

## **Postpartum Mood Disorder in the Indigenous Population**

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A growing body of evidence reports that Postpartum Mood Disorder (PPMD) not only has a negative impact on the wellbeing of new parents, but also adverse consequences for children and families (Misri et al., 2006; Yelland et al., 2009). PPMD has been shown to hinder a parent's ability to cope with mothering or fathering responsibilities (Beck, 1992, 1995; Leiferman, 2002), and disrupts the parent-infant dyad (Lanes, Kuk & Tamim, 2011). Depressed parents tend to be more withdrawn and disengaged with their infants, less responsive to infant cues and smiles, show less affection, and demonstrate more irritability and hostility than parents without PPMD (Beck, 1992, 1995; Carter et al., 2001).

When combined with other psychopathologic co-morbidities and/or life adversity (i.e. poverty, single parenting, family violence), negative parent-infant interactions are even more likely (Logsdon & Usui, 2001), putting the infant at further risk of developing an insecure attachment bond (Baker et al., 2005; Carter et al., 2001). Insecure attachment puts children at risk for long-term emotional and behavioural problems (i.e. anxiety, aggression, hyperactivity) (Letourneau et al., 2012; Carter et al., 2001).

The colonization of Indigenous Peoples is widely accepted as an underlying determinant to mental and physical health. As a direct result of colonization, and the associated economic, political and social disadvantages resulting from systemic racism, First Nation People in Northern Ontario experience a higher rate of unemployment and poverty, more physical and mental illness, and lower levels of education than the general population (Spotton, 2006). Furthermore, almost all of the "air access only" First Nation communities in Ontario are located in the North. Geographical and social isolation is a challenge for these families, and further compounds difficulties in accessing quality health care, education, affordable and nutritional food, and employment (Spotton, 2006). When parents and caregivers lack control over their own basic resources in life such as employment, income, education, and food security, this lack of control can result in anxiety, low self-esteem, and feelings of hopelessness (Reading & Wien, 2009). Additionally, MacMillan et al. (2008) have suggested a range of factors, including discrimination, identity, poverty, and inadequate parenting that contribute to the increased risk of depression and mood disorders.

Although exact rates of PPMD for First Nations People in Northern Ontario is unclear, a study of American Indigenous mothers found a PPMD prevalence rate of

23%, which investigators describe as “significantly higher than even the most liberal estimates in other populations” (Baker et al., 2005). Similar trends have been observed in Indigenous populations in New Zealand (Webster et al., 1994), and Australia (Panaretto et al., 2002).

There are 55,564 First Nations people living in the 115 Northern Ontario First Nation communities involved in the Northern Ontario Postpartum Mood Disorder Project. Just over 50% are female, with the majority of child-bearing age. Additionally, First Nations birth rates are documented at twice the comparable rate for other Canadians (Statistics Canada, 2005), which further compounds the impact of this illness for First Nations families and communities.

There is a need to consider the socio-political context of PPMD in First Nations communities. This would include what Reading and Wien (2009) have described as the collective burden of the colonial system that has created physical, psychological, economic and political disadvantage for Indigenous Peoples. In addition, it is important to consider Indigenous perspectives on parenting and child-rearing (Neckoway, Brownlee & Castella, 2007). A review of the literature reveals best practice guidelines, including the concept of Cultural Safety in maternal, child and family care, for the development of interventions for First Nations People suffering from PPMD.

## **Culturally Safe Best Practice Guidelines**

### **Cultural Safety**

The concept of “cultural safety” moves beyond cultural awareness, cultural sensitivity, and cultural competency by challenging power imbalances, institutional discrimination, and the effects of colonization and colonial relationships as they apply to health care (NCCAH, 2014). Culturally safe practitioners “recognize, respect, and acknowledge the rights of others, while culturally unsafe practitioners diminish, demean and disempower those of other cultures” (Browne, Fiske & Thomas, 2000). Brascoupe and Waters (2009) have shown that culturally safe strategies for program delivery have the potential to address inequities in mental and physical health by creating a safer environment for First Nations Peoples to access and receive services.

Establishing and maintaining trust is a pre-requisite to delivering culturally safe interventions (Brascoupe & Waters, 2009). Clients need be active partners in their own

care and involved in treatment decisions (Browne, Fisk & Thomas, 2000; Brascoupe & Waters, 2009). Treatment providers should be caring, encouraging, listen attentively, provide reassurance, and avoid criticism. By doing so, practitioners demonstrate to clients that they are accepted, respected and valued as equal participants in the therapeutic relationship (Dennis, 2003).

Culturally safe PPMD treatment options for First Nations People would take a holistic view on health, where the wellness of the mother and infant are defined not just in terms of physical health, but also spiritually, emotionally, culturally, and historically (Birch et al., 2009). In addition, an Indigenous women's individual identity will shape issues of oppression and discrimination within a therapeutic relationship or service (Van Herk, Smith & Andrew, 2011).

Kirmayer, Brass & Tait (2000) have highlighted the important role that identity and the connection to family, community and self play in the facilitation of mental wellness in Indigenous communities. Of particular importance is the concept of First Nation identity and the need to consider the individual's and community's experience with identity expression in the course of service provision and treatment for mental health issues (Kirmayer, Brass & Tait, 2000). More specifically, these authors suggest the use of measures such as McKenzie and Morrisette's (2003) "Contemporary Expressions of Aboriginal Identity Formation"(p. 25) when working with individuals experiencing mental health challenges. These authors use examples of interventions that may include collaborative approaches involving the family, community and elders and state that therapeutic practice must incorporate local concepts of person, self and family (Kirmayer, Brass & Tait, 2000; Kirmayer, Simpson & Cargo, 2003).

Culturally safe interventions would accept and be willing to integrate traditional healing practices (Birch et al., 2009), and respect the important role family and community play, particularly that of mothers and grandmothers in preserving the cultural norms in pre-and post-natal care (Birch et al., 2009).

## **Best Practices**

PPMD best practice literature stresses the need for comprehensive and culturally appropriate screening and treatment programs for First Nations People. It also identifies the importance of peer support and addressing instrumental barriers to care.

The Edinburgh Postnatal Depression Scale (EPDS) is one of the most widely used screening tools for PPMD (Campbell et al., 2007). However, until Campbell et al's 2007 Australian study, it had never been translated into language more appropriate and meaningful for Indigenous People. When the wording on the EPDS was revised in collaboration with Indigenous groups and Elders, they found that compared to the standard tool, misunderstandings of certain terms on the scale (i.e. self-harm) were reduced and more women at risk of PPMD were identified (Campbell et al., 2007; Clarke, 2008).

Bowen et al. (2014) advocate for the implementation of "lived experience" PPMD interventions. For example, peer groups where Indigenous women are invited to share stories of resilience and positive mothering after their own recovery from mental health problems in order to inform families and to support other women who may be experiencing challenges. The efficacy of peer support in the prevention and treatment of PPMD in other vulnerable Canada populations has also been documented (Dennis et al., 2007). To address the numerous instrumental barriers to care, the literature recommends that agencies provide free transportation, meals, and childcare for families who need it (Brown, Fisk & Thomas, 2000). For example, offering flexible schedules, not penalizing for missed appointments, and utilizing in-home, telephone, and web-based interventions are also effective in improving low-income mothers' access to care (Miranda et al., 2003; Dennis & Hodnett 2007). Ideally, services should be offered in a variety of settings (i.e., on and off reserve, in Aboriginal-specific settings, and mainstream healthcare settings) to address the diverse needs, comfort-levels, beliefs, and values of help-seekers (Callister, 2001, as cited in Birch et al., 2009).

### **Global Initiatives**

Globally, comprehensive screening and treatment programs for PPMD are beginning to emerge. New Zealand's *Healthy Beginnings* guidelines were released in 2011. These guidelines outline ways government bodies and service providers can build on existing services to better meet the mental health needs of mothers and infants. There is an emphasis on supporting Maori People, who experience a higher prevalence of mental health issues, teenage pregnancy, discrimination, and instrumental and social stressors. PPMD is often not identified in Maori women in the community or by primary

care professionals (Baxter 1998, as cited by Ministry of Health, 2011), so the need for culturally safe early screening and treatment options is also highlighted.

In 2010, Australia developed the *Beyondblue* National Prenatal Depression Plan, which stresses routine pre-and post-natal screening of women's emotional and mental health. The program facilitates referral and follow-up for women assessed to be at risk of, or experiencing, PPMD, with a focus on Indigenous families and addressing barriers to care (Hayes et al., 2010).

The United Kingdom has also released a set of routine PPMD screening and management guidelines. These guidelines recognize that pre-and postnatal mental illness can have serious consequences for the wellbeing of mothers, infants, partners and other family members. According to the National Institute for Health and Care Excellence (2006), PPMD screening and treatment should be culturally appropriate, be accessible to people with additional needs such as low socioeconomic status, disabilities, and to people who do not read or speak English. These recommendations stress early and ongoing support to new families, frequent assessment for PPMD at post-natal appointments, and outline a systematic approach to follow-up, referral, and community education (NICE, 2006).

### **Conclusion**

Postpartum Mood Disorders are an important issue. In order to provide culturally safe services for prevention, assessment, treatment and support for PPMD it is important to consider Indigenous worldviews on parenting, the socio-political context of First Nations communities along with an individual's and/or community's identity. B'saanibamaadsiwin Aboriginal Mental Health Program is a partner in the Northern Ontario Post Partum Mood Disorder Project. Working with First Nations across Northeastern and Northwestern Ontario B'sannibamaadsiwin will be engaging services providers working with parents and families and families with lived experiences to collaborate on recommendations for a Northern Ontario Strategy to address Postpartum Mood Disorders in Northern Ontario.

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