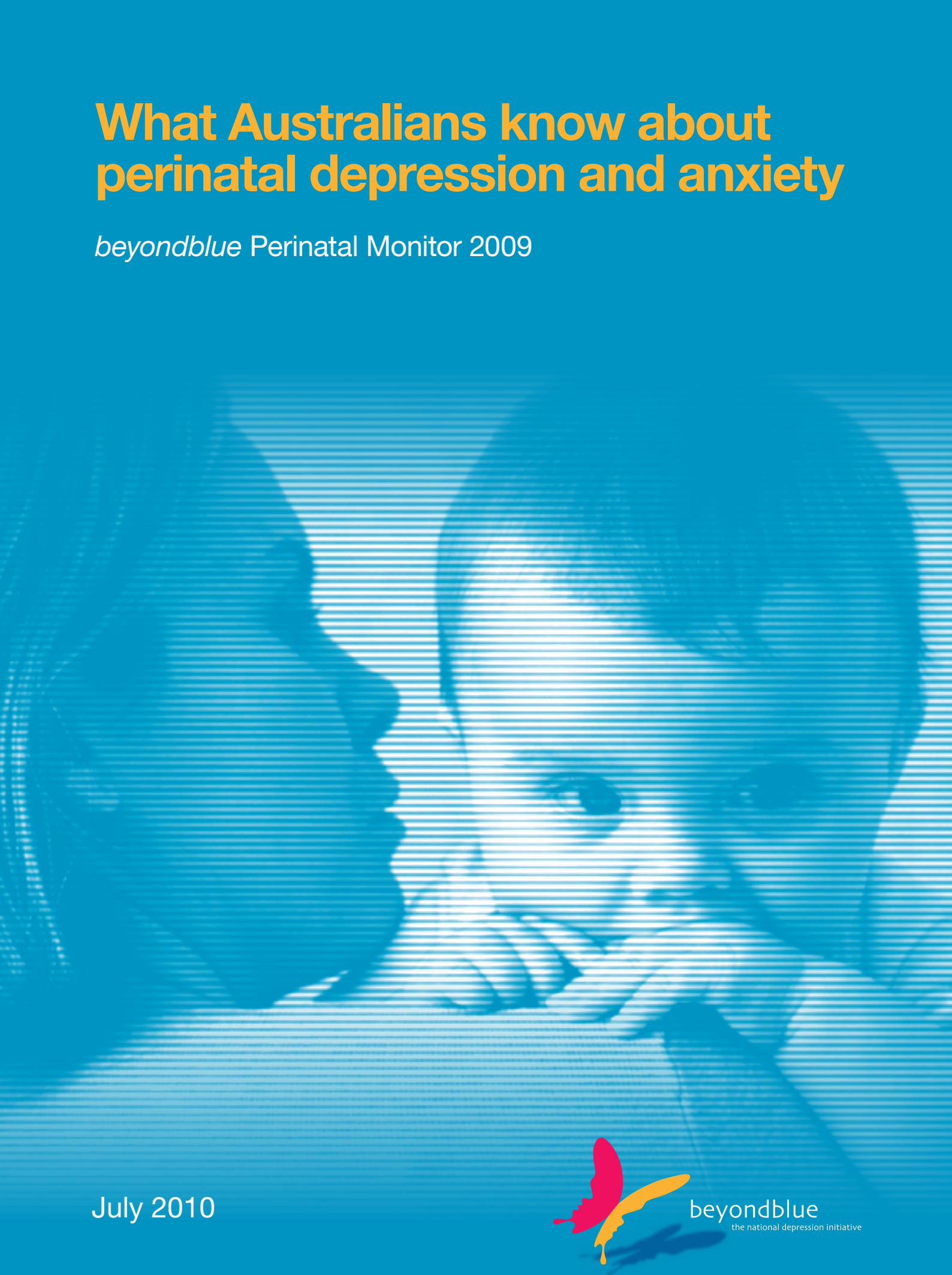
What Australians know about perinatal depression and anxiety

beyondblue Perinatal Monitor 2009



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beyondblue
the national depression initiative

Background

In late 2009, *beyondblue: the national depression initiative* conducted a national survey to investigate how the Australian community perceives perinatal (ante- and postnatal) depression and anxiety disorders. The purpose of the research is twofold. Firstly, it provides important insights and information which will inform campaign messages across sections of the community and health professionals. Secondly, the survey produces important baseline data against which progress of the initiative can be monitored over time.

This research comes at a critical time to inform the development of targeted community awareness and education campaigns under the National Perinatal Depression Initiative (NPDI).

Methodology

A telephone survey was conducted with 1,201 randomly-selected participants aged 18 and over across Australia. The sample was controlled to ensure it was representative of the population in terms of age, gender and location across metropolitan and regional areas.

The anonymous, 20-minute telephone survey was conducted between October and December 2009. The survey was designed to assess awareness, knowledge and understanding of health and mental health problems during pregnancy and in the first year following the birth of a baby. Understanding of the prevalence, symptoms and help-seeking behaviour for perinatal depression and anxiety was explored, together with attitudes (stigma).

Sample description

The final sample consisted of equal proportions of males (49 per cent) and females (51 per cent). In accordance with population distribution, 65 per cent of respondents lived in cities. A breakdown of the sample across states and territories, and metropolitan and regional areas is detailed in Table 1.

The average age of respondents was 45.4 years, and all age groups were represented across the adult population. Almost two-thirds of the sample (73 per cent) said that they were a parent, of whom 28 per cent indicated that their youngest child was under six years of age. Nineteen per cent said their youngest child was aged between 6 and 15 years, and 53 per cent had children over the age of 15.

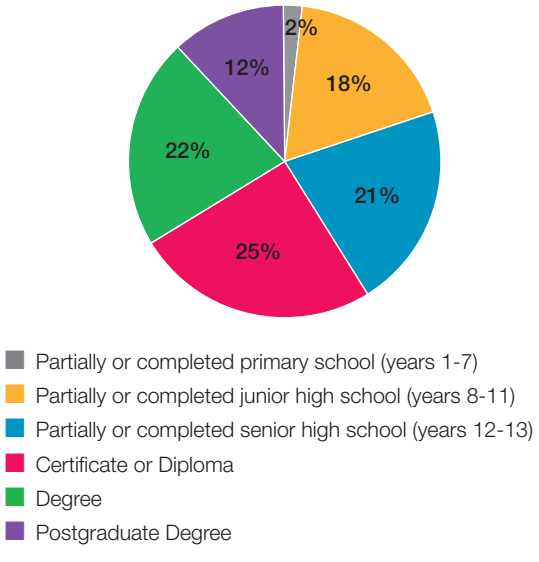
Table 1:
Breakdown of sample (N=1,201) across States/Territories

State	N	%
New South Wales	**408**	**34%**
Metro		22%
Rural		12%
Victoria	**300**	**25%**
Metro		18%
Rural		7%
Queensland	**222**	**19%**
Metro		9%
Rural		10%
Western Australia	**116**	**8%**
Metro		6%
Rural		2%
South Australia	**95**	**9%**
Metro		7%
Rural		2%
Tasmania, ACT and Northern Territory	**60**	**5%**

Whilst most people (87 per cent) spoke only English, 13 per cent of respondents indicated that as well as English, they spoke a second or third language. Ninety-eight per cent indicated that they were not of Aboriginal or Torres Straight Islander background.

Education levels varied across the population (see Figure 1) and almost half the people indicated that they were in full-time, paid employment (44 per cent). Eighteen per cent of respondents were retired and 8 per cent were studying.

Figure 1:
Percentage of respondents across educational levels



As professional training may also impact on outcomes, respondents were also asked if they had any professional training in health or mental health. Nineteen per cent of people indicated that they had professional training in the health field, with 8 per cent indicating professional training in the mental health field specifically. Finally, 85 per cent of the sample indicated that they were aware of *beyondblue*.

Results

Awareness of mental health issues during pregnancy

When asked to identify ***major health problems*** which may be experienced ***during pregnancy***, over a quarter of the sample (27 per cent), was *unable* to identify any specific problems. This was more likely to be the case for males, younger respondents (18-34), those without training in the health field, those who were not parents, and those with no awareness of *beyondblue*.

Of those who *were able* to identify health problems during pregnancy, most people were likely to identify *physical health* problems – namely, high/low blood pressure (27 per cent), diabetes (20 per cent), nausea/vomiting/morning sickness (14 per cent), obesity (7 per cent) and problems with the foetus (11 per cent).

In particular, those who were parents were more likely to list many of these health conditions which commonly occur in pregnancy, whilst those who were not parents were more likely to identify alcohol and drug problems, and "problems with the foetus".

Overall, spontaneous recognition of any *mental health problems* in this context is extremely low, with only a small proportion of people identifying anxiety (5 per cent), depression (4 per cent), postnatal depression (2 per cent) and mental health more broadly (2 per cent).

Compared to other states and territories, awareness of *anxiety* in the antenatal context was particularly high in South Australia (16 per cent) and among those aged 34 to 54, and those with year 12/13 education levels.

Moreover *depression* was more likely to be identified by those with higher education levels (postgraduate), aged 35 to 44, and with health and/or mental health training.

Finally, *alcohol and drug abuse* was identified by 7 per cent of people, particularly males, those aged over 55, those who were not parents and/or those who worked in the health field.

When asking people to identify the *major mental health problems* which may be experienced during pregnancy, recognition rates significantly increased within this mental health context (see Table 2).

Overall, *depression* during pregnancy was recognised by 40 per cent of respondents (of whom 8 per cent incorrectly referred to depression during pregnancy as *postnatal* depression).

Thirty per cent of people identified *anxiety*, particularly those living in metropolitan areas and/or those who had a higher educational level (degree or postgraduate). Whilst recognition of depression did not differ across states/territories, recognition of anxiety specifically was higher again among South Australian residents (see Table 2).

Both depression and anxiety were more likely to be identified by mental health professionals, whilst those with generic health professional backgrounds (not mental health-specific) were more likely to be aware of anxiety.

Table 2:
Spontaneous awareness of major *mental health problems* in pregnancy

Identified conditions (spontaneous)*	NSW	Vic	Qld	WA	SA	Other
Depression	33%	34%	21%	30%	33%	21%
Anxiety/fear	34%	27%	21%	22%	45%	27%
Postnatal depression	7%	9%	5%	6%	7%	11%
Perinatal depression	2%	3%	2%	2%	2%	0%
Loneliness/isolation	3%	2%	1%	5%	0%	10%
Don't know/no answer	25%	31%	33%	31%	16%	30%

* NB: multiple responses permitted

Awareness of mental health issues in the first year after the baby is born

When considering the period *following birth and the first year after having a baby*, spontaneous awareness of mental health problems is higher when compared to the antenatal period – even when asking in the general health context (see Table 3).

Table 3:
What are the major health problems which may be experienced (by women) after birth and in the first year?

Identified conditions (spontaneous)*	% of responses
Postnatal depression	**31%**
Depression	**23%**
Fatigue/sleeping problems	21%
Anxiety	**11%**
Breastfeeding problems	10%
Obesity	6%
Mental health	**4%**
Exercise/get back into shape	3%
Perinatal Depression	**1%**

* NB: multiple responses permitted

As indicated, 54 per cent of respondents spontaneously identified depression in the context of major health problems (i.e. depression, post- or perinatal). This is significantly higher than other common physical conditions such as fatigue/sleeping problems or breastfeeding problems. This level of depression awareness was consistent across the population, although significantly higher among 35 to 54 year olds. This age group was also more likely to identify the more specific term 'postnatal depression', as were those respondents with highest education levels and high awareness of *beyondblue.* Awareness of these conditions was even greater within the context of *mental health* specifically, with 63 per cent identifying depression/postnatal depression, 17 per cent recognising anxiety or fear and 15 per cent naming stress or pressure.

Knowledge and understanding

Awareness and understanding of the term 'perinatal depression'

Spontaneous identification of perinatal depression in the above contexts was negligible. When asked, 59 per cent of respondents indicated that they had "not heard of the term *perinatal* depression". Interestingly, of those who had heard of the term, when asked what it meant, 35 per cent of this subsample did not know, and only 4 per cent associated it with depression around the time of birth – whilst most of this subsample associated it with depression during pregnancy (37 per cent).

Prevalence

There was limited knowledge about the prevalence of depression in the ante- and postnatal periods. As indicated in the figures below, when asked to identify *how common depression was considered to be in the* ***antenatal*** (Figure 2a) *and* ***postnatal*** (Figure 2b) *periods*, the spread of responses shows a lack of certainty across the sample as a whole.

Figure 2a:
How common is depression in the *antenatal* period?

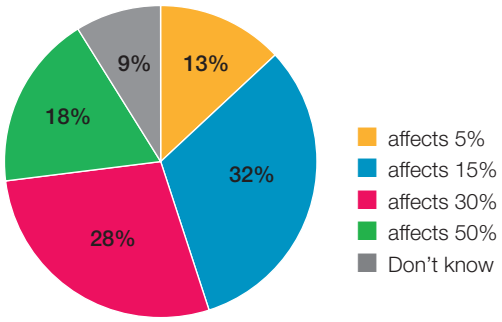
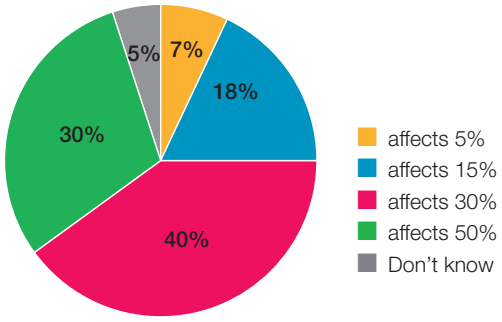


Figure 2b:
How common is depression in the *postnatal* period?



Overall, respondents *overestimated* the prevalence of depression *during pregnancy,* with 78 per cent of respondents estimating that depression affected 15 per cent or more of women during pregnancy. (The actual rate is less than 10 per cent.)

Those who were more likely to have more accurate estimates of depression rates in the antenatal period were women, those aged over 35 and those with higher education levels.

Similarly, this overestimation was also observed with respect to the *postnatal period.* Seventy per cent of respondents estimated that 30 per cent or more of women are likely to experience depression in the first year after giving birth. (The actual rate is around 16 per cent.) Those aged over 55 and living in metropolitan areas were less likely to overestimate prevalence rates. Otherwise, these observed overestimations were consistent – regardless of gender, education levels or training in the health or mental health areas.

Causes of postnatal depression

When respondents were asked ***why*** they thought women experienced postnatal depression, the most commonly identified reason was a *hormonal imbalance* (31 per cent). Interestingly, this was more likely to be stated by females, parents, those aged 35 to 44, and people with health training, higher education levels and awareness of *beyondblue*.

Many of these respondents were also more likely to associate postnatal depression with a *lack of support* which was mentioned by 22 per cent of the sample.

A similar proportion (30 per cent) attributed postnatal depression to being *unprepared or uninformed about parenthood*. This perception was more likely to be held by more highly-educated females, people from the smaller states/territories (NT, Tasmania, ACT) and people with higher awareness of *beyondblue*.

Stress and/or pressure was identified by 16 per cent of people as a cause of postnatal depression, particularly among people under 55 years and people who were not parents. Furthermore, eighteen per cent attributed postnatal depression to *not being able to cope with the baby's demands*.

Signs and symptoms

When asking respondents to identify the *signs and symptoms of postnatal depression,* they were able to identify a range of symptoms, the most common being *feeling sad/down/miserable, unable to cope with life*, *feeling tired/no energy* and *withdrawal/isolation* (see Table 4).

These common symptoms were more readily identified by people who were parents.

As shown in Table 4, the most commonly identified symptoms were *emotional* symptoms including feelings toward the infant, followed by a range of *physical* and *behavioural* symptoms.

Interestingly, there was a significant variation in the *nature* of some of the symptoms identified by men and women.

Whilst both men and women were likely to identify the more common symptoms indicated in Table 4, **men** were much more likely to spontaneously mention *anger, being irritable* and *changes in mood or mood swings*.

Women, however, were more likely to identify the emotional symptoms identified above, together with *change in weight/appetite* and *feeling stressed/anxious*.

People with training in health and/or mental health were generally more likely to identify symptoms such as *irritability; changes in appetite/weight; problems sleeping; feeling sad, down or miserable; self-neglect* and *suicidal thoughts/tendencies*.

There was some minor variation among the states/territories with respect to signs and symptoms of depression. Victorians were more likely to identify anger and stress or feeling anxious whilst South Australians more commonly reported changes in appetite or weight. People from Western Australia were more likely to identify drug and alcohol misuse or were unable to identify any specific symptoms of postnatal depression.

Those who were ***not able*** **to indicate any signs or symptoms** of postnatal depression included males, people in the younger age bracket (18-34), people in the older age bracket (55 plus), people with no health or mental health training, people who were not parents, people from Western Australia, and people with no awareness of *beyondblue.*

Table 4:
What are the signs and symptoms of postnatal depression?

Spontaneously identified signs and symptoms*	% of responses
Feeling sad/down/miserable	30%
Lack of acceptance/ worry about baby or not bonding with baby	26%
Feeling unable to cope with life	20%
Withdrawal/isolation	20%
Feeling tired/had no energy	16%
Feeling stressed/anxious	15%
Loss of interest or pleasure	11%
Having low confidence or self-esteem or negative attitude	10%
Problems sleeping	10%
Change in moods or experiencing mood swings	9%
Anger	8%
Being irritable	7%
Change in appetite or weight	7%
Lonely or lacking communication	5%
Being emotional	5%
Suicidal thoughts or tendencies	4%
Change in personality	4%
Relationship problems or breakdown	4%

* NB: multiple responses permitted

Treatments

When asking respondents *what types of treatment they thought were suitable for a woman with postnatal depression,* a range of medical, psychological and lifestyle treatments was indicated (see Table 5).

Table 5:
Types of treatment identified to be suitable for women with postnatal depression

Spontaneously identified treatments (All)*	% Respondents identified
Antidepressant medication	26%
Counselling	25%
Join a support group	23%
Talking and listening	19%
Psychotherapy	15%
Family support	13%
Doctor/GP	10%
Support/help	10%
Alcohol or drugs	9%
Rest/relaxation/time to themselves	7%
Exercise	5%
Socialise more	5%
Childcare support	5%
Behaviour therapy	4%
Nursing help	4%
Cognitive therapy	3%
Improved diet	3%
Other health professional	3%

* NB: multiple responses permitted

Overall, while antidepressants were the most frequently identified treatment, there was a high level of awareness about a range of specific non-pharmacological treatments, namely talking therapies (e.g. counselling, psychotherapy). In addition, the importance of support more generally (e.g. talking and listening, join a support group) was also identified.

Talking and listening, support groups and antidepressant medications were more likely to be identified by women, whilst men were more likely to identify psychotherapy.

Counselling was also strongly identified across the group, particularly among people aged under 55, people with health/mental health training, people living in metropolitan areas, people with high awareness of *beyondblue*, those with higher educational qualifications (postgraduate) and those who were not parents.

In addition, those with the highest education levels were also more likely to identify specific clinical treatments including antidepressant medications, cognitive therapy and behaviour therapy.

The importance of family support was more commonly identified by those over 35 years of age – with childcare support specifically identified by parents and those over 55 years of age.

When it comes to using medication to treat depression during pregnancy and after birth, most people are cautious. Only one in 10 identified antidepressants as a first choice of treatment and one in four included medication in their list of suitable treatments. This reflects community attitudes for non-drug treatments generally, together with possible concerns about the perceived effect of medication on the baby.

Choice of treatment providers

When asking people to identify *who would be their first choice if they thought they had depression during pregnancy and the postnatal period*, General Practitioners were commonly identified by both men and women and those aged over 35. The importance of family and friends was also more likely to be recognised by women specifically, and those in the younger age group (18-34 years). When comparing results across states/territories, those in the smaller states/territories (NT, Tasmania, ACT) were more likely to identify child health nurses, whilst psychiatrists were more frequently identified as first choice for treatment for those in WA for both ante- and postnatal depression.

Attitudes

In order to assess attitudes to treatment, respondents were presented with a series of statements and asked to indicate their level of agreement or disagreement with each of the items. Two sets of attitudinal statements were devised, each set given to half of the sample (N=600). A summary of these results is detailed in Table 6. As indicated, whilst there were some variations across age and gender, particularly with respect to these attitudes, there was no significant variation across states/territories.

Over half the sample perceived it to be *normal for women to feel depressed during pregnancy*. This misconception was more likely to be held among respondents under age 55, those without health or mental health training and those who were not parents.

In the postnatal context, **almost a quarter of respondents considered *postnatal depression to be a normal part of having a baby*** – a finding which was more likely among those with no awareness of *beyondblue*.

Almost a fifth of respondents perceived that *knowing how to look after a baby comes naturally to women*. People more likely to agree with this included men, people at the upper and lower age brackets, people with no mental health training and people with low awareness of *beyondblue*.

When looking at the reasons why women experience postnatal depression, a significant proportion of respondents was likely to attribute this to an ***inability to***

Table 6:
Respondents' agreement/disagreement with statements about postnatal depression (N=600)

Statement	Agree (%)	Disagree (%)	Don't know (%)
It's normal for women to feel depressed during pregnancy.	52%	43%	5%
Postnatal depression is a normal part of having a baby.	23%	71%	6%
Knowing how to look after a baby comes naturally to women.	79%	19%	2%
Women get postnatal depression because they can't cope with motherhood.	35%	61%	4%
Women get postnatal depression because they have unrealistic expectations.	52%	44%	4%
Postnatal depression didn't exist in previous generations.	7%	90%	3%
Postnatal depression is not serious.	6%	94%	0%
Postnatal depression requires special treatment.	93%	5%	2%
Postnatal depression will go away on its own as the baby gets older.	23%	68%	9%
It is only postnatal depression when you want to harm or kill the child.	5%	90%	5%
It is only postnatal depression when you're thinking about suicide.	5%	91%	4%
Only career women get postnatal depression.	2%	96%	2%
All women should be checked for depression during pregnancy.	74%	23%	3%
All women should be checked for depression after the baby is born.	81%	16%	3%
Women who take medication for postnatal depression are weak-willed.	4%	94%	2%
Women with postnatal depression can't be good mothers.	6%	93%	1%
Postnatal depression is a sign of weakness.	5%	94%	1%
Women choose to get postnatal depression.	3%	96%	1%

cope and/or having ***unrealistic expectations*****.** These perceptions were more likely to be held among older people (over 55), who were also more likely to believe that ***postnatal depression didn't exist in previous generations***. Women with careers were not specifically associated with being at greater risk of postnatal depression.

Despite the confusion regarding prevalence, most regard postnatal depression as serious and requiring special treatment. Further, postnatal depression is viewed in this context without being necessarily associated with wanting to harm or kill the child or thoughts of suicide. However, almost a quarter of people perceive that postnatal depression will go away on its own as the baby gets older. This finding is more common among males.

When considering attitudes which may be stigmatising, results are encouraging with the vast majority of respondents *disagreeing* with the statements that postnatal depression is *a sign of weakness* (94 per cent disagree), is *not serious* (94 per cent disagree), that *women choose to get postnatal depression* (96 per cent disagree), *women with postnatal depression can't be good mothers* (93 per cent disagree) and *women who take medication for postnatal depression are weak-willed* (94 per cent disagree).

Finally, attitudes surrounding screening and assessment for depression during pregnancy and following birth were explored. Almost three-quarters of the sub-sample believed that women should be checked for depression during pregnancy (women more so than men) and this increased to over 80 per cent with respect to the postnatal period.

Discussion

- Identification of physical health problems *during pregnancy*, namely diabetes, blood pressure, and problems with the foetus may reflect standard assessments undertaken during pregnancy, as health professionals routinely monitor these conditions via physiological tests (e.g. blood pressure and diabetes testing, ultrasounds). With the introduction of routine antenatal psychosocial screening (which this survey indicates respondents to be supportive of), awareness of mental health issues during pregnancy may increase over time, making this more comparable with current awareness of physiological conditions.
- Spontaneous identification of mental health problems in the *postnatal period* at least, is encouraging. This suggests that people *do* identify mental health problems such as depression and anxiety as problems that a woman may face after having a baby and in the first year.
- Whilst a significant proportion of people had heard the term *perinatal depression*, the lack of understanding about the term, together with the overestimation of depression prevalence in the ante- and postnatal periods suggests confusion. This indicates that postnatal depression is confused with the *baby blues*, a common condition related to hormonal changes which affects up to 80 per cent of women in the days immediately following birth, or general stress surrounding adjusting to a pregnancy/new baby. The

fact that this was also the case among health and mental health professionals and the general community alike, suggests a need for targeted education in this area, if this terminology is to continue to be utilised.

- This confusion with the *baby blues* is further implied when considering that a significant proportion of people identified hormonal imbalance as a reason for getting postnatal depression. This may also offer an explanation as to why a high proportion of people perceive that it is normal to have depression during pregnancy and in the postnatal period. This may have important implications for help-seeking, as early warning signs may simply be considered normal in the ante- or postnatal context, and attributed to normal hormonal changes.
- Whilst there were some interesting variations in responses from men compared to those from women, most people identify both emotional symptoms of postnatal depression, and the importance of support either from family and friends, counselling and/or support groups.
- Whilst GPs play an important role, women in particular identify family and friends as important providers of support. Therefore, families and friends have an important role to play in identifying, supporting and encouraging women to access treatment.
- Finally, assessment of perceptions and attitudes reveals that, on the whole, postnatal depression is regarded as serious and requiring treatment. Males are more likely to hold the perception that postnatal depression will go away on its own without treatment. This may have implications for partners/fathers in being positive supporters or promoters of help-seeking in their partners.
- The higher levels of stigma among older people particularly (for example perceiving that women get postnatal depression because they can't cope with motherhood or have unrealistic expectations) coupled with the perception that postnatal depression didn't exist in previous generations may have implications. As depression among this cohort may be more likely to be judged as an inadequacy or weakness, this may have implications for new parents who in turn may feel that they cannot turn to their parents/in-laws for support.
- With the majority of people holding positive attitudes towards routine screening and assessment, this can be considered positive in the light of the National Perinatal Depression Initiative.

Conclusions and recommendations

When interpreting these outcomes, it is important to consider the limitations of this research. In particular, the methodological approach (telephone survey) will bias the sample, limiting the scope of the population which can be included (i.e. non-English speaking, Indigenous).

Nevertheless, the findings highlight the importance for education and awareness campaigns aimed at all members of the community. In undertaking this activity, careful consideration needs to be given to use of the term *perinatal depression*. There needs to be clear communication about the prevalence of the condition during and following pregnancy, and how this differs from the *baby blues*, as this is likely to be contributing to the current levels of confusion and may be leading many people to consider that *depression is a normal part of having a baby*.

Communication campaigns across the whole community need to:

- define the disorders in the perinatal context
- communicate the early warning signs
- promote early detection
- promote help-seeking behaviour.

This could include specific messages directed at men, older people, and the wider community as they may play an instrumental role in identifying, supporting and encouraging the woman to access timely and appropriate assistance. This is particularly important when considering that family members and friends are identified as playing a critical support role – particularly among women themselves.

beyondblue, in partnership with the Commonwealth and all states and territories will be working closely with consumers, carers and the wider community to refine and disseminate these communication objectives as part of the National Perinatal Depression Initiative. This will involve in-depth analysis of the qualitative experience of depression among women, fathers, family members and the experience of health professionals working in the field. Progress will be monitored in subsequent research to monitor change and ensure communication objectives are being met.

For more information about perinatal depression, visit **www.beyondblue.org.au** or contact the Perinatal Depression Initiative team at **pnd@beyondblue.org.au** or **03 9810 6100**.

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