# Postnatal distress among Pacific women in New Zealand

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## Introduction

*'Had home birth baby. Had all the information, had good attitude, had a lot of confidence. Had family with me... had control of who 1 wanted there... No negatives. Everything went so smoothly, never was I scared or anything"* Pacific mother

*"Good, really excited. But scared. Never seen anything like it, just felt like in a dream or a nightmare, wasn't sure which. But when my son came out I was so proud, so happy, showing off to her mum... Our baby... something we made together, joined us forever... so soft, beautiful"* Pacific father

*"Get many complaints involving children ]8months+, many cases mothers alone, little support, they feel trapped, have unsupportive partners. Sometimes all a bit too much... lash out at the children...behaviour difficulties increase the need for supervision which puts a strain on mother's or caregiver's time and effort. Mothers usually bear burden of this. 1 think in Pacific society mother expected to be pillar of strength and carry most of burden of supervision, so much so that if something goes wrong people automatically ask where was the mother, never where was the father. "* Pacific health worker.

**" ... in Pacific society the mother is expected to be the pillar of strength and carry most of burden of supervision, so much so that if something goes wrong people automatically ask where was the mother, never where was the father. "**

These three statements reflect the paradox of the Pacific birth and post-natal experience in New Zealand - how people that are passionate about children can become sour and dispirited about the experience of child rearing in New Zealand. These statements are from a study on postnatal depression (PND)[1].

## Methods

An interview based questionnaire using five key questions with a succession of prompts and two rating questions was given to 48 Pacific (Samoan, Cook Island, Tongan, Niuean) new mothers, mothers, and fathers, and to 13 health workers (Samoan, Cook Island, European) who service Pacific Island mothers and their families. Thirteen of the new mothers completed the Edinburgh Postnatal Depression Scale (EPDS). Discussion groups with new mothers, mothers and health workers were also run. New mothers and mothers were divided into low and high risk groups on the basis of their risk factor score for stress.

## Results

### Tough times and beautiful babies

The mothers, fathers and health workers give two contrasting views of the Pacific experience of birth and the postnatal period. The first is the pervasive environment of stress caused by the high levels of demand on mothers (particularly those who work), money worries, feelings of helplessness and anger, and concerns about lack of knowledge and control. In particular, these are indications of the lack of economic resources in Pacific families The second view is a positive, loving and almost ebullient, attitude towards babies. Prompts to the question "What were the good and bad things that happened to you when you were caring for a new baby?", drew eight times more positive comments about birth or the new baby than negative ones. Mothers and fathers with

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lower risk factors reported relatively more positive experiences. Where there were negative statements about children these are frequently focused at the older more independent baby.

The mothers were asked who supported them and how helpful was that support. Husbands or partners and professionals (e.g. Plunket) were the most commonly named source of support, but mothers did not see them as being very helpful. The people who were seen as very helpful were the mothers and sisters of the mother with a new baby. Both mothers and sisters were present for about 40% of the new mothers, and both mothers and sisters were more likely to be living with people who identified strong support systems. A further finding was that mothers who had to work were less satisfied with the support they received.

## Home or New Zealand – which is better?

The traditional experience of birth was seen as involving, a strong extended family support system, and a broader, but less involved, village support system. New mothers were strongly interested in the traditional supports to childbirth and rearing, and, on the whole, felt that New Zealand was not as good an environment for this compared with "home". Health workers agreed with this, but fathers felt New Zealand provided a clearly superior environment for childbirth and rearing. The high number of mothers without partners suggests that many fathers evade responsibility. Many of the women with partners also commented on expectations that they should be able to look after baby, work. cook and clean. Fathers, on the other hand, tended to see New Zealand as a land of labour saving devices which make the mother's job simple. Some of mothers who did not have to work, supported this view. However, it was clear that new mothers saw the workload in New Zealand as being, much greater than did fathers. and the division of labour, that may have seemed fair in the Islands, as not necessarily working here. Pacific people expected much from families, and over a quarter of the people interviewed thought more support from families, fathers and older children was needed. It was notable however, that there was no specific request for the mothers and sisters of mothers with new babies to do more, suggesting that the responsibilities of fathers have diminished.

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What made Pacific mothers feel positive about New Zealand was the presence in New Zealand of the key traditional support structure - namely the support of *their* mothers. What has to be recognised is that Pacific mothers of mothers with new babies are not solitary or occasional forces. They will be frequently living with the new mother and will be the hub of the family network that will bring the other family support systems into play. These systems will provide childcare, food, house-cleaning, and money where and when these are needed. This support structure will be provided within a system of powerful spiritual beliefs, both Christian and traditional, which, while not strongly identified by the respondents as salient, underpin the Pacific views of the world, and give status both to the role of the grandmother and to that of the new mother and her baby.

## What do Pacific new mothers need?

One third of support needs for mothers with new babies were focussed on social and family support services. Ten percent of support needs related to the specific components of more money and better childcare. The mothers were divided into a "high risk" (low income, high numbers of people in the household, no partner, unemployed) and a "low risk" groups. The "high risk" group of mothers identified a much higher level of support needs than the "low risk" group. However, the "high risk" group also got more support and were more satisfied with the support they received This support was largely family support.

Family support systems are particularly in evidence in the first three months, and this was where mothers with new babies are well supported and most satisfied with the support they receive. While there are very strong social support needs around this period, the major stress for many mothers with new babies is after they return to work, or after the new baby has learned to walk and has developed some degree of independence. So while this may suggest that the common risk factors for PND should not be considered risk factors for PND in Pacific women, the possibility is that they, and their children, may well be at a higher risk of mental illness in subsequent years due to these and other negative social and economic pressures.

## The level of risk for postnatal depression

The demographic information suggested that a high proportion of the Pacific mothers should be considered at risk of PND because of low income, housing pressure and an absence of partners. Another New Zealand study in Auckland showed that Maori and solo mothers were at greater risk of

PND and commented on the economic, educational and housing disadvantage suffered by Maori.[2]

Thirteen new mothers answered the questions on the Edinburgh Postnatal Depression Scale (EDPS)[3]. The low scores of the new mothers on the test suggested that some of the characteristics that signal PND may not be useful when identifying at risk Pacific mothers with new babies. The EPDS uses descriptive terms such "sadness", "anxiety" and "fear", which were not often used by the mothers in this study. The EPDS also explores "self harming" or suicidal feelings, which appeared to be inconsistent with the spiritual beliefs of Pacific people. British researchers have also noted that questions relating to suicidal tendencies were meaningless to Bengali women who "cannot conceive of such a possibility"[4]. New mothers scored highest on two questions that were about, firstly, feelings of not coping which were commonly expressed in the interviews (feeling helpless, not knowing what to do, no energy), and secondly, feelings of guilt, which relate to the increased expectations and demands on working mothers. This last point was supported by the highly significant positive correlation between the worried/anxious sub-scale of the EPDS and being employed (described by many mothers as *having* to go back to work)

The data overall supported the view held by some other researchers that the diagnostic framework of postnatal depression may not be appropriate for recognising symptoms of postnatal mental unwellness in cultures other than western. Three possible approaches suggest themselves: 1) in the EDPS a much lower scores may have to be used since certain sub-scales are insufficiently sensitive to expressions of stress in Pacific mothers; 2) new subscales may have to be developed reflecting the language that Pacific mothers use to describe their response to stress; 3) a different assessment may have to be developed which uses verbal, non-verbal and/or situational measures. This last suggestion might include somatic indicators, and an assessment of family support available

## The resilient Pacific family

There was also a significant negative correlation between the EDPS total score and the presence of mothers in the new mother's household. This supports the view that traditional support systems have been effective in maintaining low levels of postnatal depression. This study supported the argument that the Pacific Community in New Zealand has thus far avoided the high levels of mental illness present in the Maori and (to a lesser extent) European communities, because of the protective systems intrinsic in Pacific cultures. These protective systems have been described elsewhere as 1) the strength of the Pacific churches; 2) the use of traditional diagnostic, counselling and healing processes, and 3) the strength of the family. The family is described as providing "childcare and home help for new mothers, a watching, brief for all children in the extended family, massive help at times of grief and crisis, help across the network for parents and children in conflict, help for people with mental health problems that become too much for one family to sustain, and, care and respect for the elderly"[4].

## Discussion

This study described some family support systems which are extremely resilient in the face of very difficult economic circumstances for Pacific mothers with new babies. The study also demonstrated that those systems are under attack from the relative glitter of New Zealand life, and that some fathers are no longer meeting some of their obligations to their families. The data was generally supportive of psychosocial and cultural approaches to postnatal depression which argued that the presence of quality social support systems in the postnatal period will dramatically reduce the incidence of PND, and that Pacific cultures will provide the best support system. While Pacific nations have had histories of colonisation, they are now self governing and assert strongly positive cultural identities. The preservation of Pacific mental wellness in New Zealand demanded the sustenance of protective cultural institutions, while at the same time, a recognition that New Zealand will demand change. The processes whereby Pacific communities can manage that change need to be established.

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The Pacific experience of birth contains two strongly contrasting features: the pervasive environment of stress and a powerfully positive attitude towards babies. Prompts to the question "On good and bad experiences with caring for a new baby drew eight times more positive comments about birth or the new baby than negative ones. Respondents with lower risk factors report relatively more positive experiences. Two of the most commonly named sources of support, husbands/partners and professionals, were in fact given a lower rating of helpfulness than the mothers and sisters of the

mother with a new baby. Mothers who had to work were less satisfied with the support they received.

New mothers felt that New Zealand was not as good an environment for birth and early child rearing compared with "home". Health workers agreed, but fathers disagreed. The high number of new mothers and mothers without partners suggests that many fathers evade responsibility for their wives or partners. Many women with partners comment on expectations that they should be able to look after baby, work, cook and clean, while fathers tend to see New Zealand as a place of labour saving devices which make the mother's job simple. New mothers saw the workload in New Zealand as being much greater than fathers did, and the division of labour as not necessarily fair. Over a quarter of the respondents asked for more support from families, fathers and older children.

The mothers felt positive about New Zealand when a key traditional support structure was present. One third of the support needs were focussed on social and family support services, and another 20% of support needs related to the specific components of more money and better childcare. The "high risk" group identified much higher support needs than the "low risk" group, but while the "high risk" group get more support and are more satisfied with the support they receive, this support will be largely from the family. The major stress is after mothers return to work, or after the new baby has learned to walk and has developed some degree of independence.

Low scores from the test of the EPDS confirm that some of the constructs of PND may not be useful when identifying at risk Pacific mothers. Three possible approaches are suggested to address this. It is also suggested that because of social and economic pressures, Pacific mothers could well be at higher risk of mental illness, but after the post-natal period. The study makes recommendations for the sustenance of protective Pacific cultural institutions and better preparation of expectant Pacific parents for the realities of birth and the postnatal period in New Zealand. These are as follows:

1. The development of *by Pacific for Pacific* antenatal care programmes which address the need for new parents to be fully prepared for the arrival of their new child. This preparation should include not only mental preparation but also physical and financial preparation. Within the antenatal classes partners need to be made aware of the support needs of the mother postnatally up to the first year after birth.
2. The development of *by Pacific for Pacific* health education programmes to raise awareness about the pressures on mothers, in particular working mothers with young children. Pacific Health promotion contracts with the Pacific churches and other providers need to include this area. Such programmes will provide opportunities for additional education for Pacific men as a focus, since they will not be inclined to attend antenatal classes.
3. The development *by Pacific* professional services to better meet the needs of Pacific mothers and support the protective cultural institutions around the postnatal period. Such services would involve a substantial investment in training. Services could include: Pacific midwifery, home visiting services, development of Pacific creches and language nests, etc.
4. The development of health promotion programmes specifically directed at Pacific communities, and these to be based on a community development and empowerment model aimed at improving access to resources for Pacific families and communities.
5. The recognition of the limitations of postnatal depression screening tools designed for western cultures and the development of assessment processes that recognise when Pacific families are at risk of mental illness. Such an assessment process might include measures of emotional states congruent with Pacific experience, and include measures of somatic states, and opportunities for access to traditional support structures.
7. The development of funding mechanisms that recognise the way that child care support is traditionally organised in Pacific families and which enable subsidies to be paid to family members who are outside the nuclear family but who perform child support tasks that would be normally eligible for subsidy in the context of day care services.
8. Advocacy for the development and implementation of 3-month paid maternity leave legislation.

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