

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.

**THE DISTRESSING CASE OF MODERN MOTHERING:  
EXPECTATIONS, LOSSES, AND POSTNATAL DISTRESS**

A thesis presented in partial fulfilment of the requirements for the degree of  
Doctor of Clinical Psychology at  
Massey University, Palmerston North, New Zealand.

Anita Jane Darrah  
2011



## Abstract

Becoming a mother is a significant milestone for women. Pregnancy and childbirth epitomise the most natural and normal of processes, and yet, paradoxically, they are increasingly pathologised as a medical event. This discourse of disease which surrounds motherhood has contributed to control of childbirth moving away from women as women lose confidence in their ability to perform this most natural of processes unaided. Along with losing confidence in their ability to manage the event of becoming a mother, women are losing their confidence to *be* a mother, and to mother instinctively, instead relying on media, on literature, and on others to tell them how best to do this most natural of roles.

Some argue motherhood has been subjected to media manipulation and a process of sanitisation which exposes women to mothering myths from which they build their expectations of motherhood. This creates unrealistic expectations of motherhood and therefore it is little wonder women lose confidence in their ability to mother. And if motherhood is natural and normal, how do we understand the rates of postnatal distress reported in mothers?

In order to answer that question this thesis proposes a new model of postnatal distress, which argues postnatal distress is caused by the disparity between women's prenatal expectations and their postnatal experiences. Given all women experience a disparity between expectations and experience yet not all women report postnatal distress, a moderator variable, loss, was introduced. Elements of this new refined model were subsequently tested and it was found women hold a number of expectations prior to becoming pregnant and these expectations reflect a belief in a mythical image of mothering and mothers.

Given postnatal distress has a definitive trigger, and a definitive risk population it is ideally suited to a preventative intervention. This thesis culminates with the design and piloting of such an intervention developed from the new model. The intervention uses a mindfulness-based approach which comprises a three session group format, designed to be implemented with first-time mothers during pregnancy. Findings suggest the protocol can be implemented in a meaningful way and provide initial support for the acceptability and workability of the protocol.



## Acknowledgements

*The process of writing these acknowledgements was a humbling experience. Humbling because I began to realise how many people have aided and abetted in the production of this thesis over the years. With varying levels of cheerleading interspersed with bullying and cajoling there are many individuals who have (sometimes knowingly and sometimes unwittingly) become part of my research journey.*

*To all my participants in the various studies: your graciousness in sharing your stories or your time has been much appreciated. To my supervisors, Professor Ian Evans and Mrs Cheryl Woolley: it has been a long (long) journey. Thank you for your guidance, your willingness to explain everything more than once, and most especially for never losing your sense of humour no matter how badly I was stuffing up. To Mrs Jan Dickson, my primary clinical supervisor: while not directly involved in this research process, your support and guidance in other areas has assisted in my clinical research to a large degree. Thanks go to the Psychology support staff also: to Harvey, Malcolm, Hung and also to Robyn who was an outstanding source of support in those initial, scary doctoral days.*

*To all my dungeon buddies and TAG brunchers over the years; especially to Jodi (sorry I just couldn't figure out how to fit bloviating into my thesis so it's all up to you now): to you I leave the microwave, my best wishes, and my friendship. To Mel, my fellow intern: phew! What a ride. Thanks for the hugs, the prods in the rear and the gift of your friendship. You are an amazing person and I am so proud of you.*

*To my long suffering family. Mum thanks for cheering me on even when you didn't know what for. Your unwavering belief in me has been hard to live up to sometimes but I figure mothers know best! Dad, I know this has been a rather expensive exercise for you. You don't say much but I always figured you were cheering on the inside.*

*To my amazing daughter Caitlin. I'm not sure if you have got anything from this process Kit-Kat; my goal was never to model achievement – you can do that just fine by yourself. But if you have learnt how to be wrong gracefully, how to fall down and get back up, how to doggedly stick to your goals despite many obstacles (usually including yourself!), how not to be a superwoman and how not to want to be, then I guess it hasn't been all bad.*

*To Benjamin, my wonderful son, who is such an important part of the story leading to this thesis. Your unconditional love of your mother has sometimes been more than she deserved but has always been humbly received. I love you son-shine.*

*And finally to Glenn. Throughout this process you have been so steadfast in your complete belief in me. Your pride in me and in my milestones has been so evident and I cannot begin to tell you what that has meant. My wish now is for you to follow your dream and your goals, and I can only hope that I show as much love, support, pride, and belief in your ventures as you have done for mine.*

# Table of Contents

ABSTRACT .....	III
ACKNOWLEDGEMENTS .....	V
TABLE OF CONTENTS.....	VI
LIST OF FIGURES .....	IX
LIST OF TABLES.....	X
PROLOGUE .....	XI
CHAPTER ONE: INTRODUCTION .....	1
CHAPTER TWO: PSYCHOLOGICAL DISTRESS RELATED TO THE TRANSITION TO MOTHERHOOD .....	7
Postnatal Depression.....	7
Prevalence .....	8
Effects .....	9
Etiology .....	10
Cultural Studies.....	16
Summary .....	17
Anxiety .....	17
Antenatal Anxiety .....	18
Postpartum Anxiety .....	22
Theories of Anxiety.....	25
Stress .....	29
Conclusion .....	30
CHAPTER THREE: PSYCHOLOGICAL FACTORS LEADING TO POSTNATAL DISTRESS.....	31
Expectations .....	31
Parenting and Partner Expectations: He said she said.....	31
Infant Expectations: Bonny, bouncing, and ...biddable? .....	33
Physical Expectations: Reclaiming the non-pregnant body.....	35
Mechanisms of Expectations: How we know what we know .....	36
CONCLUSIONS .....	38
Loss: When expectations go awry .....	38
Good mothers bake and other mothering myths.....	42
Conclusion .....	45
CHAPTER FOUR: STUDY ONE - EXPERT PANEL FOCUS GROUP .....	46
Introduction.....	46
Method .....	47
Participants.....	47
Procedure .....	48
Analysis .....	48

Results .....	49
Superordinate Theme One: Loss.....	49
SuperOrdinate Theme Two: Conflicts.....	54
Discussion.....	56
Conclusions.....	59
CHAPTER FIVE: A MODEL OF POSTNATAL DISTRESS .....	60
Introduction .....	60
The Model.....	60
Testing the Model: Where to from here?.....	64
CHAPTER SIX - STUDY TWO – TESTING THE LOSSES .....	65
Introduction.....	65
Method .....	66
Participants.....	66
Procedure .....	66
Analysis .....	67
Measures .....	67
Results .....	69
Known Verses Unknown - I knew that would happen... NOT .....	70
Known Verses Unknown - I knew that would happen... SEE .....	76
Losses .....	81
Influence of Others.....	83
Discussion.....	85
Conclusions.....	89
CHAPTER SEVEN: STUDY THREE - EVALUATING THE MYTHS.....	91
Introduction .....	91
RESEARCH QUESTIONS .....	93
Method .....	94
PARTICIPANTS.....	94
MEASURES .....	94
PROCEDURE.....	96
Results .....	97
DEMOGRAPHIC INFORMATION.....	97
MOTHERING MYTHS QUESTIONNAIRE .....	97
LEAP.....	106
Discussion.....	106
Conclusions.....	109
CHAPTER EIGHT: DEVELOPMENT OF AN INTERVENTION .....	111
Initial considerations.....	112
Theoretical Foundations.....	113
Prevention vs Treatment.....	114
Level of Intervention .....	116

The Psychological Imperative .....	117
The Intervention Model .....	119
CHAPTER NINE: PILOTING AN INTERVENTION .....	123
Introduction .....	123
Method .....	125
Participant .....	125
Measures .....	127
Discussion .....	135
Conclusions.....	137
CHAPTER TEN: CONCLUDING THOUGHTS.....	138
EPILOGUE .....	143
REFERENCES .....	146
APPENDIX A: INTERVENTION MANUAL .....	168
APPENDIX B: MATERNAL ATTITUDES AND MATERNAL ADJUSTMENT QUESTIONNAIRE (MAMA).....	205
APPENDIX C: DEPRESSION ANXIETY AND STRESS SCALE.....	207
APPENDIX D: STUDY ONE .....	
D: 1 STUDY ONE INFORMATION SHEET .....	210
D: 2 STUDY ONE CONSENT FORM.....	212
APPENDIX E STUDY TWO .....	
E:1 ETHICS APPROVAL.....	213
E:2 INFORMATION SHEET .....	213
E:3 CONSENT FORM.....	213
E:4 INTERVIEWER QUESTIONS.....	213
E: 5 TRANSCRIPT CONSENT LETTERS.....	220
E: 6. STUDY TWO: DEMOGRAPHIC QUESTIONNAIRE .....	221
APPENDIX F: STUDY THREE .....	
F: 1 ETHICS APPROVAL .....	222
F: 2. INFORMATION SHEET.....	223
APPENDIX G: MOTHERING MYTHS QUESTIONNAIRE.....	225
APPENDIX H: FACTOR ANALYSIS DATA (MMQ).....	230
APPENDIX I: INDIVIDUAL ITEM ENDORSEMENTS FOR MMQ.....	234
APPENDIX J STUDY FOUR.....	238
J:1 STUDY FOUR ETHICS CONSENT .....	238
J:2 STUDY FOUR CONSENT FORMS.....	239
J:3 SESSION EVALUATION SCALE .....	240

## List of Figures

Figure 4.1	Thematic Map of Experiences of the Transition to Motherhood .....	50
Figure 5.1	Information Sources for Prenatal Expectations.....	61
Figure 5.2	Interaction of Prenatal Expectations and Postnatal experiences .....	61
Figure 5.3	Areas of Disparity between Prenatal Expectations and Postnatal Experiences leading to Distress .....	62
Figure 5.4	A Model of Postnatal Distress.....	63
Figure 7.1	Overall Endorsement of Myth Items .....	99

## List of Tables

Table 6.1	PDSS Content Scales .....	68
Table 6.2	Participant Demographics (Study 2) .....	69
Table 7.1	Demographic Information (Study 3) .....	98
Table 7.2	Means and Standard Deviations for Participants' Responses on the MMQ.....	98
Table 7.3	Strength of Endorsement for MMQ Myth Items .....	98
Table 7.4	Level of Agreement and Disagreement for MMQ myth items .....	98
Table 7.5	Level of Endorsement of Realistic Items – Self Ratings. ....	100
Table 7.6	Overall Endorsement of Myth Items on the MMQ – Self and Others. ....	100
Table 7.7	Endorsement of Myth Items for Self and Others arranged into bands. ....	101
Table 7.8	Endorsement of Myth Items – Ratings for Others. ....	102
Table 7.9	Level of Agreement & Disagreement for MMQ Myth Items - Ratings for others. ....	102
Table 7.10	Level of Endorsement of Realistic Items – Self ratings. ....	103
Table 7.11	Level of Endorsement of Realistic Items – Ratings of others .....	104
Table 7.12	Correlation between MMQ Myth Item Endorsement and Age .....	105

## Prologue

It all started with a magazine article. Actually it started with the birth of my second child, but then the magazine article really got things moving. I can't remember which magazine it was, nor can I remember when exactly it was published. What I can remember is Brooke Shields' glamorous and beautifully made up image on the front cover with an eye-grabbing headline touting the exposé of her postnatal depression nightmare inside. Now I don't know Brooke Shields at all, she is probably a perfectly nice person. I have no knowledge of her life, her mothering ability, or indeed much knowledge of anything about her. I think I can honestly say, although I know she acts I've never even seen anything with her in it. Anyway, that headline really, really bugged me. I was truly enraged at whoever decided it was reasonable and realistic to portray postnatal depression in such a glamorous way.

I had had an interest in postnatal depression since emerging from its grips some years before. The interest was initially fairly self-focused and I discussed it with a number of women informally, mainly in an effort to reassure myself that my son was not going to be irreconcilably impaired as a result of my experiences, despite what the research and 'experts' said. But my postnatal depression did not look anything like Brooke Shields postnatal depression so for a brief moment of insanity, and entirely without her knowledge or consent, I found myself locked in mortal combat with Brooke Shields convinced that my experience was real while hers, somehow, was less so. Eventually I realised this wasn't a competition and began to muse about other women's experiences of postnatal depression.

One of my early postgraduate lecturers used to say "never underestimate the value of scholarly musing." We took this as a handy excuse to justify our navel gazing, but I think he may just have had a point. So I began to think more and more about postnatal distress and the actual experience of mothering. This led to more informal chats with other women, which led to me increasingly choosing to do assignments and research projects on the topic. This led to more in-depth and academic discussions with various lecturers and tutors and it was a natural progression to begin to apply my increasing psychological skill base to my thinking.

As time healed and my psychological knowledge grew I began to think more and more of postnatal depression in terms of accepted psychological principles and theories. What did the experience of postnatal depression say about *hot thoughts* about *core beliefs*, and about *catastrophic thinking*? And more importantly why did none of those models seem to fit the experiences of so many of the women I had spoken to, including my own? This led to further research which led to questions of correlation, causation, prevalence, protection, treatment, and so on. If Brooke Shields and I could share something of the same name which seemed to share little in the way of common denominators what did this mean? Given our entirely different realities was it reasonable to think postpartum depression was impervious to social class,

culture, educational attainment, age and all the other variables of which we shared no common ground?

That was where it started. It has almost ended now; several years later with the designing of a values-based intervention to assist new mothers make the transition to motherhood for the first time. My thinking has evolved to consider not just postnatal depression but the other mood states of distress and anxiety. The reason for this is quite simple – because there is a need. When talking to new mothers and in further exploring the research, it became apparent a focus on depression following childbirth was too narrow, and other forms of distress were a largely under-recognised experience large numbers of new mothers were coping with alone.

The aim of a simple, brief intervention would be to give women new ways of thinking about motherhood; to assist them to identify their assumptions and beliefs about mothers and mothering and then to evaluate the usefulness of those beliefs for themselves. Prospective mothers could begin to think about their parenting values and decide whether those beliefs and assumptions they held were moving them towards or away from their value goals. Also, by encouraging women to identify their parenting values and goals, these can then act as guides in their journey through motherhood.

This would not be a guide to motherhood, but maybe a guide to how to begin to think about being the sort of mother you would like to be. Before designing such a protocol I thought it necessary to formulate a conceptual model based on previous psychological literature and also to test some of my assumptions empirically. This thesis highlights the research journey from conceptualisation to implementation, beginning with a comprehensive literature review and ending with the first phase of testing the feasibility of my intervention protocol.

## Chapter One: Introduction

Most women who have made the transition to motherhood would probably agree becoming a mother is a life changing event. Profoundly life changing. The naturalness and the normality of the event of becoming a mother mean it is often portrayed as a non-problematic venture and for many women this is true. However as natural and normal as parenting may be, it is not without its obstacles – after-all normal and natural does not necessarily equate to easy. Given pregnancy and childbirth are natural events the question of why some women struggle is an important one, as struggle they do. Research suggests one in five women experience some degree of postnatal depression (PND), while an even greater number of women experience postnatal anxiety (PNA) at levels high enough to cause disruption to everyday functioning (Beck & Driscoll, 2006; Driscoll, 2006; van Bussel, Spitz, & Demyttenaere, 2006; Wenzel, Haugen, Jackson, & Brendle, 2005; Zaers et al., 2008).

There is a vast amount of literature offering often contradictory explanations of why this is the case, and women sometimes do not make the transition to motherhood as smoothly as they may have expected. Investigations which centre on biological triggers such as rapidly altering hormones have received some support. Psychological influences have also been investigated, including poor coping strategies, disorganised attachment, and ineffectual defence styles. What is interesting about these explanations is the tendency to locate the dysfunction or deficit within individual women. This is a fundamental attribution error which constructs the problem as theirs and theirs alone (Ross, 1977). Because of this looking beyond the obvious- at family structures, at interpersonal relationships and at broader social nuances such as the position and treatment of mothers in modern society - is often overlooked.

However, taking the context of the individual out of the equation has been strongly criticised in some quarters (Beck & Driscoll, 2006; Beck & Indman, 2005; Bernazzani et al., 2005; Mauthner, 1988; Milgrom & McCloud, 1996). It would seem considerations of factors beyond the biological experience of childbirth are needed to truly understand the event of becoming a mother. What of the emotional challenges, the psychological changes, and the reassessment of self and others that sit alongside becoming a mother? When women become mothers for the first time everything that was previously known about the self as a non-mothering individual is forever changed. Is it possible this explains, at least in part, why some women experience difficulty with the transition to motherhood? And, if the problem is not just within the individual, how much of an influence is their community, and the treatment and value of mothers assigned to and by society at large?

Let us pause a moment to consider what being a mother means. The occupation of mothering has changed tremendously, even in the last century (Eberhard-Gran, Garthus-Niegel, Garthus-Niegel, & Eskild, 2010; Kedgley, 1996). Going back even further, old-style agrarian families tended to work the land together and parenting tasks, particularly supervision of

children, was shared. Husbands often assisted in childbirth (a practice believed to demonstrate his willingness to share everything, good and bad) (Eberhard-Gran et al., 2010). With industrialisation came rationalisation and specialisation. Opportunities for work away from the land began to emerge and, for the first time, men left the private sphere to go to work in the public sphere, leaving women at home with the children. Here the modern housewife was born.

Even at the turn of the twentieth century mothering was vastly different than it is today. As a rule, babies were born in the family home and the birth was an event supported and attended by female members of the extended family. New Zealand women were expected to have a *lying in* period, lasting approximately 10 days following childbirth (Kedgley, 1996). During this time the new mother was encouraged to stay in bed while female family members took care of the running of the household and household chores. This served a number of purposes. Firstly it allowed significant recovery from the physical trials of childbirth, whilst also creating an intense bonding time for the mother and her new infant. This support by other females can be thought of along the lines of alloparenting; a concept which refers to assistance with childcare and other provisions by adults other than the biological parents (Hrdy, 1999). Secondly, arguably there was also an implicit message given that mothering and birth was outside the realm of normal everyday routine and was something that merited attention, support, and acknowledgement of the tremendous physical burden and strain women's bodies had been and were currently under. At this moment in time the mother and her new maternal role had value.

Additionally, it may well have boosted the new mother's confidence in her ability to actually mother. Research shows women with tight supportive social networks feel more comfortable and confident with aspects of the maternal role including discipline and dealing with children boundary testing than mothers whose social networks can be described as loose (Abernethy, 2009). In other words, mothers mother better when they are supported to do so.

At the time mothering skills tended to be acquired vicariously through frequent contact with younger siblings, cousins, or nieces and nephews (Hrdy, 1999). Young girls were socialised from an early age into their roles as mothers-in-training, and these roles were given both value and validity. This resulted in women who grew up with clear expectations of their future roles as mothers, but also with the expectation of support and sense of community from other women.

Within the Aotearoa/New Zealand context, the teachings of Sir Truby King and the advent of the Plunket service in 1908 impacted greatly the way mothering was done (Chapman, 2003; Kedgley, 1996). King was focused on the admirable goal of lowering infant mortality, and his plan for doing this was through improved nutrition. In an effort to achieve his goals King published a small book, 'Feeding and Care of Baby', which had a profound effect on New Zealand mothering. Aspects of the book were revolutionary for its time, for instance King was an early advocate of *breast is best*. However, the information contained in the book was

secondary to the impact it had on how mothering was learnt, because now there was a book which taught mothers about mothering (Chapman, 2003). It was not what King's book *said* so much rather it was what the book *did* that had such an impact.

The mothering mantra contained within the book was given credibility *because* it was in written form and had been penned by a local 'expert'. Therefore it seems, the book may have been perceived as far more authoritative than anyone's Aunt Sally, and one can just imagine the relief of worried new mothers who now had a quick reference guide on how to do things right. Unfortunately this also meant mothers were no longer the experts on mothering and the proverbial wisdom which had been handed down from generation to generation was gradually eroded as the written word took precedence over oral history.

King encouraged generations of women to partake in highly regimented routines he had developed stemming from his background as a medical superintendent and his research interest in malnourished calves. And while the information in the book (and later books as he was somewhat of a prolific writer) was not all bad it was most certainly not all good either. King was a supporter of eugenics, and believed emphatically in the need to produce strong capable children to develop New Zealand's national character, and, he argued, cuddling and other such attention weakened the developing character of the child (Chapman, 2003). Interestingly, this hands-off approach was contrary to thousands of years of evolutionary knowledge which had instilled in women an instinct to keep their infants close in order to maximise the baby's chances of survival (Hrdy, 1999). The instinct of a mother to comfort a crying child had, until now, served an important evolutionary purpose. Suddenly that instinct was the hallmark of an overly emotional mother and succumbing to it would supposedly risk the emerging character of the child.

At a similar time childbirth was moving away from the home and into the hospitals meaning for the first time pregnancy and childbirth sat under a model of disease (Abel & Kearns, 1991; Crossley, 2007). This took more control of the process of childbirth away from women as a discourse of pathology and fear convinced them it was not safe to do otherwise. Crossley (2007) wrote:

*"Pregnancy and childbirth has become increasingly medicalised over the past 40 years, and medical discourse around the risk and safety has served to regulate individual expectations of, and behaviours related to, the transition to motherhood (p.544).*

This meant of course doctors (usually males) became the experts and childbirth became a medical event<sup>1</sup>. As an aside an ironic aspect of the shift to male domination and hospitalisation was that it created barriers for the males who actually had a legitimate and vested interest in the process. In the early days fathers were largely excluded from the birth

---

1 Interestingly this shift to medical doctors has been linked to increased maternal mortality rates. The argument is doctors were more likely than midwives to perform invasive procedures such as vaginal examinations and forceps delivery which increased the risk for puerperal sepsis, an infection of the uterus which could, at its extreme, cause death (Mein-Smith, 1986).

process, leaving women very much isolated and unsupported and the new family fragmented before it had even been established.

So all these developments changed the way women mothered in a relatively short period of time and, perhaps equally as damaging, changed how mothering was perceived. Mothering had become something women were incapable of doing instinctually, or just with the support and guidance of other women. Rather than a natural phenomenon, pregnancy and childbirth was now a medical event, and it was dangerous and foolhardy for women to undertake such an endeavour without the guidance and direction of 'experts'.

Yet since women were convinced to surrender their rights to be the experts of their own bodies and submit to the direction of medical professionals, there has been a steady decrease in the assistance offered to them by those medical professionals. According to Ministry of Health statistics (Ministry of Health, 2003) by the new millennium the average length of hospital stay was two days following a vaginal birth which is a long way from the 10 days 'lying in' of 100 years ago and in a different world from the ritual 40 days quarantine often outlined in other cultures (Eberhard-Gran et al., 2010).

Given these changes to mothering, should we be at all surprised women have occasionally struggled with the contradiction motherhood has become? That is, a paradoxical existence whereby mothering is supposedly normal and natural but women don't know how to do it well enough without expert help. Naomi Wolfe (2001) writes in her autobiography of her transition to motherhood:

*"I don't believe most of the risks factors individually would tip so many women over the edge. But add them up: the low social status we assign to mothering; the high values western cultures place on a girlish figure; the isolation of today's nuclear family; the workplace pressure that sends husband away from home when their partners need them most; the absence of ritual that would allow the new mother to mourn her lost self; the lack of adequate follow-up care, and the overall censorious whitewash of the whole experience – the surprise should not be how many new mothers are depressed postpartum in our society, but, rather, how many, in spite of this, do well" (Extract from Misconceptions', p. 190, London: Vintage).*

This is not to suggest postpartum distress or depression is solely the creation of 20<sup>th</sup> century social treatment of mothers. Nor it is to suggest King caused women to become distressed, although one could imagine listening to a screaming infant with twenty minutes left on the clock until one was allowed to pick up the infant, would be *distressing*. Symptoms mirroring those of postpartum depression have been documented for almost as long as there have been mothers. Hippocrates wrote about what he referred to as 'milk fever', consisting of a number of physical and psychological symptoms which appeared in postpartum women 3-4 days after the onset of lactation. Whilst there is no conclusive evidence he was indeed documenting postnatal depression, such insights are interesting.

In 1858, a Parisian doctor by the name of Marcé opined previously emotionally stable women could be prone to episodes of instability associated with the birth of their child (Trede,

Baldessarini, Viguera, & Bottero, 2009). This was, perhaps, one of the first known efforts to distinguish female mental illness in general from pregnancy related cases in particular. However, these early innovations in maternal mental health were lost when Marcé died mysteriously a few years later at the young age of 36, and his contribution to and expertise around puerperal mental health was largely ignored until the inception of the Marcé Society in Britain (and later internationally) in 1980 (Trede et al., 2009).

So here we are some quarter of a millennium beyond Marcés first insights so what has improved for mothers? Certainly physically mothers fare better. According to the World Health Organisation globally 1000 women a day die from perinatal related causes, which represents a worldwide mortality rate drop of one third between 1990 and 2008 (World Bank, 2011). However, this means 1000 women a day still die from perinatal related causes so there is still room to improve.

Birth appears to be making a gradual return to the home. The New Zealand Health Information Service reported 55.3% of the women who planned to give birth at home in 2004 did so (Ministry of Health, 2007 ). These births accounted for 2.5% of all births which, although low, represents a considerable increase in the reported rate of 0.04% in the early 1970s (Gulbransen, Hilton, McKay, & Cox, 1997).

Also one could argue the amendment to the Parent Leave and Employment Protection Act ("Parental Leave and Employment Protection Act," 1987), which introduced paid parental leave in 2002 removed some of the pressure for women to return to work by subsidising a 12 week postnatal period which could be used for rest and recuperation. However, 12 weeks (now 14) barely allows time for the establishment of a routine, and the pay rate for those eligible for the paid parental leave is at minimum wage. All this points to the government still having significant inroads to make before they convince anyone mothering is an occupation of value to them.

As a whole, things should be looking up for mothers. However, I argue within this thesis that, overall, mothering is still a problematic occupation which causes considerable distress for a number of women throughout the perinatal period. Despite the changing realities of mothering, the traditional values and societal expectations remain relatively unchanged, and the assumption remains that motherhood is a universally fulfilling experience desired by all women. This clash between modernity and tradition and between expectations and reality is evidence the situation for mothers is still precarious on a number of levels. It is little wonder motherhood can be experienced as distressing.

So what exactly is postpartum distress? For the purpose of this thesis postpartum distress is defined as "experiences of depression, anxiety, or stress following childbirth at levels high enough to cause impairment in day to day functioning or relationships as reported by self or others". This definition is consistent with that used by a number of researchers in the area (Austin, 2004; Kearns, Neuwelt, Hitchman, & Lennan, 1997; Matthey, Kavanagh, Howie, Barnett, & Charles, 2004; Miller, 2007; Miller, Pallant, & Negri, 2006).

The next chapter examines these symptoms of postnatal distress. It explores the state of the current literature and identifies gaps in our knowledge. Chapter Three examines mothering expectations related to partners, to infants, and to self as mother, and argues these expectations are informed by women's exposure to unrealistic and overly positive mythical constructs of motherhood

Chapter Four examines the experiences of the transition to motherhood for a group of New Zealand women, and from there I begin to hypothesise about how to move forward in our knowledge and, more importantly, how to begin to address the difficulties experienced by significant numbers of women as they transition through this 'normal and natural' phenomenon called motherhood. Chapter Five incorporates the information covered in the literature review and the first study and introduces a new model of postnatal distress. The rest of the thesis focuses on testing components of the model, culminating in the development and initial piloting of an intervention protocol aimed at lowering the rates of postnatal distress.

The organisation of the material within the thesis represents what I believed to be a coherent and logical order. However the development of the thesis was not as linear as presented and involved reworking and rethinking as evidence was gathered. As already mentioned, the initial focus was on postnatal depression, so Chapter Two was written and this was followed by the first study (Chapter Four). However, the findings of that study suggested a focus on postnatal depression was too narrow, and my thinking evolved into a consideration of other mood states following childbirth. This involved a return to the literature and informed the writing of Chapter Three.

Progress from here followed along the lines of the presentation of the material, with the development of the model stemming from the preceding chapters. The testing of various components of the model followed and culminated in the development of the intervention as described in Chapter Eight and the piloting of it in Chapter Nine.

## **Chapter Two: Psychological Distress Related to the Transition to Motherhood**

The transition from non-mother to new mother requires significant resources and coping. It is a highly emotive time where women can feel overwhelmed both by the burden of their new infant and the impact of that new infant on their lives. Research into psychological difficulties in this time period has tended to focus on depressive mood states, predominately postnatal depression and 'baby blues'. However there is a mounting body of evidence pointing to a need to consider a broader array of psychological disturbances, including both anxiety and stress. Within this research the term postnatal distress is used as an umbrella term to encapsulate these broader psychological states of depression, stress and anxiety. This chapter highlights research in this area and concludes a tripartite model of psychological distress related to childbirth is needed to fully understand women's experiences across the transition to motherhood.

### **Postnatal Depression.**

Postpartum or postnatal depression (PND) has been described as "the thief that steals motherhood" (Beck, 2002b, p. 394). It can be characterised as insidious and debilitating, and is often suffered covertly (Spinelli, 1998). Without help it can lead to severe morbidity for both the mother and her family, in particular the infant.

PND is represented as a mood disorder which, as its name suggests, occurs after childbirth. It is classified as a non-psychotic depressive episode, and is located in the middle of a mood continuum that contains at one end a temporary depressed mood state commonly known as 'the baby blues', and postpartum psychosis at the other end (Whiffen & Johnson, 1998). The 'baby blues' are considered a transient reaction to motherhood with symptoms of tearfulness, irritability, mild depression, and labile mood which usually develops about three - five days postpartum. Postpartum psychosis on the other hand is an acute state dominated by hallucinations and agitation and it is usually, but not always, linked to pre-existing psychiatric or medical conditions; for example thyroiditis, hypothyroidism, bipolar disorder, or schizophrenia (Miller, 2002). These three postpartum states whilst related, are distinct in their respective natures, and require manifestly different levels of intervention and treatment.

Like generalised depression, symptoms of postpartum depression include sleep and appetite disturbances, despondent mood, feelings of inadequacy, impaired concentration and indecisiveness (Bozoky & Corwin, 2002). Given the similarities in symptomology, it is unsurprising that there is a level of disagreement as to whether postpartum depression is a unique disorder, thus 'entitled' to its own distinct diagnosis. Certainly the current clinical position appears to locate and treat PND as one would major depressive disorder (MDD). For example, the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) used by the

American Psychiatric Association does not allow for the diagnoses of postnatal depression as a discrete disorder. Instead it recognises a *postpartum onset specifier* to major depression if the onset is within four weeks postpartum (American Psychiatric Association, 2000).

Yet despite having these shared characteristics with major depressive disorders, there are behavioural and cognitive features which would appear to be unique to postpartum depression. Studies comparing the clinical features of postpartum depression and depression occurring outside of the postpartum found low energy levels and restlessness/agitation were characteristics of both depression types. However, the non-postpartum group reported increased sad mood, suicidal ideation, and more reduced interest. In contrast, women who experienced postpartum depression reported sad mood to be less prominent, with psychomotor symptoms (restlessness/agitation) and impaired concentration/decision-making more prominent (Bernstein et al., 2008; Hendrick, Altshuler, & Suri, 1998; Ugarriza, 2002). This is supported in further research which also found a number of characteristic features which differ between MMD and PND. Women experiencing postnatal depression endorse more items related to irritability than women experiencing other types of depression (Beck & Gable, 2000; Bozoky & Corwin, 2002).

Furthermore, a marked characteristic of postnatal depression is ego-dystonic thoughts of infant harm (Beck, 1992; Miller, 2002; Ugarriza, 2002). These aggressive, often obsessional, thoughts of harming or even killing one's infant are in marked contrast to actual maternal behaviour, and women often express great distress around the occurrence of these thoughts (Fairbrother & Woody, 2008). For example Ugarriza (2002) interviewed 30 women who self-identified as postnatally depressed. The mother's primary difficulty appeared to be confusion and guilt they reported experiencing as a result of their thoughts of hurting their babies (Ugarriza, 2002). However such thoughts are argued to be relatively common with up to 50% of women reporting the occurrence of unwanted thoughts of intentional harm.

## **PREVALENCE**

Another way to tease apart the disorders is to examine links between prevalence and risk. If major depressive disorder, ante-natal depression, and postnatal depression amount to the same disorder we would expect to see strong correlations across them. Yet that does not seem to be the case. According to studies, women who have experienced postnatal depression are at elevated risk of further episodes of postnatal depression, but not other major depressive disorders, and vice versa – women who have had a major depressive disorder are at elevated risk for further MDD episodes but not PND (Cooper & Murray, 1995; O'Hara & Swain, 1996). A meta-analysis by Beck (1996) showed whilst prenatal depression had a large predictive influence of the occurrence of PND (Cohen's  $r = 0.51$  - large effect size), MDD only had a small effect size ( $r = 0.29$ ), lower than marital dissatisfaction, childcare stress, prenatal anxiety, and low social support (Beck, 1996b). Another study by Dennerstein (1988), found mothers show

prevalence rates for depression at twice the rate of women who do not have children the same age.

Estimates of the prevalence of postnatal depression vary widely as a result of a number of factors. These factors include how postnatal depression is defined, the type of assessment (i.e. self-report versus clinical interview) and the length of the postpartum period under evaluation (White, 2008). Current estimates range from between 10-20 % of women, with most large studies showing an average rate of non-psychotic PND of 15% (O'Hara & Swain, 1996).

As with all research areas which demonstrate wide variations in prevalence rates, these figures are reasonably contentious. Perhaps most importantly the studies which generate these figures tend to rest on the assumption postpartum depression occurs relatively early on in the postpartum period – approximately four to six weeks after birth. Yet whilst there is extensive literature to contradict or at least undermine the credibility of such a narrow definition, few studies explore the occurrence of postpartum depression outside these timeframes. Thus, an argument can be made that an operational definition which restricts the occurrence of PND to the arbitrary four-six week time-frame artificially deflates rates of clinically significant PND (Beck & Driscoll, 2006).

## **EFFECTS**

The consequences of postpartum depression can be far-reaching, affecting not only the mother but also the infant and other family members, including the extended family. A New Zealand study which reviewed research findings showed depressed mothers display more uncertainty, a lack of enjoyment in caring for their infant, and exhibit a less positive attitude towards their newborn (Webster, Thompson, Mitchell, & Werry, 1994). In addition, they characteristically display less affection towards their infant and are less responsive to infant needs (Beck, 2002a). Further studies argue that when depressed, mothers interact with newborns in either a withdrawn or intrusive manner, demonstrating a less engaged and emotionally available style of parenting (Biringen, 2000; Lum & Phares, 2005). In turn, infants of depressed mothers' exhibited less positive facial expressions, vocalised less, and displayed higher levels of irritability than infants of non-depressed mothers (Beck & Gable, 2000), characteristics which are argued to compromise mother-infant bonding leading to less secure attachment (O'Hara, Scott, Gorman, & Wenzel, 2000; Pearce & Ayers, 2005).

In the longer term early maternal depression is argued to continue to impact off-spring beyond the actual duration of the symptoms. A meta-analysis of nine studies which investigated the long-term effects of PND on children over 12 months of age found an effect on children's development, both cognitive and emotional (Beck, 1998, p. 16). These effects are described as "small but significant long-term effects on the child's cognitive and emotional development" (Logsdon & Usui, 2001, p. 563), but how important these 'small but significant

effects' are, and whether there is some third variable explanation of them remains largely unexplored. However, this research showed the effect weakens as the child matures. More recently, research suggests the effects on cognitive functioning and academic achievement may be pertinent to male off-spring but not so applicable to daughters (Murray et al., 2010), although this effect was mediated by class and PND demonstrated a weak effect in low risk populations. The authors hypothesised these findings may reflect the differences in the level of association between IQ and academic performance between the genders (with girls academic performance largely unrelated to IQ). Furthermore they argue personality traits may have a role to play with characteristics commonly associated with academic success such as conscientiousness and self-discipline being more reflective of girls (Murray et al., 2010).

## **ETIOLOGY**

### *Biological Theories*

Bio-medical research is divided in its explanations of the etiology of postpartum depression and, so far, none of the theories have satisfactorily explained the varied outcome of what is a shared biological experience. One argument is that the puerperium acts as a trigger on an underlying disposition. Research has documented a genetic link in the aetiology of mood disorders and this concept has received considerable interest in the exploration of postnatal depression. But again, one wonders that if major depression is an underlying disposition which is triggered by childbirth why aren't stronger correlations evident in the literature?

Hormonal influences have also been under examination as a possible contributing factor (Dennis, 2004a; Halbreich, 2005; Muñoz, Mrazek, & Haggerty, 1996; Rees, Austin, & Parker, 2005; Wisner et al., 2004) which is understandable as maternal hormones surge throughout pregnancy at a rate unmatched at any other time in a woman's life (Harris, 1996), as does the activity of the pancreatic cells, thyroid and parathyroid glands, and the pituitary gland. This hormonal fluctuation is believed to be important as it impacts on the activation of neurotransmitter systems which in turn, are argued to increase vulnerability to depression (Steiner, Dunn, & Born, 2003). For example, oestrogens and progesterone are gonadal steroids which act to modulate neurotransmitter systems involved in the regulation of mood. These neurotransmitter systems, which include both the dopamine and serotonin systems, increase vulnerability to depression. Thus, exploration of these factors is a logical step in aiding awareness about the aetiology of PND.

Estrogen and progesterone levels escalate dramatically during the pregnancy process as a result of placental involvement. After the delivery of the placenta, these levels are plunged back to almost pre-pregnancy levels within a relatively brief timeframe, a finding which has provoked speculation and investigation of a possible contributory role for PND (Hendrick et al., 1998). However, the results of these inquiries have produced, at best, equivocal results, and

the fact remains that *all* women are subject to biological and hormonal changes throughout pregnancy and the early postpartum period and yet not all women experience PND.

One of the most lauded biological theories was posited by Dalton (1984, 1985; Dalton, 1989 ) who argued changing progesterone and estrogen levels following birth could explain depressive symptomology. In her progesterone depletion theory, she argued the rapid severing of high levels of progesterone following the delivery of the placenta after birth leaves some women vulnerable to low mood. This is because the increased progesterone during pregnancy affects levels of GABA (Gamma Aminobutyric Acid) in the brain which, as an inhibitory neurotransmitter, blocks the re-uptake of serotonin increasing the concentration of serotonin by blocking the serotonin transporter, and the rapid severing of those levels following delivery is tantamount to experiencing a withdrawal-type phenomenon. In a trial of 100 women who requested progesterone following a previous episode of PND, only nine experienced a recurrence, considerably less than the 68% recurrence rate reported in an undertreated sample (Dalton, 1985). Clearly it was beneficial for some women with specific risk factors.

There are some questions around these findings however. Firstly, the results have not been replicated in double blind trials. Secondly, one would expect to see some demonstration of a relationship between progesterone levels and differences in the incidence of depression, yet this is still to be established. Investigations of the relationship thus far have focused on the immediate postpartum period and have reported results that were either inclusive or negative (Dennis, 2004a). However, even if the depletion of progesterone explained flattened mood or baby blues in the period around the onset of lactation, there is still no empirical evidence linking baby blues 'weepiness', which occurs in the 4-5 days postpartum period, to more clinically significant depression occurring at later stages in the puerperium (Harris, 1996), especially as it has been demonstrated there are significant differences in the levels of hormones in these time periods (Dennis, 2004a; Harris, 1996). As a final point, it does seem ironic that hormones were posited as responsible for depression in pregnancy when the placental effect is at its highest level. Thus, both the presence and absence of progesterone apparently had the same effect on the mental health of women.

The role of estrogens in the development of PND has also been examined, again with equivocal results. In an effort to understand the interaction of estrogen and PND, researchers have concentrated on breastfeeding, which is known to impact on levels of estrogen. To date research in this area has not demonstrated a consistent association between the two (Dennis, 2004a; Hendrick et al., 1998). This also presents somewhat of a challenge to those that advocate the use of estrogen as a preventive measure.

There is an argument women may experience a rebound effect after delivery due to the immunosuppressant effects of high levels of cortisol during pregnancy. In other words, during pregnancy it is believed elevated levels of cortisol may act to contain naturally antibodies and, following birth, once cortisol levels drop there is a naturally occurring overcompensation. This rebound effect produces elevated rates of postpartum thyroid antibodies. Research is mixed on

this with one study finding a weak relationship between positive antibody status and depressed mood. However given the 'missing link' demonstrating a relationship between cortisol and postpartum mood the significance of this finding is yet to be determined (Hendrick et al., 1998).

Thus to conclude, studies on biological influences have arrived at results that have been either negative or contradictory. There have been a number of methodological concerns with some of these studies including not controlling for breastfeeding; which impacts on levels of prolactin, cortisol, progesterone, estrogen, and oxytocin. Independent of this hormonal effect, lactation has also been associated with both positive and negative mood changes which is somewhat confounding (Hendrick et al., 1998). Of concern with regards to some of the studies into hormonal or biological influences is the apparent lack of control for the use of antidepressant medication or other medications which may impact on hormone levels.

The finding that adoptive mothers experience rates of postnatal depression at a similar rate as biological mothers also creates somewhat of a 'spanner-in-the-works' for theorists arguing the biological perspective (Gair, 1999; Senecky et al., 2009). What is of particular interest in the Senecky research was the finding rates of depression were *lower* post-adoption than during the adoption period, suggesting more of a reactive depression or possibly a more anxious depressive episode.

Furthermore, all of the women in this study who were found to be depressed during the post adoption follow up were depressed leading up to the adoption in contrast to women experiencing postnatal depression following childbirth (Senecky et al., 2009). Finally, there is a need to consider etiological differences in the types of depression. For instance there is no research to support the notion that depression starting in the first postpartum week shares the same etiological basis as depression with an onset at three or six months, which again may be etiological different from depression that had its onset in the prenatal period.

There has also been some investigation into possible obstetric risk factors and the role they might play in the development of PND. A prospective study with women giving birth in a number of locations throughout Australia examined several obstetric variables including pregnancy complications, labour, delivery and perinatal outcomes (Johnstone, Boyce, Hickey, Morris-Yates, & Harris, 2001). According to the authors, none of the obstetric factors examined demonstrated links with a significant increase in risk for PND however other research has linked increased obstetric interventions such as C-sections and forceps delivery, with increased risk (Boyce & Todd, 1992) (Fisher, Astbury, & Smith, 1997). So again, given the totality of the research in this area, there is mixed evidence regarding the impact of obstetric variables on postnatal depression.

### *Psychosocial Themes*

A review of the relevant literature shows some of the psychosocial risk factors for postpartum depression previously considered include ethnicity (Webster, Thompson, Mitchell, & Werry, 1994; Yonkers et al., 2001); (Miller, 2002), depressed mood prior to delivery (Righetti-

Veltema, Conne-Perreard, Bousquet, & Manzano, 2002), educational attainment level (Johnstone et al., 2001) (Logsdon & Usui, 2001) socio-economic status (Robertson, Grace, Wallington, & Stewart, 2004) (Webster et al., 1994), early cessation from breast-feeding (Ferguson, Jamieson, & Lindsay, 2002); (Johnstone et al., 2001; Tammentie, Tarkka, Astedt-Kurki, & Paavilainen, 2002), psychosocial stress, and inadequate social support (Johnstone et al., 2001; Logsdon & Usui, 2001; Robertson et al., 2004; Seimyr, Edhorg, Lundh, & Sjogren, 2004). Infant factors have also been examined including having an infant with an unsettled/irritable temperament, having an infant who is physically unwell, and having an infant with poor motor skills. Unfortunately, neither the focus on psychosocial factors for the mother nor the infant factors have convincingly explained the onset of PND symptoms.

The role of perceived control on postpartum mood has received attention (Beck, 1993, 2002a; Keeton, Perry-Jenkins, & Sayer, 2008; Miller, 2007). Studies have found the higher the levels of perceived control; both of the internal processes of birth and of the levels of intervention by attending staff, the lower the levels of psychological morbidity at postnatal follow-up (Miller, 2007). The link between a perceived lack of control leading to feelings of helplessness and depressive symptomology has been extensively researched over several decades. Seligman's (Seligman, 1975; Seligman & Maier, 1967) seminal research on learned helplessness demonstrated a link between an individual's perception they lacked control over either aversive events or negative outcomes and an increase in depressive symptoms. If one was to apply Seligman's thinking to the process of childbirth one could argue the unavailability of expected resources and/or staff, unanticipated medical interventions and negative perinatal outcomes already highlighted could contribute to a sense of helplessness. Furthermore if ongoing medical procedures are deemed to be necessary this could very well compound the sense of helplessness. Thus Seligman's theory would seem to sit well here.

The concept of hopelessness - attributing aversive effects to internal, global, and stable traits within oneself whilst believing oneself to lack the ability to change or effects events (that is having no control) - has also been well researched. Again we can see how this might be applied to understand some women's journey with postnatal depression. For instance a lack of control over their own fertility is argued to be a contributing factor for adoptive mothers who experience depression post-adoption (Gair, 1999). If these women then also experience feelings of hopelessness - attributing their infertility to internal and stable traits within themselves, and believing they are powerless to change that infertility... well, distress leading to depression is not hard to imagine.

In addition to the pivotal research of Seligman, the work of Lewinsohn and colleagues has greatly influenced the development of research on depression (Lewinsohn, 1975; Lewinsohn & Amenson, 1978; Lewinsohn, Duncan, Stanton, & Hautzinger, 1986a; Lewinsohn, Fenn, Stanton, & Franklin, 1986b; Lewinsohn & Graf, 1973; Lewinsohn, Hoberman, Teri, & Hautzinger, 1985; Lewinsohn & Libet, 1972). According to Lewinsohn's research, a decrease in positive reinforcement acts as an antecedent for depressive behaviours; what is referred to as a

decrease in response-contingent reinforcement (Lewinsohn & Graf, 1973; Lewinsohn & Libet, 1972; Lewinsohn, Steinmetz, Larson, & Franklin, 1981; MacPhillamy & Lewinsohn, 1974). Lewinsohn and colleagues demonstrated a positive relationship between mood level and engagement in pleasurable activities, both the number of different types of pleasurable activities (range) and the amount of times each activity was engaged in (replications) (Lewinsohn, 1975; Lewinsohn & Amenson, 1978; Lewinsohn et al., 1986a; Lewinsohn et al., 1986b; Lewinsohn & Graf, 1973; Lewinsohn et al., 1985; Lewinsohn & Libet, 1972). This led them to argue the balance of an individual's interactions with their environment shifted in a negative direction because of the reduction in positive reinforcement and/or increase in negative or adverse events. They also argued while it may be the case a depressed individual engages in pleasurable activities less, it is also possible the direction of causation can be reversed; a person who experiences a decrease in pleasurable activities and hence a decrease in positive reinforcement may, as a result, become depressed (Lewinsohn & Graf, 1973).

Given the repetitiveness of potential non-rewarding tasks often associated with motherhood, in addition to the mental ennui women often report experiencing, it is relatively easy to understand how Lewinsohn's theory might have some relevance to thinking around postnatal depression. The early postpartum period is a time when many women experience increased isolation, sleep deprivation, interrupted routines and a decrease in personal time and space. In other words there is an increase in negative or aversive events – tiredness, chaos, workload, life stress, and a decrease in potentially positive or rewarding events – social interaction, personal time, and sense of control to name but a few. At the same time, caregiver tasks such as nappy changing, washing, cleaning, feeding, and burping, can be experienced by as unrewarding, particularly if the infant is unsettled, difficult to feed, or not easily soothed. Compounding this is the basic logistic which would suggest women who are now engaging in these new behaviours would also be experience a loss of opportunity to pursue previously enjoyed activities. That is not to suggest women are unable to engage in *any* activities which they may have previously received positive reinforcement for, but to acknowledge the feeding, bathing, washing, and care taking of an infant consumes time which is then no longer available for other things. Thus we can easily see how the model proposed by Lewinsohn and colleagues may potentially be applied to an understanding of postnatal depression. Furthermore, research examining factors associated with recovery from PND concluded regaining control was of primary importance (Beck, 1993). Thus a sense of control is argued to be an important cognitive resource, both as a protective factor against the development of depressive symptoms and a recovery factor as a promoter of resilience and coping.

It is evident from the sum of current research, depression is considered by many to be a negative symptom of poor coping. However, there are those who argue depressive behaviour can, in fact, serve an adaptive function. Firstly evolutionary theorists argue the lack of motivation and pessimism characteristic of depression conserves energy by inhibiting action (Nesse, 2000). When this thinking is considered in terms of postnatal depression, such

behaviour has the potential to be beneficial to an infant *if* it means the mother stays home (thus limiting exposure to environmental threats) remains close (thus ensuring she is able to respond quickly to infant needs), has disturbed sleep patterns (which may result in great accessibility during night time hours) and does not expend energy on other pursuits (Keller & Nesse, 2005). Also depression may well serve to inhibit responses in unfavourable situations whereby efforts to attain a goal could likely result in loss, damage, danger, or wasted effort (Hendrie & Pickles, 2009; Nesse, 2000).

It is possible depressive thinking represents more 'realistic' thinking. This is because an individual with depressed thinking has a tendency to focus on the more negative aspects of a situation and, as a result, is prepared for the realities of an experience due to this more pragmatic appraisal (Beck, 1996a; Hendrie & Pickles, 2009; Keller & Nesse, 2005; Nesse, 2000). Furthermore, it is argued this more pessimistic evaluation results in less disappointment, and arguably a great sense of control over ones future (Harwood, McLean, & Durkin, 2007).

This reasoning argues for a reverse in the direction of causality over what has been typical thinking about depression. Traditionally clinical opinion has promoted the idea that negative cognitions are an antecedent to depression and located, to a large extent, responsibility for the depression within the individual as a result of their 'faulty' cognitions. This alternative argument however, posits problematic cognitions are a consequence rather than an antecedent of depression.

There is some support in the literature for this alternate viewpoint (Seligman, 1975; Terry, Mayocchi, & Hynes, 1996). In a large longitudinal study, researchers demonstrated individuals who became depressed over the course of their research did not differ significantly in their cognitive patterns over those who showed no signs of depression (Lewinsohn et al., 1981). So while those who were depressed demonstrated higher expectancy for negative events, lower expectancy for positive events, irrational beliefs, lower self-esteem and attribution bias once depressed, this style of thinking followed the onset of depressive symptoms – it did not precede them

Another important concept relevant to this thesis is that of cognitive fusion. The idea of cognitive fusion stems from a cognitive therapy known as ACT (Acceptance and Commitment therapy), which is showing increasing efficacy in the conceptualisation and treatment of depression (Hayes, 2005; Hayes, Luomaa, Bond, Masudaa, & Lillis, 2006; Zettle, 2007). Theorists who follow this model propose individuals who become 'fused' with their thoughts or who believe their thoughts to be an accurate and true portrayal of the world have difficulty processing information which may offer contradiction of that evidence (Hayes, 2005). New mothers may, for example, have the thought they are unable to cope or that they are bad mothers. For some women these thoughts can flow in and out of consciousness with very little impact on the individual having such thoughts. However, according to the idea posited by ACT theorists, women who are fused with their thoughts will find these thoughts to be highly believable and will, in fact, go as far as to dismiss evidence which may contradict such

thoughts. Thus women with a style of cognitive fusion exhibit a sort of information processing bias where they demonstrate a tendency to believe their own internal thought processes rather than external evidence of the 'truth' of the situation.

### **CULTURAL STUDIES**

Postnatal maternal mental illness has been reported in a number of non-western cultures including China, Nigeria, and Uganda (Cox, 1979). Cox (Cox, 1979, 1983) researched new mothers from the Ganda tribe in Southern Uganda and reported similar rates of depression amongst this population as found in western mothers. He also described a illness following childbirth known as *Amakiro*, a form of postnatal psychosis, characterised by a disorganised mother/infant relationship and which has, at times, resulted in the death of the mother and child (Cox, 1979, 1983).

Nigerian culture includes a concept of 'heat in the head' which describes symptom clusters similar to postnatal depression. Closer to home studies of Pasifika women parenting in New Zealand have found rates of PND similar to that of New Zealand European women (Abbott & Williams, 2006). While the evidence of similarities in prevalence rates across cultures may, on the surface, lend support to a more biologically based etiology, social factors are argued to play an important role.

More recently research examining the experience of PND in first-time mothers from mainland China found striking similarities with findings from Western research (Gao, Chan, You, & Li, 2010). Interestingly, this research also examines the changing role of motherhood within the context of Chinese culture, and discusses how mothering has changed from traditional practice, not unlike the earlier argument of changes within the New Zealand context. The women who took part in the study reported experiencing "dissonance between tradition and modernity and between expectations and reality" (Gao et al., 2010, p. 303). They indicated they believed the stress and distress they experienced was due to these differences and were clear it was socio-cultural rather than biological processes they believed created the pressure they found themselves under.

Furthermore, Hamdan and Tamin (2011) recently reported on their research of psychosocial risk and protective factors for women in the United Arab Emirates. This study found religious affiliation, formula feeding, and number of children were predictive of PND, whilst educational attainment, life stress and employment following birth were of borderline significance.

What the sum of this research suggests is postnatal depression is not culture bound, but is part of a similar experience shared by women of different cultures. It is something inherent to mothering; a collective knowledge. It is true the bodily experiences of women; those of hormones, pregnancy and birth may be consistent across cultures and, at first glance, provide support for those who would argue for a biological explanation of PND. However,

consistently the women in these studies report on psycho-social factors; support, attachment, stress, and employment as major triggers of their depression and distress. Clinical experts then may do well to listen to what the women have to say.

### **SUMMARY**

Postnatal depression affects large numbers of women with a life-time prevalence reported anywhere between 10-50%. While some professionals argue PND reflects the same symptomology as MDD others point to research indicating some clear differences between the two disorders. Most noticeably, PND appears to be of a more irritable/agitated nature; thus is arguably more externalising than MDD. The other marked contrast is the thoughts of infant harm which are believed to be present in up to 50% of mothers, but which are contrary to the mother's actual behaviour.

Several theories have been posited to explain the etiology of postnatal depression. Biological theories focus on rapidly altering hormones and the effect this might have on mood via neurotransmitter systems. Behavioural theories examine the decrease in positive reinforcement and the increase in negative or aversive events as well as the role of hopelessness as possible contributors to depressive symptomology. Cognitive theories examining helplessness stemming from a perception of a lack of control are finding increasing support in the literature as a possible contributory factor. However, there is also some evidence to suggest helplessness and powerlessness is a consequence of rather than cause of depression. Finally, psychosocial theories examine factors external to the mother including social and marital support, infant characteristics and societal beliefs about and value assigned to the role of mothering.

### **Anxiety**

Investigation into distress related to the postnatal period has tended to focus on depressive type symptomology with little acknowledgement in the literature maternal 'distress' can consist of states other than depression (Barclay & Lloyd, 1996; Matthey, Barnett, Howie, & Kavanagh, 2003). However, given the strong link between anxiety and depression in other areas, research which has steadfastly remained focused on depression exclusively is somewhat limiting in its usefulness for explaining psychological distress. Although there are strong co-morbidities between anxiety and depression, they represent different mood states and different cognitive structures. Anxiety is more likely to precede depression than stem from it, and is often seen as a core component of depression (Chorpita & Barlow, 1998). This suggests anxiety needs to be examined in its own right in order to fully understand the psychological experiences of women making the transition to parenthood.

## **ANTENATAL ANXIETY**

Research findings suggest anxiety is more prevalent than depression in the antenatal period (Brockington, MacDonald, & Wainscott, 2006; Grant, McMahon, & Austin, 2008; Hart & McMahon, 2006; Heron et al., 2004; Lee et al., 2007; Matthey et al., 2003; Wenzel et al., 2005). For instance Faisal-Cury and Menezes (2007) investigated the prevalence of antenatal depression and anxiety in clients from a private setting. They reported 59% of women in the study had elevated levels of state anxiety and 45% of the same group had high levels of trait anxiety. This compared to a prevalence of 19.6% for antenatal depression, less than half the anxiety rate. These findings are supported in other research by Brockington et al. (2006) and Hart and McMahon (2006). In a joint UK and NZ investigation of women referred to psychiatric services, Brockington et al. (2006) reported 31% of the sample had moderate to severe antenatal anxiety compared to 14% who had moderate to severe antenatal depression. In another study designed to investigate links between mood and psychological adjustment to pregnancy, investigators found 9% of their low risk community sample screened positive for depression as opposed to 36% and 30% for trait and state anxiety respectively (Hart & McMahon, 2006).

These studies consistently point to high levels of anxiety in pregnant women with the lowest reported level showing 1 in 5 women (21%) are highly anxious as measured by the State Trait Anxiety Inventory (STAI) (Grant et al., 2008) ranging to a peak rate of over 1 in 2 (54%) reported by Lee et al (2007). Reported prevalence rates for Perinatal Panic Disorder range from 1.3% - 2% while antenatal rates of OCD have been reported between 0.2% - 1.2%; lower than rates in the postpartum (2.7% – 3.9%) as well as the estimated lifetime prevalence rate reported for the general population (2.5%) (Ross & McLean, 2006). Findings such as these have fuelled the call to consider anxiety as well as depression when assessing maternal mental health (Barclay & Lloyd, 1996; Matthey, 2004).

As yet there is no clear answer to what causes antenatal anxiety. There is evidence of a non-linear U-shaped relationship between gestational period and anxiety levels suggesting significant time effects with peaks in the first and third trimester when compared to the middle trimester (Lee et al., 2007). There is also some evidence suggesting anxiety has different triggers at different pregnancy stages. For example women may experience high levels of anxiety about maintaining the pregnancy in the initial stages however, this concern is likely to abate as the pregnancy progresses, and be replaced by other worries such as anxiety about the birth process.

As well as different anxiety triggers throughout the gestational stages, there is evidence to suggest different factors may act to protect against anxiety at different pregnancy stages. For instance perceived social support has been shown to be protective against anxiety in the second trimester but not in the first and third (Lee et al., 2007). The authors do not offer an explanation for this finding but it is possible to hypothesise due to the changing anxiety triggers

(i.e. maintaining the pregnancy in the first trimester vs. uncomplicated delivery in the third trimester) social support may act to alleviate concerns paramount in the 2<sup>nd</sup> trimester but not address primary concerns to the first and third. Further investigation would help test this hypothesis and add to our limited knowledge of antenatal anxiety.

That being said, to summarize the research covered, what seems to be known about antenatal anxiety is that there is a link between anxiety during pregnancy and pre-existing anxiety status. That is women who have an anxious way of interacting with the world tend to continue that interaction style during pregnancy. In addition, increased levels of antenatal anxiety have been linked with lower income, less education, and being single (Hart & McMahon, 2006). While no explanation of these correlations is posited by the authors, some of the variables; lower income and level of education for example, tend to increase vulnerability and uncertainty, and arguably lessen the amount of choice and control women have over their pregnancy and their environment. Another factor shown to correlate with antenatal anxiety is low self-esteem. According to Lee et al. (2007), decreased levels of self esteem during pregnancy leave women "ill-equipped to face the multitude of developmental challenges and stressors of pregnancy" (p. 1110).

Researchers argue there are a number of factors which inhibit the development of in-depth knowledge regarding antenatal maternal mental health. Specifically there is an argument systematic research into anxiety related to pregnancy and childbirth has been hampered by a lack of clear definition as to what constitutes anxiety, a lack of validated instruments for use in this population, and the strong correlation of anxiety with depression (Austin & Leader, 2000; Faisal-Cury & Menezes, 2007; Grant et al., 2008; Lee et al., 2007; Leigh & Milgrom, 2008).

Certainly, there appears to be a dearth of instruments suitable for use in maternal mental health. Commonly used instruments such as the State Trait Anxiety Inventory (STAI) and the Beck Anxiety Inventory (BAI) (regardless of which version is being utilised); tend to draw heavily on somatic symptoms. Given that pregnancy and early puerperium is a time of significant physical changes; that tiredness, difficulties with sleeping and changes in appetite, all assessed by the BAI, are common processes which accompany pregnancy, there becomes a very real danger when using these instruments of pathologising normal pregnancy events (Matthey, 2004). This could be further compounded by the lack of separate gender norms for the BAI. Women tend to score higher than men on the BAI and this tendency towards elevated scores may further over-pathologise women (Creamer, Foran, & Bell, 1995).

These questionnaires were not designed for use in an antenatal population and therefore they do not measure pregnancy specific anxieties and worries. However, there is ample research suggesting women may experience intense and specific fears about the process of pregnancy and childbirth (Brockington et al., 2006; Huizink, Mulder, Robles de Medina, Visser, & Buitelaar, 2004; Mulder et al., 2002). Furthermore while the STAI was designed to aid in the differentiation of anxiety and depression, there is substantial correlation between the Beck Depression Inventory (BDI) and the BAI suggesting they may be measuring the same

thing ([www.theaaceonline.com/stai.pdf](http://www.theaaceonline.com/stai.pdf), assessed April 27, 2010). Hence studies that rely on the BAI to give indications of baseline levels of anxiety may in fact be reporting depressive symptoms.

In addition to problems with instrumentation, efforts to produce a comprehensive picture of antenatal anxiety is confused by the high level of intra-individual variability reported in a number of the studies which examined anxiety and depression levels at multiple time points during pregnancy. For instance Lee et al (2007) reported 54% of their sample had elevated levels of anxiety as measured by the Hospital Anxiety and Depression Scale (HADS) at least one time point during their pregnancy. Yet it would seem that the majority of those women only had elevations at one of the three time points. The authors themselves categorised almost 70% of their sample having either fleeting or no problem with anxiety (Lee et al., 2007). The remaining 30% were classified as having consistent or deteriorating anxiety but this figure is not broken down further. This seems to suggest the majority of women in the study were actually coping well with maybe transient difficulties and the statement regarding elevated levels of anxiety in over half the sample may create a somewhat misleading perspective on antenatal maternal health. Another implication of this is that research which only measured antenatal mood or anxiety at one time point (i.e Austin, Tully, & Parker, 2007; Brockington et al., 2006; Grant et al., 2008; Hart, & McMahon, 2006) may be reporting results reflecting transient states rather than clinically significant ongoing difficulties with anxiety.

### *Outcomes*

Antenatal anxiety has been linked to a number of negative outcomes for women. During pregnancy elevated rates of anxiety has been linked to higher reported incidences of nausea and vomiting (Andersson, Sundstrom-Poromaa, Wulff, Astrom, & Bixo, 2004). Women with high anxiety reportedly tend to use more pregnancy-related sick leave from work, require greater analgesic assistance, and have increased numbers of planned caesarean sections (Andersson et al., 2004; Brouwers, van Baar, & Pop, 2001). Elevated anxiety levels are also correlated with high levels of concern about coping with the responsibilities of mothering, and trait anxiety has been shown to be positively correlated with maladaptive mothering cognitions (Hart & McMahon, 2006).

Anxiety during pregnancy is also argued to impact on postpartum mood. Several studies report antenatal anxiety not only creates an increased risk for elevated levels of postpartum anxiety, but also increases the levels of self-reported depression in the postpartum period (Austin, Tully, & Parker, 2007; Britton, 2007; Heron et al., 2004; Matthey, 2004; Milgrom et al., 2008; Sutter-Dallay, Giaconne-Marcésche, Glatigny-Dallay, & Verdoux, 2004). It is argued this may occur because high levels of anticipatory anxiety in the antenatal period about perceived inadequate resources to cope with motherhood transfer to depressed mood in the postpartum period as the challenges and demands of parenting become real (Lee et al., 2007). There is also concern women who experience anxiety antenatally may employ maladaptive

coping strategies such as drinking and/or smoking. While this may work to reduce anxiety symptoms in the short term it then increases the risk of adverse postnatal outcomes in the longer term (Littleton, Breitkopf, & Berenson, 2007)

Prenatal anxiety has been associated with difficult infant temperament and maternal trait anxiety has been correlated with difficulty soothing the infant (Britton, 2011). In addition McMahon et al (McMahon, Barnett, Kowalenko, & Tennant, 2005) demonstrated links between postpartum maternal ratings of infant difficulty and state/trait anxiety. The distinction with state/trait anxiety is an interesting one as there is an increasing trend to examine alternate 'forms' of anxiety. While most research with antenatal populations examines anxiety as an overarching umbrella concept, some researchers argue anxiety in this population can be divided into two distinct categories; general anxiety (similar to the concept of trait anxiety) whereby women tend to respond anxiously to a wide range of everyday situations and pregnancy-specific anxiety whereby women experience anxiety in relation to the specific events of being pregnant and giving birth (not dissimilar to the idea of trait anxiety (Brockington et al., 2006; Huizink et al., 2004; Johnson & Slade, 2003; Lee et al., 2007). In other words they may be anxious about the health and well-being of their unborn child, or be anxious about the process of giving birth, or have fears related to their ability to adequately mother their infant (Brockington et al., 2006; Huizink et al., 2004).

High levels of reported general anxiety have been linked to increased risk for the infant with higher reported rates of spontaneous abortion, preterm labour, and retarded growth, particularly in relation to head circumference (Brouwers et al., 2001; Dieter, Emory, Johnson, & Raynor, 2008; Faisal-Cury & Menezes, 2007; Mulder et al., 2002). Children of generally anxious mothers are more likely to have emotional or cognitive problems (such as ADHD and language delay) although this has been found to be moderated by other factors such as maternal diet (Talge, Neal, & Glover, 2007). In addition, antenatal anxiety is also negatively correlated with attachment quality (Grant et al., 2008).

However, the robustness of these findings have been criticised with claims there are direct correlations between sample sizes and significance findings. Littleton et al (2004) found studies with small sample sizes and those that relied on less frequently used anxiety instrumentation were more likely to report findings of significance. Conversely, their meta-analysis of studies investigating the relationship between anxiety symptoms antenatally and adverse perinatal outcomes, found no evidence between general anxiety symptoms and common outcome measures including birth weight, APGAR scores and length of labour (Littleton et al., 2007).

Just as the research regarding general anxiety appears murky, so too does that investigating the effects of pregnancy-specific anxiety. Following birth, infants of mother who had pregnancy specific anxiety show a higher tendency towards difficult temperaments, including problems with attention regulation and challenging behaviour (Huizink, de Medina, Mulder, Visser, & Buitelaar, 2002). In a large-scale longitudinal study, O'Connor, Heron,

Golding, Beveridge, and Glover (2002) reported antenatal maternal anxiety successfully predicted behavioural and emotional problems in both boys and girls at age 4 years, suggesting a possible effect of maternal mood states on fetal brain development.

However there is research to suggest pregnancy related anxiety can serve an adaptive function by focusing maternal attention on the fetus and motivating pregnant women to take a cautious approach to their own health as well as that of their infant (Hart & McMahon, 2006). Pregnancy-specific anxiety may, for example, encourage women to be more nurturing; eating well, abstaining from alcohol and cigarettes, sleeping and resting adequately. This type of anxiety is also argued to increase comforting or soothing of the baby, for example by the stroking of the stomach and conversing with the baby, both shown to increase attachment with the fetus and, following that, better maternal role development (Hart & McMahon, 2006).

### **POSTPARTUM ANXIETY**

Again compared to postnatal depression research into postpartum anxiety appears to have been relatively neglected (Ross & McLean, 2006). This bias in research investigation is puzzling "*given the recognition that significant anxiety may also be present in new mothers*" (Matthey et al, 2003, p. 140). Some researchers claim the disparity between investigation of depression and anxiety can be explained by the notion that postnatal anxiety is often overlooked or subsumed in the PND diagnosis (Matthey et al., 2003). Postnatal anxiety and postnatal depression appear to have reasonably high levels of comorbidity, just as non-pregnancy related depression and anxiety do (Beck & Driscoll, 2006; Buist, 2002; Faisal-Cury & Menezes, 2007; Miller et al., 2006). One possible explanation for this is women who experience anxiety following the birth of their child, and who are unable to satisfactorily resolve their anxiety then begin to experience depression related to their inability to move forward.

However there are some problems with the tendency to ignore investigations into, and symptoms of, anxiety. Little is known about the association between depression and anxiety, and the stability of the two disorders across the transition from pregnancy to the postpartum period. Furthermore, there are obvious implications for treatment given the two disorders require fundamental different treatment approaches. In addition the peak age of onset for anxiety disorders in women is mid to late twenties – prime childbearing years, and the neglect of researchers to consider perinatal anxiety in its own right fails to consider women who experience stand-alone anxiety symptoms without corresponding depression (Ross & McLean, 2006).

As mentioned in the previous section approximately 15% of women will experience clinically significant levels of postnatal depression (O'Hara & Swain, 1996; Webster et al., 1994; Yonkers et al., 2001). However rates of depression in the postpartum period maybe equalled if not exceeded by the number of women who experience clinical levels of anxiety (Wenzel et al., 2005). While some studies estimate 10-15% of women will experience anxiety in the

postpartum period at a level high enough to cause disruption to daily functioning (Britton, 2007; Heron et al., 2004; Miller et al., 2006), which is similar to rates of depression cited in the literature (O'Hara & Swain, 1996), other research suggests anxiety-related disorders are more prevalent, at least in the initial postpartum period, and quote rates of between 6.1% and 43% for the first six-months following childbirth (Britton, 2007; Wenzel et al., 2005). For instance Heron et al found 24.5% of respondents in a community sample experienced clinically significant depression at some stage across the timeframe under investigation (18 weeks gestation -8 months postpartum), while slightly more women (26.7%) had similar difficulties with anxiety.

There is evidence to suggest anxiety rates may be underestimated as some researchers report self-selecting sample bias in their studies with women experiencing mental health problems being less likely to return questionnaires (Britton, 2011; Heron et al., 2004). This notion of unacknowledged or unnoticed postpartum anxiety is supported in interesting research by in the Wenzel et al (2005) who investigated levels of subsyndromal anxiety in women. The authors defined women as sub-syndromal if "*(a) they fulfilled the majority, but not all of, DSM-IV diagnostic criteria for a disorder, and these symptoms caused life interference and distress, or (b) they fulfilled all of the DSM-IV diagnostic criteria for a disorder, but their symptoms did not cause sufficient life interference or distress to warrant a diagnosis*" (Wenzel et al., 2005, p. 300).

In this community sample, whilst 16.4% of women met the criteria for syndromal anxiety a further 43.1% were classified as experiencing anxiety at sub-syndromal levels. In a similar study Czarnocka and Slade (2000) investigated rates of anxiety, specifically PTSD in women 6 weeks postpartum. Three percent of their sample reported clinically significant symptoms of PTSD (increased arousal, numbing/avoidance, re-experiencing), while a further 24.2% endorsed sub-syndromal PTSD with clinically significant experiencing of at least one of the symptom domains.

Specific anxiety disorders in the postnatal period have been reviewed by Ross & McLean (2006). Disorders reviewed included Panic Disorder, Obsessive Compulsive Disorder, Post-Traumatic Stress Disorder and Generalised Anxiety Disorder.

Research suggests most women who experience OCD in the postpartum report at least one symptom related to the infant most commonly fear of accidental or deliberate harm, although obsessive thoughts of infant harm are not unique to OCD and have been reported in up to 40% of women with postpartum depression (see earlier discussion re defining differences between PPD and MDD). What differentiates these ego-dystonic thoughts from thoughts of infanticide associated with postpartum psychosis and even severe PPD is these women have insight the symptoms are unreasonable and report them as unwanted and distressing. Reports also suggest 34% - 65% of volunteer community samples experience obsessional thoughts of infant harm pointing to this being a reasonably normal feature of new parenthood (Ross & McLean, 2006).

## *Outcomes*

Elevated levels of anxiety postpartum has been linked with a number of adverse outcomes for both the mother and the infant, including diminished feelings of efficacy in the parenting role (Barnett & Parker, 1986; Gondoli, 1997 ; Porter & Hsu, 2003), reduction of coping capability, and decreased maternal reactivity/sensitivity, especially among mothers of infants with high negative emotionality (Mertesacker, Bade, Haverkock, & Pauli-Pott, 2004). In one report, mothers with high postpartum anxiety had more psychosocial pathology and their children showed more signs of maladaptation 5 years later than low-anxiety mothers (Barnett & Parker, 1986). In addition, high maternal anxiety during the first few days after delivery has been associated with later postpartum depression, suggesting the possibility that it may predispose to adverse late outcomes in both the mother and child via this known antecedent (Teissedre & Chabol, 2003).

Anxiety in the postpartum period has been related to compromised development of a secure parent-child attachment relationship (Hart & McMahon, 2006). There is also evidence to suggest emotional, behavioural, and social development in infants is affected by maternal postnatal anxiety, and that these effects persist long after the anxiety has resolved (Austin & Priest, 2005). Britton (2011) examined associations of difficult infant temperament with maternal postpartum anxiety. Difficult temperament included negative affect such as fussiness and crying, as well as frequent and intense negative emotional behaviour withdrawal from novel stimuli, irregular biological functions, intense expressiveness and slow adaptability to change. He concluded while such associations were weak in magnitude they emerged very early in the postpartum and were independent of other factors already established as associated with maternal postpartum mood (although small sample size and self selection bias may have led to underestimations of effect size).

While a number of risk factors have been identified to explain the development of postnatal anxiety there is little in the way of a comprehensive theoretical explanation available. On the one hand given early parenting is characterised by high infant demand and low parental skill based (as parents have had little time to acquire and rehearse new skills) it is arguably quite adaptive for parents to be more vigilant. Hyperarousal results in increased alertness and feelings of anxiety, which may lead to anxiety reducing behaviours such as checking the infant. These behaviours help ensure the survival of the infant and hence are evolutionally productive.

There is also increasing research into the link between a subjective experience of birth trauma and the subsequent development of post-traumatic stress disorder (Ayers & Pickering, 2001; Gamble & Creedy, 2005; Zaers et al., 2008). Birth trauma is an event occurring during the labour and/or delivery process which involves actual or threatened serious injury or death to the mother or infant, resulting in the mother involved experience intense fear, helplessness, loss of control, or horror (Beck, 2004). The prevalence of PTSD related to childbirth is estimated at 1.5% - 6% of traumatic births (Beck, 2004).

According to the Birth Trauma Association (NZ) the development of postnatal PTSD centre around women's perception of their birth experience, particularly their perceptions of control, empowerment and informed consent, as well as the perceived attitude of carers and the women's relationship with care providers. This is supported by research by Cheryl Beck (Beck, 2004) who reported findings that central to the development of childbirth related PTSD was mother's reports of not feeling in control of events or their own behaviour, especially in relation to being subjected to interventions women believed they should not have had. Women who experience birth trauma reported high levels of invasive obstetric interventions which left them feeling violated (Beck, 2004; Beck, 2004). PTSD following childbirth was also related to inadequate pain relief, which may also link back to women's perception of control and their own behaviour. Insensitivity of maternal care providers including aggressive management of birth process, failure to understand the emotional process of giving birth, failing to respect dignity and privacy and the general attitude of staff involved in the delivery process were all linked to PTSD following childbirth (Beck, 2004; Beck, 2004; Czarnocka, 2000). As can be seen these symptoms are strongly related to the actual birth experience, as opposed to events following birth.

Following the development of PTSD, women report a variety of symptoms which impact negatively on their lives and the lives of their infants. Noted symptoms include increased hyper-vigilance, postnatal isolation, a sense of loss, fear of sex or childbirth (secondary tokophobia), avoidance of other medical procedures (especially smear testing), problems with bonding, and parenting (Beck, 2004; Beck, 2004; Czarnocka & Slade, 2000; Ross & McLean, 2006). There also appears to be a link with development of depression, alcohol, or other drug dependence abuse.

## **THEORIES OF ANXIETY**

### *Crisis Theory*

Given the dramatic nature of change associated with the transition to parenting, when thinking about causes of postnatal anxiety it seems logical to consider psychological research that has previously examined the impact of profound change in other populations. Of interest is the crisis theory first outlined in the 1960's (Caplan, 1961, 1964). According to crisis theory, the onset of an overwhelming or traumatic event causes a shift in how an individual perceives either themselves or their relationships with others which then triggers a person to move through crisis steps (Caplan, 1961, 1964; Hoff, 1989). At Stage One, individuals experience increased anxiety in response to the event and familiar coping strategies are evoked to resolve elevated anxiety levels. If the usual coping mechanisms prove efficacious there is no crisis. If the coping strategies are unsuccessful however, the individual is pushed to Stage Two, with a further heightening of anxiety in response to the failure of customary methods of problem solving. By Stage Three problems are beginning to seem insurmountable, and individuals are

usually compelled to seek assistance. By Stage Four, a person is in full crisis, their usual coping is insufficient and available support systems are inadequate.

The triggering event is not necessarily negative but demands development of, and adaptation to, new coping and or roles. Thus homeostatic balance for that individual is disturbed causing a vulnerable state. Along with increased autonomic arousal, changes in cognitive functioning occur including shortened attention span, attribution bias, rumination, along with increased emotionality; anguish, anxiety, and apprehension which act together to create intolerable levels of distress for individuals. They become increasingly focused on seeking resolution, often attempting increasingly maladaptive or irrational solutions. In addition; relationships can suffer as the individual begins to assess others in light of their potential ability to solve the crisis. In essence the individual is experiencing acute disruption to their physiological and psychological homeostasis.

There are three different types of crises outlined in the crisis theory literature, and the type of particular interest to this thesis is maturational crisis. Maturational or developmental crisis, can occur during any transitional phases in normal growth and development such as starting school, puberty, or leaving home (Caplan, 1961, 1964). The basic premise is that the psychological equilibrium of an individual is challenged or disturbed and the individual can experience a number of negative states until equilibrium is restored. These states might include low mood, confusion, frustration but it would seem that loss has a role to play as well. At the core of the crisis, or perhaps more accurately of at the core of crisis resolution, is the ability to formulate and function within a new role, making the changes necessary for successful transition into that role.

Theorists are clear in their argument that it is not the situation or event itself that forms a crisis, it is how the event is perceived and responded to by the individual (Caplan, 1961, 1964; Tilden, 1980). So, although clearly there needs to be a triggering event, two other factors are necessary to the onset of a crisis state. The individual has to *perceive* the event will cause considerable disruption and/or distress, and their previously established coping mechanisms must fail to resolve the disruption. With this in mind it is easy to imagine why this may be applicable to women with infants particularly those making the transition to parenthood with their first child. Women need to successfully navigate the move from the known to the unknown reality, restructuring their goals, behaviours, cognitions and sense of self whilst simultaneously adjusting to profound physical changes, realignment of relationships and roles, and the movement from family of origin to family of procreation.

### *Acceptance and Commitment Therapy (ACT)*

To paraphrase the First Noble Truth of Buddhism, 'life is suffering'. ACT theorists too, argue certain levels of suffering are normal, what is often referred to as the 'assumption of destructive normality' (Ciarrochi, Robb, & Godsell, 2005; Fletcher & Hayes, 2005; Harris, 2009). From an ACT perspective anxiety is caused primarily by our unwillingness to have anxiety. It is

argued humans unique ability with language allows individuals to languish in their thoughts and, using fusion, avoidance, evaluation and reason giving (F.E.A.R.) react to those thoughts. According to ACT theorists there is seldom an attempt made to distinguish between having a thought (I am a bad mother) and believing the thought. In other words *I have the thought therefore it must be true*. This process of cognitive fusion, or 'buying into the thought', is believed to cause torment and suffering in individuals beyond the impact of any actual event (Hayes et al., 2006). Thus our ability to compare, evaluate, and categorise is, in some ways, both our greatest strength and our biggest burden.

While certain levels of anxiety are helpful in that they alert us to potential threats, anxiety does not distinguish between actual 'threat' and potential threat (Harris, 2009; Hayes et al., 2006). In fact anxiety is often triggered by the possibility that anxiety might be possible. As such, ACT theorists argue individuals engage in experiential avoidance (Blackledge & Hayes, 2001), and the ensuing rigorous monitoring of their environment results, in turn, in greater anxiety. Hence the ACT adage which states the problem is not the problem, the solution is the problem (Eifert & Forsyth, 2005).

### *Cognitive Behavioural*

While Seligman argued depression resulted from an individual's appraisal of their situation as uncontrollable, Chorpita and Barlow (1998), further hypothesize anxiety arises when the controllability of a situation is ambiguous. This is because individuals with anxiety disorders are characterised by cognitive biases towards threat. These individuals tend to be hypervigilant about danger in the environment and show a tendency to err on the side of caution and interpret ambiguous situations as threatening. This 'appraisal approach' is demonstrated in several models of anxiety. For instance Clark (1986) refers to catastrophic misinterpretation of bodily sensations resulting in panic attacks. According to this model individuals notice normal bodily sensations (heart palpitations) and misinterpret them as a health threat (heart attack). Through a cycle of noticing, misinterpreting and autonomic responding to cognitions, individuals work themselves up into a full blown panic attack with little apparent external input (Clark, 1986). Similarly it is argued socially anxious individuals focus on their own discomfort and anxiety symptoms during social encounters (Clark & Wells, 1995 ). This causes them to miss important social cues, impacting on their social performance which in turn compounds future social anxiety.

These models suggest distorted cognitive processes mean individuals over estimate environmental threat. At the same time there appears to be a tendency for anxious individuals to underestimate their coping and or control of the situation (heightened helplessness) (Clark & Beck, 2010). This is supported by other research which has found loss of control, believed to be associated with depression, is also strongly linked to anxiety (Chorpita & Barlow, 1998).

Alternatively, other cognitive theorists argue the distortion is in memory processes. They state information related to the perceived threat dominates to such an extent information unrelated simply becomes inaccessible.

Thinking of these models in terms of the transition to parenting it is possible to hypothesize how they might explain anxiety related to childbirth. Mothers are reportedly often overwhelmed by the responsibility of caring for their new infant (Lewis & Nicholson, 1998; Nicholson, 1999, 2003; Oakley, 1986). Women who underestimate their ability to cope may experience increasing levels of helplessness in the face of adversity. As such they begin to focus on information which confirms their biases and information which is disconfirming is increasingly inaccessible.

It is also understandable how some new mothers may overestimate the threat posed to their new infant by the outside world. Women can become increasingly isolated for fear of their baby 'catching' an illness to the extent daily functioning is impaired. Indeed 'mollycoddled, cotton wool styles of parenting' seem to be getting increased attention in the media.

Behaviours predictive of anxiety, such as agitation, restlessness, and distractibility, as well as increased autonomic responding; muscle tension and hypersensitivity have consistently been linked to diminished predictability and control.

### *Summary*

Anxiety is increasingly being recognised as a leading cause of psychological distress related to childbirth. Estimates of antenatal anxiety suggest up to 2/3 of mothers experience anxiety in the lead up to birth. The exact mechanisms responsible for the anxiety have not been defined but there is growing evidence pointing to different triggers throughout the gestational stages. However attempts to increase our understanding of gestational anxiety are hampered by several methodological issues including poor construct definition and the availability of rigorous psychometrics for use with this population.

Anxiety in the postpartum period is also relatively common and has been linked to a number of adverse outcomes for mothers including diminished feelings of efficacy, reduced coping, increase psychosocial pathology and increased risk of postnatal depression. Postpartum anxiety is also associated with some undesirable outcomes for the infant. These include increased rates of attachment issues, difficult temperament, lower levels of resilience and intense negative emotional behaviour. Estimates of prevalence range from 10%-40% for women who experience postpartum anxiety at a level high enough to cause disruption to daily functioning. Despite the high rates of both antenatal and postnatal anxiety, little is known about the stability of anxiety symptoms across the perinatal period.

While there are several competing theories of anxiety, they tend to agree on the strong cognitive component. Crisis theory argues it is the perception of threat and available coping which leads to anxiety. This is similar to cognitive theorists who maintain anxiety stems from an overestimation of threat compounded by an underestimation of available resources to

manage the threat. Finally, more recently ACT theorists have applied a slightly different understanding to how cognitions create anxiety, arguing it is our tendency to believe our thoughts without critical evaluation which led us to think threat exists where it does not.

## **Stress**

As previously mentioned there are potentially large numbers of first time mothers who experience impairment or difficulties across the transition to motherhood, but whom don't fit the clinical criteria for either depression or an anxiety based disorder. Similarly there is substantial research evidence to support the notion new parenthood is a potentially stressful time for new mothers; with the relentless demands of a new infant following the physical demands of pregnancy and childbirth (Cutrona, 1984; Figueiredo et al., 2008; Terry, 1991; Terry et al., 1996).

Lovibond and Lovibond (1995a) define stress as a distinct negative emotional state, involving chronic arousal and impaired functioning. Given the chronic nature of the arousal, there can be significant long term effects of stress including reduced immune capacity and increased risk of developing a heightened sensitivity to later depression (Choenarom, Williams, & Hagerty, 2005; Tafet, Toister-Achituv, & Shinitkzy, 2001). Thus stress, like anxiety, has both physiological and psychological manifestations.

The biological response to stress involves the activation of the sympathetic nervous systems which releases a number of chemicals including cortisol in an effort to prepare our bodies to respond (Cicchetti & Walker, 2001). In addition to the nervous system response, particular brain circuits are activated, most commonly those associated with the fight/flight response such as the limbic system including the amygdala, hippocampus and the limbic cortex (Cicchetti & Walker, 2001).

The psychological response can range from the adaptive to the maladaptive, but it is the maladaptive responding which we will focus on here. Lazarus and Folkman (1984) proposed it was the interface between the individual and the event which created stress; not so much the objective nature of the event but the individual appraisal of it. Their aptly named Transactional Model argues perception has a key role to play in the experience of stress (Lazarus & Folkman, 1984). If the individual, through primary appraisal, assesses the situation as threatening, they then must undertake a secondary appraisal and evaluate their coping repertoire. But their first appraisal, the appraisal of demand from the internal or external environment, was affected by an individual's depth of feeling about the event, their beliefs about the event and the perceptions of control relating to the event (Lazarus & Folkman, 1984). Thus like anxiety, stress has a core evaluative process which informs what the impact of the mood state on any one individual might be.

Taken together this would suggest there is a need to consider stress independent of either anxiety or depression in first time mothers. This being said it is important health

professionals involved in follow up care with these new mothers navigate cautiously a path between over-pathologising normal stress responses and under-recognising the potential impact of this normal stress response if allowed to continue unabated.

Given the need to consider stress as well as anxiety and depression in the postpartum the traditional focus on postnatal depression is somewhat problematic, and suggests a need to broaden our understanding of postpartum experiences for women. For instance, Miller et al (2006) reported 30% of women making the transition to motherhood experience some level of distress. In their research, 325 primiparous women completed the DASS-21 and the EPDS. They found 94 (28.9%) women meet the criteria for distress as measured by the DASS-21. Of those, 38 women were depressed, 23 were anxious depressed, 13 were anxious, while 15 scored above the recommended cut off on the stress scale (Miller et al., 2006). This study gives some support for the idea of assessing for stress as a distinct entity and also supports the notion of the use of the broader definition of postnatal distress.

Other studies also support this broader definition arguing the transition to parenthood is a major life event and ignoring stress and anxiety to focus on depressive symptoms fails to meet the needs of new mothers (Austin, 2003; Austin & Priest, 2005; Barclay & Lloyd, 1996; Beck, 2004; Beck & Driscoll, 2006; Britton, 2005; Faisal-Cury & Menezes, 2007; Miller, 2007). In short, given Lazarus & Folkman's determination that emotion and stress are extricably linked, and the large emotional burden of new parenthood, we should not find it unreasonable new parents are stressed.

## **Conclusion**

After considering the sum of the research, one can conclude there is ample evidence to support a three way model of postnatal distress; that is depression, anxiety, and stress. What this means is that developing a holistic understanding of the experiences of women who are making the transition to parenthood, relies on the willingness of clinicians and other health professionals to look beyond depressive symptoms, and explore with their clients other mood states. This is particularly important if hints of prevalence rates are indeed accurate. Certainly there is research evidence that anxiety and stress may outweigh depression when it comes to sheer numbers, but there is also mounting research to back claims the impact of these mood states is, like depression, both far reaching and detrimental.

Given what we know about unpredictability and uncontrollability and couple that with our knowledge of the physical effects of sleep deprivation following child birth and labour, the resilience of women who don't become anxious or distressed is indeed laudable. However for those women who experience negative mood states following childbirth this three-way model of postnatal distress is argued to provide new understanding and a starting point from which to move forward.

## **Chapter Three: Psychological Factors leading to Postnatal Distress**

The previous chapter highlighted findings that there are potentially large numbers of women experiencing impairment and clinically significant levels of distress, as well as the increasing amount of anecdotal evidence of even higher levels of sub clinical suffering. Multiple pathways to postnatal distress have been considered including biological, social, and psychological. While consideration of a number of psychosocial variables have resulted in inconclusive findings in relation to their contribution to antenatal and postnatal distress, perhaps what needs to be considered is not so much the variable but more an individual's expectation in relation to that variable. Take infant temperament for instance. Research on the impact of infant temperament has been mixed, and efforts to explain the disparity in the research findings have also been mixed. Perhaps then the missing link is not infant temperament or more research on infant temperament, but perhaps rather the disparity could be explain in terms of expectations of infant temperament.

Expectations, not only infant expectations, but also expectations of self, of partners and of the experience of parenting might then have a role to play in the functioning of parenting and the experience of distress in the parenting role.

### **Expectations**

#### **PARENTING AND PARTNER EXPECTATIONS: HE SAID SHE SAID**

Research on parenting and the transition to parenthood has a number of things to say about expectations and the impact of those expectations on parenting satisfaction and efficacy. While the research is neither new nor novel, it is highly contradictory. The transition to parenthood was viewed in early research as a time of crisis for the family (tying in with the crisis theory discussion of the previous chapter), and was examined from the perspective of the couple relationship (Belsky, 1985; Belsky, Lang, & Rovine, 1985; LeMasters, 1975; Ruble, Hackel, Fleming, & Stangor, 1988). Studies generally reported couples had highly optimistic expectations of the impact of a new infant on their marriage and, where those expectations were unfulfilled, both partners reported decreased marital satisfaction (Belsky, 1985; Belsky et al., 1985; Delmore-Ko, Pancer, Hunsberger, & Pratt, 2000; Hackel & Ruble, 1992). This seemed to be the case regardless of whether the experiences were more negative or less positive than expected.

For women, experienced spousal support and assistance is consistently reported as lower than anticipated pre-birth, and it is in this area they report the greatest violation of their prenatal expectations (Belsky, 1985; Kalmuss, Davidson, & Cushman, 1992). Women tend to indicate they are frustrated and disappointed in the disproportional effect the infant has over

their lives in comparison to their partners. For example they bore the brunt of the caregiver burden; were more likely to be physically depleted after the dual events of pregnancy and childbirth, have ongoing physical demands through breastfeeding and frequent awakenings (Belsky, 1985; Belsky et al., 1985; Dennis & Ross, 2006; Hackel & Ruble, 1992). This may explain why more women than men report decreases in marital satisfaction due primarily to unmet partner expectations (Belsky, 1985).

However, it is not simply a matter of the women holding unrealistic expectations. For both members of the partnership expectations regarding the division of household labour and childcare are generally unmatched by postnatal behaviour (Delmore-Ko et al., 2000; Hackel & Ruble, 1992; Ruble et al., 1988). In one study over a third of the sample indicated they thought parenting and household tasks would be shared equally, yet following the arrival of the baby women did more and men less, than both parties expected (Hackel & Ruble, 1992; Ruble et al., 1988). While it may be difficult, given the nature of young infant tasks for the caring burden to be equal, what seems clear in these studies is the perception the women held that the division of labour was singularly inequitable as well. What can be concluded then is, not only do couples have unrealistic expectations regarding the impact of a new infant on their marital relationship; they also tended to hold unrealistic expectations over job sharing post baby. So why is it that women report greater declines in satisfaction than do their male partner? A likely explanation is because they have lost more on the deal.

Although these discrepancies were not always large, they were associated with an increase in marital discord across the transition to parenthood. For women this tended to equate to decreases in marital satisfaction accompanied by increases in marital ambivalence and marital conflict. This was similar to the impact the discrepancies had on male partners who also reported greater feelings of marital ambivalence and decreased efforts in working within the relationship (Belsky, 1985; Dennis & Ross, 2006).

Interestingly, there appears to be a link between realistic expectations and educational attainment. In general the prenatal expectations of more highly educated couples match their postnatal experiences in comparison to the less educated members of their cohort group.

From a focus on couples, research shifted to an examination of women's experiences of the transition to motherhood, and the question of why some women experience this transition as relatively smooth, whilst other women report more difficulty. Kalmuss et al. (1992) examined discrepancies between pre-birth expectations and parenting experiences across nine domains; relationship with spouse, extended family, and friends, physical wellbeing, financial wellbeing, maternal competence, maternal satisfaction, care-giving assistance from spouse, and desire to be in paid work. Their research found while discrepancies between parenting experiences and prenatal expectations were not always large, they were significant in seven of the nine domains examined (with maternal satisfaction and relationship with extended family being non-significant). Further analysis of the relationship of expectations and experiences scores supported the hypothesis unmet expectations were negatively correlated to adjustment.

This finding is supported by other research which found women (but not men) with less accurate expectations about parenthood were most likely to have problems adjusting to the parenting role (Delmore-Ko et al., 2000; Kach & McGhee, 1982).

But again there is little explanation as to what might account for these findings. Some studies report a relationship with age, finding age and accuracy of expectations to be positively correlated (Delmore-Ko et al., 2000; Kach & McGhee, 1982). This then leads one to speculate about the earlier report of the connections between educational attainment and expectations. Is it possible this relationship is more a function of age than education, given the two are positively correlated throughout adolescence and early adulthood? How do lower educational attainment, unmet expectations and adjustment fit together? One could postulate several ideas. Firstly, lower educational attainment signals a move away from schooling and into the adult world at a younger age (by adult world it is meant a move away from dependence on family of origin and into employment and the corresponding responsibilities). Decades of research confirm a strong negative relationship between educational attainment and entry into parenthood (Bacon, 1974; Liefbroer & Corijn, 1999; Marini, 1984), meaning less educated women became mothers younger. Could it be a younger age and therefore a corresponding lack of experiences offers women less information and knowledge with which to form their expectations? Alternatively it could suggest younger women have less coping strategies in place than older women, but given other research pointing to discrimination against younger mothers combined with a lack of support and the social isolation reported by this cohort it may simply be they have more to cope with.

Kalmuss et al (1992) argued that it is our evaluations of our experiences rather than the nature of the experiences themselves that influence the adjustment to motherhood. Hence Kalmuss's and colleagues are proposing a similar explanation to Lazarus and Folkman's Transactional Model of stress. Again the event (parenting transition) undergoes a primary appraisal. If the new mother perceives a threat, then she undertakes a secondary evaluation – that of assessing her ability to cope with the event. However, not only does the event take on significance based on subjective evaluations, the evaluations themselves are formed, according to Kalmuss et al (1992) based on subjective expectations formed prior to birth.

### **INFANT EXPECTATIONS: BONNY, BOUNCING, AND ...BIDDABLE?**

Earlier research has shown mothers develop a coherent mental representation of their infants during pregnancy and by 37 weeks gestation, prospective mothers can describe their infants personality and their own expectations regarding the physical appearance of the infant (Zeanah, Keener, & Anders, 1986). So we know women can hold detailed, explicit, concrete expectations regarding the physical and psychological attributes of their child even before the infant is born. Not only that but those expectations can then have a far reaching impact on the infant and on the mother/infant dyad. For example Beniot et al (1997) reported women's

descriptions of their infants during pregnancy were associated with security of infant attachment following birth, suggesting prenatal expectations have a role to play in attachment (Benoit, Parker, & Zeanah, 1997). Furthermore, postnatal evaluations of infant temperament were reported to also be predictive of later attachment.

Another study by Pearce and Ayers (1986) examined the stability of women's perceptions of their infant across the perinatal period and the impact of women's postnatal evaluations and prenatal expectations on the dyadic bond. The authors concluded there were significant differences between expectations and evaluations with infants being less fussy and difficult, but duller and more adaptable than anticipated (Pearce & Ayers, 2005). Thus as a whole, the women in this study had infants whose characteristics exceeded their maternal expectations.

What seems to be missing from research in this area is an indication of the strength of the women's investment in their expectations. It is possible the women, while expressing clear expectations of an event or individual, also feel somewhat ambivalent about the actual outcome of those expectations. If a mother expected the child to have dark hair like the father and the infant has fair hair like the mother how much impact are those unmet expectations likely to have? This raises the question is it the expectations themselves or another variable which explains difficulties with the transition? For example is it the expectations or a lack of other available schemata's for what an infant might possibly be?

Other research suggests women who hold firmly entrenched beliefs about their infants pre-birth have more difficulty adjusting to parenthood than women who hold less strongly to particular beliefs or expectations, irrespective of whether those expectations are negative or positive (Harwood, 2004; Harwood et al., 2007; Kalmuss et al., 1992; Knight & Thirkettle, 1987; Nelson, 2003). In the Harwood research, women who were highly invested in ensuring the postnatal outcome was consistent with their prenatal expectations reported increased dissatisfaction with both the parenting role and with their infant (Harwood, 2004; Harwood et al., 2007). In other words, women who expected dark hair and were highly invested in the child having dark hair were more likely to experience difficulties with adjustment and bonding than women who expected dark hair but really did not mind either way. At a more substantive level, this means women who expected settled babies and who are strongly committed to that expectation are going to find any violation of that expectation more challenging than those who's expectations allow some room for deviation. It is this rigidity in thinking which creates difficulties with the perception of a violation of infant expectation rather than the alternative infant behaviour per se.

This might be explained in terms of attribution bias. The theory of attribution bias would suggest women with infants who failed to meet their expectations would be more likely to attribute those failures to the infant, as opposed to anything they may have done as parents (Block & Funder, 1986) Thus they would experience less satisfaction with their infant. Supporting this idea is research suggesting attribution bias is increased when individuals are

interacting with the person they are observing, in this case the infant. This makes sense as a self-defence mechanism as to attribute unmet expectations to themselves rather than the environment or situation of which they have a role in, could potentially threaten self concept.

There is ample support for the idea unrealistic expectations can heighten vulnerability to disappointment and distress in the postpartum period. Studies examining first-time mothers have consistently pointed to the link between realistic expectations and positive adjustment (Coleman et al., 1999; Delmore-Ko et al., 2000; Glass, 1983; Harwood, 2004; Harwood et al., 2007; Kalmuss et al., 1992; Knight & Thirkettle, 1987; Nelson, 2003). For example Glass (1983) researched a sample of first-time mothers from late pregnancy to early postpartum and examined differences between mothers defined as having high emotional investment in their relationships with their infants, and mothers whose relationships were characterised as having low emotional investment. The study found the essential difference between the two groups of mothers was the level of preparedness for the negative aspects of child-caring. Women who were more adequately prepared for the negative aspects of mothering, and indicated they had expected to have times when parenting was difficult, showed higher levels of emotional investment, were better able to cope with difficult times, and showed higher levels of appreciation for the more positive aspects of infant care.

There also seems to be some support in the reverse direction. Research examining women who do not experience distress found these women tended to have expectations and experiences which were compatible. Mauthner (1999) concludes in her research one reason mothers who do not become depressed might be that they do not experience a conflict between their expectations and their experiences of motherhood, either because their expectations are not high or 'unrealistic' to begin with, or because their experiences are largely positive ones. She contends it is possible mothers who do not become depressed find it easier to modify or let go of their standards; a trait which likely depends both on their ability to accept their feelings and on the accessibility of responsive and non-judgemental interpersonal professional and cultural contexts in which to discuss these feelings (Mauthner, 1999).

### **PHYSICAL EXPECTATIONS: RECLAIMING THE NON-PREGNANT BODY**

The discussion so far has indicated that women hold strong expectations of a number of the processes related to the perinatal period. This includes expectations in relation to their body. And, just as a number of expectations around support and marital satisfaction may be unrealistic, so too may some of the expectations women hold in regards to their physical recovery following child birth. Pregnancy brings with it dramatic changes in body size, shape, and function. Women's bodies, particularly in the final stages of pregnancy deviate substantially from Western societies portrayal of the ideal body, yet women in these cultures often report high levels of satisfaction with their pregnancy shape (Clark, Skouteris, Wertheim, Paxton, & Milgrom, 2009; Skouteris, 2005).

One possible explanation for this high body satisfaction is research showing women tended to use positive adaptive schemas when considering their changing figures; often perceiving an increased functionality in their bodies. Thus weight gain was often deemed representative of the important role the bodies were performing. However other research suggests, rather than being 'happy' with their new body shape, women are more likely to experience feelings of resignation and tolerance towards what they perceive as *temporary* changes to their bodies (Earle, 2003). The temporary nature of the increase in body size is heavily emphasised in literature examining women's experiences of their pregnancy body and these women are often portrayed as clear their weight gain is *all baby* (Earle, 2003, p. 249). Hence, whilst women express feelings of justification and thoughts of acceptance around their weight gain, this is clearly linked to the pregnancy and these protective schemas cease to have a valid role in the postpartum period.

Certainly, it would appear women experience higher levels of body dissatisfaction postpartum than during pregnancy (Jordan, Capdevila, & Johnson, 2005). There seems to be a common expectation bodies will 'return to normal' shortly after the birth of a child. For some women this may indeed be the case, but by and large for most women some changes are permanent such as stretch marks (although these may fade) changes in nipple colour, spider veins, and changes to the firmness of breast tissue. In addition, few women return to their pre-pregnancy weight with the average weight differences being 2.5kgs nine months postpartum (Gjerdingen et al., 2009). Women who were not prepared for these more permanent body changes may express increased dissatisfaction with their mothering role.

#### **MECHANISMS OF EXPECTATIONS: HOW WE KNOW WHAT WE KNOW**

In all, research is strongly suggesting disappointed expectations resulting from unrealistically high expectations of parenting generally have a negative impact on women's transition to mothering. However, despite this firm stance, there is little to explain what mechanisms are involved in the processes. Yet whilst no mechanism has been offered to explain this link it is possible to hypothesise a number of plausible explanations. It may be for instance, that disappointed expectations led to some cognitive dissonance. Alternatively, feelings of hopelessness or helplessness may also have a role to play.

One possible contributing factor to high expectancy is the psychology concept of optimism - expecting desired outcomes will occur and aversive outcomes will not occur has been linked extensively with positive moods states, adaptive behaviour, and decreased negative affected (Morris, 2007). Dispositional optimism is argued to promote positive strategies aimed at eliminating, reducing, or managing stressors and to decrease avoidance coping strategies which seek to ignore, withdraw, or avoid stressors (Nes & Segerstrom, 2006). This is in contrast to negative expectations which have been linked to depressed mood, decreased adaptability and increased stress. Thus it is argued that optimism through its increased

adaptability and positive mood assists with positive role adjustment in the transition to motherhood.

Equally though, there is a significant body of literature that argues depressed mood is linked with more realistic appraisal of specific life events (Hagen, 1999; Hendrie & Pickles, 2009). From this perspective, women who have some negative expectations of mothering, or who hold beliefs that the transition to motherhood may contain obstacles, may indeed be better served by those cognitions. Given that the transition to motherhood will most definitely involve difficulties of some kind, it is easy to see women who expect such difficulties are potentially more prepared to deal with them than women who don't hold such views.

Expectations may also be able to be understood in terms of schema theory. According to schema theory, all knowledge is organised into units or clusters of information which we draw on to make sense of the world. Thus, women will hold both self schema's and role schema's regarding what motherhood and mothering should and will mean for them. Schema theory would argue we are more likely to notice things which fit with our schema due to accessibility – how easily the schemata come to mind. Furthermore, when such schemas are triggered, additional information which is linked to the schema by association is also activated.

Thus women develop role schemas around mothering which lead to certain expectations. Schemas may include cognitions such as mothers are gentle, mothers bond instantly with their babies, mothers are naturally nurturing. Then, through the process of accessibility women are more likely to process information which supports their schemas and disregard information which contradicts them, or to view such occurrences as unique exceptions. As a result when viewing other mothers they are more likely to notice them being gentle and nurturing. When they themselves have experiences which contradict their schemas, for instance when they perceive themselves to be non-gentle or non-nurturing such experiences are outside their schematic representations and threaten their way of perceiving and viewing the world.

Taken en masse there appears to be a consensus in the existing literature linking unmet expectations to negative adjustment. However, there is disparity in what the research has to say regarding the impact of less negative than expected experiences. Whilst Kalmuss et al (1992) concluded experiences which are less negative than expected are associated with an easier transition to parenthood, other research argued predictability is important to individuals, and thus failure to accurately predict outcomes, whether through overly optimistic or pessimistic cognitions, would threaten images of self and impact on the ease of transition (Harwood, 2004). This position seems hard to defend though. For example, presumably individuals have rather pessimistic expectations around winning when buying a lottery ticket. While they may enjoy the 'flutter' and hope to win, arguably they don't *expect* too. Following Harwood's argument individuals who failed to accurately predict the outcome and actually won the lottery would be disappointed and have difficulty adjusting to their new wealth because of the unpredictability of the win.

## **CONCLUSIONS**

The research covered seems to be suggesting new parenthood is a time of high optimism for prospective parents and this can negatively impact on the marital relationship if the expectations are not met. For women the greatest disparity between expectations and experiences tends to be around their partners with new fathers frequently contributing less than both partners expected.

It is reasonable to conclude from the sum of this research that positive transition to motherhood correlates with sufficient preparation for and understanding of the negative aspects of childcare, that is women cope better when they have received information to enable them to adequately evaluate what being a mother may mean for them and have been able to form realistic expectations of the changes they are about to undergo. Thus women whose schemas contain information of both positive and negative aspects of mothering maybe considered to be better prepared than women who do not have such balance to their mothering schemata's.

### **Loss: When expectations go awry**

While investigations of expectations may provide some elucidation of postnatal distress, again there seems to be a missing link as to why some women? It has been established that postnatal distress occurs at different levels for different women and the manifestation of the symptoms for each individual is argued to be influenced by a number of factors, including (as already mentioned) an individual's sense of control, self-efficacy, and experienced disparity between expectations and experiences. So why do some women experience postnatal distress, yet others appear relatively unaffected by the transition to motherhood?

The difference may well be one of loss. That is, the subjective experience of loss of established behavioural patterns or beliefs about self and others throughout the processes of pregnancy, childbirth, and parenting. Firstly, although pregnancy represents some amazing gains the pregnancy itself is dominated by bodily experiences outside the control of woman. Nausea, weight gain, fetal movement, body changes, and birth can, for some women, be experienced as a series of losses. And it is not difficult to understand why. In addition to the loss of control over bodily experience, there can also be a loss of body image, loss of sex appeal and/or sexuality and loss of intimacy (Jordan et al., 2005; Rallis, 2007 ). As the pregnancy progresses women can become increasingly demobilised, which can then result in its own set of losses - loss of adult friendship, spontaneity, and loss of energy are the ones most commonly cited in the literature.

Upon giving birth, women are again faced with a new set of losses. Certainly there is a loss of freedom, independence, and previous routines; not to mention loss of possible career trajectory to name but a few. Perhaps though, the most confronting and profound loss is the loss of the known non-mothering self. Women have to relearn themselves in the role of mother.

For new mothers their ways of coping and being in the world have to change and any change occurs in the context of the loss of what was. This means the event of becoming a mother is marked by a number of losses across multiple domains of women's lives. Those losses sit in juxtaposition to the gain of the baby and occur simultaneously with a loss of known self and known coping. So whilst motherhood may involve many aspects women acknowledge as highly positive and, more importantly for most, motherhood involves becoming a mother, it also involves ceding the younger, more carefree behaviours of their pre-mothering days. Rubin (1984) wrote

*"From onset to its destination, childbearing requires an exchange of a known self in a known world for an unknown self in an unknown world" (p. 52).*

For some women this can be profoundly challenging and the sense of loss daunting. Lewis (1998) describes a process of redefinition for the women in her study, as they underwent the transition to parenthood and took on the mother identity. According to Lewis this new identity, by default, required shedding of the old non-mother identity and brought with it a sense of loss (Lewis & Nicholson, 1998).

This concept of loss in the early the postpartum period has been the subject of several informative pieces of research. For instance Beck (1992) identified 11 theme clusters in her exploration of factors leading to PND. Of those two clusters; loss of control and loss of interest in hobbies or goals dealt with direct experiences of loss. However several other theme clusters; guilt, loneliness, and diminished concentration arguably highlighted indirect forms of loss. For instance guilt often had at its core a loss of confidence in one's self and in one's decision making; what the women were effectively saying was *I feel guilty about decisions I make and actions I take as a mother*. It might be the women felt guilty for not being with their child when they made the decision to work or study, or they questioned their decision when feeling guilty about parenting choices they have made. Either way women felt guilty because they believed they had violated a moral code – the code of motherhood. As for the other clusters, the loss associated with loneliness is self-evident; the women have lost contact with others and become isolated in their role as mothers. This can be linked right back to the early introduction of this thesis where the changes in mothering was highlighted.

While Beck's research could reasonably be challenged on the ground of her focus on the experiences of a small number of women there are a number of other such studies which support Beck's findings. One such study is that conducted by Nicholson (1990). In a longitudinal study of British mothers, Nicholson interviewed 24 women across four time points, with the aim of obtaining first-hand accounts from women of their experiences of the latter part of pregnancy and the first six months postpartum (Nicholson, 1990). In total approximately four hours of interview data per participant was collected for investigation. In analysing her data, references to depression were identified and then the surrounding relevant paragraphs were examined to create an understanding of the context in which depression was talked about and

how it was related to the meaning, experience, and the biographical context of the women's life. Through an exploration of the themes of 'the meaning of depression' and the 'context of depression' a subtheme of loss was identified in Nicholson's own words, as seeming to pervade the transcripts (Nicholson, 1999, 2003). Hence this became the focus of her attention.

According to Oakley (1980), motherhood is characterised by loss of identity and a loss of a sense of a separate, autonomous and individual self. Oakley's conceptualisation of PND also looks at the loss of privacy, independence, and the loss of the culturally valued idealised, and romanticised vision of motherhood. This loss of the romanticised vision of motherhood is argued to be critically important and we will focus on it in the next section. However, as far as the overall losses are understood, Oakley concludes maternal difficulties are best understood within a bereavement framework. In contrast, Romito adopted Seligman's (1975) learned helplessness model of depression as her theoretical framework. She argued women are conditioned to be helpless, both at work and in relationships with male partners, and that they lacked control over their lives (Romito, 1990). Romito (1990) concludes women are conditioned to a degree of learned helplessness. In her research she then extends this argument, stating that the learned helplessness women experience is compounded when women discover the gap between their expectations and the reality of motherhood – the medicalisation of childbirth, the unequal division of childhood labour, the burden of care, isolation, and a gendered labour market. She argues that the greater the discrepancy between a women's expectations and the experienced reality, the greater the sense of loss of control and helplessness.

Despite the differences in explanation there are some common grounds in these disparate pieces of research. Firstly, they are both grounded in the words of women. Further, what is really interesting is that the women in this research and in other research like it (Harwood, 2004; Kalmuss et al., 1992; Kearns et al., 1997; Nicholson, 1990; Nicholson, 1999) prefer to explain their experiences in terms of specific circumstance and losses associated with motherhood; isolation, feeling overwhelmed, inability to really talk to anyone, rather than construct them as a clinical problem needing a medical explanation. That is the women do not see their postnatal distress as a medical problem requiring treatment from doctors. They do not think they are sick or diseased or vulnerable to infection. Nor do the women believe there is much wrong with their relationships with their infants. Indeed despite feeling overwhelmed by the presence of the infant almost without exception the women clearly articulate some level of positive affect towards their child. What the women in these studies point to is the losses and social repercussions of childbirth. The difficulties associated with the institution of motherhood rather than problems of mothering.

For these women, and women like them, independent of attachment with, emotional connections too, or relationship with, the new infant, motherhood is characterised by a number of losses that traverse their lives. Compounding those losses is a belief held by many women that voicing less positive attitudes towards motherhood is socially taboo. Kedgley (1996) writes in her history of motherhood in New Zealand that within the Anglo-Saxon culture of white New

Zealand, anything other than unconditional satisfaction in motherhood is considered deviant and is not to be tolerated (Kedgley, 1996). Certainly this 'conspiracy of silence' is mentioned in other research literature as well (Nicholson, 1999, 2003). In their research with women making the transition to motherhood, Lewis and Nicholson (1998) reported:

*"[The] interviews suggested that there are few ways of talking about problematic experiences of motherhood which do not imply that women are poor mothers and deficient women. Women may need to deny the losses they experience in order to present themselves, to themselves and others, as adequate mothers, at the same time as they are aware that they have lost elements of their loves which were important to them." p. 187.*

So considered together we have a scenario whereby new mothers face considerable losses, and are often placed in a position where they are unable to recognise, express, and naturally acknowledge and grieve for these losses due to the socio-cultural and political realities in which they are mother. Considered this way we can begin to develop good insight into the build up of multiple pressures facing new mothers, and one can see why research suggests these factors contribute to feelings of distress (Beck, 1993; Clemmens, Driscoll, & Beck, 2004; Driscoll, 2006; Lewis & Nicholson, 1998; Nicholson, 1999, 2003; Oakley, 1986).

However, at this stage a cautionary note needs to be sounded for although the research has been conducted with populations of women who differ substantially in age and marital status, most samples have investigated the experiences of white, middle-class American women with little research into other cultures or ethnicities (Belsky, 1985; Belsky et al., 1985; Coleman et al., 1999; Delmore-Ko et al., 2000; Kalmuss et al., 1992; Ruble et al., 1988). This leads to obvious concerns about generalisability and indicates the need for caution when extrapolating the findings beyond these populations. In New Zealand, this has clear implications for women identifying as Māori or who may not sit comfortably within the middle class framework.

A second theme of loss which seems to permeate the literature, and which ties in with the rationale of this research, was the disparity women reported their expectations of motherhood and how they subsequently experienced it in reality. Several researchers have highlighted the link between inaccurate pre-parenting expectations and adjustment challenges, and have showed increased interest in investigating the impact of expectations on women and their families, (Belsky, 1985; Coleman et al., 1999; Delmore-Ko et al., 2000; Hackel & Ruble, 1992; Knight & Thirkettle, 1987; Ruble et al., 1988; Tammentie, Paavilainen, Astedt-Kurki, & Tarkka, 2004). Overall these studies conclude early adjustment is strongly related to prenatal expectations. However, there needs to be a link established between findings of a disparity and claims that such a disparity can be, or is, experienced as loss.

Hackel and Ruble (1992) examined the impact of disconfirmed expectations on the marital relationship following the birth of a couple's first child. They concluded women may experience cognitive dissonance as a result of disconfirmed expectations as well as a violation

of role norms, and both states are believed to create tension and conflict. Thus the negative reaction experienced as a result of the disparity between expectations and reality may be twofold as there is both an anticipatory and a normative component (Hackel & Ruble, 1992).

### **Good mothers bake and other mothering myths**

It is not unreasonable for women to have expectations of mothering which are somewhat inaccurate. It is, after all, difficult to have an accurate understanding of an event one has never experienced. Or is it? It could be argued that experience occurs on two levels. One can have a theoretical or intellectual understanding of an event – in an episode of The Big Bang Theory, Sheldon argued he did not need to go in water to learn to swim because he knew *how to* swim – that is he moves his arms and legs in a prescribed way and 'swims'. He however did not have a mechanical or experiential understanding of swimming – he had never actual swum. The same could be said for many of our experiences – any number of books might give you an understanding of the *how to* of sexual intercourse, but again the actual experience of it is perhaps far more confronting than any book can prepare you for.

In this instance though, the intellectual understanding has some bases of accuracy. Yes moving your arms and legs in a prescribed way will accomplish swimming. It might require tweaking of techniques and there's nothing in that explanation about breathing, but basically, swimming of some form will occur. So if our intellectual understanding of some things can act, at the very least, as a basic approximation of actual experience, why is it that a woman's intellectual understanding of mothering is often not?

The answer has to do with the portrayal of motherhood women are exposed to. That is the books they read, the images they see, and the stories they hear. While information on swimming accurately reflects the experience of swimming, information on mothering does not necessarily accurately reflect the experience of mothering. A search on the internet for information on mothers hit on a webpage of mothering quotes

<http://www.quotegarden.com/mothers.html> . Examples included:

*Being a full-time mother is one of the highest salaried jobs in my field, since the payment is pure love. ~Mildred B. Vermont*

*A mother is a person who seeing there are only four pieces of pie for five people, promptly announces she never did care for pie. ~Tenneva Jordan*

*Any mother could perform the jobs of several air traffic controllers with ease.~Lisa Alther*

*Now, as always, the most automated appliance in a household is the mother.~Beverly Jones*

And finally

*Mother's love is peace. It need not be acquired, it need not be deserved. ~Erich Fromm*

So what we can take from this are that mother's are selfless, multi-talented, superwomen, who adjudicate (serenely), while going hungry after dishing out undeserved peace? (The hungry bit is possibly because, being unpaid (except in love), they can't afford a bigger pie!).

Nicholson (1998) argued there is a conspiracy of silence around motherhood. She writes:

*"The romanticised and idealised woman, full of love, forgiveness and selflessness, does not and cannot exist so that all mothers are destined to disappoint their children and themselves" (p. 8-9)*

What she and other researchers claim is that women cannot form a basic approximation of the 'how to' of mothering because they are only ever exposed to the sanitised and mythical version of it (Fry, 2001 ). They argue the image of mothers espoused in our media, our institutions, our policies, and our societies are completely unlike any realistic portrayal of the experience of mothering, and for women caught up in these myths failure to achieve that imaginary status in motherhood is frequently experienced as a failure (Kedgley, 1996; Nicholson, 1999, 2003). There is an argument to be made then, that holding a highly idealised image of mothering is a strong precursor to adjustment difficulties. For instance Breen (1975) in a study on adjustment writes:

*"the most striking feature amongst the women who experienced the most difficulties, was the split between a very idealised picture of what they felt a mother should be like... and the way in which they saw themselves after the birth of the baby" (Breen 1975, cited in Mauthner 1998).*

The mothering myth goes right to the core of motherhood and begins with the myth all women desire motherhood. According to research the myth of maternal drives can be understood in three stages (Apter, 1993). In stage one there is a myth all women experience a biological drive towards conceiving and bearing children. This is followed in stage two by a need to nurture those children. The final stage of the myth of maternal drives is that of stage three which claims the skills and capacities required to care for infants/children emerge or evolve immediately after birth without the need for training.

Yet although women are told motherhood is a natural and normal thing there is evidence to suggest otherwise. Johnson and Swanson (2003), argued rather than being biologically determined, motherhood is a social and historical construction. They examined the portrayal of mothers in women's magazines and other media; both those working in paid employment and those working in the home, looking for sources of cultural myths and ideologies that define contemporary motherhood. According to their research there is a dominant ideology regarding both types of mothers, and it would seem to be a lose/lose

situation. Mothers in paid employment are tired, busy and guilty; have difficulty meeting children's basic need and put their family relationships at risk. A controversial example of such a stance is the book *Parenting by Proxy: Don't have them if you won't raise them* (Schlessinger, 2000). The book argues working mothers neglect their children through their absence (ironically Schlessinger herself was a working mother who had a nationally syndicated talk show, wrote books, and hosted a failed day time talk show at the time this book was written). Schlessinger concluded parenting should be limited to traditional families of two parents, one of whom stays home with the children. Divorced or single people, homosexuals, and couples who both work should not have children, and indeed did not deserve children.

Which would seem to suggest good mothers are stay-at-home mothers, yet ironically, it would seem stay-at-home mothers fair little better in the media, being portrayed as unnaturally attached to their children to the point of over-involvement, being controlling and enmeshed, and being inflicted with 'mummy mush brain' (see <http://www.ivillage.com/stay-home-mom-frustrated-media/6-n-138353> and <http://thestayathomemother.com/node/19> as some examples of stay at home mother's experiences). So if stay-at-home mothers aren't great and working mothers are not any better, how then should mothering be done, and who gets to decide?

Clear ideals about who makes a good mother are highlighted in a number of media (Hadfield, Rudo, & Sanderson-Mann, 2007; Johnson & Swanson, 2003 ). In a recent examination of media portrayals of mothers in Britain, Hadfield et al (2007) found 'good' mothers were heterosexual, selfless, fertile, middle class, and aged between 25 -35 years old. This is supported by research by Shaw and Giles (2007) who claim older mothers are often portrayed as selfish for delaying conception and constructed as violating the 'natural' order (Shaw & Giles, 2009). Conversely younger mothers, in particular teen mothers, had 'accidents' and were seen as being at risk of social exclusion as were their offspring (Hadfield et al., 2007). Teenage mothering is viewed as a 'social problem', with young mothers acting as a financial drain on society, and teen pregnancy is treated as a disease (Breheny & Stephens, 2010). This perspective is highlighted in an article on mothering ideologies which argues:

*"We live in an era of contested motherhood ideologies. However culturally and historically aberrant and individually restrictive the dominant motherhood ideology of the last century may have been, motherhood expectations were clearly defined. The traditional mother ideology defined a "good mother" as full-time, at-home, White, middle-class, and entirely fulfilled through domestic aspirations. Scholars have challenged the patriarchal assumptions of the traditional motherhood ideology as restricting mothers' identities and selfhood, perpetuating the economic dependence of mothers, and excluding mothers who are adolescents, older, single, lesbian, or Women of Colour" (Johnston & Swanson, 2006 p. 509).*

In addition to clear ideals about who fits the criteria of the mother best, there are also clear messages given to women about what they can expect when they themselves become mothers. Mothering is portrayed as blissful in many contexts, but there appears to be a counter-revolution working in the wings to debunk the myths. According to those on the 'other'

side, there are number of commonly perpetuated myths surrounding motherhood. Things like 'good mothers always like their children' and 'good mothers bond with their children immediately'. The superwomen myth AKA 'a good mother balances it all' is perhaps one of the most powerful and destructive myths which affects mothers simply because it is unobtainable.

As a final point motherhood as an institution includes tremendous responsibilities with limited power (Nicholson, 1998). In others words while women bear the burden of mothering responsibilities, this burden is seldom accompanied by the right to choose how they mother or whether they mother at all (Nicholson, 1998). Yet women receive implicit and overt messages from a very early age telling them this is where they should pitch their expectations; this is what will be the defining moment for them as women. When women encounter the lack of status associated with motherhood it is a marked deviation from the idealised image.

### **Conclusion**

In all then, there a number of psychological factors argued to contribute to the development and/or maintenance of postnatal distress. Firstly, women hold a number of expectations as they cross the threshold from mother to non-mother, and not all of those expectations are fulfilled. Thus there is often a disparity between expectations and reality. This disparity between expectations and reality is not always problematic; however some women may experience a sense of distress as a result. The difference between women who experience the disparity as distressing and those who don't is argued to be one of loss. That is, if the disparity between expectations and reality is experienced as a loss, this loss can lead to feelings of distress and despair. Thus loss and the disparities between 'mythical' mothering and 'modern' mothering are argued in this study to be of central importance to the development and maintenance of postnatal distress. It would seem logical then that addressing these issues is seen as paramount to preventing the onset of the disorder and it is hypothesised that lowering women's experiences of loss will decrease their risk of postnatal distress.

## Chapter Four: Study One - Expert Panel Focus Group

### Introduction

When considered together, the literature on postnatal depression, postnatal anxiety, and parenting expectations lead to some tentative hypotheses about the development of postnatal distress following the transition to motherhood. As a whole, the research indicates that while biological predisposition may play a role in the development of major depressive disorders, its role in the development of postnatal depression seems controversial. For instance, hormonal influences have been shown to be inconsistently linked, as has breast-feeding. Furthermore, the science around postnatal anxiety and distress is no more definitive, indicating no clear causal link between a women's biology and her experience of postnatal distress. However, it is being argued in this thesis distress following childbirth is more about the psychosocial variables which accompany the phenomenon of motherhood as opposed the biology of being a mother.

Yet if there is some agreement in the literature indicating social factors are more causative, there is little agreement as to what they might be. And while the role of social support; particularly support from partners is accumulating a substantial evidence base (Beck, 2001; Choenarom et al., 2005; DaCosta, Larouche, Dritsa, & Brender, 2000; Figueiredo et al., 2008; Kearns et al., 1997; Leigh & Milgrom, 2008; Milgrom et al., 2008; O'Hara & Swain, 1996; Scrandis, 2005; Thio & Elliott, 2005; Yonkers et al., 2001), the role of other social phenomena is not well understood. In addition to this there is little in the research which can elucidate the experiences of New Zealand women with much of the research focused in the United Kingdom or the United States.

With so much contradictory information in the literature a decision was made to return to the fundamentals of a women-centred perspective which focuses on the first-hand accounts of women themselves. Nicholson (1986) writes:

*Women-centred refers to a perspective which takes women's accounts as central and does not consider women to be at the mercy of their hormones or in any other way intrinsically pathological. It relies on the assumption that whatever individuals report about their experience should be taken as their interpretation of reality (p. 146).*

A women-centred approach locates the individual as the expert of their own experiences, thus rather than examining the literature in an effort to understand women's transition to motherhood, a women-centred approach would involve going directly to women who had experience the phenomena of motherhood. This then affords the researcher the opportunity to glean an understanding of what it meant to be them, within their social reality, becoming mothers.

This chapter introduces and discusses a study designed to meet this need. A panel of women who were experts in their own experiences of motherhood were invited to participate in a dialogue about their experiences. The focus of the discussion was on the experiences of these women in the transition to motherhood and their perception of factors affecting their ease of that transition.

## **Method**

The approach utilised in this research draws on aspects of Interpretative Phenomenological Analysis (IPA) (Smith, 2004; Smith, Harré, & Van Langenhove, 1995; Smith, Jarman, & Osborn, 1999b). IPA is concerned with how a given individual makes sense of a given phenomenon in a given situation, and draws on both phenomenological psychology and symbolic interactionism for its theoretical roots (Smith, 1996; Smith, 2004; Smith et al., 1995; Smith et al., 1999b). IPA is ideal for research questions which aim to understand what a given experience was like for a given population (Biggerstaff & Thompson, 2008; Brocki & Wearden, 2006; Larkin, Watts, & Clifton, 2006; Smith, 1999; Smith, 2004). Thus IPA was selected because it offered a validated method of gaining meaningful insight into mothers' experiences of mothering. In addition it is argued this data collection method is most suited to research investigating issues of concern to an accessible, circumscribed, and homogenous population as is the case in this research.

However, the nature of a phenomenological approach leads to an interpretative process which is open to critique. The organising of themes is my attempt to making sense of the data, and was affected both by my understandings garnered through the literature review conducted and my own worldview. Thus, there is open acknowledgement that the data set could have been interpreted in other ways. Furthermore, there is a process of what Smith (2004) refers to as double hermeneutics whereby, while participants endeavour to make sense and articulate their experiences of their social and personal worlds I, as the researcher, am trying to make sense of the participants trying to make sense of their personal and social world. These fore-conceptions, or pre-understandings, need to be critically and reflectively evaluated, both before beginning the interpretative process and as a constant task as the process was underway (Smith, 2007).

### **PARTICIPANTS**

In line with the goals of Interpretative Phenomenological Analysis, a small, well-defined sample of five women participated in an expert panel focus group. All were multiparous with children ranging from 13- 19 years. Each identified themselves as a New Zealander of European descent. Three were married, one was in a long-term de-facto relationship with the father of her children and the other was recently divorced. All participants had a minimum of a Bachelors degree, and two had postgraduate qualifications. Four were in professional

occupations and one was a full-time postgraduate student. Participants were recruited through a social email list sent to staff at two large employers in Palmerston North, New Zealand. Pseudonyms were used to protect the identity of the women in this study.

## **PROCEDURE**

Given the aim of the study and the homogeneity of the population of interest, a focus group format was chosen as the technique of investigation. Kruger (1994) argued the focus group technique is a particularly appropriate procedure to use when the goal is to explain how people regard an experience, idea, or event. IPA is generally used in single interview format, however some work with focus groups has established its usefulness and appropriateness with this research technique (Dunne & Quayle, 2001; Flowers, Duncan, & Knussen, 2003). For instance concerns have been raised that in a group situation the focus can be on group dynamics rather than the topic under investigation thus the group can be privilege and eclipse the individual. However the nature of focus groups and the homogenous population from which participants were drawn suggest the dominance of interpersonal dynamics is likely to be minimised (Dunne & Quayle, 2001).

Following ethical approval as part of a larger study, participants were invited to attend a group session held at the School of Psychology, Massey University, Palmerston North (Appendix D: 1). All participants provided informed consent prior to the group discussion (Appendix D: 2). The discussion was facilitated by Anita Darrah and was also recorded and transcribed by her. The duration of the focus group was 105 minutes. All participants received a petrol voucher to recognise their time and contribution to the research.

Consistent with IPA studies, a non-directive, semi-structured discussion guide was used to facilitate discussion amongst participants regarding their experiences of the transition to motherhood, and being a mother in the current context they were in. Topics covered included their feelings about becoming a mother, the impact of relationships and daily functioning, as well as their experience of and satisfaction with their relationships with others including partners, family, friends, colleagues, and professionals involved in the care of the child. For the facilitator emphasis was placed on moderating discussion of both the positive and the negative mothering experiences.

## **ANALYSIS**

Interpretative phenomenological analysis was used to identify key themes in the data generated by the group. The analysis was based on the guideline provided by Smith et al., (1999) in exploring and theorizing shared experiences. This approach methodically involved:

- (1). Initial coding – Spending time analysing each individual transcript whilst keeping in mind the initial priority was the identification of shared themes across the participants accounts.

- (2). Examination of codes on individual transcripts to identify groupings which collected together the codes in meaningful ways.
- (3). Identify themes across transcripts reflecting shared aspects of experience. Generation of broad general categories aimed at inclusivity.
- (4). Re-examination of the transcripts with general categories in mind to produce a new corpus of data from extracts relating to each category.
- (5). Generating codes for the extracts and exploring relationships between emergent themes.
- (6). Translate themes into a narrative account.

## **Results**

### **SUPERORDINATE THEME ONE: LOSS**

#### *Subtheme 1: - Unexpected Chaos – Loss of Control*

##### *Unpredictability*

Unexpected events, emotions, and experiences were a persistent theme throughout the panel group discussion. The participants reported feeling the situations they were in were very volatile and they had a sense of not knowing what was coming next. The women discussed how this made them feel edgy and, at times, overwhelmed by the unpredictability of both others around them, and the situation they were in:

*"Sometimes it was all a bit overwhelming, I didn't know whether I was coming or going or what was around the corner. It's hard to explain but I hated feeling like that, I was like a possum in the headlights, that's what it was." (Jenna)*

Often the unpredicted event occurring in one aspect of their life would have a domino effect and the women reported at times feeling everything was spiralling out of control. For instance an event which disrupted infant sleep meant disrupted mother sleep, which generally undermined normal coping. Once coping was compromised, other problems which arose were experienced as even more unpredicted and uncontrollable. When this occurred, the women reported they felt a loss of control over their environment and those in it, which was highly aversive to them.

However, there were some unpredicted occurrences which were not experienced negatively by the participants in this group. For instance the women referred to particular *moments* which sporadically occurred. These *moments* were special times when something almost spiritual (usually involved their child) would unexpectedly transpire. They were characterised as moments of peace, of achievement and of pride, both of themselves and of their child.

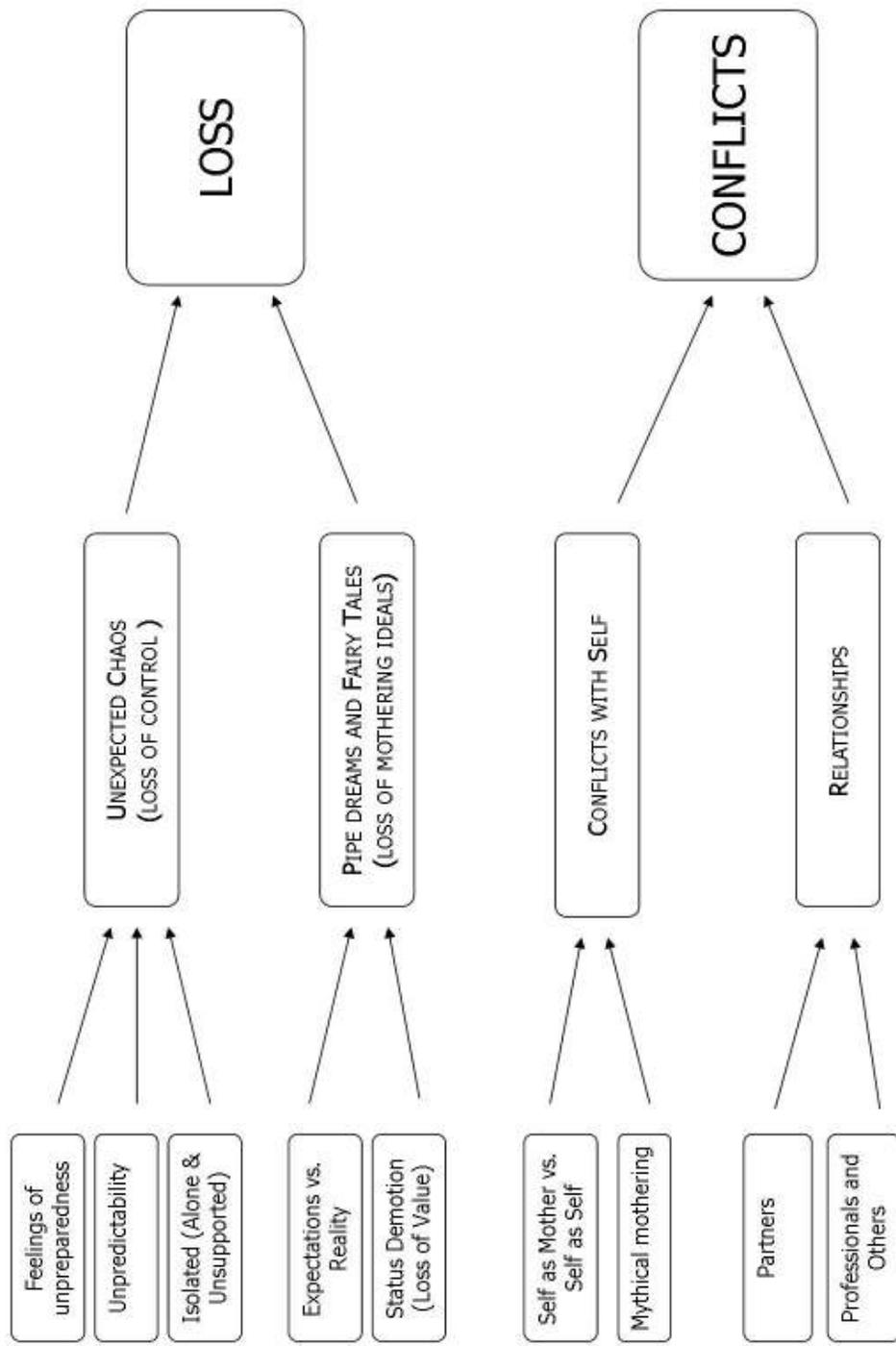


Figure 4.1. Thematic Map of Experiences of the Transition to Motherhood

Despite these times the women predominately experienced the unpredictability as aversive and threatening. The women coped by attempting to exert control over aspects of their lives they experienced as unpredictable, and gradually, as the children aged, and they grew more experienced and confident in their mothering role, the feelings of unpredictability lessen, although had never completely abated.

#### *Feelings of Unpreparedness*

The women participating on the expert panel reported feeling ill-prepared and under resourced when it came to the transition to motherhood. They acknowledged feelings of self-doubt, worry, and fear. For instance they reported feeling unprepared for the impact having children would have on all aspects of their lives. Although they knew intellectually things like their freedom of movement would be curtailed, they were not prepared for other things like the intensity of their emotional bond or their feelings of protectiveness towards their infant.

*"I wasn't prepared to lose so much of me when the kids came along, like it was all consuming, but then again I wasn't prepared to feel some of the things I felt either." (Jo)*

There was also discussion around not being prepared for, what the women termed, *infants with opinions*. Further exploration of this theme revealed the women held a belief the infants would settle relatively quickly into a routine which was to have been established by the mothers. Instead the infants quickly asserted their own personalities and position as *heads of time management*.

When the discussion turned to how they coped with these feelings the women referred to having no choice about whether to cope so just coping.

*"It was just a matter of getting on with it 'cos there was no one else." (Vicki)*

*"You just had to suck it up; my baby was depending on me." (Jo)*

#### *Isolated – Alone and Unsupported*

Unsupported and alone were frequently reported feelings, particularly once the initial thrill of the new arrival wore off for others. As a rule the women in this group considered themselves to be good mothers. They cited involvement in parent centre, playgroup or kindergartens, and later Parent Teacher Associations and sports teams as indication of the high level of interest and involvement they shared in their children's lives. Generally they reported experiencing motherhood as rewarding and life changing. However, they were very clear they considered themselves unsupported by their partners, by their community, and by central government.

Partners were often absent; sometimes working long hours, and sometimes socialising with friends. This in its self was a source of conflict for the women who, at times, resented the

lack of disruption to the fathers' previous routine when the baby was born. For the fathers the Thursday night pub nights still happened, as did Saturday sports and the drinks after the game. However, what was most often reported was not a physical absence from the partners, but an emotional and psychological absence from the fathering role. Although the women seldom discussed this with their partners they strongly indicated they believed their partners should have known more support was needed.

*"When he was there he wasn't much help, he'd play with the kids for half an hour while I cooked tea but that was about it. We'd fight about how being a father was more than just games." (Amy)*

As previously mentioned the women also felt unsupported and isolated by their local community and the central government. For example they perceived a number of government policies to be hostile to families and particularly to stay at home mothers. They cited a lack of paid maternity leave (whilst 12 weeks paid maternity leave was introduced in 2001 this was not available in the early – mid nineties which is the period of interest), lack of child support, access to affordable quality childcare, and the anti-family cultures of government workplaces and training institutions as examples of barriers they encountered, especially when their children were younger.

### *Subtheme 2: Pipe Dreams and Fairy Tales – The loss of idealised mothering*

#### *Expectations versus Reality*

The women grew up with some firm expectations around how their adult life would be. Expectations they believed others had instilled in them from an early age. For instance they expected to get married. They expected to have children (usually two with an older male child and a younger female). And they most certainly expected to find motherhood fulfilling. While universally the women reported a loving and fulfilling relationship with their children, they also reported a number of violated expectations around the experience of actual parenting.

The expectations regarding their infant were often met, and usually exceeded. Granted there were unexpected aspects such as the failure to conform to routine previously mentioned, however, overall, the women expressed delight in their children and in mothering. What becomes interesting at this stage was a secondary discussion which developed around the freedom of women to express negative experiences of mothering. So while the women all stated they had a wonderful relationship with their children, they lamented their lack of freedom to dislike mothering without feeling like they had broken some form of social taboo. Vanessa said:

*"There were times when I just wanted to sit down and have a bitch over coffee, times I wanted to say God! Being a mother sucks today; just today you know, it wasn't like I was saying it sucked all the time, but today it sucks. There was no way I could have done that."*

Given this it raises a certain level of wondering. The women all report a loving a fulfilling relationship with their children while at the same time reporting experiencing rigid societal taboos regarding expressing non-fulfilling and non-loving relationships with their children.

Even though the participants reported this wonderful relationship with their children, they drew a clear distinction between mothering and being a mother. And again while they enjoyed, in general, mothering, they expressed dissatisfaction with being a mother.

There were several reasons for this. The women discussed their beliefs they had been socialised into a certain belief system regarding motherhood and this was not matched by their experiences.

*"I felt like I'd been sold up the garden path, totally ripped off." (Amy)*

*"I'd been brought up thinking motherhood was all fairy tales and candy floss, nothing could be further from the truth." (Vanessa)*

The connecting theme seemed to be exposure to an idealised and romanticised vision of mothering, almost a Madonna-type myth, where children epitomised the fulfilment of feminine destiny and achievement. Having themselves been exposed to the social taboo around voicing the negative experiences of mothering, the women were able to see where they might have developed some of those unrealistic expectations.

#### *Status Demotion – Loss of value*

In all, throughout the focus group discussion the women acknowledged experiencing difficulties with a number of aspects of the transition to parenting. In addition they highlighted a number of losses incurred as they took up the mothering role. However, for this group of well-educated women one of the most pertinent challenges was a perceived loss in social status. These women had attained a certain level of status in their professional lives. In addition to this they had grown up believing there was a certain status attached to being a mother, that it had a value of some kind. Unfortunately, their own experiences were just the opposite. The women reported experiencing a drop in status following childbirth which they experienced as both unexpected and distressing. Mothers were exalted and supported in their expectations, but again, their experience was one of being unsupported, and at times disparaged, because of their motherhood status.

This theme arose very early in the discussions and re-emerged time and again throughout the group session. All the women in the group described feeling resentful of the status change they experienced when they became mothers. Amy's comments seemed to sum up the prevailing attitude:

*"I was just a mother, my opinion and my thoughts and knowledge were not valued at all."*

There was another aspect the women believed was part of the loss of status and that was a decline in the level of intellect the new mothers perceived were they thought to have. These women all had an above average level of education for females of European descent in New Zealand, and enjoyed intellectual pursuits, had opinions on politics, government policy, and world affairs. On becoming a mother the women reported interactions with others, particularly professionals involved in the care of their child which they characterised as belittling and patronising, and where they felt they were being spoken down to like *I was dumb*.

*"People started treating me like I was brainless, like I couldn't be a mother and have a decent level of cognitive functioning simultaneously. It used to really annoy me." (Jo)*

*"I would take [child] to the doctor and I would end up feeling like he was trying to placate me, I didn't need placating; I wasn't distressed or overwhelmed or unable to understand, I just had a sick child." (Vicki)*

### **SUPERORDINATE THEME TWO: CONFLICTS**

The second central theme of the womens dialogue revealed their transition to motherhood was characterized by significant levels of conflict, both in their relationships with others and within themselves. The conflict with others was often around disappointed expectations and insuring their right to be heard, while the inner conflict centred on the exposure to their idealised image of motherhood and their own experience of themselves as mothers.

#### *Subtheme 1: Relationships – Conflicts with others*

##### *Partners*

In regards to the partners, all the women reported having a baby had a positive impact on their intimate relationships initially, but then they experienced a decline in the relationship satisfaction as time wore on. The women believed this initial increase in relationship satisfaction was because they perceived receiving a high level of support initially. Fathers generally took leave from work and engaged in some highly nurturant behaviour: making drinks, preparing food and just generally doing things to help. However, this input generally did not last beyond the first few weeks and the women reported feeling very disappointed (and somewhat betrayed) by their partners lack of contribution.

*"The idea of a parenting partnership didn't last long; it became clear parenting was something he would do when it fitted in with his work and his mates." (Jenna)*

*"It started off really well but the novelty soon wore off, he was happy to do the fun stuff but I don't remember him doing much in the way of changing." (Jo)*

*"I felt more vulnerable once [baby] was born, like I didn't want to rock the boat too much 'cos I wasn't earning and we were completely dependent on him."* (Vanessa)

As a group the women reported egalitarian relationships with their partners pre-baby but once the baby was born they felt they lost some *power of negotiation*. For some of the women this unexpected change in the power balance of their relationship was quite threatening and anxiety provoking and was also a source of conflict as they felt their partners did not understand their concerns. Certainly there was no overt threat to either them or the child, but the women recall experienced a heightened awareness of their lack of independent means and increased demands of having a child.

#### *Professionals and Others*

There were several areas of child rearing that seemed to bring conflict between these mothers and the professionals they were involved with. Feeding was an area of particular disagreement. The women reported being criticised initially for their breast-feeding routines, and then later on for some of their decisions around the introduction of solids. It was interesting that the women reported a gradually level of deceit creeping into the relationships with others. For instance, after detecting sanctions for behaviours they had previously disclosed, the women stopped disclosing them. In the end three of the women were feeding solids and most were treating themselves to an occasional half glass of wine, and all reported feeling they could not, or did not want to, disclose this to their doctor or Plunket nurse.

Immunisation appeared to be another bone of contention between health professionals and this group of new mothers. Three of the women reported asking for more information about vaccination, and one eventually decided against immunisation. All the women reported experiencing perceived sanctions from health professionals including slurs on their parenting ability (*responsible parents vaccinate...*) emotional blackmail (*if you really loved your child...*) and challenges to their cognitive abilities (*it might be hard for you to understand...*).

Two of the women also reported strongly resenting the 'infantising' they perceived from health professionals in their children's early years, and then teachers as the children entered the education system.

*"It was like they thought I was some emotional wreck who couldn't be trusted to have a rational conversation or logical thought about my child."* (Amy)

The women in this group reported feeling bullied by Plunket nurses, GPs, and paediatricians. One woman stated at times she felt she needed to get permission from her Plunket nurse to introduce changes or make decisions related to her child (this too may offer some insight as to why some of the women stop disclosing behaviours). Another woman chose to end her contact with the Plunket service because of conflict she experienced with the nurse assigned to her care.

*"Quite frankly she was a bloody old battle-axe who bullied and badgered me constantly, in the end it just wasn't worth the hassle." (Jenna)*

#### *Subtheme 2: Conflicts with self*

Perhaps the most difficult conflict for the women to resolve was the inner conflict they experienced between the idealised image of mothers they held and their experiences of themselves as mothers. Without exception the women reported feeling they could not live up to the mothering image, and even though they knew the image was unrealistic, it still brought with it a sense of failure.

*"There was no way I could ever live up to all those expectations but I still kept trying. And then every time I tried and failed I would get cross at myself for trying in the first place, like I knew the stuff in the magazines was bull, but I still kept coming back and trying again. It was nuts." (Amy)*

There was also conflict between self as mother and self as self. In other words, the women struggled at times to maintain a sense of themselves as an autonomous being separate from their mothering identity. Yet they clearly indicated they wanted to be so much more than a mother; they wanted to be them.

### **Discussion**

The women in this group considered themselves to be capable and independent women before they had their children. They were well educated, working, and in stable relationships. To all intents and purposes they epitomised what society portrays as the modern women. However, once the children were born they reported experiencing a number of aversive events as they took on the new role of mother.

The women in this focus group highlighted a number of changes and losses which they encountered in their transition to motherhood. Both independence and an impingement on their freedom of movements were expected losses and neither of these events were reported to cause a great deal of distress. That leaves one to wonder whether it is the loss or the unexpected nature of the loss which is more problematic. Certainly the losses which were not expected, such as the loss of status, were experienced as far more distressing to the women.

Further in regard to the loss of status were the implicit attitudes of others in ascribing value to the mother role. This perceived lack of value was directly contra to the value the women themselves placed on the job they were doing. Without exception these women stated they believed this to be the most important and valuable thing they had ever done.

Another loss highlighted by the women was the loss of the *idealised image of motherhood*. They had believed the fairy tale and had experienced difficulties adapting when the myth and the reality did not align. This loss highlights an important aspect of mothering. These women emphasised that although they were excited about becoming a parent they felt unprepared and 'tricked'. They believed the role of mothers was romanticised to little girls and

were scathing of what they referred to as *the pink aisle* in chain stores such as The Warehouse, which they believed promoted gender stereotyping and socialisation for young girls by stocking junior appliances such as cleaning sets, irons, and kitchenware. In addition, the advert of crying, potty going dolls was seen as further evidence of societal control around the developing expectations of young girls.

This romanticising of motherhood has been reported in other research (Beck, 1992; Crossley, 2007; Mauthner, 1988, 1999; Oakley, 1986). Researchers have argued there is a societal conspiracy aimed at perpetuating a romantic personification of motherhood, portraying a popular mythical and magical image of mothering as powerful, natural, normal, and central to female identity (Nicholson, 1999). Some feminist writers however, argue motherhood constrains women to an inferior status in society, to the medicalisation of childbirth, poor provision of state-funded childcare, isolation, loss of occupational status and opportunity in the public sphere and gendered labour divisions in the private sphere (Crossley, 2007; Mauthner, 1999). This is certainly more in line with what the participants in this group experienced, and what they seemed completely unprepared for.

A recurring theme throughout the discussions was the mistrust that developed early on between the mothers and professionals who were charged with providing early care to the infant and advice to the new mothers. The women most strongly resented the perceived attitude of some of the professionals, who they felt, treated them with a lack of respect and dignity. Feeding was often cited as being a source of immense conflict between these women and the professionals advising them. This was interesting given the inordinate amount of focus given to infant feeding in women's magazines, parenting books, and the *Well Child/Tamariki Ora Health* books given out to the majority of mother's for their babies and young children. In particular the introduction of solids was hugely anxiety provoking as the mothers reported often feeling confused by contradictory advice. These mothers frequently struggled with knowing what was best for their child, and reported following their instinct. Further exploration of this idea found the women resorted to, in their words, 'common-sense solutions'. For example, solids were often introduced when a child who had previously been sleeping well throughout the night began to wake. By using a process of elimination, and by ruling out things like teething, diaper issues and sickness, the women generally decided the infant was waking due to hunger and introduced solids. What was particularly interesting is this was often done furtively, without discussion with their Plunket nurses. According to the women in this group this was because they felt the Plunket nurses would not support their decisions and they would be made to feel they had done something wrong.

None of these women were assessed for, or diagnosed with, any psychological difficulties, by any health professional, following the birth of their child/ren. In addition, they reported having limited or no knowledge of postnatal depression, or other forms of postnatal distress. Yet, retrospectively, one of the women is convinced she had postnatal depression. She reported a loss of interest in previously enjoyed activity, low mood, and irritability following

childbirth and throughout the early postpartum period. She does not recall anyone asking about or checking on her mood or the safety of her or her infant.

Several ideas can be drawn from the experiences of this focus group which help to inform the model of postnatal distress. Firstly, expectations of negative events, whilst sometimes temporarily disruptive, were not experienced as overly distressing. For instance, the women in this group reported they expected to experience a loss of freedom once their babies were born. This, as it turns out, was a realistic expectation and all the women reported coping well with this loss. Contrary to this there were a number of losses the women had not anticipated when they were pregnant. Perhaps the most striking of these was the loss of status they experienced in becoming a mother. This unexpected loss caused considerably more worry for these women and they reported struggling for a long time with this (in fact the women reported this as an ongoing and current difficulty even with their children in their adolescence).

The women tended to report disappointed expectations of partner support. As the study did not focus on accessing the actual level of support there is no independent evidence of what support was actually *received*. Of interest is that universally in the group, there was a lack of support *perceived*. That is, the women did not *see* support from their partners. This raises questions of whether partners need to increase the support offered, to change the type of support being offered or women need to review how they see support from their partners. Regardless, what is evident is that there is a mismatch between the level or type of support being offered, and the level or type of support being perceived. Overall, the findings from this focus group concurred with the findings cited by Belsky (Belsky, 1985; Belsky et al., 1985) and Kalmuss (Kalmuss et al., 1992) who both found participants in their studies were generally happy with their parenting role but experienced disappointed expectations of partner and others.

These losses, the loss of social status, loss of relationship balance and loss of expected support created somewhat of a paradox for these women. They reported loving their children and finding fulfilment in mothering them, whilst at the same time feeling the loss of identity, autonomy, partnership, time and status. This is in line with the findings of a British-based longitudinal qualitative study of PND which argued if these types of losses were acknowledged and validated, and the women permitted to grieve, then PND or distress could be reconstructed "as a potentially healthy experience towards psychological reintegration and personal growth rather than a pathological response to a 'happy' event" (Nicholson, 1999, p. 162). It would seem in this study the losses the women experienced and the disparities between 'mythical' mothering and 'modern' mothering were of central importance in the creation of anxiety and distress related to the mothering process. It would seem logical then that addressing these issues is seen as paramount to preventing the onset of postnatal distress.

This study aimed to examine the experience of women who have made the transition from non-mother to mother. While this aim has been met, the theorising reports the experiences of five New Zealand born women of European descent, and cannot make claims

authoritatively beyond that. For instance, the experience of New Zealand women of Maori descent may be somewhat different and research exploring those experiences offer different insights (Merritt, 2005). In addition, the historical nature of the women's experience means their recall is subject to distortion over the course of time. It may be, for instance, the women tended to recall experiences with a higher emotional content, or experiences which had a particular type of impact. However, while this may not be the one truth, it is a truth and it provides value insight into the experiences of New Zealand women.

There are also limitations with the IPA method used. It needs highlighting reporting findings using IPA means generalisations are not feasible and, as such, there are limitations in drawing conclusions beyond the population in this study. It does however, provide some insight and contextualising for further investigation. Every attempt has been made to make the data rich enough and transparent enough so that the reader is able to evaluate transferability (Smith, Flowers, & Larkin, 1999a).

## **Conclusions**

The women in this expert panel focus group reported a number of difficulties they encounter across the transition to parenthood. These difficulties were characterised by a number of loss including a loss of status and a loss of the idealised image of mothering. Some of these losses stemmed from the women holding a number of expectations which were unfulfilled. While not all of these acted as a source of distress, there was times when the disparity between expectations and experiences was distressing for the women.

## **Chapter Five: A Model of Postnatal Distress**

### **Introduction**

The previous chapters of this thesis have introduced and discussed the components argued to create a state of postnatal distress. Chapter Two investigated the elements of depression, anxiety, and stress, while Chapter Three examined literature on expectations and loss, as well as highlighting research on the myths of motherhood. What these chapters point to is the complexity of the interactions of the components which can lead to distress following the transition to motherhood. But how does it all fit together? What are the links for instance, between distress and mothering myths?

This chapter introduces a new conceptual model of postnatal distress which draws together the components highlighted and, in doing so, creates opportunities to move forward in the treatment and prevention of postnatal distress. The development of the model was, in a large part, informed by a thorough literature review of the research relating to postnatal distress which was covered in the first three chapters as well as the focus group discussed in Chapter Four.

### **The Model**

Women hold a number of expectations of mothering and mothers prior to giving birth and becoming mothers themselves (Coleman et al., 1999; Hackel & Ruble, 1992; Kach & McGhee, 1982; Knight & Thirkettle, 1987; Pearce & Ayers, 2005). In fact, girls from a very early age engage in games of mummies and daddies and, equipped with an array of pink plastic appliances, quickly begin to acquire an understanding of what it means to be a mother. For example, experimental studies show a preference for gender stereotypical nurturance toys (dolls and the like) is well established by 18 months (Serbin, Poulin-Dubois, Colburne, Sen, & Eichstedt, 2001). So expectations of motherhood begin to emerge and coalesce from a very early age, and arise from exposure to a number of different information sources as shown in Figure 5.1. Research has shown these expectations to be generally optimistic, but also unrealistic.

The question of why some of the expectations maybe unrealistic links in with the literature on mothering myths introduced in Chapter Three. Chapter Three highlighted research suggesting women are exposed to a number of commonly held myth beliefs about mothers and mothering. These myths have been found to generally lack empirical evidence, but impact on the behaviour, cognitions and emotions of mothers as well as others. While some of the myths may be negative, the overarching tone is one of overt positivity and, in general, these beliefs fail to encapsulate realistic negative aspects of mothering such as repetitious tasks, mental ennui, and poor support.

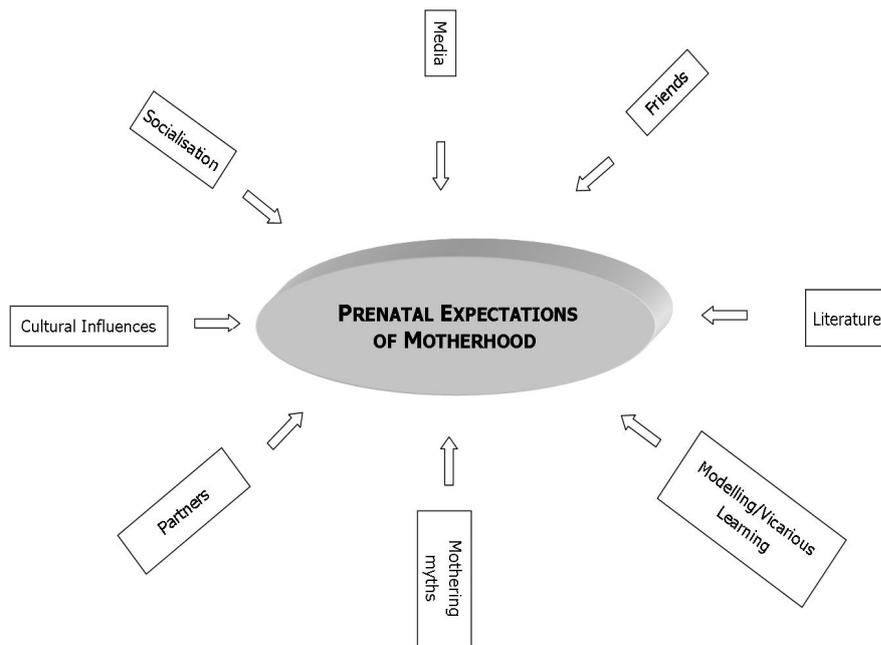


Figure 5.1. Potential Sources of Information for Women developing Pre-natal Expectations

As a result of these overly optimistic expectations women’s prenatal expectations and postnatal experiences do not always align. That is not to say that the experiences and expectations are completely unrelated. There are areas of overlap, and it is argued that this area of intersect between an individual’s prenatal expectations and their subsequent postnatal experiences is likely to result in a positive transition to motherhood (Figure 5.2).

The reason for this is that women experience no cognitive conflict in this state. They are prepared for the events which occur in this overlap. The overlap represents events which the women have realistically appraised and therefore the postnatal experience is predicted, an important factor in coping.

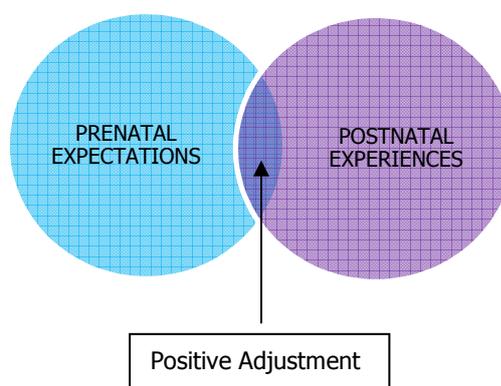


Figure 5.2. Interaction of Prenatal Expectations and Postnatal Experiences where the overlap represents a match of expectations and experiences suggesting Positive Adjustment

However, there are large areas where the expectations and experiences do not overlap each other. The new model proposes within these areas there is potential for postnatal distress (Figure 5.3). That is, if there is a disparity between prenatal expectations and postnatal experiences the disparity is experienced as postnatal distress.

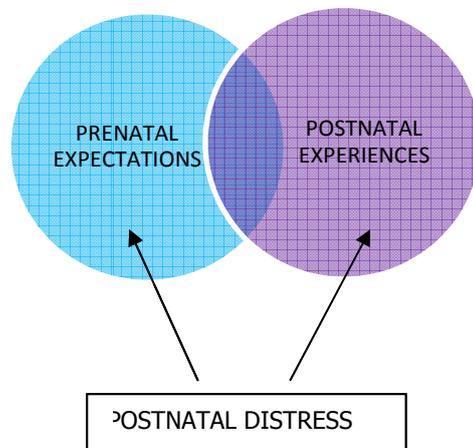


Figure 5.3: Figure showing the Areas of Disparity between Prenatal Expectations and Postnatal Experiences which were hypothesised to lead to Distress

Thus the initial equation for postnatal distress was:

$$\text{IF PNE} \neq \text{PNE}^1 \text{ THEN PNE} \pm \text{PNE}^1 = \text{DISTRESS}$$

Where PNE = prenatal expectations & PNE<sup>1</sup> = postnatal experiences

Yet one cannot accurately predict the outcome of an event one has never experienced and thus logically it would suggest there is always going to be a disparity between expectations and experience to some degree. How then do we explain why not all women transitioning to motherhood experience distress? The model argues there is a moderating factor to be considered and the moderating factor proposed by the model is loss. That is, according to the model distress will arise when the disparity is experienced as a loss by the individual women. Thus the new model states postnatal distress results from the disparity between prenatal expectations and postnatal experiences when that disparity is subjectively experienced as a loss. Therefore the equation had to be adjusted to the following:

$$\text{IF PNE} \neq \text{PNE}^1 + \text{LOSS THEN DISTRESS}$$

The new model of postnatal distress proposed is shown in Figure 5.4. The model consists of three main components. The first component is prenatal expectations; these are informed and developed by a number of factors including exposure to mythical mothering. Because of the artificially positive portrayal of motherhood women are exposed to during childhood, adolescence and early adulthood, these expectations are themselves overly optimistic. The

second component is disparity which arises from the mismatch between expectations and experiences. The final component is distress resulting from the subjective experiences of loss following the disparity.

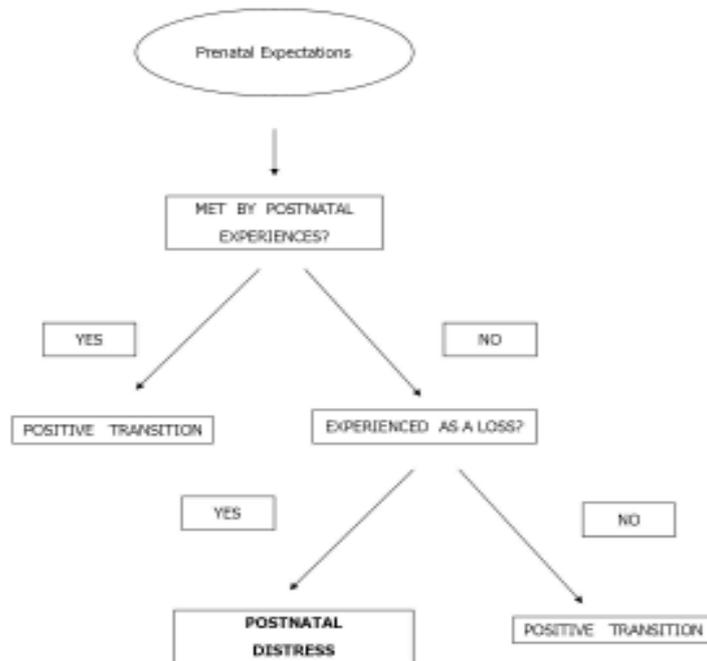


Figure 5.4. A Model of Postnatal Distress.

The question then becomes what would make some women experience the disparity as a loss while others do not? It is argued women who hold rigidly ascribed expectations of mothering and motherhood, and who are highly invested in the images and expectations which they hold, are more likely to experience a violation of that expectancy as a loss than women who are not as invested in the images they hold. Consistent with the principles of cognitive fusion and cognitive flexibility from Acceptance and Commitment Therapy (Ciarrochi et al., 2005; Fletcher & Hayes, 2005; Hayes, 2004, 2005; Hayes et al., 2006), according to this model, women who believe that because they have thoughts of motherhood those thoughts must be true experience distress when they try to then process their experiences through the filter of their thoughts.

So how does it work? Women are exposed to images of mothering and motherhood, almost from birth, with which they use to begin building schematic models of mothers and motherhood. Furthermore with little information to contradict these images (remembering the sanitising and whitewashing of motherhood discussed in Chapter Three) women become fused with the concepts that have developed. Thus despite having no direct experience with mothering, women can develop detailed and rigid expectations and ideals about life as a mother of a child.

New mothers rapidly encounter experiences which contradict some of their expectations. It is argued women who have psychological flexibility, and who are able to hold as true more than one image of mothering and motherhood, are less likely to experience distress than women who ascribe rigidly to one image. This is because once women become mothers, those who have cognitive flexibility can experience motherhood as it is, not as it says it is. These women can based their cognitions regarding mothering on their experience of motherhood rather than on preconceived intellectual understandings of others mothering.

### **Testing the Model: Where to from here?**

The existing research provides good evidence for many of the links in the model. For instance there are a number of studies which found women do experience disappointed expectations following the transition to motherhood (Delmore-Ko et al., 2000; Green et al., 1998; Harwood, 2004; Harwood et al., 2007; Kalmuss et al., 1992; Knight & Thirkettle, 1987; Pearce & Ayers, 2005; Ruble et al., 1988; Tammentie et al., 2004). However, there is no New Zealand research investigating the relevance of these findings for a local population, and as this is a pivotal assumption for the model of postnatal distress proposed, it is important to establish whether this is indeed the case. Therefore it is important to investigate the transition to motherhood for first-time mothers in New Zealand, and glean some insight into how they understand their experiences, and whether there are, indeed, some disparities from them.

Furthermore, the component of loss and its fit with postnatal experiences needs further investigation. Chapter Three highlighted some important research investigating women's experiences of loss following childbirth (Beck, 1993; Lewis & Nicholson, 1998; Nicholson, 1999, 2003; Rogan, Schmied, Barclay, Everitt, & Wyllie, 1997). However, the link with disappointed prenatal expectations needs further exploration. Importantly it needs to be established if young women who are not yet mothers do subscribe to mothering myths as posited.

Some of these questions will be addressed in forthcoming chapters. However, ultimately it is hoped the model can lead to an intervention protocol which can be used to lower the incidence of postnatal distress.

## Chapter Six - Study Two – Testing the Losses

### Introduction

The model highlighted in the previous chapter contains a number of testable assumptions. It proposes women hold, often explicit and detailed, expectations prior to giving birth: expectations about themselves as mothers, about the mothering role, about their infants, and about others, including their intimate partners. Generally speaking, while some trepidation is commonly reported with worries regarding the birth process and concerns about the health of the baby, when one considers the totality of the research examined in earlier chapters, one could hypothesise these expectations would be reasonably optimistic.

The psychological concept of *possible selves* offers a framework for understanding these explicit and detailed expectations and aspirations of mothers. According to possible selves literature each individual holds internal representations of what they might become, what they would like to become, and what they are afraid of becoming (Markus & Nurius, 1986). For women transitioning to motherhood a possible future self could be a loving and engaged mother, while a feared possible self is a mother who is disconnected or unloving. Thus these representations function both as a motivator and as an evaluative filter with which individuals interpret their current self, and aim their future behaviour.

The research which informed the development of the model further argued some of those optimistic expectations will be unmet and, according to the model, for some women, this may result in an experience of loss. That is, the model proposed women hold a number of optimistic expectations leading up to the birth of their first child, and where those expectations are unfulfilled women may experience subjective feelings of loss.

There is strong support in the literature for the subjective experience of loss following childbirth, although little based on a New Zealand population (Beck, 1996c; Beck & Indman, 2005; Brockington et al., 2006; Clemmens et al., 2004; Nicholson, 1999, 2003; Rogan et al., 1997). Women in these studies reported losses across a number of areas of functioning including relationships, career, autonomy, and status. However, whether these losses occur for New Zealand women and whether there is a link between expectations and loss for them is unclear.

This chapter introduces and discusses a study designed to address some of these gaps in the existing literature, and begin testing components of the model proposed in the Chapter Five. The study involved interviews with a purposive sample of women who had recently made the transition to motherhood. Again, as in Chapter Four, the research was conducted with a women-centred focus, taking the accounts of the women as normal, non-pathological, and true in as much as it represented their interpretation of reality. The findings of the study are discussed, and the links with the proposed model of postnatal distress highlighted.

## **Method**

The data in this chapter derived from interviews with five women who had recently become mothers. Consistent with Chapter Four the approach utilised in the study draws on aspects of Interpretative Phenomenological Analysis (IPA). IPA is an idiographic, inductive approach exploring how people ascribe meaning to their experiences in their interactions with the environment (Biggerstaff & Thompson, 2008; Brocki & Wearden, 2006; Smith, 1996; Smith et al., 1999b). It has been described in some detail in Chapter Four and therefore that information will not be repeated here.

### **PARTICIPANTS**

A small, well-defined purposive sample of first time mothers was selected, all but one who belonged to the same antenatal group. The women were all European New Zealanders who were married. Four women had singleton births and there was one set of twins. There was an equal gender division among the babies whose ages ranged from twelve weeks to eight months. The sample was well educated with all the women having training beyond secondary school. Two women had postgraduate university qualifications. Names of participants were changed to protect their anonymity.

### **PROCEDURE**

The research protocol was evaluated by peer review and was judged to be low risk (see Appendix E: 1 for a copy of the ethics approval). Women were eligible for inclusion if they were first-time mothers, able to converse in English, over the age of 18 years and capable of giving informed consent. Requests for participants were made through a local parent support group, and women who expressed interest in participating were then given information sheets about the research. Women who provided their contact details to the researcher were then contacted by phone and given the opportunity to ask for additional information (Appendix E: 2). If the women indicated they were willing to participate, an interview time was scheduled at a time and place convenient for the women. All women who were telephoned after providing contact details agreed to participate in the study.

Upon meeting, the participants were again offered the opportunity to ask questions, or address concerns before written consent was obtained (Appendix E: 3). The discussion was digitally recorded and transcribed verbatim.

Consistent with the principles of IPA, a facilitatory research interview style was adopted. This aimed to encourage women to share their stories whilst providing a safe and affirming environment for them to do so. An interview guide was utilised which enabled systematic data collection with a view to later analysis whilst leaving scope to pursue specific topics if they became important as mutually defined by the interviewer and respondent over the

course of the interview (Appendix E: 4). The interviews lasted approximately 90 minutes. At the end of the interview, participants were asked to complete the Depression Anxiety, Stress Scale and the Postpartum Depression Screening Scale. They were also asked to indicate how they felt as a result of the interview. The participants had not been selected as special cases, nor is it being claimed they are representative of new mothers in general. Rather they represent particular cases of women's experiences of the transition to motherhood in order to help gain a more detailed picture of the phenomena (Smith, 1996).

### **ANALYSIS**

The interview tapes were transcribed by the primary researcher, Anita Darrah. Data analysis was based on IPA. This approach methodically involved:

- (1) A first encounter with the text involving a detailed examination of the transcript and the noting preliminary thoughts and observations.
- (2) Identification of preliminary themes that best capture the essential aspects of the group.
- (3) Grouping of the themes together as clusters to provide an overall structure to the analysis.
- (4) Development of a master list of table of themes which identifies the main features and concerns identified by the research participant

As a final check the transcripts were then re-read in their entirety to check the integrity of the analysis with the totality of what the interviewee was expressing. The interview transcript was then returned to the appropriate participant to read through. An accompanying letter was sent with the transcript inviting the women to make changes to the transcript if they wished (Appendix E: 5). None of the women chose to do so and all signed a separate consent form to release the tape transcript. The data supported three broad themes: (a) known verses unknown (b) loss and (c) the impact of others.

### **MEASURES**

*The Depression Anxiety Stress Scale* (DASS) is a 42-item self-report measure designed to assess the three negative emotional states of depression, anxiety, and stress (Lovibond & Lovibond, 1995) (see Appendix C). Each clinical scale contains 14 items covering symptoms such as dysphoria, hopelessness, devaluation of life, self-depreciation, and anhedonia on the depression scale (DASS – D), and autonomic arousal, situational anxiety, and skeletal musculature effects as well as subjective experiences of anxious affect on the anxiety scale (DASS-A). The stress scale (DASS-S) includes items on nervous arousal, irritability, impatience, and reactivity.

Participants are asked to indicate the extent to which they have experienced each state over the past week by endorsing ratings on a 4-point Likert scale (0 = *did not apply to me at all* – 4 = *applied to me very much, or most of the time*). Scores for each clinical scale are determined by summing the relevant 14 items giving a score for state, rather than trait symptomology.

The DASS was developed using both a clinical sample and a diverse non-clinical sample (Lovibond & Lovibond, 1995b), while subsequent analyses have been conducted in community samples (Antony, Bieling, Cox, Enns, & Swinson, 1998; Crawford & Henry, 2003), clinical outpatient groups (Antony et al., 1998), older primary care patients (Gloster et al., 2008), and, more importantly for this study, postpartum populations (Miller et al., 2006). In all, there has been consistent support found for a three-factor solution representing the three scales.

*The Postpartum Depression Screening Scale (PDSS)* is a 35-item self-report measure designed to identify women at risk for developing postnatal depression. It is a self-report questionnaire that can usually be completed by respondents in 5-10 minutes, and is appropriate for use from 14 days postpartum (Beck & Gable, 2002). The PDSS measures symptoms across seven dimensions of PND; sleep/eating disturbances, anxiety/insecurity, mental confusion, guilt/shame, loss of self, emotional lability, and suicidal thoughts (Table 6.1).

Table 6.1. *Postpartum Depression Screening Scale - Content Scales\**

PDSS Content Scales		
	<i>Scale Definition</i>	<i>Item example</i>
Sleeping/Eating Disturbances	Items on this scale assess a woman's perception that her appetite and normal sleep habits have been disrupted.	I had trouble sleeping even when my baby was asleep.
Anxiety/Insecurity	These items measure a woman's feelings of anxiety, insecurity, and sense of being overwhelmed in her new mothering role.	I felt like I had to keep moving or pacing.
Emotional Lability	Items on this scale indicate the extent to which a woman feels that her emotions are unstable and out of her control.	I was scared that I would never be happy again.
Mental Confusion	The mental confusion scale provides a rating of a woman's perceived ability to concentrate, to regulate her own thought patterns and to make decisions.	I felt like I was losing my mind.
Loss of Self	Relates to a woman's perception that aspects of her personal identity have changed since she gave birth.	I felt as though I had become a stranger to myself.
Guilt/Shame	Items on this scale assess how a woman's perception of her poor mothering performance relates to feelings of guilt and shame.	I felt like I was not the mother I wanted to be.
Suicidal Thoughts	The suicidal thoughts scale assesses a woman's wish to harm herself or end her own life as an escape from postpartum depression.	I felt that my baby would be better off without me.

\* Items definitions taken from Beck & Gable (2002). Postpartum Depression Screening Scale: Manual

Each content scale contains five items, and women are asked to indicate their degree of agreement or disagreement with each item on a five-point likert scale anchored between 1 (strongly disagree) to 5 (strongly agree) in relation to how they have been feeling in the last two weeks. There is also a validity scale (INC) to identify inconsistent responding. The scale

requires a third grade reading level (equivalent to New Zealand Year 4), and can be administered orally by the examiner if the respondents' reading is not adequate for the task.

The PDSS yields a full-scale score based on responses to all 35 items with a possible range of 35 to 175. It also yields an inconsistent responding index and seven symptoms content scores. Guidelines for interpreting elevations on each scale are provided in the manual (Beck & Gable, 2002). Total scale scores that were  $\geq 60$  suggest a positive screen for depressive disorder NOS (i.e. significant symptoms of postnatal depression), while a scale score of  $\geq 80$  indicates the presence of major postpartum depression (Beck & Gable, 2002).

The items were developed through qualitative analysis of symptoms reported by women who had experienced PND (Beck, 1993, 1996c). Initial psychometric evaluation of the PDSS was undertaken with two samples. Cronbach's coefficient alpha scores indicate excellent internal consistency for the final version of the PDSS. The PDSS total scale alpha was .96, with content scale alpha ranging from .80 to .91 (Beck & Gable, 2000, 2001, 2002).

Content validity was based on the judgement of a five-member expert panel as well as a focus group of graduate clinical nurses with specialities in obstetrics and psychiatry. Changes recommended by the experts and the focus group resulted in a 56-item pilot measure. All items had coefficient alphas above .75.

## Results

The descriptive information of the group is given in Table 6.2. As can be seen this was a reasonably homogenous cohort. All participants were married females of European descent who were in their 30's. The group was well educated with 66% having a postgraduate qualification of some sort. There were four singleton births 50% of which were vaginal deliveries. The other births were unplanned emergency caesarean sections the women underwent after being advised their infants were in some distress.

Table 6.2 *Participant demographics*

	1	2	3	4	5
Marital Status	Married	Married	Married	Married	Married
Infant gender	M	M	M/F ①	F	F
Infant age	7 MTHS	7 MTHS	12 WKS	7.5 MTHS	8 MTHS
Delivery Mode	Caesarean	Caesarean	Caesarean	Vaginal	Vaginal
Years of Education	16	15	12	16	12
PDSS score	45	75/49②	56	65	39
DASS score	8	13	12	11	3
History of depression	YES	NO	NO	NO	NO

① Dizygotic twins

② Two PDSS scores two weeks apart

One participant indicated she had a prior history of depression. One participant scored in the significantly depressed range for the PDSS but not the DASS. Further investigation of her

profile on the PDSS revealed she had scored in the upper range of the sleep/eating disturbances subscale. This reflected changes to her diet in an attempt to mitigate effects of allergies in her breastfed baby. None of the other subscales were in a range which indicated difficulties. None of the questions related to suicide ideation were endorsed. The participant was followed up on and her elevated scores discussed. She agreed to complete a follow-up PDSS after two weeks, consistent with recommendations, and, at that stage, her scores were in the normal range.

### **KNOWN VERSES UNKNOWN - I KNEW THAT WOULD HAPPEN... NOT**

A recurring theme throughout the transcripts was unpreparedness. There seemed to be a large array of parenting related experiences these women did not feel well prepared for. This included infant related experiences such as the emotional bond between the mother/child dyads; as well as partner related experiences, for example, the level of support received, or perhaps more accurately, the level of support perceived. There were also a number of unexpected experiences related to becoming a mother and having to deal with the world in terms of their new role. While most often the women reported being able to activate coping strategies to deal with the unexpected occurrences, on occasion the women stated they struggled.

#### *Efforts for Preparedness – Information seeking*

All the women stated they consulted various sources for information and support about pregnancy and childbirth. However, of interest to this study was the finding information seeking seldom extended to questions of parenthood. Instead the women tended to seek information on pregnancy and birth as well as how to deal with potential infant difficulties; not sleeping or feeding for example. Popular sources of information were books and friends. It appears the women did approach their own mothers under the guise of information seeking, but it tended to take the form of reassurance seeking. The Internet was investigated, and it would appear it was seen by many of the women as having a vast array of often irrelevant information which was difficult to assimilate, and whose validity was somewhat difficult to ascertain. Where information on parenthood was garnered, irrespective of the source, the women reported the information did not prepare them at all for actually becoming parents. For example Sasha reported:

*"You read a book which suggests this is how it will work; and of course it will work every time, and so then you go into it going and you go oh why doesn't it work?"*

Similar sentiments around preparedness were expressed by Janet:

*"When you first bring them home from hospital and then go what now? Like where do I put you? What do I do with you?"*

All of the women in this group were either given pregnancy and childbirth books to read, primarily by midwives or friends, or had them recommended to them. However, when the women began to read some of the books there was a tone to them they reported they did not find helpful, and this may explain, in part, why they did not then seek further information about parenting from the same source. The women reported feeling both judged and dictated to on occasion. They also argued the books presented a rigid portrayal of the correct 'procedure', as if there was an absolute way of doing mothering. They indicated they felt if they deviated from this norm would experience future problems or failure. Effectively the message from the books the women encountered seemed to be 'either follow my instructions or create a rod for your own back'. Sasha said:

*"I read a lot of books when I was particularly sort of weepy and anxious and that almost set of precedence that I felt I couldn't I couldn't achieve so... For example I read The Baby Whisperer and it had, you know, you should be doing this and you should be doing that, and your child should be self settling by this age and, blah blah blah. That just created for me, like a standard that I couldn't reach and that caused more anxiety."*

For Collette the experience seems to have been similar where the books she encountered created expectations and confusion which did nothing for her confidence as a new mother:

*"They confused me more I think, they weren't helpful because I read the contented little baby by Gina Ford which someone had told me to get, which is about... pre-programming your child for sleep, don't give that to a mother before... yeah no they weren't, they set up expectations I think slightly on the sleep front that weren't useful; no they weren't really."*

In all, the books were reported to have a general negative impact on the women, leaving them feeling confused and inadequate. All of the women in this sample stated the books were not helpful and were misleading, for example:

*"Has it been like the book said? -no! no no no no oh no!" (Collette)*

The women also hinted at a degree of bullying in the books; a tendency for the authors to push an agenda which may be contrary to the values and beliefs of the individuals involved:

*"I'm very much, can find that sometimes information can be a little bit opinionated. I get inundated by it cos I think that it can sometimes force you in a direction that maybe isn't the right direction." (Kathy)*

And for Janet:

*"That book that my mum brought me, like I found that to be, quite judgemental, like it was sort of like, you know, **this** is the right way to do things **this** is how you do it, **if** you're not doing this then you know your baby will suffer and therefore you're a bad mum. I mean, they didn't spell it out like that, but that was the implication."*

In the end, despite all the information garnered from books, from the Internet, and from friends, the women reported feeling totally unprepared for becoming mothers. Across the board from physical reactions to infants (such as infant crying triggering the release of breast milk), to exhaustion, to recovery time to their emotional connections with the babies, the women stated they were 'clueless really' when it came to the experience of being a mother. A comment from Sasha has been selected as a humorous summary of the feelings independently conveyed throughout the interview process:

*"It's literally like buying a house, but not looking at the house before you buy it you know. This massive investment and you just literally kinda, you know move in, and then find out what's wrong with the house and wonder how to works--the locks, and where the light switches are! It's really like that; it's just insane."*

Although the women were united in stating the books they had read were unhelpful, they differed in what they thought may have been more useful for them to know. Some women thought practical information was what was missing and wanted more concrete information about how to interact with their infants. For instance how to encourage motor development. Conversely there was a trend for some of the women to feel ill-prepared for the emotional components of parenting. They stated they could work out practical chore based tasks such as changing nappies fairly quickly, however they reported the sheer intensity and relentlessness of some of the emotional aspects of parenting left them feeling drained and overwhelmed at times.

Given the women, by and large, reported books on parenting were unhelpful, I asked each of them what they would include in a book if they were to write one themselves. Most of what the women reported they would choose to include could be called non-specific reassurance. By non-specific reassurance they were referring to giving unconditional positive regard to parenting decisions, and assuring women of their expertise in their role of parent to that particular child, consist to some degree with women-centred approaches to research. An example of this was Janet's comments below:

*"I'd write a book kind of just letting people know it's actually okay to trust your gut instinct and your maternal instinct maybe, and, and, to ... to kind of not know; I mean know that the things that you can kind of gauge your babies or your success as a parent is on things like, you know, is your baby healthy? Is your baby happy? And if you can kind of tick a few boxes whatever those boxes maybe, but if you could tick a few boxes then actually you're doing a good job."*

In all, the women had made a concerted effort to prepare for the arrival of their babies. They acknowledged having worries around the arrival of the infant and thus the information seeking could be seen as an adaptive form of anxiety reduction. They attempted to access information from a variety of sources using the knowledge base they had about where to get that information. Furthermore, they expressed frustration and disillusionment when the

information proved to be of limited worth, possibly because, for these women, information gathering had been a successful strategy previously in other areas of their lives.

*Emotions, emotions, emotions...*

The women reported being surprised at the strength of what they referred to as the emotional bond with their infant. They referred to feeling attuned to their infant and having a level of awareness of their infant which they were not expecting. Overall, it seemed the women held an intellectual understanding of a mother/infant bond. They expected to love their child, they expected in fact to love them instantly, but the experience of the bond was far more intense than they had anticipated.

If the strength of the emotional bond with their infant was somewhat of a surprise for this group of women, so too was the intense and relentless nature of the emotional burden of parenting they reported. And while the emotional bond was more positive than expected, the emotional burden was just that, a burden. The participants were extremely definite in demarcating these two emotional experiences, clearly articulating a stance indicating they believed the emotional burden they referred to was different from, and independent of, the emotional attachment to their infant they experienced. So the women were referring to experiencing both emotion in the attachment bond, but also an emotional aspect of parenting independent of their attachment to their child. Pride, frustration, helplessness: the women described a gamut of emotions which they had experienced since becoming a parent at an intensity level they found surprising. Supporting this demarcation of the emotional components is the differing effects the each of the states had on the women. They reported while they generally experienced the intensity of the emotional attachment with their infant as unexpected and therefore surprising, this did not create the level of difficulties for them the other emotional aspects of parenting did. Furthermore, their own reactions to their infants were also unexpected:

*"You don't expect, when a baby cries; your baby cries, how it affects you physically, you don't expect that, when ... she cries, it goes straight through the core of me, you don't expect it." (Kathy)*

*"I have surprised myself at how much... into him that I am." (Janet)*

*"Like I just found it completely overwhelming, that you could love someone so much in such a short space of time and completely overwhelming that I had this little thing to look after and how was I going to look after her." (Sasha)*

It was interesting, however, that despite stating the unexpected strength of the bond was not problematic almost all the women mentioned it. When this idea was explored further the women tended to describe an initial awareness of their attachment which caused a 'pause' while they considered and regrouped. However, they were able to move forward from these events quite readily. So while the intense emotional bond was unexpected it did not appear to

create any sense of distress or pressure whereas the other unexpected emotional aspects of parenting, such as dealing with infant illness caused high levels of distress. Again, what this seems to be suggesting is a disparity between expectations and reality is only problematic if experienced as a loss. Consistent with the model being posited because there was no subjective experience of loss, in addition they had an unexpected event they experienced as positive; they were able to readily transition without difficulty.

For one participant, there was a concern maybe the attachment was not quite what it *should* be. She questioned whether the intensity of her emotions was enough for her son.

*"I didn't know how I was supposed to feel with him, so I questioned, kept questioning, whether I was feeling enough." (Helen)*

During this time Helen sought reassurance from both friends and her Plunket nurse, and eventually decided her infant was both healthy and happy and therefore she must be *bonded enough*.

Not all the surprises were as positive though, and the women reported a number of unexpected disparities which they experienced as distressing. For instance, the volatility of their own emotions following birth was a surprise to three of the women. Although they had heard of baby blues and postnatal depression most of the women felt this had been downplayed at antenatal classes and they were poorly prepared for the moods that followed birth. They were particularly unprepared for emotional volatility beyond the initial baby blues period of three to ten days.

*"I cried a lot the first 12 weeks, and I was a bit of a nutter, I was very anxious, I no-one told me that that could happen". (Sasha).*

For these three women experiencing the see-sawing emotions past the second postpartum week was frightening. They stated they had been told baby blues was a relatively isolated and innocuous experience and they were convinced there was something seriously wrong when their experience went beyond that. That is, the expected emotional volatility was unpleasant but manageable but when the volatility went beyond their expectations they started to become upsetting and worrying.

*"You know I was kind of at a loss, it's like well this is more than the baby blues but not quite PND (slight laugh) so where do I fit in? and I didn't have anything in there you know it didn't fit into anything so I couldn't make sense of it in my own head, and being a very logical person I, I have to make sense of things, and I think that could have been part of my problems at the time was that I couldn't make sense of it." (Janet)*

*"I think if I'd known that, prior to it all coming on I probably wouldn't have freaked out as much." (Sasha)*

So again, this disparity between expectations and experience was very distressing for the women involved. A sense of confusion seemed to permeate their discourse around their

early postpartum emotions. They did not understand them, did not expect them, and they most certainly did not like them. Compounding all this was a sense of guilt or shame, a deep sense that they should be very happy at this stage because of the baby.

*"It must seem kind of counter-intuitive I guess to the fact that I've just had a baby and I've been wanting this for so long and I should be happy but now I'm crying and it doesn't make sense, and so when you can't really make sense of it, it becomes really puzzling and quite confusing." (Janet)*

Resolution was reached when the emotions settled, somewhere in the third month generally. The women all stated their experiences left them frightened and confused during those initial postpartum months, and they strongly believed they could have been better prepared. While baby blues and postpartum depression had been mentioned at the different antenatal classes the women attended it was not enough for these women to feel their experiences were within the bounds of normality and, as a result, compounded the distress and guilt these women experienced.

*"The way it's presented probably is the problem at antenatal class it's, you know, they say well you know you have these baby blues day, you know it will just be a day blah blah blah, 24 hours you just want to cry all the time. You won't know why but you wake up the next day and it will be gone and everything will be fine. And so that's not the same as postnatal depression, so they do this comparison, kind of like this big pendulum swing from like one day of baby blues to like, you know, this massive bout of PND and so, and they don't really give you that actually, it probably exists on a bit of a continuum." (Janet).*

#### *What now? Unexpected realities of infant contact*

Aside from the emotional aspect and the general sense of being unprepared as a parent, the women in this group also reported feeling unprepared for actual contact with infants. They had limited exposure to babies prior to becoming mothers themselves, and had little in the way of mothering role models aside from their own mothers. This seemed to create some uncertainty for these new mothers who were, on occasion flummoxed as to how what to expect next.

*"I've never been around babies much... I don't know when a baby's meant to talk or crawl or walk or, I had no idea". (Helen)*

This was a strong sentiment shared by other mothers:

*"I had no clue so yeah that was good (laughs) I'd never held a child let alone thought about really even thought about little bobbies so yeah, I had no idea". (Sasha).*

The women attributed some of their sense of being unprepared for the realities of parenting to the professionals involved in their transition to motherhood. From some women there was an indication they believed the professionals such as midwives and doctors did not do

all they could to help the women prepare, while some of the group reported a sense of professionals withholding knowledge.

*'Suddenly Plunkets' come back with all these ways that your meant to be helping babies, all these sorts of thing that until you actually get to the point that you have problems no –one mentions it'. (Helen)*

### **KNOWN VERSES UNKNOWN - I KNEW THAT WOULD HAPPEN... SEE**

The women in this group clearly articulated holding a number of expectations prior to the birth of their child. These included expectations of themselves in the mothering role as well as expectations of motherhood, including how they would be treated by others in their new role. In addition the women expressed a number of expectations for their infant, and expectations of their partners.

#### *Infant Expectations*

Participants held a number of expectations about their infants during pregnancy. These included imaginings regarding physical appearance, and also personality traits. Following birth most of the women expressed satisfaction with their infants and stated their expectations had been met if not exceeded.

*"You know like you expect like to have a baby that's just cries all the kind of thing, and he's not been like that at all". (Janet)*

However there were occasions when infant expectations were not met.

*"I do remember the first few months being like but why doesn't she just establish a routine and then fit into it, and why doesn't it fit with mine (laughing), cos I really seriously thought that's just what they did". (Sasha)*

For Sasha, the disparity between her expectations and her experiences of her infant was a cause of some distress until she was able to, in her words, reframe what was happening, which effectively acted as a new way of coping for her.

Consistent with the theory behind the model, the expectations regarding the infant were highly optimistic. A strongly held expectation was the vision of the *bonny, bouncing, baby*. While the women stated they had a number of worries about infant health during pregnancy, there doesn't appear to have been discussion or consideration around how to cope with physical or development challenges if they arose. As a group the women stated infant health was highly important, and good health seemed often to be equated with good mothering, with phrases such as 'If baby is healthy then you're doing okay', commonly used.

*"The big thing for me is that, you know, my kids stay healthy I've, you know, can't imagine if they went through the health system for a childhood illness that a lot of people have to cope with, the health is a big thing, so I think if they're healthy in*

*other ways through the mind and the environment then that will help them hopefully physically. (Kathy)*

However, not all the infants were physically well. One child had severe eczema and the parents were in the process of exploring what triggered or exacerbated the symptoms. As a result the mother had a severely restricted diet, in an effort to reduce the risk of aggravating the eczema through breastfeeding. Cleaning agents, sprays, and fresheners had been adjusted, while eggs, dairy, nuts, tomatoes, and gluten had been removed from the house.

For this mother the violation of her expectation of a healthy infant was compounded by the reactions of others to her baby. The eczema was highly visible, looked unpleasant and upsetting for the child, and was a source of conflict between the parents and medical professionals involved in the infants care. In the words of the mother

*"I think it; it certainly has added a level of anxiety and stress around how to look after her you know". (Sasha)*

In addition another child showed early signs of developmental delays. In this instance the mother reported this was causing marital tension as she was convinced the father was avoiding public activities with the child out of embarrassment because he was 'behind'. Although she had not discussed her concerns or perceptions with her husband, she stated this was very distressing for her as she felt she had to process her own feelings around what was happening, as well as deal with the perceived negative behaviour of the father. In this instance there is a clear indication that the violation of expectations was distressing, certainly for the mother, and quite possibly for the father, and as such is consistent with the model being hypothesized in Chapter Five.

#### *Expectations of self as mother*

In addition to holding expectations for the infant, the women acknowledged holding many expectations about themselves in the mothering role. Consistent with the findings from Study One, there appeared to be conflict for several of the women in this study, as despite wanting to have children to mother, they made it clear they initially had little desire to actually be a mother. In general, the image held of mothers by the group was not something they found inspirational. Mothers were, in their view, stay at home women who appeared to lead fairly one-dimensional lives, were completely child focused yet lacked an understanding others might not be quite so enamoured of their off-spring.

*"They give up everything and that they think it's the be all and end all is to be a mum but they expect everyone else to think that, that it's the be all and end all, that they're a mum and that their kids are something really special, I'm sure their kids are special but, but I don't have to think that they're that special." (Collette)*

This misfit between mothering and motherhood arose time and again throughout the interviews. While the women loved their off-spring and (mostly) enjoyed mothering them, they

categorically did not like being mothers with the perceived disadvantages and social sanctions that accompanied the mother title. Belief in the phenomenon of 'baby' brain came through strongly in some of the discourse.

*"I had this vision image or something of yeah... that they lose half their brain cells when they have a baby so they just become stupid and just obsessed with their kids - everything's just baby, baby, baby, like they just throw their entire selves into to having a baby and being a mum and kind of lose themselves a bit, I almost slightly feel irritated just thinking about the type of woman". (Janet)*

*"I guess that was always my concern that if I became a mother I was somehow giving up on part of me". (Helen)*

The women in this study all had careers prior to getting pregnant and most expressed concerns about what they perceived as a lack of maternal interest before having their baby. They worried about their mothering ability during pregnancy and three of the women stated initially they did not think they would make very good mothers.

*"When I first found out I was pregnant I burst into tears and it wasn't tears of joy, I mean it was tears of shitting myself" (Janet)*

*"But I think the whole kind of feeling like I didn't have like a maternal bone in my body, I think I probably been quite surprised by how hmmm, say how well I've kind of taken to motherhood" (Kathy).*

While the unexpected strength of the emotional bond was discussed in the previous section, there was another component of the bond some of the women referred to, and that was their experience of feeling pressure to bond. For some of the women, bonding with their infant was non-problematic and they stated they immediately felt a strong connection with their child. For other women bonding was slower and this was contrary to their expectations. There was a belief that bonding would be instantaneous, and when it was not the women reported feeling distressed, and attempt to conceal their 'true feelings' about their infant from others.

*Helen "Right at the beginning when I had him I had a bit of trouble, that of not quite bonding with him like I should have, I just didn't take to him straight away... so that was quite a surprise to me*

*Interviewer "You had an expectation that your bonding would instantaneous?"*

*Helen "Oh yeah"*

*Interviewer "And was it?"*

*Helen "No; I mean it was to a certain extent but it was hard to ... I don't really know how to explain this but it's hard to try and decide whether you love him enough".*

Despite these concerns the women reported being happy in their mother role and all were developing confidence as they grew into their new identities. In addition, as the women evolved into mothers their perception of other mothers changed. From fairly stereotypical opinions about intelligence and lifestyle the group perception broadened as they developed and new appreciation for the talent of mothering.

*"I think... I think realising now that I know a lot more mums I realise that actually they, they're just juggling life, juggling everything and trying to do the best that they can so my, my kind of attitude and my perception of mums has definitely more positive." (Sasha)*

*"I think becoming a mum you start to realise that you don't give up a part of you, you just kind of create a new part that adds to all the other parts." (Janet)*

So in the case of Janet and Sasha, both expected significant losses associated with mothering. They expected to lose a large part of who they were as the baby took over their lives. Given this did not happen, what does it say about the model? The model asserts disparity between expectations and experiences will be distressing if the disparity is constructed in terms of loss. In these instances, although there was clearly a disparity between expectations and experiences, there was no corresponding loss. If anything there was a gain, although the women did not describe it in such terms. This then offers support for the model; the women were able to reframe their experiences, to defuse from their model of mothers and to experience motherhood as they found it rather than as they expected it to be.

In all the women held representations of a number of future possible selves. There was the future possible self that they would like to become who was a highly functioning multi-faceted mother who maintained a good work life balance. Conversely, there was a clear representation of a feared future self who was overly absorbed in their children with limited cognitive functioning.

#### *Expectations of partner*

The partners of the women interviewed appeared to offer considerable support in the early postpartum period. Without exception the partners took time off work following the birth, and efforts were made to participate in the care of the babies. This diligence does not appear to have lasted for the majority of the women however. While two of the women interviewed reported their husbands shared the burden of childcare at a level they were happy with, the others expressed disappointment at the level of support they were receiving.

*"I've been the one who's getting up at night and he's been in bed asleep and there's been times were I've thought DUDE! you know, WHAT ARE YOU DOING? Yeah it has been quite different I think; very different to what I expected I probably expected that he would do more, and that he would... and he hasn't." (Sasha)*

Then again, there were instances where the woman reported receiving support from their husbands that they could identify as the partner attempting to be supportive, but unfortunately, they did not experience it as supportive.

*"But it was annoying...it was not helpful at all, so he thinks he's being really helpful like he you know really tries to... he's got an interesting take on what he thinks is helping me." (Janet)*

Often the women could understand their partners were trying to be supportive but they ended up *missing the mark*. What appears to have been important is not the level of support offered, rather the perception of that support as relevant and helpful by the women. Again this is consistent with the findings in Study One and suggests the meaning behind and interpretation of helping behaviour is often incompatible.

In addition, the expectation of support the women held before the arrival of the baby appeared to have a role to play in the women's experiences of partner support. For one of the women, there was no expectation of support from her husband; she expected to be left with the bulk of the caring and the bulk of the domestic tasks and she was. For other women, they held expectations that their partners would contribute more and experienced distress and frustration when he did not.

*"I've probably been disappointed and annoyed with him at times, so I probably did expect that he'd do more" Colette*

*"I think particularly for me in the workload like that's been quite major, like I feel I'm working 24/7 and I feel like he works 12 hours". (Sasha)*

Division of labour does not appear to have been something that was discussed in detail prior to the arrival of the baby. In hindsight the women acknowledged little consideration had been given to how the couple would actually parent. Preparations focused on both the baby's physical needs – setting up of nursery, purchasing of clothes, strollers, car seats etc, and the event of birth. More philosophical discussions around parenting values and beliefs were markedly lacking, as were discussions around each partners expectation of the other, or decisions on parenting styles and roles.

*"I think if we'd had an opportunity to, to talk about some of those things, certainly for us if we'd been able to talk about how the roles would work and who was gonna do what that would have been... yeah we'd be further down the track now" (Sasha)*

*"I still think we probably could have talked some stuff through" (Kathy)*

There was some discussion as to why these conversations did not occur. Barriers were explored as to what preventing partner talk on parenting. Generally speaking the women reported it not occurring to them as an item of discussion. So it seems the women were unprepared for disagreements around parenting values and beliefs, it seems, because they held them so implicitly they were unaware of them.

As a result of this mismatch between expected partner behaviour and experienced partner behaviour, several of the women reported feeling themselves to be overwhelmed on occasion with little support. The biggest impact of this for them was a sense of a change in the power balance within the relationship, whereby the women felt more vulnerable because of the dependence of the child. For some, there was an awareness of not wanting to rock the boat

too much because they now had a child to consider, which left them feeling they had lost negotiating power. This was especial pertinent for the women who weren't working.

*"I think when your vulnerable you tend to become a bit more passive and you kind of have to check yourself and go why am I becoming passive"? Collette*

It is interesting this initial feeling of vulnerability was referred by the group of mothers with older children as well. However, there seemed to be an indication that the feeling of vulnerability was very much linked to the vulnerability of the child. That is, while the child was very young and extremely dependent the women felt more vulnerable. However, as the child grew and become less dependent, the mothers' feelings of vulnerability because of the child eased. Regretfully this connection was not further explored in the first study, as at that stage, it did not appear that significant. However, when considered with the findings from this study it does raise some interesting questions.

## **LOSSES**

The losses can be grouped under a number of sub-themes. These include loss of non-mothering self, a concept which incorporates a loss of occupational identity or status. In addition there was a loss of autonomous self, including loss of independence and loss of ease of operation. Finally, the women reported a sense of loss of control.

### *Loss of non-mothering self*

#### *Occupational identity*

As previously mentioned the women in this cohort had all been working prior to becoming mothers. One had returned to work full-time, one part time and one was studying. The loss of income for the other women was reported as a significant loss. However further exploration of this idea identified the loss was not so much the money but the tangible indication of achievement a regular wage represented. Sasha stated

*"I'm a person who has gone through life probably rightly or wrongly getting some of my self-esteem from achievements, and from... you know earning a lot of money and yeah when you take that away... that's quite major" (Sasha)*

For Sasha, and other women in the group, their pay check validated both them and their achievements. It was a tangible acknowledgement of their worth, and their contribution and thus the removal of this was experienced as a considerable loss. All in all while the women believed mothering was the most important job they had undertaken the lack of financial recognition created some distress.

#### *Status*

Several of the women had careers as professionals in which they experienced a high status level. People listened to and heeded their opinions and valued the knowledge they held.

The women had invested substantial time and energy in their careers and they were proud of the respect and kudos they received. It was a considerable shock then for the women to experience firsthand being 'just a mother'. In their role as 'just a mother' their intelligence was challenged, their emotional stability questioned and their ability to rationally problem solve was dismissed. This loss of status was, for several of the women, reported as the biggest loss and the hardest one to develop alternative means of fulfilment for.

### *Loss of autonomous self*

#### *Independence*

This was a group of well educated women who had successfully navigated the path to adulthood, held down full-time jobs, earned good money, and they were proud to have stood on their own two feet. Most had finances independent to their partners and believed they contributed equally to costs incurred by the couple. They socialised, worked and operated as independent and capable women prior to becoming pregnant. Not surprisingly then, one of the biggest losses for the women was a loss of independence. All the women spoke of missing the independence they had prior to becoming a mother. This was particularly current for the mother of the wee twins who had needed significant levels of support in the early postpartum period.

*"Having you know, to rely on other people, I never have had to I've always been very independent". (Kathy)*

For Kathy and for Sasha who had a sick infant, as well as Janet who required a blood transfusion in the days following birth, the extra support they required was readily available, but sometime difficult to ask for. These women had a strong self identity as independent and capable; an identity which came under threat after giving birth. The increased vulnerability these women experienced at this time made them feel less independent which they experienced strongly as a loss.

#### *Ease of operation*

Since the birth of their babies, the women's lives had taken on a new complexity they had not counted on. Running errands, completing housework, even visiting friends became an operation in logistical planning requiring immense amounts of supplies and reinforcements. Bottles, nappies, changes of clothes, warmers, coolers, wipes, tissues, mats, car seats, strollers, the women reported feeling bemused by the array of gadgets and gizmos they were expected to be expertly able to construct, deconstruct, load and unload, usually one-handed while juggling the aforementioned baby. For this group of women previously easy tasks had taken on a new complexity and they missed the convenience and ease of being a non-mother. Collette mused:

*"Just being able to jump into the car go down together and get the fish n chips, really miss just being able to (laughs) quickly easily with my husband get in the car and go somewhere, it's so stupid".*

#### *Relationship balance*

As was mentioned in the previous section, the women in this study reported a growing awareness of a change in their relationship balance. Silent, unspoken, negotiated roles and rights had been challenged once the women gave birth. From an equal contribution to meeting expenditure the women now relied on their partners pay check. They found themselves having to ask for money to pay bills or to have a coffee with friends, and without exception, they did not like it. The women stated their partners had not made an issue of the finances, nor had they had asked them to explain or justify any expenditure they made. By all reports the men seemed unfazed by being the sole income earner and were extremely willing to share. However, for the women this ate at their fundamental sense of being an autonomous and independent person.

*"He has gone out of his way to try, at times to try and you know never there's never an issue about money don't worry about money or don't worry about this"*  
*(Sasha)*

Despite justifications for expenditure not being asked for the women felt they needed to provide it. This left them feeling vulnerable and, at least initially, disempowered within the relationship. This seemed to occur regardless of the actual level of contribution prior to the arrival of the child. What was relevant is that previously they had made *some* contribution and now they were not.

#### *Loss of control*

Women spoke about feeling out of control, especially in the initial stages of being at home with the infant. This loss of control underscored how unprepared the women felt once they became mothers. Although most of the pregnancies were planned, for some women the pregnancies were unexpected although not unwanted. However, the unexpected nature of the pregnancy did tend to highlight a sense of a loss of control which may well have carried on thorough to the postnatal period:

*"He wasn't unwanted even then when I found out, it was the shock of it, it was just like holy shit."* (Janet)

### **INFLUENCE OF OTHERS**

A final theme which seemed to re-occur throughout the transcripts was the influence of others and the impact others had on the women's parenting efficacy. For the majority of the women the influence of professionals involved in their maternity care had a lasting impact. The women tended to report ambivalent or negative relationships, particularly with medical staff.

They stated they felt they were not listened to by some staff and, at times, reported feeling de-individualised by their involvement in the maternity system.

*"This woman was quite opinionated... I think that you can have opinions but I think that you have to read people's interpretation of how you're coming across to them, and she didn't, she was very much a talker not a listener, and you'd talk and she wouldn't hear you." (Colleen)*

The women reported they felt they were treated at times like they 'should have known better'. As if there was information they should have had and did not, or aspects of child rearing they should have known about but again, did not.

*"I'm always slightly cynical because people, medical professionals believe in absolute truths and yet they're deal with humans who are, who are different." (Sarah)*

And another

*"I had a midwife asking me if I resented the child, and I said 'no I resent the system'. I resent you asking me about it because I'm having a, you know, a moment where I'm just absolutely saturated by the whole system". (Kathy)*

Again maybe some of this could be linked back to the women's earlier concerns about not feeling prepared. Whatever their intent, it appears the medical fraternity involved in these women's care gave a clear message to the women they should have been better prepared. The strength of the impact of the medical professionals on the women was not expected. One participant went so far as to state she would put a warning in her mothering book for new mothers

*"I would definitely have in the book something about that, the battle of the professional verses the mother instinct". (Sasha)*

Family also had a major impact on the women's transition to motherhood. Most reported depending heavily upon their own mothers for reassurance and support. For this group their mothers were seen as safe and supportive, likely to lend an ear but not an opinion.

*"I think my mum more than anything and I think [I think the reason I go to my mum more than anybody else is because my mum because I know my mum won't give me an earful." (Janet)*

However, some of the women reported extended family environments which were not experienced as supportive. Grandparents in particular fitted in to this group, and, perhaps not surprisingly, so did mother-in-laws. For instance in discussing her decision to go back to work with a young infant Helen says of her mother-in-law:

*"It just didn't work for her, like in her head like mothers stay home"*

Generational differences featured strongly in discourse around grandparent involvement, with women feeling they needed to justify some of their parenting decisions.

*"I've had to make decisions that go against my family culture at times, certainly with sleep, and ...that's been very hard for me to do, to stand up and go no no no we're doing it this way". (Sasha).*

## Discussion

This study investigated the transition to motherhood for five Pākehā New Zealand women. The women were all married, well educated and gave written consent to be part of the study. The five women all reported a number of shared experiences and common concerns they encountered as they evolved into their new parenting role. Firstly there were the emotional experiences including feelings of powerlessness, frustration, and what was variously described by the women as fear, worry, or anxiety, as well as the nature of the emotion which was unexpected in its intensity. By and large the women in this study reported feeling unprepared for many of the emotional aspects of motherhood and they indicated they believed it would have been helpful to have had more information about this prior to giving birth.

The five women in this cohort had, in fact, actively sought information about pregnancy, childbirth, and infant care from a variety of sources during their pregnancy. Given so much of psychological theory is built on the assumption individuals seek information, and a basic tenet of psycho-education is that providing individuals with information is important, their active information seeking this would seem a helpful and adaptive behaviour. Given this, the question remains why was the information then not helpful?

There are several possible answers to this question. It is possible the information was not helpful because the women did not seek helpful information with potentially negative content. There is ample psychological literature on the tendency of individuals to avoid information that has the potential to be distressing, or likely to cause dissonance. Maslow once said "we can seek knowledge in order to reduce anxiety and we can also avoid knowing in order to reduce anxiety" (1963, p. 114). So from that perspective it is possible the reason the women did not experience the information they received as helpful is because they censored the type of information they learned. Maybe there is some truth to the saying *ignorance is bliss*. But given the women had a good insight into disrupted sleep and expected childhood illness, not to mention the detailed particulars of a natural birth, it seems somewhat unreasonable to argue they avoided information that was potentially uncomfortable.

A second possible explanation is that the information was not helpful because it did not accurately represent the situations the women then found themselves in. This is consistent with the theory behind the proposed model which argues women are exposed to an overly

positive and realistic portrayal of motherhood prior to having children. Thus, it is possible the information the women were able to access was not helpful because it was not relevant.

Throughout the interview process the women highlighted a number of strong and concrete expectations and beliefs they held prior to giving birth. This is consistent with research cited in the earlier chapter on expectations (Belsky, 1985; Delmore-Ko et al., 2000; Kach & McGhee, 1982; Pearce & Ayers, 2005), and gives support to the model of postnatal distress under investigation. Given the model argues that a disparity between expectations and reality can be problematic, had the women not indicated holding prenatal expectations further analysis would have been redundant. As it was the finding that the women did indeed have strong expectations was predictable.

While some of these expectations were upheld a number of them were not. Expectations about the infants were met or exceeded according to the women. Generally the women were delighted with their young babies and expressed wonderment at the impact the infants had had on their lives. Without exception the women stated they would never be without their child and the positive aspects of being with their child and sharing in their child's development far outweighed any negative aspects of having their child as part of their lives. The women's contentment with their infant is consistent with other research which found women tended to report satisfaction with their infant; whereby their experiences were significantly higher than their expectations (Harwood, 2004; Harwood et al., 2007; Pearce & Ayers, 2005).

Consistent with research on possible selves, during pregnancy the women could envision both a feared self (overly child-focused, low cognitive functioning, narrow interest) and a desired self (balanced, interesting, and engaged). Interestingly, while women were reportedly content with their mothering selves, their current selves tended to be a blend of both feared and desired self. Meaning of course, what was feared during pregnancy became desired following childbirth. So, while there was a disparity between their prenatal expectations of self and their postnatal experiences of self there was no subjective experience of loss. The women in this cohort were happy with their current selves. So, as predicted by the model of distress, because there was no experience of loss, the women did not experience the disparity as distressing.

Many of the expectations which remained unfulfilled related to the fathers of the babies and the division of labour around childrearing and household tasks. The women were, in general, disappointed at the level of support they received from their partners in these areas. While most of the men made a promising beginning, these gains were not maintained, and for the women in this study, there was a clear and unexpected discrepancy in workload. What was important was not the uneven workload, but that it was perceived to be inequitable. The women expected to do more given they spent more time with the infant. However, on an hours of work basis the women felt short-changed. For instance they commented they worked all day too and yet night time parenting was seldom shared. This lack of perceived support

from the partners has important ramifications for the transition to parenthood given other research which suggests perceived support is significantly related to a positive transition.

It is interesting not all unmet expectations caused distress or disappointment, as this is consistent with the model of postnatal distress being posited in this thesis. The model argues disappointed expectations result in distress if they are experienced as a loss. In this instance though there may well be a difference between those aspects which are unexpected and present and those which are expected but absent. For instance, the women had neither expectation around the intensity of emotional attachment, nor about the physical responses to the emotional needs of their off-spring. These events were unexpected but unremarkable in their emotional impact. Events such as not bonding immediately with the baby however caused considerable distress. Put another way, the women expected an instant bond which was absent and did not expect intense physical responses to the infant which were present. Thus the emotional intensity couldn't be experienced as a loss because it wasn't anticipated, whereas the bonding was. In all, the women appeared to feel ill-prepared to deal with the challenges of mothering when such challenges arose. Their lack of prior experience and exposure to infants compounded the sense of being unprepared as did the intensity of their emotion response and attachment with their new off-spring.

The women stated if they were to write a book for new mothers they would include reassurances of the new mother's 'fitness' to mother. Every participant made some reference to writing a book which was non-judgemental and affirming, something which validated individual women's expertise in parenting their own child. However, this trend to offer non-specific reassurance was interesting in as much as it was not what the women reported they would have liked from the books themselves. As previously mention many stated more information on the emotional experiences of motherhood would have been beneficial, while others reported practical skill-based knowledge was what they were after.

The lack of practical skills could be linked back to earlier discussions of the evolution (or de-evolution, depending on your perspective) of the mothering role. None of these women had experience in dealing with infants prior to becoming mothers. For two of them their own infant was in fact the first baby they had held. Small wonder then, that they felt grossly underprepared on some occasions. It seems that the thing that would have been most helpful for the women is something the books can't provide – experience. In all this provided important information on women the women experienced as 'missing' from their own experience of mothering. While they were open to the idea nobody could be fully prepared for the transition to parenthood they nevertheless wanted to provide reassurance of women's attempts to cope with unpreparedness.

The physical health and well-being of the infants played an integral role in the women's conceptualisations of self as a good mother. Infants who were not well or, perhaps more accurately, infants who were perceived to be physically impaired in some way be it through health or developmental delays, resulted in the mothers experiencing considerable discomfort in

the daily interactions with others. This discomfort manifested in a number of different ways. The women felt vulnerable and unable to negotiate or make demands on behalf of their child. The 'just a mother' syndrome was apparent in a number of interactions these women had, particular those with medical professionals. An interesting theme with the women was the resentment they experienced towards those who treated them as 'just a mother'. They were quite shocked at, and unprepared for, the lack of credibility they had in day to day interactions with others which left them feeling disempowered and belittled on a number of occasions. According to the women, disagreement with an expert was reconstructed by the expert as a sign of being overly emotional and irrational. After all what sensible, balanced mother would disagree with them?

Midwives fulfil a crucial role in New Zealand's maternity system, and they provided many women with much valued continuity of care which was not always available under previous models of care. Given the pivotal role of midwives this finding has a number of ramifications which could be used to assist them further meet the needs of their clients. Importantly while doctors, midwives, or clinicians may interact with many mothers, mothers themselves only interact with one doctor, one midwife, or one clinician, and it is recognition of mothers as individuals, as unique and autonomous beings, which the women in this cohort group reported was missing.

It was interesting to note that while the women wanted to become mothers and have children, they were not eager to be mothers. Mothers per se were not valued by this group, nor seen as valuable contributors to society. The participants were generally scathing of mothers, tending to characterise them as being of limited intelligence, as being overly involved in the lives of their children to the exclusion of their own needs, and incapable of putting boundaries around their roles as mothers to focus on other aspects of their environment. When this is considered, it is interesting how unprepared the women were when they encountered the same viewpoint from others once they themselves became a mothers. Again, the 'just a mother' syndrome was a huge surprise to the women who encountered it.

Sasha's comment about not wanting to be treated as a mother made it clear that that was because to be treated like a mother was to receive less than to be treated as a non-mother. Effectively, what she was saying was she believed she was not able to access the help she wanted for her daughter while she was viewed by the medical fraternity as 'the mother'. Kathy related a similar experience. Her outburst at staff which she believes resulted from exhaustion from carrying twins, having surgery and then having five weeks of interrupted sleep as her and the twins were woken and moved around to meet the needs of the hospital and staff was not understood as something quite normal. Instead the staff asked if she resented her children, questioned her bond with the twins and then, Kathy believes, dismissed her challenges of them and the systems they were operating under as her being an overemotional mother.

George Herbert Mead coined the phrase 'generalised other' to describe a process whereby widespread cultural norms and values are used as references in evaluating our own behaviour. The idea suggests we invest energy in behaving as we believe others do. Perhaps the argument can be made that these women held the concept of a generalised mother, one who was socially isolated, child-driven, and poorly educated. But, interestingly, also one who was the model of patience, who could settle their child, embrace interrupted sleep and meaningless monotony, and was selflessly dedicated to all things child. If this is the case, and the women do indeed hold an expectation of a 'generalised mother' which they do not value, this would provide some support of the loss component of the research model. For although there was clearly a disparity between expectations and experiences, the disparity was not experienced as a loss and thus was not distressing to the women involved.

In all this study provides support for the model. There were a number of unmet expectations which did not appear to cause concern for the women. Those expectations could be characterised as low investment and low impact. The women neither held the expectations strongly nor were particularly impacted when the expectations did not come to fruition. However, when the disparity was experienced as a loss, such as a loss in status and the loss of independence following losing personal income, the women reported experiencing distress.

There are a number of limitations associated with this study. Most obvious was the small and homogenous sample. All the women could be described as upper middle class; all had some level of post secondary training and all identified as Pakeha (New Zealanders of European descent). Although there is other research available on postnatal distress in a New Zealand population (Goss, 1998), further investigation of the experiences of other populations would add to our understanding of the difficulties encountered for women in the transition to motherhood.

None of the women in this study showed high distress of postnatal distress or depression, thus the link between distress and loss could not be fully investigated. However, there was anecdotal support in that the women reported disparities they personally experienced as a loss to be more distressing than those disparities which did not have a subjective loss component. Further study needs to be undertaken with women who have experienced or are experiencing postnatal distress as measured by an objective tool such as the PDSS or the DASS. This would allow a more direct investigation of the link between distress and loss.

## **CONCLUSIONS**

This study aimed to investigate components of the model of postnatal distress being proposed in this thesis. Specifically, it aimed to determine whether women do report subjective experiences of loss following the transition to motherhood. There was support for the model found with the women in this study confirming experiences of a loss of the non-mothering self, including a loss of occupational identity as well as a loss of independence, control, relationship

balance and status. In addition the study confirmed women do indeed hold a number of expectations prior to giving birth, including expectations of themselves, expectations of their partners and expectations of their infants.

## Chapter Seven: Study Three - Evaluating the Myths

### Introduction

One of the core components of my developing model of postnatal distress is the argument that there is a disparity between expectations held by women who do not have children and their subsequent experiences after having had children. In a previous chapter (Chapter Four) I confirmed that, at least for the women interviewed, there was indeed a disparity, and furthermore that this disparity could be experienced as a loss. So the question becomes why then does this disparity exist? In other words, why are expectations unmet? Is it perhaps because mothers hold unrealistic expectations? Or maybe because there are unrealistic expectations placed on them? The answer is possibly components of both.

In earlier chapters, the environment in which women mother was discussed. Without repeating much of that discussion here, it suffices to say the position of this research is to argue the current environment in which women mother can, at times, seem unreceptive and unsupportive, with women experiencing a number of losses and adverse outcomes when they choose to mother. For instance, while the mothers interviewed in the previous study acknowledged at times experiencing an unexpected joy in mothering, there was a clear sense of conflict with partners, professionals, and others while in a mother role.

But additionally this research maintains the disparity is caused, in part, by expectations held by the women regarding motherhood which are unrealistic. There is support in the literature for such a stance (Harwood, 2004; Harwood et al., 2007; Kalmuss et al., 1992), although little which offers insights as to what factors might lead to the development of unrealistic expectations in new mothers.

Some researchers point to the number of myths perpetuated regarding motherhood, and argue women are socialised into these myths to such a degree they are unable to form appropriately balanced views of motherhood (Hall, 1998; Nicholson, 1999; Oakley, 1980, 1986; Phoenix, Woollett, & Lloyd, 1991). Certainly some of the information garnered off the Internet and highlighted in Chapter Three was almost saccharin sweet, with the pendulum pointing way over to the overly positive side. Could this mean women simply do not have information with which to challenge existing motherhood schemata? If this is the case, is this then compounded by the increased isolation and changes to supports for mothers that result in limited opportunities for women who are not mothers to observe or gather conflicting information with which to modify their motherhood image? For three of the five women in Study Two, such was their isolation from infants and mothers that their own baby was the first baby they had touched. Women with children, to a degree, are somewhat invisible to women without.

Could that mean, then, that unrealistic expectations are related to life experience and therefore age? Certainly age has been investigated many times as a possible contributor to postnatal depression and postnatal anxiety, as have other demographic variables linked to life

experience such as marital status and educational attainment (Austin & Priest, 2005; Beck & Indman, 2005; Bernstein et al., 2008; Edwards, Galletly, Semmler-Booth, & Dekker, 2008; Lee et al., 2007; Miller et al., 2006; Robertson et al., 2004). However results have been inconclusive with findings reported in both directions. Despite this, the impact of these demographic variables on prenatal expectations has not been examined and one can only speculate on the relationship at this stage.

It has been said that only a powerful myth could encompass as many conflicting ideals as the myth of motherhood does (Hare-Mustin & Broderick, 1979). These myths portray motherhood as idyllic and effortless – completely unproblematic. They suggest mother/infant bonding is instantaneous, and physical recovery from the rigours of childbirth happens naturally and rapidly. Mothers don't raise their voices, have unlimited time and patience, don't get sick, and do not require respite. They unwaveringly relish their mothering role and never resent, regret, or rue having children.

However, even if women have no exposure to infants and limited exposure to mothers, all women have been mothered to some degree. How, then does that impact on her expectations of mothering? Do, for instance, women who subscribe to mythical images of motherhood report having highly positive mothering experiences? In other words, is a tendency to romanticise motherhood related to the perception of having an *idea*/mother? And conversely, could this then be used as a predictor variable? Thus, women who report highly positive mothering experiences have a higher likelihood of endorsing overly positive myth statements, which of course is of interest if myth endorsement and postnatal distress are linked, as my model of postnatal distress proposes.

So considered holistically, what does the research mean and how does that fit with the model? In a nutshell it means women hold unrealistic expectations of mothering and motherhood because society portrays mothering and motherhood in an unrealistic way, exposing young women of child-bearing age who do not have children to a variety of mothering myths which leave them ill-prepared when they actually make the transition to parenthood. It means younger women have limited opportunity to garner information with which to challenge their mother prototype and develop it into a more refined version.

So what of the impact of life experience variables such as age and education, and also the experience of being mothered? How do these variables impact on myth belief and realistic images of mothering? And importantly what defines a mothering myth? Or, for that matter, a realistic image of mothering? Finally, if societal portrayals of mothers are responsible for creating mythical mothering images, what is the relevance to New Zealand women given the research highlighting mothering myths comes predominately from America and England?

The Oxford Dictionary Online (Oxford University Press, 2011) defines a myth as a widely held but false belief or idea:

- A fictitious or imaginary person or thing
- An idealized conception of a person or thing

It is, of course, the idealized concept of a person or thing that is what is of interest in this context. Drawing on that I developed an operational definition of a mothering myth for this research which is:

*A widely held belief or assumption about motherhood within a culture, which lacks clear empirical evidence and in which holding such a belief impacts on behaviour, cognitions, or emotions.*

### **RESEARCH QUESTIONS**

In order to address the questions posed above, that is, to determine whether, there is support for the claim New Zealand young women of child-bearing age who do not have children subscribe to myths of motherhood, a study was developed. The aim of this study was firstly to determine whether women who were not mothers agreed with these mothering myths, and secondly, to ascertain their level of belief in them. Furthermore, given the developing status of research on mothering myths some initial exploratory research questions around the impact of parenting and life experience were developed. Specifically, the research questions this study aimed to address included:

- Do young women of child-bearing age who do not have children hold unrealistic expectations of mothering and motherhood?
- How do women think others perceive mothers?
- Do women with mothering experience of a non-biological child endorse items differently than women without such experience?
- Does the perception of one's own experience of being mothered impact on the nature of one's expectations of mothers?
- Is there a link between life experience as measured by marital status, age, and level of education, and overly positive expectations and beliefs as measured by the Mothering Myths Questionnaire?

From these questions a number of hypotheses were formed, namely:

- That young women of child-bearing age who do not have children will endorse myth statements.
- That participants will rate themselves as more realistic as others.
- That women who have acted in the parenting capacity with a non-biological child will have lower myth ratings than women who have not.
- That women who rate highly their experience of being parented will endorse mythical statements of motherhood more strongly.

As the links between other life experience and myth endorsements were exploratory no specific hypotheses were formed with regards to these variables.

## **Method**

A survey questionnaire was developed which inquired into the thoughts of young women of childbearing age who did not have children regarding mothers and mothering. The survey was distributed to eligible participants after receiving low risk ethics approval from the Massey University Ethics Committee (Appendix F: 1).

### **PARTICIPANTS**

Participants were recruited in a number of different ways. A particular focus was given to areas which offered a high concentration of young women. Brief presentations were made to university classes on different campuses with a high proportion of female students (nursing, social sciences, and education), outlining the research and inviting women to collect a questionnaire at the end of class if they chose. In addition I did personal approaches to groups of young women in local malls and sporting events. Local sporting clubs with a high concentration of female competitors (netball, equestrian) were approached and asked if questionnaires could be distributed through their membership.

Women were asked to complete the questionnaire if they were between the ages of 18-36 years old, did not have a child, and were capable of giving informed consent. All participants were offered reply paid envelopes but most choose to complete the questionnaire at the time. Participants in the sample covered the full range of eligible ages with the mean age being 22 years. Most were single ( $n = 102$ , 58%) and 15 (9%) were married. For the women who stated they were in some form of relationship (41%), the average length of relationship was 1.6 years ( $SD = 2.72$ ), ranging from four months to 16 years.

The participants were asked to complete the survey questionnaire, and all participants who chose to do so went into a draw to receive one of five iTunes vouchers to the value of NZ\$20.00.

### **MEASURES**

Demographic Questionnaire - The participants were asked complete a number of questions relating to demographic information and life experience, including relationship status, length in current relationship, age and parenting experience. In addition participants were asked whether they thought they might have children and, if so, an approximate timeframe when that might occur.

### *Mothering Myths Questionnaire (MMQ) (Appendix G)*

The Mothering Myths Questionnaire was specifically developed to address the research questions posed in this study. The MMQ contained 20 items gathered from variety of sources including existing research and research conducted as part of this thesis. The items consisted of statements relating to an expectation of what an individuals' situation would be like if they were to become pregnant or have a child.

Initial questionnaire items were generate by searching through literature on the myths of motherhood using the keywords mothering, motherhood, myth, mythical. Both academic databases such as PsychInfo, PsycARTICLES, Psychological and Behavioural Sciences Collection, and Web of Knowledge, as well as public assess Google were searched. In addition a number of possible items for the myth scale were generated by examining discourse in women's magazines, blogs aimed at mothers and mothering, as well as other media including television and newspaper. Finally statements which reoccurred in both the expert panel focus group in Study One and the interviews with new mothers in Study Two were included. For instance, the item *when you are pregnant even complete strangers smile at you and ask you questions* was included based in the fact it was a recurring statement in both studies.

Once an initial item list was generated, the list was given to a reference group of women who were mothers and who were experienced in professional work with women and women's issues, in order to conduct a face validity analysis of the items. The expert reference group was then asked to rate whether they believed each statement represented a realistic or mythical portrayal of motherhood. Items which the expert group rated as mythical were then collected and examined for an evidence base. Inter-rater reliability for each item was calculated. Those items which had an inter-rater reliability score over 90% for myth content and which lacked an evidence base in research literature (i.e., *having a baby cements a relationship*), were selected for the myth scale. Items which mothers had originally rated as realistic were then reviewed and included in the realistic scale if they were endorsed by the majority of mothers as realistic (i.e., *when you are pregnant even complete strangers smile as you and ask you questions*), and if there was support for the statement in research (i.e., *towards the end of one's pregnancy, back pain, difficulty sleeping and feeling tired are perfectly normal but unpleasant experiences*). At the end of this process the questionnaire contained 20 items, 11 myth and 9 realistic. The items were designated a number from 1 to 20 and a random number generator was utilised to order their presentation on the questionnaire. In the final phase of test construction, the questionnaire was piloted to a group of women fitting the profile of the target audience in order to check face validity and understanding of the items.

### *Scoring*

Each item is scored from 0 – 5 with 0 indicating strong disagreement and 5 the highest endorsement of myth statements. A score of 2 equates to *somewhat disagree* while a score of

3 equates to somewhat *agree* meaning a neutral position is not possible. Thus individuals who scored 27.5 or higher for the myth items (an average of  $\geq 2.5$  per item), were deemed to endorse myth statements of motherhood. Items included in the questionnaire which were rated as realistic by mothers in the pilot (i.e. *when you are pregnant even complete strangers smile at you and ask you questions*) were reverse scored so that disagreeing with a realistic item scored the same as agreeing with a myth one as both indicated an unrealistic expectation. The item scores were totalled with a higher score representing greater endorsement of mothering myths.

#### *LEAP – Lum Emotional Availability of Parents*

One of the research questions posed was *Does the perception of one's own experience of being mothered impact on the nature of one's expectations of mothers?* To investigate whether there was, in fact, a link between expectations of motherhood and the experience of being mothered, the LEAP – Lum Emotional Availability of Parents (Lum & Phares, 2005) was included in the survey. The LEAP is a measure of the perception of parental engagement which has been validated for use in a child and adolescent population and is available in the public domain. For the purpose to this study the form was altered from asking questions about both parents to a focus on mothers (instead of the statement *he/she supported me* the statement became *my mother supported me*). Items are scored on a six-point Likert scale from 1 = never to 6 = always, with possible scores ranging from 15 to 90 (Lum & Phares, 2005). The item is available in the public domain and is free to download off the Internet.

#### **PROCEDURE**

Once women had agreed to complete the survey following a brief verbal explanation by me, they were then given a full information sheet to read (Appendix F: 2). This gave information on voluntary participation, the right to withdraw, and confirmation of the ethical approval. If the participants were happy to continue after reading the information sheet they indicated their consent by proceeding to complete the questionnaire.

After completing the questionnaire the participants were directed to go back and re-rate the initial 20 belief statements according to how they thought the 'average' person would respond. Thus, there were two myth ratings generated by the survey: ratings of self-beliefs and ratings of expectations of others. Finally, participants who wished to be included in the iTunes voucher draw were asked to put their email address at the end of the questionnaire so they could be contacted once the draw was completed. For the purposes of the draw, completed questionnaires were assigned a number based on the order in which they were received by the primary researcher. The spread of questionnaire numbers was then entered into a random number generator freely available to the public on the internet.

## Results

A total of 280 surveys were handed out and 202 were collected back, a return rate of 72%. Of the returned questionnaires, 27 were subsequently dropped from analysis as they had not been filled out correctly and were missing the second myth ratings, the ratings of others and hence were deemed to have too much missing data. This resulted in 175 completed, fully usable questionnaires in the final data set.

### DEMOGRAPHIC INFORMATION

The demographic information for the sample is shown in Table 7.1. The majority of the participants had completed 13 years of education (54%) whilst 26 (14.9%) indicated a degree was their highest level of education and 21 participants (12%) had a postgraduate qualification. Participants indicating their highest level of education was the National Certificate of Educational Achievement (NCEA) Level Two or below was small ( $n = 5$ ; 2.9%).

Nine participants (5%) indicated they did not intend having children. For those who indicated they planned on having children at some stage in their lives, nearly two thirds of the sample (65%,  $n = 114$ ) thought children were at least 5 years away.

### MOTHERING MYTHS QUESTIONNAIRE.

The mean, standard deviation and number of responses for each MMQ item are presented in Table 7.2, while full information on each item including level of endorsement is included in Appendix I.

#### *Myth Items – Self Ratings*

A key question for this study was *Do women of child-bearing age who do not have children endorse myth statements of motherhood?* In all, seven of the eleven myth items were endorsed in the self ratings. The item with the highest endorsement was the item relating to holding the newborn (mean myth score = 4.17) (Table 7.2). This was closely followed by the belief giving birth in a hospital is safer ( $M = 3.6$ ,  $SD = 1.02$ ). Table 7.3 shows the item that was most often endorsed at a *strongly agree* level was *Holding your newborn baby for the first time is a precious moment for women* ( $n = 87$ , 50%). This followed by 38 (22%) of women.

Table 7.1. Demographic Information of Sample\*

	Age	Marital status	Length of R/Ship	level of education	parental role	plan to have child
N	Valid 175	173	174	171	174	175
	Missing 0	2	1	4	1	0
Mean	22	Flying Solo 102 (58%)	1.6	≤NCEA Level2 5 (3%)		
SD	4	In a R/ship 37 (21%)	2.7	NCEA Level3 94 (54%)	% Yes 43	% Yes 95
min	18	Defacto 19 (11%)	0.1 yrs	Bursary 5 (3%)	% No 57	% No 5.
max	36	Married 15 (9%)	16 yrs	Post-Secondary 20 (12%)		
			Degree 26 (15%)			
			Postgrad 21 (12%)			

Table 7.2. Means and Standard Deviations for Participants' Responses

Items	M	SD
Mothers have an instant bond with their baby	3.47	1.16
Giving birth in a hospital is safer	3.63	1.02
Pregnant women have a glow about them that make them look and feel radiant	3.03	0.93
Having a baby cements a relationship	1.69	1.25
Not bonding quickly with your baby can have long term consequences	2.70	1.13
Deep down, pregnant women have real fears that the baby will not be normal	1.46	0.98
It is entirely natural for a mother to sometimes regret having a baby	2.09	1.06
A woman's life can only be fulfilled if she has a baby	.99	0.98
Being a mother is a major commitment like no other	.49	0.77
Holding your newborn baby for the first time is a precious moment for women	4.17	1.20
Feeling your baby kick for the first time during pregnancy is a good feeling because it means the baby is getting bigger and stronger inside you	3.59	0.93
A mother's instinct comes with the birth of your baby	2.75	1.14
Having a baby changes a girl into a woman	1.86	1.27
During pregnancy it is common to feel a little emotionally sensitive	.83	0.66
One of the best feelings with a newborn is knowing your baby is peaceful and happy	.87	0.79
A good woman will feel nothing but joy during pregnancy, thinking of the new life she will bring into the world	1.52	1.20
Giving birth is one of the most natural things in the world and we should stop medicalising it	2.23	1.28
Newborn babies require around the clock care, making it hard on some women	.99	0.92
Towards the end of ones pregnancy, back pain, difficulty sleeping and feeling tired are perfectly normal but unpleasant experiences	1.05	0.80

Table 7.3. Strength of Endorsement for MMQ Myth Items \*

	Strongly Disagree		Somewhat Disagree		Somewhat Agree		Strongly Agree					
	n	%	n	%	n	%	n	%				
Mothers have an instant bond with their baby	0	0	15	9	16	9	52	30	58	33	35	20
Giving birth in a hospital is safer	0	0	6	3	15	9	54	31	62	35	38	22
Pregnant women have a glow about them	0	0	13	7	30	17	74	42	54	31	4	2
Babies cement relationships	37	21	49	28	31	18	47	27	11	6	0	0
Not bonding quickly can have long term consequences	4	2	22	13	47	27	61	35	32	18	9	5
A woman's life can only be fulfilled if she has a baby	62	35	73	42	22	13	16	9	2	1	0	0
Holding your newborn baby for the first time is a precious moment for women	6	3	6	3	2	1	12	7	62	35	87	50
Feeling your baby kick for the first time during pregnancy is a good feeling because it means your baby is growing bigger and stronger	2	1	6	3	6	3	52	30	90	51	18	10
A mothers instinct comes with the birth of your baby	4	2	24	14	38	22	59	34	45	26	5	3
Having a baby changes a girl into a woman	26	15	51	29	42	24	36	21	17	10	3	2
A good woman will feel nothing but joy during pregnancy, thinking of the new life she will bring into the world	36	21	61	35	44	25	23	13	7	4	4	2

Table 7.4. Level of Agreement and Disagreement for MMQ Myth Items \*

	Agree		Disagree	
	n	%	n	%
Mothers have an instant bond with their baby	145	(83)	30	(17)
Giving birth in a hospital is safer	154	(88)	21	(12)
Pregnant women have a glow about them	132	(76)	43	(25)
Babies cement relationships	58	(33)	117	(67)
Not bonding quickly can have long term consequences	102	(58)	73	(42)
A woman's life can only be fulfilled if she has a baby	18	(10)	157	(90)
Holding your newborn baby for the first time is a precious feeling your baby kick for the first time during pregnancy is a good feeling because it means your baby is growing bigger and	161	(92)	14	(8)
A mother's instinct comes with the birth of your baby	160	(91)	14	(8)
Having a baby changes a girl into a woman	109	(62)	66	(38)
A good woman will feel nothing but joy during pregnancy, thinking of the new life she will bring into the world	56	(32)	119	(68)
	34	(19)	141	(81)

\* Percentages may not add up to 100% due to missing data or rounding

who strongly agreed *Giving birth in a hospital is safer*. Thirty five (20%) women indicated they strongly agreed with the item *Mothers have an instant bond with their baby* while a further 58 (33%) *agreed*. One hundred and nine participants (62%) agreed a mothers instinct came with the birth of the baby while 82% believed the mother infant bond was instantaneous ( $n = 145$ ).

However, not all the myth items were endorsed. Table 7.4 shows two thirds ( $n = 117$ ) of the women in this sample disagreed having a baby cements a relationship, while just under 90% ( $n = 157$ ), disagreed with the item *a women's life can only be fulfilled if she has a baby*. In addition, 119 participants (68%) did not agree with the myth statement *having a baby changes a girl into a woman*. In all, as expected, the myth items scored higher on the myth scale than the realistic items.

The scores of all the items combined indicated young women of child-bearing age who do not have children did endorse the myth statements as shown in Figure 7.1. Overall, less than 20% of the raters *did not endorse* the myth items, while nearly half (47.4%) *somewhat endorsed* the items.

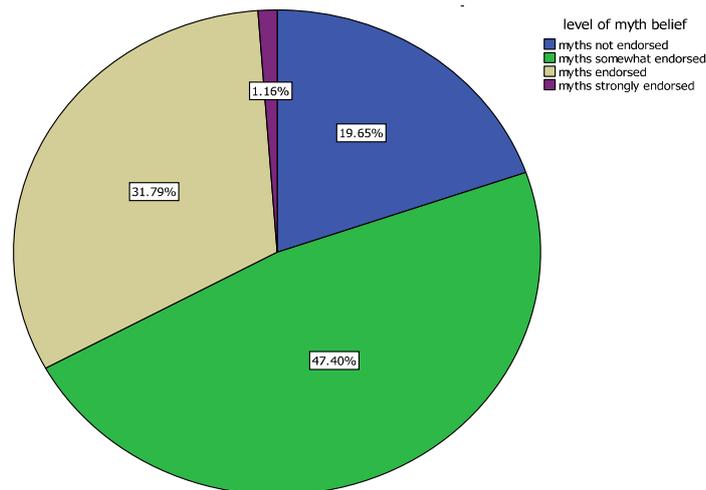


Figure 7.1. Overall Endorsements of Myth Items

### Realistic Items – Self Ratings

Of the realistic items the item rated most realistic was *Being a mother is a major commitment like no other*;  $M = 0.49$ ,  $SD = 0.77$  (Table 7.2). Investigating the level of agreement, Table 7.5 shows just over 62% ( $n = 109$ ) of the sample strongly agreed with this item and a further 31% ( $n = 54$ ) agreed. In all only 2% ( $n = 4$ ) of participants disagreed with this item. All realistic items were endorsed with agreement ranging from 59.4% *giving birth is one of the most natural things in the world and we should stop medicalising it* to 98.9% *during pregnancy it is common to feel a little emotionally sensitive*.

Table 7.5. *Level of Endorsement of Realistic Items – Ratings of Self.*

	Strongly Disagree		Disagree		Somewhat Disagree		Somewhat Agree		Agree		Strongly Agree	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Deep down, pregnant women have real fears that the baby will not be normal	1	1	5	3	15	9	57	33	71	41	26	15
It is entirely natural for a mother to sometimes regret having a baby	2	1	17	10	37	21	64	37	49	28	6	3
Being a mother is a major commitment like no other	1	1	1	1	2	1	8	5	54	31	109	62
When you are pregnant even complete strangers smile at you and ask you questions	2	1	4	2	6	3	73	42	75	42	14	8
During pregnancy it is common to feel a little emotionally sensitive	0	0	0	0	2	1	20	11	99	57	54	31
One of the best feelings with a newborn is knowing your baby is peaceful and happy	1	1	1	1	1	1	25	14	90	51	57	33
Giving birth is one of the most natural things in the world and we should stop medicalising it	9	5	21	12	41	23	45	26	49	28	10	6
Newborn babies require around the clock care, making it hard on some women	2	1	2	1	4	2	29	17	86	49	52	30
Towards the end of ones pregnancy, back pain, difficulty sleeping and feeling tired are perfectly normal but unpleasant experiences	2	1	2	1	4	2	29	17	86	49	52	30

### *Interpretation of Self Ratings*

There were several ways to interpret the MMQ. A full scale cut-off score of  $\geq 50$  indicating an average item endorsement of over 2.5 was considered. However, this would have been confounded by those who did not endorse realistic statements as these were reverse-scored, and thus failure to endorse these items would have create artificially high scores. To address this, a separate scale score, the myth-band score was calculated using only the 11 myth items. The range of possible scores on this scale was 0 – 55 with scores greater than 22 (11 items endorsed above 2) indicating a tendency to endorse myths.

A myth score--the total for the 11 myth items--was calculated for each participant, which was then used to assigned then into one of four groups: (a) myths not endorsed (score less than 22); (b) myths somewhat endorsed (score 23-32); (c) myths endorsed (score 33-43); and (d) myths strongly endorsed (scores over 43). Approximately one fifth of the sample did not endorse myth items ( $n = 35$ , 19%) as indicated by the ratings of self in Table 7.6. Almost half (47%) *somewhat agreed* with the myth statements while 53 (31%) *agreed* with the statements.

Table 7.6. *Overall Endorsement of Myth Items on the MMQ – Self and Others*

		Ratings of self		Ratings of others	
		<i>n</i>	%	<i>n</i>	%
Valid	1 myths not endorsed	35	19	3	2
	2 myths somewhat	82	47	28	16
	3 myths endorsed	53	31	108	62
	4 myths strongly endorsed	2	1	33	19
	Total	173	99	172	98
Missing	99	2	1	3	2
Total		175	100	175	100

Another way to confirm endorsement of the myths was to look at data bands. The original data set was reanalysed and myth bands were created by averaging the 11 myth items and coding into one of ten bands. Participants in the first five bands did not endorse myth statements while participants in the last five bands did. Table 7.6 shows 68 (39%) of the sample did not endorse the myth statements while 2 (1%) strongly agreed. The rest of the sample ( $n = 103$ ) endorsed the myth statements with some level of agreement (either agree or somewhat agree).

#### *Myth Items – Ratings for Others*

Participants rated 'others' as more likely to agree with the myth statements compared with their self-ratings. For the ratings of others the mean myth score was 37.8 ( $SD = 6.6$ ). Only 3 (1.7%) of the sample rated others as not endorsing the myth items while 33 (18.9%) scored others as strongly endorsing myth items (Table 7.6).

Table 7.7 shows participants rated 5% of *others* as not likely to endorse myth statements. A higher proportion were believed to be more likely to strongly endorse myth items (myth range between 4.00 – 5.00). Participants rated 32 (18%) of others as giving endorsements at the strongly agreed level as opposed to just 2 (1%) of self ratings). This difference between ratings of self and ratings of others was significant ( $t = -12.076$ , 2-tailed  $p < 0.001$   $df = 170$ ,  $x = -1.427$  (1.55) 95% confidence interval -1.660 - -1.194).

Table 7.7. *Endorsement of Myth Items for Self and Others arranged into Rating Bands*

	Range	Ratings of self					Ratings of others			
		Frequency	%	Valid %	Cumulative %	Frequency	%	Valid %	Cumulative %	
Valid	1	0.0 - 0.49	0	0	0	0	0	0.00	0	
	2	0.50 - 0.99	0	0	0	0	0	0.00	0	
	3	1.00 - 1.49	4	2	2.3	2	1	0.58	1	
	4	1.50 - 1.99	22	13	12.7	15	0	0.60	1	
	5	2.00 - 2.49	42	24	24.3	39	7	4.07	5	
	6	2.50 - 2.99	46	26	26.6	66	24	13.95	19	
	7	3.00 - 3.49	42	24	24.3	90	71	41.28	60	
	8	3.50 - 3.99	15	9	8.7	99	37	21.51	81	
	9	4.00 - 4.49	2	1	1.2	100	26	15.12	97	
	10	4.50 - 5.00	0	0	.0	100	6	3.49	100	
Total		173	99	100.0	100	172	98	100.0		
Missing	99		2	1		3	2			
Total		175	100			175	100			

Participants indicated they believed 'others' were most likely to strongly agree with the item *Holding your newborn baby for the first time is a precious moment for women* (Table 7.8). It was believed two other items *Giving birth in a hospital is safer* and *Mothers have an instant bond with their baby* would attract high levels of strongly agree endorsement. Participants indicated 50 (29%) of others would endorse these items at a

strongly agree level while a further 51% and 42% respectively would agree. Only one of the myth items *A woman's life can only be fulfilled if she has a baby* was not endorsed by the participants in the ratings of others, having marginally higher level of disagreement than agreement (50.4% vs 49.1%) (Table 7.9).

Table 7.8. *Endorsement of Myth items – 'Other' Ratings*

	Strongly Disagree		Disagree		Somewhat Disagree		Somewhat Agree		Agree		Strongly Agree	
	n	%	n	%	n	%	n	%	n	%	n	%
Mothers have an instant bond with their baby	1	1	1	1	4	2	45	26	73	42	50	29
Giving birth in a hospital is safer	1	1	1	1	4	2	29	17	89	51	50	29
Pregnant women have a glow about them	1	1	5	3	8	5	49	28	76	43	35	20
Having a baby cements a relationship	12	7	15	9	23	13	57	33	57	33	10	6
Not bonding quickly can have long term consequences	1	1	6	3	18	10	59	34	70	40	20	11
A woman's life can only be fulfilled if she has a baby	19	11	40	23	29	17	51	29	24	14	11	6
Holding your newborn baby for the first time is a precious moment for women	7	4	2	1	3	2	12	7	48	27	102	58
Feeling your baby kick for the first time during pregnancy is a good feeling because it means your baby is growing bigger and stronger	4	2	1	1	3	2	33	19	85	49	46	26
A mothers instinct comes with the birth of your baby	1	1	4	2	11	6	52	30	63	36	41	24
Having a baby changes a girl into a woman	14	8	16	9	19	11	68	39	42	24	13	7
A good woman will feel nothing but joy during pregnancy, thinking of the new life she will bring into the world	13	7	29	17	44	25	42	24	33	19	11	6

Table 7.9. *Level of Agreement and Disagreement for MMQ Myth Items – Ratings of Others*

	Agree		Disagree	
	n	%	n	%
Mothers have an instant bond with their baby	168	96.0	6	3.5
Giving birth in a hospital is safer	168	96.1	6	3.5
Pregnant women have a glow about them	160	91.4	14	8.1
Having a baby cements a relationship	124	70.9	50	28.6
Not bonding quickly can have long term consequences	149	85.1	25	14.3
A woman's life can only be fulfilled if she has a baby	86	49.1	88	50.4
Holding your newborn baby for the first time is a precious moment for	162	92.6	12	6.8
Feeling your baby kick for the first time during pregnancy is a good feeling because it means your baby is growing bigger and stronger	164	93.8	8	4.6
A mothers instinct comes with the birth of your baby	156	90.1	16	9.2
Having a baby changes a girl into a woman	123	70.3	49	28.0
A good woman will feel nothing but joy during pregnancy, thinking of the new life she will bring into the world	86	49.2	86	49.1

In all, participants rated other women in their cohort group as more likely to endorse myth items, allowing rejection of the null hypothesis. While four myth items were not supported in the self ratings (*A good woman will feel nothing but joy during pregnancy, thinking of the new life she will bring into the world; Having a baby changes a girl into a woman; A woman's life can only be fulfilled if she has a baby; Babies cement relationships*), only two items (*A good woman will feel nothing but joy during pregnancy, thinking of the new life she will bring into the world and A woman's life can only be fulfilled if she has a*

*baby*) were marginally unsupported in the 'others' ratings with agreement rates of 49.2% and 49.1% respectively.

Between the two rating scales there was a similar profile for the items most likely to be strongly endorsed, with the same items featuring in the top four for both myth subsets. Similarly the realistic items shared a common profile between ratings of self and ratings of others. The item *during pregnancy it is common to feel a little emotionally sensitive* received the highest level of endorsement in both self ratings and ratings of others (99% and 93.5% respectively). However while all realistic items were endorsed in the self ratings this was not the case for the others' ratings. Two items *when you are pregnant even complete strangers smile at you and ask you questions* and *giving birth is one of the most natural things in the world and we should stop medicalising it* were not endorsed in the rating of others.

### *Ratings of Realistic Items*

The model under investigation argues the disparity between expectations and experiences can be experienced as distressing. However the disparity could be caused by either believing untrue myth items or not believing true realistic items. So if there is a link between this it is important to ascertain whether participants endorsed realistic items in the expected way. That is, did the women in this sample rate realistic items as realistic?

Table 7.10 shows all the realistic items were endorsed as realistic, that is, all items had a higher rate of agreement than disagreement. The item *giving birth is one of the most natural things in the world and we should stop medicalising it* proved the most polarising. Almost equal numbers of participants strongly agreed and strongly disagreed with this item. In all just under 60% ( $n = 104$ ) agreed with the item. The item *it is entirely natural for a mother to sometimes regret having a baby* also attracted high rates of non endorsement with 32% ( $n = 56$ ) of participants disagreeing with this item.

Table 7.10. *Level of Endorsement of Realistic Items– Ratings of Self.*

	Strongly Disagree		Disagree		Somewhat Disagree		Somewhat Agree		Agree		Strongly Agree	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Deep down, pregnant women have real fears that the baby will not be normal	1	0.6	5	2.9	15	8.6	57	32.6	71	40.6	26	14.9
It is entirely natural for a mother to sometimes regret having a baby	2	1.1	17	9.7	37	21.1	64	36.6	49	28.0	6	3.4
Being a mother is a major commitment like no other	1	0.6	1	0.6	2	1.1	8	4.6	54	30.9	109	62.3
When you are pregnant even complete strangers smile at you and ask you questions	2	1.1	4	2.3	6	3.4	73	41.7	75	41.7	14	8.0
During pregnancy it is common to feel a little emotionally sensitive	0	0.0	0	0.0	2	1.1	20	11.4	99	56.6	54	30.9
One of the best feelings with a newborn is knowing your baby is peaceful and happy	1	0.6	1	0.6	1	0.6	25	14.3	90	51.4	57	32.6
Giving birth is one of the most natural things in the world and we should stop medicalising it	9	5.1	21	12.0	41	23.4	45	25.7	49	28.0	10	5.7
Newborn babies require around the clock care, making it hard on some women	2	1.1	2	1.1	4	2.3	29	16.6	86	49.1	52	29.7
Towards the end of ones pregnancy, back pain, difficulty sleeping and feeling tired are perfectly normal but unpleasant experiences	2	1.1	2	1.1	4	2.3	29	16.6	86	49.1	52	29.7

Table 7.11 shows the level of endorsement for each of the realistic items according to the ratings for others. Again the most highly endorsed realistic item was *during pregnancy it is common to feel a little emotionally sensitive*. Participants indicated they thought the majority of others (94%) would agree with the item, with most of others (42%) endorsing it at a strongly agree level. This was closely followed in levels of endorsement by the item being *a mother is a major commitment like no other*. Women in this sample indicated they thought almost all (93%) other women without children would agree with this item, with just under half (44%) endorsing it at a strongly agree level.

Table 7.11. *Level of Endorsement of Realistic Items– Ratings of Others.*

	Strongly Disagree		Disagree		Somewhat Disagree		Somewhat Agree		Agree		Strongly Agree	
	n	%	n	%	n	%	n	%	n	%	n	%
Deep down, pregnant women have real fears that the baby will not be normal	3	1.7	6	3.4	17	9.7	29	16.6	75	4.7	44	25.1
It is entirely natural for a mother to sometimes regret having a baby	6	3.4	33	18.9	44	25.0	50	28.6	33	18.9	8	4.6
Being a mother is a major commitment like no other	0	0.0	5	2.9	6	3.4	24	13.7	62	35.4	77	44.0
When you are pregnant even complete strangers smile at you and ask you questions	1	0.6	5	2.9	11	6.3	52	29.7	71	40.6	32	18.3
During pregnancy it is common to feel a little emotionally sensitive	0	0.0	4	2.5	3	1.9	23	14.6	58	36.9	66	42.0
One of the best feelings with a newborn is knowing your baby is peaceful and happy	2	1.3	4	2.5	3	1.9	23	14.6	57	36.3	65	41.4
Giving birth is one of the most natural things in the world and we should stop medicalising it	8	5.1	28	17.8	44	28.0	46	29.3	20	12.7	8	5.1
Newborn babies require around the clock care, making it hard on some women	1	0.6	3	1.9	4	2.5	22	14.0	74	47.1	50	31.8
Towards the end of ones pregnancy, back pain, difficulty sleeping and feeling tired are perfectly normal but unpleasant experiences	0	0.0	5	3.2	5	3.2	20	12.7	79	50.3	45	28.7

### *Ratings of Self versus Ratings of Others*

A sign test was used to explore the difference between ratings of self and ratings of others. Ratings for self were subtracted from rating for others to give a mean difference score. Positive scores indicated the rater endorsed others as rating the myth items more believable than they rated them themselves, whereas a negative score indicated participants rated themselves as more likely to endorse a myth item than others. Overall there were six missing cases leaving 169 valid scores. Of these, six showed a zero difference and there were 22 negative cases where raters endorsed myth items at a higher rate for themselves. However, in the majority of cases, 141 out of the possible 169, individuals rated the MMQ scores for others as higher, and therefore more myth endorsing, than they rated themselves.

### *MMQ Rating and Demographic Variables*

The relationship between myth ratings on the MMQ and age was investigated using Pearson product-moment correlation coefficient. There was a weak, negative correlation between the two variables ( $r = -0.25$ ,  $n = 173$   $p = 0.01$ . 2-tailed) with increased age being

associated with higher myth ratings (Table 7.12). Myth ratings were also correlated with marital status ( $r = -0.215$   $p < 0.01$ , 2-tailed), showing older or married women were less likely to endorse myth statements than younger single women. Finally, myth ratings were also significantly correlated with educational attainment ( $r = .268$   $p < 0.01$ , 2-tailed) with less educated women endorsing myth statements at a higher level than women.

Table 7.12: *Correlation between MMQ myth belief and age*

		level of myth	
		belief	age
level of myth belief	Pearson Correlation	1	-.252**
	Sig. (2-tailed)		.001
	N	173	173
age	Pearson Correlation	-.252**	1
	Sig. (2-tailed)	.001	
	N	173	175

\*\* . Correlation is significant at the 0.01 level (2-tailed).

Given the relationship between age and endorsement of myth items a significant correlation between educational attainment and endorsement levels was expected. Although the younger members of the sample were all still in educational facilities, they had lower levels of educational attainment purely as a mechanism of their ages. Partial correlation was used to explore the relationship between myth scores and educational attainment while controlling for age. There was a weak, negative partial correlation between myth scores and educational attainment, controlling for age,  $r = -0.187$ ,  $n = 166$ ,  $p < .05$ , 2-tailed, with higher levels of educational attainment being associated with lower levels of endorsement of myth items. Inspection of the zero order correlation ( $r = -0.304$ ) suggested that controlling for age did impact on the relationship between the two variables.

### *Factor Analysis*

Once individual analysis of the items was completed the 20 items of the Mothering Myths Questionnaire (MMQ) were subjected to principle component analysis (PCA) using SPSS version 18. Prior to performing PCA, the suitability of data for factor analysis was assessed. Inspection of the correlation matrix revealed the presence of many coefficients of .3 and above. The Kaiser-Meyer-Olkin value was 0.73, exceeding the recommended value of 0.6 (Kaiser 1970, 1974) and Bartlett's Test of Sphericity (Bartlett, 1954) value was significant  $p = 000$ .

Principle components analysis revealed the presence of seven components with eigenvalues exceeding 1, explaining 19.2%, 11.13%, 7.17%, 6.43%, 5.71%, 5.30%, and 5.10% of the variance respectively. An inspection of the screeplot revealed a clear break

after the third component. Using Catell's (1966) scree test, it was decided to retain three components for further investigation.

The three-component solution explained 37.5% of the variance, with Component 1 contributing 19.2%, Component 2 contributing 11.1% and Component 3 contributing 7.1%. To aid in the interpretation of these three components, oblimin rotation was performed. The rotated solution revealed all three components showed a number of strong loading and all variables loading substantially on only one component. Items representing myth statements loaded strongly onto Component 1 and items reflecting realistic statements loaded strongly onto Component 2. Component 3 was comprised primarily of items reflecting the physical event of pregnancy and childbirth.

### **LEAP**

It was hypothesised the experience of being mothered would impact on the expectations of mothers and mothering. That is, women who report a highly positive experience of being mothered would be more likely to endorse items indicating a highly positive expectation of motherhood. To test this, the relationship between endorsement of myth items and the experience of being mothered (as measured by the LEAP) was examined using Pearson product-moment correlation coefficient. There was a significant positive relationship between the two variables ( $r = .189$ ,  $n = 173$ ,  $p = 0.05$  2 tailed), with participants who rated their experiences of being mothered as more positive more likely to endorse the myth items than those with less positive experiences.

### **Discussion**

This study investigated whether a cohort group of women who did not have children but were likely to in the future, endorsed a number of common myths about mothers and mothering. The initial part of the analysis provided some support for hypothesis one, *'that young women of child-bearing age who do not have children will endorse myth statements'*. This finding supports other research suggesting women in this cohort group subscribe to, or believe in, commonly held attitudes about mothers and mothering.

However, not all myth statements were endorsed. The reason for this is not clear although it is possible these items weren't endorsed due to experience of the items. Thinking about the items from a different perspective, if we take a highly endorsed items such as *'mothers have instant bond with their baby'*, we can understand that women who are not yet mothers would have had no experience with a mother/infant bond. Thus they have no information with which to evaluate the accuracy of the statement. But if we consider an item which aroused less agreement such as *'a women's life can only be fulfilled if she has a baby'*, one can argue each participant has had some experience of 'a women's life'. Therefore having had experience of 'a women's life' participants are in a much better

position to evaluate the accuracy of the statement and to have a schema or an experience which will allow for exceptions to the rule. Also, and perhaps more importantly, there may be a cost for the women to agree with the item, because in endorsing it they are acknowledging some level of an unfulfilling life by reason of the fact they are not a mother.

This applies too, to the other items which were not endorsed. For these items endorsement may indicate something less than ideal about the very core of person. Endorsing *having a baby changes a girl into a woman*, for instance, could imply they themselves are not women, something could be construed in an offensive way and could be seen as targeting a fundamental aspect of their identity. Even the item *having a baby cements a relationship* could be construed as 'your relationship needs cementing'. Hence it is difficult to ascertain whether these items were not endorsed because they were not believed or held to be true, whether they were not endorsed because there was an ego cost in endorsing them, or whether they were not endorsed because there was a social desirability type responding happening, whereby the participants wanted to project an image of a woman, in a 'cemented' relationship, with a fulfilling life.

Earlier in the discussion on expectations, research on attribution bias was highlighted. According to this research, attribution bias is increased when individuals are interacting with the person they are observing. In this situation attribution bias acts as a self defence mechanism because it allows the individual to attribute the unfulfilled expectation on the other person rather than to the individual doing the evaluating. In other words attribution bias may explain the tendency for women in this cohort group to disagree with items which, if endorsed, indicate they have an unfulfilling life.

The participants in this study were more likely to endorse myth items at a lower rate in the self-ratings and tended to indicate they believed other women similar to them were more likely to believe in mothering myths than they were. In addition, they indicated they believed other women like themselves would endorse the myth statements at a higher level. The participants showed an overall endorsement rate of 69%, with 11% strongly agreeing with the myth items. Conversely their endorsement ratings for others was 80% with 20% in the strongly agree category.

Investigations with the postnatal women in both Study One and Study Two revealed there is some support for the argument there is a commonly held image of the generalised mother. Results from this survey seem to be suggesting not only do non mothers hold clear images of a generalised mother, but they believe generalised mothers hold strong images of other generalised mothers which are more stereotypically and mythical than their own. Again, it may come down to experience of the items or it may come down to an unspoken knowledge women are exposed to certain stereotype and images regarding mothers and mothering.

The link between a woman's experience of her mother as supportive and engaged and her subsequent endorsement of myth items was also explored. It was hypothesised *'that women who rate their experience of being parented highly will endorse mythical statements of motherhood at a higher rate.'* There was support for this hypothesis with scores on the adapted LEAP questionnaire positively related to the level of myth ratings.

It may be that this is a result of an optimistic personality type and what is actually being measured is optimistic responding. This would mean the scores on the MMQ and the LEAP showed a positive co-relation because high scores on each indicate a relatively optimistic perception of the unit of measurement (mothering engagement and mothering behaviour). It may also mean women who have positive experiences of their mother tend to hold positive images of other mothers as a result of the availability heuristic. And therefore conversely, women who rated their own mothers as less engaged may have endorsed myth items at a lower rate because they had experience of exceptions to their initial mother schema, and therefore their schemata is, for lack of a bad better word, more balanced, with both positive and negative aspects.

This finding is important as it identifies a new potential risk factor for postnatal distress. The model argues the disparity between expectations and experience for first-time mothers is due, in part, to women holding unrealistic and mythical images of motherhood. This research finding suggests a woman's perception of her mother as an engaged parent could be an important area of investigation when accessing risk of postnatal distress.

Demographic variables were explored in this study as there was limited available information from which to draw on to make specific inferences. In this study both younger and unmarried women endorsed motherhood myths at a higher rate than older or married women. It was speculated that age and marital status, may impact on level of myth belief as a function of life experience and this may indeed be the case. It might be for instance, that due to life experience, or lack of it, women simply haven't experienced mothers. If that is the case one possible explanation maybe the isolation mothering is argued to occur in. Younger women are less likely to have casual exposure to mothers and therefore have no information with which to contradict the myths to which they have been exposed to as they have grown up. Whereas women who are slightly older may begin to have friends who become mothers or usually have older partners who may have friends/ family members who have children, and thus begin to see another image of motherhood modelled.

It was argued, in this research and in other research cited throughout the literature review, that young women of child-bearing age who do not have children hold unrealistic expectations, both over estimating the positive aspects of mothering (bonding, changes in relationships, personal growth), and underestimating some more negative aspects (physical demands, intrusiveness of others, medicalisation of childbirth). In this study both types of expectations were evaluated. In all, the non-myth items were endorsed as realistic,

suggesting the women in this sample had accurately perceived some of the more negative aspects of parenting as highlighted by our expert group. For instance there was almost unanimous agreement with the item regarding some emotional sensitivity during pregnancy.

There are several limitations for this study including an over-representation of young female university students. While recruiting was done on separate campuses which created some demographic diversity between urban main centres and small provincial cities, most of the sample was either nursing or psychology undergraduates. Tapping into the mother schemas of other populations may afford a different perspective.

Despite being carefully trialled before being distributed it became clear there were some issues with interpretation around some of the questions. For instance one of the questions asked whether the participant had had experience in a parenting role. The intent of this question was to tap into women who had some mothering experience having taken day to day responsibility for the wellbeing of a child, made decisions on medical treatment, dealt with professionals involved in the care of the child such as teachers or otherwise acted in a mother role. As part of the theory behind the model is women are not well-prepared for motherhood due to lack of experience, it was considered important to be able to control for it, if indeed, women did have prior mothering type experience. This is because it is believed the day-to-day ongoing responsibility for a child, even if it is not your biological child, will alter perceptions and expectations for women who have yet to have children of their own.

It became clear throughout the data collection process that despite the intent of the question, the mothering role was interpreted as '*have you ever babysat*' by a large number of participants. The data collected from this question suggested approximately 70% of 17 year olds in this sample had acted in a mothering role. While one can make an argument babysitting is taking responsibility for a child, it is fundamentally different from on-going day to day care of a child where you have a burden of responsibility and knowledge that decisions will have long term consequences. For instance, in broad terms, in the event of an accident (beyond the usual childhood spills) a babysitter would commonly contact the parent or caregiver as soon as practical and hand over responsibility for treatment decisions to them. The parent or caregiver cannot off-load that responsibility and it is this burden; this level of commitment that, once experienced, is argued to change perceptions. Hence a decision was made to try and identify control for this type of experience. As it stands, given the skew in the data it was difficult to make meaningful comparison given the question had not been well understood.

## **Conclusions**

The study aimed to test whether young women of child-bearing age who do not have children held unrealistic expectations about mothers and mothering, either through endorsement of myth items or non-endorsement of realistic items. To investigate this, a

new survey questionnaire containing key myth statements was developed and distributed to women between the ages of 18 to 36, who were not mothers at the time of the investigation. Seven of the eleven myth statements were endorsed, with an overall agreement rate of 69% suggesting women in the cohort group under investigation generally hold unrealistic expectations about parenthood. Women were most likely to endorse the myth items if they were younger, unmarried and relatively less educated.

Further exploration revealed this group of young women of child-bearing age who do not have children tended to think other women in a similar life stage were less realistic than themselves, indicating they believed other women in their cohort group would endorse nine out of the eleven myth statements with an agreement rate of 80%. The results confirm that an image of a generalised (and idealised) mother is held by the majority of well-educated young women in New Zealand, and that this image appears to be a product of culture myths and societal portrayals of mothers, and which is overly romanticised and inaccurate.

## Chapter Eight: Development of an Intervention

This thesis has so far identified a number of issues which may affect women making the transition from non-mother to mother. The evolving (or de-evolving depending on your perspective), role of mothers was highlighted at the outset of the thesis. Until relatively recently, mothering was a recognised role which was viewed as a viable option for women in terms of work. In New Zealand before approximately the 1920's most postpartum women could expect an influx of practical help (meals cooked, housework done, and partners and other children tended), as well as community support for the mothering role. Women shared in a verbal history of mothering and generally grew up in an extended family or community environment where mothering could be learned vicariously and in a safe and supportive way.

Since then, knowledge about mothering has become the domain of experts and books have become a valued source of knowledge acquisition. Entering 'mothering' into Amazon.com with the limiters of 'English' and 'printed book' returned over a thousand results. In a recent visit to a well-known bookstore I counted 79 titles on display which professed to offer insights into parenting. Everything from taming your toddler to surviving your teen, fathers raising daughters and mothers raising sons. This is interesting as the mothers interviewed in Chapter Six were adamant the books they read hindered more than they helped.

In all there is a sense mothering has become an invisible occupation, conducted covertly in the safety of the private sphere. Sadly, it would seem as a result, opportunities for girls to learn mothering skills vicariously from women aside from their own mothers are increasingly limited.

It is not hard to draw a link between the changes to the expectations and education of mothers and the high levels of postnatal distress experienced by women mothering in the current climate. Postnatal distress was explored in Chapter Two through an examination of postnatal depression, anxiety, and stress. It was concluded the previous focus on clinical levels of postnatal depression whilst laudable, did not serve the majority of mothers well. It was acknowledged anxiety was an under-reported issue with many new mothers and the levels of subclinical anxiety were estimated to be in excess of one in two. Stress in the postpartum period was also highlighted as having a significant impact on day-to-day functioning. In all, it was concluded the experience of postnatal distress had a negative impact across many areas of daily living for mothers, infants, and their families.

The women interviewed thorough this process, both those who had recently become mothers (Chapter Six) and those who were more experienced in the mothering role (Chapter Four), highlighted a number of instances where their expectations were not meet. The women reported this had a negative impact on the transition to parenthood for them. As a

whole the women indicated they enjoyed mothering but not being mothers. That was, they loved their children but did not enjoy the isolation, loss of status, independence, and financial security, among other things, which came with being a parent. This is consistent with other research which has concluded it is the *trappings of office* which are often undesirable (Beck, 1993; Belsky et al., 1985; Coleman et al., 1999; Cutrona, 1984; Rogan et al., 1997). Thus it was the expectations which the women held of their partners and of others, rather than the expectations of their infants which were most often unmet.

What was often discussed in various guises by the women who participated in this research could be grouped together under the common theme of loss. Women, whilst embracing and loving their child, undeniably sacrifice a tremendous amount of themselves in order to parent. The women in these studies, and in studies reviewed in earlier chapters, highlighted numerous losses including the loss of status, independence, and financial security as already mentioned. But perhaps most poignant were the discussions around the loss of the mythical image of motherhood. The picture the women had created in their own minds of what motherhood was going to be for them, a picture based heavily on how these women had been socialised into the role by their school, media portrayals, by the movies they had seen, magazines they had read and indeed by their own friends and families. Nicholson (1996) talks about a conspiracy of silence around motherhood, a whitewashing or sanitising of the experience to make it *fit for public consumption*. Certainly the women in this research have shared similar stories.

So what does all this mean? It means mothers and the way women mother has changed. It means women are struggling in significant numbers with the transition to parenthood. They report feeling underprepared and overwhelmed. They report feeling duped. So what to do? The final part of this thesis sets out to answer this question by introducing the development of a brief protocol for use with first time mothers in their transition to motherhood with the aim of lowering rates of postnatal distress.

### **Initial considerations**

At the outset of the development phase there were a number of decisions which needed to be made including at what stage should the intervention be targeted, who should be targeted for the intervention and why - that is at what level does the intervention need to be pitched - and not least, what should be included in the intervention. In addition there were a number of practical considerations which needed to be resolved as well as ideological decisions to be made. For the intervention to best meet the needs of women, it needed to complement rather than contradict knowledge women may receive in traditional antenatal classes. It needed to be accessible and do-able. It needed to be meaningful and helpful to the women taking part. Finally it needed to be grounded in sound psychological principles using an accepted theoretic framework.

## THEORETICAL FOUNDATIONS

Any intervention that seeks to work with individuals needs to be grounded in sound psychological principles which have a coherent overarching theoretical framework. Several theoretical perspectives were considered but in the end the theory selected to inform the development of the intervention was Acceptance and Commitment Therapy (ACT), (Fletcher & Hayes, 2005; Hayes, 2004, 2005; Hayes et al., 2006; Hayes, Strosahl, & Wilson, 1999).

There were a number of considerations which lead to the selection of an ACT-base approach ACT incorporates a variety of cognitive and behavioural strategies in an endeavour to increase psychological flexibility. Given the research contained within this body of work, as well as research cited in the earlier literature review, has demonstrated women with rigid ideas and ideals of motherhood have greater difficulty adjusting to mothering, introducing the idea of psychological flexibility was an important consideration.

Another fundamental component of ACT is the idea of acceptance;

*"A moment by moment process of actively embracing the private events evoked in the moment without unnecessary attempts to change their frequency or form" (Fletcher & Hayes, 2005, p.319)*

When working clinically with an individual the basic idea of acceptance is to give the client skills which allow them to tolerate or 'accept' psychological distress more fully in the belief that avoidance of such distress causes psychological harm. The exploratory model discussed in chapter four suggests the disparity between expectations and reality is distressing for some women. Addressing this could be approached in two ways. One could attempt to align expectations and reality so there was no disparity. This would seem almost impossible to achieve and certainly is unlikely to be done in a timely way. Alternatively, one could attempt to address the psychological distress experienced when such a disparity occurs. That is not to say that the distress would be removed, rather that skills to manage the impact of the distress could be introduced to women in a meaningful way. Thus, again ACT seemed to be a good fit with the aims of the intervention

There is ample research supporting the use of ACT in addressing a number of different psychological issues, including depression, stress and anxiety based disorders (Eifert & Forsyth, 2005; Hayes et al., 1999; Hofmann, Sawyer, Witt, & Oh, 2010; Öst, 2008; Zettle, 2007), the three negative mood states of interest in this research. In a meta-analytic review ACT was shown to have better results than wait list, placebos, or general treatment as usual (Powers, Zum Vörde Sive Vörding, & Emmelkamp, 2009). It has proven efficacious in a group setting, and has outperformed CBT when used in a group to treat depression (Zettle & Rains, 1989). Further support was found in a recent review of the empirical evidence for ACT-based therapies which concluded ACT demonstrated efficacy in a wide range of psychological problems (Ruiz, 2010).

One of the core ideas which underpins ACT therapy is the argument the problem is not the problem, the solution is the problem. For instance, when working with a client who has difficulties with anxiety, a therapist might highlight experiences the client reported where their solution (avoidance) to the problem (anxiety) actually became the problem. That is instances where, because of their avoidance, the client missed out on living a meaningful life. In the context of this intervention the solution (obtaining the unrealistic image of mothering) in an attempt to solve the problem (distress following the transition to motherhood) becomes the problem. ACT theorists would argue this is because women view their feelings of distress and despair as aberrations. As a result the women avoid the feelings, in ACT speak they are 'unwilling to have the feelings' (Eifert & Forsyth, 2005; Harris, 2009) and so they try, and continue to try, to achieve the mythical mothering state. They buy in to the assumption of healthy normality, the mythical unrealistic image of mothering as sunshine and happiness, and the state of motherhood as natural and normal, rather than sit with the assumption of destructive normality which assumes certain levels of negative mood states in daily life are to be expected.

### **PREVENTION VS TREATMENT**

There is no research examining preventive interventions or treatment protocols for postnatal distress, and indeed it is difficult to find any research which investigates interventions with women who have co-morbid disorders alongside the depression (Boyd, Pearson, & Blehar, 2002). However, there is ample literature covering both preventative and treatment interventions for postnatal depression. This literature became a valuable source of information and was influential in some of the decision making processes related to the development of this intervention programme. As such it will be briefly covered here.

Existing research points overwhelmingly to treatment for postnatal depression delivered in the early postnatal period (Altshuler et al., 2001; Beck, 2002c; Chabrol et al., 2002; Clark, Tluczek, & Wenzel, 2003; Cooper & Murray, 1997; Cuijpers, Brannmark, & van Straten, 2007; Hight & Drummond, 2004; Honey, Bennett, & Morgan, 2002; O'Hara et al., 2000; Zlotnick, Johnson, Miller, Pearlstein, & Howard, 2001). Intuitively, there would be a certain amount of sense if one accepts the premise that postnatal depression is just that, depression in the postnatal period, and only the postnatal period. However, Chapter Two highlighted several pieces of research pointing to the onset of depression occurring in the antenatal phase. Some of that research suggested the rate of antenatal onset might be as high as half of all cases of what was being classified as postnatal depression (Yonkers et al., 2001). The implications of this antenatal onset is that traditional methods of measuring postpartum depression, which focus on the 4-6 weeks postpartum period, may leave some women undiagnosed for several months. This same research reported findings which suggested doctors or other professionals involved in maternal care may fail to recognise and

diagnose up to half of the incidences of postnatal depression they see. So when considered together, what the research seems to be suggesting is up to 50% of cases remain undiagnosed and of those that are picked up, another 50% have antenatal onset. If this is the case, the implication is that up to 75% of women who suffer from postpartum depression are either receiving delayed treatment or no treatment at all! Fortunately prevention research for mental health difficulties is gathering momentum as current best practice guidelines highlight the need to channel more resources into this area. This applies to the area of maternal mental health and there have been a number of studies published with a view to meeting those best practice guidelines (Austin et al., 2008; Boyd et al., 2002; Dennis, 2004a; Dennis, 2004b; Matthey et al., 2004).

Postpartum depression, and indeed all forms of postnatal distress, is in some ways unique, as due to the very nature of the disorders they are marked by a definitive trigger – birth. In addition, there is a relatively well defined period of risk (4-12 weeks after delivery). These factors suggest that there may be a window of opportunity for the implementation of prevention measures, and given what we know about the difficulties with identification following onset of PND, a shift in focus to prevention seems to be well justified. Indeed, in 2001, a United States Institute of mental health expert panel concluded “preventing postpartum depression is an important public health approach”(Boyd et al., 2002, p. 81).

So it would seem distress following the transition to motherhood is uniquely suited to preventative measures. Added to this, pregnancy is an ideal time to implement interventions because a large percentage of pregnant women have some kind of contact with health professionals. Thus it is somewhat ironic that despite the elevated occurrence of mental health issues in pregnancy, routine mental health checks are not carried out.

Another supporting factor for the preventative approach argument is a shift coming from America which increasingly points towards the wisdom of directing scarce health care dollars into prevention as a way of managing spiralling health care costs (Ogrodniczuk & Piper, 2003). Prevention strategies can be rolled out to greater numbers at a lower cost when highly specialised intervention, implemented by highly trained individuals is not needed. Thus the focus on prevention rather than cure is not only humane, but possibly cost-effective too.

Perhaps one of the strongest arguments for a preventive approach was a number of studies which highlighted the participants’ desire for such an intervention. For instance Ugarriza (2002) interviewed women who self-diagnosed as having postpartum depression. The participants in this study reported they thought public education and support for new mothers was missing from current maternal health programmes. Dennis and Chung-Lee (2006) reviewed published qualitative studies investigating postnatal depression help seeking barriers. In all they concluded women preferred to have talking therapies with a

non-judgemental professional rather than receive pharmacological intervention. Thus a lack of alternatives to medical intervention is a barrier to accessing help.

A final point for the prevention approach is the known difficulties in working with a depressed population. A systematic review into treatment barriers found women generally do not pro-actively seek help when experiencing low mood (Dennis & Chung-Lee, 2006). Often there is low motivation to attend due to increased isolation and withdrawal (Boyd, Diamond, & Bourjolly, 2006) although addressing logistical barriers such as transportation and childcare is believed to mitigate some of the psychological barriers such as poor motivation, hopelessness and helplessness (Boyd et al., 2006).

A lack of knowledge regarding maternal mental health has also been identified as a barrier to treatment. Women often don't recognise the onset of problems before motivational and other difficulties have begun to impact on functioning. Interestingly, the acceptance of mothering myths is a significant help seeking barrier (Dennis & Chung-Lee, 2006). This may be because women find disclosing some of their realistic mothering experiences more threatening. What this means is that belief in mothering myths not only makes one vulnerable to disappointed expectations and postnatal distress, but also decreases the likelihood the women will seek assistance once distressed. In all, given the number of potential barriers for women in accessing help once they begin to experience postnatal difficulties, targeting support, information giving and non-judgemental listening prenatally takes on even greater importance.

#### **LEVEL OF INTERVENTION**

This programme was developed as a primary intervention, seeking to decrease the number of new cases of postnatal distress. Prevention research outlines a number of different levels in which to target any intervention (Dennis, 2004b; Matthey et al., 2004; Muñoz et al., 1996). The intervention can be targeted at a universal, indicative, or selective level (Muñoz et al., 1996). Universal prevention strategies target an entire population group, or the general public; a group which has not been identified on the basis of elevated risks. Such a level of intervention is generally low cost and has low risk of negative outcomes. At the opposite end of the continuum, are indicated preventive interventions which target individuals who do not currently meet diagnostic criteria for a disorder, but who are judged to be at increased risk. In between those two approaches are selective preventive interventions, the level of intervention being utilized in this research. Selective preventive interventions are interventions which are directed at a relatively large group of individuals, in this case pregnant women, whose risk of becoming ill is higher than normal as evidenced by biological, psychological, or social risk factors (Muñoz et al., 1996).

There were several points which led to the decision to target the programme at this more general level, rather than more specifically at women whose characteristics make them

especially vulnerable to developing PND or postnatal distress. Firstly, the contradictions highlighted in the initial parts of this thesis suggest not enough is known about the characteristics of 'high risk' women to allow for meaningful study into the efficacy of a particular intervention (Ogrodniczuk & Piper, 2003). That is, our understanding of what makes women 'high risk' is not at a level that enables targeting these specific traits.

Many traits and characteristics have been posited as possible contributors to the onset of postpartum depression – including psychosocial factors such as recent life adversity (Beck, 1996b), perceived social support (Bernazzani et al., 2005), marital dissatisfaction, a past history of psychiatric illness (Boyce & Hickey, 2005), cognitive factors such as defence styles (McMahon et al., 2005), maternal attitudes (Whitton & Appleby, 1996), negative autobiographical memory (Hipwell, Reynolds, & Pitts Crick, 2004), and perceptions of self efficacy (Porter & Hsu, 2003), as well as obstetric factors such as ante-partum haemorrhage, multiple births and forceps or caesarean deliveries (Johnstone et al., 2001).

In addition to maternal factors there are a number of infant characteristics argued to play a role in the development of postpartum depression symptomology such as low soothability, difficult temperament, poor sleepers, colic/reflux or poor physical health, and the baby being of an undesired gender (Austin & Leader, 2000; Beck, 1996c, 2001; Britton, 2011; Logsdon & Usui, 2001). This is not an exhaustive list, but highlights the lack of consensus amongst practitioners and researchers in this area. Thus, the lack of empirical base does not justify, at this stage, attempts to target specific risk factors amongst specific groups of women.

The problem of course is, while research focuses on risks factors and causes nothing changes for women. While there are those who argue postnatal distress results from women doing too much of something; worrying, bonding, or socialising, and those that argue postnatal distress results from women not doing enough of something; worrying, bonding, or socialising, in the mean time, other investigations stagnate. This maybe because research into other factors can be seen as unnecessary and unproductive, thus structures seldom get challenged and even more rarely get changed. What is categorically known is that postpartum depression is linked to pregnancy and childbirth and thus all pregnant women are at a heightened risk making a selective prevention approach most appropriate.

### **THE PSYCHOLOGICAL IMPERATIVE**

Currently the prevention and treatment of PND falls under the umbrella of two main approaches, biological and psychological. The rationale for biological-based intervention stems logically from those who argue PND has a biological underpinning. Research in this area is more developed than that examining PND from psychological perspective. Indeed, when examining the literature one could be forgiven for thinking that PND was far more the

domain of medical staff as opposed to that of mental health personnel. Yet there are a number of reasons psychological interventions have an important place in the prevention and treatment of postnatal distress, not the least are the shortcomings with a solely biological approach which will be briefly discussed.

While there is evidence suggesting biology and the bodily experience of pregnancy and birth may play a role in postnatal distress this is not, and cannot be, the whole story as illustrated by the finding fathers and adoptive mothers can experience postnatal distress too (Gair, 1999; Mott, Schiller, Richards, O'Hara, & Stuart, 2011). Unfortunately, utilising a medical slant tends to attach a sick label to women. Yet the women interviewed throughout this research process strongly rejected any suggestion they were sick, pathological, or otherwise in a vulnerable states due to pregnancy and childbirth. Admittedly, conceptualising PND as a medical disorder has a number of advantages. For instance, it does provide a coherent way of discussion which crosses multiple disciplines, creating a universal understanding of description, identification, and treatment. However, despite creating this convenient framework for maternal distress, locating the distress solely within the physical individual ignores the interplay of mind, body, and culture. More worryingly the application of a sick label can ignore and invalidate the realities of motherhood including a loss of uninterrupted sleep, the difficult workload, and the overwhelming responsibility, combined with the loss and isolation that can accompany motherhood.

Investigations into biological treatments for postpartum depression have included the use of antidepressants as well as hormonal based treatments such as estrogen and progesterone therapy. Hormonal treatment has produced little in the way of conclusive data, although the effects of rapid alteration in hormonal levels on the neuroendocrine system is an area of interest, with a focus on possible genetic susceptibility to postpartum hormonal fluctuations within the monoamine and peptide pathways (Horowitz & Goodman, 2005). However, claims that estrogen therapy would be useful to prevent PND has been undermined by a lack of empirical evidence, and the rather inconvenient fact that no association has been demonstrated between PND and breastfeeding (Dennis, 2004a). As previously discussed the progesterone depletion theory, which initially showed promise, has produced inconsistent findings when applied to treatment, particularly beyond the initial phases of the postpartum period.

Research into pharmacological treatment of postnatal depression has produced mixed results. As highlighted in the earlier section on barriers to help-seeking it appears there are real difficulties in doing research with a population which is reluctant to take medication due to the risk, real or perceived, to their infant. Treatment guidelines suggest breastfeeding women with mild to moderate depression should be offered psychotherapy as the first line treatment option. However, for severely depressed women or women experiencing depression with psychotic features expert guidelines recommend the use of

antidepressants, either as a mono-treatment or, preferably, in conjunction with psychosocial interventions, regardless of the lactation status of the mother (Altshuler et al., 2001).

Prophylactic intervention for the treatment of depression in pregnancy or as a preventive strategy against the development of symptomology is more problematic. There is currently no drug available that has an FDA category A rating (controlled studies show no risks). Medications diffuse readily across the placenta with potentially devastating effects - risks to the foetus from exposure to medication include neonatal toxicity, organ malformation (during the first 12 weeks' gestation) and postnatal behavioural problems. So while we know infants are exposed to antidepressants prenatally and through breastfeeding if the mother takes them, what is less clear is the effect of this exposure on child outcomes (Boyd et al., 2002). Hence the inability of maternal carers to utilize pharmacological interventions during pregnancy and the reluctance of women to take medication whilst breastfeeding means the need for efficacious psychological interventions is pressing.

However, there have been some difficulties with psychological interventions too. Most psychological interventions have been characterized by high attrition rates and low numbers of participants. Conversely, one study that did report success at improving mood scores after their intervention attributed the success to very good attendance rates (Zlotnick et al., 2001). The poor attendance rates by the prospective mothers and, where applicable, their partners, are likely to be a significant variable in the outcome of the studies so far reported – interventions can only be successful for those who receive them. According to Matthey et al (2004) "multiple sessions decrease the likelihood of complete attendance" (p.114). This suggests the non-significant results reported by the more intensive programmes could be reflecting the low attendance and high attrition rates of the participants rather than inherent problems with the intervention.

Equally, the treatment has to be comprehensive enough to have some beneficial effect. If the treatment is too brief, the chances of evoking measurable change are remote. Thus any psychological intervention on offer needs to be precise and targeted with as shorter contact time as therapeutically possible.

However, the strongest argument for a psychological approach is the belief that postnatal distress stems from human cognitions, human behaviours, and human interactions, and it is in these areas psychology can contribute a unique insight. The issues raised in the research; of disappointed expectations, of loss, of partner support and of isolation, issues of cognitive fusion and avoidance, these are issues far better addressed by psychological approaches than medical interventions.

### **The Intervention Model**

The model of intervention proposed is a three session group programme (see Appendix A). Working from the assumption postnatal distress is tied to the experiences of

loss and the discrepancy between reality and expectations the logical goal would be to more realistically prepare women for motherhood and thus, presumably, lower their experiences of loss.

No intervention can change the fact that there will be a discrepancy between reality and experience nor can an intervention stop loss. However, consistent with an ACT approach, this intervention aims to introduce some cognitive flexibility in the way the women think about mothering. That is the intervention simply aims to give women skills that allow them to think about the discrepancy and loss in a different way, which may lead to a change their perceptions of them. In addition, knowing motivation is an issue if women do experience low mood in the future, the intervention aims to make accessing assistance as easy as possible by pre-empting some of the decision-making around help-seeking.

This intervention does not aim to remove distress; although it is possible women may experience less distress after partaking in the intervention. From an ACT perspective the goal is not no distress; the goal is acceptance of times of distress - being willing to have the distress and still remain focused on value goals. So how does that fit with the intervention?

The societal discourse of motherhood does not allow for the voicing or experience of negative emotions and cognitions. Images of mothers and mothering are realistically positive, and women report firstly, being unprepared for the negative aspects of parenting, and secondly, being unable to discuss them in the belief there is something wrong with themselves as mothers owing to the fact they are not having the unrealistically positive experience. I am proposing than by normalising negative aspects of mothering, by viewing them in terms of the assumption of destructive normality, negative experiences can stop being bad experiences. And if negative experiences stop being bad things to have, if women begin to think it's okay to experience them, and become willing to have the negative thoughts freely and without judgement, the tension or cognitive dissonance between how women feel and how they think they should feeling will be lessened or removed.

Each session is designed with a number of session goals. Session One initially focuses on building the group dynamic, establishing group rules, introducing the course rational and general housekeeping. There are some icebreaker exercises with which to start. The goals for the first session:

- (1) For group members to develop increased awareness of personal assumptions in regards to mothers and mothering
- (2) Identify participants' values and expectations around mothering and parenthood
- (3) Assist women to gain an understanding of some of their own individual parenting goals

These goals are achieved through a blend of psycho-education and specifically designed activities which aim to address the psychological principles at play.

In the second session some ACT principles which underpin the research are introduced with a view to establish further opportunities for the participants to gain cognitive diffusion from any rigid beliefs around the assumption of healthy normality as it pertains to motherhood. Participants begin to examine the idea of mothering myths and implicit beliefs. This gives women some insight into some of the myths they themselves might have been exposed to and allows them the opportunity to decide if holding a particular belief is helpful of them. The participants need to decide whether the beliefs are helping or hindering them in moving towards the parenting goals they identified for themselves in the first session. Towards the end of the session the intervention shifts focus and begins to examine links between cognitions and mood. Participants learn they have some control over their mood and how their thoughts of past experiences can impact on current functioning. Session Two goals are:

- (1) Develop an understanding of the core principles informing the development of the intervention
- (2) Gain insight into their socialisation regarding mothering and motherhood
- (3) Learn to critically evaluate mothering 'myths'
- (4) Develop an understanding of how cognitions impact on mood

Again these goals are achieved through both psycho-education and facilitator directed group exercises and psycho-education.

Session Three goals are:

- (1) To assist participants in identifying their expectations of their partners
- (2) Provide psycho-education on postnatal distress
- (3) Sharing of resources for assistance
- (4) Collection of questionnaires

The session begins with an examination of partner expectations. The participants are encouraged to identify what expectations they hold for their partners and how things will be different with the arrival of an infant. Findings regarding partner participation from the earlier studies are incorporated with other research and are shared with the group. This is an important component as the disparity between the expectations women held of partner support and input, and the perception of the support and input offered to women from partners was strongly linked to experiences of distress.

From there the focus shifts. Information on postnatal distress is introduced and women are encouraged to identify their own signs and symptoms of psychological struggle. The women are asked to consider questions such as *If I was following you around with a camera how would I know you were struggling? What would I see? What would you be doing? Or not doing?* At the completion of the exercise the women are encouraged to share

this information with significant others in their lives as a potential avenue of future support. The rationale for this sharing of information is if partners, family members or friends are aware of how this individual women react to stress, how they hold themselves, what their coping styles are or how their mood tends to be affected for instance, they are more readily able to notice when the women are struggling and assist in ways that have been pre-negotiated.

During this session we also examine expectations women hold of their partners and what women think about potential changes to their roles. The main theme is to help women prepare for changes in relationships that may have been carefully crafted pre-baby and assist them in identifying and renegotiating role changes. Finally women are given information on potential help agencies which are available for them following the birth of their baby. There are questionnaires to be completed and a debriefing for group members with post measures of mood and parenting expectations.

A final individual contact occurs approximately six weeks postnatally. There is some flexibility in this timeframe as the follow-up needs to be schedule at the convenience of the participant. Participants are given a number of measures to complete including the Postpartum Depression Screening Scale, and the Depression Anxiety and Stress Scale as outcome measures (both covered in Chapter Six). As pre-negotiated if the measures indicate signs of distress, or if the participant reports distress an intervention plan is negotiated.

This intervention is specifically designed to meet the needs of women making the transition to motherhood. The model of postnatal distress I have developed asserts the distress was linked to the disparity between expectations and reality women experienced. Seeking to understand why only some women experienced postnatal distress despite all women experiencing a disparity between prenatal expectations and postnatal experiences, the subjective experience of loss became a pivotal element in the model.

Options to lower rates of postnatal distress logically had to address this disparity, with the ultimate aim of decreasing women's experiences of loss. The intervention does this by introducing new ways of thinking about mothering and motherhood. It begins to build the blocks for cognitive diffusion and gives women some tools for cognitive flexibility.

The final chapter in this thesis is a case study where the intervention was piloted. Although designed as a group intervention a case study format was selected to allow careful monitoring of the participant in this initial phase.

# Chapter Nine: Piloting an Intervention

## Introduction

In the previous chapters I have linked together changes to the environment in which women with what appears to be an optimistic and overly positive portrayal of mothering in the media and from other information sources. I argue these factors combine to create an artificial and unrealistic expectation of motherhood which may prevent women becoming adequately prepared for the mothering role. In addition I have highlighted new research with New Zealand mothers who shared their stories of their transition to motherhood.

An expert panel focus group concluded motherhood was not what they expected it to be, highlighting they believed a lack of social support and conflict with others negatively impacted on their transition to motherhood. In addition, this group of women reported a loss of status and a loss of the idealised image of mothering as sources of distress following childbirth. Leading from that study, and informed by existing literature, a model of postnatal distress was proposed and discussed in Chapter Five. The model states the disparity between expectations and experience can lead to distress if it is accompanied by a subjective experience of loss.

In subsequent chapters I outlined studies undertaken to test the model. I concluded there was support for the model. In particular, I highlighted evidence that:

- New Zealand women hold clear expectations relating to motherhood before becoming mothers. These include expectations of self, of their partners, of their infants, and of others.
- New Zealand women feel unprepared once they become mothers.
- New Zealand women experience a disparity between prenatal expectations and postnatal.
- New Zealand women experience a loss of the non-mothering self, a loss of occupational identity, as well as losses of control, relationship balance and status.
- Those subjectively experienced losses can lead to feelings of distress.
- Young New Zealand women of childbearing age who do not have children endorse idealised myth statements related to motherhood.
- Young New Zealand women of childbearing age who do not have children believe others in their cohort group endorse idealised myth statements related to motherhood at a higher rate than they do.

Chapter Eight introduced a new intervention protocol I developed to meet the needs of new mothers as highlighted throughout this thesis. The intervention aimed to assist so-to-be mothers in critically evaluating their mothering beliefs and identifying their parenting

values. Based on principles from Acceptance and Commitment Therapy theory, the overarching aim of the intervention was to decrease the disparity between prenatal expectations and postnatal experience and, as such, lower the risk of postnatal distress.

This chapter describes the application of the protocol in an  $N = 1$  case study design. While the intervention is designed to be implemented in a group, there was a clear rationale for running an initial pilot with a single participant:

- It enables monitoring at a more intensive level which is desirable when starting with an entirely new intervention.
- It allows greater flexibility. Researchers can respond immediately to difficulties or problems which arise.
- The flexibility of a single participant facilitates refinement of the protocol as the case progresses.
- Single-case designs are a useful starting point for establishing efficacy as they can demonstrate evidence a particular technique affects a specific behaviour in a way which is clear and replicable.

In addition there were difficulties recruiting a group of women who were in a similar antenatal phase within the timeframe of the research. There were a number of reasons for this. Women who indicated they would be interested in participating tended to still be working. This impacted on their availability to attend group sessions. Secondly, the 'where from' of the recruiting posed some logistical difficulties as well. A number of midwifery services were approached and they were all graciously willing to allow flyers and posters to be placed at their place of work. However, the midwives reported a number of initial enquiries were directed at them, and they, quite rightly, were unable to provide information to women. I do not know what impacted that had on whether women made further enquiries but consideration needs to be given to this if attempting to create a group.

However it is acknowledged that the fundamental dynamic of the invention is changed without the input of a group. Exercises, such as the icebreaker exercise, were specifically designed to be implemented within a group setting and rely on participation of multiple parties. This is a shortcoming of the  $N = 1$  case study design as utilised here.

The chapter concludes with a discussion of the research and makes recommendations for the future. The advantages and disadvantages of individual versus group invention is also briefly discussed.

## Method

An informational flyer inviting first-time pregnant women to participate in the research was distributed to a local centre which offered pregnancy support and antenatal classes. The flyer asked for women who were pregnant for the first time, had conversational English skills, able to give informed consent and willing to have the session notes written up as a case-study. Three women responded. One expressed interest but her due date meant we would not have time to complete the protocol. A second woman attended the first session before going into earlier labour and being unable to attend subsequent sessions. The case described in this chapter is of the third respondent.

### **PARTICIPANT**

Jenny<sup>2</sup> was a 23-year-old female who arrived punctually for our first session and was casually dressed wearing sweatshirt and capris. Rapport was easily established and Jenny commented she was looking forward to taking part in the research. She presented as somewhat tentative at the beginning of the session but appeared to relax as the session progressed. Throughout the other sessions she maintained her punctuality and was engaged as evidenced by her willingness to participate in the exercises and her continued involvement with the research.

#### *Current Situation*

##### *Personal Situation*

Jenny was 35 weeks pregnant with her first child when she attended the first session. She reported feeling well in her pregnancy but experiencing some discomfort with her baby's increasing size. While her pregnancy had been fine, Jenny reported that foetal scans indicated the baby would be born with club foot. This had necessitated Jenny moving from her home in Hawkes Bay--which she shared with John, her partner and the baby's father--down to Palmerston North, where the specialist care the baby required both in vitro and following birth was available. Fortunately Jenny had family in Palmerston North and was currently living with her mother and step-father.

As a further consequence of her long stay in Palmerston North, Jenny and her partner had decided to give up the home they had been renting in the Hawkes Bay. Her partner had stayed in the Hawkes Bay because of his job, and although they spoke frequently, Jenny stated the cost of petrol meant they did not see each other that often. John had moved in with his sister and her partner and that meant there would be no home for Jenny and her baby to return to in the Hawkes Bay, at the present time.

---

<sup>2</sup> The names in this study have been changed to protect the confidentiality of those involved.

### *Pregnancy Information*

As previously mentioned, foetal scans had identified the baby's left foot was a club foot, a relatively common condition where the foot is rotated internally at the ankle. As a result of this diagnosis, Jenny had had multiple scans for ongoing monitoring of the situation with a view to treatment once the baby was born. The scans had also identified the baby was female and Jenny and John had picked out a name for their little girl. Jenny stated she had been forced to take early maternity leave because she had low blood pressure which was accompanied by frequent fainting spells. Jenny reported she had had no further complications or difficulties with her pregnancy.

Jenny had attended antenatal classes. She reported she found them helpful but 'negatively focused'. She explained this meant she felt they focused on all the bad things about birth and none of the potential good things. Jenny also stated she did not feel antenatal classes had prepared her for what would follow. She said while it was good to get lots of information about the birth, she felt the classes provided no information on parenting and she was hopeful she would get some useful information from attending these sessions.

Although Jenny was under the care of a paediatric specialist due to her baby's medical condition, her lead maternity carer (LMC) was a midwife. Jenny reported liking her midwife and having worked with her to develop a clear birth plan. Although her pregnancy was unplanned Jenny stated she was excited about the upcoming arrival of her baby and looking forward to being a mother.

### *Relevant Background Information*

Jenny had attended high school in Palmerston North while living with her mother and then Napier after she moved in with her father. She described herself as an average student and apparently had a good group of friends whom she felt well supported by: "*I pretty much just stayed at school to hang out with my friends, but I wasn't much of a brain*". Jenny stated enjoyed art at school and carried on with this passion in her adult life "*Art was the best thing about school for me, apart from my friends*". She sold art on Trade Me to supplement her income working for a wine bottler and wholesaler. Jenny reported her job was okay but not well paying (minimum wage) and stated she hoped to re-train into another occupation once the baby was born "*I'd really like to do kindy or something like that, but I just want to get out of factory work*".

Jenny described herself as a *bit of a worrier*, but had no previous history of mental health issues "*I think I'm pretty normal!*" She stated her main form of relaxation was her art, and she found she could get very caught up in things she was doing "*I can do my art happily for hours and hours and forget to do other stuff*".

## MEASURES

*The Depression Anxiety Stress Scales (DASS)* – (Lovibond & Lovibond, 1995b). The DASS is a 42-item self-report measure used to assess the affective states of anxiety, depression, and stress. A full description of the scale including psychometric properties and rationale for its use with this population is included in Chapter Six.

*Maternal Adjustment and Maternal Attitudes Questionnaire (MAMA)* (Kumar, Robson, & Smith, 1984). The MAMA is a self-report questionnaire specifically developed to measure a mother's perceptions and attitudes throughout pregnancy and the early postpartum. It consists of five subscales: perceptions of body, perception of intimate relationship, perception of somatic symptoms, and attitudes to sex as well as to the pregnancy and the baby (see Appendix B). The MAMA contains sixty items which women are directed to reply to in terms of how they have been feeling in the last week. Each item uses one of two Likert scales, either *never, rarely, often* or *very often*, and *not at all, a little, a lot* or *very much*. There are no cut-off scores reported by the developers, as the aim of the measure is to monitor within subject changes in attitudes and adjustment. Each subscale contains twelve items and has a maximum score of 36. A higher score indicates more positive attitude on the scale of interest.

The scale was developed and evaluated using two cohorts of women: typical women in their third trimester ( $n = 99$ ), and primipara women in their first or second trimester who were part of a longitudinal mental health study ( $n = 119$ ). Participants underwent a series of group interviews. From these interviews, and from a literature survey, preliminary questionnaire items were generated. Ninety-nine women were involved in the initial pilot of the questionnaire. Test-retest reliability across the five sub-scales was adequate with Cronbach's alpha between 0.8 *marital relationship* and 0.95 *attitudes to sex*. Criterion validity was demonstrated by comparing subscale scores and findings from clinical interviews.

*Postpartum Depression Screening Scale (PDSS)* (Beck & Gable, 2000). The PDSS is a 35-item self-report measure designed to identify women at risk for developing postnatal depression. It can usually be completed by respondents in 5-10 minutes, and is appropriate for use from 14 days postpartum (Beck & Gable, 2002). The PDSS measures symptoms across seven dimensions of PND; sleep/eating disturbances, anxiety/insecurity, mental confusion, guilt/shame, loss of self, emotional lability, and suicidal thoughts. Full details of the PDSS are given in Chapter Six.

*Session Evaluation Scale*. As the primary purpose of this study was to evaluate the acceptability of the intervention, its exercises, and its themes, a measure was devised specifically for this study to meet this need. The Session Evaluation Scale is a four-item, pen and paper visual analogue scale (Appendix J). It was based on the Outcome Rating Scale (ORS) (Miller, Duncan, & Johnson, 2002) and the Session Rating Scale (SRS) (Duncan et al.,

2003). Both of these instruments were specifically designed for brevity and ease of administration in a clinical setting. Although ultra brief, visual analogue scales of this kind have been shown to demonstrate reliability and validity, and show high levels of clinical utility (Duncan et al., 2003; Miller et al., 2002). Authors of both the SRS and the ORS report good validity in their respective instruments. The ORS demonstrated good concurrent validity with longer instruments designed to measure therapeutic change and lower levels of test-retest reliability, giving an overall psychometric profile consistent with the stated aims of the instrument. Similarly, the SRS demonstrated good internal consistency, with lower test-retest reliability. Both measures are freely available for download off the Internet.

Participants are given the visual analogue scale and asked to put a mark on the line which best fits their experience of the session they have just had. For each item the left-hand side indicates a more negative experience (*Today's session did not meet my expectations; I did not enjoy the topics in today's session*), while the right-hand side indicates a more positive experience (*Today's session met my expectations; I enjoyed the topics in today's session*). Each analogue scale is 10cm long, and the score is derived simply by measuring from the left point on the scale to the mark made by the participant, thus a mark of 6.7cm along the scale indicates a score of 6.7/10, and an experience that was more positive than negative.

### *Jenny's Baseline Psychometrics*

#### *DASS*

Depression	full scale score 14	Z score 1.10	moderate
Anxiety	full scale score 14	Z score 1.89	moderate
Stress	full scale score 17	Z score 0.87	mild

#### *MAMA*

• Somatic subscale	29/36
• Body image subscale	29/36
• Marital relationship subscale	35/36
• Attitudes to sex subscale	34/36
• Attitudes to pregnancy and the baby subscale	26/36

### *Interpretation*

The MAMA measures change overtime and cut-off scores or high or low scores are not reported. In addition, because it is a measure of within subject change, norms are not given by the developers. Jenny's scores at baseline indicate she feels relatively more positive about her relationship over other areas evaluated by the scale. This may in part explain her positive *attitude to sex subscale* scores (or potentially her relatively high

endorsement on the attitudes to sex subscale may, in part, explain her positive attitude towards her relationship). Overall she indicated she felt less positive about the pregnancy and baby, which might be explained by the concerns Jenny had over the baby's health related to its physical condition and also her reports she gave up work early because of problems with blood pressure during the pregnancy.

### *Session 1*

The initial goal of Session One was to establish a working alliance between the participant and myself. To do this I attempted to create connections through a discussion of shared interests (horses) and mutual experiences. There is substantial evidence on the importance of the working alliance in the outcome of psychotherapy, with a positive relationship between the quality of the working alliance and therapy outcome. Although this protocol does not *treat* individuals (as the individuals involved are not in need of *treatment*) as psychotherapy does, the intervention does work with them in a similar way. The working alliance, defined as the extent to which a client and a therapist work collaboratively and purposefully and connect emotionally, is therefore an essential component of the protocol (Horvath & Luborsky, 1993).

As the session progressed Jenny completed a series of questionnaires which were used to establish baselines. An overview of the session as per Text Box 1.1 (Appendix A) was provided, and an opportunity created for Jenny to discuss any questions or concerns she had about participating. Jenny reported she did not have any concerns and was looking forward to the research. She reported feeling a little bit unsure about what to expect, but hoped she could get some "*good ideas about parenting*" and was interested to know whether "*I think the right things*".

The model on which the protocol is based argues women are exposed to mythical images of mothering, which leave them ill-prepared for becoming mothers. There was support for this from the outcomes of the Mothering Myths questionnaire highlighted in Chapter Seven. Other research has found these mothering images are generally optimistic and unrealistic. Given the centrality of this concept to the model, the intervention was designed to assess at the outset what beliefs and expectations are held (see exercise 5, appendix A). The focus of this exercise is not on changing the beliefs and expectations as that would be inconsistent with an ACT approach. The focus is on bringing into awareness for the individual women what their thoughts, beliefs and expectations are, so that they may, as they are willing, evaluate the usefulness of those beliefs and expectations for themselves.

In keeping with this, the focus of the session shifted to identifying what information and beliefs Jenny held about mothers and mothering, as well as where that information had come from. Some of Jenny's beliefs identified in Exercise Five included:

- Mothers have their children as their biggest focus.
- Mothers have an instant bond with the baby.
- Mothers are naturally nurturing.
- Recovery from pregnancy and childbirth takes around six weeks.
- Mothers sharing equally in childcare responsibilities with Fathers.
- Mothers are supportive of their children and enjoy spending time with them.
- Good mothers are always available to their children.

The final component of Session One was values identification. A focus on values is consistent with ACT therapy which argues values are essential for meaningful and purposeful living. Furthermore, when women are working with their own values there simply cannot be a disparity between the values they expected and the values they experience, and it is the disparity between prenatal expectations and postnatal experiences which is a fundamental cornerstone of postnatal distress according to the research model.

Value goals are identified through therapeutic techniques such as Socratic questioning, reflection, and paraphrasing. For instance, Jenny was asked to consider what she would like her children (and others) to say about her as a parent, and how would she know she was doing a good job of parenting – what would her children be doing or not doing for example? At one stage Jenny replied her children would be happy so we delved further, using the aforementioned techniques to understand what *being happy* looked like to Jenny, and what it might mean for her children. Were they always happy or was it okay to be sad sometimes? How would she know they were happy? Could the children be unhappy and Jenny still be a good parent, say if the children were sick?

Throughout the exercise Jenny professed several times she did not know what her values were. She stated she had never really thought about parenting in that way, and found it challenging to think about these things. However, by the end of the exercise Jenny had identified several values including:

- Having a child who was confident
- Having a child who was respectful
- Being a warm and loving parent
- Establishing secure attachment patterns

Once Jenny identified her goals we discussed whether her beliefs and assumptions aided her in *keeping her feet moving in her valued direction*, a concept directly tied to values work in ACT theory. Working on the whiteboard we listed Jenny's values on the right and her beliefs and assumptions on the left. Then we tried to match them together to assess the *fit*. For instance which of Jenny's values were supported by holding the belief that a mother is always available to her children? In other words, were the beliefs and

assumptions she held likely to help or hinder her in working towards her values. At the end of the session Jenny completed the Session Evaluation scale before leaving

#### *SES SCORES*

• Expectations scale	7.6/10
• Enjoyment scale	9.7/10
• Relevance scale	9.1/10
• Overall scale	9.3/10
	36.7/10

#### *Interpretation*

Jenny's SES scores for this session indicated the session was somewhat as she expected. Jenny indicated she felt the session was highly relevant for her and that she found it very enjoyable. Overall Jenny's endorsement for the session indicated high agreement with the anchor *today's session was just right for me*.

#### *Session Two*

Session Two began with a welcome and a recap of the previous session. Jenny acknowledged feeling some confusion over the disparity between her beliefs and assumptions and her values. This experience of cognitive dissonance was to be expected as Jenny was now holding conflicting ideas simultaneously. The theory of cognitive dissonance states an individual will seek to change their beliefs, behaviour, or actions in an effort to reduce this dissonance (Cooper, 2007; Festinger, 1957; Harmon-Jones & Harmon-Jones, 2007). Alternatively, dissonance can be reduced by denying, blaming or justifying, the primary argument for why smokers continue to smoke cigarettes even with the knowledge such behaviour has potential lethal consequences. In relation to this situation, Jenny's beliefs about motherhood were discordant with her values and the inconsistency between expectations and experiences created a negative affective state. Consistent with ACT therapy there was no attempt to *fix* this for Jenny. We did however, spent time on the idea of acceptance of negative feelings as Jenny contemplated the potential ramifications of this discrepancy.

As part of that we were able to move onto the next stage of the session as outlined in the session plan and introduce some ACT theory (Textbox 2.1; Appendix A). In particular the idea of *living in our minds and not our experiences* along with *the assumptions of destructive normality* were discussed. From this, Jenny was given a new way of thinking about negative emotions, as normal, as healthy and, at times, as adaptive, but always as *something to experience as it is and not as we think it is*. Jenny initially appeared to find the idea of anxiety as helpful difficult to understand, however towards the end of the discussion

she exclaimed "I really like that idea, I had never thought anxiety could be good for you, it feels almost like a relief".

We proceeded to Exercise Three, *You are what you think*. Prior to the exercise Jenny's rating on the Happiness Scale was 9.5. Following the completion of the exercise her Happiness rating was 11.6. Jenny reported she found the exercise enjoyable and relaxing. We spent some time discussing why the scores were different, and the implication of being able to moderate mood through thoughts. As well as that, the link between experiences and language was made. This is the ACT idea that as long as we can describe something, as long as we can communicate through language, we can experience and re-experience events long after the initial threat has passed. More than that, because we use language to communicate we can experience things cognitively and emotionally that we have never actually experienced ourselves.

We then moved on to Exercise Four where we examined the link between *thinking our feelings* and *thoughts related to motherhood*. Jenny initially seemed to struggle with the ideas behind the exercise, and found it difficult to make the link between remembering a happy event and holding opinions of events she had not yet experienced. We discussed how Jenny had clear expectations and beliefs around herself as a mother and her baby despite never having been a mother. Thus those were thoughts, not experiences, and we discussed the previous exercise where Jenny was shown she could alter her mood through her thoughts.

Towards the end of the session I introduced the *Learning to let go* exercise which draws on the Tug-of-War metaphor from ACT. Jenny laughingly reported thoroughly enjoying the exercise. At the end of the session Jenny completed a SES before leaving.

#### *SES SCORES*

• Expectations scale	8.7/10
• Enjoyment scale	9.1/10
• Relevance scale	8.9/10
• Overall scale	9.2/10
	35.9/40

#### *Interpretation*

Jenny rated this session as slightly less enjoyable than the first session (9.7 v. 9.1), but even so, still rated it as highly enjoyable. It is possible the early theoretical focus was more difficult for Jenny, which might explain the drop in ratings. This session was highly endorsed on the overall scale, although again, slightly below the previous session (35.9 v. 36.7).

### *Session Three*

The initial focus of the third session was on helping Jenny overtly identify some of her core beliefs and assumptions about her partner. This included what support she thought he would offer, what his involvement with the baby would be, what would change for him, as well as how Jenny expected her partner to know about her expectations.

Jenny reported holding a number of expectations especially around his participation in infant care. She stated she had not explicitly discussed with her partner who would do what, and she decided she was going to go home and discuss her expectations with her partner that night. She also said she did not really know what he expected of her and she thought it would be useful to talk about that too. Initially Jenny had reported she expected a reasonably even contribution to the parenting responsibilities (Session One) and described the partner work as *"a bit of a wakeup"*. Even though the intent of the intervention is not primarily on changing Jenny's thought and expectations, Jenny's thinking showed a clear shift as she began to really consider the evidence base for her beliefs. She acknowledged thinking things would be that way *"because I thought that's what everybody did, I hadn't really thought we would be different, or that John might think something different to me"*.

It was clear from Jenny's report that the couple had thought a baby would strengthen their relationship. However, Jenny stated she had not given much thought to the impact of the baby on her relationship with John, and she expressed a keenness to remedy that: *"I think this is something we need to get sorted so everyone is clear, 'cos I've never really thought about it before"*.

Following work on partner expectations, the focus shifted to psycho-education around postnatal distress. Jenny reported they had covered postnatal depression in her antenatal class, and she would not get it because she *"had not had depression before"*. We spent some time discussing the link between postnatal depression and other forms of depression unrelated to childbirth. Jenny was given information on the signs and symptoms of depression as well as the other negative mood states of interest: anxiety and stress.

A fundamental premise of the theory which informed the development of this intervention protocol is that women are unprepared for some of the experiences they have following the transition to motherhood, and this may lead to feelings of distress including depression, anxiety, and stress. Chapter Eight included research on barriers to help seeking for women who feel distressed, and it was reported a significant barrier was their lack of knowledge around symptoms of distress and their inability to identify distress within themselves when in the middle of it. Thus an intervention directed at working with this population needed to include resources specifically designed to assist women with some strategies in overcoming some of those help seeking barriers. The *Okay Exercise* encourages individuals to think about the thoughts, behaviours, and strategies they tend to

fall back on when struggling and to gain insight into what they *look like* when things are getting hard for them. Jenny was asked to think about a series of questions including:

How will you know if you are doing okay after the baby is born?

What sort of things will you be doing?

What will things look like?

How will your partner know if you are doing okay?

Then Jenny was encouraged to think about those some questions in relation to not being okay. We discussed whether Jenny was comfortable to go home and share the information with her partner. She stated she was but did not want to do a contract as is suggested in the intervention protocol.

At the end of the session we discussed some stress management strategies. Jenny was given details of resources available to her, either in the area or on the net. Arrangements were made for contact for the postpartum follow-up and Jenny completed a SES before leaving.

#### *SES SCORES*

• Expectations scale	9.0
• Enjoyment scale	9.6
• Relevance scale	9.4
• Overall scale	9.2
	37.2/40

#### *Interpretation*

According to the endorsement ratings this was the best session overall for Jenny. She indicated it was both highly enjoyable and highly relevant. This may reflect Jenny's positive endorsement of the Okay exercise which she rated as the most useful exercise of the sessions.

#### *Postnatal Follow -up*

The arranged postnatal follow did not occur as Jenny ended up moving back to the Hawkes Bay before our scheduled meeting. She agreed to fill out the final measures though and these were sent thorough to her in the mail. Jenny completed the Depression Anxiety and Stress Scale (DASS) and the Postpartum Depression Screening Scale (PDSS). Jenny's PDSS score was in the normal range (full scale score = 57), as were the scores on the sub-scales of the DASS (Stress:  $z = -0.39$ ; Anxiety:  $z = -0.75$ ; Depression:  $z = 0.62$ ).

In addition she completed the Maternal Attitudes and Maternal Adjustment Scale which showed an elevation of scores on the attitudes to infant and pregnancy and body

image subscale and a decrease on the marital relationship and attitudes to sex indicating positive attitudes to the infant and her changing body but more negative attitudes to the marital relationship and to sex. This is consistent with research suggesting initial drop in marital satisfaction is normal, and supports the usefulness of the intervention in preparing women for this eventually. The finding that Jenny did experience what, following Session Three, became an *expected* decrease in relationship satisfaction which she did not experience as distressing provides evidence for the utility of the approach. Given the attitudes to sex subscale inquires about sexual intercourse at a time when women are still experiencing lochia and may not have fully recovered from birth injuries a decrease in positive attitudes towards sex is to be expected. Finally, Jenny's scores on the somatic scale had also decreased, which was arguably a functioning of giving birth.

## Discussion

This case study provides support for the acceptability and workability of an intervention protocol to lower the risk of postnatal distress research. There were a number of indicators which suggested Jenny might be at elevated risk for postnatal distress. She was separated from her partner during the pregnancy which left her with limited support. In addition there was a concern around the baby which was shown to have a club foot on foetal scans. Because of her low blood pressure Jenny had had to give up working and this, combined with the shift down to Palmerston North, had left her further isolated.

Jenny base-line assessment scores were in the normal range for stress and in the moderate range for depression and anxiety as measured by the Depression Anxiety and Stress score. She reported feeling mostly positive about her pregnancy and indicated positive adjustment to the infant as measured by the Maternal Attitudes and Maternal Adjustment Scale. The marital relationship scale indicated she felt close to her partner despite their temporary separation. Despite her elevated risk, at the postnatal follow-up Jenny's scores were in the normal range for depression, anxiety, and stress. This provides some positive evidence for the usefulness of the intervention, and is a promising start although caution needs to be exercised around the limited nature of the evidence.

Jenny experienced a decrease in relationship satisfaction following the birth of her daughter. She indicated although she felt close to her partner, he had not provided the level of support she would have liked. This is consistent with research findings which report on the experiences of other mothers and the potential decrease in relationship satisfaction is explicitly covered in Session Three of the intervention protocol. While there is no evidence to suggest Jenny may have experienced high levels of distress resulting from this had she not been expecting it, the fact that she did not experience distress when she did expect the decrease is promising.

Over the course of the sessions Jenny reported she enjoyed the exercises and found them relevant as measured by the Session Evaluation Scale. Most exercises went smoothly and operated as intended. Of all the exercises the Okay exercise was rated as being most helpful by Jenny, as it provided her with insight into her own ways of being in the world and she was able to then share that information with her partner. Overall, the feedback from the sessions was positive and the exercises were able to be applied in a meaningful way.

The intervention protocol is designed to be implemented in a group format, and the effectiveness of that delivery mode is yet to be evaluated. From here, there needs to be further testing of the intervention. Logically, the next step is to evaluate its effectiveness in a group. However, as highlighted at the beginning of the chapter there were issues with recruiting a group. This may in part be a product of the timeframe postgraduate research works within. Having time to build professional relationships, and having the time to give further information to professionals who may be willing to assist in the recruiting process may impact positively on the ability to form groups.

There were a number of advantages associated with running this invention with an individual. The needs of the individual could better be met and sessions were run at her convenience. Logistically this made the running of the protocol easier in that there were less people to accommodate. Whether that suggests it would be more practical, or achievable to continue to run the protocol in an individual format is an interesting proposition. If one was to consider running this purely as an individual intervention however, the group exercises would need to be adjusted appropriately and in a structured way.

However, the group format offers a number of advantages over the individual format. Groups of individuals with shared experiences can provide reassurance and a sense of validation to other group members as the shared nature of their experiences can provide a sense of 'normality'. In New Zealand some women chose to continue on with their antenatal group following the birth of their child, and thus the group becomes a source of peer support. The running of the protocol in a group format might provide women with further opportunities for peer support in the postnatal stage. More practically, there is less demand for clinical time, and less demand on resources and thus the group format is more cost effective.

The strength of the intervention is the simplicity of the concepts and the detail of the exercises. This allows professionals with diverse training background to understand and draw on the ideas contained within the intervention protocol itself.

## **Conclusions**

This case study highlighted the introduction and initial validation of a brief intervention protocol designed to lower the risk for the development of postnatal distress. The intervention used a values based approach based on the principles of Acceptance and Commitment Therapy. Jenny reported finding the intervention useful and engaging, and despite having a number of identifiable risk factors for postnatal distress, appears to have made the transition to motherhood successfully. This provides some preliminary support for the intervention protocol as a cost-effective and efficient method of lowering postnatal distress risk.

## Chapter Ten: Concluding Thoughts

This thesis documents a research journey which has included a number of components. It has involved: (A) a comprehensive literature review, (B) formulation of a model of distress, (C) testing of the model, (D) development of a manual based intervention to address postnatal distress, and (E) evaluating the acceptability of the manual. So how does it all fit together and what has been achieved?

I have discussed how motherhood is portrayed as natural and normal. And it is. It is hard to imagine a process which is more natural or normal. However, that does not equate to non-problematic and, as has been highlighted throughout this research, and in other research cited, women can struggle. Those experiences tend to be constructed as difficulties and shortcomings within the individual, which ignores the broader issues of prejudice, of the lack of support, of social isolation, loss of status, the financial penalties and the loss of previously negotiated partnership roles. None of that matters. Women who struggle with motherhood, or who do not want to mother, are constructed within this framework as unnatural – pathological.

Within the thesis I discuss how the role of mothering and the support for mothers has changed and eroded over the years, but the burden of mothering, the expectations of non-mothers and on mothers has not. Control of mothering has been taken away from women. In the ultimate paradox mothering, pregnancy and childbirth is perceived as so abnormal it needs medical intervention. Mothering is so difficult, so challenging, women need to consult books. Women, while embarking on the most natural of journeys are told time and time again, they do not have what it naturally takes to make the journey. They receive messages that they are unarmed and ill-prepared without expert guidance. That they should read and practice what the experts tell them because women who struggle are unnatural - pathological.

Little wonder then postnatal distress in some form seems to be experienced large numbers of women. This thesis has highlighted research giving conservative estimates of a prevalence of one in five women for postnatal depression, and rates of anxiety at levels high enough to cause disruptions to daily functioning are argued to be as great as 1 in 2. The roles of hormones and biology in postnatal distress have been investigated over the years but they have provided limited insight into mothering distress. And how can they? Very little about being a mother is about biology. Psychological theories of crisis, of helplessness, and hopelessness certainly seem more fitting. One can easily construct early motherhood as a time of crisis as mothers negotiate a new self and a new way of being in the world. Cognitive theorists argue women are hypervigilant to risk: they overestimate the threat of the outside world to their infant and develop anxiety disorders (usually giving a matching disorder to their off-spring in a two-for-one deal). At the same time women are routinely

bombarded with emotive messages of risk to their children: *kills 99.9 percent of germs, bacteria laden, disinfects, hypoallergenic, low fat, low sugar, low gluten, eco-friendly, stranger danger, safety approved*. On one level it would seem good mothers carry pocket size hand sanitizers in case they need to touch a shopping trolley, yet women who struggle are unnatural - pathological.

I have discussed research highlighting findings that women are given implicit messages of motherhood almost from birth. One only has to visit the girls' aisle at department stores like The Warehouse to know what they are. It is nauseatingly pink, filled with nurture promoting toys – dolls, kitchen appliances, gift ware, and offers a decided lack of vigorous play items such as bats, balls, or guns. Girls quickly learn it means they are quiet, passive, and nurturant. Unsurprisingly, girls then develop expectations around that role. Firstly they expect to be rewarded for conforming to it. Thus there is an expectation fulfilling the mothering role will bring status, value, and recognition. Secondly, it appears they have an expectation if they conform and become mothers they will be supported in doing so. Thirdly, there is some evidence to suggest that they have an expectation of an idealised experience of motherhood because they are told mothering is wonderful, it's magical, and it is what defines them as true women. Finally they have an expectation it will just happen, they will bond instantly with their infant, breastfeeding effortlessly, recover their pre-pregnancy shape, and most importantly they will wake-up with an in-built maternal instinct which makes them all knowing in matters of their infant. So when that doesn't happen, well, women who struggle are probably perfectly normal mothers.

Women-centred research principles demands if one is seeking to understand a phenomenon which affects women, if one wants to do research about women, it needs to be for women and of women. This thesis highlights a number of studies which aimed to honour that demand. When seeking to understand how women experienced the transition to motherhood, I asked them. Study One outlined discussions with a group of older mothers who negotiated the traps of motherhood some years before. This group highlighted their experiences of loss and conflict as they sought to establish their new mothering identities. They spoke of beliefs and expectations, they spoke of their victories and battles, and most of all how, when they struggled, they were made to feel unnatural – pathological.

Combining the sum of the literature and the findings of the first study I developed a new model of postnatal distress. The model stated women exposed to gender stereotyping and bombarded with imagines of contented mothers, immersed in a culture which espoused overly positive mothering myths, developed optimistic, and often unrealistic, prenatal expectations of the mothering role. When those expectations were violated, when there was a disparity between prenatal expectations and postnatal experiences the potential for the development of postnatal distress arose if that disparity was subjectively experienced as a loss.

Following on from that I began to test aspects of the model. I confirmed that, at least for the cohort interviewed, New Zealand women do enter into motherhood with clear expectations of themselves, of their partners, of their infants, and of the mothering role. The women reported the expert advice contained within the pregnancy and parenting books they read did little to assist them in their transition to motherhood; in fact they reported the reverse, the books created anxiety and pressure. They felt they had to 'live up to' the books' ways of doing mothering, and when they struggled, when it did not *fit* for them or their infant, they reported lacking confidence in their own evaluations, and their ability to cope with the situation. This group also reported conflict with professionals whose role it was to help them care for the infant. They spoke of being bullied, of feeling de-individualised, being infantised.

I demonstrated young women of child-bearing age who do not have children do endorse myth statements of motherhood. They believed mothers have an instant bond with their baby, they believed not bonding quickly with your baby will have long-term consequences and they believed mother's instinct comes with the birth of your child. This group of young women were more likely to endorse the myth statements if they were young, single, and less educated.

An important finding from this study was the significant relationship between an individual's subjectively rated experience of their own mother and their endorsement of mothering myths. Young women in this cohort group were more likely to endorse the myths if they reported a highly positive, and presumably idealised, image of their mother. This opens the way for an initial non-threatening path of investigation into risk of postnatal distress.

Traditional approaches to maternal mental health have focused on the treatment of postnatal depression in the months following the birth of the baby. However, this has not addressed the issues of anxiety and stress; what is collectively referred to in this thesis as postnatal distress. In contrast I have outlined a model which addresses this proposed broader understanding of women's experiences.

Postnatal distress has a definitive trigger and a reasonably well defined period of risk. That being the case, it is ideally suited for prevention approaches. Working with the findings from the previous studies, taking the assumption the pregnant women hold optimistic expectations of the event of mothering, believing that they will have been exposed to any number of mothering myths I developed an intervention protocol. The intervention did not seek to impart *expert advice*. Women had already said that was not helpful. It did not seek to medicalise; I have no training in that area. It did not seek to pathologise, to give the answers, to espouse a particular belief or way of being a mother. The intervention protocol aimed to work with women to help them identify *their* beliefs and values. It sought to encourage them to bring into conscious awareness myths of mothering they may have

been exposed to and to evaluate for themselves the usefulness of holding those beliefs was *for them*. It sought to empower them with knowledge of their own mastery of their thoughts and emotions, and importantly it sought to impart research that demonstrates women who struggle are natural – non-pathological.

The final step of this research journey was a piloting of the intervention to test the workability and acceptability of the manual. I demonstrated the manual could be successfully implemented within the indicated timeframes, the exercises were enjoyable and achieved what they were designed to do. While it is a long way from evidence it is encouraging.

As I said in the prologue, the intervention is not a guide to motherhood, but maybe a guide to how to begin to think about being the mother you would like to be. It was developed because there is a need. Women in New Zealand struggle with the transition to mothering. They struggle because they are unsupported. They struggle because they are exposed to mythical images of motherhood which set them up to feel failure. They struggle because successive governments have systematically removed support for families and devalued the mothering role.

This thesis offers a new way of conceptualising postnatal distress which acknowledges the context in which women mother as central to their experience of mothering. It has also highlighted the importance of prenatal expectations on the subsequent experiences of women following the transition to motherhood. Perhaps more importantly, it offers an opportunity to be proactive in the care of first-time mothers-to-be with an intervention protocol designed to assist women *before* they experience distress.

There are a number of professions involved in the care of women during the perinatal phase, each with valuable and unique skills as well as their own understanding of mothering. This thesis offers a framework which could be used to develop a shared understanding between these professionals, promoting continuity of care and a coherent discourse of postnatal distress. The findings from the various studies suggest professionals who do work with this cohort of women may wish to consider what expectations the women hold, as well as what experiences the women had of being mothered. Probing in these areas should provide some insight into which women may be at risk of experiencing difficulties at later stages. Furthermore all professionals working with this group could ask themselves how to address the concerns the women in this research raised about their experiences of being infantised and de-individualised. Becoming a mother is both a time of great reward and great stress. Professionals who work with this population have chosen to do so: clearly they have an interest or an empathy for this group, yet unfortunately that does not always seem to translate to the women they are trying to help, which further adds to the stress the women are under. The overall message from the participants was *acknowledge the woman in front of you as the expert of her own experiences*. Despite

operating under tremendous constraints with public health care policies which minimise contact between professionals and mothers, clinicians, doctors, midwives, nurses - indeed anyone involved in supporting this group of women need to remember their humanity and interact with the individual.

New Zealand is a great rugby nation. While the dramatic showing of the haka is invigorating at the onset it does not define the game any more than the dramatic event of birth defines a mother. Rugby is won by a team who works together to achieve a common goal, and is more about doing the hard grind than the occasional flashes of brilliance. So too is mothering about doing the hard grind, but what seems to be missing for some is the team support and the common direction. Maybe at the end of the day the best thing we as professionals working with pregnant women can do is 'touch, pause, engage'.

## Epilogue

As I first highlighted at the start of this thesis when I started researching postnatal depression it was not so much to understand it per se but to attempt to undo the damage I had been assured I had done to my son by having the audacity to experience it. In my mind I had broken him before he'd even had a chance to get started and it was up to me to repair what I could.

I didn't think about being a young woman in a new town without friends and with no family except for the hostile presence of the mother-in-law "*Well, Anita, if you didn't want to look after these children you should never have had them in the first place!*" (like sure, I did that all by myself!). I didn't think about the fact that while it was a new town for me and four hours drive from my family, my husband was moving back to his old stomping ground and so while I stayed home with two kids under three, he naturally relished the opportunity to go out and catch up with old friends.

I know the very moment I sunk into depression. It was when I rang my husband to tell him I was pregnant. I was in a bit of turmoil as it was unplanned; I loved being a mother to an 18-month-old and I had a dreadful premonition everything was about to change. I was thinking about having to cancel this and change that, juggle this and the next. I was contemplating a hundred different things including pulling out of studying, and rueing not listening to friends who told me the surest way of getting pregnant with number two was to give away all your stuff from number one. With all this in my head I rang my husband to tell him the news. He said "Well that's great news honey, but I can't talk now I'm busy at work". Whatever he meant, or whatever he thought he said, what I heard was *I'm too busy for you right now and while your life is going to hell in a handbag my life carries on.*

I couldn't work it out. The books told me all about what was wrong with me and what I was doing wrong as an explanation as to why I would struggle in the postnatal period. But it didn't fit. I had no history of depression, had a perfectly normal transition to motherhood, this wasn't my first child. I wasn't that young, wasn't single, wasn't poorly educated, wasn't poor. The attachment bond my first child was secure – she was bold and curious, developmentally doing well, she was pretty short (still is!) but otherwise she was great. My father speculated the reason I had difficulty with my second child, not my first, was that my second child was a boy. I'm pretty sure the reason I had problems with my second child and not my first is because he was born with a small hole in his heart which required frequent medical check-ups, he didn't sleep, he didn't settle, he didn't gain weight (a failure to thrive they call it, but the strong underlying message is a failure to mother). And

he didn't stop crying, for months, and months and months, while doctor after doctor after doctor told me everything I was doing wrong and not one, **not one** said *Are you okay?*

It took me ages to work out under that scenario I wasn't the one with the deficit. I was having a perfectly normal response to an incredibly abnormal and unsupportive situation. So I started looking for something that made sense of my experience, in my head, for me. Well for myself and my son because this was his story too. By the time he had turned three or four, we had healed. We had a good bond, we had worked out what worked for us and the emotional turmoil of his initial years had abated. But my interest in women's experiences of postnatal distress had taken on an intellectual life of its own. With a safe distance from the emotion of my own experiences established I began to investigate others'. The stories of the women in this thesis are not my story. Nor are they anyone else's story. It is their story of their victories and battles in their transition to motherhood. But there are striking similarities that highlight the difficult and tempestuous journey motherhood is for women. For perfectly normal, fully functioning, and non-pathological women. All the women interviewed in this research reported being unprepared. All the women reported disparities between prenatal expectations and postnatal experiences. All the women reported losses. All the women reported hostile interactions with medical staff and other professionals charge with supporting them in their mothering role.

One of the more interesting aspects of this project has been the parallel process between what the women in the studies have described and my experience of doing research with and for this population. For instance, there has been an ongoing battle to stop others pathologising pregnant women throughout and because of my research. Supervisors and colleagues who referred to my developing protocol as 'treatment' were corrected with intervention "*I can't treat them they are not sick*". There was the subtle track-change of 'facilitator' to clinician before it was changed back to facilitator: "*They don't need a clinician they are not struggling, they are not pathological*", the debate with ethics about whether pregnant participants were a vulnerable population. All these things confirmed time and again what the women in the research were saying about the infantising and medicalising of pregnant women and mothers. If these adult women were deemed capable of giving informed consent before getting pregnant by what process are they now deemed to be incapable of giving informed consent to participate without special protection? (AND as one ethics committee attempted to stipulate – without informing their General Practitioner).

I don't know how much of my experience informed the development of the model. If anything, I think it may be the other way around. I think in talking with women and listening to them, in working with the model on an intellectual level; in moments of me-time reflecting on the stories of others has given me some aha moments. I think the clinician

side of me could do what the mother side of me never could: rationalise, understand, tolerate, forgive.

As I write this my son is humorously (and hopefully) making outrageous requests for his 13<sup>th</sup> birthday. The hole in his heart is still there, and we tried to instil in him early on knowledge of, and respect for, his heart condition in the belief that information will help him make good choices about protecting it. He answers back too much, he knows everything, he doesn't change his socks often enough, and he is way too influenced by his many friends but he's mine. Maybe our rocky start affected our relationship – I don't know. I don't know what it would have been like without postnatal depression, but I do know what we have right now, in this moment, suits us. I don't know half the questions let alone the answers. But I do know he is fine.

He is my son-shine.

## References

- Abbott, M. W., & Williams, M. M. (2006). Postnatal depressive symptoms among Pacific mothers in Auckland: Prevalence and risk factors. *Australian and New Zealand Journal of Psychiatry, 40*, 230-238. doi: 10.1111/j.1440-1614.2006.01779.x
- Abel, S., & Kearns, R. A. (1991). Birth places: A geographical perspective on planned home birth in New Zealand. *Social Science Medicine, 33*, 825-834. doi: 10.1016/0277-9536(91)90387-R
- Abernethy, V. (2009). Female hierarchy: An evolutionary perspective In L. Tiger & H. T. Fowler (Eds.), *Female hierarchies* (pp. 123-134). New Brunswick, NJ: Transaction Publishers.
- Altshuler, L. L., Cohen, L. S., Moline, M. L., Kahn, D. A., Carpenter, D., Docherty, J. P., et al. (2001). Treatment of depression in women: A summary of the expert consensus guidelines. *Journal of Psychiatric Practice, 7*, 185-208.
- American Psychiatric Association. (2000). *DSM-IV-TR: Diagnostic and Statistical Manual of Mental Disorders*. Washington DC: American Psychiatric Association.
- Andersson, L., Sundstrom-Poromaa, I., Wulff, M., Astrom, M., & Bixo, M. (2004). Implications of antenatal depression and anxiety for obstetric outcome. *Obstet Gynecol, 104*, 467-476. doi: 10.1097/01.AOG.0000135277.04565.e9
- Antony, M. M., Bieling, P. J., Cox, B. J., Enns, M. W., & Swinson, R. E. (1998). Psychometric properties of the 42-Item and 21-Item versions of the Depression Anxiety Stress Scales in clinical groups and a community sample. *Psychological Assessment, 10*, 176-181. doi: 10.1037/1040-3590.10.2.176
- Austin, M.-P., & Leader, L. (2000). Maternal stress and obstetric and infant outcomes: Epidemiological findings and neuroendocrine mechanisms. *Australian and New Zealand Journal of Obstetrics and Gynaecology, 40*, 331-337. doi: 10.1111/j.1479-828X.2000.tb03344.x
- Austin, M.-P., M. Frilingos, J. Lumley, D. Hadzi-Pavlovic, W. Roncolato, S. Acland, et al. (2008). Brief antenatal cognitive behaviour therapy group intervention for the prevention of postnatal depression and anxiety: A randomised controlled trial. *Journal of Affective Disorders, 105* 35-44. doi: 10.1016/j.jad.2007.04.001
- Austin, M. P. (2003). Psychosocial assessment and management of depression and anxiety in pregnancy. *Australian Family Physician, 32*, 1 - 8.
- Austin, M. P. (2004). Antenatal screening and early intervention for "perinatal" distress, depression, and anxiety: Where to from here? *Archives of Women's Mental Health 1* doi: 10.1007/s00737-003-0034-4

- Austin, M. P., & Priest, S. R. (2005). Clinical issues in perinatal mental health: New developments in the detection and treatment of perinatal mood and anxiety disorders. *Acta Psychiatrica Scandinavica, 112*, 97-104. doi: 10.1111/j.1600-0447.2005.00549.x
- Austin, M. P., Tully, L., & Parker, G. (2007). Examining the relationship between antenatal anxiety and postnatal depression. *Journal of Affective Disorders, 101*, 169-174. doi: 10.1016/j.jad.2006.11.015
- Ayers, S., & Pickering, A. D. (2001). Do women get Post Traumatic Stress Disorder as a result of childbirth? A prospective study of incidence. *Birth, 28*, 111-118. doi: 10.1046/j.1523-536X.2001.00111.x
- Bacon, L. (1974). Early motherhood, accelerated role transition, and social pathologies. *Social Forces, 52*, 333-341.
- Barclay, L. M., & Lloyd, B. (1996). The misery of motherhood: Alternative approaches to maternal distress. *Midwifery, 12*, 136-139. doi: 10.1016/S0266-6138(96)90057-1
- Barnett, B., & Parker, G. (1986). Possible determinants, correlates and consequences of high levels of anxiety in primiparous mothers. *Psychological Medicine, 16*, 177-185. doi: 10.1017/S0033291700002610
- Beck, A. (1996a). *Depression as an evolutionary strategy*. Paper presented at the Human Behavior and Evolution Society, Evanston, IL
- Beck, C. T. (1992). The lived experience of postpartum depression: A phenomenological study. *Nursing Research, 41*, 166-170. doi: 10.1097/00006199-199205000-00008
- Beck, C. T. (1993). Teetering on the Edge: A substantive theory of postpartum depression. *Nursing Research, 42*, 42-48. doi: 10.1097/00006199-199301000-00008
- Beck, C. T. (1996b). A meta-analysis of predictors of postpartum depression. *Nursing Research, 45*, 298-304. doi: 10.1097/00006199-199609000-00008
- Beck, C. T. (1996c). Postpartum depressed mothers' experiences interacting with their children. *Nursing Research, 45*, 98-104. doi: 10.1097/00006199-199603000-00008
- Beck, C. T. (1998). The effects of postpartum depression on child development: A meta-analysis. *Archives of Psychiatric Nursing, 12*, 12-20. doi: 10.1016/s0883-9417(98)80004-6
- Beck, C. T. (2001). Predictors of postpartum depression: An update. *Nursing Research, 50*, 275-285. doi: 10.1097/00006199-200109000-00004
- Beck, C. T. (2002a). Postpartum depression: A metasynthesis. *Qualitative Health Research, 12*, 453-472. doi: 10.1177/104973202129120016
- Beck, C. T. (2002b). Revision of the Postpartum Depression Predictors Inventory. *Journal of Obstetric, Gynecologic, and Neonatal Nursing, 31*, 394-402. doi: 10.1111/j.1552-6909.2002.tb00061.x

- Beck, C. T. (2002c). Theoretical perspective of postpartum depression and their treatment implications. *American Journal of Maternal Child Nursing, 27*, 282-287. doi: 10.1097/00005721-200209000-00008
- Beck, C. T. (2004). Birth Trauma: In the Eye of the Beholder *Nursing Research, 53* 28-35. doi: 10.1097/00006199-200401000-00005
- Beck, C. T. (2004 ). Post-traumatic stress disorder after childbirth: The aftermath. *Nursing Research, 53*, 216-224. doi: 10.1097/00006199-200407000-00004
- Beck, C. T., & Driscoll, J. W. (2006). *Postpartum mood and anxiety disorders: A clinicians guide*. Massachusetts, MA: Jones and Bartlett Publishers.
- Beck, C. T., & Gable, R. K. (2000). Postpartum Depression Screening Scale: Development and psychometric testing. *Nursing Research, 49*, 272-282. doi: 10.1097/00006199-200009000-00006
- Beck, C. T., & Gable, R. K. (2001). Further validation of the Postpartum Depression Screening Scale. *Nursing Research, 50*, 155-164. doi: 10.1097/00006199-200105000-00005
- Beck, C. T., & Gable, R. K. (2002). *Postpartum Depression Screening Scale (PDSS) manual*. Los Angeles, CA: Western Psychological Services.
- Beck, C. T., & Indman, P. (2005). The many faces of postpartum depression. *Journal of Obstetric, Gynecologic, and Neonatal Nursing, 34*, 569-576. doi: 10.1177/0884217505279995
- Belsky, J. (1985). Exploring individual differences in marital change across the transition to parenthood: The role of violated expectations. *Journal of Marriage and the Family, 47*, 1037-1044. doi: 10.2307/352348
- Belsky, J., Lang, M. E., & Rovine, M. (1985). Stability and change in marriage across the transition to parenthood: A second study. *Journal of Marriage and the Family, 47*, 855-865. doi: 10.2307/352329
- Benoit, D., Parker, K. C. H., & Zeanah, C. H. (1997). Mothers' representations of their Infants assessed prenatally: Stability and association with infants' attachment classifications. *Journal of Child Psychology and Psychiatry, 38*, 307-313. doi: 10.1111/j.1469-7610.1997.tb01515.x
- Bernazzani, O., Marks, M. N., Bifulco, A., Siddle, K., Asten, P., & Conroy, S. (2005). Assessing psychosocial risk factors in pregnant/postpartum women using the Contextual Assessment of Maternity Experience (CAME). *Social Psychiatry and Psychiatric Epidemiology, 40*, 497-508. doi: 10.1007/s00127-005-0917-y
- Bernstein, I. H., Rush, J., Yonkers, K. A., Carmody, T., Woo, A., McConnell, K., et al. (2008). Symptom features of postpartum depression: Are they distinct? *Depression and Anxiety, 25*, 20-26. doi: 10.1002/da.20276

- Biggerstaff, D., & Thompson, A. R. (2008). Interpretative Phenomenological Analysis (IPA): A qualitative methodology of choice in healthcare research. *Qualitative Research in Psychology, 5*, 214-224. doi: 10.1080/14780880802314304
- Biringen, Z. (2000). Emotional availability: Conceptualization and research findings. *American Journal of Orthopsychiatry, 70*, 104-114. doi: 10.1037/h0087711
- Blackledge, J. T., & Hayes, S. C. (2001). Emotion regulation in Acceptance and Commitment Therapy. *Journal of Clinical Psychology/In Session: Psychotherapy in Practice, 57*, 243-255. doi: 10.1002/1097-4679(200102)57:2<243::AID-JCLP9>3.3.CO;2-O
- Block, J., & Funder, D. (1986). Social roles and social perception: Individual differences in attribution and error. *Journal of Personality & Social Psychology, 51*, 1200-1207. doi: 10.1037//0022-3514.51.6.1200
- Boswell, J. (1955). *Dim Horizons*. Christchurch: Whitcombe & Tombs.
- Boyce, P., & Hickey, A. (2005). Psychosocial risk factors to major depression after childbirth. *Social Psychiatry and Psychiatric Epidemiology, 40*, 605-612. doi: 10.1007/s00127-005-0931-0
- Boyce, P., & Todd, A. (1992). Increased risk to postnatal depression following caesarian section. *Medical Journal of Australia, 157*, 172-174.
- Boyd, R. C., Diamond, G. S., & Bourjolly, J. N. (2006). Developing a family-based depression prevention program in urban community mental health clinics: A qualitative investigation. *Family Process, 45*, 187-203. doi: 10.1111/j.1545-5300.2006.00090.x
- Boyd, R. C., Pearson, J. L., & Blehar, M. C. (2002). Prevention and treatment of depression in pregnancy and the postpartum period - Summary of a maternal depression roundtable: A U.S. perspective. *Archives of Women's Mental Health, 4*, 79-82.
- Bozoky, I., & Corwin, E. J. (2002). Fatigue as a predictor of postpartum depression. *Journal of Obstetric, Gynecologic, and Neonatal Nursing, 31*, 436-443. doi: 10.1111/j.1552-6909.2002.tb00066.x
- Breheny, M., & Stephens, C. (2010). Youth or disadvantage? The construction of teenage mothers in medical journals. *Culture, Health & Sexuality, 12*, 307-322. doi: 10.1080/13691050903513234
- Britton, J. R. (2005). Pre-discharge anxiety among mothers of well newborns: Prevalence and correlates. *Acta Paediatrica, 94*, 1771-1776. doi: 10.1080/08035250500192664
- Britton, J. R. (2007). Maternal anxiety: Course and antecedents during the early postpartum period. *Depression and Anxiety, 0*, 1-8. doi: 10.1002/da.20325
- Britton, J. R. (2011). Infant temperament and maternal anxiety and depressed mood in the early postpartum period. *Women & Health, 51*, 55 - 71.
- Brocki, J. M., & Wearden, A. J. (2006). A critical evaluation of the use of Interpretative Phenomenological Analysis (IPA) in health psychology. *Psychology & Health, 21*, 87-108. doi: 10.1080/14768320500230185

- Brockington, I. F., MacDonald, E., & Wainscott, G. (2006). Anxiety, obsessions, and morbid preoccupations in pregnancy and the puerperium. *Archives of Women's Mental Health, 9*, 253-263. doi: 10.1007/s00737-006-0134-z
- Brouwers, E. P. M., van Baar, A. L., & Pop, V. J. M. (2001). Maternal anxiety during pregnancy and subsequent infant development. *Infant Behavior & Development, 24*, 95-106. doi: 10.1016/S0163-6383(01)00062-5
- Buist, A. (2002). Mental health in pregnancy: The sleeping giant. *Australian Psychiatry, 10*, 203-206. doi: 10.1046/j.1440-1665.2002.00448.x
- Caplan, G. (1961). *An approach to community mental health*. New York, NY: Grune & Stratton.
- Caplan, G. (1964). *Principles of Preventive Psychiatry*. New York, NY: Basic Books, Inc.
- Chabrol, H., Teissedre, F., Saint-Jean, M., Teisseyre, N., Roge, B., & Mullet, E. (2002). Prevention and treatment of post-partum depression: A controlled randomized study on women at risk. *Psychological Medicine, 32*, 1039-1047. doi: 10.1017/S0033291702006062
- Chapman, L. (2003). In a strange garden: The life and times of Truby King. Retrieved from <http://www.nzetc.org/tm/scholarly/metadata-tei-ChaStra.html>
- Choenarom, C., Williams, R. A., & Hagerty, B. M. (2005). The role of sense of belonging and social support on stress and depression in individuals with depression. *Archives of Psychiatric Nursing, 19*, 18-29. doi: 10.1016/j.apnu.2004.11.003
- Chorpita, B. F., & Barlow, D. H. (1998). The development of anxiety: The role of control in the early environment. *Psychological Bulletin, 124*, 3-21. doi: 10.1037//0033-2909.124.1.3
- Ciarrochi, J., Robb, H., & Godsell, C. (2005). Letting a little nonverbal air into the room: Insights from Acceptance and Commitment Therapy Part 1: Philosophical and theoretical underpinnings. *Journal of Rational-Emotive & Cognitive-Behavior Therapy, 23*, 79-106. doi: 10.1007/s10942-005-0005-y
- Cicchetti, D., & Walker, E. F. (2001). Editorial: Stress and development: Biological and psychological consequences. *Development and Psychopathology, 13*, 413-418. doi: 10.1017/S0954579401003017
- Clark, A., Skouteris, H., Wertheim, E. H., Paxton, S. J., & Milgrom, J. (2009). The relationship between depression and body dissatisfaction across pregnancy and the postpartum: A prospective study. *J Health Psychol, 14*, 27-35. doi: 10.1177/1359105308097940
- Clark, D. A., & Beck, A. T. (2010). *Cognitive Therapy of Anxiety Disorders: Science and Practice*. New York, NY: Guilford Press, .
- Clark, D. M. (1986). A cognitive model of panic. *Behaviour Research and Therapy, 24*, 461-470. doi: 10.1016/0005-7967(86)90011-2

- Clark, D. M., & Wells, A. (1995). A cognitive model of social phobia. In R. G. Heimberg, M. Liebowitz, D. A. Hope & F. Schneier (Eds.), *Social phobia: Diagnosis, assessment, and treatment*. New York, NY: Guilford.
- Clark, R., Tluczek, A., & Wenzel, A. (2003). Psychotherapy for postpartum depression: A preliminary report. *American Journal of Orthopsychiatry, 73*, 441-454. doi: 10.1037/0002-9432.73.4.441
- Clemmens, D., Driscoll, J. W., & Beck, C. T. (2004). Postpartum depression as profiled through the depression screening scale. *The American Journal of Maternal/Child Nursing, 29*, 180-185. doi: 10.1097/00005721-200405000-00009
- Coleman, P., Nelson, E. S., & Sundre, D. L. (1999). The relationship between prenatal expectations and postnatal attitudes among first-time mothers. *Journal of Reproductive and Infant Psychology, 17*, 27-39. doi: 10.1080/02646839908404582
- Cooper, J. (2007). *Cognitive Dissonance: Fifty years of a classic theory*. London, UK: Sage Publications.
- Cooper, P. J., & Murray, L. (1995). Course and recurrence of postnatal depression: Evidence for the specificity of the diagnostic concept. *The British Journal of Psychiatry, 166*, 191-195. doi: 10.1192/bjp.166.2.191
- Cooper, P. J., & Murray, L. (1997). Prediction, detection, and treatment of postnatal depression. *Archives of Disease in Childhood, 77*, 97-101. doi: 10.1136/adc.77.2.97
- Cox, J. (1979). Amakirs: A Ugandan puerperal psychosis? *Social Psychiatry, 14*, 49-52. doi: 10.1007/BF00583573
- Cox, J. (1983). Postnatal depression: A comparison of Scottish and African women. *Social Psychiatry, 18*, 25-28.
- Crawford, J. R., & Henry, J. D. (2003). The Depression Anxiety Stress Scales (DASS): Normative data and latent structure in a large non-clinical sample. *British Journal of Clinical Psychology, 42*, 111.
- Creamer, M., Foran, J., & Bell, R. (1995). The Beck Anxiety Inventory in a non-clinical sample. *Behavior Research and Therapy, 33*, 477-485. doi: 10.1016/0005-7967(94)00082-U
- Crossley, M. L. (2007). Childbirth, complications and the illusion of 'choice': A case study. *Feminism & Psychology, 17*, 543-563. doi: 10.1177/0959353507083103
- Cuijpers, P., Brannmark, J. G., & van Straten, A. (2007). Psychological treatment of postpartum depression: A meta-analysis. *Journal of Clinical Psychology, 64*, 103-118. doi: 10.1002/jclp.20432
- Cutrona, C. E. (1984). Social support and stress in the transition to parenthood. *Journal of Abnormal Psychology, 93*, 378 - 390. doi: 10.1037/0021-843X.93.4.378

- Czarnocka, J., & Slade, P. (2000). Prevalence and predictors of post-traumatic stress symptoms following childbirth. *British journal of Clinical Psychology, 39*, 35-51. doi: 10.1348/014466500163095
- DaCosta, D., Larouche, J., Dritsa, M., & Brender, W. (2000). Psychosocial correlates of prepartum and postpartum depressed mood. *Journal of Affective Disorders, 59*, 31-40.
- Dalton, K. (1984). *The premenstrual syndrome and progesterone therapy* London, UK: Heinemann Medical.
- Dalton, K. (1985). Progesterone prophylaxis used successfully in postnatal depression. *The Practitioner, 229*, 507-508.
- Dalton, K. (1989 ). *Depression after childbirth : How to recognize and treat postnatal illness* (2nd ed.). Oxford [England]; New York: Oxford University Press,.
- Delmore-Ko, P., Pancer, S. M., Hunsberger, B., & Pratt, M. (2000). Becoming a parent: The relation between prenatal expectations and postnatal experience. *Journal of Family Psychology, 14*, 625-640. doi: 10.1037//0893-3200.14.4.625
- Dennerstein, L. (1988). Postnatal Depression. Transcript of a delivered paper: Department of Psychiatry, University of Melbourne.
- Dennis, C. (2004a). Preventing postpartum depression Part 1: A review of biological interventions. *Canadian Journal of Psychiatry - Revue Canadienne de Psychiatrie, 49*, 467-475. doi: 10.4088/JCP.v65n0914
- Dennis, C. (2004b). Preventing postpartum depression Part II: A critical review of nonbiological interventions. *Canadian Journal of Psychiatry - Revue Canadienne de Psychiatrie, 49*, 526-538. doi: 10.4088/JCP.v65n0915
- Dennis, C., & Chung-Lee, L. (2006). Postpartum depression help-seeking barriers and maternal treatment preferences: A qualitative systematic review. *Birth, 33*, 323-331. doi: 10.1111/j.1523-536X.2006.00130.x
- Dennis, C., & Ross, L. (2006). Women's perceptions of partner support and conflict in the development of postpartum depressive symptoms. *Journal of Advanced Nursing 56*, 588-599. doi: 10.1111/j.1365-2648.2006.04059.x
- Dieter, J. N. I., Emory, E. K., Johnson, K. C., & Raynor, B. D. (2008). Maternal depression and anxiety effects on the human fetus: Preliminary findings and clinical implications. *Infant Mental Health Journal, 29*, 420-441. doi: 10.1002/imhj.20192
- Driscoll, J. W. (2006). Postpartum depression: The state of the science. *Journal of Perinatal and Neonatal Nursing., 20*, 40-42.
- Duncan, B. L., Miller, S. D., Sparks, J. A., Claud, D. A., Reynolds, L. R., Brown, J., et al. (2003). The Session Rating Scale: Preliminary psychometric properties of a "working" alliance measure. *Journal of Brief Therapy, 3*, 3-12.

- Dunne, E. A., & Quayle, E. (2001). The Impact of iatrogenically acquired Hepatitis C infection on the well-being and relationships of a group of Irish women. *Journal of Health Psychology, 6*, 679-692. doi: 10.1177/135910530100600606
- Earle, S. (2003). "Bumps and boobs": Fatness and women's experiences of pregnancy. *Womens Studies International Forum, 26*, 245-252. doi: 10.1016/s0277-5395(03)00054-2
- Eberhard-Gran, M., Garthus-Niegel, S., Garthus-Niegel, K., & Eskild, A. (2010). Postnatal care: A cross-cultural and historical perspective. *Archives of Womens Mental Health, 13*, 459-466. doi: 10.1007/s00737-010-0175-1
- Edwards, B., Galletly, C., Semmler-Booth, T., & Dekker, G. (2008). Antenatal psychosocial risk factors and depression among women living in socioeconomically disadvantaged suburbs in Adelaide, South Australia. *Australian and New Zealand Journal of Psychiatry, 42*, 45-50.
- Eifert, G. H., & Forsyth, J. P. (2005). *Acceptance and Commitment Therapy for anxiety disorders: A practitioner's treatment guide to using mindfulness, acceptance, and values-based behavior change strategies*. Oakland, CA: New Harbinger Publications.
- Fairbrother, N., & Woody, S. R. (2008). New mothers thought's of harm related to the newborn. *Archives of Women's Mental Health, 11*, 221-229. doi: 10.1007/s00737-008-0016-7
- Faisal-Cury, A., & Menezes, P. R. (2007). Prevalence of anxiety and depression during pregnancy in a private setting sample. *Archives of Women's Mental Health, 10*, 25-32. doi: 10.1007/s00737-006-0164-6
- Ferguson, S. S., Jamieson, D. J., & Lindsay, M. (2002). Diagnosing postpartum depression: Can we do better? *American Journal of Obstetrics and Gynecology, 186*, 899-902. doi: 10.1067/mob.2002.123404
- Festinger, L. (1957). *A theory of cognitive dissonance*. Evanston, IL: Row, Peterson and Company.
- Figueiredo, B., Field, T., Diego, M., Hernandez-Reif, M., Deeds, O., & Ascencio, A. (2008). Partner relationships during the transition to parenthood. *Journal of Reproductive & Infant Psychology, 26*, 99-107. doi: 10.1080/02646830701873057
- Fisher, J., Astbury, J., & Smith, A. (1997). Adversive psychological impact of operative obstetric interventions: A prospective longitudinal study. *Australian and New Zealand Journal of Psychiatry, 31*, 728-738. doi: 10.3109/00048679709062687
- Fletcher, L., & Hayes, S. C. (2005). Relational Frame Theory, Acceptance and Commitment Therapy, and a functional analytic definition of mindfulness. *Journal of Rational-Emotive & Cognitive-Behavior Therapy, 23*, 315-336. doi: 10./s10942-005-0017-7
- Flowers, P., Duncan, B., & Knussen, C. (2003). Re-appraising HIV testing: An exploration of the psychosocial costs and benefits associated with learning one's HIV status in a

- purposive sample of Scottish gay men. *British Journal of Health Psychology*, *8*, 179-194.
- Fry, K. J. (2001 ). *"The Madonna myth": The ideology of motherhood and it's [sic] influence on women with postnatal depression*. Master of Social Work, Massey University, Turitea, Palmerston North.
- Gair, S. (1999). Distress and depression in new motherhood: Research with adoptive mother's highlights important contributing factors. *Child and Family Social Work*, *4*, 55-66. doi: 10.1046/j.1365-2206.1999.00098.x
- Gamble, J., & Creedy, D. (2005). Operative birth and development of psychological trauma symptoms. *British Journal of Midwifery*, *13*, 218-224.
- Gao, L.-l., Chan, S. W.-c., You, L., & Li, X. (2010). Experiences of postpartum depression among first -time mothers in mainland China. *Journal of Advanced Nursing*, *66*, 303-312. doi: 10.1111/j.1365-2648.2009.05169.x
- Gjerdingen, D., Fontaine, P., Crow, S., McGovern, P., Center, B., & Miner, M. (2009). Predictors of mothers' postpartum body dissatisfaction. *Women Health*, *49*, 491-504. doi: 10.1080/03630240903423998
- Glass, J. (1983). Pre-birth attitudes and adjustment to parenthood: When preparing for the worst helps. *Family Relations* *32*, 377-386. doi: 10.2307/584615
- Gloster, A. T., Rhoades, H. M., Novy, D., Klotsche, J., Senior, A., Kunik, M., et al. (2008). Psychometric properties of the Depression Anxiety and Stress Scale-21 in older primary care patients. *Journal of Affective Disorders*, *110*, 248-259. doi: 10.1016/j.jad.2008.01.023
- Gondoli, D. M., & Silverberg, S.B. (1997 ). Maternal emotional distress and diminished responsiveness: The mediating role of parenting efficacy and parental perspective-taking. *Developmental Psychology*, *33* 861-868.
- Goss, A. (1998). *Beyond the baby blues : overcoming postnatal distress in New Zealand* Auckland: HarperCollins Publishers New Zealand.
- Grant, K. A., McMahon, C., & Austin, M. P. (2008). Maternal anxiety during the transition to parenthood: A prospective study. *Journal of Affective Disorders*, *108*, 101-111. doi: 10.1016/j.jad.2007.10.002
- Green, J. M., Coupland, V. A., & Kitzinger, J. V. (1998). *Great expectations: A prospective study of women's expectations and experiences of childbirth* (2nd ed.). Cheshire, UK: Hale.
- Gulbransen, G., Hilton, J., McKay, L., & Cox, A. (1997). Home birth in New Zealand 1973-93: Incidence and mortality. *New Zealand Medical Journal*, *110*, 87-89.
- Hackel, L. S., & Ruble, D. N. (1992). Changes in the marital relationship after the first baby is born: Predicting the impact of expectancy disconfirmation. *Journal of Personality and Social Psychology*, *62*, 944-957. doi: 10.1037//0022-3514.62.6.944

- Hadfield, L., Rudoie, N., & Sanderson-Mann, J. (2007). Motherhood, choice and the British media: A time to reflect. *Gender and Education, 19*, 255 - 263. doi: 10.1080/09540250601166100
- Hagen, E. H. (1999). The functions of postpartum depression. *Evolution and Human Behaviour, 20*, 325-359. doi: 10.1016/S1090-5138(99)00016-1
- Halbreich, U. (2005). Postpartum disorders: Multiple interactions underlying mechanisms and risk factors. *Journal of Affective Disorders, 88*, 1-7. doi: 10.1016/j.jad.2005.05.002
- Hall, P. C. (1998). Mothering mythology in the late Twentieth century: Science, gender lore, and celebratory narrative. *Canadian Woman Studies, 18*, 59-63.
- Hamdan, A., & Tamim, H. (2011). Psychosocial risk and protective factors for postpartum depression in the United Arab Emirates. *Archives of Womens Mental Health, 14*, 125-133. doi: 10.1007/s00737-010-0189-8
- Hare-Mustin, R. T., & Broderick, P. C. (1979). The myth of motherhood: A study of attitudes toward motherhood. *Psychology of Women Quarterly, 4*, 114-128. doi: 10.1111/j.1471-6402.1979.tb00702.x
- Harmon-Jones, E., & Harmon-Jones, C. (2007). Cognitive Dissonance theory after 50 years of development. *Zeitschrift für Sozialpsychologie 38*, 7-16. doi: 10.1024/0044-3514.38.1.7
- Harris, B. (1996). Hormonal aspects of postnatal depression. *International Review of Psychiatry, 8*, 27.
- Harris, R. (2009). *ACT made simple: An easy-to-read primer on Acceptance and Commitment Therapy*. Oakland, CA: New Harbinger Publications.
- Hart, R., & McMahan, C. (2006). Mood state and psychological adjustment to pregnancy. *Archives of Women's Mental Health, 9*, 329-337. doi: 10.1007/s00737-006-0141-0
- Harwood, K. (2004). *Women's parenting expectations and their influence on adjustment to parenthood*. Unpublished doctoral thesis, University of Western Australia, Crawley, Western Australia.
- Harwood, K., McLean, N., & Durkin, K. (2007). First-time mothers' expectations of parenthood: What happens when optimistic expectations are not matched by later experiences? *Developmental Psychology, 43*, 1-12. doi: 10.1037/0012-1649.43.1.1
- Hayes, S. C. (2004). Acceptance and Commitment Therapy, Relational Frame Theory and the third wave of behavioural and cognitive therapies. *Behaviour Therapy, 35*, 639-665. doi: 10.1016/S0005-7894(04)80013-3
- Hayes, S. C. (2005). Stability and change in cognitive behavior therapy: Considering the implications of ACT and RFT. *Journal of Rational-Emotive & Cognitive-Behavior Therapy, 23*, 131-151. doi: 10.1007/s10942-005-0007-9

- Hayes, S. C., Luomaa, J. B., Bond, F. W., Masudaa, A., & Lillis, J. (2006). Acceptance and Commitment Therapy: Model, processes, and outcomes. *Behaviour Research and Therapy, 44*, 1-25. doi: 10.1016/j.brat.2005.06.006
- Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (1999). *Acceptance and Commitment Therapy: An experiential approach to behavior change*. New York, NY: Guilford Press.
- Hendrick, V., Altshuler, L. L., & Suri, R. (1998). Hormonal changes in the postpartum and implications for postpartum depression. *Psychosomatics, 39*, 93-101.
- Hendrie, C. A., & Pickles, A. R. (2009). Depression as an evolutionary adaptation: Implications for the development of preclinical models. *Medical Hypotheses, 72*, 342-347. doi: 10.1016/j.mehy.2008.09.053
- Heron, J., O'Connor, T. G., Evans, J., Golding, J., Glover, V., & the ALSPAC Study Team. (2004). The course of anxiety and depression through pregnancy and the postpartum in a community sample. *Journal of Affective Disorders, 80*, 65-73. doi: 10.1016/j.jad.2003.08.004
- Hight, N., & Drummond, P. (2004). A comparative evaluation of community treatments for post-partum depression: Implications for treatment and management practices. *Australian and New Zealand Journal of Psychiatry, 38*, 212-218. doi: 10.1111/j.1440-1614.2004.01342.x
- Hipwell, A. E., Reynolds, S., & Pitts Crick, E. (2004). Cognitive vulnerability to postnatal depressive symptomatology. *Journal of Reproductive and Infant Psychology, 22*, 211-227. doi: 10.1080/02646830410001723797
- Hoff, L. (1989). *People in crisis: Understanding and helping* (3rd ed.). California, CA: Addison-Wesley Publishing Co, Inc.
- Hofmann, S. G., Sawyer, A. T., Witt, A. A., & Oh, D. (2010). The effect of mindfulness-based therapy on anxiety and depression: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 78*, 169-183 doi: 10.1037/a0018555
- Honey, K. L., Bennett, P., & Morgan, M. (2002). A brief psycho-educational group intervention for postnatal depression. *British Journal of Clinical Psychology, 41*, 405-409. doi: 10.1348/014466502760387515
- Horowitz, J. A., & Goodman, J. H. (2005). Identifying and treating postpartum depression. *Journal of Obstetric, Gynecologic, and Neonatal Nursing, 34*, 264-273. doi: 10.1177/0884217505274583
- Horvath, A. O., & Luborsky, L. (1993). The role of the therapeutic alliance in psychotherapy. *Journal of Consulting and Clinical Psychology, 61*, 561-573.
- Hrdy, S. B. (1999). *Mother nature: A history of mothers, infants and natural selection*. New York, NY: Pantheon.

- Huizink, A. C., Mulder, E. J. H., Robles de Medina, P. G., Visser, G. H. A., & Buitelaar, J. K. (2004). Is pregnancy anxiety a distinctive syndrome? *Early Human Development, 79*, 81-91. doi: 10.1016/j.earlhumdev.2004.04.014
- Johnson, D. D., & Swanson, D. H. (2003 ). Invisible Mothers: A content analysis of motherhood ideologies and myths in magazines. *Sex Roles: A Journal of Research, 49*.
- Johnson, R. C., & Slade, P. (2003). Obstetric complications and anxiety during pregnancy: Is there a relationship? *Journal of Psychosomatic Obstetrics & Gynecology, 24*, 1-14. doi: 10.3109/01674820309042796
- Johnston, D. D., & Swanson, D. H. (2006 ). Constructing the "good mother": The experience of mothering ideologies by work status. *Sex Roles: A Journal of Research, 54*, 509-519. doi: 10.1007/s11199-006-9021-3
- Johnstone, S. J., Boyce, P. M., Hickey, A. R., Morris-Yates, A. D., & Harris, M. G. (2001). Obstetric risk factors for postnatal depression in urban and rural community samples. *Australian and New Zealand Journal of Psychiatry, 35*, 69-74. doi: 10.1046/j.1440-1614.2001.00862.x
- Jordan, K., Capdevila, R., & Johnson, S. (2005). Baby or beauty: A Q study into post pregnancy body image. *Journal of Reproductive & Infant Psychology, 23*, 19-31. doi: 10.1080/02646830512331330965
- Kach, J. A., & McGhee, P. E. (1982). Adjustment of early parenthood: The role of accuracy of preparenthood experiences. *Journal of Family Issues, 3*, 375-388. doi: 10.1177/019251382003003007
- Kalmuss, D., Davidson, A., & Cushman, L. (1992). Parenting expectations, experiences, and adjustment to parenthood: A test of the violated expectations framework. *Journal of Marriage and the Family, 54*, 516-526. doi: 10.2307/353238
- Kearns, R. A., Neuwelt, P. M., Hitchman, B., & Lennan, M. (1997). Social support and psychological distress before and after childbirth. *Health and Social Care in the Community, 5*, 296-308. doi: 10.1111/j.1365-2524.1997.tb00126.x
- Kedgley, S. (1996). *Mum's the word: The untold story of motherhood in New Zealand*. Auckland: Random House.
- Keeton, C. P., Perry-Jenkins, M., & Sayer, A. G. (2008). Sense of control predicts depressive and anxious symptoms across the transition to parenthood. *Journal of Family Psychology, 22*, 212-221. doi: 10.1037/0893-3200.22.2.212
- Keller, M. C., & Nesse, R. M. (2005). Is low mood an adaptation? Evidence for subtypes with symptoms that match precipitants. *Journal of Affective Disorders, 86*, 27-35. doi: 10.1016/j.jad.2004.12.005
- King, M. T. (1948). *Truby King, the man: A biography*.

- Knight, R. G., & Thirkettle, J. A. (1987). The relationship between expectations of pregnancy and birth, and transient depression in the immediate post-partum period. *Journal of Psychosomatic Research, 31*, 351-357. doi: 10.1016/0022-3999(87)90055-9
- Krueger, R. A. (1994). *Focus groups: A practical guide for applied research* (2nd ed.). London: UK: Sage.
- Kumar, R., Robson, K. M., & Smith, A. M. R. (1984). Development of a self-administered questionnaire to measure maternal adjustment and maternal attitudes during pregnancy and after delivery. *Journal of Psychosomatic Research, 28*, 43-51.
- Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology, 3*, 102-120. doi: 10.1191/1478088706qp062oa
- Lazarus, R., & Folkman, S. (1984). *Stress, appraisal and coping*. New York, NY: Springer Publishing Co.
- Lee, A. M., Lam, S. K., Sze Mun Lau, S. M., Chong, C. S. Y., Chui, H. W., & Fong, D. Y. T. (2007). Prevalence, course, and risk factors for antenatal anxiety and depression. *Obstetrics & Gynecology, 110*, 1102-1112 doi: 10.1016/0022-3999(87)90055-9
- Leigh, B., & Milgrom, J. (2008). Risk factors for antenatal depression, postnatal depression and parenting stress. *BMC Psychiatry, 8*, 24.
- LeMasters, E. E. (1975). Parenthood as crisis. *Marriage and Family Living, 19*, 352-355.
- Lewinsohn, P. M. (1975). Engagement in pleasant activities and depression level. *Journal of Abnormal Psychology, 84*, 729-731. doi: 10.1037//0021-843X.84.6.729
- Lewinsohn, P. M., & Amenson, C. S. (1978). Some relations between pleasant and unpleasant mood-related events and depression. *Journal of Abnormal Psychology, 87*, 644-654. doi: 10.1037//0021-843X.87.6.644
- Lewinsohn, P. M., Duncan, E. M., Stanton, A. K., & Hautzinger, M. (1986a). Age at first onset for nonbipolar depression. *Journal of Abnormal Psychology, 95*, 378-383. doi: 10.1037//0021-843X.95.4.378
- Lewinsohn, P. M., Fenn, D. S., Stanton, A. K., & Franklin, J. (1986b). Relation of age at onset to duration of episode in unipolar depression. *Psychology and Aging, 1*, 63-68.
- Lewinsohn, P. M., & Graf, M. (1973). Pleasant activities and depression. *Journal of Consulting and Clinical Psychology, 41*, 261-268. doi: 10.1037/h0035142
- Lewinsohn, P. M., Hoberman, H., Teri, L., & Hautzinger, M. (Eds.). (1985). *Theoretical issues in behavior therapy*. New York, NY: Academic Press.
- Lewinsohn, P. M., & Libet, J. (1972). Pleasant events, activity schedules, and depressions. *Journal of Abnormal Psychology, 79*, 291-295.
- Lewinsohn, P. M., Steinmetz, J. L., Larson, D. W., & Franklin, J. (1981). Depression-related cognitions: Antecedent or consequence? *Journal of Abnormal Psychology, 90*, 213-219. doi: 10.1037//0021-843X.90.3.213

- Lewis, S., & Nicholson, P. (1998). Talking about early motherhood: Recognising loss and reconstructing depression. *Journal of Reproductive and Infant Psychology, 16*, 177-197. doi: 10.1080/02646839808404567
- Liefbroer, A. C., & Corijn, M. (1999). Who, what, where, and when? Specifying the impact of educational attainment and labour force participation on family formation. *European Journal of Population/Revue européenne de Démographie, 15*, 45-75. doi: 10.1023/a:1006137104191
- Littleton, H. L., Breitkopf, C. R., & Berenson, A. B. (2007). Correlates of anxiety symptoms during pregnancy and association with perinatal outcomes: A meta-analysis. *American Journal of Obstetrics and Gynecology, 196*, 424-432. doi: 10.1016/j.ajog.2007.03.042
- Logsdon, C., & Usui, W. (2001). Psychosocial predictors of postpartum depression in diverse groups of women. *Western Journal of Nursing Research, 23*, 563-574.
- Lovibond, P. F., & Lovibond, S. H. (1995a). The structure of negative emotional states: Comparison of the Depression Anxiety Stress Scales (DASS) with the Beck Depression and Anxiety Inventories. *Behaviour Research and Therapy, 33*, 335-342.
- Lovibond, S. H., & Lovibond, P. F. (1995b). *Manual for the Depression Anxiety Stress Scales* (2nd ed.). Sydney, Australia: Psychology Foundation of Australia.
- Lum, J. J., & Phares, V. (2005). Assessing the emotional availability of parents. *Journal of Psychopathology and Behavioral Assessment, 27*, 211-226. doi: 10.1007/s10862-005-0637-3
- MacPhillamy, D. J., & Lewinsohn, P. M. (1974). Depression as a function of levels of desired and obtained pleasure. *Journal of Abnormal Psychology, 83*, 651-657.
- Marini, M. M. (1984). Women's Educational Attainment and the Timing of Entry into Parenthood. *American Sociological Review, 49*, 491-511.
- Markus, H., & Nurius, P. (1986). Possible Selves. *American Psychologist, 41*, 954-969.
- Maslow, A. H. (1963). The need to know and the fear of knowing. *Journal of General Psychology, 68*, 111-125.
- Matthey, S. (2004). Detection and treatment of postnatal depression (perinatal depression or anxiety). *Current Opinion in Psychiatry, 17*, 21-29. doi: 10.1097%2F00001504-200401000-00005
- Matthey, S., Barnett, B., Howie, P., & Kavanagh, D. J. (2003). Diagnosing postpartum depression in mothers and fathers: Whatever happened to anxiety? *Journal of Affective Disorders, 74*, 139-147.
- Matthey, S., Kavanagh, D. J., Howie, P., Barnett, B., & Charles, M. (2004). Prevention of postnatal distress or depression: An evaluation of an intervention at preparation for parenthood classes. *Journal of Affective Disorders, 79*, 113-126. doi: 10.1016/S0165-0327(02)00362-2

- Mauthner, N. S. (1988). 'It's a women's cry for help": A relational perspective on postnatal depression. *Feminism and Psychology, 8*, 325-355.
- Mauthner, N. S. (1999). "Feeling low and feeling really bad about feeling low": Women's experiences of motherhood and postpartum depression. *Canadian Psychology/Psychologie canadienne, 40*, 143-161.
- McMahon, C., Barnett, B., Kowalenko, N., & Tennant, C. (2005). Psychological factors associated with persistent postnatal depression: Past and current relationships, defence styles and the mediating role of insecure attachment. *Journal of Affective Disorders, 84*, 15-24. doi: 10.1016/j.jad.2004.05.005
- Mein-Smith, P. (1986). *Maternity in dispute, New Zealand, 1920-1939* Wellington, NZ: Historical Publications Branch, Department of Internal Affairs.
- Merritt, M. (2005). *A case study for helping to prevent postnatal depression: Towards a cultural tool for Maori women*. Masters degree of Philosophy, Massey University, Palmerston North, New Zealand
- Mertesacker, B., Bade, U., Haverkock, A., & Pauli-Pott, U. (2004). Predicting maternal reactivity/sensitivity: The role of infant emotionality, maternal depressiveness/anxiety, and social support. *Infant Mental Health Journal, 25*, 47-61.
- Milgrom, J., Gemmill, A. W., Bilszta, J. L., Hayes, B., Barnett, B., Brooks, J., et al. (2008). Antenatal risk factors for postnatal depression: A large prospective study. *Journal of Affective Disorders 108*, 147-157. doi: 10.1016/j.jad.2007.10.014
- Milgrom, J., & McCloud, P. I. (1996). Parenting stress and postnatal depression. *Stress Medicine, 12*, 177 - 186.
- Miller, L. J. (2002). Postpartum depression. *Journal of the American Medical Association, 287*, 762-764.
- Miller, R. (2007). *The assessment of postnatal depression, anxiety and stress using a cognitive vulnerability-stress model: A role for perceived control and individual characteristics*. Professional Doctorate of Psychology (DPsych), Swinburne University of Technology. Retrieved from <http://adt.lib.swin.edu.au/public/adt-VSWT20070927.084941/index.html>
- Miller, R., Pallant, J. F., & Negri, L. M. (2006). Anxiety and stress in the postpartum: Is there more to postnatal distress than depression. *BMC Psychiatry, 6*, No pagination specified.
- Miller, S. D., Duncan, B. L., & Johnson, L. (2002). The Outcome Rating Scale: A preliminary study of the reliability, validity, and feasibility of a brief visual analog measure. *Journal of Brief Therapy, 2*, 91-100.
- Ministry of Health. (2003). Report of maternity: Maternal and newborn information 2000 & 2001 *Annual Statistical Publication*. Wellington: New Zealand Health Information Service.

- Ministry of Health. (2007). *Report of maternity: Maternal and newborn information 2004*. Wellington: New Zealand Health Information Service.
- Morris, S. J. (2007). Attributional biases in subclinical depression: A schema-based account. *Clinical Psychology and psychotherapy, 14*, 32-47.
- Mott, S. L., Schiller, C. E., Richards, J. G., O'Hara, M. W., & Stuart, S. (2011). Depression and anxiety among postpartum and adoptive mothers. *Archives of Womens Mental Health, 14*, 335-343. doi: 10.1007/s00737-011-0227-1
- Mulder, E. J. H., Robles de Medina, P. G., Huizink, A. C., Van den Bergh, B. R. H., Buitelaar, J. K., & G.H.A., V. (2002). Prenatal maternal stress: Effects on pregnancy and the (unborn) child. *Early Human Development, 70*, 3-14. doi: 10.1016/S0378-3782(02)00075-0
- Muñoz, R. F., Mrazek, P., & Haggerty, R. (1996). Institute of Medicine report on prevention of mental disorders: Summary and commentary. *American Psychologist, 51* 1116-1122. doi: 10.1037//0003-066X.51.11.1116
- Murray, L., Arteché, A., Fearon, P., Halligan, S., Croudace, T., & Cooper, P. (2010). The effects of maternal postnatal depression and child sex on academic performance at age 16 years: A developmental approach. *Journal of Child Psychology and Psychiatry, 51*, 1150-1159. doi: 10.1111/j.1469-7610.2010.02259.x
- Nelson, A. M. (2003). Transition to motherhood. *Journal of Obstetric, Gynecologic, and Neonatal Nursing, 32*, 465-477. doi: 10.1177/0884217503255199
- Nes, L. S., & Segerstrom, S. C. (2006). Dispositional optimism and coping: A meta-analytic review. *Personality and Social Psychology Review, 10*, 235-251.
- Nesse, R. M. (2000). Is depression an adaptation? *Archives of General Psychiatry, 57*, 14-20.
- Nicholson, P. (1986). Developing a feminist approach to depression following childbirth. In S. Wilkinson (Ed.), *Feminist social psychology: Developing theory and practice* (pp. 135-149). Milton Keynes: UK: Open University.
- Nicholson, P. (1990). Understanding postnatal depression: A mother-centred approach. *Journal of Advanced Nursing, 15*, 789-695.
- Nicholson, P. (1998). *Postnatal depression: Psychology, science, and the transition to motherhood*. New York, NY: Routledge.
- Nicholson, P. (1999). Loss, happiness and postpartum depression: The ultimate paradox. *Canadian Psychology/Psychologie Canadienne, 40*, 162-178.
- Nicholson, P. (2003). Postpartum depression: Women's accounts of loss and change. In J. M. Stoppard & L. M. McMullen (Eds.), *Situating sadness: Women and depression in social context* (pp. 113-138). New York, NY: New York University Press.
- O'Hara, M., & Swain, A. (1996). Rates and risks of postpartum depression: A meta-analysis. *International Review of Psychiatry, 8*, 37-54. doi: 10.3109/09540269609037816

- O'Hara, M. W., Scott, S., Gorman, L. L., & Wenzel, A. (2000). Efficacy of Interpersonal Psychotherapy for postpartum depression. *Archives of General Psychiatry, 57*, 1039-1045. doi: 10.1001/archpsyc.57.11.1039
- Oakley, A. (1980). *Women confined: Towards a sociology of childbirth*. Oxford, UK: Martin Robertson.
- Oakley, A. (1986). *From here to maternity: Becoming a mother*. Harmondsworth, London, UK: Penguin.
- Ogrodniczuk, J. S., & Piper, W. E. (2003). Preventing postnatal depression: A review of research findings. *Harvard Review Psychiatry, 11*, 291-307. doi: 10.1080/10673220390264249
- Öst, L.-G. (2008). Efficacy of the third wave of behavioral therapies: A systematic review and meta-analysis. *Behaviour Research and Therapy, 46*, 296-321. doi: 10.1016/j.brat.2007.12.005
- Oxford University Press. (2011). Oxford English Dictionary Vol. 2011. Retrieved from <http://oxforddictionaries.com>
- Parental Leave and Employment Protection Act, 129, New Zealand Parliament (1987).
- Pearce, H., & Ayers, S. (2005). The expected child versus the actual child: Implications for the mother-baby bond. *Journal of Reproductive & Infant Psychology, 23*, 89-102. doi: 10.1080/0264683042000325528
- Phoenix, A., Woollett, A., & Lloyd, E. (Eds.). (1991). *Motherhood: Meanings, practices and ideologies*. London, England: Sage Publications.
- Porter, C. L., & Hsu, H.-C. (2003). First-time mothers' perceptions of efficacy during the transition to motherhood: Links to infant temperament. *Journal of Family Psychology, 17*, 54-64. doi: 10.1037/0893-3200.17.1.54
- Powers, M. B., Zum Vörde Sive Vörding, M. B., & Emmelkamp, P. M. G. (2009). Acceptance and Commitment Therapy: A Meta-Analytic Review. *Psychotherapy and Psychosomatics, 78*, 73-80. doi: 10.1159/000190790
- Rallis, S., Skouteris, H., Wertheim, E. H., & Paxton, S. J. . (2007 ). Predictors of body image during the first year postpartum: A prospective study. *Women & Health, 45*, 87-104. doi: 10.1300/J013v45n01\_06
- Rees, A.-M., Austin, M.-P., & Parker, G. (2005). Role of omega-3 fatty acids as a treatment for depression in the peri-natal period. *Australian and New Zealand Journal of Psychiatry, 39*, 274-280. doi: 10.1111/j.1440-1614.2005.01565.x
- Righetti-Veltema, M., Conne-Perreard, E., Bousquet, A., & Manzano, J. (2002). Postpartum depression and mother–infant relationship at 3 months old. *Journal of Affective Disorders, 70*, 291-306. doi: 10.1016/S0165-0327(01)00367-6

- Robertson, E., Grace, S., Wallington, T., & Stewart, D. E. (2004). Antenatal risk factors for postpartum depression: A synthesis of recent literature. *General Hospital Psychiatry, 26*, 289-295. doi: 10.1016/j.genhosppsy.2004.02.006
- Rogan, F., Schmied, V., Barclay, L., Everitt, L., & Wyllie, A. (1997). Becoming a mother: An analysis of women's experience of early motherhood. *Journal of Advanced Nursing, 25*, 719-728.
- Romito, P. (1990). Postpartum depression and the experience of motherhood. *Anta Obstetricia and Gynaecologica Scandinavia Suppl, 69 (154)* 1-37. doi: 10.3109/00016349009156507
- Ross, L. (1977). The intuitive psychologist and his shortcomings: Distortions in the attribution process In L. Berkowitz (Ed.), *Advances in experimental social psychology* (Vol. 10, pp. 173-220). New York: Academic Press.
- Ross, L. E., & McLean, L. M. (2006). Anxiety disorders during pregnancy and the postpartum period: A systematic review. *Journal of Clinical Psychiatry, 67*, 1285-1298. doi: 10.4088/JCP.v67n0818
- Rubin, R. (1984). *Maternal identity and the maternal experience*. New York, NY: Springer.
- Ruble, D. N., Hackel, L. S., Fleming, A. S., & Stangor, C. (1988). Changes in the marital relationship during the transition to first-time motherhood: Effects of violated expectations concerning division of household labor. *Journal of Personality and Social Psychology, 55*, 78-87. doi: 10.1037//0022-3514.55.1.78
- Ruiz, F. J. (2010). A Review of Acceptance and Commitment Therapy (ACT) Empirical evidence: Correlational, experimental psychopathology, component, and outcome studies. *International Journal of Psychology and Psychological Therapy 10*, 25-162.
- Schlessinger. (2000). *Parenting by Proxy: Don't have them if you won't raise them*. New York: HarperCollins Publishers.
- Scrandis, D. A. (2005). Normalizing postpartum depressive symptoms with social support. *American Psychiatric Nurses Association, 11*, 223-230.
- Seimyr, L., Edhorg, M., Lundh, W., & Sjogren, B. (2004). In the shadow of maternal depressed mood: Experiences of parenthood during the first year after childbirth. *Journal Of Psychosomatic Obstetrics And Gynaecology, 25*, 23-34. doi: 10.1080/01674820410001737414
- Seligman, M. E. P. (1975). *Helplessness: On depression, development, and death*. San Francisco, CA: W.H. Freeman.
- Seligman, M. E. P., & Maier, S. F. (1967). Failure to escape traumatic shock. *Journal of Experimental Psychology, 74*, 1-9. doi: 10.1037/h0024514
- Senecky, Y., Agassi, H., Inbar, D., Horesh, N., Diamond, G., Bergman, Y. S., et al. (2009). Post-adoption depression among adoptive mothers. *Journal of Affective Disorders, 115*, 62-68. doi: 10.1016/j.jad.2008.09.002

- Serbin, L. A., Poulin-Dubois, D., Colburne, K. A., Sen, M. G., & Eichstedt, J., A. (2001). Gender stereotyping in infancy: Visual preferences for and knowledge of gender-stereotyped toys in the second year. *International Journal of Psychology and Psychological Therapy*, *25*, 7-15.
- Shaw, R. L., & Giles, D. C. (2009). Motherhood on ice? A media framing analysis of older mothers in the UK news. *Psychology & Health*, *24*, 221 - 236. doi: 10.1080/08870440701601625
- Skouteris, H., Carr, R., Wertheim, E. H., Paxton, S. J., & Duncombe, D. (2005). A prospective study of factors that lead to body image dissatisfaction during pregnancy. *Body Image*, *2*, 347-361. doi: 10.1016/j.bodyim.2005.09.002
- Smith, J. A. (1996). Beyond the divide between cognition and discourse: Using Interpretative Phenomenological Analysis in Health psychology. *Psychology and Health*, *11*, 261-271.
- Smith, J. A. (1999). Identity development during the transition to motherhood: an interpretative phenomenological. *Journal of Reproductive & Infant Psychology*, *17*, 281.
- Smith, J. A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology*, *1*, 39-54. doi: 10.1191/1478088704qp004oa
- Smith, J. A. (2007). Hermeneutics, human sciences and health: Linking theory and practice. *Qualitative Research in Psychology*, *1*, 39-54.
- Smith, J. A., Flowers, P., & Larkin, M. (1999a). *Interpretative Phenomenological Analysis: Theory, Method and Research*. London: Sage Publications.
- Smith, J. A., Harré, R., & Van Langenhove, L. (1995). Idiography and the case study. In J. A. Smith, R. Harré & L. Van Langenhove (Eds.), *Rethinking psychology*. London: England: Sage.
- Smith, J. A., Jarman, M., & Osborn, M. (1999b). Doing Interpretative Phenomenological Analysis. In M. Murray & K. Chamberlain (Eds.), *Qualitative Health Psychology: Theories and methods* (pp. 218-240). London: England: Sage Publications.
- Spinelli, M. G. (1998). Psychiatric disorders during pregnancy and postpartum. *Journal of American Women's Association*, *53*, 165-169.
- Steiner, M., Dunn, E., & Born, L. (2003). Hormones and mood: From menarche to menopause and beyond. *Journal of Affective Disorders*, *74*, 67-83. doi: 10.1016/s0165-0327(02)00432-9
- Sutter-Dallay, A. L., Giaccone-Marcésche, V., Glatigny-Dallay, E., & Verdoux, H. (2004). Women with anxiety disorders during pregnancy are at increased risk of intense postnatal depressive symptoms: A prospective survey of the MATQUID cohort. *European Psychiatry*, *19*, 459-463. doi: 10.1016/j.eurpsy.2004.09.025

- Tafet, G. E., Toister-Achituv, M., & Shinitzky, M. (2001). Enhancement of serotonin uptake by cortisol: A possible link between stress and depression. *Cognitive, Affective, & Behavioral Neuroscience, 1*, 96-104. doi: 10.3758/CABN.1.1.96
- Talge, N. M., Neal, C., & Glover, V. (2007). Antenatal maternal stress and long-term effects on child neurodevelopment: How and why? *Journal of Child Psychology and Psychiatry, 48*, 245-261. doi: 0.1111/j.1469-7610.2006.01714.x
- Tammentie, T., Paavilainen, E., Astedt-Kurki, P., & Tarkka, M.-T. (2004). Family dynamics of postnatally depression mothers - Discrepancy between expectations and reality. *Journal of Clinical Nursing, 13*, 65-74. doi: 10.1111/j.1365-2648.2004.03178.x
- Tammentie, T., Tarkka, M.-T., Astedt-Kurki, P., & Paavilainen, E. (2002). Sociodemographic factors of families related to postnatal depressive symptoms of mothers. *International Journal of Nursing Practice, 8*, 240-246. doi: 10.1046/j.1440-172X.2002.00373.x
- Teissedre, F., & Chabol, H. (2003). Postnatal depression: A study of the predictive effects of postnatal anxiety. *Irish Journal of Psychological Medicine, 20*, 111-114.
- Terry, D. J. (1991). Stress, coping and adaptation to new parenthood. *Journal of Social and Personal Relationships, 8*, 527-547. doi: 10.1177/026540759184005
- Terry, D. J., Mayocchi, L., & Hynes, G. J. (1996). Depressive symptomatology in new mothers: A stress and coping perspective. *Journal of Abnormal Psychology, 105*, 220-231. doi: 10.1037//0021-843X.105.2.220
- Thio, I. M., & Elliott, T. R. (2005). Hope, social support, and postpartum depression: Disentangling the mediating effects of negative affectivity. *Journal of Clinical Psychology in Medical Settings, 12*.
- Tilden, V. P. (1980). A developmental conceptual framework for the maturational crisis of pregnancy. *Western Journal of Nursing Research, 2*, 667-678. doi: 10.1177/019394598000200402
- Trede, K., Baldessarini, R. J., Viguera, A. C., & Bottero, A. (2009). Treatise on insanity in pregnant, postpartum, and lactating women (1858) by Louis-Victor Marce: A commentary. *Harvard Review of Psychiatry, 17*, 157-165. doi: 10.1080/10673220902891802
- Tuckman, B. W. (1965). Development sequence in small groups. *Psychological Bulletin, 63*, 384-399.
- Ugarriza, D. N. (2002). Postpartum depressed women's explanation of depression. *Journal of Nursing Scholarship, 34*, 227-233. doi: 10.1111/j.1547-5069.2002.00227.x
- van Bussel, J. C. H., Spitz, B., & Demyttenaere, K. (2006). Women's mental health before, during, and after pregnancy: A population-based controlled cohort study. *Birth, 33*, 297-302. doi: 10.1111/j.1523-536X.2006.00122.x

- Webster, M. L., Thompson, J. M. D., Mitchell, E. A., & Werry, J. S. (1994). Postnatal depression in a community cohort. *Australian and New Zealand Journal of Psychiatry, 28*, 42-49. doi: 10.3109/00048679409075844
- Wenzel, A., Haugen, E. N., Jackson, L. C., & Brendle, J. R. (2005). Anxiety symptoms and disorders at eight weeks postpartum. *Journal of Anxiety Disorders, 19*, 295-311. doi: 10.1016/j.janxdis.2004.04.001
- Whiffen, V. E., & Johnson, S. M. (1998). An attachment theory framework for the treatment of childbearing depression. *Clinical Psychology: Science and Practice, 5*, 478-493. doi: 10.1111/j.1468-2850.1998.tb00168.x
- White, G. (2008). A comparison of the Postpartum Depression Screening Scale (PDSS) with the Edinburgh Postnatal Depression Scale (EPDS). *New Zealand College of Midwives' Journal, 39*.
- Whitton, A., & Appleby, L. (1996). Maternal thinking and the treatment of postnatal depression. *International Review of Psychiatry, 8*, 73-79. doi: 10.3109/09540269609037819
- Wisner, K., Perel, J., Peindl, K., Hanusa, B., Piontek, C., & Findling, R. (2004). Prevention of postpartum depression: A pilot randomized clinical trial. *American Journal of Psychiatry, 161*, 1290-1292. doi: 10.1176/appi.ajp.161.7.1290
- Wolfe, N. (2001). *Misconceptions: Truth, lies, and the unexpected on the journey to motherhood*. London, UK: Vintage.
- World Bank. (2011). World development indicators Retrieved 7th April, 2011, from <http://www.indexmundi.com/facts/indicators/SH.STA.MMRT/compare?country=nz#country=au:be:ca:fi:fr:ie:nz:no:se:gb>
- Yonkers, K. A., Ramin, S. M., Rush, A. J., Navarrete, C. A., Carmody, T., March, D., et al. (2001). Onset and persistence of postpartum depression in an inner-city maternal health clinic system. *The American Journal of Psychiatry, 158*, 1856-1863. doi: 10.1176/appi.ajp.158.11.1856
- Zaers, S., Waschke, M., & Ehlert, U. (2008). Depressive symptoms and symptoms of post-traumatic stress disorder in women after childbirth. *Journal of Psychosomatic Obstetrics & Gynecology, 29*, 61-71. doi: 10.1080/01674820701804324
- Zeanah, C., Keener, M., & Anders, T. (1986). Developing perceptions of temperament and their relation to mother and infant behaviour. *Journal of Child Psychology and Psychiatry, 27*, 499-512. doi: 10.1111/j.1469-7610.1986.tb00637.x
- Zettle, R. D. (2007). *ACT for depression: A clinician's guide to using Acceptance and Commitment Therapy in treating depression* Oakland, CA: New Harbinger Publications

- Zettle, R. D., & Rains, J. C. (1989). Group cognitive and contextual therapies in treatment of depression. *Journal of Clinical Psychology, 45*, 436-445. doi: 10.1002/1097-4679(198905)45:3<436::AID-JCLP2270450314>3.0.CO;2-L
- Zlotnick, C., Johnson, S. L., Miller, I. W., Pearlstein, T., & Howard, M. (2001). Postpartum depression in women receiving public assistance: Pilot study of an Interpersonal-therapy-oriented group intervention. *American Journal of Psychiatry, 158*, 638-640. doi: 10.1176/appi.ajp.158.4.638

## **Appendix A**

### **Intervention Manual**

## **Working with First-Time Mothers-To-Be.**



## **A Brief Intervention Protocol to Reduce Rates of Postnatal Distress.**

***Anita J. Darrah.***

## ***Session One – Building the group***

The initial focus of session one is on building supportive relationships amongst the group whilst creating a safe and therapeutic environment to enable sharing. By the end of the session, participants will feel comfortable attending further sessions and confident such attendance would be beneficial from them.

This will be achieved through:

- 🌀 Group exercises focused on ice breaking.
- 🌀 Facilitator direction.
- 🌀 Creation of a group setting which aids participants in developing a sense of belonging in the group.

### **GOALS OF SESSION ONE**

The emphasis of this session is on increasing individual awareness of personal assumptions and values. This will be achieved through a number of group exercises. In addition to a greater understanding of assumptions and values, group members will begin to identify what expectations they hold with regards to both the role of mothering and themselves as mothers. By the end of the session the participants will have attained:

- 🌀 Increased awareness of personal assumptions.
- 🌀 Insight into the values and expectations of the group and themselves.
- 🌀 Understanding of some of their own individual parenting goals.

## **FACILITATOR TASKS FOR SESSION ONE**

### *CHECKLIST*

- ✓ To welcome group members individually upon arrival and direct them to the appropriate area. The facilitator needs to be mindful individuals maybe nervous entering a novel situation.
- ✓ Aid in the development of group rules for the safety and comfort of group members.
- ✓ Monitor and facilitate participation of group members. This may involve both encouragement of reticent members and gentle direction of more verbal members. The facilitator needs to emphasise participation is an individual choice.
- ✓ Maintain group focus through the use of group exercises, prompts and appropriate therapeutic questioning.
- ✓ Monitor time and adjust session to accommodate the needs of the group.
- ✓ Emphasis should be given to highlighting this is not a therapy or treatment group. Group members are not expected to disclose very sensitive personal information and should only share the amount of information about themselves which they feel comfortable with.

## **OVERVIEW OF SESSION ONE**

- 🕒 *WELCOME AND HOUSEKEEPING*
- 🕒 *GROUP INTRODUCTIONS*
- 🕒 *COURSE OVERVIEW*
- 🕒 *ADMINISTRATION AND COLLECTION OF QUESTIONNAIRES*
- 🕒 *GROUP DISCUSSION AROUND ATTENDING*
- 🕒 *GROUP RULES*
- 🕒 *GROUP EXERCISE – EXPECTING MUMS?*
- 🕒 *GROUP EXERCISE ~ IDENTIFYING THE VALUES*
- 🕒 *WRAP UP AND BRIEFING FOR NEXT SESSION*

## **EXERCISE ONE - WELCOME –**

### *FACILITATOR INTRODUCTION AND WELCOME OF WOMEN TO THE GROUP*

The facilitator provides a welcome to the group which creates an opportunity to give a clear outline of the purpose and aims of the sessions. Information on parking and start/finish times should be provided for group members prior to the first session, but a brief reminder is appropriate. In addition other housekeeping matters should be covered in the initial welcome.

- Parking
- Toilets
- Refreshments
- Contact details

## **EXERCISE TWO - GROUP INTRODUCTIONS**

The function of the group introductions is to begin to build rapport within the group. This is a group exercise designed to ease apprehension of the individual group members in a relaxed and relevant manner. By aiding in the development of group cohesion, dropout rates can be lessened and personal disclosure facilitated. The baby names game is developed to act as a fun icebreaker exercise.

### EXERCISE TWO

#### **BABY NAMES**

##### **EQUIPMENT**

1 Piece of baby paraphernalia (potty or bath work well)  
Paper  
Pens or Pencils

##### **RULES**

Give each participant a piece of paper and ask them to write down the currently favoured name of their baby. If they are undecided or unsure of whether they are having a girl or a boy, assure them this is just for fun and ask them to just pick one for this game. Get the women to put the piece of paper with the baby's name on it into the potty or whatever piece of baby equipment is being used. Randomly draw pieces of paper out of the hat and have the group try and guess which name is preferred by which group member. When the discovery has been made, encourage the owner of the name to introduce themselves to the group and tell a little about themselves.

*FACILITATOR LEAD DISCUSSION ~ STRUCTURE AND AIMS OF GROUP*

The purpose of the group is to provide information and education to first time mothers in their transition to parenting. There are two main aims of this group. One is to explore the expectations of the group members and examine how these expectations may affect their future role as mothers. Secondly, the group aims to assist women develop skills for dealing with difficulties such as low mood or anxious worries following childbirth. By participating in the group, women also have the opportunity to meet others sharing similar experiences. The facilitator is responsible for disseminating information to the group about the group and how the sessions will be run. It is important to outline the structure of the course so participants have a realistic idea of the process of the group. This is seen as an important part of the ongoing process of informed consent. A possible example of an introduction to the course is provided in textbox 1.1.

TEXT BOX 1.1

During this first session we will be doing a number of group exercises. We will be establishing some rules for the group, before moving on to starting to think about what being a mother means for each of you. There will be some questionnaires handed out and time allocated for you to fill them in. Towards the end of the session there will be a group discussion around what values are important to you as mothers. We will keep a record of the values you identify and refer back to them throughout the remainder of the sessions.

The second session will introduce some of the ideas which have led to the development of this course. We will be doing a number of exercises together, and we will also start to examine some of the ideas about mothers that we have learnt about or been exposed to throughout our lives. We will look at how those ideas or assumptions fit with the values you identified holding.

In the third session we will look at possible changes in your relationship with your partner. I will also be giving you a number of handouts with information about supports and services that can accessed by you or your partner. There will be some extra forms to fill out during this final session.

**ADMINISTRATION/COLLECTION OF BASE-LINE QUESTIONNAIRES**

It is important to establish some base line levels in order to track shifts in maternal cognitions and mood. This research hinges on the belief women enter motherhood with firm expectations which are often disappointed. As such it is important to establish what those expectations are. To do this participants are administered the Maternal Adjustment and Maternal Attitudes Questionnaire

(MAMA) (Kumar et al., 1984). This questionnaire is specifically developed to measure a mother's perceptions of her body, her intimate relationship, and of somatic symptoms as well as her attitudes to the pregnancy and the baby. It is a 60 item self report measure which is available in the public domain (see Appendix B).

There is also a need to track mood throughout the intervention. To do this the Depression Anxiety and Stress Scale (DASS) is administered in the first and last sessions (Appendix C). The DASS is a 42-item self-report measure designed to assess the three negative emotional states of depression, anxiety, and stress (Lovibond & Lovibond, 1995b) While conceptually independent, depression and anxiety have been shown to have considerable clinical overlap, and thus the authors aimed to design an instrument that could simultaneously detect the full range of core anxious and depressive symptoms, whilst differentiating these common affective states. The DASS is particularly appealing as it has been tested with this population and found to be a reliable and valid instrument.

#### *FACILITATOR TASKS*

- ✓ Explain the need for measures and why they are used
- ✓ Carefully explain each questionnaire with full instructions on correct completion.
- ✓ Reaffirm confidentiality
- ✓ Provide clarification of areas of uncertainty
- ✓ Collect questionnaires in a way that honours the need for confidentiality.

### **Pause for Break**

#### **EXERCISE THREE -GROUP DISCUSSION**

This exercise creates opportunity for group members to voice concerns or questions they may have around group participation. Membership into a new group may create feelings of nervousness or perversely alienation. In the formative stage of group development group members have a desire for acceptance and a need to know the group is safe. Group members will tend to rely heavily on the facilitator for direction and will be focused on gathering impressions regarding the differences

and similarities between themselves and other group members (Tuckman, 1965). The primary task of the group at this stage is forming.

At this point the group members are given the opportunity to discuss how they are feeling about being part of the group. The idea is to give group members the chance to ask questions or air concerns before continuing. This is designed as a preamble to the exercise which follows regarding the creation of group rules.

### EXERCISE THREE

#### **FEELINGS**

- Ⓢ How do you feel about coming to the group?
- Ⓢ Do you have any concerns about the group?
- Ⓢ Can you share with the group what they are?
- Ⓢ What could be done to help you feel more comfortable in the group?
- Ⓢ What could be done to help you feel safer in the group?
- Ⓢ Has anything changed for you since you arrived?

### **EXERCISE FOUR - DEVELOPING GROUP RULES**

The next stage of group development usually involves some form of conflict and polarisation as the group navigates interpersonal issues; what Tuckman referred to as the 'storming' stage of his four stage forming, storming, norming and performing model of group development (Tuckman, 1965). In an effort to navigate potential pitfalls or moderate fallout from this stage the negotiation and introduction of group rules is an important next step.

The role of the facilitator at this stage includes:

- Explaining the need for group rules and boundaries.
  - To develop a sense of safety in the group with a view to facilitating honest and open discussion.
  - Creating clear expectations both for the group and of the group.
- Creating opportunity for balanced participation for all group members
- Writing down ideas without censorship.
- Modelling acceptance and tolerance of ideas.
- Seeking clarification of potential misunderstandings.

Ideas for potential group rules are given in Textbox 1.2.

TEXTBOX 1.2

<b>DEVELOPING GROUP RULES</b>		
<b>HINTS AND SUGGESTIONS</b>		
One person talking	Respecting view of others	Honesty
Staying focused	Attending all sessions	Sharing the time
Supporting one another	Being non-judgemental	Confidentiality
Not interrupting others	Notifying for non attendance	Being on time

**EXERCISE FIVE – EXPECTING MUMS**

This exercise is designed to enable the women to begin to think about what information and beliefs they hold with regards to mothering and mothers, and how that information was garnered. Once this information is highlighted it is hoped the women will begin to critically evaluate the reliability of the information. The facilitator task at this stage is to foster safe and open dialogue between the participants. An example introductory dialogue which could be used is given in text box 1.3.

TEXTBOX 1.3

**WHAT DOES BEING A MOTHER MEAN?**

As adults interacting with the world you are constantly making decisions and performing behaviours and roles almost automatically. We seldom give serious thought to how to be a good daughter, or a loyal person, or a productive employee. We just do it. Most psychologists would argue that we are, in part, a product of our environment. Whilst we might be 'biologically wired' to do certain things; the beliefs we hold, the decisions we arrive at, and the interpretations we make are influenced by our learning; from parents, from school systems, and from communities. And these beliefs or assumptions form a fundamental part of who we are.

In the next exercise I want to spend some time identifying some of those assumptions about being a mother that you might hold; in other words what does being a 'mother' mean for you? Before we do though, it is important I mention that when talking about assumptions, I'm not talking about assumptions as something that are 'bad' or 'wrong'. There is nothing inherently wrong about having assumptions; everybody has them. Sometimes, though, what can be problematic about assumptions is that we don't always realise that we hold them (maybe give example here). Of course, not realising we have certain assumptions usually means that other people; such as our partners, might not be aware that we hold them either. This can be where things get a tad unstuck.

When doing this exercise, there are number of areas it is suggested are covered. It is important to encourage the women to think broadly about their beliefs/expectations of both mothers and mothering. Suggested areas include:

- ✓ Mothers in work (*i.e. do you think it is good for mothers to work outside the home and what do you think about stay at home mums*)?
- ✓ Changes in intimate and other relationships (*i.e. what changes if any do you anticipate between you and your partner?, do you think your friends will see or treat you differently once the baby is born*)?
- ✓ Participation in childhood events (*i.e. do you think you will be involved with your child's playgroup/kindergarten/school? At what level? How does that blend with your expectations around work and relationships*)?
- ✓ The status of mothering? (*i.e. How do you think mothers are thought of in society? Do you think they are respected or valued*)? Do
- ✓ Levels of support for mothers (*i.e. Who do you think will be your greatest support as a mum? Do you think businesses where you live are child or family friendly? Do you think local and central government is supportive of mothers and families*)?

## EXERCISE FIVE

### **THE MEANING OF MUM**

#### **EQUIPMENT**

- 🕒 Paper for participants
- 🕒 Whiteboard or similar
- 🕒 Whiteboard markers or similar

#### **DIRECTIONS**

In the first part of the exercise the focus is on uncovering beliefs in relation to mothers. First ask the group to select a piece of paper and jot down on it the things they think a 'good' mother does which makes her a 'good' mother. Then ask them to note the things they think a 'bad' mother does which makes her a 'bad' mother. When finished ask group members to share what they have written and work together to identify themes or key assumptions.

The second part of the exercise focuses on beliefs and assumptions related to motherhood. Hand out more paper if necessary and ask the women to note down there beliefs about the status of mothers, support mothers receive and other areas outlined in the facilitator checklist above. Again once participants have completed this task individually, discuss as a group and note on the whiteboard themes or key assumptions of the group.

After the group has worked together to create their own collection of beliefs and assumptions the facilitator can hand out the *Assumptions about Mums* sheet (provided at the end of this session plan), explaining these are some of the assumptions/beliefs other mothers have identified holding or being exposed. The rationale for using the handout is that it normalises some of the beliefs women hold assuming an overlap between the list created by group and what appears on the sheet. Research points to a number of consistent values/beliefs held by women and it is anticipated the women in the group will conform to these expectations. The hand out can also be used as a prompt if the group is having difficulty identifying their beliefs and expectations with the facilitator. This is not ideal as the aim of the exercise is to encourage the group members to identify their own assumptions and values, and thus the handout should only be used in this way as a last resort.

#### *FACILITATOR SUMMARY OF EXERCISE.*

It is important the facilitator provides a exercise summary. This exercise is a key building block for the exercises which follow, and it is strongly advised time is spent discussing the outcome of the exercise and locating the outcome within the current literature. Textbox 1.4. provides a sample text.

#### TEXTBOX 1.4

So we all hold some assumptions about what mums should and should not do. Those assumptions help inform our expectations about being a mother ourselves. You know, research tells us that expectant mothers generally have some fairly positive beliefs or expectations about becoming a parent. When asked about things such as the division of labour, enjoyment of childcare role, and impact on the parental relationship, women tend to think things will go well. Also the closer a women comes to having a child; such as being pregnant or planning a pregnancy, the more positive her expectations will be. So, all in all, research would suggest that you are a pretty happy and optimistic lot right about now.

Optimism is good for you and positive expectations about parenthood are linked with good adjustment when you become a parent. But, and this is a big but, positive expectations are good for us when they are accompanied by positive experiences. That is, optimism is great, as long as it's realistic. However, parenting isn't all rosy, and as new parents you will be faced with an array of novel, and sometimes noxious challenges ~ you'll be tired, possibly sore, and required to master a whole lot of new tasks (and let me tell you there is a definite knack to changing nappies ~ particularly full ones!). Unrealistic expectations are more likely to be unmet or disconfirmed, and unmet or unfulfilled expectations have been associated with a more difficult adjustment to parenting. So what all this research is saying is if you are optimistic and hopeful about baby but there are things you are not looking forward to, or don't like the sound of you are probably on the right track!

Handout *The transition to motherhood*

## **EXERCISE SIX - IDENTIFYING THE GOALS AND VALUES.**

The aim of this exercise is to get group members thinking about what goals and values are important to them as mothers and parents, and the primary objective for the facilitator is to guide individuals in the group to formulate their own parenting values. These values themes will be utilised throughout the remaining sessions as 'checkpoints' when addressing expectations and preconceptions identified by further exercises. This exercise starts to examine core beliefs and values of group members and, as such, it is vital the exercise is done sensitively and safely. Again the facilitator has a number of key tasks associated with this exercise. These tasks included:

- ✓ Ensuring safety of all group members
- ✓ Creating opportunity for balanced participation for all group members
- ✓ Writing down ideas without censorship.
- ✓ Modelling acceptance and tolerance of ideas.
- ✓ Seeking clarification of potential misunderstandings.

Consistent with the ACT-based approach values are defined as "verbally constructed global desired life consequences" which are subjective, individual and persist across timeframes and situations (Hayes et al., 1999, p. 206). They cannot be judged by others, nor, it is argued, can they be fully achieved, or held like an object. Thus the value of being a loving parent for example, must continually be sought on a daily basis. The facilitator assists in the clarification of goals by using therapeutic skills such as socratic questioning, reflection, and paraphrasing.

### Exercise Six

#### **VALUES IDENTIFICATION**

##### **EQUIPMENT**

- 📍 Whiteboard or similar
- 📍 Markers
- 📍 Whiteboard cleaner

##### **DIRECTIONS**

Facilitator introduces the idea of

- 📍 What do they want for their children?
- 📍 What would they like their children (and others) to say about them as parents?
- 📍 How will they know if they have been successful parents – what will their children 'look' like; what kind of people will they be?
- 📍 What would tell them they needed to change things?

At the conclusion of the exercise the facilitator needs to draw links between the previous two exercises. The group has identified a number of beliefs and assumptions they hold about mothers and mothering, and also they have begun to identify values they hold for themselves and their children. What is important is how compatible those two belief systems are. The facilitator needs to ask the group a number of questions such as *how do your beliefs about mothers and mothering help or hinder you in achieving your parenting goals or of those things you mentioned you would like people to say about you, how many are reflected in the expectations of yourselves you identified earlier.*

For instance, women who do not have children might hold the belief that 'good mothers bake'. Home baking is considered to be an important ritual around childhood, and warm images of baking with children (particularly female children) often arise. If this was a belief identified by the group earlier on the question for the group could then become "does your belief good mothers' bake help you achieve your parenting goal of having a child who feels safe"? (or whatever their identified goal is). The exercise does not aim to challenge any of the beliefs or values. More simply, the focus of this exercise is to bring into awareness some of the tensions that may exist between expectations or beliefs women may hold and the value goals they have identified.

At the end of the exercise and the end of the session the stage should be set for the introduction of some value work in the next session, and the participants should leave the session with some insight into their own values and expectation.

#### **WRAP UP AND BRIEFING FOR NEXT SESSION**

The facilitator needs to provide a recap of the items covered in the session. Group members should be acknowledged for what they have achieved through-out the session with specific comments where relevant. As between session work participants should be encouraged to muse over their value goals and expectations without judgement. The facilitator may wish to reaffirm the group commitment to confidentiality before closing the session.

## ASSUMPTIONS ABOUT MUMS



BEING A MOTHER IS JUST INSTINCT



A WOMEN IS NOT FULFILLED/COMPLETE UNLESS SHE IS A MOTHER



BREASTFEEDING IS A NATURAL AND EASY PROCESS



BABIES JUST EAT AND SLEEP



IT GETS EASIER AT 6 AND 12 WEEKS



A MOTHER IS A SELFLESS PERSON



POSTNATAL ONLY HAPPENS TO WOMEN WITH UNDERLYING PROBLEMS



MOTHERLY LOVE IS INSTANT



BONDING IS AUTOMATIC



A BABY WILL STRENGTHEN A RELATIONSHIP

# THE TR☺NSITION TO MOTHERHO:☺D

The transition to motherhood involves adapting to physical, emotional and social changes and there is little support in society for this.

## ☺HEREFORE:

Most mother experience difficulties adjusting to their new role and may feel overwhelmed by the demands.

Myths about motherhood can create unrealistic expectations.

## ☺HEREFORE:

Unrealistic expectations lead to feelings of failure when coping problems occur.

From Milgrom et al. (2003). *Treating Postnatal Depression: A Psychological Approach for Health Care Practitioners*. Chichester: Wiley.

## Session Two

The primary focus of the second session is to introduce some of the theoretical concepts underpinning the research. Group exercises designed to demonstrate some of the theoretical principles are included in the first part of the session. In addition there is some discussion around the changing roles of mothers, as well as changes to the way society perceives and values both mothers and families. Finally the idea of 'mothering myths' are examined with some fun exercises designed to continue to building group cohesion while working to introduce key tasks of the session.

### GOALS OF SESSION TWO

The emphasis of this session is on building an understanding of the core principles informing the development of the intervention and learning to critically evaluate mothering 'myths'. This will be achieved through facilitator directed group exercises and psycho-education. Participants will gain understanding of how cognitions impact on mood and insight into some of the socialisation they may have experienced regarding mothering and motherhood. By the end of the session the participants will have:

- 📍 Gained insight into the interplay of mood and cognitions.
- 📍 Attained an understanding of their exposure to mothering myths
- 📍 Explored the impact of socialisation on their own parenting expectations

## **FACILITATOR TASKS FOR SESSION TWO**

### *Checklist*

- ✓ To welcome group members individually upon arrival.
- ✓ Monitor and facilitate participation of all group members. Again, this may involve both gentle encouragement of reticent members and gentle direction of more direct members. The facilitator needs to emphasise participation is an individual choice and informed consent is an ongoing process.
- ✓ Maintain group focus through the use of group exercises, prompts, and appropriate therapeutic techniques.
- ✓ Monitor time and adjust session to accommodate the needs of the group.
- ✓ Be mindful of the physical needs of individual group members.

## **OVERVIEW OF SESSION TWO**

- 🕒 *GREETINGS AND RECAP FROM LAST WEEK*
- 🕒 *INTRODUCTION OF ACT THEORY*
- 🕒 *GROUP EXERCISE*
- 🕒 *INTRODUCTION TO IDEA OF MOTHERING MYTHS*
- 🕒 *GROUP QUIZ*
- 🕒 *GROUP EXERCISE – TUG-OF- WAR*

### **WELCOME AND RECAP**

The facilitator provides a welcome to all group members. Any agreed upon processes which had been identified in the first session as helpful to settling the group, such as a karakia, should be utilised when appropriate. A reminder about the facilities at this stage is helpful and the facilitator should also offer a brief reminder regarding group confidentiality. The facilitator provides a brief overview of the material covered in the first session. This provides memory prompts for group members and also sets the scene for the introduction of Exercise One.

### **EXERCISE ONE: - MATCHING THE VALUES AND THE EXPECTATIONS**

In the last session group members were encouraged to consider their parenting values and examine some of the beliefs and expectations they held with regards to mothers and motherhood. If there was some disparity between the expectations and values, group members may experience some tension. Any feelings of discomfort which may have resulted from a sense of cognitive dissonance should be acknowledged and room created for this to be processed before moving on. This can be achieved in a number of different ways but above all the facilitator should model unconditional positive regard when group members are discussing their values. It cannot be emphasised enough that the overarching goal is to bring into awareness for individuals, their own values/judgements and expectations so they can work with them throughout the course, and not to change/challenge or critique individual values.

#### *Facilitator tasks*

For this exercise the key facilitator tasks include:

- ✓ Creating opportunities for individual group members to speak.
- ✓ Maintaining supportive group environment.
- ✓ Ensuring safety of individual members in the group.

### **EXERCISE TWO - INTRODUCTION OF ACT THEORY**

In this task the facilitator introduces some basic principles underpinning ACT therapy. Providing a rationale both for the exercises and for the basis of the research is vital for ensuring a collaborative relationship with group members. Also, if the clients understand the philosophy of the course it is likely they will extract further benefit from their participation. The ultimate goal of the protocol is to provide participants with new 'cards to play' instead of them having to rely on the same old cards – the same old coping. An understanding of the 'why' of the exercises as well as the 'how' of the exercises is considered to be another 'card'. More importantly perhaps disclosing information about the theoretical underpinning of the intervention is crucial to maintain the ongoing process of informed consent. Finally, by introducing some of the ACT principles, participants are alerted to some of the beliefs and assumptions which informed the research and the position of the facilitator is overly declared. While the facilitator may choose how they introduce ACT to the group a template script is provided in textbox 2.1. The core aspect of

ACT theory to communicate to the group at this time is the idea of 'the assumption of healthy normality' and its counter position – 'destructive normality'.

### TEXTBOX 2.1

I'd like to spend a bit of time chatting about some of the ideas which served as a basis for this intervention. Some of the group exercises and some of the thinking behind these sessions are based on ACT theory. ACT stands for Acceptance and Commitment therapy, and aims to encourage people to commit to valued actions; being willing, or accepting that such action may invite the presence of negative thoughts, emotions, and bodily sensations. It is a relatively new approach psychologists are utilising to think about and talk about psychological health. ACT theorists argue a certain amount of suffering and angst is perfectly normal and actually kind of good for us. This in a way is similar to some religious ideas such as those espoused in Buddhism. Really what the ACT theorists are saying is historically it paid for humans to be sensitive to threats to emotional or physical integrity such as standing at the edge of a rather big drop. The bottom line was that people who noticed these threats tended to live longer than those who didn't. The thinking is happiness served no evolutionary purpose; anxiety, arousal, and a healthy dose of paranoia did. While fear of heights, snakes and spiders seem to be relatively common, its not often you meet someone who is scared of butterflies!

That does suggest there are reason we are scared of some things are not others. So, in a nutshell ACT argues the current focus on self-esteem, and on happiness and contentment is just setting everybody up to fail. It's what ACT theorists refer to as 'the assumption of healthy normality', the idea that psychological health is what's 'normal'. But actually if you look at the evidence, its clear psychological health is not normal. Consider the rates of youth suicide in this country and the high levels of depression and anxiety; and we have to at least acknowledge the idea that these "disorders" may be more normal than not. This is what ACT theory refers to as an assumption of destructive normality; human suffering is to be expected. So what we have is ACT theorists saying if you are waiting to be happy you could be waiting for a wee while, and if there are times you are sad or anxious or a little bit depressed you are pretty normal.

### **EXERCISE THREE – YOU ARE WHAT YOU THINK**

The purpose of this exercise is to demonstrate to group members there is a link between mood and cognitions. In this exercise it is hoped participants will think themselves happy. Before starting the exercise the facilitator hands out to the group the 'happiness rating scale' (see Appendix A). The facilitator then asks the group to rate how happy they are in the present moment. An example of a possible introduction to the exercise is given in textbox 2.2.

## TEXTBOX 2.2

Before we start this exercise I'm going to hand you each a piece of paper which has a little smiley scale on it. On the scale I want you to rate how happy you are right now, right at this moment. The left end of the scale has a neutral face which stands for not-at-all-happy. On the right end of the scale there is a big smiley face. This face represents the-happiest-you-have-ever-been. Put a mark on the scale from not-at-all-happy to the-happiest-you-have-ever-been showing how happy you are feeling right now. Once you have placed a mark on the scale turn your paper over and place it upside underneath your chair or somewhere out of the way.

After the participants have placed their rating scales out of the way the facilitator reads the script for Exercise 3.

## EXERCISE 3.3

Now I would like you to go ahead and get comfortable in your chair. Sit upright with both feet flat on the floor, your arms uncrossed and your hands just resting on your lap or maybe your baby bump if that is more comfortable. When you are ready let your eyes gently close and let your body relax into your chair (pause for 10 seconds). Take some gentle breaths: in... and out... in... and out... Notice the feel and sound of your breathing as you breathe in... and out (pause 10 seconds).

Turn your attention to being inside this room. Notice any sounds happening inside the room (pause) and outside (pause 10 seconds). Notice the way your body sits in your chair (pause 10 seconds). Focus on the place where your body touches the chair. Notice the sensations you feel. How does it feel to sit where you sit? (pause 10 seconds). Next, notice the places where your body touches itself (10). Notice the spot where your hands touch your body. Notice how your feet feel in the position that they are in (10). What sensations can you notice in the rest of your body? Is bubbie moving about or resting quietly? Say hello to bubbie and move on to noticing other sensations in your body. If you feel any sensations in your body, just notice them and acknowledge their presence (pause 10 seconds). Also notice how they may, by themselves, change or shift from moment to moment. Do not try to change them (pause 10 seconds).

Let your mind wander from the room. Think of a time when you have felt really happy, maybe it was the event represented by the big smiley face on the happiness rating scale – the happiest time of your life (pause 10 seconds). What happened to make you so happy? Was there anyone else involved in the happy thing? (pause) Who were they? (pause) What did you do? (pause 10 seconds). How would other people have known you were so happy – what would they have seen that was different about you? Where in your body was your happiness? Were there other feelings as well - excitement maybe or pride? (pause). Just focus on that happy thing for a few moments (pause 10 seconds).

Then, when you are ready, let go of those thoughts and gradually widen your attention to take in the sounds around you (pause) and slowly open your eyes with the intention to bring this happy feeling to the present moment and the rest of the day.

---

<sup>3</sup> This exercise is adapted from the 'Centering Exercise' published in Eifert, G. H., & Forsyth, J. P. (2005) *Acceptance and Commitment Therapy for Anxiety Disorders: A Practitioner's Treatment Guide to Using Mindfulness, Acceptance, and Values-Based Behavior Change Strategies*. Oakland, CA: New Harbinger Publications.

At the completion of the exercise the facilitator hands out another smile scale, and instructs the participants to re-rate their mood and put a mark on the scale which represents how happy they are feeling *right now*, in this moment. The facilitator should provide a prompt reminding group members the left neutral face represents 'not-at-all-happy' and the right side smiley face represents 'the happiest they've ever been'. The ideal outcome is for participants to have two different ratings with the second rating indicating they are happier than they were with the first rating.

## **IDENTIFYING HAPPY MOMENTS**

### *FACILITATOR TASKS*

Once participants have completed both rating scales the facilitator gives the instruction to pick up the first piece of paper and compare the ratings.

The facilitator asks:

- Who has marked different spots on the scale?
- Who had a higher happiness score in the first scale?
- Who had a higher happiness score in the 2<sup>nd</sup> scale?
- Given that nothing particularly 'happy making' happened between the first and second rating times, why do you think your ratings changed?

The facilitator then provides an explanation of the exercise. The key component for the participants to grasp at this stage is their ability to alter their mood via cognitive processes. That is that they can have some control over the emotions they experience and they can chose to have A recommended text is provided in textbox 2.3. Over all we are expressing ACT is based on the idea that, generally, trying to rid ourselves of pain and distress only increases it, and turns it into something traumatic. The alternative is to accept it - but that doesn't mean being defeated or tolerating suffering. We learn to make room for painful feelings, thoughts, and sensations - allowing them to be there, coming and going without us struggling against them.

### TEXTBOX 2.3

ACT theorists believe human suffering is a common occurrence and therefore its normal. There is some evidence depression and anxiety can serve as useful and helpful responses to specific events and stressors. The trouble is we can remain depressed or anxious long after the event or stressor has passed. The way we do that is through language, and when we talk about language it is not just talking we are referring to, it is any activity used to communicate meaning such as gestures, pictures, written text, and sounds. So, we have evolved with a great ability to communicate our needs and experiences, desires, anxieties, fantasies, and feelings to others. This is great because we can potentially get those needs, desires, or fantasies met by others when we talk about them. We can seek reassurance for our anxieties and receive help when threatened. The potential downside is we are able to relive/re-experience these events again and again, long after the initial threat or event is over because we can describe it and relate it, we can close our eyes and see it. So you felt happier in the second rating because you had the ability to recall and remember the happiest moment of your life and to re-experience it again.

Funnily enough through language we don't have to experience something to experience it! We can imagine it, talk about it, manipulate it, grieve for it, and be frightening by it without ever experiencing it directly. Think September 11, think Boxing Day tsunami, think the Kahui twins. We can do this because we live in our minds, not our experiences. When we experience something as aversive, we have thoughts which accompany those emotions. Thoughts like *bad*, *scary* and judgements which accompany those thoughts – *I can't cope; I am hopeless, the world is hostile*. However, soon we link the thoughts to the emotions, the two become fused together, and then we only have to think to feel.

#### **EXERCISE FOUR – MAKING THE LINKS**

At this stage the facilitator can make the link with the participants own expectations and beliefs around motherhood and mothering. The link to be made is the fact that despite having no experience of mothering the participants were able to articulate clear ideas and ideals and the reason they could do this is through language. Discourses, images, symbols, and text all directing and informing how they understand mothering and motherhood to be. The facilitator needs to allow time for group discussion as this is a somewhat abstract concept with which participants may struggle.

#### **PAUSE FOR BREAK**

### *FACILITATOR TASK*

After the break the facilitator welcomes back everyone into the group and waits for group members to settle before introducing the next topic which covers modern mothering. Mothering is not new. We haven't just 'discovered' it, women have been doing it successfully without help from doctors, midwives, and a psychologists for a lot longer than they have been doing it with them. The purpose of the next stage is to get women to think about how mothering may have changed over the time and what those changes may mean for them in terms of support and expectations from others as well as how that may impact on their own expectations. This is done thorough psycho-education, but the facilitator is encouraged to make this as interactive as possible.

A brief history of mothering in New Zealand for reference is provided in text box 2.4. After providing some insight into mothering it is good to leave some space for the group to discuss how that might affect them. What is it likely to mean in terms of support and understanding from older family members for instance?

At the end of the exercise the facilitator can chose to finish with a few thought provoking ideas such as introducing *the quick quiz*.

### **A QUICK QUIZ**

- 🕒 How many of you have held a newborn baby?
- 🕒 How many of you have practice at waking 3 hourly? – note that's not waking after 3 hours sleep that's waking 3 hours after the last time you woke
- 🕒 What about the birth experience is going to suddenly made this a natural occurrence for you?
- 🕒 What will happen so this is suddenly normal?

## TEXTBOX 2.4

Women are mothering in a different world from which their grandmothers and even mothers were operating in. Certainly the role of mothering is almost unrecognisable from even older times. Historically, mothering was a community activity shared amongst women with familial or tribal ties. Thus women raised children in environments that were characterised by (1) the constant presence of others, (2) extensive previous exposure to babies and infants, (3) support of older or more experienced women, and (4) an acceptance of the legitimacy of the mothering role. In many cultures, the first 40 postpartum days are hugely important. Some cultures believe the mother/ infant bond depends on a community of women; particularly older, more experienced women, mothering the mother so she in turn can focus on mothering her baby.

Interestingly, early European New Zealand was quite similar. In the late 1800's childbirth was accepted as exhausting, and it was not uncommon for women to have help during late pregnancy and for several weeks following birth (Boswell, 1955). Midwives became part of the household, often acting as cooks, maids, and nurses for the entire family. A period of lying in lasting around 10 days was normal practice which helped both physical rejuvenation and the establishment of breastfeeding. In addition to providing for physical needs the period of lying in served an important social function. This was a time when female friends and relatives besieged the residence providing practical support, and more importantly, sharing their own expertise and wisdom of childbirth and mothering.

Yet within a generation mothering completely changed and arguably no-one was singularly more instrumental in the change than Dr. Truby King, central to the foundation of the Plunket movement (King, 1948). Dr. King, a medical superintendent of a mental hospital had a laudable aim to lower infant mortality and believed breastfeeding was pivotal in achieving that goal (Ironically, this opinion was informed by his research on malnourished cows which is not that flattering to breastfeeding women!). As admirable as his goal was, he argued fulfilment of it relied on the implementation of and adherence to his childcare routine, a inhumanely rigid regime which was, in all practicality, unobtainable. For example Dr. King recommended commencing toilet training at six weeks, ensuring infant bowel movements by 10am. There was to be no playing, rocking, or unnecessary handling of babies, and good mothers of course, repressed all signs of mental precocity (i.e. intelligence) in their infant. The role of an infant was to learn obedience because obedience in infancy was the foundation of all later powers of self control (Kedgley, 1996). There is no indication Dr. King interviewed a single mother or observed a single infant, yet he developed a regime which was to become a national obsession; an unreachable benchmark for mothering. While his belief in breast is best was revolutionary for the time; his insistence women feed for only two minutes on each breast every four hours meant feeding was difficult to establish and all but impossible to maintain – and no doubt also meant that there were a lot of incredibly hungry babies around despite his training in malnourishment.

By the 50's and 60's New Zealand mothers were a bit of a mess, bearing in mind that these farcical child-rearing practices were to be carried out during a depression, and two world wars; a time that the majority of women were solo parents with several young children at home. Feminist critics have accused Dr. King's regime of destroying the natural mothering instinct of generations of New Zealand women. As harsh as that may be it is easy to see how the practice of mothering as passed down historically from mother to daughter got lost in the hype and genuine concern for infant welfare.

Roll forward and we now have mothers disappearing into socially isolated suburbs, extended families atomised, and women and children removed from the public sphere. Society appears to be operating under the misnomer women automatically know their mothering role and, after the most physically debilitating event, they will naturally have enough energy left to give their all without a pause for replenishment. Not so!

## ***Exercise Five - Learning to let go***

Earlier Exercise Two established with group members that their thoughts can override their experiences; that scary thoughts *I'm bad*, or *the world is threatening*, become believable as people fuse with them. ACT theory argues individuals tend to use avoidance and control as a way of coping with scary thoughts, and that problems then stem from their attempts at control. In ACT speak *the problem is not the problem, the solution is the problem* (Eifert & Forsyth, 2005).

Indisputably motherhood comes with an array of commitments and responsibilities as well as expectations. How individuals deal with those commitments and responsibilities though can vary widely. Applying the earlier idea from ACT this suggests difficulties will arise if individuals are unduly focused on control as a means for dealing with demands, or if, for instance, avoidance is utilised to deal with disappointed expectations.

This is a fun, hands on exercise designed help participants come into contact with acceptance; the idea of accepting what is, as it is and letting go of distractions. Too often people get sidetracked from their goals and expend vast amounts of energy managing anxiety or stress or other general life events which distract them from keeping their feet pointed in their valued direction. This exercise encourages the participants to come to the realisation that some battles are futile and challenges their willingness to let go of useless battles and move forward. Participants can see sometimes the cost of remaining invested in their control strategies means they are no longer focused on pursuing their value goals. For this exercise one volunteer symbolises Mum and the other volunteer symbolises the commitments and responsibilities which accompany motherhood; commitments and responsibilities such as career, childcare, marriage/ partnership, finances etc. The exercise ends when a group member realises the best way for Mum to keep moving towards her value goal is to drop the drop and stop fighting.

### *Facilitator tasks*

Above all this exercise needs to be done carefully with due acknowledgement the participants in the exercise are pregnant! The facilitator is tasked with keeping the exercise on track and ensuring the participants remain safe. This exercise demonstrates the idea of acceptance – the group members learn if they accept that commitments and responsibilities will always be there tugging at

them, demand of them, and sometimes the harder they pull the harder they are pulled back Finally the facilitator can make the following observation:

*Notice the commitments and responsibilities are still there – they haven't gone anywhere. What is different is you are no longer involved in a struggle with them and your hands and feet are now free to do other things.*

### EXERCISE 5<sup>4</sup>

#### **EQUIPMENT**

- ☉ A piece of rope
- ☉ Volunteers x 2
- ☉ Sheet of cardboard or paper to represent despair

#### **INSTRUCTIONS**

Get the volunteers to stand facing each other and give them an end of the piece of rope each. Place the sheet of paper on the floor. Explain the piece of paper represents the pit of despair and the job of the volunteer being Mum is to avoid being pulled into the pit of despair, while the job of the volunteer being commitments and responsibilities is to pull Mum in. Keep the game going as long as is safe or until someone guesses the 'moral of the story' which is ~ no matter how hard you pull you keep getting drawn towards the pit of despair. Your job is not to pull harder ~ your job is to learn to drop the rope.

### **WRAP UP AND BRIEFING FOR NEXT SESSION**

---

<sup>4</sup> Adapted from the tug-of-war metaphor IN Hayes, S. C., Strosahl, K.D., & Wilson, K. G. (1999). Acceptance and Commitment Therapy: An experiential approach to behavior change. New York, NY: Guilford Press.

## Happiness Rating Scale

How happy am I feeling right now?



## Session Three

Session Three begins with an examination of partner expectations. The participants are encouraged to identify what expectations they hold for their partners, and how things will be different with the arrival of an infant. Findings regarding partner participation from the earlier studies are incorporated with other research and are shared with the group. This is an important component as the disparity between the expectations women held of partner support and input, and the perception of the support and input offered to women from partners was strongly linked to experiences of distress.

From there the focus shifts. Information on postnatal distress is introduced and women are encouraged to identify their own signs and symptoms of psychological struggle. The women are asked to consider questions such as *If I was following you around with a camera how would I know you were struggling? What would I see? What would you be doing? Or not doing?.* At the completion of the exercise the women are encouraged to share this information with significant others in their lives as a potential avenue of future support. The rationale for this sharing of information is if partners, family members or friends are aware of how this individual women react to stress, how they hold themselves, what their coping styles are or how their mood tends to be affected for instance, they are more readily able to notice when the women are struggling and assist in ways that have been pre-negotiated.

During this session we also examine expectations women hold of their partners and what women think about potential changes to their roles. The main theme is to help women prepare for changes in relationships that may have been carefully crafted pre-baby and assist them in identifying and renegotiating role changes. Finally women are given information on potential help agencies which are available for them following the birth of their baby. There are questionnaires to be completed and a debriefing for group members with post measures of mood and parenting expectations. This will be achieved through:

- 📍 Psycho-education
- 📍 Group Discussion
- 📍 Problem Solving Exercises
- 📍 Resource Sharing

### **GOALS OF SESSION THREE**

The emphasis of this session is on developing understanding of personal ways of being under stress, as well as encouraging the group to think about the changing roles of their partners

- 🌀 To assist participants in identifying their expectations of their partners
- 🌀 Provide psycho-education on postnatal distress
- 🌀 Sharing of resources for assistance
- 🌀 Collection of questionnaires

### **FACILITATOR TASKS FOR SESSION THREE**

Before starting the structured part of the session the facilitator is encouraged to take time to check in with the group about their feelings on the group disbandment. They should also inquire as to whether there is any special ceremonial the group wishes to undertake to mark the end of the group. This can take the form of a general discussion, and is important as it enables the facilitator time to accommodate any appropriate ways of disbanding the group to meet the needs of the group.

- 🌀 Welcome of Group Members and recap of previous material
- 🌀 Monitoring and facilitation of group participation
- 🌀 Monitor time and adjust session to accommodate the needs of the group
- 🌀 Provide opportunity for review and any processes related to the end of the group which maybe appropriate as agreed on by the group.

### **OVERVIEW OF SESSION THREE**

- 🌀 *RECAP FROM LAST WEEK*
- 🌀 *INTRODUCTION OF SESSION TOPIC ~ COUPLES STUFF*
- 🌀 *GROUP DISCUSSION ~ EXPECTATIONS OF PARTNER*
- 🌀 *PND*
- 🌀 *OK EXERCISE*
- 🌀 *ARRANGEMENTS FOR FOLLOW-UP*
- 🌀 *GROUP DISBANDMENT*

The first part of the final session examines partner expectations. At this stage the group members are encouraged to begin to think about their partners in their new parenting role, and to formulate in a clear and concrete way, expectations which they may be holding. As research suggests one of the leading causes of difficulties with the transition to parenthood is disappointed partner expectations, the first exercise is designed to pre-empt this somewhat. An introduction to this exercise is given in Textbox 3.1

### TEXTBOX 3.1

#### Partner Expectations – Tell them about it.

Most fathers-to-be would genuinely believe they are equal opportunists. Now, perhaps more than ever, financial decisions are shared, life choices negotiated, and goals jointly agreed. Father's certainly have a vested interest in making things equal, after all, it's potentially their little girl who is going to be out there fighting in the big bad world one day. I have yet to meet a husband or father who doesn't care whether or not his wife or partner is happy, or who doesn't like to describe himself as a hands-on-kind-of-Dad. So what's the problem?

Relationships are initially built on equal foundations, like building stones laid side by side, level in the ground. Routines are established, roles demarcated and expectations declared. But then the rules change. Imagine that one of the building stone has extra weight put onto it. There is another little building stone to hold up and support. Now the building stone with the extra weight begins to sink a bit, and in doing so, it twists away from the other building stone, and suddenly, subtly, the stones are no longer even.

Yet an equitable, negotiated relationship is crucial to a healthy adjustment to motherhood. A recent study in Australia examined first-time mother's expectations across the transition to parenthood, and concluded, for the women in the study, the support of their partners was instrumental in a positive transition to motherhood and far more important than the support of others, such as their friends and family<sup>5</sup>. Yet even women who reported high levels of support from their partners experienced a decline in relationship adjustment scores. As new parents the couple relationship suffered.

There were a number of factors that contributed to poorer postnatal relationship adjustment including the way couples divided up household labour, and the way the new baby changed the nature of the time couples spent together.

Compounding all that was the problem that paradoxically, although negotiating for two, women don't get twice the votes. In fact, power often shifts away from mothers', particularly stay at home mothers, who suddenly find themselves incredibly vulnerable, and unwillingly to take risks that longer are only risks to them.

---

<sup>5</sup> Harwood, K., McLean, N., & Durkin, K. (2007). First-time mothers' expectations of parenthood: What happens when expectations are not matched by later experiences? *Developmental Psychology, 43*, 1 – 12

## **EXERCISE ONE - GROUP DISCUSSION PARTNER ROLES**

For this exercise the facilitator directs a group discussion on partner roles. The purpose of this exercise is to encourage the women to begin to think about their expectations of their partners heading in to parenthood. While members of the group may have clearly established relationships with their partners as partners, however the rules are about to change. The partners are about to become fathers so what are the expectations for group members of their partners in the fatherhood role?

### EXERCISE ONE

#### **PARTNER EXPECTATIONS**

We've spent a lot of time talking about what things you might want for the baby and how you think things might be for you. Now I want to spend a little bit of time talking about what changes you think might happen for your partner. What is it going to mean to them when the baby is born? How will things be different and what sort of things do you think they might do to cope with the changes? How will your expectations of them change? How will they know what your expectations are?

#### *FACILITATOR CHECKLIST*

When directing this exercise the facilitator needs to ensure certain areas are covered. Again it is important to encourage the women to think broadly about beliefs and expectations of their partners.

Key questions to be discussed include:

- ✓ After the baby is born, have you and your partner talked about how things might change?
- ✓ How much time does your partner spend on housework and home chores now?
- ✓ Do you think he will do more around the house once the baby comes?
- ✓ How much more?
- ✓ Has this been agreed?
- ✓ What provisions are there for dispute resolution?

At the conclusion of the discussion the facilitator can choose to share some research findings with the participants.

- 📍 *Research shows fathers do on average 4 minutes a day of extra housework than non-fathers, and that this 'boom' is temporary. After the first couple of months they do less than they used to do because they are working all day and you're at home'*

However,

- 📍 *Partners who do more housework get more sex (there's studies to prove it). Apparently women find housework sexy ~ but only when other people are doing it!*

#### *FACILITATOR- LED DISCUSSION - INTRODUCING POSTNATAL DEPRESSION*

At this stage in the session the focus shifts to psycho-education. The final tasks of the facilitator are to provide women with information regarding postnatal distress to assist them in developing insight into their own ways of being when they experience low mood or distress.

Textbox 3.2 contains a brief history for postnatal depression for reference. The facilitator can choose whether to share this with group members. The key take home message from the history is postnatal depression has been documented in women for a long time and there is no definitive answer as to why some women experience it and some do not. Despite this, we do know a lot about helping with depression and distress so women are not alone.

That is followed by a list of symptoms which may indicate there is some difficulty with low mood (Textbox 3.3). When covering this section it is important to stress to the group members all these items are perfectly normal occasional occurrences and what they need to consider is (A) frequency and (B) impact. As a guiding principle ask the women to consider whether they or others are worried about these things. If so they should implement the agreed on action plan from the OK exercise (to follow).

### TEXTBOX 3.2

#### **SOME INFORMATION ON POSTNATAL DEPRESSION**

Postnatal depression is not a new phenomenon; it has been documented for centuries. Hippocrates (460 BC – 370 BC) writings referred to *milk fever* which consisted of a number of physical and psychological symptoms that appeared in postpartum women 3-4 days after the onset of lactation. Whilst there is no conclusive evidence he was documenting postnatal depression such insights are interesting. In 1858, Marcé, a Parisian doctor argued previously emotionally stable women could experience episodes of instability associated with the birth of their child. This was one of the first known efforts to distinguish mental illness in pregnancy related cases.

Research into postnatal depression has identified numerous potential contributors all of which are argued to be partially responsible for PND. The sum of the research suggests women either have too much of something, isolation, pre-existing depression, anxiety, estrogen, or too little of something, social support, appropriate coping mechanisms, progesterone etc. Either way, traditionally, fault and responsibility for postnatal depression has been located within the individual; the problem is something that the mother is either doing too much of, or not doing enough of. The medicalisation of postnatal depression, and indeed other forms of postnatal distress, provides a widespread understanding of the definition, identification, and treatment. However, despite the convenient framework for maternal distress, locating that distress solely within the physical individual ignores the interplay of mind and body. In addition, the application of a sick label ignores and invalidates the realities of a loss of uninterrupted sleep, the impossible workload, and the overwhelming responsibility, combined with the loss and isolation that can accompany motherhood for some women.

### TEXTBOX 3.3

#### **SOME SIGNS OF LOW MOOD**

- ④ Changes to eating habits – Either eating too much or not enough.
- ④ Changes to personal care routine - not getting dressed in the morning or even not getting up in the morning.
- ④ Increased Isolations – Not going out or limiting contact with others.
- ④ Changes in coping - Not being able to take care of everyday chores.
- ④ Unusual levels of irritability.
- ④ Changes to sleeping unrelated to the baby - difficulty getting to sleep even when baby is settled and it is your usual time to sleep, or frequent waking unrelated to the baby's sleep/wake cycle,
- ④ Others commenting they are concerned or worried about changes.

### *FACILITATOR TASKS*

In the coverage given to postnatal mood states is important for the facilitator to give accurate information without being so specific women miss more general signs of difficulties. Earlier studies with new mothers found although the women knew they were struggling they did not consider postnatal depression because the information they had was that PND occurred 4-6 weeks following birth. The narrowness of the definition these women received was instrumental in discouraging them from seeking help with their low mood state. Therefore the facilitator should emphasise:

- The diversity of symptoms – there is no one-size fits all diagnosis.
- More days than not – Having good days interspersed with bad days does not automatically rule out the existence of postnatal depression.
- While most depression occurs in the early postpartum it is quite common to have periods of low mood and depression at a later stage.
- Irritability is common in postnatal depression. Being angry or having externalising rather than internalising symptoms again does not preclude postnatal depression.

One of the difficulties for women seeking assistance with postnatal depression or distress is that the symptoms may be counterproductive to help seeking. This is particularly the case with PND as it is often characterised by low motivation, poor problem solving and in some cases, a lack of insight into the situation. Women who experienced PND often report one of two things; either a lack of knowledge they had PND or understanding they had PND (or at least were struggling), or some insight into their difficulties but having no idea how to go about accessing help.

The OK exercise was specifically designed to give the women in the group insight into their thoughts and behaviours which will assist them to notice times when they might be struggling. The facilitator encourages the women to write down their thoughts. Although they do not need to share their answers with the group, the facilitator should encourage the women to share the information on the list with a safe person. This is designed to act as an early intervention tool if the women should need assistance at a later date.

## EXERCISE TWO

### **THE OKAY EXERCISE**

- Ⓢ How will you know if you are doing OKAY after your baby is born?
- Ⓢ What will you be doing?
- Ⓢ What will things look like?
- Ⓢ How will your partner know you're doing OKAY?
- Ⓢ How will you know if you are struggling after the birth of your baby?
- Ⓢ What will you be doing?
- Ⓢ What will things look like?
- Ⓢ How will your partner know?
- Ⓢ What does postnatal depression look like? What are some of the things you might do or feel that would make you think you might have PND?
- Ⓢ Have you and your partner discussed what might happen if you get postnatal depression?
- Ⓢ Where would you go for help?

### **GROUP RECAP AND CLOSURE**

The final task is for the group facilitator to oversee a recap of the sessions. On a whiteboard or similar write down take home messages from the group. This is a final opportunity for the group members to seek clarification around any points which have arisen. Check contact details are correct and confirm any follow-up arrangements which have been made. Allow time for any closing processes which the group may have indicated needing.

## HINTS FOR STRESS MANAGEMENT

### *Plan your time:*

- Plan ahead and try not to leave things till the last minute where possible

### *Set Goals and Priorities:*

- Decide what is important for you- What are your priorities? Are they realistic?

### *Assertiveness:*

- Know what you want to say, do, or ask for, believe you have rights, and knowing what they are.

### *Talk things over:*

- Getting things out of your system is important and it allows you to communicate your wants, needs, and desires to others and elicit their support. Friends and family can provide good support, but also support groups and counselling services can be of value.

### *Hobbies:*

- Try and have a hobby or interest that is just for you and gets you away from your everyday pressures.

### *Exercise and Relaxation:*

- Exercise help with stress chemicals and at the same time releases other chemicals which make us feel good. Relaxation is also helpful for many people

### *Confronting the Problem:*

- Try to identify the source of the problem and consider how you can change things. While most of the ideas above will help you manage your stress to some degree the stress will continue until issues are confronted. Remember often the problem is not the problem the solution is the problem.



## Available Resources

Plunketline – 0800 933 922 7am-12am, 7 days  
Depression helpline 0800 111 757 [www.depression.org.nz](http://www.depression.org.nz)  
Lifeline 0800 543354 [www.lifeline.org.nz](http://www.lifeline.org.nz)  
Postnatal Distress Support  
Network Trust  
[www.postnataldistress.org.nz](http://www.postnataldistress.org.nz)

Trauma and birth Stress (TABS) [www.tabs.org.nz](http://www.tabs.org.nz)

Antenatal and postnatal mental health: [www.nice.org.uk](http://www.nice.org.uk)

Postpartum Support International: [www.postpartum.net](http://www.postpartum.net)

Mental Health Foundation  
[www.mentalhealth.org.nz](http://www.mentalhealth.org.nz)

Marce Society [www.marcesociety.com](http://www.marcesociety.com)

–

### AND FOR DADS:

New Zealand Mens' and Fathers Support Groups <http://menz.org.nz>

Postpartum men  
[www.postpartummen.com](http://www.postpartummen.com)

New Zealand Father and Child Society:  
<http://fatherandchild.org.nz>

Essentially Men (09) 376-2386 [www.essentiallymen.net](http://www.essentiallymen.net)

DIY Father <http://diyfather.com/>

Mental Health Foundation  
[www.mentalhealth.org.nz](http://www.mentalhealth.org.nz)

Depression helpline 0800 111 757 [www.depression.org.nz](http://www.depression.org.nz)

Lifeline 0800 543354 [www.lifeline.org.nz](http://www.lifeline.org.nz)

### FINALLY A DAD'S ADVICE TO OTHER DAD'S CONCERNED ABOUT THEIR

#### PARTNERS

- ✓ Contact help as soon as you recognise that there is a problem
- ✓ Keep a balance between your work and home commitments
- ✓ Follow your guts – If you think something is wrong don't be fobbed off
- ✓ Utilise the professional services available to men ~ there aren't many of them, and you may have to hunt around, but use them where you can.

## Appendix B: Maternal Attitudes and Maternal Adjustment Questionnaire (MAMA).

### Maternal Attitudes & Maternal Adjustment Questionnaire (MAMA)

Kumar, R., Robson, K. M., & Smith, A. M. R. (1984).

Please complete each question by putting a circle around the answer which most closely applies to you. Work quickly and please remember to answer each question. We want to know how you have been feeling during the last week. If you have not considered some of the questions during the past week, ahead and answer them on your present feelings.

Do you get out of breath easily?	Very Often	Often	Rarely	Never
Have you felt attractive?	Never	Rarely	Often	Very Often
Has there been tension between you and your partner - irritability, unpleasant silence, etc?	Never	Rarely	Often	Very Often
Have you been perspiring a lot?	Never	Rarely	Often	Very Often
Have you found your partner sexually desirable?	Never	Rarely	Often	Very Often
Have you vomited?	Never	Rarely	Often	Very Often
Have you been worried that you might not be a good mother?	Not at all	A Little	A Lot	Very Much
Have arguments between you and your partner come close to blows?	Very Often	Often	Rarely	Never
Have you felt faint or dizzy?	Never	Rarely	Often	Very Often
Have you been worried about hurting your baby inside you?	Not at all	A Little	A Lot	Very Much
Do you think your partner has found you sexually desirable?	Very Often	Often	Rarely	Never
Have you felt that your body smelt nice?	Never	Rarely	Often	Very Often
Have you look forward to having sexual intercourse?	Not at all	A Little	A Lot	Very Much
Has it worried you that you may not have any time to yourself once the baby is born?	Not at all	A Little	A Lot	Very Much
Have you found it easy to show affection to your partner?	Very Often	Often	Rarely	Never
Have you regretted being pregnant?	Never	Rarely	Often	Very Often
Have you experienced tingling sensations in your breasts?	Very Often	Often	Rarely	Never
Have you felt that your breasts were too small?	Not at all	A Little	A Lot	Very Much
Have you liked the shape of your body?	Not at all	A Little	A Lot	Very Much
Have you felt shy about sex?	Very Much	A lot	A Little	Not at all
Have you felt that your face was attractive?	Not at all	A Little	A Lot	Very Much
Has the thought of wearing maternity clothes appealed to you?	Very Much	A lot	A Little	Not at all
Have you felt that sexual intercourse might be less private because there is a baby inside you?	Very Much	A lot	A Little	Not at all
Have you been feeling happy that you are pregnant?	Not at all	A Little	A Lot	Very Much
Have you enjoyed kissing and petting?	Very Much	A lot	A Little	Not at all
Has your partner helped in the running of the house?	Very Much	A lot	A Little	Not at all
Have you suffered from constipation?	Never	Rarely	Often	Very Often
Has the thought of having more children appealed to you?	Not at all	A Little	A Lot	Very Much

Have you felt that pregnancy was unpleasant?	Very Much	A lot	A Little	Not at all
Have you been wondering whether having sexual intercourse might be harmful for the baby?	Not at all	A Little	A Lot	Very Much
Have you felt that your breast were too big?	Not at all	A Little	A Lot	Very Much
Have you felt full of energy?	Very Often	Often	Rarely	Never
Have your ankles swollen up?	Very Often	Often	Rarely	Never
Have you felt that your partner was paying you too little attention?	Very Often	Often	Rarely	Never
Have you felt wide awake in the daytime?	Very Often	Often	Rarely	Never
Has your partner seemed to ignore how you were feeling?	Very Often	Often	Rarely	Never
Has your partner tried to share your interests?	Never	Rarely	Often	Very Often
Have you suffered from indigestion or heartburn?	Never	Rarely	Often	Very Often
Have you felt tense and unhappy at the thought of sexual intercourse?	Never	Rarely	Often	Very Often
Have you been looking forward to catering for your baby's needs?	Not at all	A Little	A Lot	Very Much
Have you felt nauseated (felt sick)?	Very Often	Often	Rarely	Never
Have you felt that sex was unpleasant?	Very Much	A lot	A Little	Not at all
Have you felt that your partner went out too often without you?	Never	Rarely	Often	Very Often
Have you felt proud of your appearance?	Very Much	A lot	A Little	Not at all
Have you felt that you were easily aroused sexually?	Never	Rarely	Often	Very Often
Have you been having pleasurable daydreams about sex?	Very Often	Often	Rarely	Never
Have you felt that your body was soft and cuddly?	Very Much	A lot	A Little	Not at all
Have you been feeling closer to your partner since you became pregnant?	Never	Rarely	Often	Very Often
Have your body felt awkward and ungainly?	Very Much	A lot	A Little	Not at all
Have you felt like putting your arms round your partner and cuddling them?	Very Much	A lot	A Little	Not at all
Have you been wondering whether your baby will be healthy and normal?	Not at all	A Little	A Lot	Very Much
Has your partner shown affection to you?	Very Often	Often	Rarely	Never
Have you felt that your complexion was poor?	Very Much	A lot	A Little	Not at all
Have you felt that life will be more difficult after the baby is born?	Not at all	A Little	A Lot	Very Much
Have you felt that your breasts were attractive?	Not at all	A Little	A Lot	Very Much
Have you wished that you could rely on your partner to look after you?	Very Often	Often	Rarely	Never
Have you felt that you were too fat?	Very Much	A lot	A Little	Not at all
Have you wanted to have sexual intercourse?	Not at all	A Little	A Lot	Very Much
Have you enjoyed your food?	Very Much	A lot	A Little	Not at all
Has the thought of breast-feeding your baby appealed to you?	Not at all	A Little	A Lot	Very Much

## Appendix C: Depression, Anxiety and Stress Scale (DASS)

<b>DASS</b>		Name:	Date:
<p>Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you <i>over the past week</i>. There are no right or wrong answers. Do not spend too much time on any statement.</p> <p><i>The rating scale is as follows:</i></p> <p>0 Did not apply to me at all            1 Applied to me to some degree, or some of the time            2 Applied to me to a considerable degree, or a good part of time            3 Applied to me very much, or most of the time</p>			
1	I found myself getting upset by quite trivial things	0	1 2 3
2	I was aware of dryness of my mouth	0	1 2 3
3	I couldn't seem to experience any positive feeling at all	0	1 2 3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1 2 3
5	I just couldn't seem to get going	0	1 2 3
6	I tended to over-react to situations	0	1 2 3
7	I had a feeling of shakiness (eg, legs going to give way)	0	1 2 3
8	I found it difficult to relax	0	1 2 3
9	I found myself in situations that made me so anxious I was most relieved when they ended	0	1 2 3
10	I felt that I had nothing to look forward to	0	1 2 3
11	I found myself getting upset rather easily	0	1 2 3
12	I felt that I was using a lot of nervous energy	0	1 2 3
13	I felt sad and depressed	0	1 2 3
14	I found myself getting impatient when I was delayed in any way (eg, lifts, traffic lights, being kept waiting)	0	1 2 3
15	I had a feeling of faintness	0	1 2 3
16	I felt that I had lost interest in just about everything	0	1 2 3
17	I felt I wasn't worth much as a person	0	1 2 3
18	I felt that I was rather touchy	0	1 2 3
19	I perspired noticeably (eg, hands sweaty) in the absence of high temperatures or physical exertion	0	1 2 3
20	I felt scared without any good reason	0	1 2 3
21	I felt that life wasn't worthwhile	0	1 2 3

Please turn the page →

<i>Reminder of rating scale:</i>					
0	Did not apply to me at all				
1	Applied to me to some degree, or some of the time				
2	Applied to me to a considerable degree, or a good part of time				
3	Applied to me very much, or most of the time				
22	I found it hard to wind down	0	1	2	3
23	I had difficulty in swallowing	0	1	2	3
24	I couldn't seem to get any enjoyment out of the things I did	0	1	2	3
25	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
26	I felt down-hearted and blue	0	1	2	3
27	I found that I was very irritable	0	1	2	3
28	I felt I was close to panic	0	1	2	3
29	I found it hard to calm down after something upset me	0	1	2	3
30	I feared that I would be "thrown" by some trivial but unfamiliar task	0	1	2	3
31	I was unable to become enthusiastic about anything	0	1	2	3
32	I found it difficult to tolerate interruptions to what I was doing	0	1	2	3
33	I was in a state of nervous tension	0	1	2	3
34	I felt I was pretty worthless	0	1	2	3
35	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
36	I felt terrified	0	1	2	3
37	I could see nothing in the future to be hopeful about	0	1	2	3
38	I felt that life was meaningless	0	1	2	3
39	I found myself getting agitated	0	1	2	3
40	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
41	I experienced trembling (eg, in the hands)	0	1	2	3
42	I found it difficult to work up the initiative to do things	0	1	2	3

Lovibond, S. H., & Lovibond, P. F. (1995). *Manual for the Depression Anxiety Stress Scales* (2nd ed.). Sydney, Australia: Psychology Foundation of Australia

## **Appendix D**

### **Study One**

**D: 1 INFORMATION SHEET**

**D: 2 CONSENT FORM**

## D: 1 STUDY ONE INFORMATION SHEET

# M-ODERN M-OTHERING: THE MYTHS, THE MAYHEM, AND THE MAGIC

You are invited to participate in a research project designed help understand how women think and feel about becoming mothers. Your assistance would help in our search for better understanding of womens' emotional experiences (both good and bad) of being a mother. This research is being conducted as partial fulfilment of requirements for the degree of Doctor of Clinical Psychology. The principal researcher for this research is Anita Darrah. The research will be conducted under the supervision of Professor Ian Evans (Professor of Psychology, Massey University); Mrs Cheryl Woolley (Tunitoa Clinical Co-ordinator); and Dr. Joanne Taylor (Senior Lecturer in Clinical Psychology).

### ***Am I eligible to participate?***

The participants that I am seeking are mothers with older children who are comfort talking about their experiences within a group of mothers, and, in addition:

- are comfortable conversing in English.
- are over 18 years of age and able to give informed consent to participate.
- are willing to allow the interview being taped and/or videoed.

### ***What you will be asked to do***

I would like you to take part in a group discussion in which you will be asked questions about being a mother. The interview should take between 1.5 – 2 hours. The interview will be videoed and/or tape recorded and information you give will be used to gain a deeper understanding of how women feel and think about the transition to motherhood. You will be asked to consider a number of things including how you felt about becoming a mother, and what you expected mothering to be like.

The value of the knowledge obtained from this research is that it will help other mothers like you in the future. We know some women find motherhood difficult, and experience high levels of distress which affects them, their babies, and other members of their families. From this study we hope to gain a better understanding of what typical women find helpful and positive about being a mother and also what women might find most difficult, and from these insights to work out effective ways of helping them and their babies.

We will provide some reimbursement for any travel costs associated with attendance in this project.



### ***What happens to the information you provide***

The data collected will be anonymised (have your name removed and personal details age etc) so that you can not be identified. The tapes and data will be stored at Massey University, and only the researcher Anita Darrah and the supervisors listed at the top of this form will have access to any data that could identify you. The data will be archived after the project is completed in a new data storage facility being constructed by the School of Psychology in our workshop area. Storage will be for five years after which data will be identified for secure destruction.

### ***Your rights as a participant***

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- Decline to answer any particular question;**
- Withdraw from the study at any time;**
- Ask any questions about the study at any time during participation;**
- Provide information on the understanding that your name will not be used unless you give permission to the researcher;**
- Be given access to a summary of the project findings when it is concluded;**
- Ask for the audio/video tape to be turned off at any time during the interview.**

### ***Project Contacts***

If you have any questions or comments about the project please contact the principal researcher Anita Darrah (06) 356 9099 x 2033, 027 7217982, email [anitadarrah@gmail.com](mailto:anitadarrah@gmail.com); or Professor Ian Evans (04) 801 5799 x 62125, email [I.M.Evans@massey.ac.nz](mailto:I.M.Evans@massey.ac.nz).

*"This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named above are responsible for the ethical conduct of this research. If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher (s), please contact Professor John O'Neill, Director, Research Ethics, telephone 06 350 5249, email [humanethics@massey.ac.nz](mailto:humanethics@massey.ac.nz)".*

**D: 2 STUDY ONE CONSENT FORM**

**M-☀-D E R N M-☀-T H R I N G:  
T H R I M Y T H S, T H R I M A Y H : @ : M,  
A N D T H R I M A G I C ✨**

**PARTICIPANT CONSENT FORM**

**This consent form will be held for a period of five (5) years**

- I have read and understood the information sheet
- I have had the opportunity to use whanau support or a friend to help me ask questions and understand the study.
- I agree to participate in the group discussion under the conditions outlined in the information sheet.
- I agree not to discuss information related to others in the group outside of the group
- I understand the discussion will be digitally recorded
- I understand my participation in this study is voluntary (my choice) and I may withdraw from the study at any time.

**Signature:**

**Date:**

\_\_\_\_\_

**Full Name - Printed**

\_\_\_\_\_



## **Appendix E Study Two**

**E:1 ETHICS APPROVAL**

**E:2 INFORMATION SHEET**

**E:3 CONSENT FORM**

**E:4 INTERVIEWER QUESTIONS**

**E:5 TRANSCRIPTION CONSENT LETTER**

**E:6 DEMOGRAPHIC QUESTIONNAIRE**

## E:1 STUDY TWO ETHICS



MASSEY UNIVERSITY

25 February 2010

Anita Darrah  
4 Kilkenny Place  
PALMERSTON NORTH

Dear Anita

**Re: Modern Mothering**

Thank you for your Low Risk Notification which was received on 22 February 2010.

Your project has been recorded on the Low Risk Database which is reported in the Annual Report of the Massey University Human Ethics Committees.

The low risk notification for this project is valid for a maximum of three years.

Please notify me if situations subsequently occur which cause you to reconsider your initial ethical analysis that it is safe to proceed without approval by one of the University's Human Ethics Committees.

Please note that travel undertaken by students must be approved by the supervisor and the relevant Pro Vice-Chancellor and be in accordance with the Policy and Procedures for Course-Related Student Travel Overseas. In addition, the supervisor must advise the University's Insurance Officer.

**A reminder to include the following statement on all public documents:**

*"This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named above are responsible for the ethical conduct of this research."*

*If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher(s), please contact Professor John O'Neill, Director (Research Ethics), telephone 06 350 5249, e-mail [humanethics@massey.ac.nz](mailto:humanethics@massey.ac.nz)."*

Please note that if a sponsoring organisation, funding authority or a journal in which you wish to publish requires evidence of committee approval (with an approval number), you will have to provide a full application to one of the University's Human Ethics Committees. You should also note that such an approval can only be provided prior to the commencement of the research.

Yours sincerely

John G O'Neill (Professor)  
Chair, Human Ethics Chairs' Committee and  
Director (Research Ethics)

cc Prof Ian Evans  
School of Psychology  
Wellington

Assoc Prof Mandy Morgan, HoS  
School of Psychology  
PN320

Massey University Human Ethics Committee  
Accredited by the Health Research Council

Te Kōwhiri  
ki Pārehurua

Research Ethics Office, Massey University, Private Bag 11222, Palmerston North 4402, New Zealand  
T +64 6 350 5573 +64 6 350 5575 F +64 6 350 5622  
E [humanethics@massey.ac.nz](mailto:humanethics@massey.ac.nz) [atira@ethics@massey.ac.nz](mailto:atira@ethics@massey.ac.nz) [gtc@massey.ac.nz](mailto:gtc@massey.ac.nz)  
[www.massey.ac.nz](http://www.massey.ac.nz)

## E:2 STUDY TWO INFORMATION SHEET

# MODERN MOTHERING: THE MYTHS, THE MAYHEM, AND THE MAGIC

You are invited to participate in a research project designed help understand how women think and feel about becoming mothers. Your assistance would help in our search for better understanding of women's' emotional experiences (both good and bad) of new motherhood. This research is being conducted as partial fulfilment of requirements for the degree of Doctor of Clinical Psychology. The principal researcher for this research is Anita Darrah. The research will be conducted under the supervision of Professor Ian Evans (Professor of Psychology, Massey University); Mrs Cheryl Woolley (Turitea Clinical Co-ordinator); and Dr. Joanne Taylor (Senior Lecturer in Clinical Psychology).

### ***Am I eligible to participate?***

The participants that I am seeking are women have had a child within the last 6 months, and, in addition:

- are comfortable conversing in English.
- are over 18 years of age and able to give informed consent to participate.
- are willing to allow the interview being taped and/or videoed.

### ***What you will be asked to do***

I would like you to take part in an interview in which you will be asked questions about being a mother. The interview should take between 1.5 – 2 hours. The interview will be videoed and/or tape recorded and information you give will be used to gain a deeper understanding of how women feel and think about the transition to motherhood. You will be asked to consider a number of things including how you felt about becoming a mother, and what you expected mothering to be like.

You will also be asked to fill in a brief questionnaire about how you are currently feeling. The value of the knowledge obtained from this research is that it will help other mothers like you in the future. We know some women find motherhood difficult, and experience high levels of distress which affects them, their babies, and other members of their families. From this study we hope to gain a

better understanding of what typical women find helpful and positive about being a mother and also what women might find most difficult, and from these insights to work out effective ways of helping them and their babies.

We will provide some reimbursement for any travel costs associated with attendance in this project.

### ***What happens to the information you provide***

The interview data collected, including video tapes and completed questionnaires, will be anonymised (have your name removed and personal details age etc) so that you can not be identified. Your name and contact details, which are required to provide you with a summary of the results, will be kept separate from your completed questionnaires. The questionnaires and data will be stored at Massey University, and only the researcher Anita Darrah and the supervisors listed at the top of this form will have access to any data that could identify you. The data will be archived after the project is completed in a new data storage facility being constructed by the School of Psychology in our workshop area. Storage will be for five years after which data will be identified for secure destruction.

### ***Your rights as a participant***

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- **Decline to answer any particular question;**
- **Withdraw from the study at any time;**
- **Ask any questions about the study at any time during participation;**
- **Provide information on the understanding that your name will not be used unless you give permission to the researcher;**
- **Be given access to a summary of the project findings when it is concluded;**
- **Ask for the audio/video tape to be turned off at any time during the interview.**

### ***Project Contacts***

If you have any questions or comments about the project please contact the principal researcher Anita Darrah (06) 356 9099 x 2033, 027 7217982, email [anitadarrah@gmail.com](mailto:anitadarrah@gmail.com); or Professor Ian Evans (04) 801 5799 x 62125, email [I.M.Evans@massey.ac.nz](mailto:I.M.Evans@massey.ac.nz).

*This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named above are responsible for the ethical conduct of this research. If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher(s), please contact Professor John O'Neill, Director, Research Ethics, telephone 06 350 5249, email [humanethics@massey.ac.nz](mailto:humanethics@massey.ac.nz)*

### E:3. STUDY TWO CONSENT FORM

# M-ODERN M-OTHERING THE MYTHS, THE MAYHEM AND THE MAGIC

## Consent for participation for Postpartum interview

**This consent form will be held for a period of five (5) years**

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

- I agree/do not agree to the interview being audio taped.
- In agreeing to taping the interview I understand that I can have the taping stopped at any time.
- I understand that I can choose not to answer any question/s.
- I wish/do not wish to have my tapes returned to me.
- I understand I have the right to edit the transcript of my interview before it is used in the study.
- I understand that my participation in this study is voluntary (my choice) and that I have the right to withdraw from the study at any stage.
- I wish/do not wish to have data placed in an official archive.
- I agree to participate in this study under the conditions set out in the Information Sheet.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Full Name printed** - \_\_\_\_\_

## **E: 4 STUDY TWO INTERVIEW SCHEDULE**

### **Postpartum Interview with new mothers**

#### **Interview Questions**

##### **QUESTIONS REGARDING KNOWLEDGE SEEKING PRE BABY**

*Did you read books or magazines about parenting before you had your baby?*

What sort of books / magazines did you read?

Was that helpful for you?

Has it been like the books said it would be?

If you could write a book for new mums what are some of the things you would put in it?

*Did you talk to friends/family/work colleagues about parenting before you had your baby?*

What sort of things did you talk about?

Was that helpful for you?

Has it been like the friend/family member/ colleague said it would be?

If you could have a talk with a new mum what are some of the things you might say?

##### **QUESTIONS REGARDING EXPECTATIONS**

*Have there been things which have happened since you became a mum that have been a bit of a surprise or that you weren't expecting?*

Can you tell me a bit about that?

How was that for you ? (thoughts/feelings/bodily sensations)

How have you coped with these unexpected things? (adaptive functioning)

### **QUESTIONS REGARDING PARENTING BELIEFS**

If you had to make up a story about or describe what you thought a 'typical mum' was like before you had your baby how would the story/description go? (what would she do/think/say)?

What about now. Would the story change in anyway?

Are you like the mum in the story?

How are you similar/dis-similar?

*Overall has motherhood been like you expected it to be (likert scale anchors  
0 = not at all like I expected 10 = exactly like I expected*

### **QUESTIONS REGARDING THE BEST/WORST**

*What has been the best thing about becoming a mum?*

*Becoming a mum means lots of changes and research suggests women often miss certain things after becoming a mum – for example free-time or their old figure – have there been times when you feel like you miss things you had/did before baby was born?*

Is it okay to talk about that for a bit?

What things did you miss?

How is that for you? (thoughts/feelings/bodily sensations)

Have you replaced those things with other things (adaptive functioning – meeting needs in novel ways).

**E: 5 TRANSCRIPT CONSENT LETTER**



Dear .....

Enclosed is a copy of the transcript from our interview conducted on the ..... Please read over the transcript. If you have queries or concerns regarding the transcript please highlight them and return the transcript to me by the ..... so we can discuss them. If you think the transcript accurately represents what we discussed, you do not have to return the transcript to me, but please sign the enclosed consent form and return to me by the .....

Again thank you for your time and interest in my research. Your input is very much appreciated.

Kind regards

Anita Darrah..

## E: 6. STUDY TWO: DEMOGRAPHIC QUESTIONNAIRE

### MODERN MOTHERING: THE MYTHS, THE MAYHEM, AND THE MAGIC

#### *Information about you*

AGE

ETHNICITY

MARITAL STATUS

---

HIGHEST QUALIFICATION

Secondary School Qualification

Tertiary Diploma/Certificate

Bachelor Degree

Postgraduate Qualification

APPROXIMATE FAMILY INCOME

≤ \$40,000

\$40,000 — \$55,000

\$55,000 — \$70,000

≥ \$70,000

#### *Information about your baby*

BABY'S GENDER

*M/F*

BABY'S DATE OF BIRTH

\_\_\_/\_\_\_/\_\_\_

In general, how would you describe your baby's health?

---

In general, how would you describe your baby's temperament?

---

Was your pregnancy planned?

*Y/N*

Were you working/training before you became pregnant?

*Y/N*

Are you working/training now?

*Y/N*

# Appendix F: Study Three

## F: 1 ETHICS APPROVAL

## F: 2 INFORMATION SHEET



MASSEY UNIVERSITY

1 March 2011

Anita Darrah  
4 Kilkenny Place  
Fitzherbert  
PALMERSTON NORTH 4410

Dear Anita

**Re: Modern Mothering**

Thank you for your Low Risk Notification which was received on 17 February 2011.

Your project has been recorded on the Low Risk Database which is reported in the Annual Report of the Massey University Human Ethics Committees.

The low risk notification for this project is valid for a maximum of three years.

Please notify me if situations subsequently occur which cause you to reconsider your initial ethical analysis that it is safe to proceed without approval by one of the University's Human Ethics Committees.

Please note that travel undertaken by students must be approved by the supervisor and the relevant Pro Vice-Chancellor and be in accordance with the Policy and Procedures for Course-Related Student Travel Overseas. In addition, the supervisor must advise the University's Insurance Officer.

**A reminder to include the following statement on all public documents:**

*"This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named above are responsible for the ethical conduct of this research."*

*If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher(s), please contact Professor John O'Neill, Director (Research Ethics), telephone 06 350 5249, e-mail [humanethics@massey.ac.nz](mailto:humanethics@massey.ac.nz)."*

Please note that if a sponsoring organisation, funding authority or a journal in which you wish to publish requires evidence of committee approval (with an approval number), you will have to provide a full application to one of the University's Human Ethics Committees. You should also note that such an approval can only be provided prior to the commencement of the research.

Yours sincerely

John G O'Neill (Professor)  
Chair, Human Ethics Chairs' Committee and  
Director (Research Ethics)

cc: Prof Ian Evans  
School of Psychology  
Wellington

Assoc Prof Mandy Morgan, HoS  
School of Psychology  
PN520

---

Massey University Human Ethics Committee  
Accredited by the Health Research Council

Ti Kaitiaki  
ki Pānuihanga

Research Ethics Office, Massey University, Private Bag 11022, Palmerston North 4412 New Zealand  
T +64 6 390 9113 +64 6 398 5675 F +64 6 390 9612  
E [humanethics@massey.ac.nz](mailto:humanethics@massey.ac.nz) [anmethics@massey.ac.nz](mailto:anmethics@massey.ac.nz) [gr@research.ac.nz](mailto:gr@research.ac.nz)  
[www.massey.ac.nz](http://www.massey.ac.nz)

## F: 2. INFORMATION SHEET



# THOUGHTS ABOUT M-O-D-E-R-N M-O-T-H-E-R-I-N-G

### ***Please Help!***

***I am seeking young women between the ages of 18 years and 36 years who have not had a child.***

Hi, my name is Anita Darrah and I am conducting a research project on the attitudes of young women who are not yet mothers but might become a mum sometime in the future.

I'd be very grateful if you could fill out this brief questionnaire which asks you some questions about yourself as well as some questions about your thoughts on mothers and babies. I'll also be asking you a bunch of questions about other stuff like your own mum and worries which you may have. It should take you about ten minutes to complete. Note that there are 5 pages—please address the questions on EACH page.

To thank you for your time you will go in a draw to win one of 5 \$20 iTunes vouchers. You will need to provide your email contact so I can let you know if you win! Please write it clearly at the bottom of the attached questionnaire. **WE WILL REMOVE THIS POTENTIALLY IDENTIFYING INFORMATION FROM THE QUESTIONNAIRE ITSELF BEFORE LOOKING AT OR RECORDING YOUR ANSWERS, SO YOU CAN BE ASSURED OF CONFIDENTIALITY.** Your e-mail address will not be used for any other reason, nor will it be provided to any other person(s).

### ***What happens to the information you provide***

The information you give me is anonymised—your name is not collected and your e-mail address will be detached from the questionnaire prior to scoring. The data are then analysed using statistical methods and reported only as group averages. The questionnaires and data are stored securely at Massey University for a while, after which they are destroyed.

### ***Your rights as a participant***

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- **Decline to answer any particular question;**
- **Withdraw from the study at any time;**
- **Ask any questions about the study at any time during participation;**
- **Provide information on the understanding that your name will not be used;**
- **Be given access to a summary of the project findings when it is concluded.**

In order to obtain this summary, you will need to log on to the School of Psychology (Massey) website and go to the web page of my supervising professor, Ian Evans ([www.massey.ac.nz](http://www.massey.ac.nz) and follow the links). From there you will be directed to a summary of my findings. Remember, of course, that this will take a few months to complete!

### ***Project Contacts***

My research is being conducted as partial fulfilment of requirements for the degree of Doctor of Clinical Psychology. It is being conducted under the supervision of Professor Ian Evans Professor of Psychology, (Massey University) and Mrs. Cheryl Woolley (Turitea Clinical Co-ordinator).

If you have any questions or comments about the project please contact me, Anita Darrah (06) 356 9099 x 2033, 027 7217982, email [anitadarrah@gmail.com](mailto:anitadarrah@gmail.com); or Professor Ian Evans (04) 801 5799 x 62125, email [I.M.Evans@massey.ac.nz](mailto:I.M.Evans@massey.ac.nz).

*This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named above are responsible for the ethical conduct of this research. If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher(s), please contact Professor John O'Neill, Director, Research Ethics, telephone 06 350 5249, email [humanethics@massey.ac.nz](mailto:humanethics@massey.ac.nz).*

**Please keep this information sheet for yourself. Tear it off the questionnaire and return only the questionnaire. This will help you remember all of the above information if you need it later for any reason. Thanks!**

## APPENDIX G: MOTHERING MYTHS QUESTIONNAIRE

# THOUGHTS ABOUT MODERN MOTHERING

**Please tell me a little bit about yourself** (Please circle the appropriate answer. If you do not wish to answer a particular question, please circle *decline to answer*):

Age (in years) .....

**1/ What is your relationship status?**

Flying solo                      In a relationship                      Bunking down together  
Got a hubby                      Decline to answer

**2/ Years in current relationship?** ..... Decline to answer

**3/ What is your Highest level of Education?**

NCEA (level 1)      NCEA (level 2)      NCEA (level 3)      Bursary  
Certificate          Diploma                  Degree                  Post-Grad  
Qualification Other                  Decline to answer

**4/ Have you ever been involved with babies or young children in such a way that you were acting in the role of parent/ guardian?** YES NO

**5/ Do you plan on having children at some stage in your life?** YES NO

◊ If "yes" can you give some idea of the timeframe in which you think this might happen?

Within the next year      1-2 years                  2-5 years      5 years plus

Decline to answer

**BELIEFS.** The following statements are commonly held beliefs about mums and their babies. I'd like you to indicate your level of agreement with the statements. Don't spend too much time thinking about your answer; just circle the one which reflects your opinions best — there are no incorrect responses.

**Pease rate the statements on the following scale (circle one)**

*strongly disagree*   *disagree*   *somewhat disagree*   *somewhat agree*   *agree*   *strongly agree*

**Mothers have an instant bond with their baby**

*strongly disagree*   *disagree*   *somewhat disagree*   *somewhat agree*   *agree*   *strongly agree*

**Giving birth in a hospital is safer**

*strongly disagree*   *disagree*   *somewhat disagree*   *somewhat agree*   *agree*   *strongly agree*

**Pregnant women have a glow about them that makes them look and feel radiant**

*strongly disagree*   *disagree*   *somewhat disagree*   *somewhat agree*   *agree*   *strongly agree*

**Having a baby cements a relationship**

*strongly disagree*   *disagree*   *somewhat disagree*   *somewhat agree*   *agree*   *strongly agree*

**Not bonding quickly with your baby can have long-term consequences**

*strongly disagree*   *disagree*   *somewhat disagree*   *somewhat agree*   *agree*   *strongly agree*

**Deep down, pregnant women have real fears that the baby will not be normal**

*strongly disagree*   *disagree*   *somewhat disagree*   *somewhat agree*   *agree*   *strongly agree*

**It is entirely natural for a mother to sometimes regret having a baby**

*strongly disagree*   *disagree*   *somewhat disagree*   *somewhat agree*   *agree*   *strongly agree*

**A woman's life can really only be fulfilled if she has a baby**

*strongly disagree*   *disagree*   *somewhat disagree*   *somewhat agree*   *agree*   *strongly agree*

**Being a mother is a major commitment like no other**

*strongly disagree*   *disagree*   *somewhat disagree*   *somewhat agree*   *agree*   *strongly agree*

**Holding your newborn baby for the first time is a precious moment for women**

*strongly disagree*   *disagree*   *somewhat disagree*   *somewhat agree*   *agree*   *strongly agree*

**When you are pregnant even complete strangers smile at you and ask you questions**

*strongly disagree*   *disagree*   *somewhat disagree*   *somewhat agree*   *agree*   *strongly agree*

**Feeling your baby kick for the first time during pregnancy is a good feeling because it means the baby is getting bigger and stronger inside you**

*strongly disagree*   *disagree*   *somewhat disagree*   *somewhat agree*   *agree*   *strongly agree*

**A mother's instinct comes with the birth of your baby**

*strongly disagree*   *disagree*   *somewhat disagree*   *somewhat agree*   *agree*   *strongly agree*

**Having a baby changes a girl into a woman**

*strongly disagree*   *disagree*   *somewhat disagree*   *somewhat agree*   *agree*   *strongly agree*

**During pregnancy it is common to feel a little emotionally sensitive**

*strongly disagree*   *disagree*   *somewhat disagree*   *somewhat agree*   *agree*   *strongly agree*

**One of the best feelings with a newborn is knowing that your baby is peaceful and happy**

*strongly disagree*   *disagree*   *somewhat disagree*   *somewhat agree*   *agree*   *strongly agree*

**A good woman will feel nothing but joy during pregnancy, thinking of the new life she will bring into the world**

*strongly disagree*   *disagree*   *somewhat disagree*   *somewhat agree*   *agree*   *strongly agree*

**Giving birth is one of the most natural things in the world and we should stop medicalising it**

*strongly disagree*   *disagree*   *somewhat disagree*   *somewhat agree*   *agree*   *strongly agree*

**Newborn babies require around the clock care, making it hard on some women**

*strongly disagree*   *disagree*   *somewhat disagree*   *somewhat agree*   *agree*   *strongly agree*

**Towards the end of one's pregnancy, back pain, difficulty sleeping, and feeling tired are perfectly normal but unpleasant experiences**

*strongly disagree*   *disagree*   *somewhat disagree*   *somewhat agree*   *agree*   *strongly agree*

Now I would really like to get an idea of how you experienced being mothered yourself. Please think about and then rate your mother's behaviour towards you as a child or young person.

**Please answer on the following scale** *Circle one*

*Never          Rarely          Sometimes          Often          Very Often          Always*

**MY MOTHER...**

**Supported me**

*Never          Rarely          Sometimes          Often          Very Often          Always*

**Consoled me when I was upset**

*Never          Rarely          Sometimes          Often          Very Often          Always*

**Showed she cared about me**

*Never          Rarely          Sometimes          Often          Very Often          Always*

**Showed a genuine interest in me**

*Never          Rarely          Sometimes          Often          Very Often          Always*

**Remembered things that were important to me**

*Never          Rarely          Sometimes          Often          Very Often          Always*

**Was available to talk at anytime**

*Never          Rarely          Sometimes          Often          Very Often          Always*

**Spent extra time with me just because she wanted to**

*Never          Rarely          Sometimes          Often          Very Often          Always*

**Was willing to talk about my troubles**

*Never          Rarely          Sometimes          Often          Very Often          Always*

**Valued my input**

*Never          Rarely          Sometimes          Often          Very Often          Always*

**Was emotionally available to me**

*Never          Rarely          Sometimes          Often          Very Often          Always*

**Made me feel wanted**

*Never          Rarely          Sometimes          Often          Very Often          Always*

**Praised me**

*Never          Rarely          Sometimes          Often          Very Often          Always*

**Was understanding**

*Never          Rarely          Sometimes          Often          Very Often          Always*

**Asked questions in a caring manner**

*Never          Rarely          Sometimes          Often          Very Often          Always*

**Pursued talking with me about my interest**

*Never          Rarely          Sometimes          Often          Very Often          Always*

Thoughts about modern mothering questionnaire

**OK, nearly done!** Would you now please go back to the first 20 statements on the second page, and put a short line through the answer that you think most young women of your age would have provided. In other words, thinking about your friends, or things you read in magazines, how do you think the average person would have responded to the statement? PLEASE do not alter your answer, which might be the same or completely different to what you think is the general opinion on each item. When you are done, each of the answer options:

*strongly disagree--disagree--somewhat disagree--somewhat agree--agree—strongly agree*

should have both a circle around one and a line through one. This will tell us not only what your opinion is but what you think is the typical opinion of other young women such as yourself.

THANK YOU FOR YOUR HELP!

Anita will cut here:

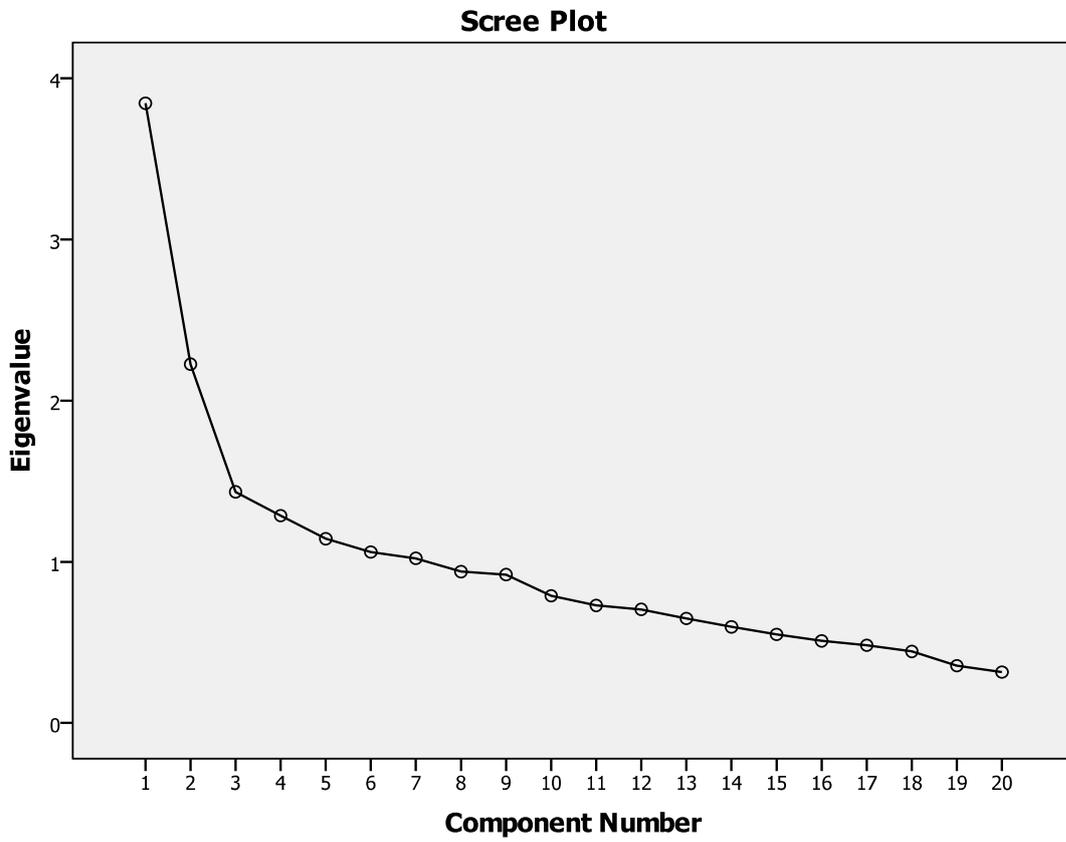
.....  
.....

I'd like to be in the draw for the iTunes voucher. My e-mail address is:

# Appendix H

## FACTOR ANALYSIS DATA

### MOTHERING MYTHS QUESTIONNAIRE (MMQ)





**Pattern Matrix<sup>a</sup>**

	Component		
	1	2	3
A good woman will feel nothing but joy during pregnancy, thinking of the new life she will bring into the world	.712		
Having a baby changes a girl into a woman	.700		
A mothers instinct comes with the birth of your baby	.677		
Mothers have an instant bond with their baby	.652		
a woman's life can only be fulfilled if she has a baby	.547		
regret having a baby	.506		
Holding your newborn baby for the first time is a precious moment for women	.471		
Giving birth in a hospital is safer	.421		
One of the best feelings with a newborn is knowing your baby is peaceful and happy not bonding quickly can have long term consequences	-.318		
Towards the end of ones pregnancy, back pain, difficulty sleeping and feeling tired are perfectly normal but unpleasant experiences		.668	
Newborn babies require around the clock care, making it hard on some women		.616	
During pregnancy it is common to feel a little emotionally sensitive		.582	
Being a mother is a major commitment like no other		.552	
Feeling your baby kick for the first time during pregnancy is a good feeling			.556
Pregnant women have a glow about them			.542
Babies cement relationships	.442		.527
When you are pregnant even complete strangers smile at you and ask you questions		.394	-.489
Giving birth is one of the most natural things in the world and we should stop medicalising it			.445
real fears the baby will not be normal		.342	.396

Extraction Method: Principal Component Analysis.

Rotation Method: Oblimin with Kaiser Normalization.

a. Rotation converged in 19 iterations.

**Structure Matrix**

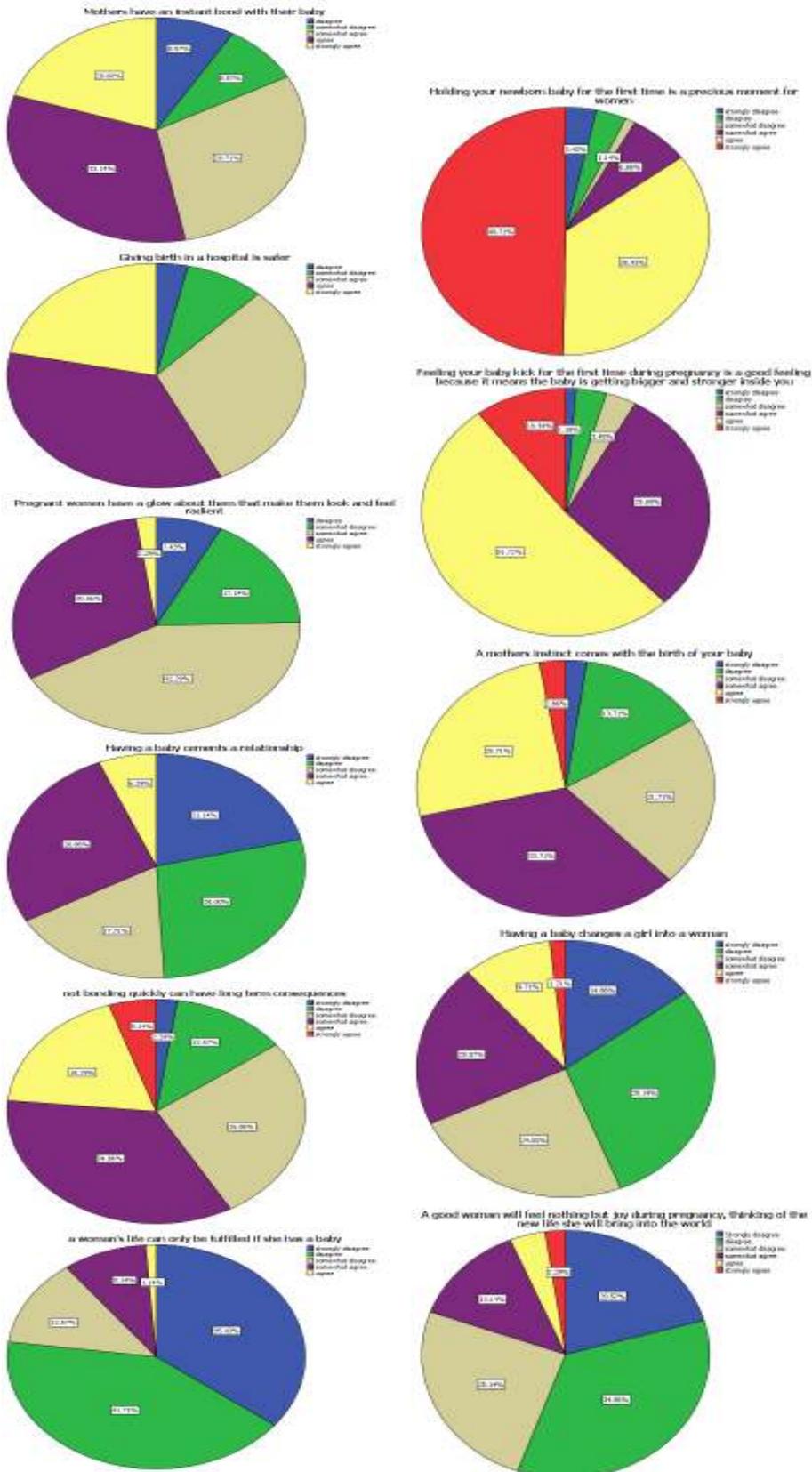
	Component		
	1	2	3
Having a baby changes a girl into a woman	.718		
A good woman will feel nothing but joy during pregnancy, thinking of the new life she will bring into the world	.695		
A mothers instinct comes with the birth of your baby	.687		
Mothers have an instant bond with their baby	.673		
a woman's life can only be fulfilled if she has a baby	.548		
Holding your newborn baby for the first time is a precious moment for women	.498	-.304	
regret having a baby	.462		
Giving birth in a hopsital is safer	.407		
One of the best feelings with a newborn is knowing your baby is peaceful and happy	-.338	.316	
not bonding quickly can have long term consequences			
Towards the end of ones pregnancy, back pain, difficulty sleeping and feeling tired are perfectly normal but unpleasant experiences		.646	
Newborn babies require around the clock care, making it hard on some women		.627	
During pregnancy it is common to feel a little emotionally sensitive		.585	
Being a mother is a major commitment like no other		.557	
Feeling your baby kick for the first time during pregnancy is a good feeling			.586
Babies cement relationships	.503		.579
Pregnant women have a glow about them			.572
When you are pregnant even complete strangers smile at you and ask you questions		.402	-.488
Giving birth is one of the most natural things in the world and we should stop medicalising it			.449
real fears the baby will not be normal		.341	.355

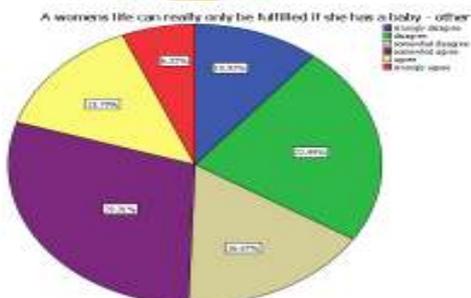
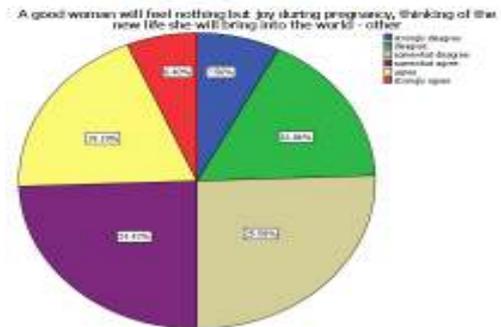
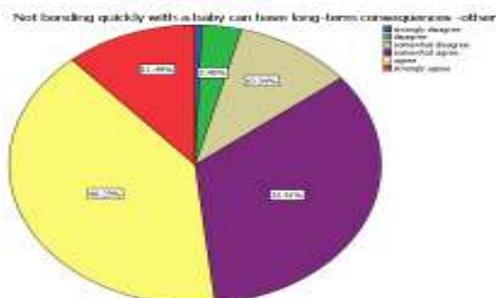
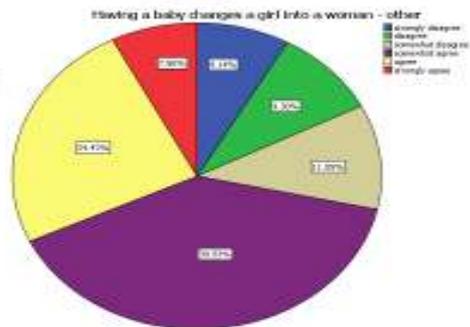
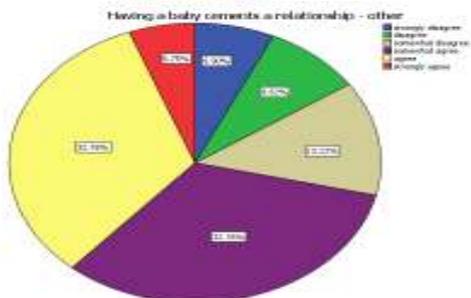
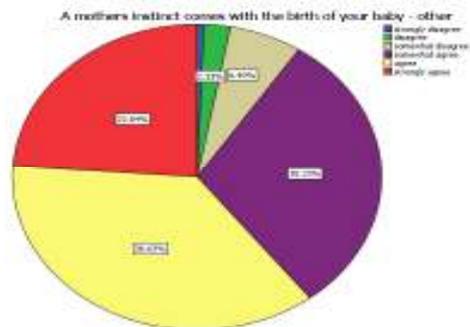
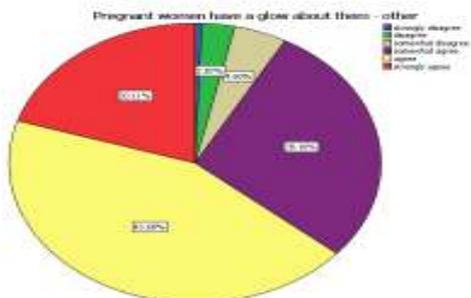
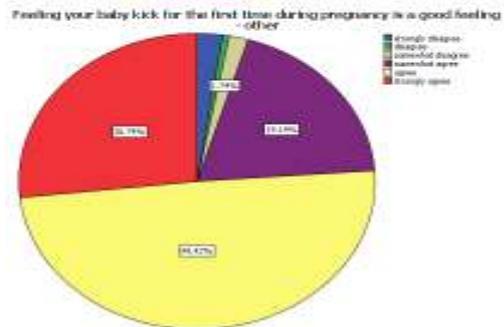
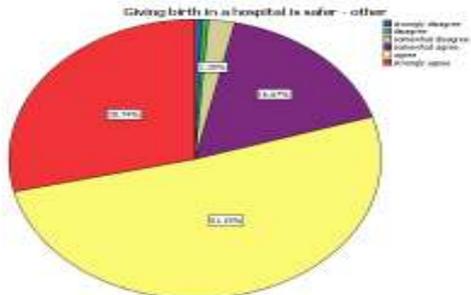
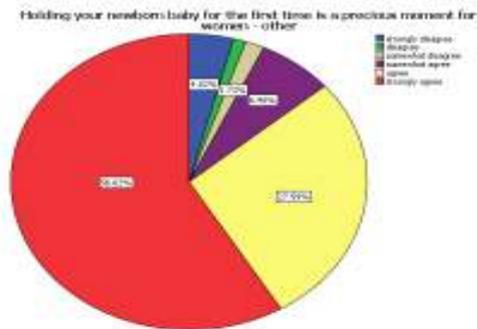
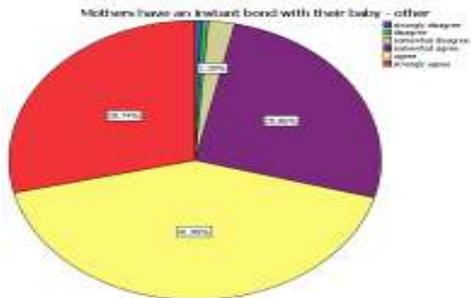
Extraction Method: Principal Component Analysis.

Rotation Method: Oblimin with Kaiser Normalization.

# Appendix I: Individual Item Endorsements for MMQ

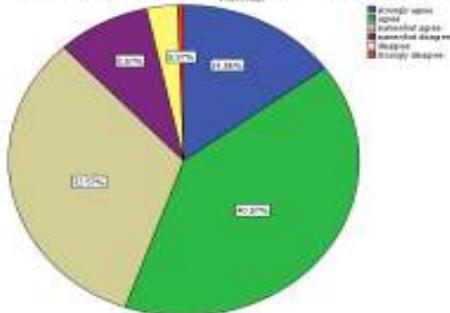
## Myth Items – Ratings of Self & Others



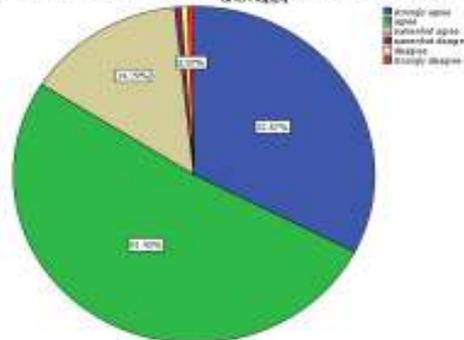


## Realistic Items – Ratings for Self

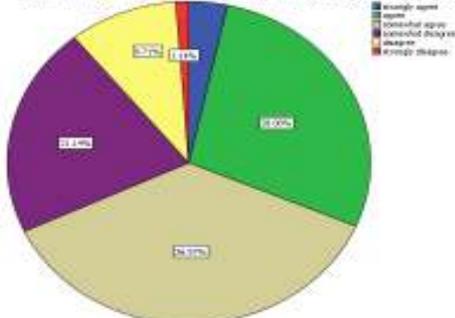
Deep down, pregnant women have real fears that the baby will not be normal



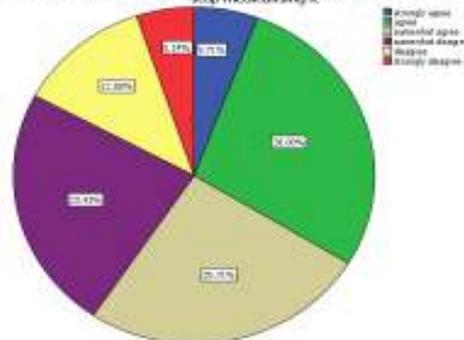
One of the best feelings with a newborn is knowing your baby is peaceful and happy



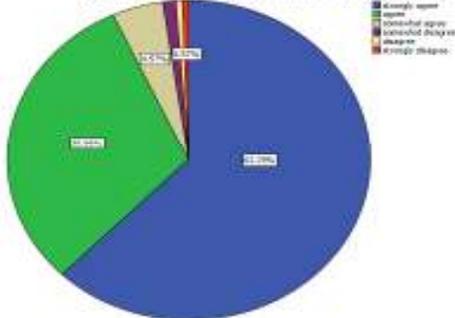
It is entirely natural for a mother to sometimes regret having a baby



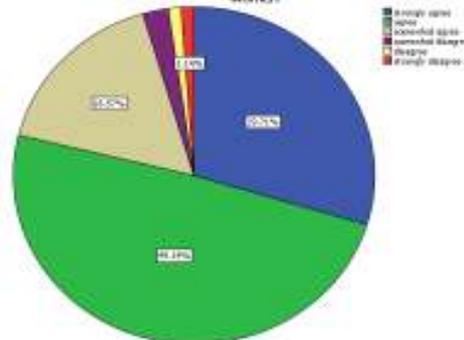
Giving birth is one of the most natural things in the world and we should stop medicalising it



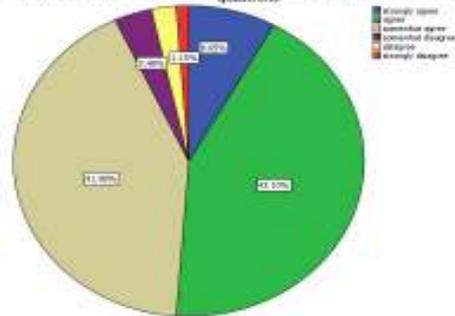
Being a mother is a major commitment like no other



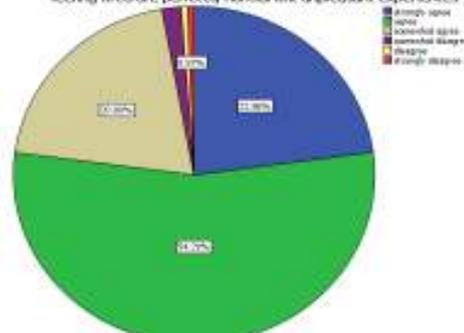
Newborn babies require around the clock care, making it hard on some women



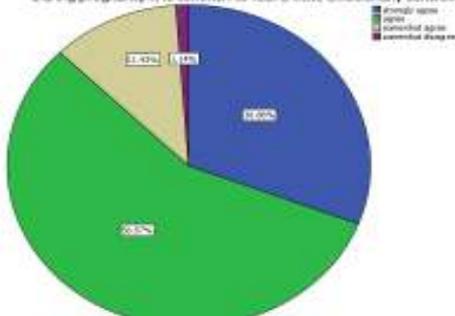
When you are pregnant even complete strangers smile at you and ask you questions



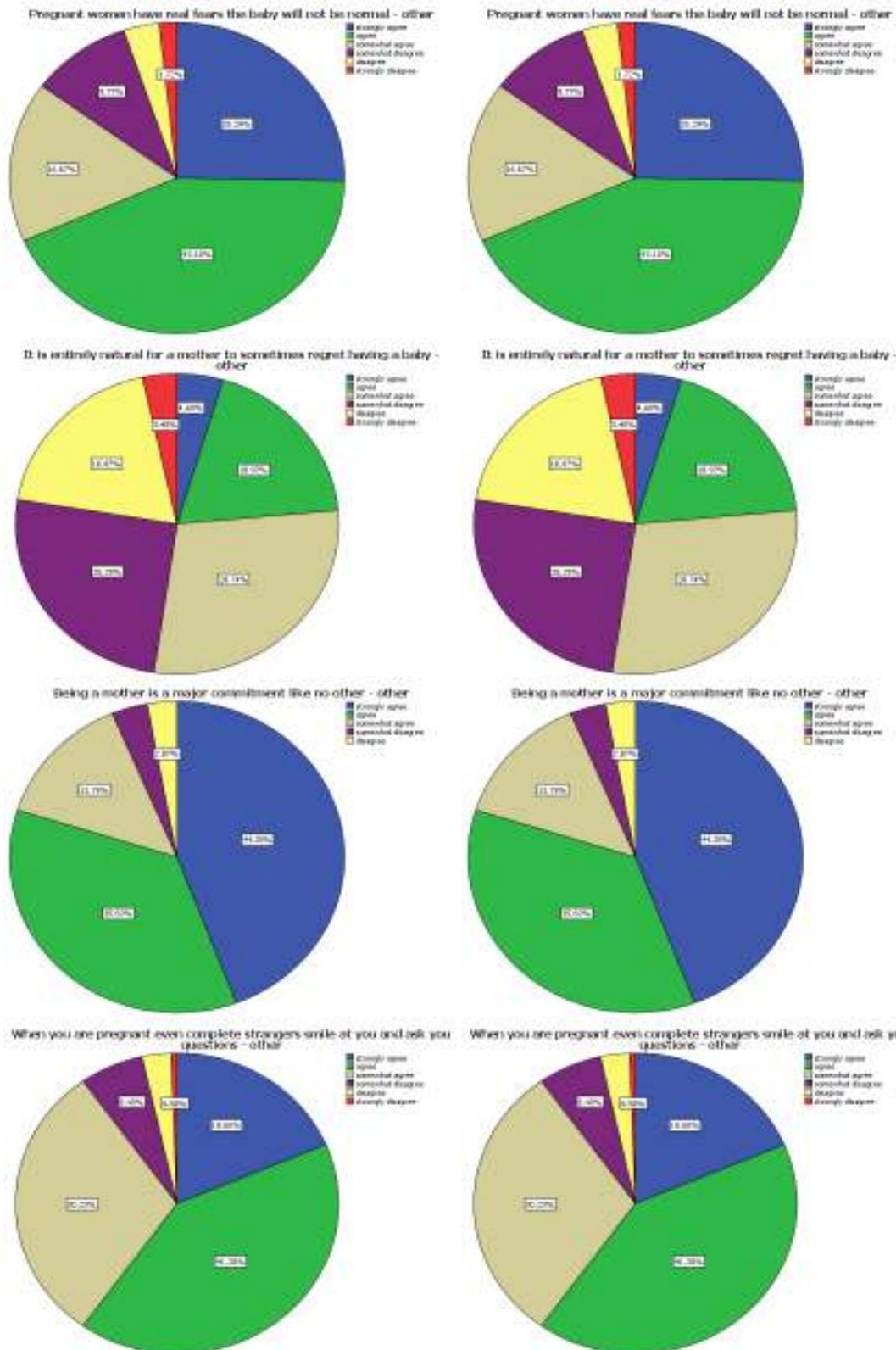
Towards the end of ones pregnancy, back pain, difficulty sleeping and feeling tired are perfectly normal but unpleasant experiences



During pregnancy it is common to feel a little emotionally sensitive



## Realistic Items – Ratings for Others



# Appendix J Study Four

## J: 1 ETHICS CONSENT

## J: 2 CONSENT FORM J: 3

## J: 3 SESSION EVALUATION SCALE

## J:1 STUDY FOUR ETHICS CONSENT



MASSEY UNIVERSITY

8 July 2011

Arita Dorrah  
4 Kilkenny Place  
Ponsonby  
PALMERSTON NORTH 4410

Dear Arita

**Re: Modern Mothering**

Thank you for your Low Risk Notification which was received on 30 June 2011.

Your project has been recorded on the Low Risk Database which is reported in the Annual Report of the Massey University Human Ethics Committees.

The low risk notification for this project is valid for a maximum of three years.

Please notify me if situations subsequently occur which cause you to reconsider your initial ethical analysis that it is safe to proceed without approval by one of the University's Human Ethics Committees.

Please note that travel undertaken by students must be approved by the supervisor and the relevant Pro Vice-Chancellor and be in accordance with the Policy and Procedures for Course-Related Student Travel Overseas. In addition, the supervisor must advise the University's Insurance Officer.

**A reminder to include the following statement on all public documents:**

*"This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named above are responsible for the ethical conduct of this research."*

*If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher(s), please contact Professor John O'Neill, Director (Research Ethics), telephone 06 250 5249, e-mail [humanethics@massey.ac.nz](mailto:humanethics@massey.ac.nz)."*

Please note that if a sponsoring organisation, funding authority or a journal in which you wish to publish requires evidence of committee approval (with an approval number), you will have to provide a full application to one of the University's Human Ethics Committees. You should also note that such an approval can only be provided prior to the commencement of the research.

Yours sincerely

John G O'Neill (Professor)  
Chair, Human Ethics Chairs' Committee and  
Director (Research Ethics)

cc: Prof Ian Evans  
School of Psychology  
Wellington

Assoc Prof Mansy Morgan, HoS  
School of Psychology  
PN320

Massey University Human Ethics Committee  
Accredited by the Health Research Council

To: Kauranga  
ki Pihikiamu

Research Ethics Office, Massey University, Private Bag 1120, Palmerston North 4400, New Zealand  
T +64 3 326 5222 +64 3 326 5275 F +64 3 326 5814  
E [humanethics@massey.ac.nz](mailto:humanethics@massey.ac.nz) [ethics@massey.ac.nz](mailto:ethics@massey.ac.nz) [gc@massey.ac.nz](mailto:gc@massey.ac.nz)  
[www.massey.ac.nz](http://www.massey.ac.nz)

**M-ODERN M-OTHORING:  
TH- MYTHS, TH- MAYH-OM,  
AND TH- MAGIC**

**PARTICIPANT CONSENT FORM**

**This consent form will be held for a period of five (5) years**

- I have read and understood the information sheet
- I have had the opportunity to use whanau support or a friend to help me ask questions and understand the study.
- I agree to participate in the programme under the conditions outlined in the information sheet.
- I understand my participation in this study is voluntary (my choice) and I may withdraw from the study at any time.

**Signature:**

**Date:**

**Full Name - Printed**



## J:3 SESSION EVALUATION SCALE

### SESSION EVALUATION SCALE

Please rate today's session by placing a mark on the line which best fits your experience

**EXPECTATIONS**

Today's session did not meet my expectations ←-----→ Today's session met my expectations

**ENJOYMENT**

I did not enjoy the topics in today's session ←-----→ I enjoyed the topics in today's session

**RELEVANCE**

The topics in today's session were not helpful ←-----→ The topics in today's session were helpful for me

**OVERALL**

Today's session was not right for me ←-----→ Today's session was just right for me