together as support, or which may only seem to a mother to be a jumble of confusing and contradictory messages (Barber, 2008).

There is no coordinated policy in New Zealand that dictates universal screening for perinatal emotional disorders—the new guidelines for primary care come closest, in recommending that caregivers ask about depression (New Zealand Guidelines Group, 2008), but there is no guarantee that any woman will receive this basic screening.

What to ask?

Even when a medical practice or primary care organisation does develop a systematic process of screening for perinatal mental health, the focus is still almost always on depression, rather than the full spectrum of anxiety, stress and mood symptoms. For example, although the New Zealand Guidelines Group (2008) acknowledges the importance of anxiety and other mental disorders in pregnancy and postnatally, they focus their recommendations specifically on depression. Although there is a high level of comorbidity and mixing of depressive and anxious symptoms, there

are some women whose symptoms do not fit the stereotype of the depressed, exhausted mother, and who may be missed by screening tools and attitudes that are too narrow.

There is one anxiety symptom in particular that can be enormously distressing and isolating, and is rarely asked about—vivid thoughts and images of harming the baby. Interestingly, a recent study (Fairbrother & Woody, 2008) found that intrusive thoughts about harm coming to the baby, either intentionally or unintentionally, were nearly universal among mothers in the weeks following childbirth. Virtually all mothers reported thoughts of accidental harm coming to their infants, and almost half, at four weeks, reported thoughts of intentionally hurting their infants. In this normal group, these thoughts tended to become less frequent over time (Fairbrother & Woody, 2008). In clinical populations of mothers with perinatal emotional disorders, thoughts of harming the infant also occur, and although they are very rarely acted upon, they are a source of intense distress (Abramowitz et al., 2003; Humenik & Fingerhut, 2007). Asking about and acknowledging these experiences in a way that is not punitive or judgmental, but opens the door to women to talk about their stress and distress, may help to prevent some of the painful rumination and self-recrimination that often accompanies this symptom.

In addition, then, to questions about sadness, fatigue, and anhedonia, it is important to ask about worry, and also perhaps to say something like "Lots of mothers tell me that they sometimes have scary thoughts or images about their babies, or the birth, or things that have happened—have you been bothered by anything like that?" If the mother acknowledges intrusive thoughts, the clinician must then assess the nature and severity of these thoughts. In some cases, the message may be "You are in good company—this is part of the normal reaction to motherhood." In others, it may be to emphasise that these painful thoughts are a red flag, alerting that the level of stress is too high, and the mother needs to care for herself, as well as her baby—but again, reassuring that these thoughts are not unusual, and do not mean that she is losing her mind, which is the secret fear that tortures and silences many women.

The issue of harm to the baby raises the spectre of postnatal psychosis, and may raise the anxiety not only of the mother but also of the clinician. Unlike perinatal emotional disorders, postnatal psychosis is rare—estimated at 2/1000 births (Ferguson, 2007). It typically comes on quickly in the days and weeks after delivery, and is associated with disorganisation, confusion, hallucinations, and delusions (Lusskin, Pundiak, & Habbib, 2007). This level of psychotic symptoms and dysfunction is quite different from the reaction of the typical woman who is struggling with intrusive thoughts. It is important to be aware of the possibility of psychosis, particularly in women with a bipolar disorder, who are at increased risk (Lusskin, Pundiak, & Habbib, 2007), but in most primary care and general mental health settings, the large majority of women who fear hurting their babies are struggling with anxiety and low mood, not psychosis.

Low mood, though, may come in a variety of forms, and although major depression is the most common clinical disorder, there is a spectrum of difficulties that can emerge perinatally—in fact, any of the psychological disorders can be triggered, or uncovered, by the stress of pregnancy and parenting. Some women may not meet full criteria for a major depressive episode, but struggle with the major changes in their lives, and experience intense feelings that are probably best described as an adjustment disorder (Dunnewold & Sanford, 1994). These women are legitimately distressed, but have difficulty accessing mental health services because their level of severity is below the threshold imposed by limited resources. They are a group who may be in a good position to benefit from peer support groups and/or group therapy, though the effectiveness of these interventions, especially prenatally, has not been well studied (Austin et al., 2008).

It is also important, when assessing any woman with signs of a perinatal mood disorder, to consider the possibility of bipolar disorder. What appears to be depression may be an episode of a bipolar illness, and the distinction may have important implications for treatment, both pharmacologically and psychologically (Cullen-Drill, Smith, & Morris, 2008). In one recent study (Sharma, Khan, Corpse, & Sharma, 2008), when women who had previously been given a diagnosis of postnatal depression were assessed systematically, about half met criteria for a bipolar spectrum disorder. Only two percent fit a classic Bipolar I picture, but many had Bipolar II or other clinical features of unstable mood. In addition, many had comorbid anxiety and/or substance use disorders. A careful history with questions about periods of irritability, impulsivity, reduced need for sleep, and racing thoughts, as well as substance use and other symptoms, is an important part of a careful assessment of mood problems in the perinatal period (Cullen-Drill, Smith, & Morris, 2008).

What to do about it.

A key problem in encouraging screening is the question of what to do when a problem is uncovered (Nylen, Segre, & O'Hara, 2005). If services are readily available, accessible, effective, and culturally appropriate, the task may be to provide information, referral, and perhaps some follow-up to ensure that the referral has been successful. Unfortunately, however, this is rarely the case. Communities vary in how services are organised, but especially for women whose symptoms are in the mild to moderate range, who may not qualify for services provided by specialty maternal mental health providers, obtaining appropriate services can be difficult.

There is good evidence, particularly for the postnatal period, that psychotherapy—especially cognitive-behaviour therapy and interpersonal therapy—is effective for treating postnatal depression (Ferguson, 2007; Kopelman & Stuart, 2005; Misri & Kendrick, 2007; New Zealand Guidelines Group, 2008). These treatments have been shown to be effective in New Zealand in both individual (Wilson, Bobier, & Macdonald, 2004) and group (Griffiths & Barker-Collo, 2008) formats, although their use has been primarily described with clients of NZ European ethnicity, and it is not clear whether they are as effective and appropriate for other cultural groups. There is some evidence that different

ethnic groups may have different rates of postnatal distress and/or may respond differently to the screening methods and tools used (Abbott & Williams, 2006; Segre, Losch, & O'Hara, 2006; Thio et al., 2006). It would make sense to consider (and study) whether interventions developed and tested largely in a dominant western culture are appropriate and effective for a variety of New Zealand ethnic groups, including Māori, Pacific and Asian peoples, and immigrants.

In practice, even if services are available, though, many women who appear to be distressed, according to their responses to screening tools, do not take up services when they are offered (Carter et al., 2005; Tam, Newton, Dern, & Parry, 2002). In one study (Flynn, O'Mahan, Massey, & Marcus, 2006), only about 1/3 of women who had a diagnosed major depressive disorder during pregnancy received any treatment. This was in spite of an intervention where their obstetricians were informed of their depression, and they received a personal phone call with information on depression and treatment resources from a practice nurse. There may be a variety of factors that influence women's decisions about seeking treatment, including stigma, concerns about medication, cultural mismatch in perspectives and priorities, family obligations, financial limitations, and fears of being seen as a "bad mother" (Freeman, 2007). Sensitive and thoughtful investigation of the obstacles to following through on a referral is crucial, both on an individual level and more broadly, to contribute to service delivery and programme planning.

Psychologists and Primary Perinatal Care

Psychologists are well placed to consider and integrate the multiple factors that are involved in perinatal mental health care. This is because, at best, psychologists are trained as careful thinkers on the boundary between science and practice, looking at the evidence as it emerges, and considering what it means for the person, the family and the community. There are opportunities at all levels for psychologists to contribute to the issues and problems of perinatal mental health care—as clinicians, working with mothers and fathers and babies and helping them to find a way forward; as researchers, trying to figure out what works, and why; as teachers, educating students and colleagues about the needs and problems and joys of parenthood; and as policy makers, and advisers to policy makers, considering how what we do as a society affects mothers, fathers, and through them their children.

Psychologists can help, then, but in order to do that effectively, we need to learn a few more things. First, more of us need to become familiar with the culture of the medical world, and learn what works in collaboration with our colleagues in primary care, maternity services and well-child care. We need to understand the systems, both in terms of their overarching philosophies and the individuals involved, who are the ones on the front lines, juggling appointments and making room for tears and secrets. Whether the psychologist is on site in the clinic, or a more remote source of back-up consultation and referral, we need to be able to talk with colleagues from different disciplines with confidence in our own skills and knowledge, and respect for theirs.

Second, we need to continue to learn about the biological/psychological interface. There is growing literature on the psychobiology of stress which is relevant and important to the work of psychologists, especially those in primary care. The technical literature can be daunting, but some accessible explanations are available (Sapolksy, 2004) and can be a good starting point for learning and reflecting on the reciprocity of mind and body. Similarly, it is becoming clear that, as humans are social animals, human brains are shaped in relationships, and early caregiving relationships undergird the capacity for emotional regulation and socialisation in a fundamental way (Cozolino, 2006). It is this foundation that is undermined by perinatal distress, and the more we understand the processes involved, the better able we will be to design interventions that work for both mother and baby.

Third, we need to try to comprehend the health care and social service systems that families use, and take a look at the experiences of a variety of mothers, fathers, and others who interact with these systems. Often these experiences are positive, and families feel helped (Barber, 2008); however, there are also circumstances in which families feel criticised, blamed, excluded, or slip through the cracks and are unable to access supports and treatments that might help. Related to this, we need to understand the experiences of families of different cultural groups, how their views about mothering and families affect their own experiences of parenthood, what they need in terms of support and health care, and how they interact with the sometimes intimidating or confusing organisations that provide health care and social services.

In the end, it is a matter of psychologists talking to, listening to, and working alongside midwives, physicians, nurses, social workers, counsellors, childbirth educators, home visitors and (most importantly) mothers, fathers, and babies. It may take all our social and political skills, our scientific acumen, our therapy know-how, and our compassion to find ways to untangle what is tangled, and weave what can be woven into a stronger, safer future for families in our communities.

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