PND
Post & Ante-Natal Distress
Support Group Wellington

Post and Antenatal Distress Wellington: Counselling Service Evidence Base

Part one: PND in NZ - what's the story?

April 2017

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The 'evidence'

In writing this article I have reviewed some recent, relevant and quality research relating to postnatal distress. This type of research is limited, especially in the New Zealand context. In the research PND tends to have a narrow and clinical definition, different to how we perceive PND here at PND Wellington. At PND Wellington we have a holistic view of postnatal distress - we look at the physical aspects, psychological aspects, social aspects, situational aspects and emotional aspects of the contributing factors, symptoms, and impacts relating to PND. It covers a broad spectrum of feelings, thoughts, and sensations. We don't use a set criteria or classifications in our work. Therefore in my research I found that it was difficult at times to reconcile the evidence I have collected in my own practice with the 'scientific' evidence base.

I've realised there is a need for much more research, but a variety of types of research and different research questions, when it comes to finding out more about what people experience during postnatal challenges, what their perceived contributing factors were, what helps, and even how people experience 'personal growth' as a result of the initial challenges. These aspects are easy to see in my 'practice based' evidence, but not so easy to see in the hard evidence I came across. As a result this article looks at both evidence, and practice based evidence and I've also focused, as much as research would allow, on New Zealand (NZ)

evidence. We are fortunate enough in NZ to currently have a longitudinal study on 7000 Kiwi children called 'Growing Up in New Zealand', which gathers information from parents before birth, and after birth. This research is providing invaluable evidence for PND in NZ.

This three-part article series will be covering some PND facts, how PND is defined, what it looks like, what contributes, and what helps. The focus of this article is on women, but PND does affect Dads too. You can refer to Underwood et al (2017) for their research on postnatal depression amongst Kiwi Dads, if you're interested. In this article I'm using the acronym PND to stand for postnatal distress and postnatal depression interchangeably.

PND defined

According to the field of Psychiatry post-natal depression is defined as a major depressive episode that begins within a month of delivery of a baby (APA 2000 DSM-IV-TR cited Hubner-Lieberman, 2012). Wylie (2011), however, found that researchers differ on their opinion regarding how PND is defined:

> *'Post-natal depression is viewed by some as a distinct psychological state and by others as part of a continuum. Some take a conventional standpoint and perceive PND as a detached, specific entity, inherently linked to childbirth, whilst others view it as multifaceted in terms of definition and aetiology'.*

This means that research on PND varies in terms of what is being measured (anxiety, depression, distress), how it's being measured (scales such as the Edinburgh Postnatal Depression Scale (EPDS)), the scores being measured, and when the test is taken (how soon after birth). The most common scale used to measure PND in research is the EPDS, with a score above 12 as an indicator of depressive illness of varying severity, with possible depression at a score of 10 or more (maximum score is 30). The EPDS also has questions relating to anxiety. In this article, I cover mainly depression and anxiety symptoms because they're the most common according to the research (MoH, 2011).

At PND Wellington we use the term Postnatal Distress, in an attempt to cover more of the continuum of symptoms people can experience. This is why at PND Wellington we don't use any medical eligibility criteria for our support services. We look at how people are holistically and we support people all along the continuum of different feelings a person can have (with the exception of more rare and severe symptoms such as psychosis, which other services provide support for). We also don't have child birth as a criterion for accessing our services. We work with Dads too, and couples - because of the influence of intimate relationships on our well-being, and vice versa.

The problem with defining PND is that it can't easily account for the individuality of distressing type symptoms such as trauma, anxiety, stress, loss, adjustment issues that come at any time associated with birth, babies and parenting generally. The changes that you see in yourself, and what your loved ones notice, are a great gauge for whether you could benefit from extra supports. This means looking at changes in feelings (mood), thinking (psych and intellectually), socially, physical/physiological changes, and situational changes too.

Is PND a problem in New Zealand?

Parenting brings pressure on our body, mind, spirit, relationships, and our living situation. In some ways it's very ironic that parents are often under the most amount of stress during the time when babies are rapidly growing and developing, and arguably, need us to be 'on form' more than ever! However, another perspective is that this time is also an opportunity for massive self development that can help us parent for the remaining 18+ years, which are also critical too (the brain is still developing up until age 25 some research now suggests). Research also shows that the experience of PND is very similar to depression generally (Wylie, 2011), and these feelings could arise at any other point in our parenting journey. Based on what I see in my practice, I believe that on the most part, PND is really understandable, like other depression, anxiety, trauma…given the circumstances we are facing when we are parenting young (and not so young) children.

In terms of whether NZ has more of a 'problem' compared to other countries, it's difficult to say because as mentioned above, research design varies. Also, there could be cultural differences in terms of how people perceive their symptoms and report their symptoms, so this could also affect how one country's prevalence rates could look compared to another. Whether NZ parents experience more or less PND than parents in other countries, or not, the important thing is that parents are supported during this time for the wellbeing of the entire family.

Some statistics

Our most recent NZ based evidence, from Growing Up In NZ study, which was measured by scoring >12 on the EDPS, at 9 months after birth suggests that:

- **8% of Kiwi mums experience postnatal depression symptoms (Underwood et al, 2016). Other New Zealand and Australian research suggests that between 10% and 20% of women reported that they experienced moderate to severe depression for at least a few months in the year after birth (Schmied et al 2013).**

- **17.5% of Pacific women, 8.4% of Asian women, and 11% of Maori women experience postnatal depression symptoms (Underwood et al 2016).**

- **Internationally, statistics suggest an estimated 13% to 18% of women experience postnatal depression symptoms (cited Underwood, 2017), and between 8% - 43% of women experience postnatal anxiety symptoms (Glasheen, 2010).**

- **4.3% of Kiwi Dads experience postnatal depression symptoms (Underwood et al, 2017). Internationally, statistics suggest an estimated 3% to 12% of men experience postnatal depression symptoms (cited Underwood, 2017).**

What does PND look and feel like?

As mentioned above, the types of feelings, thoughts, behaviours, and physical sensations associated with PND vary from person to person. In my own practice based evidence, I often see the more 'high' feelings than the 'low' - so more anxiety than depression. I also see more 'over-thinking' than shutting down. I see a lot of fear based thinking often around anticipated guilt, and this often results in control type behaviours - i.e. directly fixated on controlling the baby's sleep or indirectly fixating on cleaning or checking. These behaviours are tiring and taxing and perpetuate the fearful thoughts and feelings. Physical sensations are often jittery, heart racing, shallow breathing, unable to calm. Sometimes, if these hyperarousal type feelings continue, then I see the more hypoarousal or 'low' feelings start to creep in. I also see symptoms relating to loss, and this aligns with NZ researcher Anita Darrah's (2011) view that PND is experienced as a loss - loss of prenatal expectations of 'mythical' motherhood and mothering. However, these features are possibly just reflective of the clients I see, rather than indicators for PND generally.

The research evidence base tells a slightly different picture, most reviews suggested a similar combination of the following list of symptoms that are commonly associated with postnatal depression. Interestingly, they are no different to the clinical features of depression that arise at any other time in the life continuum (NICE, 2007, Wisner et al. 1999, cited Wylie et al 2011).

1. **Low mood and loss of enjoyment**
2. **Anxiety**
3. **Disturbed sleep and eating patterns**
4. **Poor concentration**
5. **Low self-esteem**
6. **Low energy levels**
7. **Loss of libido**

Schmied et al (2013) in their review of research found that PND symptoms are not as long-lasting or as severe as in pregnancy and five years after birth. So although PND gets a lot of attention, for the mother it is possibly not as significant for her as antenatal depression, or when the baby is no longer a baby anymore. Given that PND symptoms are similar to any other

depression or anxiety, and are possibly not as extreme compared to other times in a person's life, I see PND as a fairly rational response in dealing with a pretty 'irrational' situation. A situation that requires raising a child (for many, it's primarily in isolation) while trying to cope with other physical (injuries after childbirth), emotional (a huge adjustment with often no time to process), psychological (we feel pressure to perform), and social (impacts on our relationships), and situational (we suddenly have a noisier household) - demands. I wonder whether more support for parents and families would offset a lot of the pressure relating to PND and its impacts.

To be continued…Part Two of this article series looks at contributing factors, and impacts of PND on your well-being.

What next?

I'm Emma Heaney-Yeatts, the Lead Counsellor at PND Wellington. I have two young boys and my own experience with postnatal distress. I'm a qualified counsellor and full member of the New Zealand Association of Counsellors.

If you want impartial, confidential and professional support while you negotiate your parenting journey then PND Wellington has Counsellors to help. Our fees range from free to low-cost depending on the level of experience of the Counsellor. On our website you can access a description of the Counsellors we have, their locations and fees - so you can find a counsellor that fits. See www.pnd.org.nz under 'Get help', 'Low cost counselling'.

PND Wellington produces it's Purple Book, which contains more information about PND and the signs, symptoms and contributing factors. Contact us below if you want copies.

Phone: 04 4723135
Email: pnd.wellington@gmail.com or emma.pnd.wellington@gmail.com
Facebook - search PND Wellington Support (closed group).

The content in this article is not intended to replace any medical advice. If you are feeling unsafe then seek emergency help immediately.

Acknowledgements

I'd like to acknowledge Lisa Underwood, from the Growing Up in NZ study, for her assistance, research, and the data she has provided for use in this article series.

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Part two: PND in NZ - what's the story?

May 2017

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The 'evidence'

Part two of this article series looks at contributing factors to Postnatal Distress (PND). Part one looked at PND definitions and contributing factors. As I mentioned in Part one, this article series uses both evidence based research and practice base evidence to inform its opinions. Sometimes these two types of evidence provide different pictures. This is because the definition of PND that we use at PND Wellington, which encompasses stress/distress, anxiety and depression, is broader than the clinical definition researchers use (usually postnatal depression symptoms as classified by the Edinburgh Postnatal Depression Scale). However, for ease of writing this article, I use the term PND to stand for postnatal depression and postnatal distress.

I've also focused, as much as research would allow, on New Zealand (NZ) evidence. We are fortunate enough in NZ to currently have a longitudinal study on 7000 Kiwi children called 'Growing Up in New Zealand', which gathers information from parents before birth, and after birth. This research is providing invaluable evidence for PND in NZ. The focus of this article series is on women, but PND does affect Dads too. You can refer to Underwood et al (2017) for their research on postnatal depression amongst Kiwi Dads, if you're interested.

Part three of this article series looks at what helps to recover from PND and to be stronger going forward.

Contributing factors

The factors that contribute to PND are as diverse as the way PND presents itself for different people. My practice based evidence suggests that having little or no family or social support and relationship difficulties is a risk factor for seeking help for PND related challenges. Also being the eldest female sibling seems to be a commonality across my clients, which may contribute to these clients difficulties in relinquishing control when it comes to raising their baby. High intelligence and a (paid) career orientation also seem to be factors at play, as well as European ethnicity. However, this could simply reflect the client profile that I have at PND Wellington, as opposed to reflecting most people who experience PND related challenges. In saying that, some of the commonalities I mention above are also noted in the research.

Common risk factors - NZ

Schmied (2013) in their review of NZ, Australian, and international research found that a previous history of depression and/or anxiety and poor partner relationships are two of the strongest predictors of perinatal depression (depression as classified by the Edinburgh Postnatal Depression Scale). Likewise, Underwood (2016) in their NZ study found the following risk factors:

For postnatal depression only:

- **stress (as they perceive it),**

- **being Pacific or Asian ethnicity,**
- **not being in a paid job during pregnancy,**
- **and pre-pregnancy depression.**

For antenatal and postnatal depression:

- **stress (as they perceive it)**
- **having a difficult relationship/family environment during pregnancy,**
- **being Pacific or Asian ethnicity,**
- **not having a paid job during pregnancy,**
- **anxiety during pregnancy,**
- **anxiety before pregnancy,**
- **and one or more alcoholic drinks during pregnancy.**

Ethnicity statistics

Also according to Underwood et al 2016:

- **Asian women made up 13.8% of the total sample, yet made up more than that (14.7%) in the group of women who had postnatal depression symptoms (n=422).**

- **Pacific women made up 11.9% of the total sample, yet made up more than that (25.7%) in the group of women who had postnatal depression symptoms.**

- **Pacific and Asian women made up only 25.7% of the total sample yet made up more than that (40.4%) in the group of women who had postnatal depression symptoms. When other influencing factors were taken into account, Pacific and Asian ethnicity was disproportionately associated with PND.**

- **Māori women made up 12.7% of total sample, yet made up more than that (17.6%) in the group of women who had postnatal depression symptoms. However when other influencing factors were taken into account, such as employment status, Māori ethnicity was not a factor that was significantly associated with PND.**

- **European women made up 58% of the total sample, yet made up less than that (39%) in the group of women who had postnatal depression symptoms.**

Pacific and Asian ethnicity

Other research also supports Underwood et al's (2016) finding that Pacific and Asian ethnicity is disproportionately associated with PND. In another NZ research review, Asian ethnicity was one of only two variables (the other was low household income) significantly associated with higher rates of PND (HPA, 2016). In that study the Pacific Island sample was too small to find an association but in the Pacific Island Families Study, 16.4% of mothers were assessed as probably experiencing depression, ranging from 7.6% for Samoans to 30.9% for Tongans (Abbott, 2006).

Māori ethnicity

Underwood et al (2016) found that Māori ethnicity is not significantly associated with PND compared to other factors. However, other research on PND and Māori women is minimal, so it's difficult to know to what extent PND is an issue for Māori women, and what supports are culturally accessible. In any case it is important that there are appropriate and accessible services or avenues available for Māori women affected by PND, but knowing what these look like is a gap in the research base. This is something that PND Wellington wants to learn more about.

Common risk factors - International research

With the exception of Pacific and Asian ethnicity, NZ risk factors are similar to that of international risk factors for AND and PND. In their review of international research, Underwood et al (Beck, 2001, Robertson, 2004, cited Underwood, 2016) found the following risk factors:

For postnatal depression only:

- **Antenatal mental health problems, especially depression and anxiety**
- **Infant temperament**
- **Low self-esteem**
- **Obstetric complications**

For antenatal and/or postnatal depression:

- **Being single**
- **Lack of social support**
- **Low income/socioeconomic status**
- **Past history of depression or anxiety**
- **Relationship problems or abuse**
- **Stress/stressful life events**
- **Unplanned pregnancy**

Interestingly, infant temperament, low self esteem, and obstetric complications feature in the international evidence. This is in line with what I see in my practice, but these don't feature in the NZ based risk factors.

Other factors

There are also other factors mentioned in research and evident in practice, including physiological, practical, social and sociological factors.

Physiological factors

There is little recent evidence on biological causes, which was, historically seen as the primary cause of PND. However Bloch (2005 cited Hubner-Liebermann, 2012) found a subgroup of women with PND who experienced sensitivity to hormonal changes, especially estrogen and progesterone. Underwood et al (2017) in their research regarding PND and Dads also referred to maternal perinatal depression being linked to physiological changes (e.g., hormone fluctuations).

Sleep deprivation has also been a subject of research. There is evidence that subjectively reported disrupted or poor sleep during pregnancy and the postpartum period impacts the development of postpartum depression, with not enough evidence to determine whether sleep affects either postpartum anxiety or psychosis (Lawson et al 2015). In my practice it seems lack of quality sleep can both contribute to and result from feelings of depression and/or anxiety.

Practical factors

Another perspective on PND is that external factors contribute to depressive feelings. Matthey, (2009) developed the '*Reasons for postnatal distress checklist***' to ascertain women's perceptions of causes of their distress. Practical stressors were more commonly endorsed by mothers as the reason for their postnatal depression, anxiety or distress, rather than more intrapsychic stressors. This suggests that the work involved in being a mother may simply be too much for one person, and this is definitely something I see in my practice. It's very rare for me to have a client with good practical supports. In saying that, often I see my clients feeling**

overwhelmed with too much work but also reluctant to ask for help in that they fear judgement - indicating there are psychological stressors at play too.

Psychological factors - FEARS

Hubner-Liebermann (2012) supports the perspective that PND is associated with the mother's fear of failure and feelings of inadequacy in meeting the child's needs. He suggests that any problems, such as breastfeeding, are interpreted as '*confirmation of their own failure, reinforcing the vicious circle and their ever-increasing exhaustion***'. So in summary if a mum fears failure, they try harder, become tired, problems occur, they believe they're a failure, they try harder and become even more exhausted, they try harder and so on. This is something I see in my practice also.**

Difficulties occur when mums are ashamed of how they're feeling so they suffer in silence, as Hubner-Liebermann (2012) illustrates:

> '*…because of the personal and societal expectations of undiluted joy, the taboo against depression is even greater than at other times. The women are afraid to express their negative feelings towards their child and their perceived failure as mothers.'*

Social factors

Lack of social support may be a cause and a consequence of PND. Research in New Zealand via the National Maternal Mental Health Survey (NMMHS) has shown that women experiencing PND reported less social support and connectedness, less perceived coping self-efficacy, lower personal wellbeing, and more feelings of social isolation and exclusion. These findings indicate that women experiencing PND encounter compounding risk factors, such as low general family wellbeing, and social isolation. Although this research cannot infer which comes first; PND or low social support - other research suggests the relationship is bidirectional (Koenders et al., 2015 cited HPA, 2016).

Sociological factors

Thurtle (1995) has a broader perspective on the impact of society on motherhood and PND:

> '*Post-natal mental ill health can be seen as the response to emotional and socio-cultural stress on the individual woman and family at the time of childbirth, as well as the stress that may be inherent in the structure of society and constantly impinging upon women's lives*'

She goes on to suggest that PND could be a social construct, used to label women who don't have 'just the right amount of anxiety' for raising a child, or are not exhibiting enough male behaviours. In her research she found three perspectives; that PND essentially exists because:

1. **it's diagnosed as part of the system, the system in which women find it easier to express their unhappiness (compared to men) and therefore are more likely to get into the medical system.**
2. **of the stress that motherhood entails (social situation, work roles, poverty, poor housing) combined with the high expectations of the role of motherhood, imposed by mothers themselves and those around them.**
3. **it's a product of patriarchal labelling, by which feminists argue that throughout history women have been seen as weak and vulnerable (Showalter, 1987, cited Thurtle, 1995) and labelled as ill because they were not male or at least demonstrating male characteristics and behaviours (Chesler, 1982, cited Thurtle, 1995).**

Grief and loss factors

Another perspective I think is worth mentioning is the view of the NZ researcher, Anita Darrah which is that PND symptoms arise from feelings of loss - specifically, a loss of prenatal expectations of 'mythical' motherhood and mothering. This triggers emotions associated with the grief process (denial, anger, anxiety, depression).

In summary

There are a range of common contributing factors to PND, some unique to New Zealand such as Pacific and Asian ethnicity, others such as infant temperament, obstetric complications, and low self-esteem which are evident in international literature and in my practice-based evidence. There are also other factors involved such as lack of practical and social support, and loss of expectations.

It is tricky to compare apples with apples in this field, where definitions differ across the research, so it's important to know that YOU are YOUR best gauge of whether you are feeling OK or not - despite what you feel you SHOULD be feeling. This is on a physical, social, psychological and emotional level. If you feel your balance is out then there are people and places to help you find it again - for your benefit, and your family's too.

What next?

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PND Wellington produces it's Purple Book, which contains more information about PND and the signs, symptoms and contributing factors. Contact us below if you want copies.
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Facebook - search PND Wellington Support and ask to join (secret group).

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Part three: PND in NZ - what's the story?

June 2017

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The 'evidence'

Part three of this article series looks at the impacts of Postnatal Distress (PND) on your well-being and what helps to support your well-being. Part two looked at contributing factors to PND. As I mentioned in Part one, this article series uses both evidence based research and practice based evidence to inform its opinions. Sometimes these two types of evidence provide different pictures. This is because the definition of PND that we use at PND Wellington, which encompasses stress/distress, anxiety and depression, is broader than the clinical definition researchers use (usually postnatal *depression* symptoms as classified by the Edinburgh Postnatal Depression Scale). However, for ease of writing this article, I use the term PND to cover all definitions.

I've also focused, as much as research would allow, on New Zealand (NZ) evidence. We are fortunate enough in NZ to currently have a longitudinal study on 7000 Kiwi children called 'Growing Up in New Zealand', which gathers information from parents before birth, and after birth. This research is providing invaluable evidence for PND in NZ. The focus of this article series is on women, but PND does affect Dads too. You can refer to Underwood et al (2017) for their research on postnatal depression amongst Kiwi Dads, if you're interested.

The impacts of PND on your wellbeing

Compounding factors and culminating effects

As varied are the feelings, thoughts and behaviours that people have in response to a child coming into their lives, so too are the effects. We can feel the effects on all levels, body, mind, social, situational, and physical. For example, if we are experiencing low mood we may avoid social interactions and then begin to feel socially isolated as well. Or, if we have an unsettled baby, we might find our mind becoming obsessed or fixated on trying to fix something that's outside of our realm of knowledge or control - and this can affect our emotions. Also, after birth or caesarean, our bodies might not be able to function or exercise as it did previously, and this can be a source of frustration.

Our early and presenting signs of stress, distress, depression, and anxiety can lead to further impacts on body, mind, spirit, socially, and situationally. Our responses, and others responses, can create a vicious circle where it's hard to see the cause from the consequence. For example, we may fear failure so we try even harder, exhaust ourselves as a result, which means our performance is down - triggering feelings of failure. Often what we really need is the opposite to what we have the urge to do (i.e. go faster and harder) - stopping and breathing can be the best medicine when we're in a muddle.

The upside though is that when experiencing these early signs we can take them as indicators that our balance in these areas might be a bit out and that we can do things to bring balance back. For example if physically we are less able as we were before baby, we could do things to still keep fit enough. We can still maintain contact with people via phone and email if it's difficult for us to get out and about. If we have an unsettled and loud baby, instead of taking on sole responsibility of settling baby, we could share responsibility with others so that we can maintain our own sense of peace and calm. If you feel that you don't have the

skills and expertise to adjust to life with baby, instead of suffering in silence you can reach out for help to figure out what the learning opportunity is for you. These learnings might be practical, and they might be intra-psychic. All of these learnings put us in better stead for what we might need to face in future - i.e. it builds our resilience.

What helps to support your wellbeing

As mentioned above, types of feelings and thoughts associated with PND are similar to any other depressive or anxious episode, therefore if practicable, many of the strategies for dealing with these are effective for mums also. This includes general wellbeing strategies in body, mind, spirit, socially and situationally. For more tips and services, see PND Wellington's Purple Book for a list. This section looks at the main types of support that come up in the research.

Culturally appropriate support and services

It's important to find services and support that you connect with, this might be orientated around your ethnicity, interests, and lifestyle. For example some mums prefer the coffee catch up sort of support, others prefer one on one, some mums prefer connecting over exercise or at a reading group. We are all diverse and unique but we are social creatures so we enjoy being able to bond and feel supported with those we connect with, and this might be oriented around our culture and/or ethnicity.

For example some Māori women might prefer to seek support within the wider whānau and from services that are by Māori for Māori, with focus on whakawhānaungatanga, or whānau or kin shared responsibility and collaboration (MoH, 2011). Such services include the Tamariki Ora well-child programme, and Nāku Ēnei Tamariki, which offer social services for Māori and Pasifika in the Hutt area. Taeaomanino Trust is a Pacific social service and counselling provider in Porirua. There are also support groups that are oriented around cultural orientation, for example the Chinese Plunket In your Neighbourhood (PIN) Group in Johnsonville Plunket. Such groups can be helpful in creating and maintaining a sense of community for mums.

PND Wellington can provide Chinese and Japanese speaking counsellors and we are in the process of providing accessible information for parents who speak these languages. We also endeavour to make our service more accessible to all cultures, particularly in relation to Pasifika and Māori.

Specialist Maternal Mental Health Services and respite care

Most District Health Boards (DHB) provide Specialist Maternal Mental Health Care, which, like Capital and Coast MMH, consists of nurse home visits, consultations with a Psychiatrist, and psychological or psychotherapeutic interventions. Eligibility criteria usually apply and your doctor can refer you for assessment.

A few Health Boards in NZ also offer respite care for mums. Canterbury DHB currently provides New Zealand's only tertiary mothers and babies unit, with five beds for the Southern region (MoH, 2011), which is in line with the UK recommendation of 0.25-0.75 respite beds per 1000 deliveries.

Non-directive counselling and support

Theories vary on how and why counselling works, some theorists believe that like any other supportive and trusting relationship - therapy helps people discover their own inner resources, and to learn new skills in order to solve problems and improve their functionality in living.

Interpersonal Therapy (IPT), or Person-Centred Therapy centres on a quality relationship between therapist and client, which is characterised by empathy, congruence, positive regard, and non-judgment. Hubner-Liebermann (2012) suggests that IPT for PND concentrates on the woman's changing role, on the demands and expectations associated with the role of mother, and on interpersonal/familial conflicts. Interventions that are based in the mother's home, such as home-visits, phone and internet-based support, can make access to help more realistic, practicable, private, and accessible (Hubner-Liebermann, 2012).

The efficacy of therapeutic home-visits are supported by a UK study in the 1980s that found a marked improvement in PND recovery when women were provided with a one hour postnatal non-directive counselling session by a health visitor (Holden, et al, 1989, cited Morrell, 2006), these are now widely implemented in the UK as 'Listening Visits'.

PND Wellington provide online support via its Facebook page, it also provides phone support, and considers home visits on a case by case basis.

Mindfulness and Drawing Therapy

In my practice I see the benefits of proactively practising self care - and this starts with awareness of body, mind, spirit. Mindfulness practices can help uncover this for you. Mindfulness Works operates short courses around the country. Along the same lines, is drawing therapy, which is meditative in practice but also helps access the more subconscious intra-psychic issues that might be at play for you.

At PND Wellington, some of our counsellors are trained in Drawing Therapy. See our details below for more information.

Specialist therapy

Specialist therapies such as Cognitive Behavioural Therapy (CBT) are proven to be helpful for some people (Hoffbrand et al, 2001 cited Wylie, 2011). However other research suggests that evidence supporting one psychological therapy over another is small - suggesting that choice of therapy comes down to your own preference and availability of therapies to you (NICE 2007, cited Wylie, 2011). Hubner-Liebermann (2012) reviewed research on the effectiveness of different therapies for PND and found that:

> *'all evaluated psychotherapeutic and psychosocial interventions, such as peer support, supportive therapy, cognitive behavioural therapy, IPT, and psychodynamic therapy, were significantly more effective than standard aftercare—at least for the first year postpartum'.*

In my practice, I have seen mindfulness and cognitive based techniques work to process trauma - this means looking at thoughts, feeling, sensations associated with disturbing memories, and learning to desensitise triggering stimuli. Drawing therapy can be useful to activate and reprocess the traumas, as can be Eye Movement Desensitisation Therapy (Weeks, 2013; Van Der Kolk, 2014).

It is important that your therapist is skilled in providing therapeutic services, one way of checking is to find out if they are associated with a professional body such as the NZ Association of Counsellors. That way you know they have sufficient training, expertise and abide by professional ethics.

Anti-depressant medication

It is common to worry about the side effects of medication on baby, when breastfeeding, however these side-effects are often outweighed by the benefits of Mum feeling calmer and more confident - and that relief also benefits baby (Weeks, 2013). Most antidepressants enter the breastmilk in minuscule amounts, and you and baby can also be monitored for side-effects (Weeks, 2013). Research shows that, in principle, breastfeeding is compatible with antidepressant medication (Hubner-Liebermann, 2012), such as the tricyclic antidepressants (TCA) (imipramine, nortryptaline) and the frequently prescribed Selective Serotonin Re-uptake Inhibitors (SSRI) such as fluoxetine, paroxetine, sertraline, and citalopram.

SSRIs work by slowing the removal of serotonin from the nerve synapse - essentially letting your own serotonin (a feel-good hormone) work better. While SSRIs are detectable in breastmillk, risks can be managed by for example starting on a single agent at the lowest possible dose, and monitoring any side effects (Hubner-Liebermann, 2012). SSRIs tend to have less side effects, are better tolerated, and less toxic in overdose than TCAs (which tend to have little or no detection in breastmilk) (Weeks, 2013). SSRIs remain the main group of drugs prescribed to treat PND (Looper 2007, cited Wylie, 2011).

It is important that you and your family share the decision in whether or not to take medication while breastfeeding, and that you feel well-informed about the benefits and risks. Also keep communication open with your doctor in case you need to change.

Birth support person/postnatal doula

In my practice I've met several women who on reflection would have had a specialist support person with them during the birth, to help explain to them what was happening and provide comfort during emergency situations. This is also supported by the research.

Salam (et al 2014) suggests that it's only in recent times that women have given birth in hospital rather than at home, so continuous support during labour has become an exception rather than the routine. She goes on to say that 'concerns about dehumanisation of women's birth experiences' have instigated a resurgence of continuous, one-to-one support by women for women during labour. This includes emotional support (continuous presence, reassurance and praise), information about labour progress and advice regarding coping techniques, comfort measures (such as comforting touch, massage, warm baths/showers, promoting adequate fluid intake and output) and advocacy (helping the woman articulate her wishes to others).

Continuous social support has shown significant clinical benefits for women and infants. A systematic review by Hodnett et al. (cited Salam, 2014) reported that women allocated to continuous support were more likely to have a spontaneous vaginal birth, less likely to have intrapartum analgesia, or report dissatisfaction. In addition, their labours were shorter, they were less likely to have a caesarean or instrumental vaginal birth, regional analgesia, or a baby with a low 5-minute Apgar score.

The benefits for mothers and babies of continuous social support throughout labour and childbirth, and postnatally are clear. For more information about such services in your area, ask your midwife or doctor. Lovemamas is one such postnatal doula business, based in Wellington. Bellycare also provides pregnancy and postnatal body care for mums in Wellington.

Partner support

Research shows that when partners are involved in group support for the Mums, that their depressive symptoms can significantly decrease (Misri et al 200, cited Wylie, 2011). I see this in practice, where the dyadic relationship in a partnership can be healing, which is promoted by working together and providing empathy for each other. Couples counselling can further enhance communication and support systems. This is founded in psychotherapy theory, where deep thoughts and feelings and unresolved wounds might come to the surface under the stress of parenting.

Some of our counsellors at PND Wellington are able to offer coaching to couples to help them work on helping each other heal from the old wounds that may have opened up.

Self-care and exercise

Some research has shown that improving fitness by pram walking can reduce depression symptoms in Mums (Armstrong et al , 2004). Exercise is often associated with managing general depression and anxiety. However, it can be a challenge for mums with young babies to fit in regular exercise, and also to adjust their expectations about the type of exercise they can realistically do. This is where self-care comes in, and many mums find that in order to maintain their equilibrium they need to accept extra support to enable them to meet their own needs, for example utilising family and friends to look after the baby so mum can take time to re-fill her tank. For many mums who don't have childcare in their own networks, this may require utilising some paid help from a reputable nanny/childcare company such as Porse, or a Postnatal Doula such as Lovemamas.

In practice, I notice that it can be helpful for people to become more aware of their negative self-talk in order to be able to challenge it. This can start with removing words like 'should' 'must' 'ought'. For example, instead of thinking 'I SHOULD hang out the washing, tidy the kitchen and clean the bathroom, so I MUST to get the baby to sleep NOW', it may be more helpful to think 'I want to have the house a little bit tidier, so I'll take it slowly and work around baby and me'.

Starting early

Seeking support sooner rather than later puts you in good stead to work through what's bothering you, and to become more resilient in the long run. Research suggests that early detection of PND is helpful in order to access appropriate support (NICE, 2007, cited Wylie 2011). There are a variety of support options available. Many antenatal programmes now look more in depth into PND, for example the Johnsonville Plunket antenatal course. This helps to remove taboo and stigma around PND, and to also open doors for support that may be required later. For some mums a support group and/or online support can be enough to help cope with the situational demands of parenting. For mums who are struggling with more intra-psychic challenges then some

counselling support can help you work through what's underneath. Medication can also help enable you to engage better in any counselling/psychological work.

Being honest with how you feel is the first and most important step - and then reaching out for support is the next step.

What next?

I'm Emma Heaney-Yeatts, the Lead Counsellor at PND Wellington. I have two young boys and my own experience with postnatal distress. I'm a qualified counsellor and full member of the New Zealand Association of Counsellors.

If you want impartial, confidential and professional support while you negotiate your parenting journey then PND Wellington has Counsellors to help. Couples counselling (where it relates to PND) is also available. Our fees range from free to low-cost depending on the level of experience of the Counsellor. On our website you can access a description of the Counsellors we have, their locations and fees - so you can find a counsellor that fits. See www.pnd.org.nz under 'Get help', 'Low cost counselling'.

PND Wellington produces it's Purple Book, which contains more information about PND and the signs, symptoms and contributing factors. Contact us below if you want copies.

Phone: 04 4723135 (just leave a message and we will call you back).
Email: pnd.wellington@gmail.com or emma.pnd.wellington@gmail.com
Facebook - search PND Wellington Support and ask to join (secret group).

The content in this article is not intended to replace any medical advice. If you are feeling unsafe then seek emergency help immediately.

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