Copyright is owned by the Author of the thesis. Permission is given for a copy to be downloaded by an individual for the purpose of research and private study only. The thesis may not be reproduced elsewhere without the permission of the Author.
PERINATAL MENTAL HEALTH POLICY: YOUNG WOMEN'S MENTAL HEALTH SUPPORT DURING PREGNANCY

A thesis presented in partial fulfilment of the requirements for the degree of

Masters of Philosophy
in
Social Policy

at Massey University, Turitea, Palmerston North, New Zealand

Jane Elizabeth Parsons
2008
Abstract

A woman's reproductive period is when she is most likely to suffer mental ill-health with this risk increased for young women. Mental ill-health in the perinatal period is identified as common but with significant implications for the young women and her family (Dearman et al., 2007; Petrillo et al., 2005; Riecher-Rössler & Steiner, 2005). From as early as a few weeks post conception, the foetal brain is found to be affected by maternal stress and mental ill-health. This continues to affect the infant postnatally and is exacerbated if maternal mental ill-health is not treated. Young women are more likely to experience impediments to their wellbeing in the perinatal period. Thus, introduction of suitable formal support perinatally can have a prophylactic effect on maternal and infant mental illness.

Through feminist research methods, utilising semi-structured qualitative interviews, four pregnant women thirty years and under in the perinatal stage of pregnancy and four health professionals working in the field of maternal mental health explore with the researcher their experiences of mental health support and education during pregnancy. This research demonstrates how services are currently unable to appropriately meet the needs of young pregnant women due to lack of attention to gender and youth issues and the dominance of a medical model understanding that has allowed this negation through minimising holistic, contextual treatment. The gendered construction of health services and recent market principles in state provisions are evidenced by the compartmentalisation of services, lack of collaboration between these services, competition for resources, and rigidly defined roles of health professionals that present access barriers for young pregnant women. A need to enhance formal supports and create policy frameworks and practice guidelines to direct this support is identified alongside recommendations for increased service provision, education, and screening at the primary healthcare level.
Acknowledgments

I wish to acknowledge first the role of family support to young women in difficult situations, because at times I have been one of those. To the young women who participated in this research and their families and supports, the time provided for this research and your depth of experience and willingness for nothing in return was amazing and I thank you. Thanks to the participants from the community who gave their time and expertise for nothing else but the interest in their fields and in this research. Thanks especially to Chris Pederson. Your passion for maternal mental health, primary health care, and women's health triggered my own, and subsequently this research. Your advice in many areas of this work and my life has been invaluable.

Regarding my own family; we are too big to acknowledge everyone but I will try to do justice to some while holding you all in this space. Thanks to all my extended family for your support and for bringing me back down to earth when I needed it. We had some hard stuff as a family unit to cope with in the midst of this endeavour but you all continued to support and encourage me despite my stress and crankiness. Mum – you are awesome and I have drawn strength from you. Somehow you manage to balance what is important to you, including being a supportive mother, grandmother, daughter, sister, friend, and so on while maintaining your own self and independence. This character, and battling what you have the last two years, brings me to aspire to you. Dad, as my biggest fan, you have done a great job cheering me on. I am sorry though, that I do not have all the answers for you. Nothing I have done has been done without you both as my parents.

To my brothers; thanks for not having a clue what I was doing all this time but being impressed and offering to help anyway. Z, thanks for living with me and putting up with so much over the last few years, not many brothers would do the same. Thanks to you, your friends and Ana for always bringing out the fun, young side. Clint and Em, thanks for all your support and for Jacob and Caleb who keep me grounded in what is most important. I know this work impacted on you all.

Ana, thanks for your design assistance. There are many things in my life that wouldn't be so much fun without you – you are a hugely talented individual.
Also Glen, keep up the hard work that you do as a social worker through your fantastic nature and way of working.

Thank you to all my supportive friends and family. I am very blessed to have you all.

To my professional friends and colleagues, thanks also for your patience and encouragement. Karen Shepherd, I don't know which category of people to put you in as in my life you have fitted into almost all of them. Thank you for the support.

Finally, to my supervisors; Carole Adamson, Jenny Jakobs and Jenny Coleman, I thought we did the long distance supervisory relationship well despite malfunctions in technology and communication at times! Thank you for the calm, consistent guidance, gentle kicks and containment. You held unwavering faith in my abilities and this research when my own was very fragile. Thanks for coming on board at the crux time Jenny C. It was uncanny how pretty much everything you and Jenny J said was right, even if I didn't think so at the time.

It could not be truer, based on all of the support I have received that helped me to complete this work that; "Human beings of all ages are happiest and able to deploy their talents to best advantage when they are confident that, standing behind them there are one or more trusted persons who will come to their aid should difficulties arise." John Bowlby (1970).
Table of Contents

Abstract .............................................................................. ii
Acknowledgements ................................................................ iii
Table of Contents ................................................................ v
List of Figures ....................................................................... x
Glossary ............................................................................... xi
List of Abbreviations ........................................................... xv

Introduction ........................................................................1
Maternal Mental Health: The Earliest of Interventions ... 1
  Introduction ........................................................................1
  Aims of the research ....................................................... 2
  Feminist Theory and maternal mental health ................... 2
  The researcher: Theory and experience .......................... 3
  Structure of the thesis ..................................................... 5
  Conclusion ...................................................................... 6

Chapter One ..................................................................... 7
Current Context: The Politics of Pregnancy ................... 7
  Introduction ...................................................................... 7
  The perinatal period ....................................................... 7
  International obligations ................................................ 8
  National provisions ....................................................... 10
  Te Tiriti O Waitangi ....................................................... 11
  Policy ............................................................................. 12
  Lead Maternity Carers .................................................... 13
  Evidence based guidelines ............................................. 14
  Primary health care ....................................................... 15
  Secondary and tertiary health services ......................... 16
  Maternal Mental Health and gender constructions ....... 17
  Local provisions .......................................................... 18
  District Health Boards ................................................... 18
  Provisions for maternal mental health ......................... 18
  Local and community services ..................................... 19
  Conclusion .................................................................... 20

Chapter 2 ........................................................................ 21
Models of Intervention and Treatment in Maternal Mental Health
  Introduction .................................................................... 21
  The medical model ....................................................... 21
  The medical model and mental health ......................... 22
  Diagnostic Classification .............................................. 23
  Feminist constructions of mental health ....................... 23
  Gender .......................................................................... 24
  Social constructions of health ...................................... 24
  Labelling, power and control ........................................ 26
  Medicalisation of reproductive capacity ...................... 27
Ethical issues ........................................................................ 61

Human ethics application .................................................. 61
  Minimisation of harm .................................................... 61
  Informed consent ......................................................... 62
  Privacy and confidentiality ........................................... 64
  Cultural and social responsibility .................................. 65

Selection and recruitment of participants ......................... 65

Young pregnant women .................................................. 65
  Participant criteria ..................................................... 65
  Recruitment procedures ............................................ 66
  Participant profiles ..................................................... 67

Key informants ................................................................... 68
  Participant criteria ..................................................... 68
  Recruitment procedures ............................................ 68
  Key informant profiles ................................................ 68

Data analysis and triangulation .......................................... 69

Theme analysis .............................................................. 69

Feminist analysis ............................................................ 69

Triangulation ...................................................................... 70

Limitations of the research ............................................... 70

Sample limits ................................................................. 70

Participant recruitment .................................................. 71

Difficulties in participant recruitment ................................ 71

Impacts of qualitative and feminist methodology ............... 72
  Reliability and generalisation ....................................... 72
  Researcher bias .......................................................... 73
  Relinquishing of control .............................................. 73

Conclusion ......................................................................... 74

Chapter 5 ........................................................................ 75

Perspectives of four young pregnant women ...................... 75

Introduction ...................................................................... 75

The participants ............................................................. 75
  Meagan ........................................................................ 75
  Sarah ......................................................................... 76
  Charisma ................................................................. 76
  Michelle ................................................................. 76

Partners and informal supports ........................................ 77

A focus on physical health issues and postpartum issues .... 80

First pregnancy: expectations and knowledge .................... 81

Resources ........................................................................ 82

Importance of midwives .................................................. 83

Antenatal education ......................................................... 86

Mental health information .............................................. 87

Role of general practitioners .......................................... 88

Accessibility of health and support services ..................... 89

Education/vocation ......................................................... 92
<table>
<thead>
<tr>
<th>Conclusion</th>
<th>93</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chapter 6</strong></td>
<td>94</td>
</tr>
<tr>
<td>Perspectives of four health professionals</td>
<td>94</td>
</tr>
<tr>
<td>Introduction</td>
<td>94</td>
</tr>
<tr>
<td>The key informants</td>
<td>94</td>
</tr>
<tr>
<td>Sally</td>
<td>94</td>
</tr>
<tr>
<td>Fiona</td>
<td>95</td>
</tr>
<tr>
<td>Beth</td>
<td>95</td>
</tr>
<tr>
<td>Clive</td>
<td>95</td>
</tr>
<tr>
<td>Psychological development of young people</td>
<td>95</td>
</tr>
<tr>
<td>Informal support</td>
<td>96</td>
</tr>
<tr>
<td>Stigma of mental health issues</td>
<td>97</td>
</tr>
<tr>
<td>A focus on physical health issues and postpartum issues</td>
<td>98</td>
</tr>
<tr>
<td>Suitability of health and support services</td>
<td>99</td>
</tr>
<tr>
<td>Funding and resourcing</td>
<td>101</td>
</tr>
<tr>
<td>Maternal Mental Health Specialist role</td>
<td>101</td>
</tr>
<tr>
<td>Midwifery support</td>
<td>103</td>
</tr>
<tr>
<td>Role of general practitioners</td>
<td>104</td>
</tr>
<tr>
<td>Medication</td>
<td>106</td>
</tr>
<tr>
<td>Collaboration between services</td>
<td>107</td>
</tr>
<tr>
<td>Lack of screening perinatally</td>
<td>109</td>
</tr>
<tr>
<td>Policy</td>
<td>111</td>
</tr>
<tr>
<td>Lack of preventative measures</td>
<td>112</td>
</tr>
<tr>
<td>Conclusion</td>
<td>113</td>
</tr>
<tr>
<td><strong>Chapter 7</strong></td>
<td>114</td>
</tr>
<tr>
<td>Analysis and Discussion</td>
<td>114</td>
</tr>
<tr>
<td>Introduction</td>
<td>114</td>
</tr>
<tr>
<td>Constructions surrounding young pregnant women</td>
<td>115</td>
</tr>
<tr>
<td>Stereotypes of young pregnant women</td>
<td>115</td>
</tr>
<tr>
<td>Blame and stigmatisation</td>
<td>117</td>
</tr>
<tr>
<td>Physiological definitions</td>
<td>118</td>
</tr>
<tr>
<td>Developmental stages of adolescence and early adulthood</td>
<td>118</td>
</tr>
<tr>
<td>Conceptions of health</td>
<td>119</td>
</tr>
<tr>
<td><strong>Gendered nature of mental health services</strong></td>
<td>120</td>
</tr>
<tr>
<td>Women and mental health</td>
<td>120</td>
</tr>
<tr>
<td>Mental illness defined through gender</td>
<td>121</td>
</tr>
<tr>
<td>Youth and health services</td>
<td>121</td>
</tr>
<tr>
<td>Power and advocacy</td>
<td>122</td>
</tr>
<tr>
<td>Impact on health professionals</td>
<td>123</td>
</tr>
<tr>
<td>Concepts of pathology</td>
<td>123</td>
</tr>
<tr>
<td>Social control</td>
<td>124</td>
</tr>
<tr>
<td>Help-seeking</td>
<td>124</td>
</tr>
<tr>
<td>Validity of professional experience</td>
<td>125</td>
</tr>
</tbody>
</table>
Influence of the medical model ........................................ 125
Compartmentalisation of health issues .............................. 125
Medical authority and links with masculine attributes ......... 126
Avoidance of mental health and mental health promotion .... 127
Construction of health services ....................................... 127
Funding and competition ............................................... 128
Lack of preventative measures ........................................ 128
Individualism ............................................................. 129
Policy ............................................................................ 130
State sector marketisation ............................................... 130
Primary Health Organisations ......................................... 131
Conclusion ...................................................................... 132

Chapter 8 ............................................................... 133
Recommendations and Conclusions ................................. 133
Introduction .................................................................... 133
Recommendation One ..................................................... 133
Recommendation Two ...................................................... 134
Recommendation Three ................................................... 134
Recommendation Four ..................................................... 135
Recommendation Five ..................................................... 136
Recommendation Six ......................................................... 137
Recommendation Seven .................................................. 137
Recommendation Eight .................................................... 138
Recommendations for further research ............................. 139
Conclusion ...................................................................... 140

Appendices .................................................................. 141
Appendix One: Figures and Tables .................................. 141
Table One: Teenage pregnancy rates ............................... 141
Table Two: Number of teenage pregnancies per capita .... 143
Table Three: Lead Maternity Carer rates ......................... 144
Table Four: LMC rates per DHB .................................... 145
Table Five: Mental Health Service Use ............................ 146
Appendix Two: Health and Disability Human Ethics Application ................................................................. 148
Appendix Three: Research advertisement ....................... 160
Appendix Four: Information Sheets ................................. 161
Appendix Five: Consent Form ........................................ 166
Appendix Six: Transcribers confidentiality agreement ....... 168
References ..................................................................... 169
Bibliography ................................................................. 186
List of Figures

Table 1: International teenage pregnancy rates per capita 141
Table 2: Number of teenage births per country 143
Table 3: Lead Maternity Carer rates 144
Table 4: Lead Maternity Carer rates per DHB 145
Table 5: Mental Health Service Use in New Zealand by sex 146
Glossary

'At risk' or 'high risk': These terms have been used interchangeably to identify an individual's potential for development of poor mental and physical outcomes. Risk factors are characteristics that increase the probability of the occurrence, severity, duration or frequency of later disorder (Lewis, 2005; Magyary, 2002, p. 335; Zeanah, 2000, p.439). Due to the limiting and stigmatising nature of this terminology, as well as the culturally bound construction of such terms, 'increased vulnerability', 'vulnerable', or 'pre-disposed' is utilised as this reflects better the complexity of environmental interactions that may cause young mothers and their children to be more susceptible to poor outcomes.

Constructionism: View that knowledge is created by human beings who invent concepts, models and schemes to make sense of experience as opposed to discovering knowledge (as in a positivist understanding). A perspective that considers facts, descriptions and other features of 'objective reality' to be inescapably contingent and rhetorical. Follows the traditional view of social constructionism, a strand of constructivism where people are seen as produced (constructed) through social interaction rather than through genetic programming and biological maturation (Hepburn, 2006, p. 38). A constructionist view is argued for in feminist theory that sees gender issues and categorisation as constructed rather than as an essential nature. Social Constructivism stands that our constructions are also mental (as with constructivism) but created in our social relations and conversations similarly to how constructivism states understandings are created in relation to objects.

District Health Boards (DHB): Democratically elected boards of governance for secondary (hospital based) and some tertiary (specialist) health care services.

Epidemiology: The quantitative study of the causes, distribution, prevention and control of disease in populations (Swann, Bowe, McCormick & Kosmin, 2003; p., 80).

Evidence Based Research: The best current research information available
based on a systematic analysis of the effectiveness of a treatment, service, or any other intervention and its use, in order to produce the best outcome, result or effect (Swann et al., 2003, p. 60).

**Evidence Based Practice:** An approach to service provision that is focused upon ensuring consumers are given the most effective and appropriate provision as indicated by current research findings (Swann et al., 2003, p. 60).

**Incidence rate:** Rate at which new disease events occur in a population for a particular disorder.

**Infancy:** The period of life from birth to five years.

**Lead Maternity Carer (LMC):** Health professional (usually a midwife) that takes responsibility for a woman's care throughout her pregnancy and postpartum period including the management of labour and birth (Health Funding Authority, 2000).

**Mental health and maternal mental health:** Specific mental health disorders are described as per the Diagnostic and Statistical Manual Volume 4 (American Psychiatric Association, 2004); however, where they are referred to as occurring during pregnancy this specifier will be added. For example, 'Adjustment disorder in pregnancy' or 'depression during pregnancy'. The DSM IV uses the specifier "Postpartum onset" for diagnosis of current mental disorder if the individual is displaying the criteria for that disorder and onset occurs within four weeks of childbirth. For example, Postpartum Depression (also referred to as Postnatal Depression) or Postpartum Psychosis. The DSMIV differentiates the former from 'baby-blues' as this is not seen as impairing the individuals functioning. The term 'baby-blues', is felt to invalidate Mothers' experiences and is not used in this thesis. Instead specific disorders are identified and, where the criterion for such disorders is not met, yet mood or psychiatric difficulties are noted, the terms 'emotional difficulties' or 'psychological difficulties' or 'problems' are utilised. The absence of a mental disorder in mothers or children does not alone imply optimal emotional or psychosocial development, thus both mental and emotional/psychological health promotion is referred to (Jenkins, 2003, p. 189; Magyary, 2002, p. 346).

**Morbidity:** Assessment of the burden of disease.

Obstetrics: The branch of medicine dealing with pregnancy, labour, and the puerperium (Saunders, 2001).

Parturition: Childbirth

Perinatal: Relating to the period shortly before and after birth: from the 20th to the 29th weeks of gestation to 1-4 weeks after birth (Saunders, 2001).

NOTE: when referencing 'perinatally' this spelling will be used. However, within the literature perinataly and perinatally is used interchangeably. For the purposes of this research spelling of perinatally is used to concur with the typical spelling of postnatally.

Perinatology: The branch of medicine (Obstetrics and Pediatrics) concerned with the perinatal period (Saunders, 2001).

Policy Practice: The effort to influence the development, enactment, implementation, or assessment of social policies (Chaplin, 2007).

Postnatal: Occurring after birth with reference to the newborn (Saunders, 2001).

Postpartum: Occurring after birth with reference to the mother (Saunders, 2001).

Prenatal: Preceding birth

Prevalence Rate: The amount of cases currently known for a particular disorder.

Preventative or early intervention: Process whereby family conditions, parenting behaviour, and/or individual's behaviour are altered to increase the probability of normal developmental trajectories and to decrease potential for later disorders (Zeanah, p. 439).

Primiparous: Adjective. Women who have had one pregnancy resulting in one or more viable young (Saunders, 2001).

Public Health Organisation (PHO): Not-for-profit organisations made up of health clinics and groups with an interest in primary (non-hospital or specialist) healthcare (Rose, 2004). PHOs are contracted to provide services to District Health Boards.

Puerperium: The period or state of confinement after childbirth (Saunders, 2001).
Social Justice: The means by which societies allocate their resources such as material goods and social benefits, rights, and protections to ensure a fair distribution of societal resources to all people.

Social Psychology: The broad description attributed to the study of various post-structuralist phenomenologies (see Constructivist/Social Constructivist as one of these).

Teenage: 13-19 years. In some studies teenage is operationalised as being from 12 years.
List of Abbreviations

CEDAW – Convention on the Elimination of all Discrimination against Women.
CBT – Cognitive Behavioural Therapy
DHB – District Health Board
DSM – Diagnostic and Statistical Manual
GP- General Practitioner
ICCPR - International Covenant on Civil and Political Rights
ICD 10 – International Classification of disorders
IPT – Interpersonal Therapy
LMC – Lead Maternity Carer
MMH – Maternal Mental Health
OCD – Obsessive Compulsive Disorder
OECD – Organisation of Economic and Cultural Development
PND – Post Natal Depression
PHO – Primary Health Organisation
PPD – Post Partum Depression
PTSD – Post-Traumatic Stress Disorder
UNCROC - United Nations Convention on the Rights of the Child
WHO – World Health Organisation