

Fact Sheet 1.

Maori

Tikanga (cultural values and beliefs)

The impact of our own cultural values and beliefs has a strong influence on the way we relate to each other. This can cause complications for doctors, nurses and midwives as it is particularly important to be aware of these issues when relating to patients who are often vulnerable. Behaviour and practices that are not consistent with Maori beliefs, values and concepts, can distress Maori and result in a lack of confidence and lack of participation in health care services.



Karakia

Karakia is “Incantation –particularly the ancient rites proper to every important matter in the life of the Maori”. Is a “normal” part of Tikanga Maori. Karakia may briefly precede assessment or healing or it may be an integral and ongoing part of the healing process, associated with other rituals like wai tapu (blessed water). Karakia is appropriate in preparation for, during and following birth.

- Karakia helps whanau:
 - To be focused
 - To achieve their goal
 - To maintain values
 - To protect everyone

Pregnancy and prenatal care (haputanga)

Pregnancy and prenatal care (haputanga) is a very special time for all. Maori believe that mothers and babies should be comfortable and relaxed throughout the pregnancy and birth. They feel that a baby is fully aware of what is going on in his or her environment and having a mum as calm and relaxed as possible for the entire pregnancy is of great benefit to the baby. Haputanga is a traditional Maori approach that utilises a combination of gentle belly massage, body alignment and pressure points.

Some benefits of haputanga for the whaea (mother) It eases discomfort during the pregnancy such as; back pains, strains, muscle aches, bladder and organ discomfort, tiredness and depression and stress relief. It also tends to shorten the length of labour and facilitates an easier birth.

Some benefits of haputanga for the peepi (baby) It helps keep the baby relaxed and calm, provides more room for the womb to expand so that the baby can move and grow comfortably and aids with keeping the amniotic fluid well balanced.

Nga matua (fathers) In the Maori culture fathers to be are taught how to do the Maori pregnancy massage and are advised to do it as often as possible, which helps create a more comfortable pregnancy for both whaea (mother) and peepi (baby). Sharing this form of intimacy helps form a close bond between the matua, whaea me te peepi, (father, mother and baby).

Postpartum care for whaea (mums) Repositioning of internal organs and realignment of the body after birth by haputanga is thought to help with postpartum depression.

Care for peepi and tamariki (babies and children) Infant/child chiropractic and cranial-sacral therapy. Energetic removal of birth trauma by these methods it is believed help with sleep disturbances; (reoccurring nightmares); colic; allergies; anger and depression.



Te whare tangata whenua (placenta), pito (umbilical cord)

Each of the terms below relates to different stages of the procreation – creation process and each state is seen as tapu. The female genital is regarded as tapu “Te Whare Tangata” or the “house of people and is where the procreation begins. **Whenua** relates to the placenta and to the land. The **whenua** (afterbirth) is returned to the **whenua** (land) and with the **pito** (umbilical cord) bond the link between the newborn and **papatuanuku**(mother earth). With this affinity established, each individual fulfils the role of curator, for papatuanuku (mother earth), which remains life long. **Whanau** relates to giving birth and to the family. **Hapu** relates to being pregnant and is also a sub-tribe of the **Iwi** (people) **Koiwi** (bones). **Hapu** – pregnant. **Hapu** – to conceive or being pregnant. A **wahine** (woman) is in a state of **tapu** when she is with peepi (baby/child). She is the bearer of the iwi (generations to come) and should be protected and guarded with respect.

A Maori Health Worker and/or Maori minister are offered should they want **karakia** (blessing) on the return of the afterbirth.

See also:

www.matatini.co.nz website of the Maori mental health workforce development

www.ngamaia.co.nz website of Nga Maia, a national organisation representing and fostering Maori midwifery.

There have been very few studies of postnatal depression in Maori women but it appears to be at least, perhaps more, common than in pakeha women.

References

Tupara, H. & Ihimaera, L. (2004) In the Context of midwifery Practice Recognition and management of Mental Health. Published by Te Rau Matatini.

Webster, M., Thompson, J. Mitchell, E., & Werry, J. (1994). Postnatal depression in a community cohort. Australian and New Zealand Journal of Psychiatry, 28(1); 42-49.

Source: www.mothersmatter.co.nz

Fact Sheet 2.

Pasifika

This term is used to refer to those from the Pacific Islands, such as Samoa, Tonga and Rarotonga.



The process of pregnancy and childbirth in the Pacific region is a **cause for celebration**, and very much a **community affair**. In the islands, once a woman goes into labour the family and neighbours will gather around the home, bringing and cooking food, looking after other children and waiting for the news of the new member of the community. Towards the end of the pregnancy a woman will often drink traditional brews to encourage an easy labour. The **placenta** will be either buried, or wrapped and thrown into the sea. At home in the islands, women would usually be delivered by other women, and the male's role is to cook the food and organise the other children. In New Zealand, most women would expect their partner to support them during labour.

Key Points:

1. **Food is a very important part of life** with the expectation of a large celebration meal once the child has been born – special food will be prepared and even if a woman is in hospital it will be brought to her along with extended family members.
2. The family is of great importance, and a **woman would expect to rest** and be supported by her extended family for up to several months post partum. Her job is to feed the baby.
3. Women in New Zealand **may feel very abandoned** and distressed when they live in relative isolation without all this family and community support. This isolation is thought to add to the risk of developing PND.
4. **Modesty, and humility** are also strong values amongst Pasifika, and it can be intensely humiliating to have one's genitals uncovered in front of men in particular. It is considered rude to disagree with figures of authority or to complain and often another family member will advise staff of concerns rather than the woman herself.
5. **Privacy or confidentiality** is different amongst Pasifika, and a family will expect to be fully involved in decision making regarding the woman and her baby.
6. It is usual for **infants and toddlers to sleep in bed** with other family members and often to get carried around during the day. Older siblings and other relatives will have a large role in caring for the baby.
7. The rates of post natal depression (using a screening questionnaire) amongst Pasifika women were highly variable in a recent New Zealand study, ranging from a low of 7% amongst Samoan women to a high of 30% in Tongan women.
8. Unfortunately Pasifika women tend to **present with severe illness** rather than in earlier stages of distress and there is no information (yet) as to the prevalence of post partum illness in this population, or about any differences between the Island and New Zealand born Pacific women.

References

Siale A Foliaki, Jesse Kokaua, David Schaaf, Colin Tukuitonga, for the New Zealand Mental Health Survey Research Team. Twelve-month and lifetime prevalences of mental disorders and treatment contact among Pacific people in Te Rau Hinengaro: The New Zealand Mental Health Survey.2006. *Australia and New Zealand Journal of Psychiatry* 40(10): 924-934

Abbott MW, Williams MM. Postnatal depressive symptoms among Pacific mothers in Auckland: prevalence and risk factors.2006. *Australian and New Zealand Journal of Psychiatry* 40(3): 230-238

Source: www.mothersmatter.co.nz

Fact Sheet 3.

Asian

There are many Asian cultures and the following are therefore only generalisations.

In traditional Chinese culture child bearing and the postpartum time is a time where the **mother is nurtured**.

There is a cultural practice of *peiyue* –which is a post-partum custom of mandated family support. (Usually considered to be provided by a female family member for 4 or more hours per day for 4-6 weeks postpartum).



Researchers have written: “In most contemporary Asian societies, recently delivered women are **still regarded as vulnerable**, and are exempted from their household duties for an extended period. Such exemption is usually made possible by the continual presence of a **designated elder female** kin, mostly the woman’s mother or mother-in-law. This practice, called *peiyue* in the Chinese culture, consolidates and formalises post-partum support, guaranteed passage of child-rearing knowledge, and protects the mother from exhaustion and sleep deprivation”.

Some researchers have suggested that, “*peiyue*, as a socio-moral custom that ‘mothers the mother’, **may prevent social isolation and postnatal depression**”.

On the other hand some say that, “this practice may **increase tension** between members of the family who have different values. For centuries, **tense relationships between women and their mothers-in-law** have been a source of disharmony in Chinese and many other Asian societies”. (This may be a common feature of many cultures, not just Asian).

Where there is a **harmonious relationship** between the ‘new’ mother and the woman providing the *peiyue* the risk of postpartum depression is reduced.

PND may still occur (and rates are similar to non-Asian population rates) especially when Asian women are **isolated from their families**. Good family support reduces the risk

Some other issues which may be relevant are the tendency of Asian cultures to:

- Value family ties highly.
- Value hard work and achievement.
- Value loyalty and commitment with a strong sense of pride.
- Value self control.

Sometimes there is a lot of **stigma around mental illness** and family may go to some lengths to ‘keep this within the family’.

References

Dominic Lee, Alexander Yip, Tony Leung & Tony Chung (2004). Ethno epidemiology of postnatal depression. Prospective multivariate study of sociocultural risk factors in a Chinese population in Hong Kong. *British Journal of Psychiatry*, 184:34-40
Source: www.mothersmatter.co.nz

Fact Sheet 4.

Migrant and refugees

This covers **many ethnic and cultural groups**.

Many of those in this group, especially refugees, have gone through **very traumatic times**.

This can have very significant effects on the mental health of an individual and a family.

As well, there are huge **adjustment demands**; a new language, new customs, new climate and often minimal support.

If you add a new baby to all this, then the **demands can become overwhelming** for couples.

Having an interpreter can be essential to help communicate with medical professionals but it is not always desired by the 'patient' and her family. They may feel issues of confidentiality are likely to be breached because these are often **small communities** where everyone knows everyone else.

Sometimes a partner will interpret and this may **"hide" what is actually happening** to a woman. He may be reluctant to acknowledge the true extent of the problem.

This can be **very frustrating for the health professionals** who may feel that there is a problem but who are unable to get to the bottom of it.

It is important to continue to **offer support to the family** and keep asking in different ways - hopefully with time - the problems will come out.

See Ruth de Sousa's website www.wairua.com for more detailed information.

References

Source: www.mothersmatter.co.nz

Fact Sheet 5.

Pakeha/European

Some of the typical values and belief systems may include:

- Respect for person and property.
- A desire for neatness and order.
- Valuing a balance between hard work and leisure.
- High value on sport.
- Being on time, and valuing routine.
- Controlling emotions, can have trouble revealing feelings.
- Not interfering in other peoples lives.
- Children need to be 'controlled/managed/quiet'.
- Independence, managing to do things on our own.
- Mothers have high expectations on themselves as mothers and also on their babies. They often expect the "perfect" baby.

While some of these values can be positive they can also work against women. For example if "cleanliness is next to godliness" then it will be hard for Pakeha/Europeans to relax at home unless the home is spotless.

The **pressure of these messages from society** can be particularly hard for someone who is depressed. Pakeha/European society **encourages "perfectionism"**. Mothers who become depressed can have high expectations of being the "perfect mother" and experience a huge sense of failure when the reality is quite different. These women can find it more **difficult to acknowledge and disclose their feelings**.

Often the **pressure comes from within a person** as much as from others because Pakeha/Europeans have lived with these expectations all their life. They can find it hard to admit their needs and expect to "be able to cope".

"My house was a mess and I thought that if I felt in control of my housework then I would feel in control of everything else. Now I realise that it isn't really important to have a clean and tidy house
-Katie

Over the past generation it has become much more culturally acceptable to breast feed in public and to recognise the needs of children in a variety of settings e.g. toys in waiting rooms. A **greater expectation for men** to be involved with their children has also developed.

References

Source: www.mothersmatter.co.nz

Fact Sheet 6.

Attitudes and engagement.

If primary care is to increase support for women experiencing postnatal depression and their families, the key lies in engagement and the relationships that are developed. The best outcomes for people with depression happen when a good therapeutic relationship is forged between health care professionals and the consumer, and supported by collaborative care, case management and stepped care¹.

Women are more likely to develop emotional problems after childbirth than at any other time in their lives and the life prevalence of major depression in women is almost twice that of men². There has been a shift in how mental health issues surrounding childbirth are considered with a broadening of the concept of postnatal depression to include the spectrum of depressive and anxiety states arising in the perinatal period. Every woman deserves to be supported at this time in her life.

'Those babies in my arms, at my breast, clutching my hands, pulling my hair, teething on my heart, tugging at my sleeve, one child in a stroller, one helping me push, ceaselessly absorbing all my loyalty and love – those children redefined every question of bravery, courage and independence'.
Alex Schulman, writer.

Strategies for engagement:

1. Correct pronunciation of a person's name is fundamental. Learning how to pronounce Maori and other names correctly has been suggested a 'perhaps the single greatest way to show respect to Maori and patients³'. If you are unsure then ask the patient for help.
2. Listening – Sometimes the most powerful thing a person can do is just listen. Listen openly and honestly, allow the mother to speak, or just be. Affirm her struggles and her abilities. In doing so you can shift her perspective from one of weakness to capability. Often in those first weeks and months of exhaustion and confusion, well-meaning people try to 'fix' problems by offering techniques and solutions to manage issues such as sleep or feeding. However, these suggestions can result in distancing a mother from both her instincts and her baby's needs. Instead, engaging in warm conversation, pursuing what a mother is feeling and thinking, and validating her thoughts and ideas, can be a better way to lend real support⁴.
3. Encourage women to voice their feelings-
Studies of new mothers indicate that women who are able to ask for help when they need it suffer far less postnatal depression than women who pretend they are coping or women who wait until they are overwhelmed and resentful.
4. Include partners and family – All women need emotional support from families and friends and it can be easy to withdraw from them when depressed.
5. Maori and Pacific people prefer personal contact that allows them to see the face, hear the voice and see body language to establish a relationship⁵. [References](#)

¹ Beyondblue National Action Plan for Perinatal Mental Health 2008-2015: Full Report, p19.

² Kohen, D. (2001). Psychiatric services for women. *Advances in Psychiatric Treatment*, 7, 328-334.

³ http://www.nzgg.org.nz/guidelines/0152/Depression_Guideline.pdf

⁴ www.centreforattachment.com

⁵ Maori Cultural Competencies for Providers. He Whakatauki. June 2004. ACC

Fact Sheet 7.

Social cultural family context.

In the twenty first century motherhood is no longer the primary role of women in the western world and increasingly across the globe. While childbirth is a life changing event, parenting is often not well supported and seen as an individual responsibility rather than a societal one. With more disparate communities, work schedules, demands of day-to-day living and a family un-friendly society that makes it difficult to return to work the potential for depression increases⁶. With childbirth a mother is born as well as a baby. It is a time of enormous emotional changes. Women are much less likely to experience postnatal depression if they have emotional and tangible support. Fathers, partners and family are critical in this support. Midwives, Plunket nurses, general practice, Maori health providers, support groups and friends can be a source of this support too. In countries and societies where women receive holistic and meaningful postnatal support postnatal depression rates are virtually nonexistent compared with 10%-20% in western countries.

However there is no consistent support for the hypothesis of cultural differences in the prevalence of postnatal depression. In most cultures, there is stigma associated with experiencing psychological problems and it may be more acceptable to present with somatic complaints following childbirth⁷.

Many cultures have their own treatment and care practices which many people find helpful and which can often provide additional benefits to health and wellbeing. Rongoa Maori is the indigenous health and healing practice of New Zealand. Tohunga Puna Ora is a traditional healing practitioner. Traditional healing for many Pacific Islands' people involves massage, herbal remedies and spiritual healers.

Maori:

There is very little research on postnatal depression and Maori. However it is well documented that Maori have a higher prevalence of mental health disorders and lower rates of accessing treatment, therefore it follows that PND is an issue for Maori at least as much as the overall population.

Pacific:

Pacific women living in New Zealand have PND rates at the upper range of those typically reported. In addition to ethnicity their risk factors have been identified as; first baby, stress due to insufficient food, low income, transport problems, dissatisfaction with pregnancy, birth experience, baby's sleep patterns, partner relationship and home. Pacific families that retain elements of traditional Pacific identity and culture have had lower rates of PND in some studies suggesting there is a protective role⁸. Also Pacific beliefs about mental health allow greater tolerance for behaviours that in Western medical terms might seem unusual or even bizarre and this in turn may account for a perception of lower rates of diagnosed mental illness in Pacific populations⁹.

⁶ Ruth deSouza (2008) Postnatal depression and more. www.wairua.co.nz/ruth/mentalhealth .

⁷ National Health and Medical Research Council (2000). Postnatal Depression. A Systematic Review of Published Scientific Literature to 1999. www.nhmrc.gov.au/publications/synopses/files/wh29_a.pdf

⁸ Abbott M & Williams M (2006) Postnatal depressive symptoms among Pacific mothers in Auckland: prevalence and risk factors.

⁹ Ministry of Health (2005) Te Orau Ora: Pacific Mental Health Profile. Wellington: MoH p17.

Fact Sheet 8.

Appropriate level interventions

WATCHFUL WAITING

In mild depression, if the mother does not want treatment or may recover with no intervention, then arrange further assessment. This should be within two weeks. If the mother does not return then it is important to make contact and check how things are going.

SLEEP AND ANXIETY MANAGEMENT

Overcoming sleeping problems:

See Fact Sheet:

- Sleeping Well.
- The Living Life to the Full website has a sleep management component which is free for patients to access at: www.livinglifetothefull.com

Sleeping and Babies:

Babies have sleep needs that are quite distinct from those of adults. They have shorter sleep cycles, spend much more time in REM (also called dreaming sleep), and don't establish a circadian rhythm (doing the majority of their sleeping at night) until about 3 months of age. Sleep researchers note that the human sleep mechanism is not completely formed until five years of age and night waking is the norm in babies and young children.

Night waking in babies serves many healthy and protective functions. It allows frequent feeding and the intake of needed nutrition for growth; it creates the opportunity for emotional reconnection and stimulation of optimal brain development; and it is potentially protective against SIDS, allowing babies to avoid long periods of time in deep sleep that can leave them vulnerable....

It is normal to want a good night's sleep and there are alternative ways of creating more peaceful nights for families. These include: infant massage and touch, which is proven to help babies settle and achieve sleep; calming evening routines such as a warm bath, soft music and dim lights; and carrying baby either in arms or in a soft baby carrier such as a sling. For parents who feel particularly exhausted, sleep research shows that napping significantly compensates for minor sleep deprivation. Thus napping, when baby naps, can be way to overcome the negative impact of night waking. Similarly, it is important to remember to hold realistic expectations. Having a baby is a 24-hour-a-day job.

EXERCISE AND PHYSICAL ACTIVITY:

- There is evidence that physical activity has antidepressant effects and daily exercise is a recommended self-help strategy for depression and postnatal depression¹⁰¹¹. See self-help fact sheet Keeping Active for mothers.
- Exercise may be used in addition to other therapies or, for women who are reluctant to use antidepressant medication or have limited access to psychological therapies, physical exercise may be a plausible option.
- For women who are depressed and caring for young children barriers to physical activity may include lack of child care, energy, motivation, support, time etc.
- A therapeutic relationship between the woman and her nurse/midwife/doctor may help to identify how to overcome these barriers.
- Consider the use of a Green Prescription to help support an increase in physical activity.

¹⁰ http://www.nzgg.org.nz/guidelines/0152/Depression_Guideline.pdf Identification of Common Mental Disorders and Management of Depression in Primary Care. July 2008. Ministry of Health.

¹¹ National Institute for Clinical Evidence. Depression: Management of Depression in Primary and Secondary Care. Clinical Guideline 23. London: 2004 Appendix E.

- There is a dose-response relationship between intensity of exercise and reduction in stress symptoms.
- Planning a schedule for exercise can make it easier to stick to.

See Fact Sheet:

- Keeping Active
- Activity schedule sheet

GUIDED SELF-MANAGEMENT



Guided self-help is an acceptable intervention for mild to moderate depression¹². For patients with mild depression consider guided self-help that consists of the provision of appropriate written materials or websites and limited support over 6 to 9 weeks, including follow up, from a professional who typically introduces the self-help material and reviews progress and outcome¹³.

¹² http://www.nzgg.org.nz/guidelines/0152/Depression_Guideline.pdf Identification of Common Mental Disorders and Management of Depression in Primary Care. July 2008. Ministry of Health.

¹³ National Institute for Clinical Evidence. Depression: Management of Depression in Primary and Secondary Care. Clinical Guideline 23. London: 2004 Appendix E.

Fact Sheet 9.

Computerised cognitive behaviour therapy (cCBT)

CBT is a psychotherapy based on cognitions, assumptions, beliefs and behaviours with the aim of influencing negative emotions that relate to inaccurate appraisal of events. The objectives of CBT typically are to identify irrational or maladaptive thoughts assumptions or beliefs that are related to negative emotions and to replace them with more realistic and self helping alternatives. CBT online increases access for people who live in isolated areas, areas with limited cognitive behaviour therapists or people who prefer to work things through themselves.

Computerised CBT has been shown to be clinically effective in the treatment of anxiety, depression and mixed anxiety/depression in general practice and it has been found to be acceptable to patients¹⁴¹⁵. As primary health care is required to provide evidence based interventions practitioners may find out more about cCBT from the review conducted by the British Association for Behavioural and Cognitive Therapies¹⁶ (click on link in footnotes to view).

The use of cCBT has been successful with the programmes Mood Gym by the Australian National University and Beating the Blues programme which is part of the NHS service in the UK. Beating the Blues is free in the UK but currently is at a cost in NZ. The Beating the Blues programme is being piloted in 2008 in New Zealand at four sites in the Northern North Island. One of the sites, Tihewa Mauriora, Kaikohe, will be looking specifically at how the programme could help Maori and what cultural modifications, if any, may be required in the future¹⁷. Opening Doors Ltd is a provider of psychological healthcare services in New Zealand and is undertaking the pilot project.

Free cCBT Sites:

- www.blackdoginstitute.org.au
- www.moodgym.anu.edu.au Australia National University
- www.livinglifetothefull.com Downloadable CBT course developed by Dr Chris Williams and supported by the Depression Alliance Scotland and the NHS.
- www.moodjuice.scot.nhs.uk supported by Adult Clinical Psychology Service, NHS Forth Valley, Scotland.

n.b. these programmes have very different presentations and will likely appeal to different people.

¹⁴ The British Journal of Psychiatry (2004) 185: 46-54 Clinical efficacy of computerized cognitive-behaviour therapy for anxiety and depression in primary care: randomized controlled trial.

¹⁵ Primary Care Mental Health Plan 2008-2015, Best Practice, p19.

¹⁶ British Association for Behavioural and Cognitive Therapies (2006) Review of Free to Access Computerised Cognitive Behaviour Therapy Websites - www.stpct.nhs.uk/services/mental_health/mindmap/other/ccbt.pdf

¹⁷ www.reuters.com/article/pressRelease/idUS72963+16-Jan-2008+RNS20080116

Fact Sheet 10.

Attachment theory and impact of perinatal mental health issues on the infant

Children form attachments to their main caregivers and it is as important for their growth and development as breathing and feeding. The brain is user dependent and at birth only about 15% is connected. Brain connections are formed in response to a baby's day to day experiences and what happens repeatedly forms patterns in the infant brain. Interactions with caregivers develop these patterns which are key to child development. Infant attachment influences a child's future physical and mental health¹⁸.

“Kids need relationships”

Bruce Perry, Child Trauma Academy, Texas.

Above all we need to remember that the brain is the most important organ we possess. Research in recent years has provided vital new information. New ways of visualising how neurons are formed and located under genetic guidance prior to birth and of how the child's personal experiences then take over to connect these cells so that the messages they carry can be delivered to specific sites in the brain, provide the basic parts of a revolution in scientific knowledge about the infant brain¹⁹. Babies emerge from the womb preferring their mother's voices, knowing their mother's scent and wanting their mother's company. This doesn't mean that another person can't do the nurturing and do it well. It just means that physiologically and emotionally, mothers are primed to do this job. However, that's not the end of the story. Every relationship in a child's life sculpts the brain architecture and imprints a map for negotiating the world. Just as plants need sunshine along with soil and water, babies need more than just one important person in their lives. Fathers – or significant others of any kind, including grandparents, same sex partners and close friends – bring another way of being and being loved to the lives of their children.

Attachment classifications

- Secure Attachment:
 - Characterized by the infants expressing distress or protest when left by parent, greeting the parent positively, and actively seeking contact or interaction when the parent returns. If the infant is distressed, close contact with the parent is sufficient to become soothed and return to play and exploration.
- Insecure-Avoidant Attachment:
 - Characterized by absence of distress and an absence of contact-seeking but also by avoidance of eye contact when the parent returns and active moving away from parent if the parent approaches. Tension and anger, if expressed at all, are usually expressed in displacement (throwing toys) rather than at the parent.
- Insecure-Ambivalent Attachment:
 - Characterized by distress and contact-seeking behaviour occurring in combination with direct expressions of anger and failure to be soothed.
- Insecure-Disorganised Attachment:
 - Characterized by a diverse set of behaviours indicating conflict, apprehension or confusion. Often seen as distress at parent's absence mixed with avoidance of the parent on reunion.

¹⁸ Lyons-Ruth K. Depression and the Parenting of Young Children: Making the Case for Early Preventive Mental Health Services. Harvard Rev Psychiatry Sept/Oct 2000.

¹⁹ Perry B. 2002. Childhood Experience and the Expression of Genetic Potential: What Childhood Neglect Tells Us About Nature and Nurture. Brain and Mind 3: 79-100, 2002.

Table 2. Influences on attachment:	
Maternal	Infant
<ul style="list-style-type: none"> ❖ Responsiveness ❖ Own mental state (and childhood) ❖ Reflective functioning ❖ Personality ❖ Depression ❖ Stress-parenting, life events ❖ Marital satisfaction and social support 	<ul style="list-style-type: none"> ❖ Unique characteristics ❖ Reactivity to environment and people ❖ Special needs (e.g. premature, developmentally delayed etc.)

Attachment and Postnatal Depression.

Mother's depression scores have been shown to be predictive of poorer cognitive and social outcomes for infants²⁰. The children of depressed mothers display greater social, behavioural and academic impairment than do the children of mothers who are not depressed. In addition current socio-economic circumstances can have an effect. However infants in low income families whose mothers are not depressed maintain normal development.

Both the mother's childhood experiences and her depressive symptoms are related to interactions with her infant. The most important factors in the mother's childhood are the experience of parental warmth, peer friendships, family conflict and parental psychopathology.

Research shows that a number of mothers with postnatal depression CAN provide sensitive care giving and engender secure attachment bonds²¹.

Attachment issues are not confined to high risk families. While the majority of children develop secure attachment some do not. Studies have shown up to 19% of children in middle income families without risk factors have developed disorganized attachment²².

Attachment and Growth:

Depression in mothers of children with faltering growth during the first 2 years of life is significantly greater than in mothers of children who are gaining weight appropriately. In view of the high rates of maternal depression in children with poor weight gain, clinical management at presentation of either problem should focus on both members of the mother-child dyad and on the interaction between mother and child. These findings have implications for all professionals who work in primary and secondary health care²³.

²⁰ Lyons-Ruth K. Depression and the Parenting of Young Children: Making the Case for Early Preventive Mental Health Services. Harvard Rev Psychiatry Sept/Oct 2000.

²¹ McMahon, C., Barnett, B., Kowalenko, N., Tennant, C. 2006 Maternal state of mind regarding attachment moderates the impact of maternal depression on child, Journal of Child Psychology and Psychiatry, 47, pp. 660-669

²² Lyons-Ruth K. From Birth to School-age: Influence of Maternal Factors, Infant Attachment, and Preventive Intervention on Outcomes of the Infant at Social Risk. Prospettive Psicoanalitiche nel Lavoro Istituzionale 1999:2;165-198.

²³ O'Brien, L. Heycock, E. Hanna, M. Jones, P. Cox, J. Postnatal Depression and Faltering Growth: A Community Study. PEDIATRICS vol 113 No.5 May 2004 pp. 1242- 1247

Attachment and Infant Colic:

Postnatal maternal depressive symptoms and insecure attachment style have been associated with infantile colic. Screening and early intervention of postnatal depression might promote the health of both the mother and infant²⁴.

²⁴ <http://adc.bmj.com/cgi/content/abstract/91/5/417> Mother's postpartum psychological adjustment and infantile colic .Archives of Disease in Childhood 2006;91:417-419

Fact Sheet 11.

Feeding and Postnatal Depression.

Recent research indicates that breastfeeding helps protect babies from the negative effects of post-natal depression. It appears that the emotional and physiological experience of being breastfed alleviates some of the impact of living with a depressed mother. Add to that a mother who gets the advantage of relaxing breastfeeding hormones and it is clear that breastfeeding can benefit many mother-baby pairs who might have difficulty connecting to each other. However for some mothers breastfeeding adds to their stress so these issues need to be explored with consideration of the mother's emotional health.

While the importance of what we feed our children cannot be underestimated, from an attachment point of view, it is how we feed them that is most important...

Each feeding is just a moment that can be easily overlooked, but these moments of loving interaction string together to form the basis of a lifetime of security.

Too often, the choice about what and how to feed a baby centres upon nutrition. Discussions about breast milk, formula, starting solids and schedules all seem to focus upon meeting a child's physical needs. Is he getting enough? Is this the best substance for her growing body? Is he gaining weight? Does she feed too often? While the importance of what we feed our children cannot be underestimated, from an attachment point of view, it is how we feed them that is most important.

From both a physiological and psychological perspective, breastfeeding is the optimal choice for feeding babies. Most everyone knows that breast milk is the 'best food' for baby – even the formula companies tell you that. But why is it the best choice for babies' emotional needs? What makes breastfeeding so special? And, if a mother chooses not to breastfeed, can these special qualities be mirrored in a formula feeding relationship?

Breastfeeding sets up a mother and baby for optimal bonding and attuned communication. In an optimal breastfeeding relationship, mother and baby 'talk' to each other in a near-constant fashion. Because a newborn baby needs to feed often and around the clock, mother and baby stay in close contact. Mother learns her baby's cues and signs for hunger, as well as other needs for closeness that are often met through the breastfeeding experience. By feeding on demand, a mother not only establishes an adequate milk supply but also teaches her baby that she will sensitively and effectively respond to fluctuating needs, always aware of her baby's signals. Through that awareness she sets the stage for her baby's ability to feel fully nurtured and secure. Over time, this intense need will lessen as her baby moves toward greater and greater independence, but the foundation of understanding and communication between mother and child will remain.

Breastfeeding promotes eye contact, which is associated with a mutually reinforcing cycle of pleasurable hormones that flow between mother and baby. The skin-to-skin contact, inherent in a breastfeeding experience, also induces "love hormones" in both mother and baby. Oxytocin, a peptide hormone important for the creation of positive emotion and healthy social connections, is one such substance. Oxytocin inhibits the negative impact of stress and increases the healing rate of wounds. It is essential for bonding and feeling good in relationships.

But what if a mother doesn't want to breastfeed? Or tried but was not able to continue? Does that mean that she and her baby cannot participate in this bonding ritual that occurs around feeding? Absolutely not. See fact sheet: Tips for mothers to promote attachment when feeding.

Regardless of the feeding method, it is important to remember that feeding, especially for a young baby, is more than just intake of nutrition. This is one of baby's first experiences of being cared for and that care extends beyond hunger. How a baby is held, looked at, spoken to... all these things contribute to the attachment relationship and they are all present in feeding situations. Carrying baby, comforting touch, and infant massage are also ways of increasing the flow of hormones like oxytocin and deepening the parent-baby bond. These strategies are available to all families, regardless of feeding method.

References

Sources:

www.brainwavetrust.org.nz

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www.centreforattachment.co.nz

Fact Sheet 12.

Mental health issues for fathers/partners and family

From the moment of that first contraction, the world can appear to forget fathers. Everything suddenly revolves around breasts, bonding and maternal instinct, leaving fathers to wonder where and how they fit in. Yet the process of becoming a father is an equally important birth. As with women, the arrival of a baby gives rise to a new identity for men. Men experience the highs and the lows, the confusion and need for support.

Impact of Mother's Postnatal Depression:

Family life can be affected in far reaching ways from restrictions in social and leisure activities, a fall in family income, strain on the couple relationship and effects on the mother-infant attachment. This may present as withdrawal or unpredictable behaviour, conflicts with partner or inconsistent parenting.

See Fact Sheet:

Helping someone with depression.

Men's Postnatal Depression:

Dads can get depressed without the mother being depressed.

About one in twenty fathers are at risk of PND.

Table 3. Signs of PND in Fathers	
<ul style="list-style-type: none">• feeling low and helpless• not attaching to the baby• problems with partner• wanting to run away	<ul style="list-style-type: none">• feeling it is all too hard,• being hard on oneself and saying I'm not doing it properly, I'm no good as a dad

How to encourage men to talk about what is happening:

- Antenatally men are often on the sidelines with the focus on the pregnant partner. Men can feel like the handbag at antenatal classes but they can feel included throughout the course if there is a focus on parenting rather than antenatal. This can help prepare men if things get difficult and don't go according to plan postnatally.
- Dads often get depressed at 8 - 10 weeks after the baby is born, when it all kicks in and they are tired and might realize how overwhelming it all is.
- Partners and others can tell men it is ok/normal to feel overwhelmed.
- Partners can ask 'how are you doing?' and if they say something like 'I'm tired but I'm fine' then say 'but how are you really feeling?' – tired like you can't go on with life or tired like I just need a good sleep are two very different things.
- Some men have not been parented warmly themselves and need encouragement to spend time with their infants.

- Men are often success orientated so difficulties with adjusting to an infant can affect their view of their own performance.
- It can be helpful for new fathers to have time alone with their infant to have a go at things without being observed by others and feeling self conscious.
- Father-infant time together fosters attachment and can be helped by routine activities each day together like putting baby down to sleep, bathing or nappy changing.

Postnatal depression and fatherhood is well discussed on Youtube in several New Zealand and Australian interviews which dads can access online. See www.youtube.com and type postnatal depression into search box.

See Fact Sheet:

Fathers