
Maternal mental health: Making a difference

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Abstract

This research project explores what makes a difference in women's recovery from postpartum distress. As postpartum distress can interfere in the establishment of secure attachment the need for early intervention is vital. This project, based on principles of feminist research, used questionnaires and interviews to canvas women who had accessed the mainstream maternal mental health service of Taranaki District Health Board. The women in this study felt they had benefited from individual and group work alongside medication, but crucial to their recovery was also informal support from family and friends and self care. While evidence-based practice is a dominant discourse in health at present, what these women told us was that kind, non judgemental support helped them recover. When women didn't have this kind of support from their families, friends or professionals the recovery process was impeded.

Introduction

The term postpartum distress was chosen for this project as a 'catch-all, or a general term covering all levels of the illness' (Goss, 1998, p. 4) inclusive of depression, anxiety, post traumatic stress disorder and psychosis associated with childbirth (Mental Health Foundation, 2002). This generic term has been used to ensure the study was not limited by any one diagnosis. Much of the literature focuses on depression which excludes those with a 'different' diagnosis.

Discourse around this subject is contradictory. On the one hand, medical definitions, as prescribed by the Diagnostic and Statistical Manual IV (DSM-IV) (American Psychiatric Association, 2000) perceive postpartum depression as a pathological reaction to childbirth (Nicholson, 2001; Parsons, 2009). This discourse is dominant, embedded in the medical model and underpins evidence-based practice (Parsons, 2009) which is embraced and used by mental health services. On the other hand there are approaches and perspectives which run counter to this, such as holistic approaches and the feminist perspective. There is a body of feminist literature which argues that postpartum distress is a natural reaction to the change and loss which follows childbirth (Littlewood & McHugh, 1997; Nicholson, 1999; Oakley, 1980).

The link between postpartum mental illness and an increased chance of attachment difficulties has been documented (Gerhardt, 2004; Hannah, 2005; Hornstein, Trautmann-Villalba, Hohm, Rave, Wortmann-Fleischer & Schwarz, 2006; Milgrom, Martin & Negri, 2003; Parsons, 2009). If a mother experiences postpartum distress it is likely to impinge upon, and interfere with, her ability to bond with her baby. All of this indicates that the more effective service delivery to women experiencing postpartum distress can be, the better the outcomes will be, not only for her, but for her children, partner and other members of her family/support system.

The system around the mother and baby are affected by postpartum distress. Roberts, Bushnell, Collings and Purdie (2006) found that men who have a partner with postpartum depression have poorer psychological health than those who have a partner who is well. This finding is similar to that of Boath, Pryce and Cox (1998) and Franks, Henwood and Bowden (2007) whose research indicated that when a woman had post natal distress there was a negative impact for partners. The couple's relationship suffers, as do children and other family members, who carry the 'burden'. Again, the need for early and effective intervention is crucial for healthy functioning of the social system around the mother and baby.

Literature indicates that a holistic approach is needed in the successful treatment of postpartum distress (Milgrom, et al., 1999; Parsons, 2009) and that women require a 'wrap around' support system following childbirth, minimising negative effects on support systems is important. In Parson's (2009) study she found that women with strong informal support systems fared better, but if this was not available 'formal support services became even more important' (p.16). One respondent in this study had recently moved to the province and had no support network; her only support was from professionals and a professionally run support group. This 'worked for her' as it mirrored informal support (Milgrom et al., 1999).

This study found that the nature of the support offered to women is a determining factor in its success, a finding which is similar to a London study which concluded that women valued a 'woman-focused, non-judgmental and friendly' service (Austerberry, Wiggins, Turner & Oakley, 2004, pp. 462-3). This idea of safe, ongoing support is backed up by Scott (2010) who found that 'good helping relationships are more 'ways of being' than they are about strategies or techniques' (p. 24). So, while talk in mental health services may be about evidence-based practice what the women told us they found most helpful and the literature shows is that 'safe', caring and accepting professionals are what makes a difference not the modality or evidence they used.

Likewise Mauthner (1999) who carried out a qualitative study in England of 40 women's experiences of motherhood and postpartum distress found that it 'occurs when women are unable to experience, express and validate their feelings and needs within supportive, accepting and non-judgmental interpersonal relationships and cultural contexts' (p. 145). Women with postpartum distress withdraw from relationships and experience isolation: 'social withdrawal seemed to characterise all of the women's experiences of depression' (Mauthner, 1999, p. 163). In Mauthner's (1999) research she found that women experiencing postpartum distress were silenced and 'shut down'. When women discussed their illness they felt they had challenged 'cultural myths of motherhood' (p.164) which are often 'sacred cows' in a society. The ideal of the content, fulfilled loving mother is hard to contradict. If women talk about feelings of detachment from their baby or that they are

not happy in their new role this can result in shocked responses from others and judgement about their mothering.

Methodology

This study's aim was to hear what women from a provincial community, Taranaki, had to say about what worked for them. Feminist research principles were used to achieve this; the women's experience was placed at the 'centre' and given value. The importance of hearing what women have to say about their experience of postpartum distress is reinforced by Mauthner (1999), who states that historically research in this area has been positivist in nature and has 'disregarded mothers as a source of knowledge' (p. 145).

Taranaki District Health Board service delivery area provided the geographical boundary for the study. Taranaki is the smallest province in the country and while it has one city, New Plymouth, and a number of small towns, the traditional 'backbone' of the province is farming, particularly dairy farming. In this study a number of respondents lived rurally which impacted on their daily lives, contributing to their isolation because of the distances required to get to services or to have contact with adults outside their nuclear family. As this province is in itself isolated on the 'bump' of the North Island, access to specialised services can be compromised by distance. For example, the nearest residential mother/baby unit is Hamilton.

Only those who had accessed the mainstream maternal mental health service were canvassed. There is a 'parallel' Māori service in Taranaki provided by a kaupapa Māori provider. The intention was not to marginalise the women who access this service but to acknowledge that they have different needs and experiences. Any research conducted with them needs to be based on kaupapa Māori methodology (Janke & Taiapa, 2003). Information from this study has been shared with staff of the kaupapa Māori service.

One hundred and eighty three questionnaires with open-ended questions were sent to women who had used the Maternal Mental Health Service of the Taranaki District Health Board since it began in 2001. It excluded those who had been seen in the previous 12 months in order to protect potentially vulnerable women. The response rate was poor, with only 25 returns. We chose not to resend the survey as we considered this may be intrusive. There were a high number of 'return to sender' and we postulate that the women may have 'moved on' emotionally as well as physically.

On the questionnaire women indicated if they were willing to be interviewed. From these questionnaires six women were selected randomly for interview. These women were interviewed in their homes using a semi-structured interview process, based on the written questionnaire. The data from both the postal survey and the face-to-face interviews was used in the data analysis and the quotes used are taken from both sources.

An inductive approach was used to analyse the data. Themes and common threads were drawn out from the interview transcripts and the questionnaires. From these themes recommendations were constructed.

As this research involved service users of Taranaki District Health Board we applied for and gained approval from the Ethics Committee of the Ministry of Health's Health Research

Council of New Zealand before commencement of the project. This ensured the project was 'safe' and was a way of protecting the women from harm.

Results

The themes identified fell into the broad categories of factors which helped recovery and barriers to wellness. Factors which assisted recovery were categorised into themes of primary and secondary health care, the benefits of group work, medication, informal or organic support systems and self care.

In primary health care, which related particularly to general practitioners and well child providers, it was evident that practitioners need to have knowledge of maternal mental illness and be able to identify when a woman is experiencing difficulty. Early detection of post natal distress by these professionals and respondents indicated they appreciated this and the effectiveness of this is supported by literature (Scott, 2010). Contact with a primary health care provider was often the first step towards recovery for the respondents. Having a supportive, non-judgemental and kind health worker made a difference. The importance of this is counter to the ideas of efficiency and effectiveness which are part of the dominant discourse of evidence-based practice (Pease, 2009).

Participant: Found my GP [to be] very understanding and non-judgemental.

Participant: I felt genuinely heard and validated [in relation to primary health care provider].

Concerning the secondary health service, home visiting by a non-judgemental and empathic worker made a difference.

Participant: I think one-on-one for me was essential. If I'd just stopped at the group session it wouldn't have been enough for me; I think I probably would have relapsed or something.

Participant: One of the best things was being visited at home when things were really tough. Don't expect us to make it out of the house.

There was support for the 12-week group programme, 'Adjustment to Parenthood', run by the Maternal Mental Health team at Taranaki District Health Board. The group was seen by the respondents as an important part of their recovery and two main reasons were identified for this. Firstly, the group enabled the respondents to develop a support network of women experiencing similar difficulties to themselves. There was also a sense of hope and inspiration when women identified others in their group further along the path to recovery.

Participant: That I am not alone with my depression and that some of these women have come out the other side and were doing alright for themselves.

Secondly, the group was seen as useful for the skills the women learnt throughout the 12 weeks and the transferable aspect of these skills to other areas of their lives. Skills learnt and seen as valuable include cognitive behavioural skills, assertiveness skills, raising self esteem and awareness of how to maintain a relationship with a partner after becoming a parent.

Participant: The skills I learnt in the 12 weeks have carried through in every aspect of my life.

As in the literature, a combination of individual sessions and group work alongside appropriate medication appeared to be effective. Medication was viewed as vital in the respondent's recovery as long as it was 'right' (the right type of medication and the right dose).

Participant: Thank God the first medication he put me on worked for me as I don't know what would have happened if it didn't.

Participant: Antidepressants work well for me...they make me feel less angry with the world.

Being identified early as having post natal distress and receiving ongoing support from significant others, in particular partners, family members and 'girlfriends' was significant, which is a similar finding to Parsons (2009).

Participant: I knew I was slipping and losing it and it took my Mum to walk in and say you need help.

Participant: I definitely think you need your girlfriends around when you have a baby.

Participant: I'm sure if I didn't have the husband I have ... he's just a rock.

For respondents, being unwell challenged them to consider the way they took care of themselves. They identified that paying attention to their need for self care was an important aspect of recovery.

Participant: Not realising at the beginning that before I could take good care of my boys I needed to take care of myself.

Participant: I was having my bubble bath every Tuesday night.

Participant: I think you learnt to be a little bit kinder on yourself.

Barriers to recovery fell into themes of stigma and discrimination, poor performing professionals, isolation and being undermined by family members and friends. Despite the campaigns about mental illness, a strong theme from the respondents was of discrimination and stigmatisation.

Participant: It's almost like you're given a label and I'm forever the girl who got postnatal depression.

This included not only the comments and attitudes of others but also internalised stigma. For example, respondents were distressed when attending outpatient appointments at the community mental health service which is on hospital grounds.

Participant: I almost went home before the appointment when entering the mental health unit; that's not the right place for PND women.

There was an indication from the respondents that maternal mental health services should be situated in the community rather than a hospital setting.

The attitude and/or lack of knowledge of professionals is a barrier to achieving wellness and at times to accessing services. This includes unhelpful professionals or those with 'silencing' behaviour, such as not validating the woman's experience.

Participant: Health professionals making wrong judgements and/or not understanding your situation, thereby compounding your own feelings of low self belief, guilt and no confidence in your ability as a Mum.

Participant: One lady I went to asked me what I wanted from her. Well, really, how was I to know what I wanted?

Isolation was a factor mentioned by respondents as contributing to, and maintaining, their post natal distress. Two types of isolation were experienced, firstly geographical.

Participant: I hated living out here. I just felt very alone, it was just awful.

Participant: Mostly my isolation of not knowing anyone and not realising what was happening to me, thinking maybe this is just how I am, totally unsuitable as a mother and unable to do what comes naturally to everyone else.

For women accessing services in Taranaki, geographical isolation is part of their reality which is exacerbated by rises in fuel costs over recent years. Secondly, some women were isolated from a meaningful support system while having people around them.

Participant: My husband has never been a believer in depression so he was not understanding at all in the beginning.

Participant: My mother-in-law came and sat on her fat arse expecting me to run around after her.

This highlights the importance of good education for professionals and for work with significant others to improve social connections and informal support systems.

Discussion and conclusion

The women in this study were clear that support from others was vital in the recovery of their mental health. It appears that this is most useful when it is provided by a woman's existing social networks; her partner, mother, mother-in-law, other family members or friends. A number of women commented that a family member was the one to identify they were not well and to take action. The other side of this is that if support is not forthcoming from a woman's own support system it undermines and delays her recovery.

In these instances the support of professionals is vital to fill the void. From the women's stories and comments we can establish that the more the professional support mirrors a natural support system the more useful it is. It was not the evidence-based practice the respondents commented on, rather the kindness of professionals they had appreciated and being able to talk about how they felt and what they were experiencing without judgement. Alongside this, being visited at home was appreciated, which mirrors an organic form of support. Practical support at home including 'mother craft' was also considered useful. This can be seen as 'filling the gap' when people are living away from natural support systems or the systems are inadequate or unwilling to assist.

It appears that group work is effective as it creates an environment in which women can receive support from their peers, thus reducing their isolation. While the content of the group sessions was important to some women, for others the opportunity to be 'out of the house' and with others in a similar situation was the most healing.

Other areas worthy of note were around medication and self care. For a significant number of respondents being on medication which 'worked' was the start of their journey to wellness. A small number of women had negative experiences with medication and this exacerbated their illness and caused distress at a vulnerable time. A significant number of women identified self care strategies from bubble baths through to self affirmations and an acceptance of themselves and their situation.

While the dominant discourse in health is around practice approaches informed by evidence-based practice, this research project indicates that women want support from their own networks or if this is not forthcoming to have professionals who are kind, genuine and 'safe'.

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