

# Perinatal Depression – Where Are We in 2008?

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## Abstract

Perinatal Depression affects 16% of Australian women, with long term potential negative consequences. This article from a key note address at the Women's International Mental Health conference in Melbourne 2008, reflects on the author's clinical and research experience and where appropriate with reference to the literature, to make a case for making changes to health system and society to improve outcomes for Australian families.

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## Perinatal Depression – Psychosocial Influences

At a recent International Women's conference in Melbourne, Australia, the media hooked onto – amongst other things – a suggestion that perhaps the baby bonus (a one off cash payment to new mothers) might be better directed to services supporting new mothers. Whilst this was inflamed to “mothers use baby bonus for plasma TV's” and their responses of “and why not” (News.com.au, 2008), the underlying message the media conveyed was one that the baby bonus – unlike paid maternity leave – does not give the message to women and society that motherhood is important. Instead women are given the message that it is easy, natural and instinctive – and that they are failures if this is not the case; when this is not the case the result is confusion, guilt and at odds with expectations (Dennis and Chung-Lee, 2006). When googling images for sad mother and baby, all that comes up is this title – and that you won't find it and an article explaining why; in contrast are the many images of happy mothers and babies. One is either the perfect mother – see images of Princess Mary of Denmark; or bad - see any number of articles and web site images of Brittany Spears.

A number of cultures are more successful in promoting motherhood's importance – substantial paid leave for instance in Scandinavian countries. Others are better at supporting new mothers. In a number of traditional Asian cultures, for the first month or two postnatally, the mother is cocooned, kept away from housework and cared for by family. There is some

evidence that this has at least a small protective effect against developing depression (Lee et al., 2004).

Support, or rather the lack of it, consistently comes up as a risk factor for postnatal depression (O'Hara and Swain, 1996, Milgrom et al., 2008). In particular practical and emotional support, and support from mother and partner appear the most crucial (Milgrom et al., 2008, Dennis and Ross, 2006). Other psychosocial factors interplay with this; low income, childcare stress and stressful life events also seen to be important (O'Hara and Swain, 1996, Beck, 2001). If we combine this knowledge with Western societal unrealistic expectations imbedded in media hype and misinformation, as well as our communities structure that further promotes isolation – home ownership in “new” suburbs that are affordable but distant from supports and family, and lack of paid maternity leave sending people rapidly back into the work force to fulfil the “having everything and having it now” mindset – then we have a lethal cocktail. Combine this with those we know who are most at risk – those with family and past histories of depression, childhood abuse (and hence lack of role models for parenting) (O'Hara and Swain, 1996) the result is not just postnatal depression, but antenatal anxiety and depression that then continues through the postnatal period. These factors then continue to work against women; they delay getting help because they do not recognise themselves as depressed, as well as issues such as stigma, fears of being a bad mother and of failure (Dennis and Chung-Lee, 2006).

## Why Does It Matter?

Increasingly research shows that the early years, beginning in utero, are crucial to development and later mental health. Whilst we are as yet unable to tease out the relative contributions of genetics and environment, considerable work on the latter suggests a strong role for “mothering” and the mothering environment. Animal studies show “good” and “stressed” mothering behaviour influences the offspring's biology – which may in turn influence its' ability to mother later in life (Brummelte et al., 2006). Human studies have shown maternal anxiety in pregnancy affects infants biologically in a way that may predispose to later

mental ill health (O'Connor et al., 2002), as well as maternal depression postnatally being associated with poorer emotional and behavioural outcomes for children, possibly through insecure attachment, role modelling and poorer parenting techniques, as well as exposure to other risk factors (eg poverty, domestic violence) more common in a mentally ill population (Murray and Cooper, 1997b, Murray and Cooper, 1997a, Buist, 1998).

Many studies have looked at how many women perinatal depression affects. Our large beyondblue study screened 40,000 women for perinatal depression across Australia and assessed its feasibility and acceptability; unlike many studies, it included rural, regional, public, private, Indigenous and non-English speaking women, and suggested the Australian figure is at least 16% (Buist et al., 2008). This is a little higher than, but in keeping with, O'Hara & Swain's 1996 meta-analysis (O'Hara and Swain, 1996). A quarter of those identified in our study as potentially depressed did not seek or accept help (Buist et al., 2006); of those who did, they are likely to have had psychological and pharmacological treatment aimed primarily at their mood. These are known to be effective (Dennis, 2004, Dennis and Stewart, 2004), but there is still a risk of chronicity, particularly for those continuing without supports or whose childhood issues continue to trouble them (Buist and Janson, 2001), and these inputs do not necessarily improve attachment, parenting and thus the child outcome.

This means that a significant proportion of the next generation who are going to face major social challenges such as global warming and the obesity and diabetes epidemics, already touted as decreasing their life expectancy - with reduced social structure (ie higher divorce rates and less religion) and a higher propensity for mental illness. Our increased youth suicide may already be an example of the difficulties and potential poor outcomes.

In other words, mothers – and fathers – matter: and we need to do something.

### **The Way Forward – an Opinion**

As an academic it is tempting to answer that the way forward is to do more research; we are on the cusp of far greater understanding of the complicated and fascinating ways that biology and psychology interrelate. And indeed this research does need to be done, and in greater understanding will be better and more targeted treatments. But we can't wait, and there is ample evidence to begin with.

In bringing about change three key factors need consideration.

The first is identification. Currently most women are not identified early because there is no routine screening or psychosocial assessment in pregnancy or the postpartum; we know that if not routinely asked, even experienced clinicians can easily miss depression (Hatton et al., 2007, Buist et al., 2002), and that women themselves are poor at recognition (Buist et al., 2007, Dennis and Chung-Lee, 2006). Canada currently routinely asks all pregnant women a few, basic psychosocial assessment questions. Other countries have brought screening in particular regions but not universally. Leading on from this, in Australia, beyondblue, a not for profit depression initiative that funded the large screening feasibility study have been leaders in broadening perspective on perinatal depression with respect to putting research into practice. They are currently working with a Steering committee and State and Federal government to bring routine assessment in as part of perinatal care for all women. This requires coupling with training and ongoing support of midwives and maternal child health nurses in particular, but also of a broader range of health professional involved in perinatal care.

However, there also needs to be pathways to care for these women.

This leads to the second factor and a harder and more costly task, that is, what care is available. In the original beyondblue study available services – General Practitioners (GPs) in particular – were relied upon to assess women who may have been depressed. There was understandable angst from this group, concerned that they would be inundated. In fact it appears that this did not happen; GP's already see most postnatal women – it just changed the content and direction of the interview. With training they felt better able to care for these women, and referred less to mental health services. And most likely the education the women received through the screening process, which included an information booklet, enabled them to use services more appropriately and efficiently (Buist et al., 2007). This does not take away from the fact however that services are patchy and often inadequate, and at a worldwide level often nonexistent. Melbourne, Australia is the only city in the world with adequate inpatient mother-baby unit beds for the more seriously ill. In particular, there are few services available to target the emotional well-being and development of the infant, which is the greatest risk and cost to the community when things don't go well.

There is no easy answer to this, and just providing more money and more services is also not enough.

The third factor that needs consideration is that of the bigger picture – how much as a society do we value

motherhood and our children? Returning to the baby bonus, whilst many new parents value it to help ends meet with the increased cost of life with a new mouth to feed, paying the bills does not help these women feel more confident as a mother and does not help their transition to parenthood which is so often at odds to their fantasy, or help them make up for the sleepless nights that can begin the spiral into despair.

Ideally it would be better to help these things, and help them early, so parenthood can begin in a positive way and the child not blamed and labelled as colicky, having reflux, being unsettled or difficult. The baby bonus would pay for a “Doula” or mothercraft nurse (easier to train and more attractive for some than nursing) for a significant period; though Doula’s have not in themselves been evaluated in this context, similar types of input have been shown to be beneficial for those at risk (Shaw et al., 2006, Olds, 2005). This “Doula” traditionally cares for the mother, cares for the baby, helps where she is needed, providing relief, support – and helping with confidence. Though hard to evaluate its effect, it would provide a strong message that mothering is important and valued (rather than being given money for delivering a baby for your country) as well as helping, if coordinated carefully, with the early identification of depression and anxiety, those at risk of this and other parenting issues.

To shift the slide away from valuing parenting and the family unit we as a society need to ask ourselves hard questions – and harness the media in a supportive partnership to promote the messages we think should be heard. The hard questions are not trivial – where do gay parents, and single parents fit in if “family” values are promoted? How much are we prepared to push longer paid maternity and paternity leave – and how much as a country can we afford (or what are we prepared to give up)? How do we teach the bigger picture of better parenting – sacrifice, being tough and providing boundaries - when this generation has promoted you can have it and have it all? We don’t have the answers – but unless we ask the questions and find them, then we can expect more perinatal depression and anxiety – and more poor outcomes for the subsequent generations.

## References

- Beck, C. (2001) Revision of the Postpartum Depression Predictors Inventory. *Journal of Obstetrics & Gynecology* NN, 31(4), 394-402.
- Brummelte, S., Pawluski, J. L. & Galea, L. A. (2006) High post-partum levels of corticosterone given to dams influence postnatal hippocampal cell proliferation and behavior of offspring: A model of post-partum stress and possible depression. *Hormones and Behavior*, 50, 370-382.
- Buist, A. (1998) Childhood abuse, postpartum depression and parenting difficulties: a literature review of associations. *Australian & New Zealand Journal of Psychiatry*, 32, 370-378.
- Buist, A., et al. (2002) To screen or not to screen - that is the question in perinatal depression. *Medical Journal of Australia*, 7/10/02 Issue, S101-S105.
- Buist, A. and Janson, H. (2001) Childhood Abuse, Parenting and Postpartum Depression : A three Year follow up study. *Child Abuse and Neglect*, 25, 909-921.
- Buist, A., et al. (2007) Impact of education on women with perinatal depression. *Journal of Psychosomatic Obstetrics and Gynaecology*, 28(1), 49-54.
- Buist, A. E., et al. (2008) Postnatal mental health of women giving birth in Australia 2002-2004: findings from the beyondblue National Postnatal Depression Program. *Australian & New Zealand Journal of Psychiatry*, 42, 66-73.
- Buist, A. E., et al. (2006) Acceptability of routine screening for Postnatal Depression. *Journal of Affective Disorders*, 93, 233-237.
- Dennis, C.-L. (2004) Treatment of Postpartum Depression: Part 2. A clinical review of nonbiological interventions. *Journal of Clinical Psychiatry*, 69(9), 1252-1264.
- Dennis, C.-L. and Chung-Lee, L. (2006) Postpartum depression help-seeking barriers and maternal treatment preferences: a qualitative systematic review. *Birth*, 33(4), 323-331.
- Dennis, C.-L. and Ross, L. E. (2006) Women's perceptions of partner support and conflict in the development of postpartum depressive symptoms. *Journal of Advanced Nursing*, 56(6), 588-599.
- Dennis, C.-L. and Stewart, D. (2004) Treatment of postpartum depression: Part 1. A critical review of biological interventions. *Journal of Clinical Psychiatry*, 65(9), 1242-1251.
- Hatton, D., Harrison-Hohner, J., Matarazzo, J., Edwards, P., Lewy, A. and Davis, L. (2007) Missed antenatal depression among high risk women: a secondary analysis. *Archives of Women's Mental Health*, 10, 121-123.
- Lee, D. T., Yip, A. S., Leung, T. Y. and Chung, T. K. (2004) Ethnoepidemiology of postnatal depression. Prospective multivariate study of sociocultural risk factors in a Chinese population in Hong Kong. *British Journal of Psychiatry*, 184, 34-40.
- Milgrom, J., et al. (2008) Antenatal risk factors for postnatal depression: a large prospective study. *Journal of Affective Disorders*, 108(1-2), 147-157.
- Murray, L. and Cooper, P. (1997a) Effects of postnatal depression on infant development. *Archives of Disease in Childhood*, 77(2), 99-101.
- Murray, L. and Cooper, P. (1997b) Postpartum depression and child development. *Psychological Medicine*, 27, 253-260.

- News.com.au (2008) Spend baby bonus on nurses, not TVs In [www.news.com.au/story](http://www.news.com.au/story).
- O'Connor, T., Heron, J., Golding, J., Beveridge, M., Glover, V. and & the ALSPAC Study Team (2002) Antenatal Anxiety Predicts Child Behavioural/Emotional Problems Independently of Postnatal Depression. *Journal of American Academy of Child Adolescents Psychiatry*, 41(12), 1470-1477.
- O'Hara, M. and Swain, A. (1996) Rates and risks of postpartum depression - a meta-analysis. *International Review in Psychiatry*, 8, 37-54.
- Olds, D. (2005) In *Enhancing early attachments*. (Eds, Berlin, L., Ziv, Y., Amaya-Jackson, L. and Greenberg, M.) Guilford Press, NY.
- Shaw, E., Levitt, C. and Wong, S. (2006) Systematic review of the literature on postpartum care: effectiveness of postpartum support to improve maternal parenting, mental health, quality of life, and physical health. *Birth*, 33(2), 210-220.

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