PERINATAL MENTAL DISTRESS: AN UNDER-RECOGNISED CONCERN

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Perinatal mental distress: A critically important public health issue

Maternal mental health remains a critically important yet under-recognised issue. It needs much greater priority within public policy frameworks in Aotearoa New Zealand. Mental distress during the perinatal period (encompassing conception through pregnancy to one year after birth) is thought to affect at least 15% of New Zealand women, although this figure obscures the heightened risk among women of Māori, Asian, and Pacific ethnicity, for whom rates can reach one in three. The figure also excludes the probable high prevalence of women whose symptoms fall just below the threshold of clinical detection but whose functioning and wellbeing can be as significantly affected as those meeting the criteria for formal diagnosis.

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For example, the prevalence of women with high subclinical levels of mental distress after birth was estimated at about 14% in a small Auckland-based survey. Larger, more recent studies overseas have reported high subclinical levels of distress in up to 30% of pregnant women. In total, therefore, mental distress may affect nearly half of all pregnant and postnatal women.

‘Distress’ is used here as an umbrella term to capture the range of symptoms women experience. Distress most often manifests as depression, but women also frequently exhibit anxiety and may suffer from obsessive-compulsive traits, bipolar disorder or, more rarely, psychosis.

Maternal mental distress can have serious consequences for both the woman and her baby. Adverse pregnancy outcomes, as well as the unpleasant and potentially disabling effects on mood and daily functioning, are common to major depressive disorders and are well documented in women experiencing
perinatal distress. For some women, the extent of their suffering can be too much to bear. Suicide is the largest single cause of death for New Zealand women during and in the six weeks following pregnancy. New Zealand’s maternal suicide rate is about six times higher than that of the United Kingdom, and wāhine Māori are over three times more likely to die by suicide than New Zealand European women.8, 9 As part of their symptoms, mothers may experience intrusive thoughts about harming their baby.

\[I\text{ was standing in the kitchen and I remember having the most peaceful and clear thought: I’ll kill myself. If I’m dead, I’ll be asleep. – Emily Writes, writer and mother.10}\]

In the longer term, children whose mothers were hindered in their bonding and parenting capabilities due to mental distress, even at mild to moderate levels, may go on to have mood disorders including anxiety, and girls have a much higher chance of experiencing depression during pregnancy when they reach that life stage.11 Depression during pregnancy is associated with altered fetal brain development and biochemistry, including compromised development of executive functions in the child.13, 14 Impaired executive functions place a person at greater risk of negative lifelong consequences such as school failure, job instability, and poorer physical and mental health.12 Supporting women with their mental health is therefore a vital step in interrupting intergenerational cycles of negative impact.12, 15

\[I\text{ wanted my baby to feel as helpless as I did, and take responsibility for the frustration that I was feeling – which is a ludicrous thing for a baby to do. – Hayley, a New Zealand mother.16}\]

A complex interplay of biology and society

A woman’s risk of developing perinatal distress is likely determined by the interaction of biological factors with her wider social and environmental context. It is clear that the psychosocial risk factors for developing perinatal distress are also common to mental distress in the general population, such as low income, lack of social support, or a difficult family environment.17 But the risk and any biological propensity can be exacerbated by pregnancy-related factors. In New Zealand women, such factors include unplanned or complicated pregnancy, difficult birth experience, and infant temperament.1, 3, 18

\[I\text{t feels like I’ve been eroding away. Losing who I am, the very essence of myself. – Linda Jane Keegan, writer and mother.19}\]

Emerging research into the biological contributors to perinatal distress suggests possible hormonal and genetic influences, although the specific mechanisms are not yet clear.20-25 Certain genes have been found to play a role in both perinatal distress and non-perinatal mental disorders, while other genes may be unique to perinatal distress.21, 23, 26

A hormone system that could potentially be involved is one that is activated in response to stress called the hypothalamic-pituitary-adrenal axis.21 It can be altered by a steroid called allopregnanolone that is derived from the hormone progesterone, which the placenta makes during pregnancy.27 Recent research has linked low levels of allopregnanolone with increased likelihood of perinatal distress.

\[\text{ii Executive functions are a set of cognitive processes that help with paying attention, planning ahead, working towards goals, and restricting impulsive behaviours. They are essential for success in school and working life, and for maintaining good relationships with others.22}\]
In 2019, a synthetic form of allopregnanolone called brexanolone was approved in the United States as the first-ever drug designed specifically to treat perinatal distress.20, 28

Although there is more to understand, what is clear is that perinatal distress is more than simply a social or a hormonal issue. Symptoms of distress that many women experience after their baby is born must not be dismissed as simply being the 'baby blues' that are assumed and expected to be minor and temporary. While biological influences may include hormone-driven baby blues for some women who only develop transient symptoms after giving birth, perinatal distress is a discrete, complex, and important phenomenon about which understandings have rapidly evolved in recent years.

Mum said: 'it's okay, it's just the baby blues'. I remember distinctly thinking: 'I don't think baby blues include trying to kill your child'. – Erica, a New Zealand mother.16

Perinatal mental distress often starts before or during pregnancy, even if it is unrecognised until after the birth. Some women experience depression or anxiety for the first time after they give birth, but for many who experience perinatal distress, their general mood state of less-than-optimal mental wellbeing largely remains constant throughout pregnancy and into the postnatal period.29 The strongest predictor of postnatal distress is depression during pregnancy, and the most important risk factor for distress during pregnancy is a prior history of depression or anxiety.29, 30 Postnatal distress is therefore frequently a continuation of a set of symptoms that emerged during or even before pregnancy. However, the demands of caring for a newborn, such as the rapid increase in sleep deprivation, can affect or compound a woman's distress.31 The experience of motherhood and any other related factors, such as a traumatic birth or a baby requiring intensive care or changed domestic circumstances, can exacerbate pre-existing distress to the point where a previously unnoticed or well-managed issue becomes more pressingly apparent to the woman and those around her.

Prevention approaches

Since perinatal distress symptoms appearing after birth are often indicative of an earlier problem, early intervention is paramount. Managing distress during pregnancy helps prevent a woman's condition from worsening once she gives birth,31 and lessens the amount of stress her baby is exposed to in utero, thus reducing intergenerational consequences. Universal screening should be implemented for all pregnant women at the first lead maternity carer visit, and repeated in mid-pregnancy and again postnatally. Midwives and other lead maternity carers are ideally placed to carry out screening; however, it is imperative that any screening programme is supported by appropriately-resourced maternal mental health services.32 At present, existing publicly-funded services are insufficient to meet women's needs, particularly for Māori, Pacific, and Asian women.33 Services should be available for women experiencing any degree of distress, not only those most severely affected,6, 32 and women with a prior history of mental illness should automatically be offered a referral for specialist help.

The Edinburgh Postnatal Depression Scaleiii is a widely-used screening tool for perinatal distress in the community. This tool has been validated for Tongan and Samoan women living in New Zealand,34 but it does not appear to have been tested for relevance in Māori women. Furthermore, it may not pick up on differences in symptom presentation in high-risk groups due to differences in how mental distress manifests in non-Western cultures. For instance, perinatal distress may present primarily as physical

iii This tool was initially developed to screen specifically for postnatal depression, as reflected in its name; however, it is now also used for screening during pregnancy.
ailments rather than emotional or mood problems in Māori women.35 Similarly, Asian women may experience unexplainable pain such as stomach pain or headaches as their body’s way of expressing that something is wrong.36 Consideration should be given to the development of a screening tool customised to New Zealand’s diverse ethnic makeup, encompassing a wider range of cultural world views and concepts of wellbeing. Such a tool should use the term ‘perinatal distress’ rather than ‘postnatal depression’ to reflect the fact that symptoms are not limited to depression and may present at any time during pregnancy.

Raised awareness of the high prevalence of perinatal distress is needed to reduce stigma and encourage women to seek help. Awareness should be promoted in partners, wider family and whānau, and healthcare providers, as well as women themselves.

One day I placed my screaming baby on the floor, went to the shed ... and called my husband.

*if I didn't have that fleeting moment and call him I don't know if I or my baby would be here today.* – Jess, a New Zealand mother.16

Families need support to thrive. Firstly, support can help prevent perinatal distress in the first place. Secondly, proactive support of children whose mothers were affected will reduce the likelihood of those children developing mental illness. At a societal level, this requires continued investment in social policies aimed at improving the social determinants of health, as well as prioritising family-focused policies such as paid parental leave.11, 17

**Management approaches**

Management should follow a two-pronged approach. Firstly, women at risk of developing perinatal distress would benefit from preventive care to reduce the chance of them becoming symptomatically unwell and women with existing symptoms need treatment and environmental management to help restore wellbeing. This should include being able to choose psychosocial and psychological interventions, either instead of or in addition to medication. Psychotherapy, cognitive behavioural therapy, counselling, and peer telephone support are all effective at both preventing and treating perinatal distress.37, 38 Women should also have the choice to access culturally-appropriate options.36, 39

*I’m born from Papatūānuku,*iv so of course I return to her for healing.

– Joanne Rama, midwife and mother.39

For a minority of women, management will include antidepressant medication, which may be effective at reducing the severity of symptoms.41 There are limitations to antidepressants, including a lack of evidence of efficacy for preventing perinatal distress,42 concerns around taking medication during pregnancy and while breastfeeding, and a distrust of European medical philosophies by some women.35, 36 Treatment with brexanolone, the recently approved drug for perinatal distress, is promising but costly and requires an inpatient stay. Research is ongoing to develop oral formulations,20, 28 which when available could be considered.

iv In the Māori world view, Papatūānuku is the land. She is a mother earth figure who gives birth to all things, including people.40
Secondly, women affected by perinatal distress may find it more difficult to bond with their child.\(^1\) This imposes an extra burden on these children, who are already at increased risk of psychological disorders and impaired executive functions due to potential genetic risk factors and the altered fetal brain development that is associated with maternal depression during pregnancy. To assess mother-child bonding, a tool such as the Postpartum Bonding Questionnaire could be used. Women and their family and whānau should be offered early assistance where needed, such as tailored parenting classes with suggestions for home-based activities that promote bonding and interaction. Effective interventions include skin-to-skin contact for infants and responsively engaging in ‘serve and return’ (interactive to-and-fro) activities with older babies that can help brain development.\(^1\) Women whose symptoms are more severe may require more intensive support to optimise their relationship with their newborn. This may include interactive therapies provided through specialised mother-infant mental health services and/or a period of care in a mother and baby inpatient or day unit.\(^{43}\)

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_‘I’m going to counselling now to deal with issues that I never even knew were there. It’s helped me realise . . . that a lot that has happened is not all my fault.’_  
— Roimata, a New Zealand mother.\(^{35}\)

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Fetal life and early childhood is a time of rapid brain development, and at this stage the brain is at its most malleable or plastic. Supportive social policies are therefore crucial for young families during this window of opportunity. Children should be assessed for executive functioning during the preschool years and offered individualised interventions if required. This will help provide a strong foundation for lifelong wellbeing for that child and for future generations.
References


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