Perinatal mental health of young women

Jane Parsons

Jane Parsons is a clinical social worker and Dialectical Behaviour Therapy Coordinator in the Child Adolescent and Family Mental Health and Alcohol and Drug service. Jane's focus is with youth and women's mental health needs with a passion in maternal and parental mental health and professional supervision.

Abstract

This article stems from research conducted with four pregnant women and four health professionals. Feminist research methods using semi-structured qualitative interviews explored experiences of mental health support and education provided during the perinatal stage. This article outlines the themes the pregnant women identified as significant to their mental health during pregnancy then concludes with the researcher's analysis of these areas. These themes highlight areas of perinatal care and social work practice that can impact the health of the mother, and therefore the child, in a preventative manner.

Introduction

A woman's reproductive period is when she is most likely to suffer mental ill-health, with this risk increased for young women. Mental ill-health in the perinatal period is identified as common but with significant implications for the young woman and her family (Dearman, Gutteridge & Waheed, 2007; Petrillo, Nonacs, Viguera & Cohen, 2005; Riecher-Rössler & Steiner, 2005). From as early as a few weeks post conception, the foetal brain is found to be affected by maternal stress and mental ill-health. This continues to affect the infant post-natally and is exacerbated if maternal mental ill-health is not treated. Young women are more likely to experience impediments to their wellbeing in the perinatal period. Thus, introduction of suitable formal support perinatally can have a prophylactic effect on maternal and infant mental illness.

Through feminist research methods, utilising semi-structured qualitative interviews, four pregnant women 30 years and under in the perinatal stage of pregnancy explored with the researcher their experiences of mental health support and education during pregnancy. This research found that not all services are currently appropriately meeting the needs of young pregnant women. A lack of attention to gender and youth issues and the dominance of a medical model understanding minimises holistic, contextual treatment. The gendered construction of health services and market principles in state provisions are evidenced by compartmentalisation of services, lack of collaboration between these services, competition for resources, and rigidly defined roles of health professionals that present access barriers for young pregnant women. A need to enhance formal supports and create policy frameworks and practice guidelines to direct this support was identified alongside recommendations for increased service provision, education and screening at the primary healthcare level.

Methodology

The criteria for participation in the research were women, 30 years of age or under who were in the perinatal stage of their first pregnancies. The age limit was chosen to represent the younger half of pregnant women in New Zealand as the current median age of pregnancy is 30 years (highest fertility rate in 19 years, 2009). The participants were chosen from the general population with two of the four participants identifying a previous experience of mental illness. One of these two participants was receiving treatment for her mental health and addiction issues during the pregnancy.

It was important that women's own perspectives of their perinatal care were gathered alongside the opinions of health professionals. This reflects a growing focus on service-users' perspectives in mental health research (Davis, 2005; Davis, Barnes, & Rogers, 2006). The research required human ethics approval from Massey University and the Plunket Society. The details of these applications and approvals can be found in Parsons (2008).

One of the participants was 30 years of age, one 20, and two were 18 at the time of the interviews. Three of the four women interviewed identified as Maori with two of these women referencing their iwi and hapu. This is significant as young, pregnant Maori women face multiple sites of stigmatisation. Maori women have additional complexities in their perinatal care identified by Maori authors and researchers such as Herd (2006), Semmons (2006), Wepa and Te Huia (2006). These researchers have identified the need for Maori women to be supported by services and research designed by Maori with Maori as much as possible (Herd, 2006, Wepa and Te Huia).

Core themes

The raw data collected from the four interviews was analysed using a thematic and feminist approach, with a number of core themes emerging. These themes are outlined here both in the order of importance the participants placed on them and the extent of referencing made to them amongst the participants.

Partners and informal supports

The participants who self-reported as faring better in their pregnancy had the strongest informal supports. Karen (1998) identifies that having a reliable support person is correlated with a woman's ability to handle pregnancy and parenthood and this was reflected in the data. The participants self-reported as less concerned about their mental health decompensating in this period based on the strength of their partner's support:

> I don't think that I'll get really stressed out really because I've got quite good support and stuff so I don't really think that will be a big problem for me […] and if I do have a breakdown I think my mum and my partner would be quite helpful.

Two participants, who were very close in age, fared differently depending on their social circumstances. This reflects the importance placed, within the literature, on appropriate partner and family support, sound family health history, and freedom from abuse, violence, and alcohol and drug misuse. These factors are recognised risk factors for mental illness in pregnancy (Cherry, Dylan & Douglas, 2001; Cohen & Nonacs, 2005; Elster, 1990; Sherr, 1995; Swann, Bowe, McCormick & Kosmin, 2003).

Three of the four women viewed their partner as their primary and most effective support. These partners were utilised for emotional support rather than their knowledge of pregnancy:

> My partner, he doesn't know much about [pregnancy], I tend to talk to him but he doesn't know much if I ask him a question.

Alternatively, all the participants identified the women in their lives who had experience of child-bearing such as mothers, partner's mothers and grandmothers, as their avenue for pregnancy-related support. This role-modeling from other women is identified by Wepa and Te Huia (2006) as a very traditional and normative process for young Maori women.

Two of the women who had reduced extended family support felt that their support was lacking. Magyary (2002) stresses that connectivity with others is essential for mental wellbeing. Informal supports are vital as women were more likely to disclose matters within these networks rather than to their health professionals. Dearman et al. (2007) believe this reluctance amongst women to seek help from professionals stems from fear of a negative reaction. For those women who did not have extensive informal networks, formal support services became even more important.

A focus on physical health issues and post-partum issues
The first question asked of the participants was how the pregnancy had been for them to date. When asked this question each of the four interviewees commented from the outset about how they were feeling physically, such as whether they had suffered morning sickness. Even when asked directly to comment on their emotional wellbeing the women at times referenced a physical component.

Two of the four participants did not identify mental health issues that can be triggered by pregnancy and appeared surprised by the questions around this. When the participants were aware of maternal mental health issues these were focused on depression and the post-partum period:

> I might have this totally wrong but people tend to focus on the post-natal depression rather than ante-natal if you like people don't seem to focus on ante-natal depression I mean obviously it can happen but I don't know for example if there's an ante-natal depression support group available? No one really seems to focus on the ante-natal depression possibility.

The misconception that mental health information would be received later in their maternity care highlights the lack of accurate and timely information in this period. Additionally, one participant's lamenting of the poor community services in the ante and perinatal period indicates a lack of formal support for women at this time. The Health Funding Authority (2000) has acknowledged that women are not receiving adequate information in pregnancy; however, this recognition does not appear to have been transferred into practical application.

First pregnancy: Expectations and knowledge
When asked about their expectations and knowledge of pregnancy, all four of the young women identified a range of different expectations, often from comparisons with other pregnant women, which appeared to create some anxiety if not met:

I think I did expect things to be different. Maybe that's my fault for having these expectations.

This is consistent with Fry's (2001) thesis that explores the pressure placed upon women by core myths of motherhood. Unrealistic expectations placed upon pregnant women can exacerbate maternal mental illness when these ideals of motherhood are frequently unable to be met (Chelser, 1997; Fry, 2001).

Adjusting to the unknowns of pregnancy can trigger a pregnant woman's feelings of anxiety and fear as well as a concern for reassurance that what they are going through is 'normal'. A number of times the participants asked the researcher what she thought of their experiences and whether this was usual. Two participants felt they had little to no knowledge about pregnancy, or even very practical matters such as how to secure a midwife. The younger women appeared less conscious of their lack of knowledge not expressing concern around this. Elster (1990) recognises this difference between the concerns and personalities, and thus parenting styles, of younger and older mothers.

Wakschlag & Hans, (2000) connect a lack of knowledge and information to young women's lack of preparation for pregnancy, identifying that for this population pregnancies are often unplanned. Even those who have planned their pregnancies can find themselves unprepared, which was the case for one participant:

I didn't know anything and I wanted a bit more information, like what happens now and a bit more of the process than just 'now you go to a midwife'. I wanted to know a bit more about pregnancy stuff and what to expect now. [...] I didn't know anything much.

A lack of knowledge of pregnancy is lamented by Wepa and Te Huia (2006) as indicative of the breakdown of cultural safety in pregnancy.

It would have been considered unusual for a female adolescent not to have a clear idea of what to expect with her first pregnancy, given the high level of support and education that was available to her (Wepa & Te Huia, 2006, p. 27).

It was important for the young women in this study that they receive practical ideas and advice about what to expect as this helped alleviate anxiety. The four participants referred to the use of books and other practical resources including audio-visual materials, the internet and resources provided by the midwife.

Importance of midwives, ante-natal classes and other professionals

Midwives

Midwives play a crucial role, second only to partners and families, in supporting young women in the perinatal period. Midwives were essential as the primary formal support that women accessed when concerned about anything, whether physical or mental with their pregnancy. However, a range of relationships with the midwives were identified. Service delivery provided to the participants changed depending on who the midwife was at the time and whether the midwife was hospital or community based. The low workforce numbers of midwives overall and particularly a lack of Maori midwives is problematic as recognised in the literature (Wepa & Te Huia, 2006). Women who are 19 years or under are

also less likely to feel they receive enough information when choosing a lead maternity carer (National Health Committee, 1999). Both young, Maori and rural-based women receive less midwifery visits than allocated (New Zealand Health Information Service, 2006).

The participants did not always have a completely open relationship with their midwife believing that the focus of this service was upon physical health needs and the baby, rather than themselves:

> I don't feel that I can tell her my problems. I just have to see her and it's all about the baby really.

They also did not feel they received all the information they could have from their midwife.

One participant had particular issues establishing a relationship with one midwife due to structural barriers that hampered her securing a consistent person in this role. This is a historical problem recognised by the National Health Committee (1999). Sometimes the disclosure of sensitive issues to the midwife was considered in a careful and tentative manner. More happily, all of the women found their midwives were approachable and contactable at any time. However, the participants all demonstrated a desire not to bother the midwife with their problems. This tentativeness and the inconsistency in midwifery care is concerning when stability is necessary to counter the instability caused by mental ill-health and to recognise subtle changes in a woman's presentation (Price, 2007).

Other professionals / ante-natal classes

A feeling that the midwife was only concerned with the baby's status and wellbeing and the apparent lack of attendance to previous mental health issues of the women led two of the young women to look elsewhere for support for themselves. For example, the two accessed other counsellors. The desire to find ante-natal and childbirth education classes also triggered contact with different services.

There were some concerns expressed about ante-natal classes by three of the participants. Some classes had a cost associated with them or were limited to members. One participant did not feel this cost was worth the benefits she would receive as a member. Young women that are struggling financially may not access services that will cost.

General practitioners

While the four participants often spontaneously talked about their midwives they did not tend to refer to their general practitioner. The participants were asked specifically about their involvement with their GP in order to get a clear picture of what professionals the participants were involved with and how they experienced this contact.

All four participants had minimal or no contact with their GPs. It appeared from the participant interviews that for three of the four women the GP role in the pregnancy was limited to diagnosis of pregnancy. Cost, availability and relationship quality were all factors for the women in the amount of contact they had with health professionals, particularly GPs.

One participant did not feel the GP was a suitable person with whom to discuss mental health matters. The GP was associated with medication and prescribing, which was deemed unhelpful for emotional concerns. Despite this the midwife and general practitioner were

the primary health providers the participants identified they would contact if they had any mental health concerns during the perinatal period. In a survey completed by the National Health Committee (1999) some women identified they would have preferred their doctor and midwives to work better together and that the transfer between these maternal health professionals and other services was problematic. This is consistent with the experiences of the four participants for example with additional community support services or counsellors.

Accessibility of health and support services

Most participants felt their midwives were easily accessible and responsive, while networking with additional services varied. None of the participants identified services they could access if concerned about their emotional health but stated they would access their midwife or informal supports if this occurred. Thus the general practitioner and midwifery roles had a primary function in connecting the young women with wider health and maternity services. From the interviews conducted the process of attaining additional supports and midwives usually began at the point where the pregnancy was confirmed. For example if women were tested at the GP surgery it was here that they received information about midwives or viewed flyers about pregnancy services in the community.

The participants did not appear well-informed about services that were available to them. This reflected both participants' lack of knowledge of support services available and a void of appropriate services:

> I asked right at the beginning is there anything in [local area] for pregnant women [...] at the time I didn't have anybody in my situation really actually pregnant that I knew in the town, I don't know what I was actually looking for, some kind of support group.

Price states 'an inconsistency and lack of coordinated services have also been identified as major factors in perinatal mental healthcare' (Price, 2007, p. 5). One participant wondered about the level of support services available and felt this needed to be addressed. Services the participants did access that were discussed more positively were those with youth-friendly, comfortable and approachable environments. This included having a warm, physical space that did not appear too clinical, to meet others of their age and situation, and to receive information.

Education/vocation

While the four participants were not directly questioned around their educational or employment plans, discussion of these matters usually arose when women were talking about the support they had in their pregnancy. Of significance in the research, and an indicator to the researcher of the women's motivation, three of the four women were in or studying towards professional employment. Those completing their studies received positive, supportive responses from their education providers with clear vocational goals following the achievement of their qualification.

> The teachers are nice [...] they kind of make special allowances and stuff for me [. . .].

Hill, Fouché and Worrall (2005) completed more targeted research on the impact and importance of education during pregnancy and post-natally for adolescents. They identified

numerous factors that can help or impair adolescents' educational achievement at this time. Herd (2006) has recognised the importance of completing education for Maori women with children. Thus, it was pleasing to hear from all of the participants who were engaged in tertiary education that adjustments were in place to allow them to complete their studies.

Analysis

Several themes stand out from the data and are presented below. These include stigmatisation, blame, physiological definitions, economic contribution, health concepts, the gendered nature of mental health, youth and their access to health services, concepts of pathology, social control and a bio-medical focus.

Stigmatisation

Throughout the research findings and within the literature, 'risk' factors for young women are frequently identified. Risk factors become attributed to certain groups, such as young pregnant women, and are difficult for these populations to lose (Beckwith, 2000; Nash, 2001; Zeanah, 2000). Risk factors are generally enforced on populations, determined by health professionals rather than those affected. Within the participant interviews, pregnant young women were able to identify their own 'risk factors', some of which paralleled those the health professionals identified and some that differed as they were based on systemic issues. For example, costs of attending general practitioners and the lack of relationship building by GPs were identified by the participants as concerns. However, these systemic risk factors were not overtly identified by the health professionals, reflecting how individualistic health models can be.

The prevalent stereotypes of young pregnant women were not reflected in the interviews with the four participants. Instead, the four participants were motivated and focused on the wellbeing of their unborn child, often contending with difficult life circumstances. They demonstrated selflessness in wanting to be involved with the research so that they could share their experiences and help other young women. While health professionals utilise health jargon to criticise behaviours of young pregnant women, two of the participants attempted to frame their responses about health professionals in a non-critical way.

Blame

The young pregnant women tended to blame themselves for aspects of their situation. This self-blame was identified in the interviews when women were perceived as living within negative circumstances or not meeting others' expectations through their pregnancy. Even if the young women's needs were not being met by health professionals the participants would question whether this was because of something they had or had not done. This reflects the ingrained woman-blaming that occurs within western societies that blame the young woman for her individual actions, or blame the young woman's own mother for not socialising her correctly (Chesler, 1997).

Such blame emerges from societal values inherent in matters of youth pregnancy that surround illegitimacy, perceived promiscuity and moral behaviour, and the family (Chesler, 1997; Sherr, 1995). This remains apparent in the present day with matters such as teen pregnancy, a situation that for other cultures may be accepted. The time spent with the young pregnant women demonstrated how the women were coping in sometimes very difficult

circumstances and how their families supported and accepted them without buying into a cultural perception of the situation as an offensive one.

Physiological definitions

Women continue to be defined by their bodies and physiological changes (Chesler, 1997; Price, 2007; Showalter, 1985). Pregnancy is one of the greatest of these physiological changes as women's bodies go through extensive physical change. The historical literature identifies the phenomenon where women are seen as reproductive creatures without an individual or sexual identity (Chesler, 1997; Showalter, 1985) and this continues today. This conceptualisation of women is so ingrained in New Zealand society and the medical system that the young women interviewed unknowingly maintain it themselves by referring primarily to physical issues and minimising emotional responses to their social circumstances (Gutteridge, 2007).

Economic contribution

Three of the four young women interviewed referred spontaneously to their employment and educational plans despite this not being a part of the interview schedule. Such questioning was purposely omitted to avoid collusion with an economic focus that determines a person's worth by their contribution to the national economy. That the young pregnant women felt a need to justify their future plans demonstrates the devaluing of our society on women's work within the family and child-raising (Price, 2007). On an individual level the references also reflect the importance of having a sense of mastery and productivity to wellbeing. However, overwork and stress are major triggers to women's ill-health (Hall, 2007).

Health concepts

The young pregnant women interviewed had very different backgrounds and cultures which impacted on their conceptions of what is healthy and meaningful to them. However, the health professionals had few mechanisms to capture the meanings of mental wellbeing for young women. When one of the participants referred to labile emotions connected with hormonal changes of pregnancy, she minimised this as not significant and judged herself as overreacting. This participant did not seek assistance with these matters, coping with them alone. Gutteridge (2007) has recognised the propensity of women to do this because their emotional health needs are ignored or seen as an individual problem by health professionals.

The literature base warns that perinatal interventions can further marginalise already oppressed groups. The New Zealand Health Information Service found a 'noticeably higher concentration of mothers living in more deprived areas' (2006, p.17). Three of the participants received information in pamphlets, but women who do not have good literacy skills will not be able to discover support services and information in this manner. Similarly, women who do not have the financial resources needed to transport themselves may not access services they need. This, coupled with the reduction in home visiting further discriminates against poorer women and youth, some of whom may not drive or have appropriate supports to take them. Thus, health inequalities can be exacerbated (Shakespeare, 2005).

Gendered nature of mental health services

Women are overrepresented within most mental health statistics both in New Zealand and other western countries. In particular, female hospital admissions are frequently in excess of males, with outpatient and community settings also dominated by female clients (Fry,

2001; New Zealand Health Information Service, 2006). Travis and Compton (2001) questioned whether higher rates of certain mental health issues mean there is actually a higher morbidity in women or whether they are reflective of socially constructed gender roles or gender bias in psychiatric diagnosis.

The findings in this research suggest that young women are being expected to fit into services and health structures created by men and those who are not connected with youth issues and may even carry negative stereotypes of young pregnant women (Price, 2007). Young women are often blamed for their lowered uptake of mental health and general health services; however, matters not acknowledged are the barriers that may be impeding this help-seeking. If services are not youth-focused, young women are less inclined to seek help (Shakespeare, 2005).

Youth and health services
Creative ways to reach youth populations are required (Parsons, 2008). Clinical experience shows that young women do access supports for shorter periods of time. They often have limited transport or other access barriers and they may have partners or family that are unsupportive of their therapy needs (Parsons, 2008). Additionally, young women desire clear connections between the supports available and their own identified goals. The women interviewed all discussed aspects of health services they did or did not respond to. For example, interpersonal styles of some health professionals meant the young woman did not engage (Parsons, 2008). Use of technology, such as text messaging, was more helpful. The only female doctor referred to in the participant or key informant interviews was providing such access to young women, with good outcomes.

The current research revealed there were few services created by young women for young women. Reference was made to one youth-friendly pregnancy service and one women's centre which was resourced minimally and not specifically for pregnancy matters or mental health. Primarily, young women are expected to have their needs met in male-centred services. Many young women present with the impacts of trauma and domestic violence that can be triggered within services males attend and that are dominated by male professionals (Price, 2007). This occurs at a time when the young women are already emotionally vulnerable (Price, 2007).

There was little indication from either the health professionals interviewed or the young women participating in this study as to who are acting as advocates for young women within such systems. Price (2007) states an advocacy role is needed to ensure women-centred interventions are received by young women. The interviews with young women indicated a level of frustration that minimal services were offered to them in the perinatal period, but also a resignation to this.

Concepts of pathology
In a particular cultural context, notions of gender influence the definition and, consequently the treatment of, mental disorder (Showalter, 1985, p. 5). From the research data the participants referred to depression and anxiety as potential mental health issues faced by women. Depression and anxiety have become more socially acceptable disorders for women, as reflected in the prevalence rates of the diagnosis of these disorders for women aged 10-39 years (Abramowitz, Larsen, & Moore, 2006). There is a propensity to assign such diagnoses

which individualise problems rather than acknowledging their social causes. No recognition was made of other presenting mental health issues that may be less endearing or reflect 'non-feminine' behaviours, such as alcohol and drug addictions or puerperal psychosis.

Labrum (1990) recognises that this propensity to avoid other diagnoses has a long history in New Zealand. Acknowledging the increased incidence of traumatic events faced by young women means acknowledging the marginalisation of women in a society where men continue to overpower women by exploiting sexual and reproductive difference.

Travis & Compton (2001) identify that the lived realities of women's lives are characterised by a social context that places them in powerless positions. This is particularly the case for young pregnant women. The power differentials and societal repercussions faced can lower self-esteem and exacerbate feelings of helplessness, anger and hopelessness that interfere with treatment (Travis & Compton, 2001). Travis and Compton maintain that it is actually the expressed anger from reactions to such powerless situations that become pathologised in individual women rather than any inherent mental health problem.

Social control

In health policy and research, pregnant women have become targeted because they have to access services at some point in their pregnancy. Young women can have valid fears of statutory services based on previous engagement with such services as this contact may have been influenced by the stereotypes of young mothers discussed previously (Leverton, 2005). Shakespeare (2005) identifies evidence that women do not want to be screened, or labelled 'depressed' and in fact often do not consider themselves depressed. The young women interviewed did not appear to associate with such language, instead identifying their own terminology that was meaningful to them. This demonstrates the importance of allowing women to categorise and identify their own experiences, rather than having labels enforced upon them.

A bio-medical focus

The comments made by the participants regarding contact with the GP indicate the daily expression of a medical model. Some of the problems within maternity services that this research found such as the medicalisation of childbirth have had the most significant impact on Maori women (Wepa & Te Huia, 2006). GPs are expected to consult with women in a very limited time frame which is enough, under a biochemical understanding, to assess, diagnose and treat medically. However, in 15 minutes the doctor cannot, as recommended by Hall (2007), attend to the young women's physical, mental, spiritual, social and cultural needs required for well-being. Instead, women have to attempt to access numerous health providers to have these holistic needs met (Parsons, 2008).

Within the interviews the young pregnant women and the health professionals referred firstly and frequently to physical health issues of pregnancy. Such a focus on physical matters reflects problems inherent in a medical model understanding of health. Mental health presentations do not easily lend themselves to a medical model analysis. There are numerous causal factors for mental illness that make it difficult to reduce such illnesses to one causal factor as the medical model attempts through imposing a reductionist and mechanistic framework (Donnelly & McGilloway, 2007). Knowledge held about the epidemiology of mental health issues associated with pregnancy is much less than that known of many physical illnesses

which medical professionals have researched. Rather than acknowledge the problems inherent in a medical paradigm, mental health matters are avoided as they highlight these deficits. Subsequently, the disease and deficit focus undermines mental health promotion.

Implications for social work practice

Social and community workers should have a core role in assisting women during the perinatal period. This is because there are areas where their input is beneficial but also due to the considerable influence this period has on a young woman and her family and offspring. Primarily, social workers' intervention with psycho-social issues is relevant. Social and community workers can assess and attend to informal and social supports and work alongside the young women and their family to improve these. These supports are shown in this research, and within the literature, to be the most potentially problematic *and* the most protective for young women's maternal mental health.

Secondly, the focus on social justice and equitable access to resources is essential. The trauma associated with oppression of marginalised groups, such as young women, is compounded when women are blamed and pathologised for their situations. This is often the case for young mothers who are blamed for becoming pregnant and engaging in socially unaccepted behaviours (Sherr, 1995). A social work role becomes important in this field as one of the commitments of the Aotearoa New Zealand Association of Social Workers is 'to advocate for full social justice in Aotearoa New Zealand and address oppression on the grounds of race, gender, disability, sexual orientation, economic status and age' (Aotearoa New Zealand Association of Social Workers, 1993, p. 22). The research showed that younger pregnant women have multiple sites of stigmatisation alongside numerous access barriers. Social workers can break down the stereotypes around young pregnant women that the participants themselves inadvertently reinforce in their own discourse but do not necessarily demonstrate in their actions and lives.

Finally, the holistic and contextual viewpoint of a social work paradigm can ensure more than just the physical health of the mother and child in utero is attended to. The incorporation of social workers into public health organisations, primary health care and general practitioner sites will go some way to achieving this. Health social and community workers cannot assume women are discussing non-physical issues with their midwife or GP. The social workers' networking, collaboration and liaison skills come to the fore as women, professionals and policy writers have recognised the need for increased communication between maternity providers. The 21st century social worker working alongside generation 'Y' must be familiar with how technology can be used to get information to young and new parents and thus increase access and support, without which many women are at risk of unsatisfactory support.

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