Research Update 2015

Communication around perinatal emotional and mental health

The rationale for a new approach to positioning information *outside* of a mental health context.

It is well established that the perinatal period is the time is a woman's life when she is *most likely* to develop mental health conditions. As a result, often communication approaches have traditionally been positioned within this *mental health/illness* context.

However, as outlined in this research summary, qualitative and quantitative research outcomes demonstrates that such an approach is likely to be counterproductive – as this does not fit with the mindset of consumers.

Further the unique attributes of stigma within the *perinatal context specifically* highlight the importance of raising awareness and educating women and men in the context of 'having a baby' as opposed to the context of 'mental health' or 'mental illness.

COPE
Centre of Perinatal Excellence

Background

Extensive qualitative research originally undertaken by *beyondblue* with women who had a history of perinatal (pre and/or postnatal) depression and/or anxiety, revealed a number of barriers to identification of symptoms, accessing of information and treatment.

Following, the extent to which these themes were reflected across the population was then evaluated by COPE: Centre of Perinatal Excellence. This was achieved through quantifying the observed themes (as identified in the qualitative research) through an online survey of over 1045 women who had a personal history of perinatal depression and/or anxiety.

This executive summary provides an outline of these research methodologies to demonstrate the extent to which these initial findings are represented across a broader sub-population and discusses their relevance to future approaches to communication in the context of perinatal mental health.

What delays early identification, information and help seeking?

Initial qualitative research indicated with women who had experienced pre or postnatal depression and/or anxiety did not seek help early. Rather help was often not sought until a *crisis was reached* or the women described themselves as reaching *breaking point*.

A range of reasons were able to be attributed this delay in identification and help seeking.

#1: Conditions are perceived to be conceptually different

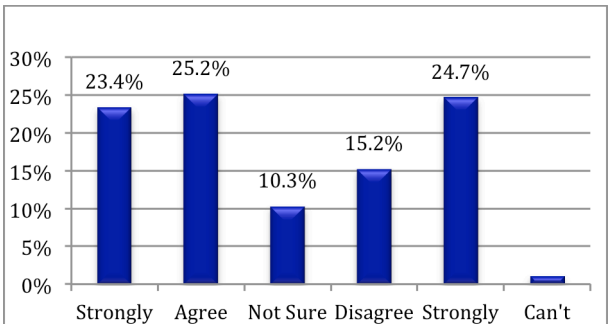
Many women indicated that they did not view depression and anxiety in the perinatal period to be the same as that that may be experienced at other times of life. Contrary to clinicians' views, consumers are more likely to view these conditions in the context of having a baby (a 'complication' of pregnancy or 'having a baby') as opposed to a mental health condition.

As a result, signs and symptoms are commonly viewed within the context of pregnancy, the baby blues, or adjusting to a new baby - as opposed to signs of clinical depression or anxiety.

"I just put it down to hormones and thought it would pass, six months after her birth I was still there."

By attributing possible signs of perinatal depression and/or anxiety to the context of having a baby, the opportunity for detection (and early intervention) in pregnancy or early in the postnatal period is often missed. For example, almost half of those in a sample of 802 women did not recognise symptoms of depression/anxiety in pregnancy.

Fig 1: I probably had symptoms of depression and/or anxiety while pregnant but I didn't recognise them



Often therefore, symptoms of depression or anxiety were only recognised in hindsight (and often not until the subsequent birth years later).

"I did not realise until I looked back that I had been feeling abnormally anxious over the first year of my daughter's life.

#2: High expectations

Women also described holding high expectations of what pregnancy and motherhood were likely to be like.

"I wanted the experience to be so much – I wanted to make it lovely for everybody, so I kept playing the part. I felt like an actress in a role until I couldn't hold it together any longer"

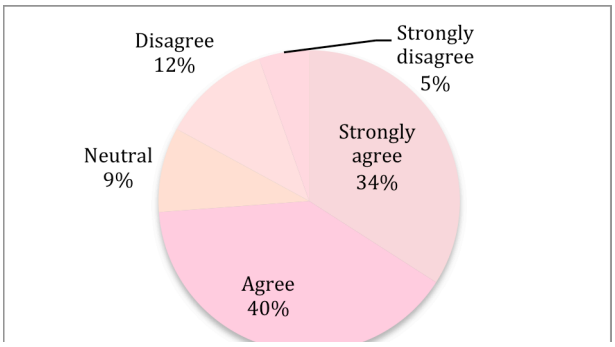
When, however these perceptions or ideals did not align with the reality of their experience, many women denied their symptoms (hoping they would pass). Women commonly described feeling ashamed and would not disclose to others.

"I wish I had got help earlier and told people, but I was too ashamed. Everyone around me saw me as a 'coper'. I couldn't tell them I wasn't.

This finding is reflected across the larger sample of over one thousand women.

Here almost three quarters of women (74%) indicated that they *did not want to admit that they were not coping*, and did not seek timely support or treatment.

Fig 2: I did not want to admit that I was not coping (N=1045)



#3: Stigma

It is within this context that stigma surrounding perinatal mental health conditions may be considered *unique* – as one's ability to cope is not only associated with them *as a person*, but also *as a mother* and how she may be viewed or judged in this new role.

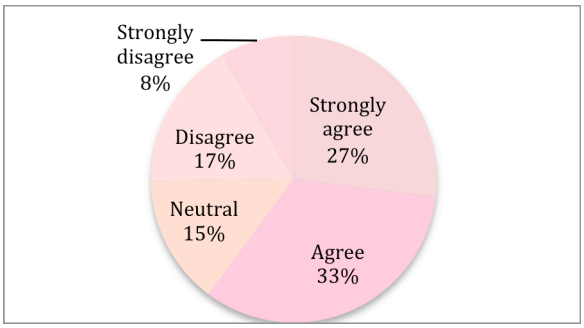
"I didn't want people to think that I couldn't do something, that I wasn't on top of everything and you're supposed to be radiant and happy - like all those ads on TV. You see the mothers radiant and perfect and wonderful – which I am not"

The pressure to live up to personal expectations (and societal pressures) and fear of judgment by others means often women do not share or disclose to others.

"I feel that many women are ashamed to admit how that are honestly feeling and/or coping. As a result, when I asked other women what their experience was, the comments I received were all positive. It was only when I opened up by saying I wasn't coping that other mothers opened up".

Non-disclosure means that women are often left feeling that *they are the only ones* who may be struggling or needing help and support.

Fig3: Motherhood seemed to come more easily to other mothers (N=1014)



Meanwhile media images of motherhood ideals were reinforcing their feelings of inadequacy and failure – further compounding on their depression and anxiety.

"You feel like a failure – you have this beautiful baby and you are not able to provide for him"

I felt sad, really sad and like I'd failed, I was hopeless and not good enough to be a

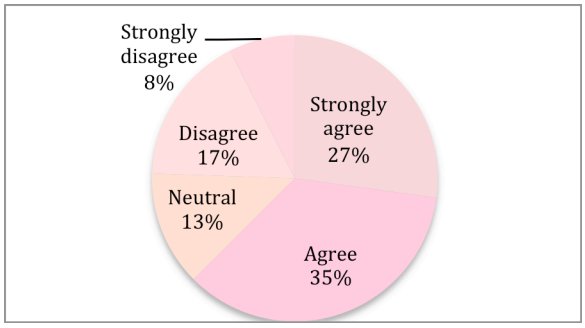
Within this context of motherhood, many women describe feeling *angry, ashamed* and/or *guilty* about experiencing their symptoms - at a time that was supposed to be such a positive time of life.

"I felt guilty as I wanted a baby for so long and when I finally had him, I felt anxious and depressed. I was so ashamed of myself"

"I felt so ashamed to feel this way, for feeling guilty and being seeing to have been a failure"

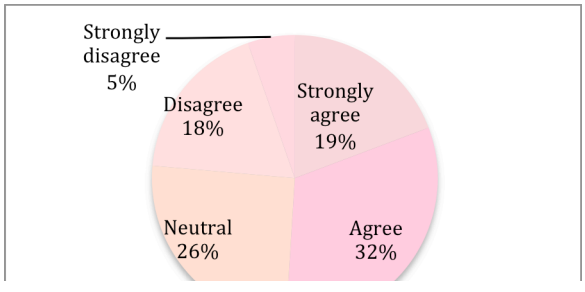
These feelings of guilt and failure were likely to remain for many years. In the larger sample, over half (52%) of women indicated that *'they were a failure as a mother'* and 62% indicated that feelings of guilt still remain with them to this day.

Figure 4: Feelings of guilt still remain with me (N=1011)



Furthermore, stigmatising attitudes surrounding conditions such as postnatal depression and the perception of those affected being of danger to others (particularly babies), are likely *further* inhibit acceptance and disclosure. This includes disclosure to health professionals due to the fear that the baby may be removed from their mother's care.

Figure 5: If you say you have postnatal depression people think that you are not safe to be around babies (N=1018)



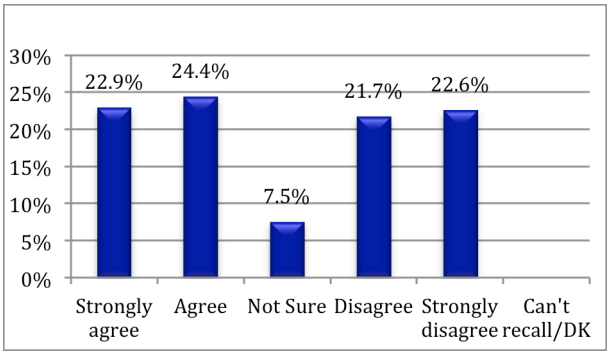
Implications for screening and disclosure

Many women fear how they may be judged by family, friends and even health professionals - which can also inhibit disclosure.

"I didn't show how I felt to the obstetrician – I was a successful, coping person"

These findings were also indicated in the larger quantitative sample where a significant proportion of women 44% were not confident to disclose how they truly felt to their antenatal healthcare professional.

Fig 6: I felt (feel) confident to tell my obstetrician/ midwife how I was/am truly feeling during the pregnancy (N=802)



In turn this also impacts on disclosure at the point of screening.

"I didn't want people to think I was not coping, I didn't tell the truth."

"I wasn't entirely honest in my answers with the nurse (felt like I would be judged)."

Key conclusions:

- There is a strong desire for women to want to view possible symptoms of perinatal depression/anxiety as 'normal' and within the context of having a baby.
- The context of motherhood leads many women to hold high expectations that are constantly reinforced by the media. This unique context places additional pressure on many women, and when these ideals are not met this can lead to denial, shame, grief and/or feelings of failure which ultimately compounds depression and anxiety.
- Perinatal mental health is likely to be even more highly stigmatised due to underlying perceptions of the mother's increased likelihood of harming her baby. Fears of how a mother will be judged by family friends and even health professionals, impacts on disclosure and screening practice.
- To address these challenges, information surrounding emotional and mental health needs to be positioned within the context of 'looking after yourself and managing the challenges that can come with having a baby'. This is in contrast to positioning information in the context of a mental illness, which is not likely to be to considered relevant (because information is viewed in the context of having a baby) or is likely to be too confronting for the consumer.

"I saw all of the brochures there, but I didn't think that information would be pertinent to me, so I didn't pay attention"

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