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"The Madonna Myth" - the ideology of motherhood and it's influence on women with Postnatal Depression

A thesis presented in partial fulfilment of the requirements of the degree of Master of Social Work

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Kim Jacqueline Fry

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ABSTRACT

This thesis explores whether societal myths surrounding motherhood can contribute to the development of Postnatal Depression (PND) for some women. It considers the social construction of motherhood and the transmission of powerful messages to women, both before and during motherhood. It examines what happens when the reality of motherhood does not meet the idealise images of motherhood.

The research involved face to face interviews with six women who had experienced PND. The key findings were that there are two strong myths surrounding motherhood. Mothers and non-mothers keep these alive in society. The myths are firstly, that motherhood is a natural stage for women in heterosexual relationships and that therefore the act of mothering is instinctual. The second myth is that motherhood brings with it fulfilment and happiness for the individual woman. The research found that the reality of motherhood also contains losses of identity and feelings of guilt and failure. These feelings are compounded for women with PND.

The findings give rise to recommendations including increasing education and information about PND for pregnant women, increasing support services for new mothers more open and honest discussion in society about the realities of motherhood and the need to value mothers and their contribution to society.

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CHAPTER ONE

INTRODUCTION - THE MADONNA MYTH

INTRODUCTION

The title of this introductory chapter - The Madonna Myth - is a phrase used to describe a belief in society that mothers, and motherhood, are like the Madonna images - saintly, self sacrificing, all loving, passive and obedient (Bartlett, 1994; Littlewood and McHugh, 1997). This image of motherhood is transmitted to women throughout their lives, from various sources in our society.

This chapter aims to explain the reasons I chose to research the myths surrounding motherhood and their influence on women who develop Postnatal Depression (PND). I will then briefly explain the research undertaken and the aims of the thesis. The chapter also outlines the structure of this thesis and the contents of each chapter within it.

MY PERSPECTIVE

My interest in this area came from working for six years as a social worker in a community mental health team. During this time I developed a passion for, and commitment to, working with women with PND. At the time of working in this area, I was aware of the consistent barrage of beliefs that are transmitted to women throughout their lives about motherhood. It was from there that I began to question these influences on the development of PND in some women and to develop my ideas for this research.

While my belief is that messages and expectations of motherhood could contribute to the development of PND in some women, I acknowledge that these messages also surround women who do not develop PND. This research

does not compare mothers who developed PND to those who have not developed PND in relation to my theory. However, this research does provide information on the messages and beliefs six women, who did developed PND, experienced in their lives.

AIM OF THE THESIS

Women experience images and messages about motherhood continually throughout their lives, and this thesis is an exploration of what these messages are and where they come from. These images and messages are received both overtly and covertly from family, friends, the media, and New Zealand society in general and have become myths about being a mother that are often believed without question or examination. The messages formulate expectations in women about what motherhood will be like and are often unrealistic and impossible to achieve.

When this idealised picture of motherhood - one that I call the Madonna myth - does not materialise for women they may feel guilt, failure and unhappiness. The purpose of this thesis is to explore whether the images of motherhood can contribute to the development of PND.

Mental health research has historically focused on possible psychological, biological and organic causes of PND. The possible social causes of PND have had little attention until recent years. In this thesis I have explored the social causes of PND and focused on the myths of motherhood and the idealised image of motherhood created by these myths. The aim of this thesis has been to examine three key questions in relation to my research;

1. How has New Zealand society's perception of motherhood influenced mothers who participated in this study and who developed PND?
2. Where do mothers who develop PND gain their information about motherhood?
3. In mothers who develop PND, what were their individual expectations of motherhood?

MY RESEARCH

The research undertaken in this thesis involved interviews with six women who had experienced PND after the birth of one or more of their children. The interviews explored the influences that contributed to their image of themselves as mothers and their reality of motherhood. It is important to note that the images these women described are specific to the time period in which I conducted the interviews, 1999, and the influences on New Zealand society during their lifetimes. The participants were born between the years 1953 and 1967. The images of motherhood have changed with each era and are not static (Forna, 1999; Kedgley, 1996; Thurer, 1994), and therefore the images uncovered by this study relate to both the time and place of the participants lives.

STRUCTURE OF THE THESIS

Chapter one introduces the thesis topic, including the researchers personal interest in the area, the aims of the thesis and the research undertaken. The chapter also outlines the thesis structure.

Chapter two outlines the literature and other research on PND. It begins with an exploration of women and mental illness. The chapter describes PND, including the main features of the condition and the treatments currently used to assist women with PND. The chapter then moves on to the causal explanations of PND, focusing in particular on the social causes as this is the main area of interest in this thesis. The chief social influence that is researched, the ideology of motherhood in New Zealand, is expanded on in chapter three.

Chapter three is devoted to the glorification of motherhood and the myths that sustain this. The chapter begins by investigating the belief that motherhood is natural and women are biologically destined to have children. The ideology of a 'good mother', which begins even before pregnancy and is reinforced by the media and child-care books, is examined next. The chapter then turns to two further myths of motherhood and how they are transmitted in society. An

exploration of the reality of motherhood and the guilt associated with trying to live up to the myths, are covered next in chapter three. It concludes with a consideration of the dilemmas of working mothers and the loss of identity through motherhood.

Chapter four discusses the methodology utilised in this research. This chapter outlines the theoretical basis of feminist, qualitative research. The research process is then explained, including preparation of the interview guide and ethical issues encountered in the research. The chapter details the process used to enlist participants, the undertaking of a pilot interview and subsequent alterations made to the interview guide and process. A profile of the participants and observations of the interviews, including how data was collected follows on in the chapter. The chapter then describes the transcribing process, which included ensuring confidentiality and anonymity for the participants. The chapter concludes with observations of the research experience including the analytical framework used to organise and understand the data.

Chapters five and six present the stories from the six women I interviewed. Chapter five follows the chronological order from the interview guide. The questions in the first three sections of the guide related to the participants perceptions of motherhood from childhood through to pregnancy and finally to becoming a mother. The first questions explored the influences and images they remember as they grew up. The questions then turned to the influences on the decision, or non-decision in some cases, to become pregnant. This section of the interview included their experiences when they were pregnant. The final questions explored their experiences of motherhood, including the reality of this new role compared to the expectations they had prior to motherhood.

Chapter six continues the account of the women's stories following the order of the interview guide. This chapter deals with the respondents' experiences of PND and how that affected their image of themselves as mothers. The women's struggles with the illness and the stigma attached to this label and also the relief at having a name for their feelings and receiving help are then discussed. The chapter continues with the participant's responses to the final

questions about their thoughts on New Zealand society's attitude to mothers in general and in particular to mothers with PND. This section illustrates the participants views on how mothers and mothers with PND are valued in New Zealand society today. The chapter concludes with suggestions from the participants on ideas and recommended changes that New Zealand could make at community, national and policy levels to assist women who have PND.

Chapter seven draws on the literature from chapters two and three together with the research findings in chapters five and six, and analyses the information from both sources. In doing this the chapter provides illustrations of data that both reflects the literature, and data that contrasts with the literature. This chapter revisits the possible social causes of PND and looks at the social changes that the role of motherhood brings for mothers in New Zealand society. The chapter then expands on the myths and expectations of motherhood in light of the research. The data used is from the messages and expectations the participants had of motherhood from their childhood through to becoming mothers. This information is interwoven with the literature that motherhood is a normal and expected part of a woman's life, that motherhood is instinctual and natural and that motherhood brings with it happiness and fulfilment. The chapter then investigates how the research participants coped with the stigma around having a mental illness, feelings of failure as a mother and the lack of information about possible negative experiences in motherhood, including PND, given to the participants before they had their babies. The chapter concludes by interpreting the participants experiences and thoughts on possible solutions to assist mothers with PND, with the literature regarding current policies and health resources in New Zealand for mothers, both with and without PND.

Chapter eight concludes the thesis. It summarises the key findings of the thesis, revisiting the myths of motherhood as social causes that can contribute to the development of PND in some women. The chapter then looks at recommendations drawn from the thesis which include practical recommendations in areas such as training for health professionals and distributing more realistic information on motherhood to pregnant women in antenatal classes. Other recommendations covered are for practical support for

mothers in the way of support groups, home help and child-care. The section also looks at the changes needed to challenge the myths and messages in society about motherhood. The chapter examines the limitations of the research undertaken in the thesis and makes recommendations for future research into the causes of PND. The chapter ends with a final thought on the subject area.

CONCLUSION

This chapter provides an introduction to the thesis on the myths of motherhood as a social causal factor in the development of PND in some women. I chose this area to research because of a personal interest after years of working with women with PND. The thesis aims to examine the issue of what were the messages and beliefs that influenced the participants, where did they come from, and how did they match up with the reality of motherhood.

The next chapter introduces the topic of PND by exploring the literature and research on the subject, it focuses on the possible social causes of PND and treatment options in relation to PND.

CHAPTER TWO

"IT WAS JUST LIKE A HORRIBLE DARK CLOUD CAME OVER ME" - SHARON[1]

INTRODUCTION

> "In the mornings when she wakes, her eyelids won't open straight away, glued together by dread. She rubs them to get rid of the sticky substance beneath, but there's nothing there, just remorseless light when finally she begins to face each day. The person she remembers being, before this, before pregnancy, before Nathan, has gone. The waviness in her hair disappears, the small curling fronds around her face. The weeping returns" (Kidman, 1996, p 102).

The above quote illustrates the emotional intensity of the experience of Post Natal Depression (PND). This chapter is devoted to an examination of PND. Before explaining PND it is important to look at the relationship women have had with psychiatry and mental health. There is a general perception that women have, for many years, been defined in terms of their bodies and more specifically, their reproductive system. The chapter then explains what PND is and the other post partum distresses that women can experience. The debate about whether PND is an abnormal reaction to childbirth and motherhood is discussed. Next the theories of possible causes and treatment of PND are covered. Throughout the chapter, other research[2] that has been conducted in the area of PND is referred to.

[1] Sharon is one of the research participants in this thesis. See chapters five and six.

[2] The studies excluded are those that examined the impact of PND on parent child relationships, research on fathers and male partners and research done prior to 1990. I chose this date to keep my research current.

WOMEN AND MENTAL HEALTH

The issues surrounding the way that women are defined in the area of mental health are not new and have been around for many centuries. Jane Ussher (1991) discusses women's past categorisation from witches to penis enviers to neurotic housewives. New Zealand mental health services followed overseas thinking, and women were hospitalised and treated because they did not conform to society's stereotypical expectations of women (Brookes, 1998).

Today women experience mental illnesses such as depression, anxiety and somatisation (illnesses related to the body) more frequently than men. They are also more highly represented in the admission rates to psychiatric hospitals in the age ranges 10 to 39 years, than men (Romans, Walsh and Baxter, 1997). This high representation may be because the period from age 10 to age 39 is one of extreme physical and hormonal change for women. However, the line of thought that women's biological and hormonal changes can lead to mental health problems is dangerous, as it "... will overemphasise the reductionist approach that 'biology is destiny', that how a person feels, thinks and behaves comes to be understood solely as functions of the individual bodily systems ..." (Romans, 1998, p 8). The ages 10 to 39 are also the time for women where, by becoming aware of their biological reproductive ability, the issue of motherhood comes into their thoughts (Cameron, 1997).

This leads on to a second reason why women appear more prevalently in mental health services, and that is that they are more willing to talk about their problems and seek help (Pilgrim and Rogers, 1994). Men, in contrast, are more likely to turn to alcohol and violence as a way to deal with their problems, which may bring them into contact with the mental health services (Adams, 1997; Haines, 1987). If women become mothers they are also in frequent contact with various health services, and may be given a mental health diagnosis from these sources (Romans, 1998).

Another theory on why there is a prevalence of women in mental health is related to the definition of a mentally healthy person. The definition of a well

adjusted adult is based on traits that are aligned to male characteristics rather than female ones (Taylor, 1996). Therefore a mentally well adjusted female has to aspire to male behaviours, impossible to do, for in child-bearing "... there is no male behaviour to emulate" (Thurtle, 1995, p 421).

Women's oppression in society is also a factor in their mental health, in that misogynist practices are also evident in mental health practice and services. These practices act to contain women "... and as a part of the constrictions ... lead to madness itself because they create a culture of incarceration and oppression within which madness is the inevitable outcome for women" (Ussher, 1991, p 20). Susan Faludi (1991) discusses the pop psychology and self help wave in the 1980s whereby women were advised that they are the products of their own individual making, thus ignoring the greater social forces at play.

> "Backlash psychology turned a blind eye to all the... put-downs from mass media and Hollywood, all the verbal attacks from moral crusaders and political leaders, all the frightening reports from scholars and 'experts', and all the rage, whether in the from of firebombings of women's clinics or sexual harassment or rape" (Faludi, 1991, p 372).

To summarise the argument thus far, women have historically been defined by society's acceptance or non-acceptance of their behaviour. Women's high rates as users of mental health services have been explained as being caused by their biological or hormonal changes, their willingness to seek help, if mothers - their frequent contact with health professionals, and because the 'healthy adult person' definition is male. Society's oppression of women also labels women as mentally unwell.

To examine women's experience of PND, it is also important to look at the wider societal context. "Pregnancy, childbirth, and motherhood occur within a larger social milieu that structures the adult roles of women and men in

particular ways and defines the personal and social meanings of mothering" (Taylor, 1996 p 30). The wider societal context of pregnancy and motherhood is examined in more depth in chapter three. An experience of motherhood for some women is PND, which is part of a category of mental health problems called postnatal distress.

POSTNATAL DISTRESS

There is a consensus among writers that there are three types of distress which can occur after a woman has had a baby, the baby blues, PND and postpartum psychosis. These three conditions can be seen as representing a continuum of reactions, not "... a single entity. Rather, a full range - or spectrum - of emotional reactions and symptoms appears to be possible in the postpartum period" (Dunnewold and Sanford, 1994, pp 17 - 18).

The 'baby blues', (also known as the 'milk blues', 'maternity blues' or 'post-natal blues'), is the most common post natal reaction and affects 50% to 80% of all new mothers. It occurs approximately five days after the birth of the child and lasts usually until the tenth day. It is characterised by feelings of sadness, tearfulness and anxiety and it usually subsides by itself (Dunnewold and Sanford, 1994; Goss, 1998; Nonacs and Cohen, 1998). However the new mother and family may need reassurance that this is normal and a time limited reaction (Ugarriza, 1992). There is strong evidence that "..it is not related to any environmental, social or cultural factors " (Lee, 1997, p 95), but is a hormonal reaction (Millis and Kornblith, 1992; Goss, 1998; Lee, 1997).

At the other end of the spectrum, in terms of severity and occurrence, is postpartum psychosis (PPP). Also known as 'puerperal psychosis', it is a rare occurrence affecting 0.1% - 0.2% of mothers (Goss, 1998; Nonacs and Cohen, 1998; Ugarriza, 1992). It can have a rapid onset, within two to three days after the birth, but usually is evident at two weeks post partum (Millis and Kornblith, 1992; Nonacs and Cohen, 1998). The symptoms of PPP are delusions, hallucinations, manic and depressed mood swings and bizarre behaviour (Millis and Kornblith, 1992; Goss, 1998; Lee, 1997; Nonacs and Cohen, 1998;

Ugarriza, 1992). Hospitalisation and medication are needed because of the "... serious risk this disorder poses to both the mother and her baby" (Millis and Kornblith, 1992, p 194). Evidence suggests that this condition also has a biological cause. Like other psychotic illnesses, history of a previous psychotic episode is a risk factor (Lee, 1997; Nonacs and Cohen, 1998), therefore women who have a history of psychosis are advised to have regular contact with their doctors if planning another pregnancy (Goss, 1998).

The third condition that can occur in the postnatal period (and the one that is addressed in this thesis) is postnatal depression, or postpartum depression, (PND). It is a condition that 10 - 20% of all mothers experience and can occur between two weeks and a year after giving birth. PND is characterised by low mood, tearfulness, irritability, anxiety, thoughts of suicide and guilt and a lack of energy (Goss, 1998; Lee, 1997; Nonacs and Cohen, 1998; Ugarriza, 1992). Associated with these symptoms is a loss of self esteem as the new mother feels unable to cope and incompetent as a mother (Dunnewold and Sanford, 1994).

American researcher Cheryl Beck (1993) studied 12 women who attended a PND support group. The researcher co-facilitated group sessions over 18 months recording notes afterwards, and then interviewed the women individually, tape recording and later transcribing the interviews. Beck studied the symbolic interactionism which "... focuses on how persons view their circumstances, how they interact, and how these processes change" (Beck, 1993, p 43). By coding the results Beck found that loss of control is the "... basic social psychological problem in postpartum depression" (Beck, 1993, p 44). She described this as 'teetering on the edge'. Beck's research supported a psychological explanation of PND, this theory is outlined further in this chapter.

Postnatal distress comprises three conditions - the baby blues, PND and postpartum psychosis, all of which can be seen as ranging on a continuum rather than three separate conditions. All have features in common relating to the mood of the mother. While two of these - the baby blues and postpartum

psychosis - have established biological causes, the cause of PND is still unclear. The next section addresses the issue of PND in more detail.

PND - A NORMAL REACTION TO MOTHERHOOD?

The symptoms of PND described above are common in the process of adjusting to motherhood and these 'symptoms' are felt in some degree by all new mothers (Taylor, 1996), so the question is - is PND really that uncommon or abnormal? Some authors question the validity of diagnosing any postnatal distress as abnormal because of its large incidence in new mothers (Littlewood and McHugh, 1997). If up to 75% of all new mothers experience some form of postnatal distress "... should a mental upset be seen as the norm?" (Thurtle, 1995, p 416). PND could also be seen as "... as a problem of adjustment to new social and personal circumstances" (Lee, 1997, pp 95 - 96). Indeed, Murray, Cox, Chapman and Jones (1995), found that depression is a "... common and socially disabling disorder affecting mothers of young children" (Murray et al, 1995, p 599).

Other writers suggest other diagnoses in this period such as post traumatic stress disorder, postpartum anxiety reactions and postpartum thought reaction (Dunnewold and Sanford, 1994; Littlewood and McHugh, 1997). An interesting piece of research that supports the idea that PND is a normal reaction to motherhood is Paula Nicholson's (1990). Her concept is that PND, "... rather than ... being an individual illness or vulnerability, ... is more akin to a normal grief reaction" (Nicholson, 1990, p 689). Nicholson's longitudinal study consisted of three interviews conducted at one, three and six months postnatally. The sample was of 24 first, second and third time mothers, aged between 21 and 41 years of age. The interviews were semi-structured, each one lasting approximately an hour (up to ten hours per respondent). Women volunteered because they felt they might develop PND after giving birth. Her analysis developed a profile of the occurrence of depression and the women's definitions and explanations of this. She concluded that having a baby,

> "... does involve an 'event' and often stress, but it also requires a total change of role; it involves a change in body-image and loss of former psychological identity; it affects the balance of relationships and power inside and outside the home and orientation to work/career (even if the woman returns to work) and subjects frequently report they have less in common with old friends" (Nicholson, 1990, p 694).

Nicholson is overt in her statement that this study is a psychological one, not a medical/biological or social study. It is important to note however, that her findings did uncover social factors, such as loss of previous relationships, as a causal factor in PND.

PND can be seen as a normal reaction to the change in role as a woman adjusts to motherhood. It can be also seen as a grief reaction associated with the loss of a previous identity, and changes in relationships.

DETECTION

PND is still a distinct mental health diagnosis and there is evidence to suggest that many women with PND go undiagnosed and untreated (Cox, Holden and Sagovsky, 1987; Meager and Milgrom, 1996). This problem with detection and helping women is due to several reasons, and led to researchers such as Cox et al (1987) to developed a tool to assist with this issue.

Problems with detection

There are several problems in the detection of PND. Firstly, as mentioned above the symptoms are common in all mothers after childbirth (Taylor, 1996). Women who are suffering from PND can sometimes ignore the symptoms because they think it is a normal reaction and will down-play or ignore their feelings (Nonacs and Cohen, 1998; Ugarriza, 1992).

Secondly, women are influenced by the popular myth that motherhood is a positive experience (Dunnewold and Sanford, 1994). It "... remains a popular and professional assumption that becoming a mother equates with 'happiness' despite the high incidence of some kind of negative emotional reaction" (Nicholson, 1990, p 694). Depressed postpartum women may hide their "... negative feelings because our culture[3] depicts the birth of a child as a highly positive event" (Whiffen, 1992, p 490). Women experiencing any negative feelings and who are not coping with the motherhood role may feel guilt, shame and failure when the lived experience is not a positive one (Meager and Milgrom, 1996; Taylor, 1996). This point is examined in detail in the next chapter on motherhood.

The third factor in the problem of detecting and treating PND is that PND is a mental illness and in today's Western society there is a stigma attached to those who suffer from it (Goss, 1998; Littlewood and McHugh, 1997; Thurtle, 1995). Stigma comes from negative stereotypes of people with mental illnesses and leads to prejudice. Indeed some people "... with mental illness believe the effects of stigma are worse than the illness itself" (Collings and Ellis, 1997, p 63). By giving someone a name or a label for their mental health problem, their individual identity and personality can be lost (Leibrich, 1998). However, conversely in relation to postnatal distress, by calling it a mental health issue it can legitimise a woman's experience - 'there is something medical wrong with me, it's not all in my head' - and assist women to receive the help needed.

> "Labels can be useful in trying to develop an understanding of mental health problems. They also serve a purpose in helping people with problems in common to come together to form support groups. But it is important to remember that people are people, not their labels" (Haines, 1987, p 137).

[3] Whiffen is a Canadian author.

The Edinburgh Postnatal Depression Scale (EPDS)

An aid to detection is the use of a tool such as the Edinburgh Postnatal Depression Scale (EPDS) developed by Cox et al (1987). This tool is a ten item self report scale for use six to eight weeks post partum. The woman is asked to choose a response to each of the ten questions that relate closest to how she has felt in the previous week. Cox et al developed the scale in 1987 and it has been validated through numerous testing since that time (Nonacs and Cohen, 1998).

Assessment guidelines for health care professionals that include PND detection and appropriate cultural assessments are also suggested ways to assist with early detection (Millis and Kornblith, 1992; Ugarriza, 1992).

One study that tested the EPDS in New Zealand is a piece of research conducted in Auckland by Webster, Thompson, Mitchell and Werry (1994). Their aim was to see if screening for PND early in the postpartum period was useful. This study was a longitudinal one of 340 women who gave birth in a specific time period (May 1989). Both Maori and European women were interviewed. The researchers utilised Plunket nurses and public health nurses to distribute the questionnaires as these health professionals were seeing the women in the four week postpartum time period that the researchers wanted to capture. The questionnaire was comprised of the Edinburgh Postnatal Depression Scale (EPDS), questions from other scales as well as demographic questions. For validity, a semi structured clinical interview was also conducted on a random smaller sample (27) at eight to ten weeks post partum. For safety, if women scored high in the EPDS or were severely depressed in the interview they were referred, with their agreement, to the local community mental health service for assistance. Webster et al concluded that routine use of a tool such as the EPDS is useful as it would "... identify many of the women whose depression and distress is not otherwise detected by health workers" (Webster, Thompson, Mitchell and Werry, 1994, p 48).

Another New Zealand study that also found that mothers did not openly admit to their depressive symptoms was undertaken in Christchurch by McGill, Burrows, Holland, Langer and Sweet (1995). This study addressed postnatal depression by surveying 1330 women who were six to nine months post partum. Participants were recruited by the researchers visiting the maternity unit every second day for six months, hence the large sample. Questionnaires, along with a list of resources, were sent to 2000 women and 66% were returned. The researchers worked closely with the postnatal support group in the Christchurch region in developing the questionnaire. The questionnaire contained the Edinburgh Postnatal Depression Scale (EPDS) and 44 other wide ranging questions such as childhood experiences, socio-economic history and status, and experiences of pregnancy, birth and motherhood. They noted, through using a tool, that the incidence of PND is higher than previously thought.

To summarise, detecting PND is difficult for several reasons. The transition to motherhood is stressful and the question arises that if these 'symptoms' of PND are common in all new mothers, postnatal distress can be seen as a normal part of motherhood. Mothers who are not coping are fearful of asking for help because they feel they are failing at motherhood. The stigma of having a mental health label also creates barriers to women who need help, however having a name for how you are feeling can be useful. There are several tools that have been researched and proven effective in assisting with the detection of PND. The EPDS being one that it commonly used and tested. One of the main ways to assist in the detection and treatment for women with PND is to understand the possible causes of PND, and look at prevention or intervening earlier with mothers with PND.

CAUSES OF PND

There is no clear cut cause or reason for women developing PND. Many researchers have, however been studying and proposing theories. There are three main camps of thought around the causes of PND. Firstly, there are those who see the condition as biological or hormonal. Secondly are psychological

causal theories. Lastly are the social causal theories, which I will touch on briefly as chapter three covers this area in more detail.

Biological theories

The most renowned of the biological theorists is Katharina Dalton (1980) who sees women's hormonal imbalance of progesterone during pregnancy and after childbirth as the primary problem. Progesterone increases up to 50 times more than normally produced in a non-pregnant woman and production dramatically reduces during birth as it is produced from the placenta, which is delivered after the baby. Dalton also links this hormonal imbalance to her study of premenstrual syndrome (Goss, 1998; Littlewood and McHugh, 1997; Thurtle, 1995).

McGill et al's (1995) research in New Zealand supported the association of PND and hormonal levels. They concluded that risk factors such as depression before and during pregnancy, a history of premenstrual tension and low spirits and nausea in later pregnancy could assist with detection of PND. However they also include other non-hormonal risk factors to be measured after the birth such as low levels of income and education, problems with partner relationships and decreased confidence, energy and happiness (McGill et al, 1995).

This biological/ hormonal theory has been challenged and subsequent research has proved this theory invalid or inconclusive (Lee, 1997; Whiffen, 1992). If, for example, PND is purely hormonal then it follows that pregnant women's hormonal levels could be tested and treated by balancing the levels. This testing and treating of PND does not occur.

Other biological theories have focused on the chemical imbalance in the brain (Goss, 1998), hormonal imbalances in breastfeeding, complications during childbirth, previous mental illness or familial history of mental illness (Dunnewold and Sanford, 1994; Goss, 1998; Littlewood and McHugh, 1997).

Psychological theories

The second area of thought is that the condition has a psychological cause. It is not surprising that, with the enormous personal change the event causes, there is a psychological reaction to childbirth. In fact "... if you feel that your world has been turned upside down, it has" (Dunnewold and Sanford, 1994, p 66). PND can be seen as a disturbance in the woman's cognition akin to post-traumatic stress disorder (Buist, 1996, Littlewood and McHugh, 1997, Thurtle 1995).

Warner, Appleby, Whitton and Faragher (1997) developed a tool, the Maternal Attitude Questionnaire (MAQ), to measure the relationship between maternal attitudes towards motherhood and PND. The tool was designed to measure "... cognitions relating to role change, expectations of motherhood, and expectations of self as a mother in postnatal women" (Warner et al, 1997, p 351).They approached women in the postpartum period from maternity units South Manchester, England, recruiting nearly 3000 women. They used two tools with the women initially, the EPDS and Revised Clinical Schedule (CIS-R)[4].

From this they developed the MAQ which asked women to rate agreement or disagreement with a series of questions about expectations of motherhood, expectations of self and others and role conflicts. Through this research Warner et al were able to refine the MAQ tool. They concluded that the MAQ could be a useful tool to assess emotional symptoms and treatments. This study, while focused on the individual's cognition and not the sociological impacts of motherhood, provided useful tools for my study. For example, the questions designed around expectations of motherhood and expectations of self as a mother assisted me in designing the interview guide.

Another popular psychological causal idea is of unresolved childhood trauma or abuse (Dunnewold and Sanford, 1994; Littlewood and McHugh, 1997). This

[4] The CIS-R is a structured interview designed for assessing psychiatric disorders in the community. It assesses "... the severity and frequency of psychological symptoms in the week prior to interview" (Warner et al, 1997, p 352).

theory identifies the fact that a traumatic event such as childbirth can trigger off unresolved memories and also that a mother who suffered from child abuse might feel she cannot give her baby "... the love she never received from her own mother.." (Goss, 1998, p 34).

The final theory under the psychological umbrella is the personality traits of the mother. If a mother is a perfectionist or likes to be in control of her environment the theory is that she will experience a shock as she tries to cope with the unpredictable nature of caring for a baby (Dunnewold and Sanford, 1994; Goss, 1998; Littlewood and McHugh, 1997).

A negative feature of psychological causation is the tendency to "... 'blame the victim' by seeing difficulties as intrapersonal and related to the woman's vulnerability or predispositions" (DeSouza, 1997, p 3). These theories, like biological theories, tend to overlook the influence of culture, social support, women's position in patriarchal society and the traumatic life event that the transition to parenthood is (Goss, 1998; Lee, 1997; Littlewood and McHugh, 1997; Mauthner, 1993; Thurtle, 1995).

Social theories

Social theories are the third area of thinking about the causes of PND. A strong indicator that PND is not linked just to biological or psychological characteristics of the individual mother is the recent evidence that men can also experience PND (Goss, 1998; Lee, 1997).

PND has been linked to a lack of adequate social supports for mothers (Webster et al, 1994). Isolation can be related to the lack of community support for mothers. "Children are often actively excluded from the public sphere, and therefore any adult who has the care of children is actively excluded with them" (Littlewood and McHugh, 1997, p 78). The new demands of the mothering role can also be 'invisible' to others, so support is not offered (Meager and Milgrom, 1996). This isolation can also be seen as a result of the increase in nuclear families and the new mother not having extended family near by her

(Dunnewold and Sanford, 1994; Goss, 1998; Thurtle, 1995). However, the "... geographical and social isolation of the nuclear family makes the giving of practical support difficult, yet with earlier deaths and larger families one wonders how much support was ever given" (Thurtle, 1995, p 420). McPherson (2000) also disputes the idea that the distance from extended family has led to isolation for mothers. Her New Zealand thesis illustrates that it is the availability and giving of assistance that has changed.

Logsdon, McBride and Birkimer (1994) conducted a longitudinal study of social support and postpartum depression. They recruited 105 married middle class women in America through obstetricians and excluded any women with complicated pregnancies and also women with a mental health illness or history or with marital problems. These exclusions were made so the study could look specifically at the support the women prenatally perceived they would need and the support they felt they received postnatally. Logsdon et al were testing the role transition theory which states that "... it is difficult to determine the demands and support needs of a new role before one enters into it" (Logsdon et al, 1994, p 450). People rehearse new roles from past experiences, often imagining positive outcomes, and when reality does not match this idea tension and conflict can arise.

In Logsdon et al's research three questionnaires were administered one month before the birth and again six weeks after delivery. The conclusion was that "... to the extent that support is not the type or amount desired, depression may increase" (Logsdon et al, 1994, p 454). McIntosh (1993) concurs with this argument. In his Scottish study he found that, "... those women who reported that their partners had not provided them with what they considered to be an adequate amount of assistance were significantly more likely to suffer from depression" (McIntosh, 1993, p 247). Logsdon et al also found that not only is perceived and experienced support related to PND, but also perceived postpartum closeness with the partner .

Relationships change with the additional family member and some mothers find that their marriages or partnerships are affected negatively (Dunnewold and

Sanford, 1994). Couples may find that they have little or no time for themselves individually or as a couple. In fact "..the birth of a baby may constitute a crisis in the parent's relationship.." (Lee, 1997, p 100). Lee also commented that PND is due to the change in the division of household labour that occurs after a baby is born. She comments that this division is inequitable due to assumptions made by both parents that child-care and related household chores are women's domain (Lee, 1997).

Murray et al (1995) researched women with postnatal depression and compared them to mothers with depression who were not pregnant and had not given birth in the previous year - a control group - in Stoke-on-Trent, England. They administered the EPDS and a standardised psychiatric interview. Their results showed no correlation between social class and depression in either group, nor with past psychiatric history in themselves or their family and depression. They conclude that PND

> "... is more contingent on acute biopsychosocial stresses caused by the arrival of a new family member ... interruption of work outside the home and is more likely to occur if there is a difficult relationship between the woman and her mother" (Murray et al, 1995, p 599).

If a mother gives up her paid work she may feel isolated in her new role, and feel a loss of herself as an individual (Villani, 1997). There is an expectation in society that it is the woman who will give up work when she has a baby, not the man (Lee, 1997). Additionally both men and women,

> "... internalize the cultural notion that child care is women's business, and that women are, or should be, experts while the role of men is, or should be, to provide financial support to the mother so that she is able to take care of the baby" (Lee, 1997, p 100).

This 'cultural notion' that the female partner, as the natural care-giver of a new born baby, should be the partner to leave work and care for the child, also fits in with the economic reality that men, on average, earn more than women (Easting, 1992).

The status of motherhood is paid only lip service. While society applauds women who do what is acknowledged to be the hardest job in the world without any pay or job description, they are not rewarded with any status. Betsy Wearing's (1984) Australian research on the ideology of motherhood noted that, while the job of motherhood was valued by mothers themselves " ... in the wider man's world of big business, finance and world shattering decisions, ... the job holds little status" (Wearing, 1984, p 69).

Mothers who consider going back to work are faced with the issue of child-care and experience additional guilt and worry about the safety of their baby (Goss, 1998; Thurtle, 1995). In recent times there have been numerous reports on abuse and inadequate care by child-care centres and nannies, and mothers often feel they are to blame. It is a no win situation. Forna (1999) gives one extreme example in the story of Mathew Eappen, whose death was the subject of a trial of his British nanny Louise Woodward. She observed that to many people it was his mother who was on trial not Woodward because "... she chose to work ... instead of being a full-time mother, because she was married to a doctor and did not 'need' to work, because she left her child to be cared for by someone else" (Forna, 1999, p 2). Women who choose not to return to paid employment also face criticism from other people, including working mothers (Villani, 1997; Woods, 1993). This issue is explored in more detail in the next chapter.

The third social factor that influences women is the image of motherhood that is present in Western society. The media portrays mothers and motherhood as pleasurable with images of a happy smiling mother and a cute and perfect baby. The image of the ideal mother is used by marketing men to "... to sell feel-good movies, baked goods and cold remedies" (Forna, 1999, p 10). Yet this picture of perfection is not reality. When women's expectations of

motherhood do not become actualised then PND can occur (Logsdon et al, 1994). McIntosh (1993) found that with his survey of new mothers, their expectations of motherhood were "... formulated very largely on the basis of the typically romanticized portrayals of motherhood which so abound in women's magazines and the official literature for expectant mothers" (McIntosh, 1993, p 248). These media images continue to be used and remain alive and well because our culture supports this stereotype (Goss, 1998).

One piece of research that studied expectations matching reality was conducted by James McIntosh (1993). McIntosh conducted a longitudinal study in Glasgow, Scotland, of 60 women whom he had randomly selected from antenatal clinics. He undertook six semi structured interviews with each participant - once prenatally, then at two monthly intervals postnatally until the baby was about nine months old. He asked the women about their experiences of motherhood and if they felt depressed and correlated the two. His findings indicate a correlation between unrealistic expectations of motherhood and PND. He concludes that,

> "... factors involved in depression may have a strong socially mediated or interpretive component, especially with regard to the role of expectations in structuring individuals interpretations of external events and circumstances" (McIntosh, 1993, p 248).

McIntosh's research, and his theoretical premise that PND is a social construct, formed a basis for my research.

There have been some theories that suggest PND is only a Western phenomenon, and researchers have made generalisations to other cultures because people "... living in highly technical Western cultures view their world as being natural and that the world view of other cultures is only a variation of their own" (Ugarriza, 1992, p 29). Studies on other cultures are difficult due to language and interpretation differences. However some studies that have been

conducted on other cultures have indicated that mothers from different cultures do experience similar symptoms (Goss, 1998; Thurtle, 1995).

While the three theories are presented here as separate ideologies, in practice authors and researchers often combine them. Keeping a balance of all three theories is a juggling act for researchers (Romans, 1998). Sociological research on PND, while increasing, is still scarce and subsequently research into this area has drawn upon feminist authors (Thurtle, 1995). I will expand on the social causal factors in my next chapter on motherhood. These theories around the possible causes of PND correlate with the types of available treatments for PND.

TREATMENT

The different types of treatment of PND follow the relevant causal theory. For example biological theory is treated with medical, pharmaceutical intervention and psychological theorists look towards psychotherapy and cognitive treatment.

Like most mental illnesses, medication is often utilised. Even advocates of psychological theory of causation of PND support medication in some instances. They acknowledge that medication can help the woman "... to feel better faster, particularly when biochemical stresses have 'tipped the balance'" (Dunnewold and Sanford, 1994, p 191). Medications for PND come from the range of anti-depressants, anti-anxiety and anti-psychotic medications (Millis and Kornblith, 1992). When prescribing medications the doctor must be aware of whether the woman is breastfeeding and sometimes the woman may need to give this up in order to take these medications (Goss, 1998).

Counselling and cognitive therapy are treatment options that follow the psychological causation theory. Therapy can be in the form of individual, couple or group therapy. Support groups have also been found useful in helping the woman cope with PND (Goss, 1998; Littlewood and McHugh, 1997; Taylor, 1996). Support groups can also be used in conjunction with medication.

Meager and Milgrom (1996) conducted a study in Australia of support groups. They studied 20 women in a ten week group that focused on changing negative thoughts, increasing social supports and communication. The research, although small and with a high drop-out rate, did find the group approach assisted the women who stayed in the group. An interesting observation from the research was that "... keeping depressed mothers on a wait-list is contra-indicated" (Meager and Milgrom, 1996, p 858). They advocated offering women on waiting lists the opportunity to meet in a group for social and emotional support until they could participate in an intervention group. A support group could include a mother who has had PND. The power of meeting a role model, who has experienced the same mental health problem and, having survived it, is leading a productive life is also very supportive to someone who is feeling isolated and hopeless (Deegan, 1993).

Most treatments are also provided in conjunction with support and education and not on their own (Goss, 1998; Littlewood and McHugh, 1997; Millis and Kornblith, 1992; Thurtle, 1995). This multi-faceted approach to treating PND mirrors the treatment approaches for most mental health illnesses. Education on PND for the woman, her family and others before the baby is born is advocated as a means to prevent and raise awareness of the condition (Balcombe, 1996; Goss, 1998; McIntosh, 1993; Millis and Kornblith, 1992; Ugarriza, 1992). However, Brown, Lumley, Small and Astbury (1994) in their Australian study, noted that childbirth educators felt that the enormity of childbirth led to first time mothers to block out thinking about the future, which would include issues such as PND.

Education after the woman develops PND is also needed as both the woman and her family "... need reassurance that these disorders are neither the result of personal shortcomings nor the onset of chronic mental illness" (Millis and Kornblith, 1992, p 196). McGill et al advocate strongly for support for partners in treating PND because "... the greatest victim of postnatal depression is the partner relationship" (McGill et al, 1995, p 164).

One of the best forms of treatment is prevention. This can sometimes be done by assessing the possible risk factors to an individual woman in developing PND (Logsdon et al, 1994; McGill et al, 1995). Prevention, however, is difficult because even though the risk factors have been studied for a long time, "... there is little consistent evidence to suggest that any particular demographic factor places a woman at increased risk" (Nonacs and Cohen, 1998, p 35). One indicator is women who have had depression prenatally (Logsdon et al, 1994), have had PND previously or have a mental illness currently (Goss, 1998; Nonacs and Cohen, 1998).

The other form of prevention is to "... address the feminist interpretation of postnatal depression and aim to promote a more positive and realistic concept of motherhood" (Balcombe, 1996, p 33). Taylor (1996) calls the PND self-help groups in America an example of a political movement that challenges the myth that motherhood is a purely positive experience.

> "By moving the discussion of deviant motherhood ... into the public domain, women who have organized around postpartum illness have brought to light the heavy demands on modern motherhood and are calling attention to the way that maternal self-sacrifice undermines women's identities and well-being" (Taylor, 1996, p 179)

There are several treatments that are advocated to assist women's recovery from PND. These fall into the three theoretical camps as do causal theories of biological - medication, psychological - cognitive therapy, and social - support and education. Treatments for PND also cut across the three camps and are often provided conjointly not separately. The best form of treatment for PND as with all health problems is prevention and education.

CONCLUSION

Women historically have always had a tenuous relationship with mental illnesses and the psychiatric profession. PND is an example of how women are uniquely studied, diagnosed and treated due to their reproductive function in society.

PND and related post natal distresses are far more common than previously thought and, like other mental illnesses, PND is not an exact science so the 'treatments' and 'cures' vary according to the theory of the cause. However, there is growing evidence and acceptance that PND has a strong sociological component and that women's perceptions of themselves as mothers can impact on the development of PND. Feelings of guilt and failure often occur because the reality of motherhood is not like the image that has been created by the influences of our society and culture. These images of motherhood and how they influence women's expectations of motherhood, are explored further in the next chapter.

CHAPTER THREE

THE GLORIFICATION OF MOTHERHOOD

INTRODUCTION

According to Ann Oakley (1982) the myth of motherhood rests on three beliefs. These are that "... all women need to be mothers, all mothers need their children, all children need their mothers" (Oakley, 1982, p 186). The interconnection between motherhood and womanhood is socially accepted as the norm in New Zealand society (Pihama, 1998). Furthermore, the image of a good mother is perpetuated and transmitted in society through messages from family, friends, the media and myths. Women grow up with these images and messages about motherhood and these continue through to adulthood. If a women becomes a mother she may find that the myths of motherhood don't eventuate into reality, this can contribute to the development of PND. This chapter addresses the glorification of motherhood in society.

The chapter begins with a brief definition of the word myth. These beliefs and ideas are dealt with throughout the whole chapter. The next section, 'It's only natural' deals with issues of why women become mothers and the myths surrounding this. Biology and adult status are two areas that are examined in a historical context. The section concludes with a look at 'deviant' women - women who choose not to have children and lesbian women who choose to have children.

The chapter then turns to the image of a good mother. After a woman becomes pregnant there are messages from society on how she should care for the growing foetus. The ideology of an ideal family in which to raise children is also discussed. The role of experts and their theories on motherhood throughout history are briefly discussed next, and lastly two myths of motherhood are examined. These myths are maternal instinct and happiness - mother love. By examining these myths I aim to show that they have no scientific basis,

although the experts provide scientific explanations in order to legitimate these myths. These myths are still strong and persistent today.

The last section in this chapter is on the ideology of a 'Supermum'. Women were told in the 1980s that they could have it all - career and a family, however this comes at many costs, for example guilt and burnout. Other costs that mothers face are the financial and social costs regarding child-care, an issue that was raised in the previous chapter. Lastly the section looks at the loss of identity that some mothers feel when they become mothers.

The overriding theme throughout this chapter is that the motherhood ideology and the image of a 'good mother' are socially constructed and influenced by the culture, politics and economic policy of the time.

THE MEANING OF MYTHS

A myth is defined in the *Pocket Oxford Dictionary* as;

> " 1. traditional story (usually) involving supernatural or imaginary persons and embodying popular ideas on natural or social phenomena etc... 3. widely held but false notion. 4. fictitious person or idea..." (Thompson, 1992).

Myths have been created around motherhood and they sustain the social order in society by linking myths to ideology. "What is 'normal' is ideological; what is 'natural' is often mythical. Myth is used to justify ideology" (Cameron, 1997, p 94). Myths become part of popular thought in society by being transmitted through messages and ideas in society.

'IT'S ONLY NATURAL'

Biology is destiny

A popular television programme *Ally McBeal* had an award winning episode in which the main character - Ally McBeal, a 20 something lawyer - dreamed nightly of a dancing baby, and felt an overwhelming urge to have a baby due to her 'biological clock'. This image of a biological clock ticking away increasingly louder in women as they age, is one repeated regularly on TV programmes in our Western culture. The idea that women have a biological instinct to have children that starts for all women around the mid twenties is alive and well in today's society.

Women are aware from a very young age that their biological make-up relates to their potential for reproduction.

> "She knows from the very roots of her feminine core gender-identity that she has a reproductive organ, which in the event of sexual intercourse might produce a pregnancy that will change her body drastically, albeit temporarily, and will also deeply affect her whole life" (Welldon, 1992, p 20).

This view that motherhood is linked to women's biological make up, and therefore is inevitable, is ingrained in history. The view strengthened in the late nineteenth century when, not by coincidence, women were beginning to question and challenge their role in society. Medical science supported the biological theory of motherhood and 'proved' that women were destined to be mothers and in fact "... women who gave their energies to anything else were more prone to illness and more likely to produce defective offspring" (Eyer, 1995, p 42).

This view that women are created for motherhood alone extended to beliefs that women should only strive for passive, domestic tasks in their lives. This

included rejecting any intellectual and artistic endeavours, and in the late 1800s and early 1900s doctors would prescribe ceasing these activities for all women's ailments. Education was believed to cause a woman's uterus to atrophy (Eyer, 1995; Villani, 1997). Of course this view only applied to white, privileged women of the day and women of other ethnic and class groups were not entitled be treated like a 'lady', therefore these rules did not apply to them (Forna, 1999).

In the 1920s, Freud, the founder of psychoanalysis, stated that all girls have 'penis envy', when, as they become aware that they do not have a penis like their father and male siblings, they realise they are biologically inferior to males (Freud, 1964). The theory goes on to state that to resolve penis envy girls must, as they develop, become aware that motherhood is their destiny. Traditional psychoanalysis saw the desire to be a mother as an important developmental stage for women. "The traditional psychoanalytic approach sees motherhood as based on innate instinctual drives and hence as a normal characteristic of women's identity" (Woollett and Phoenix, 1991, p 40).

Psychoanalytic theory stated that there was a 'natural urge' to want to become a mother and that "... 'normal' women desire a child, and that those who reject motherhood are rejecting femininity" (Glenn, 1994, p 9). Deviance, in the form of psychological, personality and/or sexual 'problems', would occur as a result of this rejection. Some of Freud's ideas have now been discounted, however they still have an influence on current thought in this area.

This theory that biology is destiny was challenged during the 60s and 70s in the feminist movement. Betty Friedan (1997) in her book *The Feminine Mystique,* and author Kate Millett (1970) both argued that social and cultural structures are powerful in society and have created the idea that motherhood is destiny and equated it with femininity (Eyer, 1995; Forna, 1999; Villani, 1997). These beliefs and structures oppressed women in society. "Friedan rallied against a notion that, to her, was painfully obvious - that the prevailing beliefs about what was proper conduct for a woman barred women from the freedoms of human existence and a voice in human destiny" (Villani, 1997, p 26).

Likewise, Bartlett (1994) notes that "... if the maternal instinct does exist in humans it is fragile and easily overladen by cultural imperatives" (Bartlett, 1994, p 56). These beliefs that women are designed - biologically, and therefore naturally - to have children also extends to their ability to raise children and I will continue this discussion in my next section on the 'ideal mother'.

Motherhood equals Adulthood

The step taken when a woman becomes a mother also leads to recognition that the woman is now an adult (Cameron, 1997; Lee, 1997; Letherby, 1994). Motherhood also symbolises the development of a woman into adulthood, as a rite of passage. Girls are trained from early on that their life will follow a certain pattern with motherhood being an important part of their lives (Woollett, 1991). They will often see motherhood as a definite component in their future plans.

This view is supported by psychoanalysis which "... views parenthood as the natural culmination of 'normal' development to adulthood ..." (Bartlett, 1994, p 17). The desire to become a mother as 'mandatory' comes from the idea that life follows a pattern of marriage, buying a home and having a family. It is expected that this will occur without question (Forna, 1999; Reiger, 1991; Woollett, 1991). Interestingly, this expectation of marriage is not a reality in New Zealand, with marriage rates declining over the last thirty years and, in 1995 "... the general marriage rate (per 1000 not married aged 16 + years) was 39% of it's 1971 level" (Pool, Jackson and Dickson, 1998, p 108).

Cameron (1997) in her 1990 New Zealand study on why people have children noted that people who don't have children are seen as "... less 'mature'; in not assuming responsibility for the care and well-being of another, they had not demonstrated that they had properly 'grown up' and could 'be responsible'" (Cameron, 1997, p 9).

Marshall (1991) studied child-care manuals in the United Kingdom and found a major theme in them was that mothering was both satisfying and important. She

called it the 'Ultimate Fulfilment account' which serves two functions; "... that not only is childbearing the best way to become properly human, but that having a child for a man is emotionally fulfilling for a woman" (Marshall, 1991, p 68). New Zealand writer Sue Kedgley (1996) also recalls the idea, when she grew up in the sixties, that "... the only way a woman could be truly fulfilled was as a mother" (Kedgley, 1996, p v).

Sometimes the definition of a relationship for a couple depends on having children - without children the family is not seen to be complete, and the relationship is threatened (Simons, 1990; Villani, 1997). The notions of altruism and self sacrifice by becoming a mother are also common themes that sometimes takes on a spiritual aspect. "Motherhood as nirvana is perhaps our most powerful societal myth, one that serves to funnel women's aspirations into a solitary field that promises great rewards for selflessness and virtue" (Villani, 1997, p 35).

To have given birth to and raised a child is seen in society as entry into adulthood because it grants women a clear identity as producers of the next generation (Woollett, 1991). New Zealand society also sees child-rearing as an integral part of a woman's female identity. "The perceived natural role for women of child-rearing was therefore claimed to be important for the development of the female identity" (Easting, 1992, p 123). Motherhood also gives women a common identity with each other (Woollett, 1991). Motherhood is also seen as more important than any other area of a woman's life, even if she succeeds in other ways. Female Hollywood celebrities are frequently quoted in magazines and on TV expressing their opinion that giving birth and raising their children is the most rewarding area of their life. It's almost as if motherhood is a calling or a vocation that an adult woman cannot deny.

This entry into adulthood is ironic because some women "... often feel less than adult and report a deterioration of their sense of self-worth and personality and a loss of financial independence as part of their experience of motherhood" (Letherby, 1994, p 526). The issue of loss of self worth and personality will be expanded on later in this chapter.

On examining these two myths - that biology is destiny and motherhood equals adulthood - it is evident that they only apply to women who are in stable, married, heterosexual lifestyles. Women who do not fit this image are labelled as deviant (DiLapi, 1989; Letherby, 1994).

Deviance

One group of women who are 'deviant' in their behaviour are women who are childless by choice. The fact that there are women who make a conscious decision not to have children challenges the myth that there is a biological urge to reproduce. Many women who choose this option are told they are unnatural by other people because they are suppressing this natural urge (Bartlett, 1994; Simons, 1990). Yet, if the biological instinct does exist then these women would not be able to fight it or indeed would suffer extreme psychological damage. This does not occur. "If there is a maternal instinct, why should a woman want to stop at 1.8 children... Should she not be driven by her biology to conceive again and again?" (Bartlett, 1994, p 53). Whether it is reality or not, the myth of maternal instinct is universal and powerful (Cameron, 1997).

For women who choose not to have children, the decision is often questioned by society and becomes a public rather than private matter (Cameron, 1997; Letherby, 1994). However for these women,

> "children or being a parent just has not entered into their evaluation or expectation of adult role *for themselves.* How, then, do they craft their own identities when the majority of adults in their greater society - parents - craft them so negatively?" (Cameron, 1997, pp 191 - 192).

One such example of how powerful the issue of chosen childlessness is, occurred during the last elections here in New Zealand in 1999. The leader of the Labour party, Helen Clark, found her childless status was frequently compared to her opposition Jenny Shipley - a mother - by the National party's

campaign. The message was that as a mother, Jenny Shipley would understand the needs of New Zealanders better, because mothers are attuned to listening to, and meeting, other people's needs. Helen Clark often had to defend her childlessness and prove she could understand our needs as a nation.

The second group of women who are considered deviants by challenging the myths of wanting to become a mother, are lesbian mothers. This growing group of women challenge patriarchal society and it's concept of family (DiLapi, 1989). Previously the two concepts - mother and lesbian - were thought to be diametrically opposed.

> "Demanding the right to be a mother suggests a repudiation of gender conventions that define 'mother' and 'lesbian' as inherently incompatible identities, the former natural and intrinsic to women, organized around altruism, the latter unnatural, and organized around self-indulgence" (Lewin, 1994, p 350).

However, this group of women are proving that it is possible to be both mother and lesbian and indeed the fact that they are lesbian does not exclude them fulfilling their 'maternal urges'. (Hornstein, 1985, p 373). In fact some lesbian women felt they not only had had a biological instinct and drive to achieve motherhood, but they also believed that it equated to adult status (Lewin, 1994). However the status of lesbians, and lesbian mothers, in society is still as 'abnormal' women. The dominant belief is that being "... attractive to a man has been seen, along with her desire to be a mother, as a defining element of a woman's female identity" (Simons, 1990, p 168). The maternal instinct and biological clock myths are acceptable in heterosexual women only and that "... many people only consider women's desire for children to be 'natural' if accompanied by the desire for heterosexual sex" (Letherby, 1994, p 526).

The desire to be a mother is shrouded in mythology. I have exposed the contradictions on two myths here, namely that women are biologically destined

to be mothers and that motherhood is a woman's rite of passage into adulthood. Myths serve an important purpose in society. "Pressure to have children is legitimated, implicitly or explicitly, by a mythology of childbearing and childrearing that is pervasive and probably has a long history" (Cameron, 1997, p 112). The next section of this chapter examines the beliefs and myths about childbearing and child-rearing.

'A GOOD MOTHER ALWAYS ...'

Preparation

After a woman has decided to become a mother, or becomes pregnant, she receives messages, both explicit and implicit, about how to best prepare for pregnancy. Women have expectations placed on them to "... ensure that they are healthy and 'ready' for motherhood, (and) that their children are planned rather than conceived accidentally" (Woollett and Phoenix, 1991, p 43). Magazines, books and television inform women about the right way to prepare their bodies for conception and pregnancy. Unfortunately, there is so much information that useful facts can be mislaid in the deluge, leaving the woman confused (Forna, 1999). When a woman becomes pregnant she is treated as special in Western society, but with the congratulations comes the awareness that her body has become public property for all to comment on (Phoenix and Woollett, 1991).

Technology now allows people to see the foetus and identify its human characteristics before birth. This phenomena is the emergence of the foetus as an entity in itself and the pregnant woman's role is to provide a safe haven for this new life. The "... mother's own body, and along with it, her subjectivity, are sidelined to make the fetus central. While the mother's body still bears the burdens it did before, these burdens are not the central focus" (Kaplan, 1994, p 134).

This rise of 'foetal rights' has led to pregnant women being placed under surveillance and at times punished if they harm the foetus (Forna, 1999;

Kaplan, 1994; Thurer, 1997). Everything the woman eats, drinks, breaths and feels is to be monitored and altered if the experts deem it will damage the foetus, however this pressure to put pregnant women under the microscope deflects from the larger issues.

> "The seas are awash with toxic waste, chemicals leach into the rivers, hazardous dump sites border playgrounds and while the rest of us continue to consume obscene quantities, we ensure pregnant women only eat what is nutritious and don't 'poison' their bodies with alcohol or additives" (Forna, 1999, p 88).

The women who are targeted most by the 'pregnancy police' are often the poorest (Kaplan, 1994; Phoenix and Woollett, 1991). Due to their low socio-economic status they often have the inability to have healthy diets and low stress lifestyles. Further to this, politicians in America also proclaim that some women in this group become pregnant simply to receive extra benefits (Eyer, 1996).

Women who become pregnant receive continuous messages about the right way to prepare and take care of themselves in the interest of the foetus. Pregnancy information is often conflicting but always gives a positive outlook and the impending joys that motherhood will bring. Antenatal classes will often focus on the positives and ignore, or gloss over, the negatives. For example women who have had postnatal depression (PND) "... point out that more mothers suffer from PND than will have twins, a Caesarean birth, or many other complications that are discussed in great detail during class. Yet the time given (in antenatal classes) to discussing PND is often minimal" (Goss, 1998, p 43).

Society's idea of the correct way to behave during pregnancy also includes ideas on the ideal family structure. Current thinking defines the ideal age for a woman to conceive as 20 to 40 years of age and as being married "... preferably before conception and definitely before the birth" (Littlewood and McHugh, 1997, p 79). In Pakeha New Zealand culture however, this link

between marriage and childbirth is more traditional than current. Cohabitation has become, over the last thirty years, an excepted substitute for marriage (Pool et al, 1998).

The ideal family

The concept of the normal or ideal family structure is socially constructed as is the ideal pregnancy. DiLapi (1989) developed a 'motherhood hierarchy' which examined the most appropriate mother as deemed by American society and her access to resources. The criteria for placement of the hierarchy are - sexual orientation, family form, fertility status, method of achieving pregnancy/parenthood, and decisions to parent (DiLapi, 1989)[5]. There are three categories in the hierarchy

1. The Appropriate mother who is heterosexual, of legal age, married, fertile, pregnant by intercourse with her husband, able-bodied, normal intellect, middle to upper class, financially supported by her husband.
2. The Marginal mother who is heterosexual but unmarried. It also includes birth mothers, surrogate mothers, disabled mother, foster mothers, teen mothers, single mothers and working mothers and, interestingly, women who are childless. Women in this category are those who "... fail to fulfil their social roles in an appropriate and timely way within the traditional family" (DiLapi, 1989, p 111).
3. The Inappropriate mother is the lesbian mother. Women are placed in this category because of homophobic myths such as - assumption that the child will suffer due to a lack of a father (male) role model, fear that the child will grow up gay, the assumption that the mother is single and therefore working and will not be able to give adequate time to the child, the myth that lesbian relationships are unstable and transient and finally the myth that lesbians are perverse and molest children. These myths reflect "... the homophobia and heterosexism of our culture and these falsehoods are easily dispelled after a review of the literature"(DiLapi, 1989, p 117).

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[5] DiLapi did not include the mothers race/ethnicity in the hierarchy.

Phoenix and Woollett (1991) also note that "... politicians and others from the New Right[6] explicitly stated that children should be reared in 'real' families (heterosexual couples) rather than 'pretended' families (gay or lesbian couples)" (Phoenix and Woollett, 1992, p 14 - 15). New Zealand society also stresses heterosexual unions as the only way to construct families (Pihama, 1998).

It would be interesting to look at DiLapi's hierarchy in today's context, ten years on from when it was developed, to see if there are any changes to the categories. Some may have changed but I believe the 'appropriate mother' category has not changed, and still exerts pressure on women today.

The 'normal family' is also politically construed so that at times of social and economic unrest the breakdown of the 'family' is commonly blamed by politicians for the society's problems.

> "It is arguably when 'the family' changes in ways that conflict with a state's political aims that concerns about motherhood and 'the family' are expressed because state practices contain prevalent cultural constructions about women" (Phoenix and Woollett, 1991, p 16).

A New Zealand example of a debate about normal and ideal family structure in our current ideology is the debate on matrimonial property rights. Right wing political groups and some traditional religious organisations believe firmly that property rights, such as those allowed to married couples, should remain exclusively to that group and not allow defacto or gay/lesbian couples the same rights. The myths about lesbian 'families' - outlined earlier in this section can also be myths to these non traditional groups, for example that de facto relationships are unstable.

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[6] Phoenix and Woollett (1991) use this term in relation to the implementation of clause 28 of the 1988 Local Government Act in the United Kingdom. This clause made it illegal to promote

Motherhood is regulated by the current ideologies in society about the family. However, 'the family' is changing and new structures are appearing alongside the nuclear family (DiLapi, 1989; Eyer, 1996). John Bradley (1995) notes that Maori whanau structures have changed historically, particularly with the shift of Maori to urban areas which lessened their ties with their marae in rural settings. However, although large numbers of Maori still reside in urban areas more Maori are self identifying with their Iwi and there is a "... re-emergence of Tribalism" (Bradley, 1995, p 28). Whatever the changes in family structures, motherhood will always have the central role in the family and mothers will be in the firing line for the blame for society's ills (Phillips, 1988). "The current lament over our lost family values is really about the loss of values that were once given to mothers alone to guard ... women have long been designated guardians of these ideals" (Eyer, 1996, p 33). This theme is expanded on later in this chapter.

The way that society communicates the image of the right family structure is through the media, such as advertising (Bartlett, 1994; Goss, 1998). Information on the 'right way to mother' floods every popular medium today from magazines, books, television and movies to the internet. These popular images of the 'right' way to conceive, experience pregnancy and raise a child come from, or are influenced by, the 'experts' in motherhood and child-care (Eyer, 1996; Marshall, 1991).

The experts

The ideology of motherhood is not static (Reiger, 1991), it has changed over time according to the forces - political, economic, religious, social - that were dominant at the time (Kedgley, 1996). Similarly the 'right' way to mother has also changed over time (Hays, 1996; Marshall, 1991). "An historical perspective makes us redefine our most basic assumptions about human nature and motherhood. What seems 'natural' in one period appears unnatural in another"

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homosexuality. The New Right is the section of parliament that supported this and applied it to the concept of the 'real' families.

(Forna, 1999, p 43 - 44). Motherhood has gone through enormous changes in the last century.

The rise of scientific thought in the early twentieth century led to advances in medicine. This scientific era also focused on women's roles in society and led to the medicalization of motherhood (Eyer, 1996; Reiger, 1991). "If romance had characterised motherhood in the previous century, then the twentieth century gave rise to the scientific mother" (Forna, 1999, p 49). In 1920s New Zealand, high maternal mortality rates led the Health Department to develop regulations that enforced childbirth in hospitals, rather than at home. The regulations "... transformed birth from a natural process into a pathological, surgical procedure that was 'done' to women" (Kedgley, 1996, p 80).

One of the experts predominant during this time was Sir Fredrick Truby King, the founding father of New Zealand's Plunket organisation. King's theories about child-rearing came from his time as superintendent at Seacliff Mental Hospital where he conducted research about feeding on the farm animals. He became a great believer and advocate of breastfeeding, even theorising that mental disorders were a result of not being breastfed (Parry, 1982). King admonished a woman who chose not to breast feed and stated that she

> "... is densely ignorant of the duties of maternity, and does not realise the injustice she is doing to herself and her offspring. She has no knowledge of or respect for the laws of Nature and imagines that advertising charlatans have superseded Providence in the feeding of babies" (Parry, 1982, p 33).

King advocated for four hourly feeding schedules (even waking the baby up to feed), leaving babies to cry and discouraged physical displays of emotion by the mother to her child. He thought that mothers were not instinctual and needed to be trained. Furthermore, "... he regarded mothers as inadequate, ignorant and lacking in discipline. A mother was all that stood between him (King) and the creation of the perfect child" (Forna, 1999, p 55).

King's ideas were followed in earnest here in New Zealand since the turn of the century, and the Plunket society, although it has changed a great deal from King's visions, still exists. Some of his thoughts were challenged by the next wave of experts.

John Bowlby's theory that babies needed to bond with their biological mothers, was developed in the 1940s and 1950s. If children didn't bond they were maternally deprived and this would show up detrimentally later in life (Bowlby, 1982). Other researchers picked up this theory and quantified it with studies of attachment in other species. A result of this research was that mothers in the post-war period were encouraged, through the guise of this scientific evidence, to leave work and return to the home environment (Eyer, 1996; Forna, 1999; Kedgley, 1996). During World War Two, women in New Zealand were

> "... pressed into production in factories and on farms. They very successfully and cheerfully did everything that men did. Their 'thanks' was to be told after the war that they could and should do only one thing – full-time housework and mothering" (Dann, 1985, p 2).

His theory however can be critiqued, as the research was flawed and ignored other significant factors at the time. "The children whose case histories make up the bulk of his work were deprived of everything, including ordinary human contact and any kind of affection" (Forna, 1999, p 62).

Bowlby's theory of attachment has been altered over time to redress his original claim that only the biological mother could provide the appropriate attachment (Bowlby, 1982). "Attachment is a protective mechanism which enables young children to explore their environment knowing that they can return to the safety of significant adults" (Aldgate, 1991, p 13).

Another expert that still has influence today is Benjamin Spock, whose books remain number one best sellers in America (Forna, 1999; Hays, 1996). Spock

continued along similar lines to Bowlby regarding the importance of bonding between mother and child. However, his theory on child-rearing was that the child will decide when it is hungry, ready for toilet training, ready to sleep and so forth (Hays, 1996). This theory meant the mother had to be "... on hand twenty-four hours a day while baby did things in his own time" (Forna, 1999, p 69). Spock also supported the popular thinking of the day that a mother's role was at home with the child, not in the workforce (Forna, 1999).

Spock advocated that motherhood was instinctual but still insisted that a mother consult her medical adviser and his book at all times (Eyer, 1996; Hays, 1996). This contradiction is evident in all the three theorists outlined above and is still evident in the myths and child-care books of today.

Mothers do, however, filter the information they gather from reading child-care books (Hays, 1996). Mothers with more than one child are also more discerning about what they read about child-care. "Generally, women are more relaxed with second and subsequent children, as they gain confidence, and then take a more sceptical attitude to the professionals' suggestions" (Reiger, 1991, p 51).

In summary, the (all male) experts present a no-win situation for mothers. On the one hand they say that motherhood is instinctual and natural, but on the other that a mother needs expert advice to do the 'job' well. Women are also given the message from the child-care experts that they need to be at the beck and call of their children at all times.

The two Madonna myths

I will now turn to two of the popular myths that abound in today's society. These myths have their origins with the experts I have discussed earlier and are perpetuated by child-care manuals, magazines and television. They outline what is 'normal' when a woman becomes a mother.

1. Maternal Instinct

Maternal instinct supports the myth that motherhood is a natural state for women. It is linked to the theory of a biological drive in women to become a mother that was outlined in the first section of this chapter. Our biological cousins in the animal world are the basis of this theory - what's natural for animals must be natural for us! "The mothering experience is a bestial and visceral experience, bringing us close to our animal nature... It is about being sensitive and attentive to subtleties and entails the kind of strength that comes from succumbing to the natural process of life" (Leonhardt-Lupa, 1995, p 47).

Mothers, according to this view, will instinctively understand and know how to mother. For example, a recent article in Woman's Day magazine wrote about 'motherease'. This is the 'sing-song rise and fall' in a mother's voice as she talks to her baby. Mothers are reassured that this is natural and they don't need to be taught it. "The amazing thing is, you don't have to try it - Mother Nature has primed you to speak to your baby in exactly the way it needs" ("Experts call it 'motherease'", 2000, p 60).

This theory is contradicted by those who write the child-care manuals and articles because if mothering is innate and instinctual then mothers wouldn't need to read and learn about it (Eyer, 1996; Marshall, 1991). "Although many people still take it for granted that parents 'naturally' care for their children and that women's motherly love is automatic ... (a) variety of experts give advice on the management of family relationships through the mass media" (Reiger, 1991, p 46).

The myth that mothering is instinctual is also narrow in it's view because it assumes that all women come from the same culture and socio-economic status and have the same background and life experiences. "Theories like this ... are misleading because they suggest a closed system between biology input and behaviour or feeling, which would suggest that there was no room for variation" (Apter, 1985, p 13). This myth of maternal instinct also correlates with the bonding theory developed by Bowlby in that "... biology was indeed destiny

and that only when natural, instinctual processes are interrupted, do women fail at motherhood" (Forna, 1999, p 82).

2. Happiness and love

The emotions that women are meant to feel when they become mothers are happiness, joy and pleasure and an overwhelming love for the baby (Leonhardt-Lupa, 1995; Marshall, 1991).

> "Society is quite clear about what your emotions are supposed to be once your baby is born. Television, movies, magazines, newspapers all give you the message that happiness, calm, satisfaction, joy and pride are the norm when a baby arrives" (Dunnewold and Sanford, 1994, p 3).

The myth is that joy and pleasure are inevitable when women become mothers (Marshall, 1991; Price Knowles, 1990). This myth, like the other myths, is perpetuated by the media. Motherhood is celebrated as a joyous occasion in our society. It is "... emphasized that this is a special experience, being essentially creative and positive" (Marshall, 1991, p 68).

If women do not experience motherhood as a joyous and happy time, they tend to suffer in silence as our society does not support the notion that motherhood is anything but pleasurable. "In the 1990s, with images of blissful motherhood assailing us from magazines, advertising hoardings and TV commercial breaks admitting that you regret having had your children is, if not quite treason, then certainly heresy" (Fairley, 1990, p 38). The myth of happiness is so strong and pervasive in society a mother has no space to express any unhappiness she may experience.

Alongside the acceptable emotion of happiness is love which is "... said to be hard to hold back, ready to 'burst out', it is 'total' and if not immediately present this is not cause for concern because it will inevitably grow" (Marshall, 1991, p

69). If a mother feels any emotions that don't equate to happiness and love then this is cause for concern for it is not considered 'normal' (Marshall, 1991). These pervasive ideas relate to the discussion in chapter two about the genesis of postnatal depression, where if a woman feels unable to cope she may hide these emotions, fearful of others response and being labelled 'crazy or 'nuts'. "The real tragedy is that women remain silent about their suffering... But is it any wonder?" (Villani, 1997, p 47).

All these myths feed the ideology of the 'good mother' and idealise a perfect model for all mothers to emulate to. "Elevated to an almost saintly role, the idealised mother is seen as self-denying, self-sacrificing, and unconditionally loving" (Bartlett, 1994, p 63 - 64). If a mother doesn't respond in the way that myths describe then she alone is responsible for the future happiness and behaviour of her child. This pressure to do everything right can lead to mothers feeling guilt and blame (Eyer, 1996; Forna, 1999; Hays, 1996). It is this issue and other issues around child-care that is addressed next.

'THE ADVENTURES OF SUPERMUM'

Guilt

Joanna Paul (1997), a New Zealand journalist, has a chapter in her book titled, 'Am I raising a serial killer?'. "I've just finished reading this book about serial killers and their humble beginnings. It appears they all have one eerie thing in common: their lousy relationships with their mothers" (Paul, 1997, p 211).

Mothers are aware that they, through society's valorisation of motherhood, are held responsible for their child's, and in turn society's, future.

> "Although fathers, paid caregivers, and others may help out, in the end it is mothers who are held responsible and who understand themselves as accountable not only for keeping the kids fed and housed but also for shaping the

> kinds of adults those children will become" (Hays, 1996, p 108).

The resulting pressure of the constant question 'am I doing the right thing?' is that mothers feel guilty (Thurer, 1994). Guilt is one of the major themes that Villani (1997) calls the 'mother crisis'. It is tied into feelings of failure as a mother and as a contributor to society.

These feelings of guilt are perpetuated in society by the experts that I have previously addressed in this chapter, and by the media. By cashing in on mother's anxiety and fears, child-care books, developmental toys and magazines thrive (Eyer, 1996).

> "The collective burden of all the advice which is offered on a daily, weekly, annual basis is intolerable and it would require someone of superhuman capabilities to follow it all. The futility of trying to conform to so many pressures means that many mothers feel like failures, and the lasting effect on almost all mothers is the battle with guilt which has come to characterize modern motherhood" (Forna, 1999, p 87).

A New Zealand example of information overload and guilt is a news story about babies developing flat heads. The incidence of this in New Zealand has apparently risen and the cause is due to babies sleeping on their backs - which is the recommended position to prevent cot death. An article in *The Dominion* newspaper quotes a craniofacial surgeon as describing the issue as an 'epidemic'. The surgeon also said that there is 'soft evidence' (whatever that is) from a report that compared babies who had flat heads with their siblings who did not. They found "... a difference in terms of special education interventions in primary school ... things like hyperactivity, needing remedial reading and other help" (Aldridge, 2000, p 7).

The article gave clear warnings to parents about this condition, and advice on how to avoid it from one expert, but also it gave unclear advice from another expert. The national paediatrician for Plunket is quoted. "'Sure, parents are worried and you can't answer the question' ... but 'the condition is a cosmetic problem, it does your baby's brain no harm'" (Aldridge, 2000, p 7). What's a good mother to do! A mother whose baby had flat head stated on *TV One News* that she felt 'so guilty'.

Another guilt trap is that mothers are told that their influence ultimately effects their child's psychological development and future. As with Joanna Paul's quote at the beginning of this section, there is a belief that children are innocent and pure, and, "... in the current mother mythology, children are seen as eminently perfectible. There are no bad children, only bad parents" (Thurer, 1994, p xxii). Mothers are told that how they interact with their children can damage their development (Eyer, 1996; Forna, 1999; Thurer, 1994). Society is seen as an evil place and it is a mother's responsibility to improve the world through raising children. Mothers are also responsible for individuals who are not raised to be good citizens (Paul, 1997).

> "In the present era the virtue of citizens has become a distant echo, as evidenced in widespread disenchantment with a political process perceived as competitive and corrupt. One of the few sources left for making the world a better place seems to be grounded in the ethic of maternal love and unselfishness and in children's apparent innocence, purity and goodness" (Hays, 1996, p 174).

One of the current guilt traps that is hotly debated is that of the working mother and fear that child-care damages children (Eyer, 1996; Forna, 1999). The 1990s Supermum was told, by the media, that she could have it all but what she wasn't told was that it came with a side order of guilt and burn-out.

Working mums

Despite all the myths about mothers being the only ones to appropriately care for their child, over half of all mothers in America defy this notion and go to work (Eyer, 1996; Forna, 1999; Hays, 1996; Villani, 1997). According to the 1996 census, 51.6% of New Zealand women in two parent families work either full or part time in paid employment (Statistics New Zealand, 1998). What these mothers are defying are the 'commandments' of good motherhood.

> "Thou shalt worry that anyone but yourself who takes care of your children will shame you and damage them. Thou shalt see your husband, baby-sitter, neighbor, day care provider, aunt, and grandmother as a threat to your standing as a Good Mother. Thou shalt regret involvement in any activity that you enjoy more than being with your children. Most of all, thou shalt feel guilty about working outside the home" (Eyer, 1996, p 72).

Much research has been conducted on working mothers and the effect it has on children (Eyer, 1996; Tizard, 1991; Villani, 1997). Interestingly, little similar research has been done on the effect of working fathers, leaving them out of the debate (Forna, 1999). This is because of the way mothers are socially defined. "Employed mothers, it can be argued, are problematic precisely because they are defined as problems. Employed fathers are not considered to be, or to have problems, because the social construction of fatherhood subsumes both worker and provider role" (Lewis, 1991, p 198).

Research on the effects of working mothers on children's psychological development indicates that having a working mother does not necessarily hinder a child's development (Eyer, 1996; Tizard, 1991). Research recently suggests that day care can be beneficially to children.

> "In fact, new knowledge about the way in which the brains of very young children develop, and the direction of recent

> research, is beginning to indicate that pre-school education and the opportunity it presents for children to interact with others and to develop socially, verbally and intellectually, may be more beneficial than being at home" (Forna, 1999, p 238).

Most women work because they need the money (Forna, 1999) but also some mothers say they work to get stimulation outside of the home (Else, 1996; Hays, 1996). There is also pressure in today's society to return to work as soon as possible or your career will suffer (Eyer, 1996), or your education wasted (Woods, 1993). Mothers who work do not fit the 'ideal worker' stereotype which is a male dominated ideology. Thus working mothers are "... doubly stigmatized by social definitions which cast them as deviant both as mothers and as employees" (Lewis, 1991, p 197).

Yet if most mothers work and the research indicates that there is no harm and in fact there may be benefits to child-care, how is it that working mothers are not supported by policy and ideology, and end up feeling guilty? One of the reasons is called the 'mummy wars'. This is "... the unnatural divide between mothers who have outside jobs or careers and mothers who have chosen to stay home with their children" (Villani, 1997, p 171). Gael Woods (1993) experienced this first hand.

> "I was constantly told by my betters, those in paid work, or just 'work', as they called it, that I was unfulfilled, was wasting my education, and would end up on valium with a bad case of galloping empty nest syndrome. And that was the plus side!" (Woods, 1993, p 3).

What has occurred is that mothers on both sides of this debate are angry, defensive and unable to listen to each other (Hays, 1996). The mothers within each group, which are culturally diametrically opposed, feel unsure about their image as a mother.

> "Yet both groups also continue to experience and express some ambivalence about their current positions, feeling pushed and pulled in two directions. One would assume that they would cope with their ambivalence by simply returning to their list of good reasons for what they are doing what they do" (Hays, 1996, p 145).

These myths of the 'working mum' and 'stay at home mum' are perpetuated in our culture, like so many images, by the media. The working mother trying to live up to the ideal 'Supermum' image and have it all is portrayed as not coping and unhappy and the stay at home mum is bored and frumpy (Eyer, 1996; Hays, 1996). These two different images of a 'good mother' clash, and bring about ambivalence and feeling of failure for individual mothers alike (Hays, 1996).

One reason that this 'war' continues is the myths of motherhood. The myths support the notion that a good mother needs to be at home with the child to bond and thereby successfully assisting the child with their psychological development (Eyer, 1996). However, mothers who choose to be at home experience pressure from others to return to work (Hays, 1996; Villani, 1997; Woods, 1993).

The myth also slates day care, as, according to the experts, it cannot provide maternal attachment - the only 'natural' bond 9Eyer, 1996; Tizard, 1991). However, research shows that young children "can and do become attached to those who look after them, as well as to other children. These attachments are not likely to weaken their attachment to their mothers, but can provide additional sources of comfort and security" (Tizard, 1991, p 191).

Another reason that women continue to feel guilt about working and utilising child-care is the current policies and attitudes that are in existence regarding child-care. There are many stories that make front page news about children who have been harmed or badly treated by child care and nannies and women

who are considering these options have to "bear the brunt of 'Bad Mother' criticism" (Villani, 1997, p 189).

The myth that women are naturally equipped to mother also leads two parent heterosexual families deciding that if one of them is to be the full time carer, it is logical for it to be the women (Lee, 1997). This myth is also strongly supported by economic reality. The reality is that "... in a labour market characterized by male patterns of existence as well as by low pay and a small range of occupational choices for women, parents will recognise that the opportunity costs for men to stay as home will be higher than those for women" (Easting, 1992, p 123).

Policies regarding child-care issues such as parental leave are being debated in New Zealand.

> "New Zealand's leave conditions for working mums are put to shame by about 120 countries where new mothers can stay home and still be paid. Even Sudan, Congo, Egypt and Kuwait give mothers at least eight weeks with their babies on full pay" (Langdon, 1999, p 11).

The country that is held up as having a model parental leave system is Sweden. There parents have

> "... fifteen months' childbirth leave, which can be used up to the child's eighth birthday, and can be shared or transferred between the mother and the father .. ten days paternity leave, sixty days a year per child of compensated family leave and the right to reduce working hours. All this as well as a ... comprehensive child-care system, for which parents are responsible for meeting only 10 per cent of costs" (Forna, 1999, p 240).

Yet the catch cry of politicians is that it would cost too much and that having children is an individual choice that employers have no control over (Langdon, 1999). This argument that it is an individual choice has been, and still needs to be, challenged. It is acknowledged that parents take on the majority of responsibility when they have a child but "raising the next generation is a community responsibility. Parents need to be valued and supported in their role" ("Parental leave issue important", 1999, p 6).

The ideology that mothers choose to have children, are natural caregivers and therefore are solely responsible for their upbringing brings me to my final point - loss of identity.

Loss of identity

The myths of motherhood construct another ideology, and another constraint on 'Supermum', that is when a woman has a baby she, as a mother, becomes one with her child. This fusion "involves treating mother and child as a single entity with unitary interests. This fusion denies personhood and agency to both" (Glenn, 1994, p 13). Marshall (1991) in her analysis of child-care manuals found that these books support mothers laying aside their personal interests and activities. Furthermore they assert that this will be instinctual and natural to do.

This myth is perpetuated by the words used to describe mothers who do and don't give up personal interests.

> "Bad mothers leave their children without the nurturing and guidance they need so they can go to parties, take vacations, go out to bars, or make more money then they really need. Appropriate motherhood, on the other hand, involves sacrifice" (Hays, 1996, p 168).

Sacrifice and selflessness are common words to describe what 'good mothers' do (Glenn, 1994). However these words and associated beliefs can lead to women losing a sense of themselves for the sake of their child.

Several studies (Brown et al, 1994; Littlewood and McHugh, 1997; Nicholson, 1990; Villani, 1997) indicate that women feel an immense sense of loss, involving loss of individuality, loss of identity, loss of social support and loss of confidence when they become mothers. As discussed in chapter two, these losses have also been linked with the development of PND. With these losses mothers are confused by the mixed messages from society's myths that state that this role is fulfilling and natural. For example,

> "... for many women, motherhood leaves them feeling that they have become faceless, nameless non-adults when they have a child. This becomes particularly problematic because women are led to believe that once they become mothers they enter the world of 'grown-up' women" (Littlewood and McHugh, 1997, p 78).

Mothers feel like they have lost their identity because the role of motherhood is not valued by society (Woods, 1993). Motherhood tasks are often carried out in private, removed from the public world and this can create isolation for the mother (Astbury, 1994; Brown et al, 1994). The messages that our culture continues to give mothers is that they are doing the most important role in our society - that of raising our future generation. But with this message comes the unspoken expectation that a mother's role is of a support person, that of a prompt standing in the wings of the stage to their child - the main actor. "Yet, even as mother is all-powerful, she ceases to exist. She exists bodily, of course, but her needs as a person become null and void" (Thurer, 1994, p xvii).

CONCLUSION: THE AIR THAT WE BREATHE

The status of Motherhood is glorified and the images of what, or who, makes a good mother are, mostly but not totally, presented in our society without questioning - is this reality? "As with most myths, the current Western version is so pervasive that, like air, it is unnoticeable" (Thurer, 1994, p xv).

The notion of the model mother must, as already stated, be seen in context of history, culture and the political structure at the time (Phillips, 1988). Motherhood has undergone radical changes over time, yet the experts, the child-care books and magazines continue to promote the myths that for women motherhood is natural, instinctual and that mothers unconditionally love their children (Eyer, 1996; Forna, 1999; Marshall, 1991; Thurer, 1994).

These myths are kept alive through mothers themselves, by not discussing the realities of motherhood and challenging the myths. "There is a nasty habit one forms after becoming a new mum in the nineties - underplaying the downside and overkilling the upside" (Paul, 1997, p 107). The government keeps motherhood myths alive to justify their reluctance to address the issues of child-care, child rearing and parental leave (Eyer, 1996; Hays, 1996; Langdon 1999).

The myths allow the current patriarchal ideology to remain intact and, in doing so, keep motherhood out of the public arena. This "ideology helps to reproduce the existing gender hierarchy and to contribute, with little social or financial compensation for the mothers who sustain it's tenets, to the maintenance of capitalism and the centralized state" (Hays, 1996, p 178).

Betty Friedan described 'the problem with no name' as the mind numbing experiences of domestic work women were expected to do in their role as wife and mother. Aminatta Forna (1999) feels that this has changed.

> "Today's 'problem with no name' is the myth about motherhood. The myth denies that the problems of hundreds and thousands of women are real or valid and

> instead insists that they are natural and inevitable. And in so doing it negates efforts at analysis, even the creation of a rhetoric or framework that would allow women to discuss the source of their problems" (Forna, 1999, p 260)

The next chapter details the design of my research that examined the ways these myths impact on New Zealand women who develop postnatal depression.

CHAPTER FOUR

METHODOLOGY

INTRODUCTION

This chapter outlines the research methodology utilised in the study, that is feminist, qualitative research. The research design is then explained including the process for applying to the Massey University Ethics Committee for approval to undertake the research, preparation of the interview guide and the process of enlisting participants. The chapter continues with a description of the pilot interview and changes to the process and interview guide made at that point. The research design also includes the process for the remaining interviews with the six participants in this study. The chapter concludes with a description of the process of organising the data for analysis.

RESEARCH METHODOLOGY

Feminist Research

There are several principles of feminist research. Firstly, feminist researchers must aim to improve women's lives (Smith and Noble-Spruell, 1986). The research must examine the impact it will have on women's' lives, both individually and collectively. As women themselves, feminist researchers have an understanding of oppression and powerlessness, and a connection with their subjects because of this. Researchers should create a means to articulate women's experiences "... rather than merely creating data for oneself as a researcher" (Finch, 1984, p 86). To assist women's lives, researchers should publish their work. Dale Spender, in her analysis of published feminist research, notes the male bias and gate-keeping in the publishing process. She argues that publishing is as important as the research itself, and that feminists must challenge sexism in the publishing houses (Spender, 1981). To address this principle this thesis will be available in the Massey University library and I will

send a summary of it to the Post and Ante-Natal Distress Support Group (Wellington) Incorporated (PANDS Group) who assisted me with the research. I will also be writing an article for the Social Work Review Journal. In order to reach other women I will consider approaching popular women's magazines with the findings of my research.

Secondly, all feminist research should have a political analysis (Jayaratne and Stewart, 1991). Furthermore, this should be based on feminist theory and include a commitment to challenge oppression, making the personal political (Mies, 1983). Research "... should work towards a theory and practice that combines the personal and political, throwing light on how everyday struggles are linked to social structures" (Smith and Noble-Spruell, 1986, pp 145 - 146). In following this principle this thesis examines current policies and practices regarding motherhood, and makes recommendations to improve the lives of mothers who have PND.

The question of who owns the data (Smith and Noble-Spruell, 1986) and who takes care of the participants information when disseminating the data is an important one. Finch (1984) noted in her research of clergy wives and daycare centres, that the results of the study could be misinterpreted and cause detriment to not only the women in the study, but also have a negative implication for women in general. To address this she incorporated a political analysis with her data interpretation. Feminist researchers also believe that the data collected belongs to the people from whom it was collected, and they should make the decision about the dissemination of this (Clifford-Walton, 1998). While I could not follow this idea as the research is part of the requirement for my Masterate, and dissemination had already been decided, I did return the audio-tapes to the participants and made a commitment to send a summary of the thesis to the PANDS Group.

Researcher's awareness of the impact their presence has on the research is the third principle of feminist research. This stance opposes and challenges the scientific belief that advocates researchers distance themselves from their subjects to ensure they are value and neutral free. Feminist researchers argue

that to detach themselves "... is impossible, and what appears as scholarly detachment is in reality only a matter of careful disguise " (Eichler, 1988, p 13).

Feminist researchers must also aim to develop a collaborative, non-exploitative relationship with participants (Smith and Noble-Spruell, 1986). Feminist researchers want to remove the barriers between the researcher and the participants and "... actively involve the researched in all aspects of the research ..." (Clifford-Walton, 1998, p 36).

If a feminist researcher is a woman, this can add another dimension to the research of women subjects as participants can find it easier to trust and talk to another women, because "... both parties share a subordinate structural position by virtue of their gender" (Finch, 1984, p 76). Finch also points out that some women welcome the chance to talk and will freely discuss issues that would not be discovered if the researcher was male.

Ann Oakley (1981) in her research of interviewing new mothers, challenged the usual interview techniques at that time, as depersonalising both the interviewer and the interviewee. She illustrated an alternative to the relationship between the interviewer and interviewee that is not simply a matter of prescribed questions and answers, but of rapport building. Oakley highlights the relationship that must develop between researcher and subject, for rapport to be built, and quality research to be achieved. She warns that if we do not let women talk freely in an unstructured way we will objectify our sisters (Oakley, 1981). This reciprocity can then "... enable people to change by encouraging self-reflection and a deeper understanding of their particular situations" (Lather, 1986, p 443).

The final principle of feminist research is the need for researchers to be committed to carrying out quality research (Jayaratne and Stewart, 1991), and make public the results. This includes utilising existing research methods and incorporating new ones consistent with feminist theory.

> "There is collective agreement that feminist researchers need to ask questions and collect data based on feminist theory, and that they need to be liberated from the restraints and value hierarchies of malestream research while not throwing out quantitative methods or rigorous investigation" (Smith and Noble-Spruell, 1986, p 145).

Jayaratne and Stewart (1991) state the importance of being honest about the problems of the chosen methodology. It is also important not to reject certain methods and techniques, because they do not at first glance, fit in with feminism. Objectivity, for example, is not possible and feminist thought may be to throw out all traditional research methods, but "... the logical consequence of such a principled stance is that research, including the implied cumulative knowledge it generates, is impossible" (Eichler, 1988, p 11).

Qualitative Research

When feminist research theory was developing, researchers saw that the way quantitative research, the traditional tool for research was used at the time, did not fully meet the needs of women - as researchers or as subjects (Jayaratne and Stewart, 1991). While these methods do not have to be exclusive, and can be mutually beneficial as research methods (Smith and Noble-Spruell, 1986), the research I undertook utilised a qualitative methodology by conducting in-depth interviews, using open ended questions and focussing on the women's experiences of motherhood and PND.

This piece of research utilised the four key principles of feminist research. By researching PND and the myths of motherhood, I aimed to improve women's lives. I designed questions around the current social policies in New Zealand and applied a feminist analysis on motherhood and women's lives throughout the research. I was aware of my presence during the interview and the vulnerability of discussing the subject matter with the participants. Finally, I was committed to undertaking quality research through the completion of this thesis.

A qualitative data collection method to collect data was used by gathering a small sample - six participants - and by designing open-ended questions, to enable the women's stories to be recorded. I also designed prompt words alongside each question to assist if necessary.

RESEARCH DESIGN

This section outlines the research design process. It begins with the literature review process and then explains the process by which approval from the Massey University Human Ethics Committee (MUHEC) was gained. The section then discusses the design of the questions for the interview guide and other research that was used to assist in the design. Next the section deals with accessing participants, recruiting participants, participant demographics and undertaking a pilot interview. The section concludes with some observations of the research design and interview process.

Reviewing the Literature

The process of reviewing the literature began long before undertaking this thesis. As I have been working with women with PND for many years I have continually read literature on the topic. Reading other research and books on PND, and on the topic of motherhood in New Zealand, provided important material for this thesis. I systematically and objectively selected material to read by requesting the Massey Library to search for key words of 'post-natal depression' and 'motherhood'. I also searched the Palmerston North Public Library as well as the Massey Library myself for books on PND and motherhood. I rejected research material that was prior to 1990, with the exception of Cox et al's (1987) research detailing their development of the Edinburgh Postnatal Depression Scale, because of the significance of this tool (refer to chapter two). I also rejected research material that covered the effect on men when their female partners have PND and material on child development when the mother has had PND.

Glesne and Peshkin (1992) state that literature review is essential for several reasons. Firstly, by scanning the literature it can verify that the topic is justifiable. Secondly, it can assist in finding the focus of the topic. For me this was an important step as the topic of PND can be very wide and, as I noted in chapter two, much has been written about the possible biological and psychological theories of PND.

The third reason on why literature review is essential is that it can assist in developing the research design and the interview questions. In designing the research questions I adapted other research questionnaires - this is expanded on later in this chapter. Lastly, Glesne and Peshkin note that reviewing the literature is an ongoing process that "... cannot be completed before data collection and analysis" (Glesne and Peshkin, 1992, p 18). I noticed that information about motherhood in New Zealand was constantly appearing in the media. For example, discussions about paid parental leave were appearing in newspapers during the writing of this thesis.

Ethical Issues

I was required to apply to the MUHEC as my research involved human subjects. The application (appendix 1) had to consider the five principles in the Human Ethics Committee code. The code is designed to cover the participants, the researcher and the University. To gain approval from the MUHEC I needed to prove that I had thoroughly planned the research and noted the potential risks involved, covering the five principles.

Informed consent

The first principle is informed consent. It is imperative that the participant fully understands the research purpose and format and their rights. A compelling example of the drastic consequences of ignoring this principle in research occurred in the 'unfortunate experiment' in Auckland's National Women's Hospital. Women were unknowing participants in the research, and had their

health put at extreme risks, because their informed consent had not been gained (Coney, 1988).

Informed consent can be verbal but it is best in a written format. To enable this to be understood clearly I prepared an information sheet (appendix 2) outlining these issues. Participants gave their consent in a written format (appendix 3) and this included their rights. I included information on what will or may happen with the results, that is, where else they will be read and heard.

Confidentiality

The second principle is confidentiality and this includes the storage of information such as transcripts and written records from the participants. These were kept in my home in a secure place. Each participant's taped material was returned to them to avoid confidentiality being breached. I also informed them that the written transcripts would be disposed once I had completed my thesis. To cover confidentiality I used pseudonyms for the women, their children, partners and friends.

Minimising harm

As I had worked for many years in the area of PND in the Palmerston North region, I decided to reduce the possible risk and harm of interviewing past clients by going out of the area. I also gained participants via a support group organiser who approached past (not current) members, ie. women who were not currently experiencing PND. This was to reduce the potential risk of interviewing a woman who was still coping with PND and may find the interview distressful. Another potential issue for the participants was the possible relapse of their PND as a result of discussing their experiences with myself and to address this I drew participants' attention to the information sheet. I also prepared a resource list of contact names and addresses of Mental Health services and other support services the participants could contact if this occurred. The opportunity to withdraw if the research became distressing for them was also an option outlined before commencing the interviews.

Truthfulness

The fourth principle is truthfulness. To comply with this principle I ensured that I gave accurate information about the research, dissemination of findings, storage of information and so on, to the participants. This included the possibility that I may present this information to other audiences, for example my employer who by supporting my study will require me to present this information to colleagues. Truthfulness also applies when, in the context of the interviews, the participants wanted or needed to know personal information about myself and to address this I was honest about the fact that I am not a mother and that I work in mental health services. I was also honest about my ethical and legal stance if I believed the participant was becoming harmed by the research I would need to inform or include mental health services for safety reasons.

Social sensitivity

The last principle is social sensitivity. As I studied women I brought an awareness of gender issues. I informed the organiser of the group that I wished to interview women of the same ethnic group as myself. There were two reasons for this decision. Firstly, I believed that as a Pakeha I could not interview women of different ethnic backgrounds without first ensuring that I dealt with them and their information in a culturally safe way (Smith, 1986). Bryson (1979) warns researchers to be aware of their world views and cultural differences, otherwise the problem being studied can be incorrectly attributed to the people being researched, instead of the techniques and method of interpretation used by the researcher.

The second reason for me to limit the study to women of the same ethnic group as myself, is that by interviewing women from other ethnic groups I would have introduced another variable between the participants. Cultural variables in research need to be properly attended to in interpreting data (Patton, 1990). It would be ideal to solve these issues as they are not surmountable (Bryson,

1979; Smith, 1986), but this would have taken more time and resources than I had available to me.

Design of questions

Initially I planned to hold group discussions with five or six women who had experienced PND. However, in the designing phase I realised that this was not ideal and altered the design to in-depth interviews with the participants individually. This change was due to two reasons. Firstly, possible complications with confidentiality could arise. If the women knew each other previously, they may not feel comfortable talking openly in a group. Secondly, if any of the women were unable to attend a group session on one or more occasion, that would lead to unreliable data.

In designing the research interview I had to be mindful of the dilemma of interviewing women and being drawn into a conversation with participants that does not fit the 'question and answer' format (Oakley, 1981). I was aware that this may occur with my research, as I was proposing to interview mothers who may be feeling isolated. Oakley also found out there are benefits to both the researcher and subject as a result of them establishing a rapport and the importance of spending time and energy doing this.

The interview questions were to be semi-structured. Graham (1984) argues that even semi-structured interviews can be exploitative. She proposes a narrative, storytelling interview technique to counteract what she sees as an abusive technique. This technique does this by "... more effectively safeguarding the rights of informants to participate as subjects as well as objects in the construction of sociological knowledge" (Graham, 1984, pp 118 -119). While I agree with and support this view point, I had to be realistic in terms of my research limitations, and nominated to use a semi-structured interview technique. The limitations I were faced with included time, money and the purpose of the research.

I based the design of the questions in the interview around the woman's expectations of motherhood and her experience of PND. I utilised questions already developed such as Warner et al (1997), who created the Maternal Attitudes Questionnaire (MAQ), a questionnaire to measure women's attitudes, and Paula Nicholson (1990) who developed questions for her research on mother's experience of motherhood. James McIntosh (1993) also researched social issues similar to my research. The other questionnaire commonly used in detecting PND is the EPDS, developed by Cox et al in 1987. These questionnaires have been discussed in chapter two.

I was clear to develop open ended questions in order to encourage discussion around the issues rather than closed questions which tend to stifle this. I used one of my supervisor's questionnaires for format ideas, for example a clear structure and sections to the interview. I also developed prompts so that, if needed, I could assist the participant to remain focused and add direction and/or clarification to my questions.

The interview guide (appendix 5) was divided into five main sections. Firstly I gathered some demographic detail by asking questions around age, children's ages and so on. This was deliberately placed at the beginning of the interview to give me an idea of their family structure as well as a 'warm up' to form a rapport, by asking questions that were not too intrusive to begin with (Taylor and Bogdan, 1998). It also introduces the mode of the discussion as a 'question and answer' interview.

The second and third section's of the guide were arranged chronologically to guide the participants through from their childhood to motherhood. Section two focused on the thoughts and influences the women experienced as they grew up, that contributed to their perceptions of motherhood. This section was designed to include prompts about their different life stages, for example, what their role models were at the time and what the media images of motherhood were at the time. These questions were designed to gain information about what messages New Zealand society gave them about the role of motherhood.

The third section of the interview concentrated on the woman's experience of pregnancy and of motherhood. These questions were designed to assess if their perceptions of motherhood had altered from their childhood and their experience of other people when they were pregnant. I also aimed to find out about their first experiences of motherhood and if their reality matched their vision of what motherhood would be like.

The next section was centred around the participant's experience with PND and how they and others around them perceived the illness. This section was placed fourth as I was aware that it may bring up some unpleasant memories about that experience, and the other earlier sections were less intrusive and therefore would enable the woman to relax into the interview. I wanted to include this section to also allow the woman to tell her story and theories about what happened.

The final section concerned changes that may assist mothers, including mothers who experience PND. This section was placed at the end of the interview to allow the participants to focus on solutions and actions, therefore looking at positive ideas. Before starting this section I also acknowledged that we had been discussing some memories that may have been unpleasant and painful and thanked them for allowing me to discuss this with them. The purpose of this was to overtly close the section and inform them that we were near the end of the interview.

At the end of the interview I also asked if they wanted to add anything else, this allowed the participant to freely include any other thoughts that I may not have picked up on.

Accessing potential participants

As outlined in my proposal to the ethics committee, I decided to conduct the interviews in the Wellington area. I chose this region as I have worked for many years in the Palmerston North area and I did not want the situation of interviewing a previous client and the ethical dilemma that would present. I also

chose Wellington because of its close proximity to Palmerston North and because I know the Wellington area reasonably well as I grew up just outside of the region. The third factor was that I had met the organiser of the PANDS Group through my work. I had also met the Maternal Mental Health Team based in Wellington so I was aware of their role.

I wrote to the organiser of the PANDS Group in March 1999, outlining my research and requesting assistance to recruit interviewees (appendix 5). The reply was positive. After receiving the MUHEC approval, I again wrote requesting that we meet to discuss the research project so that she could assist me in recruiting participants (appendix 6). We arranged a date to meet and discuss recruiting participants.

As mentioned earlier, my sample size was six. The reasons for this small sample were, as Patton (1990) states, dependent on the purpose of my research and the resources I had available to me. As this was a qualitative research project for my Masterate thesis this number was the most practical. Small samples have benefits over large samples in that in-depth information "... from a small number of people can be very valuable, especially if the cases are information-rich" (Patton, 1990, p 184). The interviews conducted in this research proved to be very information rich.

Recruitment of participants

When I met with the organiser of the PANDS Group we discussed how to recruit participants. She had already thought of a few potential women who had been part of the PANDS Group in the past. This technique of recruiting participants through one source is called snowballing, a useful way to recruit participants for qualitative research (Patton, 1990). Snowballing involves starting with "... one person or a small number of people, (winning) their trust and (asking) them to introduce you to others (Taylor and Bogdan, 1998, p 32). By using this technique I was able to ensure that the women I approached had recovered from PND, did not have to make a toll call to contact me, were willing to be interviewed and had background information on the research and myself

from a trusted source - the organiser of the PANDS Group. Snowballing does have limitations in that it can limit the diversity of participants (Taylor and Bogdan, 1998), and the participants may be given misinformation due to the information going through another person, not directly connected with the research. To the best of my knowledge this did not occur for the research I conducted.

I also prepared a poster to be displayed at the group and to give to potential participants (appendix 7). This poster also listed the organiser as a contact person, for the same reasons as outlined above. The PANDS Group organiser gave me the names of Plunket rooms in the region that I could utilise for interviews if necessary. I also clarified that Wellington was the region I wanted to research. We agreed that she would start recruiting women from Wellington and if there were not enough then she would approach women from the Hutt Valley region.

The organiser of the PANDS Group provided me with eight names of women who were wiling to take part in the research. She informed me that one of these women, due to personal issues, would be best contacted as a 'last resort'. She made no other suggestions about who to approach first. I telephoned the women on the list and after introducing myself, asked if they were aware of the research and if they had any questions about it. If they were still willing and able to see me, I arranged a date and time. I offered each participant the option of child-care and coming to a venue away from their home but all preferred it to take place at home so that their children would either be cared for by family members or would be at school or child-care. At this point I clarified with the women that I needed to have their uninterrupted time for the duration of the interview, so if other members of the family around they needed to be aware of this. I also confirmed their street addresses.

To conduct the interviews I used a tape recorder and also had paper and pen. I only used paper to note down relevant facts like the children's names to assist me in the flow of the interview. I also took with me a prepared list of contact organisations in case they needed to discuss any issues that may have arisen

afterwards. I also had some spare information and consent forms. I allowed an hour to an hour and a half for each interview.

Participant demographics

At the time of the interviews;

* All six participants lived in the Wellington region.
* Their ages ranged from 32 to 46.
* Five women were living with a male partner; one woman was single.
* One woman had one child, four women had two children and one woman had three.
* One woman was a full time mother at home. The other five all had paid employment part time, no one worked full time. One woman also did some part time voluntary work. One woman also stated that she was studying part time as well.
* Of the five women who were in paid employment, four of them worked in administration occupations. One worked as a school teacher. One also ran a business as well as other work.
* The children's ages ranges from 8 1/2 months to 16 years.

Mary and Naomi experienced PND after the birth of their first children only; Sharon and Clare experienced PND after their last child only. Both Jan and Susan experienced PND after the birth of both of their children.

Pilot interview

A pilot interview can assist in research design by testing the tool, the interview technique and the researchers observation skills (Glesne and Peshkin, 1992). Piloting or pre-testing should be done with people similar to the group to be studied (Babbie, 1998; Glesne and Peshkin, 1992), to achieve this I interviewed one of the volunteer participants. After the pilot changes can be made to the tool, the process or the researcher themselves to correct mistakes, remove ambiguity and improve the researchers skills (Babbie, 1998; Glesne and Peshkin, 1992).

The pilot interview was arranged by telephone. I offered the option of paid child-care and a venue but the participant chose her own home when the children were out and her partner was at work. I posted the consent form and information sheet to her so it would arrive before we met. After I conducted the interview I gained verbal feedback about the questions and the interview style. She stated that she felt it was good and not too intrusive or threatening. This was important as I was aware that the questions were around an event and time that was distressing and it may be difficult to discuss.

After the pilot I made some changes. From a practical point of view, I needed to ensure I had an extension cord for the tape deck as we had to shift the table in order to plug the machine in. I also borrowed an external microphone for the tape deck as the in-built microphone, while adequate, was not sharp enough.

Observations of the interviews

During the research period I kept a diary and recorded my progress. I also wrote down how I felt the interviews went and any surprising factors and personal responses along the way. On every interview occasion the participants had remembered I was coming and had prepared the environment so that the children were cared for elsewhere and we had some private space in the house. On one occasion a participant's child was not asleep as she usually was and on another the noise made by a participant's child interrupted us. These were only minor interruptions.

I asked for the signed consent form before I began each interview. I also asked if there were any other questions. Three of the women had definite time limits due to children returning from school or needing to be picked up. I kept these in mind to pace the interviews accordingly and to ensure that if we did start to go over the agreed time, I would point this out.

I had to organise myself plugging the tape recorder in and making sure it was placed so it would pick up both our voices. I outlined the format of the interview

to each participant following the information on the consent and information sheets. I reiterated that they could request the tape recorder to be turned off at any time. No one requested this to occur during the interviews. The only notes I made were at the beginning of the interview were jotting down the participants children's names and ages so I could refer to them during the interview if needed.

During the interview I worked my way through my questions. At times I would follow the participant's train of thought and in doing so would get several questions answered together. Because of my practical social work experience, I was comfortable enough to allow this to occur, while still keeping control over the process. If there were any pauses or the women asked for clarification I used the prompts I had prepared.

Three of the participants became tearful during their interviews. When this happened I did not try to divert the women's emotions but left some space and offered encouragement using empathetic counselling skills. In doing this I validated how they were feeling in talking about past unhappy events.

The length of each interview varied with the shortest being just under one hour and the longest an hour and a half. After the tape was turned off, all of the women continued to discuss the issues of PND and my research. Three women said that in talking about PND they were able to acknowledge that they still had some emotional issues to address and we discussed these briefly. I gave one woman some ideas of where to go for further assistance. One woman commented that if she had had the questions before the interview it would have helped her to remember her childhood perceptions of motherhood.

I gave each woman the list of contact agencies I had prepared and I also gave them my telephone number and invited them to call me if they wanted to. No one did contact me by telephone afterwards. I also informed them that the next step was transcribing the tapes and informed them that when I was finished I would return it to them for their verification. One woman told me she did not

need to see the transcript but I informed her that I had to do this as part of the research process and she accepted this explanation.

An observation I made of myself during the interview process was that I was able to cope with the participants wandering off the topic and I was able to pull the interview back on track. I think my training and experience as a social worker meant I had the ability to listen and assess the interview. I have counselling skills that enabled me to attend to the participants when they became tearful while still keeping focused on the interview purpose. This was an area that I highlighted in my ethics proposal. It was important for me to remember my role was as researcher not counsellor. For example, one woman said she could not remember her childhood at all. In my work situation I would have explored this further as my theoretical knowledge would have indicated possible abuse as a child.

To summarise, the process of undertaking this research involved several steps. Firstly, I reviewed the literature. This was an ongoing process that started before I undertook this thesis and continued throughout writing the thesis. I gained approval from the MUHEC. The major ethical concerns for me were to ensure that I did not interview women who I had known previously through my professional work, and to ensure that the interview process did not harm them by contributing to a relapse. Prevention and safeguards were put in place to address this. In developing the interview guide, I utilised other research that has been undertaken in this area. The PANDS Group assisted the process by which I accessed, recruited and undertook a pilot interview. The main observations I made during the interview process were that the topic area of motherhood is large and restricting women to discuss only a few areas was difficult. For some women the interview process was emotional and raised additional issues. I utilised my counselling skills to attend to these and to assist them in seeking further avenues of help.

The next section discusses the transcription process and methods used to sort the data collected from the interviews.

DATA ANALYSIS

Transcribing

I transcribed the tapes myself and found this was a long process. I also found that while listening to the interviews again I was able to pick up on nuances that a typed script would not. For example, when women were tearful, laughing or quoting a third person in a sarcastic way. Taylor and Bogdan (1998) note that in qualitative research most researchers analyse and code their own data. In doing this researchers also "... draw on their firsthand experience with settings, informants, or documents to interpret data" (Taylor and Bogdan, 1998, p 141).

Some other observations I made were that some of the women avoided or misunderstood questions and I was unable to get them back on track. Most of the women found talking about the birth experience easy to do and indeed I found that some were difficult to shift off the topic. I concluded that the issue of motherhood is so large that it is difficult to keep discussions on a small part of the experience. Because of the conversational style of the interview, women would often answer my list of questions at different parts of the interview.

Several questions were raised for me while I was transcribing. Firstly, that even though the women I interviewed acknowledged that the myths of motherhood are inaccurate, they still keep them alive and do not challenge them. Secondly, a lot of the women used the word 'failure' when describing how they felt when they were not coping. And lastly, two of the women associated PND with being 'nuts', 'scary' and 'crazy'. The stigma of having a mental illness is still alive and well. These issues are discussed in chapters seven and eight.

The transcripts were returned to all participants with a letter, (appendix 8), a form to sign, a self addressed paid envelope and a box of chocolates to say thank you. Four of the six transcripts were returned within a fortnight. After consulting with one of my supervisors I wrote to the two unanswered participants asking that they return the transcripts or comments to me within a three week time period (appendix 9). I did not receive a reply to these two

letters. Having done all I could to get their feedback, I proceeded with the research.

Only one participant wanted changes to be made to the transcript. These changes were two word changes and removal of a reference to protect confidentiality. I made these alterations. I also changed the names of the women, their children, partners and family members and friends at this time, keeping a record of the code I used.

Coding

The next stage of data analysis was coding the information I had gathered. A coding method needs to be developed by the researcher and there are no hard and fast rules about this stage (Patton, 1990; Taylor and Bogdan, 1998). The purpose of coding is the "... bringing together and analyzing all the data bearing on major themes, ideas, concepts, interpretations and propositions" (Taylor and Bogdan, 1998, p 151).

In order to analyse the data, I undertook two coding methods. Firstly I went through each transcript and, using coloured pens and highlighter pens, coded the main themes to be extracted for chapters five, six, seven and eight of this thesis. I then went through the complete interviews again and noted when there was a message about motherhood, pregnancy or PND from others. I developed a table which noted the page reference, what the message was, and the source of the message. These tables served several purposes. Firstly, by re-reading the transcripts I became familiar with the women's stories again and was able to easily recall and locate quotes. Secondly, I was able to extract the major themes for the research. Thirdly, the table gave me an easy reference system to locate the information for the next two chapters.

As the interviews were structured into separate sections the task of ordering them for chapters five and six was clear cut. However, I noted that the women would also discuss their own experiences in the last section - where I asked for

their thoughts and ideas for future services and changes. The system used to highlight themes enabled me to easily locate relevant material.

The themes that emerged from the transcripts were also analysed in relation to the literature that had been reviewed in chapters two and three of this thesis. Chapters seven and eight discuss these linkages and themes and in doing so draw conclusions and recommendations from all the material contained in the thesis.

CONCLUSION

This chapter explains the reasons why I chose feminist, qualitative research methodology and why it was appropriate to the research topic. As I was interviewing women participants about an experience which is uniquely female, that of motherhood and PND, and because I am a woman conducting the research, feminist research methodology suited the research. Qualitative research also allowed me to gather data in an in-depth, interview style that met the research aims and objectives.

Through the research design I gained approval from the MUHEC by addressing the five areas of informed consent, confidentiality, minimising harm, truthfulness and social sensitivity. To meet these I chose to conduct my research out of Palmerston North, as I had worked in this area, to minimise the risk of interviewing any past clients. Issues of relapse in PND were paid due attention in the research design as well.

In designing the research questions I adapted and built on other research questionnaires designed for similar studies to my own. I was fortunate enough to have a person willing to assist in recruiting the six participants. This also ensured that the women I interviewed had recovered from their PND. A pilot interview was undertaken and minor changes made to the interview tool. There were also some interesting observations made about the interviews such as the ease at which women discussed their experiences.

Data analysis took time due to transcribing the transcripts myself but this enabled me to reacquaint myself with the content of the interviews and recognise themes between them. Coding was used to collate and analyse the data which had been extracted and ordered into the next two chapters. The data analysis was completed by linking the literature reviewed with the data collected from my research. This is contained in chapters seven and eight of this thesis.

Chapter five begins presenting the data from the research by focusing on the first part of the interviews. The large amount of data gathered has meant that it is presented across two chapters - chapter five and chapter six. Chapter five covers the participants' perceptions of motherhood from childhood through pregnancy to their initial experiences of motherhood.

CHAPTER FIVE

FAIRYTALES AND FANTASIES

INTRODUCTION

This chapter deals with the first part of the stories that my six participants told me during the taped interviews I had with them in October and November 1999. I have structured this chapter around the first three sections of questions in the interview guide (appendix 4). These questions were aimed at my objectives for this research which were,

1. How has New Zealand society's perception of motherhood influenced mothers who participated in this study and who developed PND?
2. Where do mothers who develop PND gain their information about motherhood?
3. In mothers who develop PND, what were their individual expectations of motherhood?

Firstly, I asked what the participants ideas of motherhood were when they were growing up, and where these came from. I asked this to ascertain how motherhood is remembered by the women when they were young and the role models that were around them at the time.

Next, I asked about the interviewees thoughts when they became pregnant and how they perceived themselves and how others perceived them as pregnant women. These questions were to examine if their earlier memories and thoughts of motherhood changed in any way.

I then asked the participants about when they became mothers and if their expectations of motherhood became reality for them. This section addresses issues such as working versus non working mothers and identity changes that the women felt. In this section the women also discussed feelings of joy at

motherhood and feelings of failure and lack of control of their lives once they became mothers.

CHILDHOOD IMAGES

All of the women could recall images that formed ideas of what motherhood was going to be like as they were growing up. The participants in this research were born in the 1950s and 1960s and the images developed from those years are very different to their own experiences of motherhood in the 1980s and 1990s. The concept of the family in post war New Zealand was of a sanctuary, and motherhood was idealised and valued. This idea that motherhood was a woman's vocation, continued into the 1970s, when the participants would have been children or adolescents. (Kedgley, 1996).

While some of their images of motherhood differed, every women I interviewed had strong memories that it would be a positive, rosy and relaxing time.

I suppose I thought that women would have an easier life too, because you didn't really have any pressures or stress on you and you were your own boss and you could sort of please yourself and you would have quite a lot of time to do what you liked apart from having the children and they would just come along as well and there wouldn't be too many interruptions. I had the idea that it would be a nice life - Sharon

Another image that came through was that motherhood would also be a normal life stage for women.

So I always used to think it would be lovely and it would be a nice - not really a sort of job - but the way your life would be at that stage - Sharon

... so motherhood seemed quite a natural thing to do. That's what women did. They might have had little jobs on the side ... that they did in their house or something. It was ... normal, it ... seemed to be easy, that anyone could do it. That was the feeling that I had, that it was achievable - Naomi

Naomi's quote and others above also illustrate the beliefs that it would be natural for a woman to become a mother. This is discussed later in this chapter.

Several women talked about how their idea of motherhood was, now they look back on it, an unrealistic fairytale image.

I think it was all that 1950 stuff. Being at home, making cakes and having a nice house and fairytale land stuff - Clare

I think I thought it was a bit of a fantasy. A bit like Cinderella, you go off and meet the prince and live happily ever after and have lovely children, who never misbehave and are just delights to be around - Jan

These memories came mainly from their most influential role model, their mothers. Several of the women talked about how their own mothers were very busy. These memories formed more realistic images of what it was like for their mothers.

I was always conscious of how busy mothers were - Jan

So in reflection I guess it was a busy life for Mum - Susan

Other influences on their images of motherhood were friend's mothers and relatives who were becoming mothers. As Naomi's quote below illustrates during her time of growing up, motherhood was a burgeoning industry.

(I gained images from) my mother and the women in the community. It was a bit of a boom time, lots of kids in the neighbourhood. Becoming a mother was all around me really - Naomi

... where I grew up not many mothers worked... She (my mother) was always there when we were there anyway so it was always like mothers

were always around you all the time ... (For) virtually everyone I knew, their mothers were at home - Sharon

Jan's images from friends' mothers supported the idea of motherhood being busy and also highlighted that there were different sorts of mothers.

One mother of my girlfriend was ... very, what I would say, wrapped the children up in cotton wool ... was always there after school with baked biscuits and made special treats and that sort of thing. And the other friend, her mother ... worked full time I think. She may have been there when we got home from school. But Hilary was always left to see to herself and often had to help get the dinner ready... So they were very different (mothers) - Jan

Susan's mother suffered from periods of depression while Susan was growing up and this influenced her, in that she saw other friend's mothers and was aware of the differences due to her mother's illness.

I guess over those intervening years I did spend more time at friends' houses and their mothers were more available. We'd go round and we'd cook together at their house and Mum just couldn't take things like that on board. So I tended not to have people round at my place - Susan

Jan remembered friends who became pregnant at a young age and the influence that had on her, which was that it wasn't a hard job.

... I have three girlfriends who were all pregnant and had their first babies at 19. We were exactly the same age. It's quite funny because I don't think I got the impression from them that it was that hard! - Jan

Naomi remembers her sister becoming a mother and although she viewed her as being trapped by this, there was still the idea that motherhood was an easy and achievable option.

I suppose I still looked at it as an easy option. I still thought it was one of those things that anyone can do and if I can have this career and do all these things out there in the world then I should be able to have a child too and cope with that - Naomi

Several women, when talking about these images from friends and relatives, remember consciously deciding that becoming mothers was not what they wanted to do at that time, due to plans for further education and a future career.

When I lived in a small town a lot of girls were getting married at 19 and a lot of them did actually just have children and I used to think "Well I don't want that sort of life yet"... I wanted children one day because I really loved children, but I thought I was too young and I still wanted to have a bit of a life - Sharon

All of the women mentioned observing other mothers not coping and yet were able to justify that when they became mothers they would cope. Two of the women went on to train and work in the area of child-care for preschoolers, and were around young children all day. Looking back, they were still able to minimise the reality of how hard it may be looking after children as a mother. Before they had children of their own, both women blamed the children's yelling or bad behaviour on the mothers.

I nannied ... (and it's) a very good idea. And that was dynamite, absolute dynamite! But then I thought, I just blamed it, (the children's behaviour), on the families... But then I just thought, "But they're not mine"... I just thought (being a mother) ... was a bit more like hard work. But then I also put it back to, "They're not my children". It will be easier when I love them as mine - Clare

Other women also felt that although they observed other parents having difficulty that they would be different and would cope.

Always I thought that she (my neighbour) had troubles and other people had troubles but it wasn't going to be like that for me - Naomi

I saw people in various situations and thought "I'd never do that. That's awful, I wouldn't do it that way I'd do it this way". Even in my family I would see the way my brother might relate to his sons and think, "I don't think I'd take that approach, I'd do it this way" - Jan

The women all spoke of their childhood images of motherhood as they were growing up as unrealistic, now they look back on them. Even when they saw other mothers not coping they all assumed that when they became mothers they would cope. Their positive images and myths of motherhood remained.

The next group of questions I asked were around the time they decided to, or for some women didn't decide to, become pregnant. With these questions I was wanting to see if the myths of motherhood changed when they became pregnant and in what way.

BECOMING A MOTHER

The decision to become a mother for the first time was varied among the participants in this study. Three of the women accidentally became pregnant. For two of them, they felt that while it wasn't a conscious decision, they decided to continue with the pregnancy.

Well it was an accident, I suppose it wasn't a planned pregnancy so that's how I started. But it definitely wasn't an unwanted baby and I had been with my partner for probably eight years or something, so it was a good time - Mary

One woman had her first pregnancy terminated because she felt she and her partner were not ready to become parents at the time.

It was an accident. I (had) left and went over to England, and then Richard (my partner) followed me about seven months later... I was absolutely shattered. I went to the doctor because I thought I better had and it (being pregnant) was a huge shock - Clare

Clare's next pregnancy, and the remaining three women's first pregnancies, were planned. The decision for this was due to a feeling that their circumstances were right and it was the next logical step in their, and their partner's lives.

I think in many respects it seemed like the natural thing to do, it was the natural progression. Steven and I were in a stable relationship, we moved in together, we got engaged, we got married, we'd done an overseas trip, we'd brought a house and you have children. That's the way it happens! - Jan

Jan's quote below illustrates that the decision was also influenced by messages from other people.

You always get that, especially once you're engaged, you've been married, they (friends and family) only let you go for about a year and they're asking you, "When is the baby (coming)? Are you going to have a family? There aren't any problems are there?"... Yes that did come out. There was certainly the expectation that once you got married you were going to have children, and if you didn't have children then there was something wrong with one or other (of) you - Jan

Seeing other women - friends and family - around them becoming pregnant also influenced some of the women by bringing back early memories of wanting children.

So perhaps in hindsight that (friends becoming mothers) did precipitate having children, because it brought back the dream for me of being a

mother that you could do all that without it being a big stressful issue - Susan

So I sort of got kind of quite 'clucky' with them (a friend's children) and it sort of brought back feelings of when all the kids in the neighbourhood used to come up and see me and I used to do things with them - Sharon

For Susan becoming pregnant felt, in some ways, a non-decision.

There was no reason not to, more than wanting to, it's just that there wasn't a reason not to have children - Susan

For Jan the pressure to have more than one child, was greater than the pressure to have children in the first place. There appeared to be an expectation that the normal family size is more than one child.

Well, I think the expectation ... is that you will not have one child, you will have more than one child. Because there is this view out there (that) nobody wants to be an only child and nobody wants to bring up an only child. (An) only child, they're always spoilt and don't like sharing and ... I guess to some extent that probably came into play more than actually having the first baby - Jan

The pressure of the 'biological clock' was also a factor for Jan.

I was conscious of the biological clock ticking over and thinking 'If I'm going to have a family I'd rather get it over and done with by the time I'm 35' - Jan

The circumstances around women becoming pregnant for the first time varied from planned to unplanned decisions. The majority of them decided to become pregnant, or continued with their pregnancy, because it was the right stage in their and their partner's lives. These messages about parenthood being the logical next step in their relationships were heard from other people as well.

The 'biological clock' and feeling 'clucky' around other mothers and their children were also factors they felt influenced their decision to become mothers.

The next questions I asked were regarding the experiences of pregnancy. I wanted to know if the myths about motherhood experienced earlier on in their lives remained. I was also interested in what other information, images and myths were gained about pregnancy, the birth and motherhood during this time and from what sources.

PREGNANCY

Pregnancy is a very public state for women. It is obvious to other people that a pregnant women's identity has changed and they will soon become a mother. Once pregnant, the majority of the women I interviewed described the time as wonderful as they felt others treated them as special.

From about then (pregnancy) and from when you first have your baby people are interested... It's all "When's your baby due" and "How are you?" and you sort of felt a bit special, because you've got that little bit of attention... So you sort of feel a little bit proud and special. I suppose that was quite nice - Sharon

I could see myself focusing more and more on the glamour of being a pregnant mum. It is really glamorous, everyone gives you lots of compliments. "You're looking so good", it's quite different (from when you're not pregnant)... I guess I thought at that time I felt really special, as a pregnant mother and as a mother of a very young baby - Susan

Pregnancy for Mary was not a pleasant experience due to the messages her partner's father gave her about her identity.

I didn't like that pregnancy thing. I know my partner's father was calling me - little - "Oh here's little mummy" and I just hated it, I found it very patronising - Mary

Naomi was a single woman when she became pregnant. She observed that her pregnant state allowed her entry into the couple world of her teacher colleagues.

I think (with) the women that I taught with, who were mothers themselves, ... it was like becoming part of the club or part of the 'whanau scene'. You gained access to their world, I suppose. Whereas before I felt outside of it and as a single woman, a lot of people, ... couples, see you as a threat ... I think (by) being pregnant you gain admittance - Naomi

When the women did become pregnant, for some of them their expectations of motherhood changed little from before they were pregnant. One image that remained was of motherhood being a wonderful, positive experience.

I was going to be great, I was going to have these well behaved children, lovely child, and it was going to be all right - Clare

I thought it would be a very positive experience, a time to take a bit of a rest out of ... paid work and have lots of spare time. It was going to be great for me, great for my relationship and we were all going to be one great big happy family - Mary

Another image that returned for some women was that of motherhood being easy and that they would cope with it.

I thought I'd be really fair, loving, patient, understanding, (and) tolerant. (I) thought I'd have all the time in the world for the kids - Jan

All the women remembered receiving positive messages about motherhood from a variety of sources such as friends and families.

Someone I was working with, I remember (her) saying to me ... "Oh what a wonderful time you are going to have sitting in front of the fire, holding

this baby, you know holding him and just watching TV". And I sort of had that vision - yes I think it will be a bit like that too - Mary

Everyone was so happy, all waiting for this baby. Everything would go well - Clare

Another source of images about birth and motherhood came from the media, videos and books. Mary recalls books containing positive images.

I'm a reader and once I get pregnant or anything I will then go and get lots of books and sort of try and gain as much knowledge and information as I can. Everything I ever picked up, any of those pregnancy books, they would always sort of portray this positive situation - Mary

Jan's experience was that books gave a balanced view of motherhood.

I think there's still the really strong emphasis (in books) on what a wonderful experience this is and how privileged we are to be able to have children and it's such a special time. All those sorts of things. But I guess there was a balance in there with - it's difficult if you get a colicky baby and that type of thing as well - Jan

Sharon remembers reading a book but not believing it literally, and in fact it only became useful after she had her baby.

I remember buying this, a friend recommended to me, ... Sheila Kitsinger's book 'Baby and Child' I think it was ... so I read all up (on all) sort of bits about that, but I didn't really take it in and I only remember using it like a bible once I actually had the baby, and I would look things up - Sharon

Another major source of information were antenatal classes that most of the women attended for their first pregnancy. Some women remembered the classes discussed possible negative events such as colic and caesarean sections but not PND.

I got that I was going to have a natural birth. I didn't even consider I would have a caesarean... Everything would go well, I just didn't think that it wouldn't go like it was supposed to go... I remember talking about it (caesarean sections) but it wasn't going to happen to me! They covered it very briefly, very briefly. And when it happened to me I had no idea - Clare

I went along and did the antenatal classes and spoke to a few women who had just recently had babies, and I suppose I got a sense from that that it (motherhood) wasn't going to be quite as easy as I had thought. (But) that was only in terms of things like sleepless nights, and establishing breast feeding and colic and teething and those sorts of things. Practical things - Jan

Interestingly some women recall being selective about what information they listened to at classes and what they ignored.

I'm sure they would (have) spoken to us about it (caesarean sections), all these things that can happen but they don't go into it too much I don't think. Also, I don't think, probably you don't want to hear that stuff so you don't listen a bit - Sharon

Susan deliberately choose not to attend antenatal classes. She felt quite strongly that she did not want to get caught up in the hype of motherhood.

I didn't join (an) antenatal group. And I think in my head at the time I didn't want to become wrapped up in pregnancy and be with a big group of people who were (just) going through a common experience. I just wanted to enjoy my own experience ... I just wanted to deal with the practicalities of how to get through childbirth. I didn't want to get too swept along - Susan

The women with more than one child were very aware that during their second pregnancy, they had a more realistic expectation about the birth and motherhood.

Yes. I knew everything by the time I was pregnant with Tom. So the illusion had been well and truly dispelled! - Jan

I had had Postnatal Depression quite badly with my first (baby) so I was very prepared in my mind of how I was going to cope if I had it again... I'd (also) had a very traumatic first birth and difficult circumstances so I knew it wasn't going to, it's not all like it's meant to be, like it's portrayed. Much more realistic - Mary

Clare became pregnant again by accident and recalled her ambivalent feelings about that pregnancy compared to her other pregnancies, which included three miscarriages. These feelings relate to earlier quotes from women about feeling that the time was right to start a family, for Clare the time was wrong for another child.

I didn't want it to start with. And it was so odd for me because I'd lost three (by miscarriage) and I was trying so hard to hang on to Andy, (my second child), the whole time. I wanted this one to fall out... I had a theory (that) all my friends were moving on ... and I was all of a sudden, bang! Back to square one. I felt like I'd been held behind - Clare

Pregnancy for most of the women interviewed felt like a special time. Messages from other sources such as other people, books and antenatal classes supported this view and reinforced the myths about childbirth and motherhood that the woman learnt earlier on in life. The participants believed once again that it would be easy, natural and positive. Reality came from experience, the interviewees who had two or more children had had the myths dispelled.

EXPERIENCES OF MOTHERHOOD

I asked the women what their very first experience of motherhood was after they gave birth.

Positive experiences.

For most of them the feelings and thoughts were positive. For some this feeling continued for some time.

One of joy and I couldn't believe it after all these years - Naomi

It was just an absolute breeze. I used to take her out for hours all the time, push her around in town or go to peoples houses and I thought "This is just a fantastic life." And it was really good for about the first year and a half - Sharon

Even if the birth experience was unpleasant the women often reported feeling good.

She was delivered by caesarean. So that sort of blew me away because, I wasn't expecting to have a caesarean, I thought that I would just have a natural delivery. But then it didn't worry me too much. Once I had her that was all that mattered, she was OK and I was OK. I was really happy to have her. It was a bit unreal for the first couple of days, lying there and looking at her and thinking, "Oh my goodness, that's my baby!" For the first couple of days I think it was fairly, ... pretty cruisy - Jan

Instinctual and natural motherhood.

For some of the women there were expectations that they would naturally and instinctually know what to do when their baby was born.

I think I felt myself that I should know what to do ... - Clare

Sometimes this instinct became reality and sometimes it didn't.

That (breastfeeding) was something that I thought, you know, you just put your baby on your boob and they drank and that's the end of it. And I hadn't realised how sore it would be and how painful cracked nipples are, and engorged breasts and lumps and all those horrible things. I had no idea about that - Jan

One of the messages about motherhood that several of the women commented on was the immediate bond and feelings of love for the baby as soon as it was born. For most of the women this bond and love became true.

The birth experience itself was an absolute nightmare, but when he was in my arms ... they say love takes a long time to come (but) it was just like wham! I was crying and the birth experience was forgotten for a short while - Clare

I think what I expected was a bond, which was there, but it was a bond of pull and tug. A bonding relationship that would go beyond any relationship I'd had with another adult ... - Naomi

Jan's questioned her experience of the bond, wondering if what she was feeling was right as it wasn't as overwhelming as she had expected.

There's so much expectation there that you're going to bond with your baby, you know the minute it's born you're going to go "Wow, this is amazing!" I thought it was pretty amazing ... (but) I expected to have this overwhelming, indescribable feeling... I did think it was a really neat experience and, "This is wonderful", and I felt really happy to have my baby. But, I sort of thought "Is this what it's supposed to feel like, or is it supposed to feel better than this?" - Jan

Lack of control

One issue that all the women noted was their feeling they had a lack of control over their lives when they became mothers.

The only thing (that was unexpected) is not being able to be completely organised, like I remember I could never go anywhere until possibly late morning, because it took me so long ... just to be organised... I remember being invited to some women's group thing and then ringing up ... and I was absolutely freaking out thinking "I can't possibly come to morning things do you ever have things on in the afternoon?" - Sharon

For Naomi, the out of control feeling of having to put someone else's needs ahead of her own, was a new experience.

(I didn't expect to be) feeling that I couldn't dictate what I would do at what time. Someone else's needs having to come first, because for all my adult years, apart from when I was in relationships, even when I was being part of a family group I could ... always (take) myself away - Naomi

Some mothers such as Jan felt out of control when they couldn't soothe their baby.

It was the really cranky baby in the middle of the night and during the day that I found really difficult. Because, I couldn't understand why that would be happening. And why I couldn't fix it - Jan

Two of the women talked about the realisation that their task as a mother is enormous and frightening.

The first night I was home with her there was quite a major earthquake, a big earthquake, and I was sitting in bed with her and the enormity, ... the enormity of the task and what was ahead, hit me. The scariness of being alone with a baby - Naomi

Identity changes

Most of the women noted that their identity had changed, sometimes drastically, when they became a mother. Many of the women talked about society's messages of the change in their identity when they became mothers. These included changes felt in their identity from an individual person to a mother and child 'unit'.

People become more concerned about your child than they do about you. They always ask about the child or the baby, or you get stopped in the street and (they say) "Cute little baby" etc. I suppose you are seen as an appendage, to the side of (the baby)... I was engaging through my child - Naomi

I felt like I had lost my identity, I was just this thing that's function was to look after people. I felt like I had lost my brain and that's not something I like to feel - Mary

For some the change in identity was due to the change from working outside the home to being at home all day and the lack of outside affirmation. All of the women had given up paid employment when they became mothers.

(At my job) I had a lot of feedback on how I was doing. I was really good at my job, so I didn't necessarily get constant feedback on how good I was at my job, but I felt good. Because I knew that I was doing a good job and I knew that I'd handled a particular task or project well. And that gave me a lot of self esteem, pride, I guess. And at home, I didn't get that, I didn't get any feedback, the baby didn't give me any feedback - Jan

This change in identity was often related to the feeling that they were not contributing financially to the relationship with their partner, or to society, by staying at home. This conflict between working outside of the home or not was mentioned by all of the women.

But you felt a bit like you were a second class citizen really, because then you thought "Oh, you're just a housewife at home really". And often (that's) what you see around you, and you think well you haven't got much brains when you're at home, because you're not using your brain much - Sharon

If I was talking to anybody in a conversation and told them what I did for a job when I was working, they were really interested to know, "What's he like to work for?" But as soon as you say, "I'm a mum." Next person! - Jan

Returning to work

A few women talked about the pressure they felt from others to return to work as soon as possible.

I did feel that when you go out and socialise with other people and they ask, "What do you do?" I felt like I had to justify, "But I'm going back to work soon!" - Mary

For Clare she felt that to be a working mother should have been achievable. This is tied up with feelings of guilt at not being able to do both 'jobs' and be a kind of 'Supermum', as discussed in chapter three.

When I wasn't a working mum it was ... like I should be out there working, I should be contributing. I should be able to work and do it all - Clare

Susan noticed the message from society that there are two options - a mother at home or a working mother, and that the latter option is not desirable.

I think there's still that message that you're either a mother at home with the kids or you 'stick them in creche' as some people say, as if it's the worse thing in the world to do ... - Susan

When some of the women did return to some form of work there were good and bad experiences. For Naomi, the attitude of the workplace was supportive when she returned after having five years as a full time mother.

That was good, it was challenging. It was good because the work situation is very family supportive, it's very flexible. Your family commitments are given - Naomi

Other women also felt that going back to work was positive by giving them a feeling of financial independence, contributing financially to the family and time away from the children.

It changes how I felt about myself as a person. I felt like I was contributing again (to the family), ... And selfishly it gave me a boost, people saying, "There she is!" You get a bit of feedback that you're doing a good job - Clare

From that day, virtually, that's what saved me, just going out there in the world and feeling like I was me again, being away from the children and like I was earning money as well, ... and virtually from there was my recovery, really - Sharon

Susan returned to her work full time reluctantly, and then resigned. She is glad she had the opportunity to be able to make that decision.

I felt dragged back to work more than wanting to go ... I mean (I worked) part time as a scientist, but you still have got the same amount of reading and keeping in touch with what's happening with your field... That's what I decided, I'm not committed to this... So that was good, I made that decision to stop work - Susan

The issue of child-care for Clare was that although she had an identity again, this was counteracted with the feeling of guilt at leaving her child in child-care.

I felt incredibly guilty, the whole time... I missed him. I felt someone else was having the joy... Someone else was having input into my child all day, every day - Clare

Support

Another common experience of motherhood was the feeling of being isolated and without support.

There was no-one around (in the community). It was really isolated and (it was) a really strange feeling. Everyone was at work and they had older children, no-one had little ones... So there was no-one around during the day and it was (a) really weird feeling - Sharon

Some women talked about the lack of family and friends support due to the change in relationships that occur after having children.

But my whole life just changed incredibly. Going out for lunch, meeting friends and going to a cafe for lunch. Even if you just bought a $2.50 sandwich and a drink of water, you were in a cafe, having lunch with a whole lot of other people that were there doing the same thing. Now, I was at home eating a ham sandwich by myself! - Jan

For Mary the isolation was due to a recent shift to the area, where she and her partner had no social support networks.

(We had) just moved to Wellington, and I was working in a kindergarten so I knew people but they were parents and you can't mix with them because you're the kid's teacher. Really, until I went and formed my own groups I didn't know anybody and felt very isolated. Quite lonely - Mary

Clare noted that there was lots of attention and support for her prior to having the baby that disappeared once he was born. This was an unexpected experience.

(I didn't expect) being on my own so much. I think you have all this support and then bang, you're left with the reality of this little baby - Clare

Some of the women joined new mothers groups or continued seeing their antenatal group members. These experiences were reported as mainly negative.

I stayed away from a lot of those groups after I had the second ... (child), because a lot of them all the women would sit around have cups of tea and eat food in the morning or afternoon... Going on about, nothing really intelligent, like about their washing or about their kids all the time. I've got my kids at home and you like to talk a little bit about it but I want to talk about other things too, but I didn't know what. I sort of got a bit bored with that... Then also, I remember going to the Plunket thing and I thought well I'll try to meet some different sorts of people and went along to them. It was really shocking for me, because these women at the Plunket, were really nasty, catty women about each other. And they never used to talk about their children, because they said, "we can't be bothered speaking about our kids", but I like to balance of everything... So after a while I never went back to that sort of thing - Sharon

Because I found, (when) I went to a couple of postnatal courses that the parents centre ran ... I sort of felt a little bit like I was out of it... Because I think sometimes these mothers put it all on, and there were a whole lot of really gushy, "Isn't Johnny gorgeous", sort of people, and I wasn't feeling like that. In some respects it probably would have been better if I hadn't gone along - Jan

Both Jan and Sharon had negative experiences of support groups for new mothers. This could have been due to the individual group members and

structure of the group, or due to their PND and feelings of unhappiness with the motherhood role.

Support from other family members also differed with each woman after she became a mother. Mary's experience illustrates differences she felt between her mother-in-law and mothers support.

As far as like my mother-in-law goes, all of a sudden (she took).. this even more of a hierarchy thing over you, like "Listen to me I know more about it than you, you should follow me because you know nothing"... So all of a sudden (I felt like) I didn't have a clue I was stupid and I needed to be educated. My mother was completely different she is very supportive and was just there for me and went with whatever I wished to go with, even if in her head she may of been thinking "I wouldn't be doing it like that", she let me work it out myself - Mary

Along with their changing identities and roles, some women also noted their relationships with partners altered.

Like before we had the children, we'd go out for dinners and we'd go out to the pictures and we'd see friends and we'd do things with them. But virtually after I had my daughter it stopped, so to the extent that ... perhaps three times a year we'd go out - Sharon

No, there was a problem. He (my partner) did find it very difficult not having me. And I've always been, copying my mother, made him dinners and looked after him. It's very hard when you've got a newborn baby - Clare

Feelings of failure

A common theme for all the mothers interviewed was the feeling of being a failure at motherhood at times and feeling guilty about this. This would occur periodically when they felt they were not coping with the tasks of motherhood.

(As a mother, I felt a) bit of a failure, not just a bit. A failure. In hindsight, I suppose it's a lesson for me in humility and that I didn't know it. And (a feeling of) respect too, that it is a hard job and that I didn't fully understand the ramifications or the implications of motherhood. I took a lot for granted - Naomi

Also then I had cracked nipples ... and they were bleeding all the time and opening up. I felt a real failure too, because I was a La Leche Leader and I should (have) known what to do. But I fed my first child the same way and had no trouble - Sharon

For Clare having a child with visible eczema and herpes on his head, even though it was only temporary, led to feelings of failure at being a mother as well.

They weren't doing any harm but they looked terrible and I was so embarrassed I didn't go out of the house ... it really impacted (on me) that I didn't have this beautiful, perfect baby ... - Clare

These feelings of failure occur because of the inability to live up to unrealistic images women hold of motherhood.

I think it's (feelings of failure) inevitable because like the image that I had of motherhood being 'easy peasy', the images that anyone's picking on (at) any age or any era ... you're always going to be trying to meet those or not meet them. Depending on your personality or what your agenda is - Naomi

CONCLUSION

The women I interviewed all had some experiences and expectations of motherhood in common and some that were unique to them individually. They all grew up believing motherhood was easy, and a natural role for women. Even

though most of the women mentioned an awareness that motherhood was tough, they all assumed that they would be better mothers than others.

Some of the women accidentally became pregnant, however all talked about how they felt special and enjoyed the attention of pregnancy. The information gained during pregnancy often supported the myths and dreams they had when young. There was also the belief that motherhood was the normal next stage in their relationship.

All of the women felt that they were not prepared fully for the impact of motherhood and the huge changes this role would have on their lives. They all experienced vast changes in their identities and roles from non-mother to mother in relation to their family, friendships and in society. However, some of the myths such as immediate feelings of love and bonding with their baby did come true for some of the women I interviewed. Feelings of lack of control, guilt and failure were also common for the women.

The next chapter will continue to present the data recorded in the interviews I held with the six participants. The focus will be on the second and third parts of the interview questions which looked at the women's experience of PND and then the women's thoughts on policy and community changes that may assist women with PND. Following this, chapter seven will analyse the data presented here in light of the literature from chapters two and three on PND and on motherhood.

CHAPTER SIX

REALITY AND RECOVERY

INTRODUCTION

This chapter follows on from chapter five by completing the stories that my six participants told me. The chapter is set out in the chronological order of the questions I asked the participants. It is divided into two sections, the first section deals with their experiences of PND. The questions I asked the participants were around how their image of motherhood changed and their perceptions of themselves altered after they became aware they had PND. I also asked about how other people reacted to them when they had PND and the stigma of having a mental illness.

In wrapping up the interviews I asked the women for their thoughts regarding the status of motherhood and women with PND in New Zealand society. Their replies form the second section of this chapter. I finished the interviews by asking them for suggestions for the future, what changes they would like to see at a community level and at a government level, and these are included here.

The participants all had common experiences in relation to accessing the PANDS Group. The women's thoughts and experiences reflect the influences of the time when these questions were asked - late 1999, and the fact that these women are all living in a specific region of New Zealand - Wellington. Wellington, the capital city of New Zealand, is the third largest city in New Zealand. The region is well serviced by public amenities, such as public transport, compared to other rural regions of New Zealand (Statistics New Zealand, 1998b). I have discussed the uniqueness of these factors in this chapter.

POSTNATAL DEPRESSION

Finding out

The range of their babies age at which the women felt their depression starting was between three weeks and six months. The symptoms and feelings that the women I interviewed experienced prior to acknowledging they had PND included crying, feeling out of control, anxious and suicidal.

We were driving along on the motorway and I thought, "Now might be a good idea to open the door and jump out." And I thought, "This is not good!" - Jan

I went to the doctor ... and (said),"I don't know what's wrong with me, I just can't cope, I'm worried and with floods of tears"... I just fell apart basically - Clare

I started to feel sick and have all these symptoms of crying, anxiety, panic attacks and things like that - Mary

How the women discovered they were suffering from PND varied, but commonly the diagnosis was made by their GP. For some women their GP was someone they were seeing often anyway with their new baby and so it was natural to talk to them.

He, (my doctor), came out and ... I thought "I really want to tell you but I can't, and I wish something would happen that I could", and then he just tapped me on the shoulder, he's sort of quite a caring man anyway, and said "And how are you Sharon, are you OK?" But I think he would just say that to anyone, not thinking I looked funny or anything. Maybe he did think (I looked unwell) because I looked really drained - Sharon

For Susan the diagnosis came about because of a friend showing concern.

I remember sitting out on the steps one day with one of those two women (friends) ... and she said "You're not happy are you?" and then I just crumbled ... and I thought, "Yes, it's not working" - Susan

Clare had antenatal depression which turned into postnatal depression after the birth.

They called it antenatal depression, and then changed it to postnatal depression. Which to me is bizarre. I mean, it didn't feel any different - Clare

Jan had experienced PND previously and was able to recognise it and access support quickly.

Definitely, I knew (I had PND again)... So I just said to Steven, (my husband), "That's it, I'm just going straight back (to get treatment)" - Jan

Having acknowledged that they did have PND was welcomed by the participants with a mixture of relief and dread. Some women described relief at knowing that there was something wrong, that they had an illness and they could get help with it.

(My GP said) "Yes you have got PND" and I thought "Phew, I'm glad I did the right diagnosis myself". I was quite pleased that I had sort of figured it out and relief really. Relief that I had been given a label - Mary

I felt two things actually. I felt really bad, like "What have I done, I've got to 36 and how can this be happening to me, what have I done wrong? I'd done this". On the other hand it was like, "They've (the maternal mental health team) given me a name for it"... I said "I had postnatal depression", I just felt so much better - Clare

All of the women experienced PND with at least one of their children, Jan experienced it after both of her children. She was aware that she could get PND again but it still came as a shock.

Because I'd gone for ... three months, without feeling any depression at all, I had thought there was no way I was going to get PND. I knew there was a 50% chance that I was going to get it, but I was gong to be the 50% that didn't, not the ones that did the second time. So that really surprised me - Jan

For some women having a diagnosis of PND also led to feelings of failure.

Disappointed I suppose, that I couldn't do the things that I thought I should do and that I wanted to do. That my life was not on the path I wanted it to be. And I felt really out of control - Susan

No, I didn't admit to it at all, that's part of that failure (feeling). I don't know if I did any reading or anything like that at that time, I think I just kept soldiering on - Naomi

Stigma

For all of the participants there was stigma attached to having a mental health illness. Stereotypical images of mental illness came to mind for some of the women. Jan's quote below indicates she thought she was going 'nuts' and would be separated from her child.

I was a bit concerned when I was told that I had PND, that I was going nuts. "Oh my goodness they're going to send me off to the hospital and take my baby away." So that was really quite scary - Jan

A lot of the women kept their illness hidden from others. Some women avoided telling some people for fear of their reaction because it is an mental illness, and they were aware of the stigma of this in today's society.

But there was still some people, I felt like, "I don't really want to tell them" because they might think I was a bit strange or they just couldn't understand - Sharon.

I could see it (stigma towards PND) on people's faces, even now I don't openly go out there and tell everybody that I've had PND. I've seen it happen in the community. Somebody that I know has had PND... And these other people are saying "Oh yes, she's had PND!" As if it's some reason that she should be dismissed, it's just awful. Basically, I think it's the mental illness stigma - Jan

Some of the women talked about keeping up appearances. Mary, who kept her illness hidden from a Plunket support group, eventually told them. Their reaction was one of shock because she kept up the pretence so well.

I didn't tell anyone for ages. The Plunket nurse got me into one of those PIN group things and I think after quite a few months I told them and they all were stunned because I was very careful about putting on that brave face and I couldn't be seen as not coping, especially someone with this early childhood background who thought - I know a bit about that I'm going to be OK. And they used to say to me "You'll be all right, of all the people in the room you'll be the one to cope, you'll know what to do" and I was thinking "You've got no idea what I'm feeling inside" but I didn't tell anybody (until later on) - Mary

I spent a lot of time pretending and a lot of time not turning up to things, because it was just too hard trying to pretend with people ... I didn't want to cry in front of people I didn't know very well, I didn't want to cry in front of people I did know very well either... I didn't want to do that with people that were the way I wanted to be probably, it was another way of saying, "I can't do it"... So I just stayed away from things like that - Susan

Sharon also kept her illness hidden from others and was able to keep doing the practical tasks she felt were essential to mothering.

I could still look after them, which I thought that's what you have to do. As long as they're clothed and fed and kept warm and they're given love, because I was always cuddling them... So I still cared for them, all the things you did as a mother, but inside I was all this depression. So I knew I was still a good mother, I thought I was still doing all the good things ... I'm still getting all their needs met. And with my husband too, the house was always tidy and I used to do dinner and the washing, it was all kept up. Because, later on when I told people in some of my groups they (said) "Oh God, we'd never of suspected that you would, because your house is always so tidy and your children are always so well looked after, and you always look so good". It's inside, it's hidden, you can't see it - Sharon

Naomi didn't admit she had PND to others for a while because she felt it was a private, not public, issue. I asked her if she talked to others about having PND.

No. Because I thought at that time, through the whole parenting experience, I'd become a much more emotional person. Once I'd admitted it and became part of that (PND support) group it was like that became a public statement about a private anguish - Naomi

The women all found that when they did tell other people their reactions differed. Some of these reactions increased the stigma of having a mental illness for some of the women.

Yes, my mother said to me, "You haven't got clinical depression"... It's almost like a daughter of hers couldn't be depressed - Clare

My Dad thought it was absolutely absurd, especially when I started taking medication. He just couldn't believe that anyone would take medication for something that's all in their head. "Pull your socks up, get on with it." (He had) that sort of attitude - Jan

For Susan whose mother had been disabled with PND, these memories stopped her from telling others she had PND.

I felt vulnerable enough already with a few people knowing (I had PND) and feeling like I couldn't do it, (motherhood), myself... Probably it would have been an influence again of my mum. When she couldn't cope she really didn't cope and everyone came in (to help) and she stopped giving out to them and to her family. She became a bit of a sponge. I didn't want to be a sponge - Susan

There were also many good and supportive reactions from people.

My brother likes me a lot better, before I ... belong(ed) to committees, ran half marathons, pretended I was superwoman I think. And now I've sort of fallen apart, I get on a lot better with him - Clare

My mother was absolutely marvellous because she'd known about postnatal (depression). Once I told her she said "Yes I remember women in my day being a bit like that" And she'd actually probably been reading up about it or heard (about) it more now. So she was just so lovely to me, so neat to me and she always has been - Sharon

For Mary, telling her mother also led to her mother disclosing her PND experience.

I did tell my mother and she was great and she came and stayed with me for quite a while ... and she told me that she actually had (had) PND with my younger sister ... and it was interesting, I didn't know that. I was ten and I do remember her sitting with the baby a lot on her own in Sally's room, holding her on her own and looking upset but I didn't know why - Mary

Information

Some of the women, when they realised they had PND, recalled hearing about it before. Sharon remembered seeing an advert on television when she was younger about PND. But when her GP diagnosed her with PND she couldn't recall hearing any information about it recently.

But then he (my GP) actually said to me, "I think you've got postnatal depression", and I thought "What's that?" I think I'd heard a little bit about it by then maybe, I must (have), I think. I can't (have) been too sure about it because I never got help - Sharon

This lack of information was also noted in antenatal classes that Jan attended prior to having her first baby .

I didn't know anything about it really, didn't know anything at all about it. I think they might have mentioned it in a five minute snippet in the antenatal class. But I didn't have any idea about it, what it was or how it made you feel - Jan

Mary was aware of PND and had written information from her training about the subject. She feels this helped her to identify the problem and access assistance.

When I was a kindergarten teacher I was really into parent education... I remember pulling this brochure out of my parent education kit and thinking, and reading it through, "This is what I've got, this is me, this is me!" - Mary

Treatment

The treatment that each woman received varied. All of them connected with the Post and Antenatal Distress Support Group (PANDS) in Wellington for help. This is the group where I enlisted my participants from.

Susan came across the group from seeing a poster before she had the diagnosis of PND.

I rang Alice (from the support group), I think I saw a poster somewhere. I think I was still trying to work out whether that's (PND) what I was experiencing... So I went along to the support group. That was quite helpful - Susan

Naomi joined the group as a volunteer first, to assist other women.

Joining up, I realised that there were issues I still hadn't dealt with and so through the training, I confronted some of those things that I had been trying to not admit to the world. I had admitted it in here but I hadn't admitted it to (the world) - Naomi

Three women also went on medication for their symptoms and found this helped.

She (my GP) said "What you need to do is antidepressants and counselling to sort it out." And ... I thought "No I've never had anything like that, I only had antibiotics once, I'd never been into hospital until I had this child." It was all just too much for me, "I'm not that bad I'm not one of those people." And she convinced me that (that) was what I needed and I thought, well I've got to go with that - Mary

Two of the women were also referred to the Maternal Mental Health Team (MMHT)[7] in Wellington for support as well. For Jan, the ease with which she could get help from them, was of great benefit to her.

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[7] The Maternal Mental Health Team is a team of mental health professionals working in the Capital Coast Health region, funded by the Health Funding Authority. They work with women who have a moderate to severe psychiatric disorder, which includes women with Postnatal Depression.

I was really, really lucky with my treatment. I went to a GP who referred me immediately to the maternal mental health unit at Porirua... And I think because I'd ... had treatment through them with (my first baby) Charlotte and they (had) said, "If you have any problems, come back."... I just came back and rang them and I just went in and went straight on to the medication - Jan

And they (the Maternal Mental Health Team) kept saying "You will get better" and I don't know if anyone understands how wonderful that is. 'You'll get better' - three words - Clare

Three women were also referred on to counselling from other sources as well. The women found this was useful in conjunction with other treatment and/or support.

And then she, (my GP), organised me to see a social worker at the hospital and she was great. And I started antidepressants and all of a sudden two months of hell started to turn into (something) I could cope (with) - Mary

Yes. I talked to my GP ... and she said, "I think you need to go and talk with someone", she sent me along to a cognitive psychologist. And that was quite helpful, but I think I saw her too soon and I don't know. She was really helpful, she taught me things like grounding and breathing exercises and getting rid of some stress and anxiety - Susan

Sharon also had support from her local Karitane unit and found this to be extremely important in her recovery.

I ended up spending three months at the Karitane unit, every day. By then I couldn't cope at home and I felt like I just wanted to get out of the house... I'd rush and get everything done so I could just get out of the house, because I wanted to have people with me that understand me. Because here I'd found these people and they're really lovely - Sharon

The women that I interviewed had a variety of experiences with PND. Finding out they had PND ranged from self-discovery to diagnosis by their GPs. There were mixtures of relief and dread with this, and feelings of failing at the motherhood role.

Along with these feelings, many of the women kept their illness hidden for fear of other's reactions and the stigma of having a mental illness. When some of the women did tell others they had both positive and negative reactions. Many of the women recall having little information on the topic of PND before they became mothers.

All the women received support from the PANDS group. This was inevitable due to the recruitment method used. All of the women felt all the different treatment and assistance helped in their recovery from PND.

This leads onto the next section of this chapter where I asked the women about their thoughts on how society views motherhood, PND and what action can be taken to assist women who develop PND, such as education in antenatal classes.

THOUGHTS FOR THE FUTURE

The last questions I asked were around the interviewee's thoughts about current attitudes to motherhood and mothers with PND and for their ideas on any changes at a local as well as policy level. These questions were designed and placed at the end of the interview for three reasons. Firstly, to move away from the personal and often upsetting discussions of PND, and bring them back to focus on the present day. Secondly, to allow participants to express any solutions and actions they think could be taken which will assist other women who may experience PND. And thirdly, it also reintroduced the research objectives into the interview, which were around the messages that New Zealand society has on this topic.

New Zealand society's views

The first question I asked all the women was what they thought New Zealand society's views of motherhood were. All the women talked about the lack of value given to mothers.

They don't give them the credit they deserve - Clare

Like today, at this stage, I don't think they value them very much. Which I think is really sad - Sharon

A lot of women mentioned that society views the task as easy and as a female occupation.

At the bottom of the pile, pretty well down there towards the bottom of the pile. It's just seen as a job the women are expected to do and it's not too difficult. "How difficult can it be to stay home all day?" - Jan

The next two quotes also indicate the view that people ignore, or don't want to hear about the negative side of motherhood. The quotes also illustrate now the myths of motherhood get perpetuated, even by those who have had babies.

I think they, (people in society), have a very rosy view of mothers, really. I don't think they know the reality of it, even people who have been mothers. Everyone says to you, "Are you enjoying your baby?", even people who have had babies - Clare

I think there is just so much 'blanket' information out there about how wonderful being a mother is. And almost reinforcing society's opinion that it is easy. To me people seem to think or view that if you're talking about how difficult something is, then you're being negative and "We don't like negative people, we don't want to hear it". But that's part of life. It's not all sweet smelling roses. And OK, it's not the negativity that counts it's how you deal with it, but that's not to say it doesn't exist - Jan

Mary mentioned this view of motherhood being an easy task, in relation to the parental leave policy that is currently being debated in government[8].

I still feel the dominant thinking would be ... that mothers have got it easy and that it's a nice cruisy time of their life and why should they get any paid parental leave. It's not fair it's their job to be a mother, that's why they are created to have children - Mary

Susan's comments below state how children are excluded from the public arena, and that mothers are also excluded due to their role in relation to children.

Children are really labelled as 'children' they're not treated as little people. Like you go into town ... and it's completely child unfriendly. And it makes you feel like you have to protect your kids or you have to be around them all the time for them to be part of the world, to sort of interpret things and to interpret them to the rest of the world. And I think that puts you in a particular role - Susan

What do you do all day?

The relationship between being a working mother and a non-working mother was also mentioned by participants. The image of a mother at home 'losing her brains' came through.

But I think it's ... like "You're only a housewife". Like even on forms you put ... 'home-maker' or things like that, And I think they still seem to think that they are a bit thick really - Sharon

Naomi's opinion was that it is a balancing act between work and family.

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[8] The Paid Parental Leave Bill proposes that all employers pay a levy tax to enable working mothers to take 12 weeks leave at 80 to 100 per cent of her normal salary (Langdon, 1999).

I think (motherhood) ... to me, in terms of society now, (is) wrapped up in being a working person and contributing to the financial pool of the family. And one of juggling, constantly juggling career and home and family - Naomi

Susan talked about her experience and view that her workplace, in the voluntary sector, is family friendly.

I think it's starting to change, like my workplace is really mother friendly and that ... you can take leave without pay during the school holidays and things. But that's the (voluntary) sector and I don't know how big it is in the corporate world - Susan

I then asked what the participants thought New Zealand society's view of women who have PND is. Some women felt it was more accepted today than in previous eras.

I think generally it seems to be more accepted to say you've got it or you had it, especially compared to our grandmother's day. Because I am sure a lot of them had it, it's just that they tucked it away and never dealt with it. I think there is more acceptance but we've still a long way to go, (like) anything to do with mental health - Mary

Clare also got an unusual reaction from someone about the status of PND.

One woman said to me "It's getting trendy". It doesn't feel very trendy that's for sure! I thought, "What an odd thing to say!" I wasn't sure if it was a compliment or what. It was weird - Clare

While there was a feeling from three participants that it was more accepted, there was still this notion of failure and blame on the individual woman.

I think it's probably far more recognised now. It's acknowledged. But then by saying that I'm sure that ... even though it might be talked about or acknowledged, it's not going to stop you feeling a sense of failure - Naomi

(The view is) ... it's their fault. It's taken me a long time to realise it's not my fault. Society views depression very badly anyway. For some reason postnatal depression seems to be more accepted, but depression is depression really - Clare

This view of PND being a failure also meant that it could be hidden away from others. This idea comes from the feeling of stigma and shame that women mentioned earlier in their personal experiences.

I think it forces people to keep it to themselves. I think it's viewed as a weakness rather than an experience that can be worked through and got through - Susan

I don't think there's a lot of time for (women with PND) ... really. Even now, it's still something to be hidden away really and still not spoken about much. It's slowly coming out like with the groups ... I belong to now, helping women. But I still think it's hidden a bit - Sharon

Changes

My next questions were about what changes they thought could be implemented at a community level to assist women who developed PND. The women all responded with suggested changes that could be made individually, locally and nationally.

Several women spoke of the need to advertise PND and support groups in GP surgeries.

Even like advertising in doctors surgeries and things ... 'postnatal depression it's very common', or things like that. (That would help) people to be more aware of things - Sharon

Education of GPs, Plunket nurses and other health professionals were amongst other suggestions.

I think at every surgery there should be someone there who can spot the signs. I mean the Plunket nurse sort of does, but they're busy. I think there needs to be someone in the surgery who knows the signs - Naomi

My personal opinion is that there is a lot of the old traditional thinking in the Plunket nurses. There's a lot of Plunket nurses that still won't refer to (the PANDS group) ... who want to try and deal with it themselves and I'm not saying that they don't have the experience or the resources but they don't (refer)... Somehow there probably does need to be a bit more cohesiveness between the health professionals and education and not pushing out this myth that it is going to be all a wonderful happy experience and cute babies - Mary

A few women also talked about the national 0800 Plunket line. At the time of the interviews the funding for this service had run out and there was a lot of debate about whether the government would continue to fund it[9].

... that Plunket line, that 0800 number the 24 hour one. I don't know what the situation is with that at the moment, but the funding of that needs to be assured, and access throughout the country - Naomi

If there was something like that ... that women could ring up ... that it was well known, that if you were feeling down, you could ring these people and get some help. I'm sure it would save huge dollars and it ... would be

[9] The National government did reinstate funding for the 0800 Plunketline in August 1999, but only for 12 hours a day. The Labour government increased the funding in May 2000 to allow the 24 hour service to return (Kuiper, 2000).

(a) huge support for women. Just having the Plunket 0800 number is really quite nice - Clare

Changes in the hospital system were also suggested such as longer stays after giving birth, and mother and child units.

The stay in hospital has got to be longer. To me a big thing about being a mum is confidence and there's no way that a first time mother can have a baby and leave hospital two days later feeling confident - Jan

I know in Melbourne where they have mother and child wards where a woman can go with their baby, and have a ... professional team - a psychologist, midwife all those sort of professionals working with you, in a supportive way. I'm sure if that was available to families that private anguish wouldn't necessarily go on - Naomi

As well as the above suggestions, access to specialists such as the Maternal Mental Health Team was suggested.

I think from my experience from the maternal mental health unit, it's just sad everybody doesn't have them. And it's sad that they can only pick the cases which they see as (severe), it's a shame that they can't be there for everyone - Clare

All the women who attended ante-natal classes felt that these also had to change and discuss PND in more depth.

I actually went to one last year with a friend (who) was pregnant, I was her support person. I was really interested to see what they would say about that, (PND), but I didn't let on that I belonged to a group or anything. And they virtually don't cover anything really, they don't go into it much. But then it's hard to because you've got all the other topics to cover as well - Sharon

Going back to the antenatal classes... Yes it was a gloss job, the whole antenatal scene. I think at the time of antenatal classes if you knew about those (PND support) groups, I can't remember them telling us about them but maybe they do and I just thought, "I won't need that"! If you're actually visited by someone, a face from the groups and not just handed out pamphlets - Naomi

As the next two quotes indicate they also recognised that they may not have been in the right space to hear about negative factors like PND at that time.

But I still get the feeling ... and (I) look at myself way back when ... (I went) to these classes, you're not really listening to that (information about PND)... They give out leaflets and they say this happens, but you wonder how many people think about it or "I should be managing" or "It's too embarrassing" - Sharon

I know, like I went through a pregnancy that was heaven and floated through and yes that sort of 'cotton- wooled' about the real world. And if you were going to antenatal classes and you knew that the next week you were going to be presented with someone from postnatal depression, you might think "I won't go to that one, I'll skip that night" - Naomi

A lot of women also advocated for support services and systems to decrease women's feelings of isolation.

Maybe more support networks, maybe more things for mothers. More ground support - Clare

I had fantastic support from the Karitane Centre... And that was just amazing... If you're in a situation where you don't think it's so hot being a mother for whatever reason ... where you're with a group of women who are all ... 'coo-coo', 'gush, gush', you're not going to talk to them about your difficulties are you? And so you have got to have somewhere else to

go ... I could go to the Karitane Centre and sit there all day if I wanted to - Jan

Susan felt this need for support could be widened to include people who experience any kind of problem.

I'm sure there's a lot of common threads between other people going through difficult times in their life and just the chance (to talk gets) ... rid of the isolation - Susan

At a wider level some women commented on the need to change attitudes in society towards motherhood and PND.

I think it's probably the media and the public really, (that need to) work on that sort of thing. To try and value ... motherhood more, and put it across that it is a really important role. You're probably only going to get that more when there's more, not really publicity, but more attention paid to things or people talk more about that sort of thing or it's brought to light more - Sharon

Susan felt that de-stigmatising PND by not labelling women who have it would assist recovery.

(Making PND) more common to other people's experience so it doesn't stand out on a little box on it's own - "These woman have got PND". But "These women are finding life really difficult at the moment and I'm sure things will get better for them" - Susan

Policy changes

The last question I asked was what policy changes my participants thought the government could make to improve the well-being of women who had PND. Several of the above ideas were repeated such as the funding for the 0800 Plunket line. Other ideas were about funding other support services.

Maybe, they could just give some money or just give some hom(
Just someone to come in and just help you for two hours a day, just a face to see, to drag you back to reality - Clare

Other ideas were funding for education about PND. Mary argued that there would be long term benefits for education and awareness.

I think if society or the government really wants to put their money where their mouth is, they should be giving resources and finance to say this is a condition or an illness just like heart diseases and that a lot of people are getting it. Maybe we need to do a lot more education and helping people cope with it, get over it quicker. It would certainly save the taxpayer a lot of money from medication if there (were) a lot more people out there, paid by governments or health funding authorities, getting out there and talking about it - Mary

Another idea was having policies supported by government such as paid parental leave.

If they could give mothers some support, even if it was like, you know all these other countries have paid leave, (like) Britain - Clare

Susan described her vision for this to include paid leave for fathers, in addition to annual leave in which they are already entitled. She describes her family's experience of not having this option.

I definitely think that men should be given leave, with or without pay, for us it wouldn't of been a huge impact, just to be able to have two weeks ... (but) I know for most families that's not the case. Fathers feel left out of early parenting experience. I know David (my husband) felt really left out and I think it would of helped us as a family a lot more if he'd been part of that early nurturing... The feeling that it's very valuable ... limited time, that was a real pressure for both of us - Susan

It is important to note that under the current Parental Leave and Employment Protection Act (1987), New Zealand male partners are entitled to two weeks unpaid paternity leave (Else, 1996). Susan's point is that for many families this is not financially viable, and the limited time of two weeks caused stress for her family.

Regarding support for mothers to return to work such as family friendly work places, Mary also felt this would be valuable for women who had PND, to decrease their low self esteem. She also expanded this theory to include all mothers.

Because a lot of people who have PND say they feel isolated and worthless and they want to do something to contribute or get their financial independence back... Women have got heaps to offer in the workplace and why penalise them because they are now mothers, if they want to work and they want to offer something to the business why not let them come back in. Surely if the business is able to subsidise a creche or something like that, then it's going to make the woman a lot happier because she knows the child is near by and is being cared for. Whereas a lot of people are sceptical about going back to work because they are worried about nannies and child-care and all that. So I think it can only be a good thing - Mary

Susan also felt the government could support alternative family structures to assist women who had PND. She based her thoughts on her observations of other cultures.

Policies that encourage families to stay together as wider families... New Zealand's becoming much more multi-cultural too and those values are important (to) other families if they manage to hold onto them... Like kids going off to school with their aunts and uncles and cousins it doesn't necessarily have to be their mum. But that just really takes the pressure off one or two people and it's much more fun - Susan

The next chapter will link these final thoughts and suggestions to policy implications and community developments for New Zealand.

CONCLUSION

This chapter completes the stories of the six women who participated in my research. All of the women had different experiences when they found out they had PND. Some of the reactions were of relief while others felt it was a failure on their part.

The stigma around having PND came from family, friends as well as the public. Because of this stigma and related fears, the women often hid their illness from others and kept up the appearance that all was well.

Another common experience was a lack of awareness of PND. Some of the women felt that they may have been informed about this in antenatal classes, but that they choose to ignore it as it is a negative outcome in what they wanted to believe was going to be a positive event. Women advocated for education at every service that a mother may use.

The women all received some form of support or treatment for their illness. Once they did receive help, the response from others and the treatment was beneficial.

The women all felt that motherhood has very little status in New Zealand, and that it is seen as an easy task by society. Issues around working mothers and possible solutions were also mentioned.

Comments were made that PND is seen to be more accepted these days, however most of the women remembered their experiences and felt that stigma and feelings of failure mean that women keep their PND hidden.

Lastly, ideas for change were education of health professionals, keeping the 0800 Plunket-line and funding other support programmes, increasing hospital stays and increased access to Maternal Mental Health Teams. Other ideas were around de-stigmatising PND and changing attitudes to motherhood in society so that mothers who are finding things difficult, even if they do not have PND, can talk about it.

The next chapter will link the women's comments recorded in this chapter and chapter five to the literature in chapters two and three on PND and motherhood. Chapter seven will also expand on some of the thoughts and suggestions that the women made for policy and community changes that may assist women with PND.

CHAPTER SEVEN

WHEN FANTASY MEETS REALITY

INTRODUCTION

This chapter will analyse the data gathered from the interviews with the six participants in light of the literature on PND (chapter two) and motherhood (chapter three). The chapter is structured into four parts. First the social causal theory of PND is discussed. As outlined in chapter two much of the research to date has focused on biological and psychological causes; little research has been done on the social causes. The areas addressed are women's identity changes, invisibility of motherhood, loss of control, changes in relationships, child-care and advice and information.

The next section deals with the myths of motherhood and the expectations women have of motherhood, which can contribute to women developing PND. I believe these myths are the main social influences on the development of PND. The section expands on the myths that motherhood is natural and instinctual, that motherhood is part of being an adult for women, and lastly that motherhood is happy and fulfilling.

The chapter then returns to the participants lived experiences of PND and the impact on them of having a mental illness label. There are positive and negative impacts of this in terms of relief at having a name for how they feel to the stigma of having a mental health illness. Finally, the chapter analyses the interviewees experiences of treatments and solutions that they personally found useful as well as their comments and ideas in assisting other women who have PND. The women's experiences are linked with literature and other research findings in this area.

SOCIAL CAUSAL THEORIES OF PND

In chapter two, the three theories regarding the possible causes of PND were outlined. The theory that this research concentrated on was the social causation theory.

Identity changes

For most of the women interviewed the change in their identity began when they were pregnant. Both Susan and Sharon noticed that other people paid more attention to them when they became pregnant and both commented that it was a welcome intrusion into their lives. They felt the change in identity was to a more positive and special role. Naomi noticed that she became accepted into the 'married mother's world' of her workmates. These comments mirror the literature which notes that this change in role is profound because pregnancy is a noticeable state for most women, so their new role is very public (Phoenix and Woollett, 1991). This special interest heralds the change from being a woman to being the bearer of a new life (Kaplan, 1994). The focus of interactions with others, changes to care and concern of the foetus and 'an interest' by others into issues such as the woman's health.

Mary's experience was different to Susan's and Sharon's as she did not like the negative comments made by her father-in-law. Her comments reflect the points made in the next section on the loss of identity when the woman becomes a mother. Mary may have been experiencing this loss during her pregnancy or there may have been some personal relationship issues with her father-in-law that were not explored in the research interview.

In contrast to pregnancy, once they became mothers, many of the women interviewed expressed the feeling that their identity was lost. Other researchers have found that mothers feel that their individual identity as a person is lost when they become mothers (Brown et al, 1994; Littlewood and McHugh, 1997; Thurtle, 1995; Villani, 1997). Naomi noticed she became an appendage to her

new baby. She wasn't a separate person any more. This mirrors Glenn's (1994) comments that mother and child are seen by society as one person.

Nicholson (1990) sees childbirth and motherhood fitting into a grief or bereavement reaction model. These losses to a woman's former identity can be closely aligned to other losses that occur in her life. This is reflected in Jan and Sharon's comment's on the changes in their lives, noting the things they used to do and could no longer do, as mothers.

Second-class citizen

Many of the women commented on the expectation from society that a mother puts her own interests and needs aside. As Naomi stated, people were more concerned about her child than they were about her. Clare felt selfish when she received positive feedback from her work colleagues on her return to work. This finding mirrors the literature on society's belief that self sacrifice by the mother, for the well being of the child, is a trait of a good mother (Astbury, 1994; Glenn, 1994; Hays, 1996; Marshall, 1991; Thurer, 1994).

Mary also noted that she felt she was 'losing her brain'. This was echoed by other women interviewed who felt a common opinion in society is that motherhood, because it is removed from the public, working sphere, does not require any brain power. All the participants interviewed had given up working in the public arena when they became mothers. Sharon echoed Mary's comment that other people felt she wasn't using her brain now she wasn't working. She also mentions that she felt like a second class citizen. Similarly, Woods (1993) had the experience of other people telling her she was wasting her education by being a full-time mother.

Woods (1993) also commented that the motherhood role has little value in New Zealand society. Motherhood is socially constructed in a public - private dichotomy with paid work, and therefore not worth a monetary value (Glenn, 1994).

Lack of control

All the women interviewed spoke about the lack of control over their lives they felt when they became mothers. Several woman talked about their need to have routines and that this was lost once a child came along. Sharon talked about being unable to organise her life like before and feeling out of control once she became a mother. The issue of lack of control also arises when looking after a new baby doesn't go by the book. Jan experienced feeling out of control when she couldn't soothe her new baby. Naomi talked about returning home after having her daughter and experiencing an earthquake. She realised the enormity of her task as a mother and this scared her.

Feeling a loss of control is one of the areas Beck (1993) researched as being a major factor in women's experience of PND. She called this "... teetering on the edge, which refers to the fine line between sanity and insanity" (Beck, 1993, p 44). However, it seems this feeling of lack of control occurs not just with women who suffer from PND, but for mothers in general (Goss, 1998). My research, like Beck's research, did not compare mothers who developed PND with those who did not develop PND. Further research into this is suggested in the next chapter.

Isolation

One of the startling consequences of motherhood for the women interviewed was the isolation they felt when they became mothers. Jan compared when she was able to afford the money and time to meet friends for lunch to the isolation she experienced when she became a mother.

The isolation of a new mother is a reality in today's society where many mothers return to work (Statistics New Zealand, 1998). People are also more mobile and thus often do not have extended family nearby to support them in times of need such as with a new baby (Goss, 1998; Dunnewold and Sanford, 1994). Sharon, who noticed the lack of other new mothers like herself in her community, illustrated this isolation. Mary felt her isolation was due to the fact

that she and her partner had just moved to the area and had yet to make friends.

Mothers also feel isolated in society because children are often excluded from the public arena. Mothers, because they are the care-givers of children are also excluded (Littlewood and McHugh, 1997). Astbury (1994), Brown et al (1994) and Meager and Milgrom (1996) all discovered, in research they separately conducted, that because a mother's work is largely carried out in the privacy of one's home and therefore is not visible to the public sector, it creates isolation for the mother. Susan puts her experience of feeling isolated down to this factor. This isolation is also reflected in Jan's comment that when she was working, people would be very interested in her because of her job, however when she became a mother she felt others thought she wasn't interesting any more. The issue of child-care and working mothers is addressed later on in this section.

Lack of support

Logsdon et al (1994) found that a factor in developing PND was not how much support the individual woman received but how much she perceived she needed and was receiving. Some of the women interviewed found that the new mothers support groups they attended postnatally did not meet their needs. Jan and Sharon both felt the groups they attended did not help them cope with motherhood. In fact Sharon admitted that she did not know what she wanted from these groups but on trying different groups she gave up.

In reality it is not about just having support but having the kind of support that the mother wants and needs, and that this can be different for each mother. Mary identified that the support she got from her mother-in law was not helpful as she felt she was being told off all the time, whereas she felt her mother was supportive. Clare commented on the sudden change from having lots of support during pregnancy to none when the baby was born. This reflects the research findings by McIntosh (1993) that the enormity of the workload and the unpreparedness of the mother to cope with it without support, can be a factor in

developing PND. Webster et al (1994) also found lack of support a factor in the development of PND. The issue of support, both practical and emotional, as an option for assisting mothers is addressed in the solutions section of this chapter.

Relationship changes

One of the major impacts of childbirth is relationship change with partners. In the women interviewed some felt that there were changes in their relationships when they became mothers. Clare's experience illustrates that role changes in the home may lead to the new mother being unable to fulfil previous roles in the relationship. The majority of women spoken to felt their division of labour in the household had not changed and in fact, when they were diagnosed with PND their partners assisted more. This is in contrast to Lee (1997) who found that the mother's dissatisfaction with her new role, and the quality of her relationship with her partner declined with the arrival of a child. Also, Logsdon et al (1994) discovered that the feelings of closeness by the woman to her partner were a factor in the development of PND. The addition of a new family member also causes stress in relationships, which can be linked to the development of PND (Murray et al, 1995).

In McIntosh's (1993) research of women postnatally, he found that new mothers did not think their partners contributed enough support and assistance. He concluded that it was the mother's *perception* of the support they received that was the issue, not the actual amount of support. The fact that my research indicated lower levels of dissatisfaction in this area may be due to the timing of the research. McIntosh conducted two monthly interviews for up to nine months after the birth of the baby. The research I conducted consisted of one interview with each woman and the ages of their children at the time ranged from eight and a half months to 16 years old. Therefore because the women I interviewed were looking back and remembering their experiences and not immersed in the experience of PND as McIntosh's participants were, their recall may have been less than accurate (Babbie, 1998).

In response to an interview question about changes in household roles, Sharon indicated that she and her husband did less together as a couple after her first child was born. This is supported by the literature, which states that relationship changes can involve lack of time as a couple (Dunnewold and Sanford, 1994). Again, these changes after childbirth are not unique to women who develop PND, but in fact occur for many couples.

Returning to work and child-care

Issues surrounding returning to work after becoming a mother were mentioned by all the women interviewed. For many there were feelings of guilt at not working and contributing to their relationship and to society. Mary felt she had to justify not working by saying that she was returning to work soon. This reflects the literature which notes that there is pressure for women to return to work (Eyer, 1996; Woods, 1993). Mary's comments also illustrate the common theme in society that motherhood is not viewed as real work. This relates to an earlier point about motherhood being devalued by society.

There is a division between working mothers and stay at home mothers with 'either/or' options (Hays, 1996; Villani, 1997). This division has created debate about the benefits and detriment's - to the children - of working mothers. However, some research has not supported the view that it is detrimental and in fact shows that there can be benefits to early child-care (Eyer, 1996; Forna, 1999; Tizard, 1991). This is illustrated by Susan's comments that as a mother you either stay at home or go back to work and use a creche. She added that using a creche is viewed negatively.

One of the consequences of facing this either/or option regarding staying at home or paid work is guilt. Clare felt guilty at leaving her child in child-care and thought that she was missing out on his life. Mothers do feel selfish if they enjoy time away from their children or are rewarded for not being at home (Eyer, 1996). The reality of being a working mother is guilt and fear that child-care is unsafe for the child (Goss, 1998; Thurtle, 1995). Naomi said it is a constant juggling act of home and work.

Sharon, whose return to work was suggested by a health professional to help her recover from her PND, felt that it helped her regain her identity. She was able to be away from her children and was earning money. Clare also felt 'boosted' by returning to work and said it was due to other people's recognition of her skills, which increased her value in herself. This mirrors the literature on why women return to work, for some it is because they need the money (Forna, 1999), but for others it is to get stimulation outside of the home (Else, 1996; Hays, 1996).

Susan returned to her previous career and then left. She is happy with this decision and is grateful that she had that opportunity. It is interesting to note that she now works part-time, in a job that allows her more flexibility. Eyer (1996) notes that being able to choose part-time work, or staying at home with children is only experienced by a small proportion of mothers, most have to return to work for economic reasons. Conversely, while I did not specifically ask the women in my research why they returned to work, none of the participants mentioned it was for financial reasons.

Advice and Information

Another contributing factor under social causes of PND, is the popular media images of motherhood. Motherhood is portrayed as a positive event (Fairley, 1990) and advertisers use images of this to sell products as they do with all advertising (Forna, 1999; Villani, 1997). These myths however are not developed in isolation, they are ingrained in our culture (Goss, 1998).

The media is not only used to advertise but also to entertain and communicate information. Other sources of information available to new mothers and mothers-to-be are child-care books. This medium is a common way to transmit the myths of motherhood to mothers (Dunnewold and Sanford, 1994; Marshall, 1991; Reiger, 1991). Mary recalls how the books she read presented motherhood in a positive light. Jan however, felt that although most of the books were positive about motherhood there was a balance in the material they

presented. The women interviewed did not however, feel that they followed these manuals word for word, but they selected what they read. Sharon remembers having a child-care book but not using it until after she had had her first child.

This is illustrated in the literature by Hays (1996), who calls this selective reading and reshaping of information as 'sorting the mail'. In her study of new mothers she found they would read and take in information from others (not just books), but only follow advice that could be reshaped and fitted into their own social, cultural and financial circumstances. However, all the mothers in her research felt pressured to live up to the 'good mother' image (Hays, 1996).

None of the women interviewed commented on one finding that the literature stated, which was that pregnant women were bombarded with information about their new role often leaving them confused about what was the 'right thing' for their baby (Eyer, 1996; Forna, 1999). This may be due to the questions during the interviews, which focused on the information sources and messages during pregnancy rather than how they felt about the information and advice. The incongruence with the literature may also be due to the fact that all but one of the women interviewed welcomed the intrusion and could only recall feeling special while pregnant.

Advice is also given by friends and families. This advice reinforces many of the motherhood myths that motherhood will be a wonderful experience. Mary and Clare both experienced positive messages and images of what motherhood was going to be like from family and friends. This is supported by Paul (1997) who noted that other mothers also down-play the negative aspects of motherhood when talking to other mothers. Positive messages are not only given by others, but there is also a conspiracy of silence so that negative messages and information are not discussed.

Several of the women also spoke about seeing family and friends not coping with motherhood but rationalised their observations and believed that they would be successful at motherhood when they became mothers. Clare nannied

before she became pregnant and saw other mothers not coping with motherhood but did not think that would happen to her. She put their problems down to the individual mother's fault or blamed the individual child's behaviour. Naomi and Jan also observed family and friends not coping with parenthood but thought they would be able to cope. Although Hays (1991) commented on women 'sorting the mail' regarding child-care books, this theory can also apply to the images of motherhood women selected from observing other parents.

Another common place to gain information was antenatal classes. Some messages received from the classes were mainly positive about motherhood. Jan and Clare remembered hearing about negative events like caesarean's, colic and the sleepless nights, but only briefly and felt most of the classes focused on the positive aspects of childbirth and motherhood. Sharon's experience of antenatal classes as a support person, after she had recovered from PND, was that PND was not discussed in any depth. This reflects McIntosh's (1993) findings that mothers reported that the topic of PND was either not discussed or was dismissed at antenatal classes. McGill et al's (1995) study of Christchurch new mothers noted that there is resistance to discussing PND in antenatal classes. Their research unfortunately does not go into what the resistance is, but it may be due to the mistaken belief that if you discuss a mental illness like PND then that may bring on the illness. The reality is that mental health promotion, education and stigma reduction are recognised ways to assist women who develop PND (Balcombe, 1996; Millis and Kornblith, 1992; Disley, 1997; Goss, 1998; Littlewood and McHugh, 1997; McIntosh, 1993; Thurtle 1995; Ugarriza, 1992). Antenatal classes and other health professional's knowledge of PND are areas that the women interviewed felt could be improved. This issue is addressed later on.

An interesting finding from my research was that the women felt they did not take on board any of the negative experiences that may have been discussed at antenatal classes. For example, Sharon thinks that caesarean sections would have been discussed but that she probably didn't want to hear about it and so choose not to listen. As with earlier comments, Hays (1996) theory of

selecting what information women listened to can also apply to the antenatal classes.

The reality therefore may be that 'unpleasant' topics such as caesarean sections and PND are discussed at antenatal classes, but that the cultural milieu regarding motherhood as a positive and joyous event prevents women from internalising these as possibly occurring to them. Naomi and Sharon both feel that they would not have been in the right space to hear about PND when they were at antenatal classes.

There are many social influences that women experience when they become mothers. These begin when women are pregnant and their identity changes due to how society sees and treats them. There are losses around individual identity and of control when women become mothers and mothers are expected to put their child's needs before theirs. Perhaps compounding this loss is also a common feeling of isolation as new mothers, and with relationship changes with their partners. All the women interviewed expressed shock at the huge change regarding their status when they gave up work and the 'working' versus 'stay-at-home' mother dichotomy that they experienced first hand.

Information and advice came from many sources. Interestingly, many participants commented that although they may have been given information on the negative side of motherhood, including PND information, they acknowledge that they may have chosen to ignore this. This is due to 'sorting the mail' and the enduring cultural myths of motherhood, which lead to the expectations of what motherhood will be like. I believe the gap between expectation and reality is an influential social factor that may contribute to the development of PND.

It is also important to note that although this section examines possible social causes in relation to the development of PND, many of the above social experiences are common to all mothers.

MYTHS AND EXPECTATIONS - FROM CHILDHOOD TO MOTHERHOOD

All mothers are inundated daily with advice, information and images about mothering and messages about how a certain product or practice is what 'good' mothers do (Forna, 1999). These messages influence and form mothers expectations. Expectations of motherhood is the area that I concentrated on when interviewing the participants.

The most predominant of all social influences on pregnant women and mothers are the expectations that society places on the experiences they will have as mothers. For example, the expectation that it will be natural, easy and fulfilling (Lee, 1997). If these expectations are not realised, they can lead to feelings of failure and guilt in the mother.

These forces create the myths of motherhood and begin to be instilled in women from a very young age through a variety of mediums. Some of these have already been covered such as books, advertising and television. Naomi, Sharon and Jan recall their childhood impressions of motherhood were formed from their mother, friend's mothers and other mothers in the community. The chapter will now examine in more depth the influences that the research participants felt and how they affected them.

A normal part of life

Motherhood, as a normal part of a woman's life cycle, is experienced from an early age from many influences which surround young girls. Both Sharon and Naomi commented that when they were young, they believed motherhood was a normal part or stage of women's life. This links in with Easting (1992) and Woollett (1991) who state that becoming a mother is seen in society as a normal, expected part of a woman's female identity. Motherhood also is equated with adulthood (Bartlett, 1994; Cameron, 1997; Lee, 1997; Letherby, 1994) and can be seen as a normal rite of passage for a girl into womanhood, which is taken for granted and not questioned (Reiger, 1991).

It was interesting that many of the participants made a decision to have a career, or 'have a life' as Sharon said, before having children and consciously avoided motherhood for some years. Clare had her first pregnancy terminated as she did not think the time was right for parenthood in her and her partner's lives. She also did not want her third child as she felt that all her friends were moving on with their lives and she was 'back to square one'. Forna (1999) observes that although women nowadays are choosing to delay motherhood until their careers have been established, the mythology of motherhood cannot be escaped only delayed.

For some women, the decision to have children is seen as the next stage in their relationship (Forna, 1999; Reiger, 1991; Woollett, 1991). Jan talked about the stages her life had been through and parenthood was next on the list for her and her husband. For Jan this message was supported by comments from family and friends.

The couple's decision can just 'happen' without questioning why or looking at alternatives because it is accepted by society as the natural step for couples. Even if the pregnancy is not planned, as in Mary's case, the decision to continue was made because it was a 'good time' in her and her partner's relationship. Susan commented that for her it was more of a non-decision, that there weren't any reasons not to have children.

For Naomi, who was single at the time of her pregnancy, she felt an acceptance from women with partners and a welcome into the 'heterosexual couple' world by being pregnant. Motherhood grants women entry to a different level of involvement with other mothers because of the common identity (Woollett, 1991). Naomi's feeling of belonging to the 'heterosexual couple' world indicates that she felt no discrimination about being a single mother. This is in contrast to DiLapi's (1989) model of families, where Naomi would be a 'marginal mother', and therefore subject to discrimination. However, Naomi's status also indicates that the nuclear family structure is changing (DiLapi, 1989; Eyer, 1996).

Natural and instinctual

The second expectation of motherhood is that it is a natural desire for women to become mothers, just as it is natural for all female animals to reproduce. This includes the belief that mothers will know instinctively how to care for their baby. These thoughts of the natural-ness and of the ease of the motherhood role started in childhood for the women who took part in this study.

For Sharon the image of motherhood when she was young was that it would be 'easy'. It is interesting to note that many of the women were aware that mothers had a busy life, yet the idealisation of it being easy and achievable was strong and probably dominated overall. Naomi talked about thinking she could have it all - career and motherhood - when she was growing up, because she believed motherhood was easy. Jan had friends who became mothers at 19, yet doesn't recall getting the impression from them that it was a hard job.

Women are aware from an early age that they are biologically different from males because they are capable of reproducing (Eyer, 1995; Welldon, 1992). The theory that women are biologically designed to have children rang true with some of the women interviewed when we spoke of why they became mothers. Jan referred to being conscious that her 'biological clock' was ticking away. Sharon talked about feeling 'clucky' around friend's children. Both these terms are accepted in society as explanations of how women feel about motherhood. For Susan, seeing other friends become mothers brought back her 'dream' that motherhood would be easy.

The belief that women have a biological clock, as Jan described, is common in today's society, and as Jan mentioned she felt that she needed to have a family by a certain age. Littlewood and McHugh (1997) note that in current thinking the ideal age to become a mother is between 20 and 40 years. As mentioned previously, many of the women delayed having children, wanting to have a career before motherhood. Additional concerns for the older mother, such as possible birth defects and infertility are further proof that nature cannot be defied (Forna, 1999).

The belief that mothers should naturally know what to do was prevalent with the women I spoke to. Before giving birth, Jan thought that breastfeeding was natural and instinctual, not realising how sore and painful it was until experiencing it. After Clare had her baby she believed she should have instinctively known what to do for the baby. Sharon's experience of cracked nipples also led her to feel a failure because she 'should have known' what to do.

The belief is that women, once they have physically given birth, will naturally and instinctively know how to care for their new baby (Littlewood and McHugh, 1997). This belief is perpetuated by both the father and mother in that they both assume that the mother is the natural expert in child-care (Lee, 1997).

One of the most common myths that all the women discussed was the bonding or attachment myth. Some women did indeed experience a bond straight away when their baby was born. Naomi felt this bond was powerful. For Jan, while she felt an immediate bond, she questioned whether she felt the correct amount. This mythical, biological urge for mothers to instinctually bond and care for one's offspring is perpetuated by the media and child-care experts (Bowlby, 1982; Eyer, 1996). The message is that if women fail at feeling this maternal bond then they are failing at being good mothers (Forna, 1999).

Sharon and Jan both felt that after having their first children, life was initially easy, for Jan this feeling lasted a few days, but for Sharon she felt she had a 'fantastic' life for a year and a half. Sharon's experience, while unique within the research, may illustrate several points. Firstly, that the literature in this thesis focuses on the negative experiences of motherhood only, and has not addressed the fact that motherhood can be pleasurable. Secondly, this point may illustrate that Sharon's positive memories helped her through her experience of PND after her second child and other negative events in her life. Sharon's memories may also be exaggerated to keep the myths of motherhood alive in her life.

This leads onto the next myth of motherhood, which is that motherhood is the ultimate fulfilment for women. This is also perpetuated by current ideology (Marshall, 1991).

Happiness and fulfilment

The concepts of happiness and fulfilment are that by becoming a mother a woman will feel complete (Leonhardt-Lupa, 1995; Marshall, 1991). This romantic idea, like other images of motherhood, can begin in a woman's childhood. Both Clare and Jan talked about having fantasy and fairytale images of motherhood when they were young.

There is another myth in society, which is for a marriage to be fulfilled and happy, it must include children (Cameron, 1997; Hays, 1996; Marshall, 1991). This happy picture of life with children continued to be upheld by most of the women interviewed when they were pregnant with their first child. Mary's vision of motherhood when she was first pregnant was that motherhood was going to be an easy, restful task and would be good for her family.

These images of motherhood being a fulfilling goal for a woman and her male partner are perpetuated by magazines, child-care books, advertisers and the media in general (Dunnewold and Sanford, 1994; Forna, 1999; McIntosh, 1993; Marshall, 1991).

Jan and Mary both commented on the fact that their first experiences of motherhood made them more realistic about motherhood the second time around. Jan felt the 'happy illusion' of motherhood went because she had experienced motherhood already. This finding was supported by Reiger (1991) who stated that for women who had more than one child their expectations of motherhood when they were pregnant for the second or third time were more realistic as they were more relaxed and confident. However, Jan experienced PND with her second child as well, which contradicts this finding.

This illusion of happiness and fulfilment is kept alive not just by the media and friends and families who celebrate in the excitement of pregnancy and birth, but also by the mothers themselves. Clare, Mary and Jan all talked about the positive messages they got from others and the internal images they had of motherhood being positive when they were pregnant. Mary and Jan also said that they had images of themselves as being perfect mothers for their child. Susan avoided antenatal classes because she didn't want to get 'swept along' and wrapped up in her pregnancy. Her comment illustrates her impression that these classes romanticise motherhood, a view that is supported by researchers (McIntosh, 1993) and will be addressed further in this chapter.

The observation by participants in this study that society focuses on motherhood bringing happiness and fulfilment reflects the literature. The reality that motherhood does not bring ultimate fulfilment and happiness is not talked about openly. The reason that this occurs is the need for society to legitimise and maintain the arduous and invisible role of mothers by creating a mythology of happiness (Cameron, 1997; Villani, 1997). Admitting to unhappiness or unfulfilment in the role of motherhood can lead to feelings of failure and guilt in mothers because all the information received has told them that motherhood is the ultimate fulfilment (Fairley, 1990; Marshall, 1991). Naomi felt a failure as a mother and was humbled because before she became a mother she didn't understand how hard a job it was. Motherhood is set up as nirvana according to Villani (1997). This phenomena was evident in this study. However, it is important to note that the experiences described by the participants in this research are universal for all mothers, not just women who develop PND. This research is unable to clearly attribute a causal theory of PND with these myths because mothers who did not develop PND were not studied. This limitation and suggestions for future research is discussed in the next chapter.

Women's expectations of motherhood are based on the myths that motherhood is a normal part of a woman's life; that motherhood is natural, instinctual and easy and that motherhood brings happiness and fulfilment. If these do not come true, as so often happens, then mothers feel a sense of loss, failure and guilt that they are individually failing. Other social pressures, expectations and

changes to their lives and identity also add to the feelings of failure and inadequacy when the task of motherhood that women believe will be easy, natural and fulfilling for them and their family, do not come true. These all combine to create possible social causes of PND.

In the next section the women's stories of the reality of having PND are presented and analysed with the literature. Their experiences' contrast with the high expectations and fantasises of what they would be like as mothers.

GETTING PND - THE REALITY OF MOTHERHOOD

"This is not good"

All of the women interviewed had noted signs and symptoms that they were not coping. Jan felt suicidal, Clare felt she couldn't cope and was crying and 'fell apart'. Mary also was crying, feeling anxious and having panic attacks. The symptoms these women had, echo the research and literature on the symptoms of PND which are low mood, tearfulness, irritability, anxiety, thoughts of suicide, guilt, feeling unable to cope and lack of energy (Dunnewold and Sanford, 1994; Goss, 1998; Lee, 1997; Nonacs and Cohen, 1998; Ugarriza, 1992). The existence of these symptoms led to a diagnosis of PND for all the women in this study. Having a diagnosis impacted on their experience of the illness and of motherhood.

Impact of labelling

Having a name for how you are feeling can be useful, however labelling can also lead to the person being seen *as* their illness, not as a person *with* an illness. As Julie Leibrich, a mental health survivor, puts it, "I am not my illness, I am not a walking diagnosis" (Leibrich, 1998).

Another problem with labelling is that illness can be treated only by medical intervention, thus ignoring the social and environmental contexts that the woman lives within (Haines, 1987; Littlewood and McHugh, 1997; Thurtle,

1995). This does not reflect my participant's experiences as they were treated with a variety of methods not just medical. The reactions the women in this study felt when they were diagnosed with PND varied. For some women it was a mixture of relief that what they were experiencing wasn't normal.

Relief

Mary spoke about the relief she felt at being given a label. For others it was a mixture of relief and feelings of failure. Clare talked about asking herself what had she done wrong as well as feeling relief that now she had a label she could get help. This feeling of relief at getting a label and receiving help is mirrored by Haines (1987) who stated that it can bring people with common problems together to form support groups. The issue of support is developed further in the next sections of the chapter.

Failure

Being diagnosed with PND can also lead to feelings of failure as a mother. For example, Naomi didn't admit to having PND for some time due to feelings of failure. Susan felt out of control when she was diagnosed. This relates to the previously discussed myth that motherhood is natural and instinctual for women, therefore postnatal distress is unnatural and the woman is failing in her role as mother (Littlewood and McHugh, 1997).

Stigma

For the participants, another of the down sides of admitting that they had PND was due to the stigma of having a mental illness. Stigma is a very real issue in today's society and women with PND can experience this (Goss, 1998; Littlewood and McHugh, 1997; Thurtle, 1995). For some women the stigma of PND brought with it a real fear. This relates to Jan's fear, which extended to a belief that her baby would be taken away because she was 'nuts', and therefore unable to care for her baby.

Some women experienced this stigma first hand from their family. Clare and Jan both had parents who minimised their distress and Jan's father told her to pull her socks up and get on with it! These reactions were not useful in helping the women to cope. Other women found positive responses from family and friends. For example, Sharon found her mother was supportive.

Keeping up appearances

Women receive messages about motherhood being a positive event from society, so they feel unable to openly admit to any negative feelings (Nonacs and Cohen, 1998; Whiffen, 1992; Ugarriza, 1992). Keeping up appearances relates to the myth that motherhood is a happy and fulfilling time and if a mother is not feeling this then she may feel guilt and a failure (Dunnewold and Sanford, 1994; Meager and Milgrom, 1996; Nicholson, 1990; Taylor, 1996; Whiffen, 1992).

Webster et al's (1994) study indicated that some women had not even discussed their symptoms of PND with their GP or Plunket nurse. This reluctance to talk and admit to not coping stems from feelings of inadequacy as a mother. It is also due to the lack of discussion about PND and the unpleasant realities of motherhood in society (Forna, 1999; Goss, 1998).

The research findings in this study support this. Some of the women were very good at covering up and hiding how they felt to the outside world. Jan avoided telling certain people who she felt wouldn't understand. Sharon found that when she later told some people in groups that she belonged to, they had no idea she was unwell. She explains how she kept going as a mother by meeting her family's needs.

Other women who also avoided telling others had surprising reactions when they did disclose that they had PND. Mary eventually told her parent group and they were shocked because she seemed to be coping with motherhood. This is because many of the women were adept at keeping kept their illness hidden.

Susan and Naomi kept up pretences that they were coping by avoiding certain situations because of a fear of appearing incapable of mothering. Susan was affected by memories of her mother who suffered from depression and who she saw as 'vulnerable' and 'sponging off' people. This fear prevented her from disclosing her reality to others and keeping up the appearance that she was coping like other mothers appeared to be.

Given the strength of the myths of motherhood as a wonderful experience, and the stigma of mental illness it is no wonder that the women in this study hid their PND. However, in keeping up appearances and not admitting their illness to others their problems were compounded.

Information

The lack of open discussion and information available about PND is another problem that contributes to the stigma and feelings of failure. Some of my participants felt they did not have adequate information about PND before having children. Jan and Sharon both explained their shock at being told they had PND as neither woman felt they had received any information about it. For Jan this lack of information was at her antenatal classes where she says there may have been only a snippet of information on PND. Changes in the area of antenatal education will be addressed later in this chapter. The myths of motherhood and of birth processes being only positive need to be challenged in antenatal education (McIntosh, 1993).

Although having information may not reduce or prevent PND, for Mary it enabled her to be prepared. She firstly self diagnosed PND because she had written information available to her, and then she had it confirmed by her GP.

All the participants described the negative side to having PND, a mental illness, and the stigma of this label. There was also the feeling of failure in not coping with motherhood, which is contradictory to one of the motherhood myths that it is a natural and a joyous time. This chapter now examines some of the solutions the women felt assisted them with their recovery from PND as well as

some of the ideas that the participants suggested could assist the status of motherhood and support all women who develop PND. The reason these two sections are combined is because in the course of the interview the women discussed both their personal experiences and their thoughts for the future.

SOLUTIONS

To assist women who develop PND involves changes at many levels of New Zealand society. This requires recognition of the way PND and motherhood are viewed in New Zealand at individual, family, community, social and political levels.

Valuing Motherhood

The value of mothers must be increased by society. Currently mothers are not valued highly, as Jan puts it 'they are at the bottom of the pile'. Mary observed that motherhood is seen as an easy and cruisy time in New Zealand society. The messages that motherhood is not valued and can be done by anyone is supported by the literature (Brown et al, 1994; Littlewood and McHugh, 1997; Nicholson, 1990; Thurer, 1994; Villani, 1997; Woods, 1993).

To increase the value of motherhood, mothers must value themselves by increasing their own self-esteem, regaining their lost identity and stop blaming themselves (Thurer, 1994; Villani, 1997). At a wider level societal level the myths about motherhood and the idea of the 'good mother' must be challenged, and the reality of motherhood talked about (Forna, 1999).

Sharon felt that motherhood needs to be valued more and the media is a good place to communicate this message. Her comments mirror the literature findings on the media's power to convey messages about motherhood (Dunnewold and Sanford, 1994; Fairley, 1990; Forna, 1999; Goss, 1998).

Destigmatisation

PND, like other mental illnesses, needs to be de-stigmatised (Goss, 1998; Leibrich, 1998). Mary felt that PND is more accepted in today's society but that we still had a long way to go. Clare was told that PND is a 'trendy' illness by someone, a comment that Clare felt minimised her experience. The term 'trendy' implies that it is a popular thing to say you have PND, like a designer accessory, rather than being a real illness.

Susan suggested making PND, as a label, less important and alternatively saying that a woman is not coping just like many people don't cope with life. Because the majority of mothers experience some form of post-partum distress, perhaps then this distress should be seen as the norm of motherhood (Littlewood and McHugh, 1997; Thurtle, 1995).

Parental Leave

The issues of parental leave, working mothers and child-care was mentioned by several participants. Clare suggested more paid parental leave time and Susan suggested increased paid leave for partners. Paid parental leave would support parents, but the government is concerned about the costs of this to the country (Langdon, 1999).

Policies need to address this issue and support women in having the choice of returning to work or remaining at home (Woods, 1993). Overseas policies on parental leave give mothers the message that the task of raising children is a community and societal responsibility and a worthy occupation (Forna, 1999; Langdon, 1999). If this message is given and supported by society then this would hopefully reduce mothers feeling guilty at using child-care.

Mary also wanted to see more family friendly workplaces with creches. She felt that many women would welcome returning to work knowing their baby was nearby and that workplaces would benefit from having experienced staff return.

Susan noted her workplace was family friendly and this made a difference to her well being.

Family Structures

Ideologically, Susan talked about changing the way New Zealand views family structures. She felt that there are lots of alternative structures to the nuclear family and that mothers shouldn't be restricted from life just because they are the main caregivers. Forna (1999) supported this view and stated that to challenge our monocultural view of motherhood and families while allowing society to value alternative family structures would also give the community a greater sense of responsibility in raising children. There is a saying that it takes a village to raise a child, not just one person (Eyer, 1996). Sharing the responsibility for raising children and looking at alternative 'family' structures also challenges the motherhood myth that mothers are the only ones able to bond, nurture and care for their own child (Aldgate, 1991; Bowlby, 1982; Forna, 1999; Hays, 1996).

0800 Plunketline

One common support solution was the 0800 Plunket line. Clare and Naomi both felt that it was very useful and needed to continue to be funded. Current funding is not enough to meet the demand (Kuiper, 2000). Clare felt that if the government put in money to the 0800 phone line, it would save money in the long run by preventing mother's distress becoming a major problem.

Education on PND

Education on PND and the realities of motherhood is another solution, not just for the mother but also for her partner (McGill et al, 1995). Health professionals that expectant mothers see need to examine the messages they communicate to their clients. Nicholson (1990) commented on the implications for nursing and midwives due to the high incidence of PND in mothers. She stated that for many professionals, motherhood equates with happiness (Nicholson, 1990).

Her observation is that the professionals who have contact with expectant and new mothers perpetuate this myth. This view is supported by Mary's comments that Plunket nurses still reinforce the myth that motherhood is wonderful. Sharon mentioned advertising in GPs surgeries as a method to educate and increase awareness of PND to assist with early intervention for help.

Antenatal classes have also been identified earlier in this chapter as a forum whereby information about PND can be distributed. McIntosh (1993) advocates for antenatal classes to attend to issues such as PND and also to debunk the romantic image of motherhood. Sharon had attended a class recently with a friend and commented that they touched on the topic of PND only briefly. However she also commented that they had to cover lots of topics in a short space of time. Currently, antenatal classes should be completed within six weeks and be for at least 12 hours overall. The content includes access to maternity services, pregnancy care, labour and birth care, and care following birth. The last area includes information on PND as well as four other topics relating to postnatal care of mother and child (Ministry of Health, 2000). A lot to cover in only 12 hours. An idea that was discussed at an Adjustment to Parenthood Workshop in Auckland in 1997 was increasing existing antenatal classes to cover the first six months of the babies' lives as often that is when the information is more useful and relevant.

Naomi also felt that antenatal classes were too positive about motherhood and having someone from the PANDS Group attend a class would be helpful. This idea is similar to Deegan's (1993) theory that having a survivor as a role model assists with recovery. The point being that having someone who has been through the experience of having PND can have a great impact on women.

However, the paradox is that women may choose to not listen to information about the negative side of parenthood or avoid attending classes that covered such topics. Both Naomi and Sharon mentioned that during their pregnancy they would not have taken on board any negative information, Naomi admits she would have missed an antenatal class if she knew it would be on a negative topic such as PND. This whole area of taking on board negative

information about childbirth and motherhood is fuelled by the overwhelmingly powerful myths of motherhood.

Early detection

Health professionals such as Plunket nurses have the ideal opportunity to assist mothers with detecting of PND, because of the regular visits they make to new mothers. Using tools such as the EPDS could assist with this (McGill et al, 1995; Webster et al, 1994), as could other tools developed to assist with early detection (Astbury, 1994; Warner et al, 1997).

Plunket recently offered to help with early detection of domestic abuse by asking new mothers if they felt threatened and wanted help (Haines, 2000). The Plunket Society acknowledges that its Plunket nurses build up unique relationships with new mothers so asking questions, or administering the EPDS could be achievable.

Medication and counselling

Some of the women in this research were assisted in their recovery with medication which is a recognised form of treatment in PND (Millis and Kornblith, 1992; Dunnewold and Sanford, 1994; Goss, 1998). Mary initially found the idea of medications frightening, however her GP, with whom she had a good relationship, convinced her that this would help.

The types of counselling that the women in this study received varied, but the women who received this were positive about the value it made in their recovery. Susan had therapy from a psychologist and although she felt that it may have been too soon for her to work on issues, looking back she felt she did gain from it.

The participants positive experiences of having a mixture of medication and counselling to assist with PND, is supported by the literature that advocates for medications to be supplemented with other forms of treatment such as

counselling (Goss,1998; Millis and Kornblith, 1992). Dunnewold and Sanford (1994) see medication as a useful adjunct to psychotherapy.

Maternal Mental Health Team

Three of the women interviewed also received help from the Maternal Mental Health Team (MMHT) in the region and found this support and treatment valuable. Clare's involvement with that service, which began before she gave birth, was positive. Her experience indicates that being told that she would recover - 'you'll get better' - was of great support to her.

After being referred to the MMHT by her GP, Jan felt reassured as well. Jan's comments also indicate her relief when she heard that her experience of PND wasn't 'normal', that it wasn't her failing at motherhood but an illness and that she could be helped.

Access to specialist services such as the MMHT was advocated by Clare, who felt it was unfair that only mothers with severe PND can receive their help. The MMHT, as part of the Capital Coast Health Ltd, Health and Hospital Service, are only funded to see women who have a moderate to severe mental illness. Severity is assessed by the MMHT. Access to them is via a GP or another Health and Hospital Service funded mental health service.

Support

Support was also a common idea from participants to assist women with PND. Longer hospital stays were mentioned by Jan, who felt unconfident at leaving hospital two days after giving birth. This is reflected in Woods (1993) who also advocated for longer hospital stays, saying that the current policy for early discharge - within 48 hours - puts pressure on mothers who are coping with a new and frightening task.

Clare mentioned support in the form of home help and support groups. Some of the women attended support groups but found that they did not meet their

needs. Jan also felt that there is so much 'blanket' information about how positive motherhood is, so that if women do talk about the negatives then people do not want to listen. Often it is not the type or amount of support that women receives that is helpful or not, but the women's *perceptions* of the support, that ultimately means they find it helpful or not (Logsdon et al, 1994). A solution of support per say may not be the simple answer as every mother will have different expectations. Support will have to be available in a range of options to suit different mothers' needs.

CONCLUSION

Society sets up contradictions in terms of what motherhood is supposed to be like when the reality of it is often different (McIntosh, 1993). The romanticised view of motherhood is perpetuated by New Zealand society through the media, through our celebrations of pregnancy and birth, by our optimistic vision of motherhood and by our reluctance to discuss negative experiences. The socialisation is complete when mothers themselves perpetuate the positive view.

Women who try to live up to these ideals are set up to fail (Thurtle, 1995). The failure is felt personally by mothers and can contribute to the development of PND. Mothers need to be supported to see that it is the ideology of motherhood that is failing them, not them failing to be good mothers. The ideology of motherhood is ingrained in New Zealand culture and effects all mothers, yet some women develop PND and others do not. This research has only studied six women who had PND and their expectations of motherhood, and so direct social causal conclusions can not be made. Suggestions for future research in this field are made in the last chapter.

Women who experience PND need to be encouraged to talk about their experiences and the reality of living with an illness that contradicts the expected joys of motherhood. Women fear that if they speak up they will be seen as a 'bad' mother and possibly have their children removed (Brown et al, 1994).

Many of the suggestions by participants in this study to assist in prevention and treatment for women with PND focussed around support of some kind. There are policy implications for the suggested changes to parental leave that the government is currently debating. Education and information about PND and motherhood were also high on the list of recommendations. The fear of being seen as a failure as a mother, and our atmosphere of positivity about the motherhood role prevent mothers from admitting they are not happy with motherhood and not coping with it.

The next and final chapter concludes the thesis. Key findings from the research and literature are drawn out and recommendations for addressing the issue of PND and the myths of motherhood are made. Finally, suggestions for the future research in this area are considered.

CHAPTER EIGHT

MOTHERHOOD IN THE 21ST CENTURY

INTRODUCTION

This chapter concludes the thesis by highlighting the key findings of the thesis, making recommendations for practical changes, attitudinal changes and political changes, to address the issue of PND. There are limitations to my research and the chapter discusses these before suggesting further research in this area. Finally, the chapter ends with a final thought on this topic.

The aim of this thesis was to examine the ideology of motherhood as a contributing factor of PND. Ten to twenty percent of all mothers will experience PND after having a baby (Goss, 1998; Lee, 1997; Nonacs and Cohen, 1998; Ugarriza, 1992). This condition forms part of a continuum of postnatal distress which ranges from the baby blues, which most women experience within a few days of giving birth, through to postpartum psychosis, with PND falling between these two experiences in both frequency and severity. Most women will experience some form of postnatal distress after childbirth, however this fact is not widely acknowledged in New Zealand society.

Studies into the causes of PND have focused on possible biological and psychological causes. This thesis has examined the social influences and in particular the myths surrounding motherhood. How these myths are supported and perpetuated in society and how they impact on mothers who developed PND has been the prime focus of this research.

The ideology of motherhood is transmitted to women throughout their lives in various forms. The transmission process creates myths about motherhood. When these myths do not become reality then women often feel they are failing at motherhood. Becoming a mother is fraught with contradictions and differing advice which changes, and is embedded in the economic, political and social

climate of the time. The complexity of this information, along with a new role that may involve a loss of identity, can contribute to a mother feeling distressed and depressed. The nature and stigma of depression and feelings of failure and unhappiness with the motherhood role are combined with the contradictory images and messages that this should be a time of joy and contentment. Mothers experiencing this inconsistent bombardment can be too afraid and guilty to admit they are not coping, making their isolation and depression deeper.

KEY FINDINGS

The three questions addressed in the research were;

1. How has New Zealand society's perception of motherhood influenced mothers who participated in this study and who developed PND?
2. Where do mothers who develop PND gain their information about motherhood?
3. In mothers who develop PND, what were their individual expectations of motherhood?

The key findings of this study are that two strong myths ran throughout the lives of the women interviewed. These myths are likely to run throughout the lives of all women, however this research only focused on six women who had PND. The first myth is that motherhood is natural, normal and instinctual. The belief is that motherhood is part of nature's design for a woman's life, that all women desire to become mothers and that there is a 'biological clock' ticking away inside them. The myth is also that motherhood is a rite of passage from girlhood to womanhood. Additionally, the myth is that parenthood is a 'normal' stage for a 'normal' couple - that is a heterosexual couple. The myth also conveys the message that once a woman becomes a mother, not only will she have an immediate bond with her new baby, but she will instinctively know how to care for the baby.

The second myth is that motherhood is the ultimate fulfilment for a woman and she will find great happiness through that role. This myth creates images of the

Madonna, an ever-loving mother with a perfect child and partner. The image is of a 'good mother', one who puts aside her own needs and wants for the sake of the baby and in doing so, will find bliss and satisfaction in her life. Both these myths created individual images for the participants in this study of what they would be like as mothers. Importantly, these preconceptions were not always achievable.

A key finding in this research was that when myths don't become reality, the women interviewed experienced feelings of failure as a mother. They saw themselves as inadequate and not living up to the image of the 'good' mother. The women in the study interpreted the fact that their lives did not meet their expectations of motherhood as personal failure on their part.

Another key point arising from this thesis was that, for the mothers interviewed, their reality of motherhood also brought about loss of control in their lives and losses in identity. These detrimental changes were not mentioned in the fairytale images of motherhood. The largest depravity was leaving paid employment to become mothers at home. The women in the study all spoke about feeling like they had 'lost their brains' when they became mothers at home, their new role having no value. They received clear messages to this effect from people they came into contact with. The return to work, for most of the women, brought back their self esteem, although it also brought with it feelings of guilt at using child-care.

All of the women interviewed had both good and bad experiences of PND. Many of the women 'kept up appearances' and did not admit to others they were ill. Many were very careful about appearing that they were coping with motherhood. While all of the women described the negative way that PND had affected their lives, there was also the relief at being diagnosed. This indicated to some that they were ill and not failing at motherhood. The treatment the women in this research received from health professionals after diagnosis was positive and assisted them back to good health. However, the lack of information about PND - before they were diagnosed and the stigma of having

a mental illness led to some unpleasant experiences for some of the participants and this is one of the areas of recommendation.

RECOMMENDATIONS

The data uncovered by this thesis supports several key strands in the literature and leads to a number of recommendations. To address the possible social factors that may contribute to the development of PND, we need to challenge and change our views on motherhood and the services provided to mothers. Some of these recommendations are already in action in some form, others have financial implications and others will require a debunking of the myths of motherhood.

The first practical area of recommendation is training health professionals to recognise PND. Early detection and assistance of PND is vital to assist women in their recovery (Nonacs and Cohen, 1998). Midwives and Plunket nurses regularly visit new mothers and could be trained to recognise the signs that a new mother may be experiencing PND. To do this they would need to use an appropriate tool such as the Edinburgh Postnatal Depression Scale (McGill et al, 1995), along with other clinical assessments (Cox et al, 1987). Other tools that have been developed which may also provide assistance are the Maternal Attitudes Questionnaire (Warner et al, 1997) and the Experience of Motherhood Questionnaire (Astbury, 1994), both of which have been developed for use in this area. Women with PND can down play their symptoms and not ask for help because of the very nature of depression, the stigma of having a mental illness and the fact that admitting that you're not enjoying or coping with motherhood is taboo in society. Using an assessment tool can uncover PND (Webster et al, 1994; Ugarriza, 1992).

Another practical recommendation is the need to discuss PND and the negative sides of motherhood more openly. There is a real need to include PND discussions in antenatal classes to assist mothers-to-be (McIntosh, 1993). Antenatal classes also need to address the emotional and psychological impact and changes to relationships that occur in the transition to parenthood (Millis

and Kornblith, 1992; Lee, 1997). This includes health professionals assisting mothers to see that the event of motherhood is closely akin to a grief reaction with losses associated with the new role (Nicholson, 1990). However, as several of my participants admitted, one of the problems about discussing the negative side of motherhood in antenatal classes is that they would avoid attending the class or would not take notice of the negative information in the session. Pregnant women do block out thoughts of the future, including the possibility of having PND (Brown et al, 1994).

A solution, and one of the key practical recommendations arising from my research, would be to extend antenatal classes to cover a period after the birth of the baby, thereby becoming ante and postnatal classes. Ideally classes could start antenatally then continue for six months after birth. This would give women an already established safe and trusting group in which to talk about the realities of motherhood. There will of course be funding implications for increasing the length of time of antenatal classes (the cost of a facilitator and rooms) and to assist with transport and child-care. Antenatal classes are presently funded by the Ministry of Health for 12 hour, six week programmes (Ministry of Health, 2000). Goss (1998) also talks about extending the care plan that women are encouraged to prepare which looks at planning the practical aspects of childbirth. She suggests including potential social, psychological and spiritual changes that can occur for up to a year after childbirth.

Another method to overcome women blocking out information or avoiding classes about PND would be to have women who have had PND talk about their experience in classes. Naomi commented that having someone from the PANDS group talk to the antenatal class would be more memorable than having a discussion on PND. Discussing PND in ante/postnatal classes and having women who have survived PND talk at these classes would also destigmatise the condition. While PND may not be seen as disabling and as unacceptable as other mental health problems, it is still viewed negatively in New Zealand society. To improve the health of women who have PND, it is important for society to cease stigmatising and blaming anyone who has a mental health illness. This can be addressed by educating the public on mental

illness (Romans et al, 1997). Strategies for mental health promotion and prevention need to also include community development approaches to enhance "... health by fostering individual and community action" (Disley, 1997, p 458).

The Mental Health Commission, formed and funded after the *Mason Report* (Mason, Johnstone and Crowe, 1993), actively addresses mental health discrimination and stigma. While these initiatives address all mental health issues and not PND specifically, their actions will have a flow on effect on PND. A recent publication reported on the progress of the Mental Health Commission. In February 2000 a national media campaign *Like Minds, Like Mine* was launched. This included advertisements and as 0800 information telephone service. Following this, a network of consumer groups were formed and contributed to a national advisory group on stigma and discrimination. Locally funded programmes to counter stigma and discrimination associated with mental illness were also formed during 2000. The Mental Health Commission also published guidelines to reduce stigma for employers in July 2000 (Mental Health Commission, 2001).

Other community action is the development of support groups for mothers who have PND. There is evidence from other research that support groups as a treatment modality, run with or without trained professional leaders, work well for women with PND (Meager and Milgrom, 1996; Whiffen, 1992). Support groups enable women to connect with others who have the same experiences and feelings as themselves (Taylor, 1996). Susan, from my research, felt that support groups helped reduce people's isolation. The type of support group needed will be different for each woman and is sometimes a matter of trial and error as some of my participants discovered. The difficulty new mothers have in getting to support groups, for example getting organised to leave the house, must be taken into account to assist women to attend (Meager and Milgrom, 1996).

Services also need to change to meet the practical needs and demands of motherhood (Reiger, 1991). Support could be in the form of practical home help

and child-care (McIntosh, 1993). In my research, Clare mentioned this as a way to assist women with PND. Some of the women in my research also mentioned increasing the stay in hospital. The current policy for public hospitals in New Zealand is such that if a woman leaves hospital within five days post delivery she can receive a supply of home help and nappies. This policy encourages women to leave hospital as soon as possible after birth. While in some respects this is good, as birth is not an illness and therefore should not need 'hospitalisation'. However, if a woman feels pressured to go home when she doesn't feel confident or is going home to little support this can do little to assist women in the transition to motherhood (Woods, 1993). This support will cost either in increased hospital stays, or increased support at home.

Other policies must also be implemented to support mothers who work outside the home. For example, the implementation of 'family friendly' workplaces which include employer provided child-care facilities (Callister, Podmore, Galtry and Sawicka, 1995). Mary stated in my research, that she thought women would feel happier returning to work knowing that their child is close by.

Paid parental leave is also another policy that would assist women to feel that as mothers, they are worthy citizens of New Zealand. Paid parental leave would also indicate to mothers and fathers that raising children is a valuable task and it is the responsibility of the whole country not just the individual parents. (Eyer, 1996; Forna, 1999; Langdon, 1999).

New Zealand society needs to expose the myths of motherhood by encouraging discourse on the reality of motherhood. This will allow women to see that they are not failing at motherhood but rather that society fails to provide realistic images of the motherhood role (Eyer, 1996; Thurer 1994). However, myths are ingrained in our culture and to dispute them challenges deeply held beliefs and traditions that serve reproductive and patriarchal purposes (Cameron, 1997; Thurtle, 1994). The media, which perpetuates these myths, needs to promote the reality of motherhood (Goss, 1998; Lee, 1997). Mothers need to talk honestly with each other, without fear of retribution, about the myths and the realities of motherhood. Health professionals, for example

GPs, need to break through the fear that the myths create and ask mothers how motherhood really is, and listen to the answer without judging or minimising. To reduce the guilt, fear and shame at not coping, mothers-to-be and fathers-to be, need education on how to parent because it is not a natural instinct (Taylor, 1996).

Individually, we must all take responsibility for caring for and supporting mothers and taking care of the children in our country.

> "So now is the time for all of us, men and women, parents and non-parents, rich and poor, to become more like mothers and assume a caring stewardship of the land and it's people" (Eyer, 1996, p 33).

RECOMMENDATIONS FOR FUTURE DIRECTIONS AND RESEARCH

My research focused on the sociological influences that may cause PND, therefore I did not examine in detail biological or psychological factors. My research did not examine these causal factors and I acknowledge that current thinking is that PND has multi-causal factors. I did not conduct any psychological or hormonal testing on the participants to see if these were factors involved with their development of PND. Two of the women I did interview mentioned that their mothers had PND, so they may have had a genetic predisposition to develop PND.

An area of further research could utilise the tools I have developed but undertake research with a control group of women of simular age and life experiences, who had not developed PND. By comparing the experiences of a control group with women who did develop PND, the social factors and influences on the development of PND may become more clearly attributable than I have been able to prove.

The method I employed required participants to be retrospective in their memories of their childhood and experiences when pregnant. This approach

may have missed some experiences as I was relying on their memories which were selective (Babbie, 1998). One participant said she could not remember much about her childhood, so I did not ask her many questions around that topic because I felt this was her way of telling me that she did not want to discuss this time in her life.

Further research on this area could take the form of a longitudinal study, following women before they become pregnant through to pregnancy and after childbirth. This technique would give more accurate data on the influences on expectations of motherhood than gathered, as my study was retrospective.

Another area of research could further examine the myths in New Zealand society and how they are perpetuated and transmitted. This research could look at areas such as the media images of motherhood, the content of antenatal classes and how non-mothers relate to mothers and mothers-to-be on a day to day basis, and thus how myths of motherhood are perpetuated.

Finally, one issue that was raised was the question of why mothers-to-be do not listen to information about the less appealing side of childbirth and motherhood. Several of the women stated that they are sure that this information was available to them but they deleted or distilled what they took on board. Research could look at teaching methods or cognitive techniques to assist mothers-to-be to internalise negative information about childbirth and motherhood.

FINAL THOUGHT

Globally, and in New Zealand, we will always have and need mothers in our society. Motherhood as with most human experiences will always be part joy and part frustration. Postnatal distress will always be part of motherhood for some women. Mothers need to talk honestly, and listen without judgment to each other about the good and the bad times as a mother. Health professionals need to actively support and educate mothers-to-be on PND and work on destigmatising PND. Childbearing is of concern to us all and all New Zealand

citizens need to talk about the myths of motherhood and how they affect mothers-to-be and mothers. We need to assist mothers in caring for their children. Furthermore, we need to challenge policies and practises so that together we care for mothers and do not assume they are coping.

APPENDIX 1

APPLICATION TO THE HUMAN ETHICS COMMITTEE

MASSEY UNIVERSITY

NAME OF APPLICANT:	Kim Fry
STATUS OF APPLICANT:	Masterate of Social Work Student
DEPARTMENT:	Social Work and Social Policy
CURRENT EMPLOYMENT:	MidCentral Health.
PROJECT STATUS:	Masterate Research. MSW 100 point thesis
FUNDING SOURCES:	Application to SPSW Graduate Research Fund
SUPERVISORS:	Wendy Parker and Gwen Ellis
TITLE OF RESEARCH PROJECT:	"The Madonna Myth" - the ideology of motherhood and it's influence on women with Postnatal Depression.
ATTACHMENTS:	Information Sheet Consent Form

SIGNATURES:

Researcher: ______________________________

Supervisors: ______________________________

____

DATE: ______________________________

Description

A. Justification

Postnatal depression (PND) affects 10-20% of all mothers (Mental Health Foundation Pamphlet). The cause of this condition, like other psychiatric conditions, is not known and therefore the treatment and prevention of PND is never clear cut and simple. What I have observed in my work in this area, is that the expectations of motherhood influence women a great deal in today's society. These influences can lead to unrealistic expectations that the new mother places on herself and in turn play a part in the development of Postnatal depression in the mother.

B. Objectives

The aims of the research are;

1. How does New Zealand society's perception of motherhood influence mothers who develop PND?
2. Where do mothers who develop PND gain their information about motherhood?
3. What were (and are) mothers who develop PND expectations of motherhood?

C. Procedures for recruiting participants

Participants will be women who have had PND and have had contact with the Wellington Post and Ante-Natal Distress Support Group (PANDS Group).

I have contacted the PANDS Group in Wellington, who work in this area, regarding their possible support and assistance in recruitment and they have responded favourably to this request.

I plan to interview six women individually. I will ask questions on issues around the topic, the format of the interviews will be an informal discussion.

D. Procedures in which research participants will be involved

Participants will be voluntary, and they will be enrolled through information that I will send to the PANDS Group. I will ask that the group disseminate the information and give any volunteers my contact information.

When contacted I will discuss the overview of my research and send the volunteers the information sheets and consent sheets, which outline the study. If they agree to take part, they will sign and return the consent sheet.

The sessions will be audio-taped and transcribed. The participants will be given the opportunity to verify these.

E. Procedures for handling information and materials produced in the course of the research.

I will transcribe the tapes, unless funding becomes available to employ a transcriber. If a transcriber is employed then a confidentiality agreement will be drawn up and signed by them.

The written material from the interviews and the tapes will be viewed by the researcher, participants (and the transcriber if employed) only. The participants, in discussion can amend these with myself.

The written material and tapes will be offered to the participants after the research has been completed. The written material and the tapes will be destroyed after the research if the participants do not want these.

The written material and the tapes will be stored in the researchers home office.

Ethical Concerns

A. Access to Participants

I have contacted the Wellington PANDS Group, who will assists me to enlist a group of women to participate in the research. Because I have worked in the area of PND in my home town of Palmerston North I decided to go to Wellington so that I would not face potential conflicts of interest by potentially interviewing a past client of mine.

B. Informed Consent

Potential participants will be sent an information sheet and consent form to read before volunteering for the research. They will be invited to contact me and ask questions regarding the research before signing the consent form.

C. Anonymity and Confidentiality

The researcher will honour confidentiality and anonymity by using pseudonyms and removing and identifying features.

The PANDS Group may want a copy of my finished thesis and I am willing to provide them with one. I will make this overt to the participants, as they may easily be identifiable by other PANDS Group members.

D. Potential Harm to Participants

Participants may experience a relapse or a return of depressive symptoms through discussing their experiences. However, others research conducted in this area has not noted that this occurred. I will minimise any likelihood of this by asking the PANDS Group for volunteers as they will be aware of any women who are or are not currently stable enough to participate. There is also a risk of relapse for mothers who have just given birth and I will screen these women out for this reason. I will also discuss this possibility with the participants before we commence. I also plan to contact the Maternal Mental Health Service (MMHS) that operates in the Wellington region to develop a support system for the participants if a relapse should occur.

If any participant's voice suicidal or self harm thoughts during or after the sessions I will also contact the MMHS. This will be overt in the information sheet. As I am a Mental Health professional I could not ethically ignore these concerns if a participant raised them.

Another option is to modify my research if this becomes an issue.

I believe, however, that the questions I am asking will be addressing issues that will not bring up their negative experiences of PND, rather I will be examining their thoughts and perceptions of motherhood and their sources of information.

E. Potential Harm to the Researcher

I am a Mental Health professional and have practised in the area for 10 years. The majority of my work during this time has been working with women with PND and this experience and knowledge will assist me to deal with any potential harm. I have regular supervision through my work and can utilise this forum to discuss any issues should they arise.

I will also utilise my supervisors to discuss any risks or problems for myself, if they occur during the research.

F. Potential Harm to the University

There is a potential harm if a participant experienced a relapse and sued the University. This is being addressed through this application to the ethics committee and the information and consent forms.

The process for recruitment outlined above, will also minimise this risk.

G. Participants Right to Decline

Participants will be given information about the right to decline or withdraw at any time during the research. They will receive this information in the information sheet and by signing the consent form.

H. Uses of the Information

The information collected will only be used for the purposes of the research, the research report and for publication of academic work. A copy of the thesis will be available at the University library.

As mentioned above the PANDS Group may request a copy of this as they are participating in the research and I will grant this request. The thesis will be subject to copyright.

I. Conflict of Interest/ Conflict of Roles

As I am conducting the research in Wellington, an area I have not worked in professionally, I do not see any conflict of interests. If a volunteer was a previous client of mine and has moved to Wellington, I will decline her as a volunteer.

I will be clear from the outset that my role is as researcher not as a health professional, and that if the participants need professional help that there are agencies and people to contact. I will assist in facilitating this contact, as I cannot ethically ignore the signs of mental unwellness. I have outlined this above.

J. Other Ethical Concerns

Another ethical concern may arise if the participants in the discussion disclose current care and protection issues regarding their children. Some women who have suffered from PND may have been unable to care safely for their children and they may discuss this in the interview. It is important that I am clear about my role as a researcher and the boundaries of this, but ethically I cannot ignore this disclosure if it is current. I will make this overt at the beginning.

Legal Concerns

A. Legislation

Privacy Act 1993. This will be observed by the use of confidentiality and anonymity

B. Other Legal Concerns

Cultural Concerns

Not applicable as I will be interviewing women from the same culture as myself

Other Bodies Relevant to this Research

A. Ethics Committee

Not applicable

B. Professional Codes

I am a member of the New Zealand Association of Social Workers Aotearoa and will observe their code of ethics.

Other Relevant Issues

There are no other issues that I wish to raise with the ethics committee.

APPENDIX 2

"The Madonna Myth" - the ideology of motherhood and it's influences on pakeha women with Post-Natal Depression.

INFORMATION SHEET

Who is the Researcher?

My name is Kim Fry. I am currently a part-time Masterate of Social Work student at Massey University. I am undertaking my thesis over the next two years. As part of this I am researching the above topic. As well as being a part-time student, I work full-time in the Mental Health Service at MidCentral Health in Palmerston North. I have worked there for 7 years as a Social Worker and a Team Leader in a Community Mental Health Team. During this time I have worked primarily with women who had Post-Natal Depression (PND), and their families. I currently work as a Service Coordinator with the service. This research is independent of MidCentral Health Ltd.

How to contact the researcher.

I can be contacted on telephone 06 *** **** (After Hours). My mailing address is *************, Palmerston North.

My supervisors for this research are Wendy Parker and Gwen Ellis at Massey University and they can be contacted by telephone on (Wendy) - 06 3505343, (Gwen) - 06 350 4301.

What is the Research about?

With this research I aim to look at how societal views about motherhood impact on women who develop Post-Natal Depression. There is a lot of research on the theories of why some women develop PND, and these often focus on possible biological and psychological causes. I believe that New Zealand society's expectations of mothers impacts on all women, not just those who develop PND. I want to explore these pressures that can contribute to the development of PND in some women.

What will Participants be invited to do?

If you are willing to participate in this study, then I will discuss details of the study over the telephone and answer any questions you may have before we meet. I am planning to interview six women, individually. These interviews will be audio-taped. These sessions will be 1 1/2 to 2 hours in total and I plan to undertake them in a week in October 1999. These will be held in Wellington at a venue that we have agreed is comfortable and convenient for you. I have made arrangements for qualified child-care to be provided if you require this.

You will have the right to request that the recording is stopped at any time during the interview. You can also refuse to answer any particular questions at any time. You can also withdraw from the study at any time.
After the interview I will contact you with the edited transcripts and invite you to discuss with me any points that you wish to correct.

You also have the right to ask questions about the research at any time during the research.

How will confidentiality and anonymity be kept?

Your anonymity will be kept in the writing of the study by the use of pseudonyms.

What will be the role of the researcher?

As this study will be dealing with your personal experiences of PND, I have prepared a list of resources and contact people for participants to assist you if any issues arise during, or after the study.

If I am concerned in any way about your mental health after any of the sessions, I will discuss these with you. If I am seriously concerned, I may make contact with the Wellington Maternal Mental Health Team. This will be done with your full knowledge.

Your Rights.

During this study you have the right to withdraw at any time, ask questions about the research at any time, and have your confidentiality and anonymity kept at all times.

You also have the right to know what the information you will be providing will be used for, which is that the research results will be used for the thesis I am currently undertaking. I will also use the study results for any subsequent articles that I will write regarding this topic. The Wellington Post and Ante-Natal Distress Support Group may request a copy or a summary of my thesis for their library. The decision to grant this request will be made with all my participants.

APPENDIX 3

"The Madonna Myth" - the ideology of motherhood and it's influences on pakeha women with Post-Natal Depression.

CONSENT FORM

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 understand I have the right to withdraw from the study at any time and to decline to answer any particular questions.

I agree to provide information to the researcher on the understanding that my name will not be used without my permission.
(The information will be used for this research and publications arising form this research project).

I agree/do not agree to the interview/s being audio taped and written.

I also understand that I have the right to ask for the audio taping to cease recording at any time during the interview.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signed ______________________________

Name ______________________________

Date ______________________________

APPENDIX 4

INTERVIEW QUESTIONS

Introduction

During this interview I would like to discuss with you what you thoughts were about motherhood when you were young and before you were pregnant, and then what influenced you when you became a mother and how these may have contributed to you developing PND.

Most research on the subject of PND has looked at possible biological, (eg. hormonal), and psychological, (eg. personality types), causes of PND. I want to look at the sociological aspects of motherhood in New Zealand and how it has affected you.

During this interview we will be discussing your experience of PND and this may bring back some negative memories for you. If you wish to stop the interview at any time please ask, and if you wish for the tape to be turned off at any time please ask. I have also prepared a resource sheet for you to take away so that if you need further help after the interview you know who to contact.

I expect this interview will take an hour. Do you have a time limit?

We will start with a number of short questions to give me a profile of you. I will then ask questions around your thoughts on motherhood when you were young and before your baby or babies were born and then questions on after your baby/babies were born. Then, I have some questions on your experience of PND and finally, I have some questions on your thoughts of how mothers are viewed in New Zealand society today.

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Research Questions

(For my own purposes, to keep in mind when interviewing)

1. How does NZ society's perception of motherhood influence mothers who develop PND?
2. Where do mothers who develop PND gain their information about motherhood?
3. In mothers who develop PND, what were their individual expectations of motherhood?

I would like to start by recording some general information about you.

Name

(Remind them of the use of pseudonyms)

Age

Number of children, sex and age (DOB)

Current work eg. fulltime employment outside the home, fulltime mother.

To begin with I would like to take you back to the time before you had any children and the influences on you before you became pregnant

When you were a young girl, what was your image of motherhood?
Prompt - *General image of motherhood*

Where did you get these images/ information on motherhood from?
Prompts - *Role models, any prominent women*
Media, books, any particular TV shows
Own mother
School

When you became an adolescent, what were your images of motherhood?
Prompts- *As above, any differences*

Where did you get these images from?
Prompts - *As above, any differences*

When you were an adult, and before you became pregnant, what was your image of motherhood?
Prompts- *As above, any differences*

Where did you get these images from?
Prompts - *As above, any differences*

Now I would like to move on to the time when you became pregnant.
Prompt- if several children also note differences of before becoming a mother and before having subsequent children and developing PND.

Why did you become a mother?
Prompt - *Natural, maternal instinct*
Part of being a woman?
Part of being an adult?
An 'accident'?
Pressure from others?

When you became pregnant, did your image of motherhood change from before and how?
Prompt - *Myths of motherhood - supermum*

Where did you get these images/ information on motherhood from?
Prompts - *Role models*
Media, books, antenatal classes
Other mothers, friends with children
Own mother

What did you expect motherhood to be like for you, personally?
Prompt - *Personal image of self as a mother, I've always coped?*
Personal image of your relationships with others?
Positive expectations -time of joy
Negative expectations- losses/ limitations

How did people treat you as a pregnant woman?
Prompt - *Were there differences if pregnant more than once?*

Now I would like to talk about the time after your first baby was born.
Prompt - if several children note differences between first and subsequent children.

What was your first experience of motherhood?
Prompt - *Was it easier/ harder than you thought?*
Do you think you had too rosy a picture, when you were younger, when you were pregnant?

What were the most unexpected/ difficult parts of motherhood for you?
Prompts - *Any losses, disappointments?*
Transition, time of crisis?

What were the most expected parts?

How did your role as a woman change after becoming a mother?
Prompts - *Did you stop work?*
Did the roles in the household change?
Did your identity change?
Self image change?

How did other people treat you after you became a mother?
Prompt - *Expectations that you would have natural maternal instincts?*
Relationship with partner change?

Now I would like to focus on how PND affected you

What were the ages of your child(ren) when you first developed PND?
Prompt - *Did you develop PND after all or only one of your children?*

What was your living situation at the time?
Prompt - *Were you isolated from family and friends and other support?*
Were you a single mother?
Had you just moved?

Did you have a significant other/partner at the time of these births?

How did it effect you when you found out you had PND?
Prompt - *Failure as a mother?*
Relief to be diagnosed?

How did people treat you after you developed PND?
Prompt - *Did you tell anyone?*

Acknowledge participants, thank them and now moving on to the general aspects.

Finally, I would like to ask for your views on New Zealand society

How do you think NZ society views mothers?
Prompt - *Value of mothers in NZ society*
View of pregnant women and any change when she becomes a mother?

How do you think NZ society views mothers who have PND?
Prompt - *Stigma*
Failures/not a real mother
Illness

Do you think there is anything the government could do that would assist mothers to prevent and/or assist those who develop PND?
Prompts - *Family friendly workplaces*
Paid maternity leave
Gender equality
More funding for Plunket etc

Are there any community changes you think would help mothers to prevent assist and/or those who develop PND?
Prompts - *Community awareness*
Destigmatisation of PND
Changes in prenatal/ postnatal care

APPENDIX 5

14 March 1999

****
Palmerston North

To Whom it May Concern

I am writing to your organisation to request assistance with my thesis project that I have just begun. I am a Masterate of Social Work student at Massey University and this year I have started my thesis research project. The subject of my thesis is the social construction of motherhood and its influence on women who have had Postnatal Depression. I plan to undertake the fieldwork component later this year and will need some women to talk to regarding their feelings and thoughts about motherhood prior to experiencing Postnatal Depression.

At this point, I am just beginning to look at the project, developing my questions and preparing to present it to the Ethics Committee at Massey University, but I thought I would write to you now so that I could let you know what I am hoping to do and that I would appreciate working with you to complete this project.

I am a part-time student as I work full-time in the Mental Heath Service at MidCentral Health in Palmerston North. At present I am a Service Coordinator with the service, before this I was a Social Worker and Team Leader with a Community Mental Health Team. There I worked primarily in the area of Postnatal Depression, running the education groups and seeing women and their families over the 6 years I was there. It is this experience that has led me to decide to study Postnatal Depression as my thesis.

If you have any immediate questions, please contact me at the above address, otherwise I will write to you again when my project is taking more shape and I have been to the Ethics Committee and received their approval.

Yours faithfully

Kim Fry (Ms)
B.S.W.

APPENDIX 6

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Post and Ante-Natal Distress Support Group (Wellington) Inc
P O Box 9727
Marion Square
Wellington

18 September 1999

Dear ____

I wrote to you in March this year about my thesis research project on PND. I have received approval from the Massey Ethics Committee and have prepared my interview questions, so I am all ready to start. I would like to take you up on your offer to be interviewed for my project as I need to complete a 'pilot' interview, before beginning the other interviews. I can use the 'pilot' interview in my research, but it gives me a chance to test out my questions.

I would also like to discuss how to recruit other participants as I need to complete 6 interviews. I have some ideas on recruiting, but would like to discuss this with you first.
I have received funding for child-care and for venue hire, but as I do not know Wellington that well I would appreciate advice from you on this. For example, is there a possibility that I could hire a room from your group for these interviews?

I will call you later on this week to discuss this further and, if you are still willing to be interviewed to arrange a time, perhaps for next week, if it is convenient for you. I thought I would write to you first so you are aware of the queries I have before I call you. I have also enclosed an information sheet and consent form that need to be signed before the interview.

I look forward to speaking to you soon.

Yours sincerely

Kim Fry
PS: Yes we did meet in Levin when you gave a talk on PND support groups. Unfortunately there wasn't the energy around to follow this up at the time.

APPENDIX 7

EXPECTATIONS
OF MOTHERHOOD AND LINKS WITH POST-NATAL
DEPRESSION

HAVE YOU HAD POST-NATAL DEPRESSION?

WOULD YOU BE WILLING TO TAKE PART IN A RESEARCH PROJECT?

WOULD YOU BE ABLE TO VOLUNTEER APPROXIMATELY AN HOUR OF YOUR TIME TO TALK ABOUT YOUR EXPERIENCE OF MOTHERHOOD?

CHILD-CARE CAN BE ARRANGED AND A SUITABLE VENUE TO TALK PRIVATELY AS WELL.

HI, MY NAME IS KIM FRY, I AM A MASTER OF SOCIAL WORK STUDENT CURRENTLY COMPLETING MY THESIS ON THE ABOVE TOPIC.

PLEASE CONTACT ME ON 06 ******* (COLLECT)AFTER 5 PM OR ON WEEKENDS OR CONTACT *******, HERE AT THE SUPPORT GROUP WITH YOUR DETAILS AND I WILL CONTACT YOU BY TELEPHONE.

THANK YOU

APPENDIX 8

26 January 2000

****
Palmerston North

Dear

I have finally finished transcribing all the tapes and as promised I am sending it to you for your verification.

Could you look at this and if you have anything you would like to be altered, please mark the script and return it to me in the envelope provided. If you think this is an accurate record of our interview can you send back the attached note only. I will be changing your name and your family members names when I write up my thesis, I have kept them in here so you can easily read the script.

I have also enclosed the original tape for you to keep.

I would like to thank you very much for your time in allowing me to interview you and also for sharing with me your experiences. I have a lot of excellent information from the interviews for my thesis.

If you need anything clarified, please feel free to contact me by telephone (06 * ****).**

Yours Faithfully

Kim Fry

APPENDIX 9

5 March 2000

****
Palmerston North

Dear ____

About a month ago I sent you the transcript from the interview I had with you last November about your experience with postnatal depression. I am writing to you again as I have not heard back from you about it.

Could you please look at it as soon as possible and if you have anything you would like to be altered, please mark the script and return it to me. If you think it is an accurate record of our interview can you send back the note that was in the envelope.

If you need anything clarified, please feel free to contact me by telephone (06 * ****).**

If I do not hear from you by 19 March I will assume that you are happy with the script.

Yours Faithfully

Kim Fry

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