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**Knowledge, Early Recognition and Acceptance:
The Journey to Recovery from Postnatal
Depression**

A thesis presented in partial fulfilment of the requirements for the degree of

Master of Arts

in

Nursing

at Massey University, Wellington, New Zealand.

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2006

I dedicate this study to all new mothers in the hope that their parenting experience will be enjoyable.

ABSTRACT

The purpose of this qualitative study was to explore with women their experience of postnatal depression (PND), with a specific emphasis on what factors assisted and what factors hindered their recovery.

Eight women who had suffered at some stage from PND took part in the study. Interviews were carried out using an in-depth interview technique with open-ended questions regarding their subjective experience, which were audio-taped and then transcribed.

Using thematic analysis, the information obtained from the interviews was analysed and significant statements extracted. Patterns emerged and were clustered into three major themes: **Knowledge**, **Early recognition** and **Acceptance**. These three themes and the patterns within them were all closely entwined, each influencing the other and having a major effect on the woman's experience of PND and her recovery. Lack of knowledge was identified as a major hindrance to recovery, with women describing feelings of being in the dark, not knowing what was happening to them and feeling like a failure. This lack of knowledge was a barrier to seeking help, causing a delay in recognition and treatment which prolonged the illness and forced these women to suffer in silence. The opposite also applied where prior experience of PND enabled women to recognise the symptoms, seek help, receive treatment and recover more quickly.

Postnatal depression is a common complication following childbirth. It can have devastating effects on the mother, the infant, the family and society. Recovery is not possible without knowledge about this condition, not only for the women themselves, but for society as a whole, including health professionals.

Women in this study recognised that early recognition played a major role in their recovery, but also identified acceptance as a problem for themselves, health professionals and society, in delaying this process.

As a result of this study, gaps within the New Zealand health service were identified, such as a lack of education about PND, parenting of a new baby and support services available in the community. Unrealistic expectations of mothers and the romantic media hype about childbirth and motherhood were also identified as an issue.

ACKNOWLEDGEMENTS

There are a number of people I would like to thank, because without them my thesis might never have come this far. First, a big thank you to the women who willingly and courageously participated in this study by telling the stories of their personal experience of PND, without them this thesis would not have been possible. A big thank you to my supervisor, Associate Professor Dr Gillian White, for always being available, for having the faith and confidence in me to complete what appeared to me to be an agonising marathon at times. Her encouragement throughout the development of this thesis is what has brought it to its completion, for which I am truly grateful.

Thanks must also go to Good Health Wanganui Management Staff for their approval and support and also to my colleagues at Community Mental Health Wanganui for their support and understanding of my preoccupation and vagueness from time to time. Thanks also to Members of the Central Regional Ethics Committee for their approval and for keeping me on track with the annual update reports, and Massey University Human Ethics Committee for their approval and advice. I would also like to thank Georgina for her administrative support.

Finally, a big thank you to my family and friends who put up with my unavailability and stress attacks. Their encouragement and faith in my ability to actually finish this project has been of great help. Special thanks must go to Tara for her patience, expert advice and finishing touches to ensure the presentation of a scholarly thesis.

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Chapter One

Introduction

Background

Becoming a mother is one of the most challenging jobs facing a woman. Women often have preconceived ideas of how motherhood will be and may have unrealistic expectations of themselves as mothers. Such unrealistic images can lead to feelings of failure which in turn can lead to anxiety and depression. Depression is a common complication following childbirth and it affects 10-20% of women (Beck, Reynolds & Rutowski, 1992; Hobfoll, Ritter, Lavin, Hulsizer, & Cameron, 1995). Postnatal depression (PND) frequently goes unrecognised (Beck & Gable (2001).

Denial, ignorance and myths about motherhood are common barriers to seeking appropriate treatment for this serious condition (Honikman cited in Kendall-Tackett, 2005). Unfortunately the cause is not fully understood and there may be a variety of factors contributing to it including biological, social, psychological and emotional. What is recognised as a contributing factor is a lack of support both emotional and practical during this crucial period of adjustment to motherhood. Mothers frequently feel overwhelmed by the responsibility and the sheer workload associated with the role of motherhood, with sleep deprivation leading to tiredness and exhaustion a continuing problem.

Symptoms associated with PND can be confusing to a new mother experiencing negative feelings about motherhood and her new baby when she had believed that motherhood was supposed to be a happy and fulfilling time in a her life.

In searching key words in the research literature it is apparent that varying definitions of postnatal depression are offered by authors. As the terms postnatal, depression and recovery are key to this study, working definitions for these concepts were therefore developed prior to undertaking a literature review. A synopsis of these working definitions is thus included as part of this introduction.

Key Term Definitions

Depression

The American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM – IV) (1994, p. 327) places depression in different categories according to specific criteria, and recognises PND as a form of general depression with a specifier coded ‘postpartum depression’, or a major depressive disorder with postpartum onset i.e. onset of episode within 4 weeks postpartum.

Clinical practitioners however, recognise that a longer period of symptom development is not uncommon. According to Milgrom, Martin, and Negri (1999, p. 11):

Most women with postnatal depression develop symptoms of depression in the first three months postpartum, although a second peak has been observed at six to eight months postpartum. Cooper, Campbell, Day, Kenerley and Bond (1988) reported that 50% of PND start within the first three months, and 75% of cases by six months postpartum.

According to the DSM - IV (1994, p. 325) the diagnostic criteria for a major depressive disorder are:

A. Five or more of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

(1) Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful).

(2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).

(3) Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.

(4) Insomnia or hypersomnia nearly every day.

(5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).

(6) Fatigue or loss of energy nearly every day.

(7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

(8) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).

(9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms do not meet criteria for a Mixed Episode e.g., rapid mood swings.

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

E. The symptoms are not better accounted for by bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterised by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

Women who become depressed postnatally may meet the criteria for a major depressive disorder as described above or may present with only some of those symptoms and fall into a range of other diagnostic categories recognised by the DSM-IV (1994, p. 327) including:

- Minor depressive disorder (depressive disorder, not otherwise specified), which is similar to major depression but requires the presence of only two of the additional criteria;
- Adjustment disorder with depressed mood, which is characterised by marked distress and impaired functioning over what would be expected, in response to an *identifiable stressor*. However, bereavement is not included in this diagnosis;
- Dysthymic disorder, which refers to chronic depressed mood over two years, accompanied by a number of the symptoms that are described in postnatal depression. It is arguable whether this would be considered as PND unless symptoms worsened following pregnancy or delivery;
- Mixed anxiety-depressive disorder, which is currently a research category in the DSM-IV and refers to the presence of both depressive and severe anxiety symptoms, which may be generalised or associated with panic attacks.

Postnatal

Postnatal is defined by Fowler and Fowler (1995, p. 1068) as: “characteristic of or relating to the period after childbirth” however, there is no timeframe given in this definition. Cheryl Tatano Beck (cited in Kendall-Tackett, 2005, p. 4), states that postpartum includes the entire first year following the birth of a child. For the purpose of this study postnatal and postpartum will be used interchangeably and Beck’s definition will be followed here. In contrast, Antenatal is defined by Fowler and Fowler as existing or occurring before birth, or relating to the period of pregnancy.

Recovery

Recovery is defined as: the process of becoming fit and healthy again after an illness or injury (Rundell, 2006). The Mental Health Commission (2000, p. 33) describes recovery in relation to mental illness as a journey which is different for everyone:

For some people with mental illness, recovery is a road they travel on once or twice, to a destination that is relatively easy to find. For others, recovery is more like a maze with an elusive destination, a maze which takes a lifetime to navigate.

Recovery is happening when people can live well in the presence or absence of their mental illness, and the many losses that may come in its wake, such as isolation, poverty, unemployment and discrimination. Recovery does not always mean that people will return to full health or retrieve all their losses, but it does mean that people can live well in spite of them.

A clinical psychologist, Pat Deegan (1988, p. 11) who had herself been diagnosed with a mental illness, introduced the idea of recovery in the context of psychiatric rehabilitation but drew a careful distinction between the two:

Rehabilitation refers to the services and technologies that are made available to disabled persons so that they may learn to adapt to their world. Recovery refers to the lived or real life experience of persons as they accept and overcome the challenge of the disability.

In *Recovery and Wellness: Models of Hope and Empowerment for People with Mental Illness* (2001, p. 1), Cantana Brown discusses the Recovery Model which she describes as a 'consumer movement' in which the client gains control over their life, learns to appreciate and value the uniqueness of self and feels a sense of belonging by participating in a community and by establishing and realising hopes and dreams. Such a model may be difficult for health professionals to accept as they may find it challenging to come to terms with changing the focus of control to a client-centred recovery approach.

In practice, health professionals follow the definition offered by the Mental Health Commission (2000, p. 33) in describing recovery as a 'journey' or a process. For the purpose of this study, the Mental Health Commission definition of recovery will be used. Coleman (1999), who suffered a serious mental health disorder, explains that any journey to recovery must have a beginning or starting point and there are some essential components required for a journey to be successful; one of these is the ability to be able to navigate to your desired destination. Coleman talked about his journey to recovery being kick started by his support worker who encouraged him to go to a support group showing faith in him and his potential. People were an essential part of the recovery process for him and he described them as navigators in the journey to his recovery. People were the building bricks of recovery according to Coleman who reasoned (p. 16):

If people are the building bricks of recovery then the cornerstone must be self. I believe without reservation that the biggest hurdle we face on our journey to recovery is ourselves. Recovery requires self-confidence, self-esteem, self-awareness and self-acceptance. Without this recovery is not just impossible, it is not worth it.

The journey to recovery is essentially an individual one that can only be shared partly with others. It is within the individual to find the tools, strength and skills required to complete the journey. Just as the experience of depression after childbirth is unique for each woman, so is their experience of the journey to recovery.

Mental health workers in New Zealand are all required by the Mental Health Commission (2000, p. 6) to use a recovery approach, which means they should:

- Show that they have hope for the client and his or her recovery;
- Listen to the client and treat them with respect;
- Involve the client in decisions about their treatment and care;
- Support the client to manage their own mental health problem.

There remains a gap in the research literature related specifically to recovery from PND. My understanding based on clinical experience and background research for this study, is that depression following childbirth is just that, and given the appropriate support and recognition of their discomfort, and need for extra support during this period, women will fully recover. However there is a large gap in the literature to date to support this opinion, hence the reason for this study.

The Researcher

I have a personal and professional interest in women's health, first as a woman and a mother who remembers only too well the difficulties of motherhood, especially of trying to live up to the expectations of others including those of society as a whole. Second, I am also a health professional and have worked and have specialised in the area of maternal infant/child and family health since 1986. This has included working as a Midwife, Plunket Nurse, Nursing Tutor (teaching the obstetric component to third year Comprehensive Nurses) and more recently as a Specialist Maternal Mental Health Clinician. It became obvious to me that depression following childbirth was one of the most common and the most difficult problems facing women in New Zealand today. It was also apparent that every woman's experience of PND was different and unique to them. Unfortunately many women seemed reluctant to seek help because of their feelings of failure as a mother and of the stigma associated with PND being diagnosed as a mental illness.

In the course of my work, I observed that some women receiving treatment for PND recovered quite quickly while for others recovery was a long slow process. I became interested in finding a way to gather scientific data to obtain a better understanding of what it was that influenced this, more specifically, what factors assisted and what hindered a woman's recovery from PND.

As a Specialist Maternal Mental Health Clinician, I spend much of my working day listening to women's stories of their experience of PND. Some women reported feeling better from just telling their story and having someone listen to it, others reported that practical help is what made the difference for them and for others it was medication.

Building on this narrative background, I became interested in understanding the common themes in women's experience of PND. By listening to women tell their stories, I decided to focus specifically on analysing what lead to their recovery from PND and what common factors emerged which hindered recovery.

Aims of the Research

The aim of this study was to explore with women (who had recovered or were recovering) their experience of having PND – what helped and what hindered their recovery. The emphasis of the study was what the women now know about PND and their experience of recovery. Every woman's experience of PND is different. Interventions and strategies that are helpful for one may hinder the recovery of another. Where gaps in the health service are identified, they can possibly be addressed at a minimal cost to reduce the incidence of PND, therefore, eliminating or at least reducing the long-term effects of mental illness on women, their family and the community. By listening to the women themselves, their voices can be heard by health professionals and those in a position to affect social policy and thereby ensure that appropriate support and assistance is available to sufferers of PND, or indeed to all new mothers.

Research Methodology

The research methodology for this study which is expanded upon in Chapter 3 is qualitative and explores with women their experience of postnatal depression (PND), specifically examining what factors assisted them and what hindered their recovery. The decision to use a qualitative method is driven by my own assumption of what constitutes reality, as Minichiello, Sullivan, Greenwood and Axford (1999, p. 38) explain: "...the ways in which we, as researchers, will go about getting at knowledge and the techniques we use to collect evidence are directly related to our image of social reality; the way in which we think we can know it and the way we think it ought to be studied." Qualitative methods are used by researchers to shed light on social reality and the important interactions between individuals (Minichiello, et al., 1999). Understanding the point of view of others, their interpretations and meanings define this social reality. Consequently, tools for qualitative research are designed with this purpose in mind – to allow the researcher to gain access to the individual's words, actions and interpretations (Minichiello, et al., 1999). By seeking out women's experiences in the form of stories, this study uses the qualitative paradigm to

define social reality as it is for women who experience the phenomenon of PND. As stated by Berggren-Clive (1998, p. 103), "Women are the experts of their own lives, yet their voices are missing in the existing body of knowledge about depression after childbirth". This study therefore is from the often overlooked perspective of women.

It is anticipated that the findings from this study will be useful in identifying gaps in our health and/or social services which could then be addressed at a minimal cost to reduce the incidence of PND, therefore, eliminating or at least reducing the long-term effects of mental illness on women, their families and the community. Furthermore, findings from this study will provide the groundwork for further research and a basis to inform the efforts of health professionals in assisting families to cope with PND.

Qualitative research derives from a naturalistic paradigm therefore it seems 'natural' that in undertaking the research for this thesis that people's stories are indeed the kernel of knowledge. The women taking part in this study told their stories, what it was like for them having PND, their lived experience and what factors assisted or hindered their recovery. As Gilligan and Price (1993, p. 36) state:

The narrative metaphor proposes that persons live their lives by stories – that these stories are shaping of life and that they have real, not imagined, effects – and these stories provide the structure of life.

Qualitative research has become more popular in recent years as it is a research paradigm in which the main objective is to examine and describe phenomena as they are consciously experienced by the individual (Beck, 1992).

Thematic Analysis

While there are a number of accepted methods of qualitative data analyses the method selected for this study is thematic analysis. Briefly, thematic analysis is used to translate the raw data into themes or patterns and then classifying or encoding the pattern.

Thematic analysis enables the researcher to use a wide variety of types of information in a systematic manner that increases their accuracy or sensitivity in understanding and interpreting observations about people, events, situations and organisations by identifying themes and coding them. Coffey and Atkinson (1996, p. 27) state “Coding can be thought about as a way of relating our data to our ideas about these data”. They emphasise that coding provides many benefits in the organisation, processing and analysis of qualitative information.

Thesis Outline

Chapter 1 briefly introduces the phenomenon of PND. Working definitions of the main terms used throughout this study are described. The researcher is also introduced and the Chapter concludes with a brief outline of the research method used for the study.

A review of the relevant literature pertaining to the key terms postnatal depression, recovery, experience and treatment is undertaken in Chapter 2. In addition, PND is discussed in depth with a particular emphasis on incidence and prevalence, consequences, experience and a comparison of current treatment methods.

In Chapter 3 the research design and method of data analysis is explained and justified within its broader framework of qualitative research.

The use of individual interviews is discussed in the fourth Chapter. Thematic analysis is used to take the findings and to code and group them according to common themes.

In pulling together the three major themes drawn from the findings, Chapter 5 provides analysis of these findings and draws them together to identify significant gaps within the health service of New Zealand.

By way of conclusion, the means to address these gaps within New Zealand's health service to improve the health and wellbeing of mothers, infants and their families, are discussed in Chapter 6 along with areas for further research.

Chapter Two

Literature Review

In preparation for this research a review of available relevant literature was carried out. A Medline, Cinahl and Tepuna search was performed of English-language journals for pertinent articles published since 1990. The reference lists of the articles retrieved in the search were also reviewed as well as those of major obstetric and psychiatric texts. The key words used in the search were 'postnatal depression' and 'recovery'. Added were 'experience' and 'treatment'.

Historical Review

Hippocrates was the first to write about the psychological and/or physiological problems following childbirth (Lloyd, 1978). Such problems were thought to be caused by what was believed at that time to be 'milk fever' because it occurred at the same time as the onset of lactation about 3-4 days postnatal. The fever was associated with both physical and psychological symptoms which caused weeping episodes often accompanied by hysteria (Littlewood & McHugh, 1997). However, it was most likely associated with what we now refer to as the postnatal blues or possibly that of puerperal infection which was common at that time and frequently resulted in the death of the mother. During the Middle Ages, a woman with postnatal depression (PND) was often considered to be a witch (Cox, 1986) and was very likely to be beheaded, strangled, and sometimes even burned alive, because people with a mental disorder at that time were thought to be possessed by demons. Littlewood and McHugh (p. 9) state that:

Many factors were prevalent in the Middle Ages that would have masked any documentation of psychological disturbance following childbirth such as:

- High maternal and child mortality rates;
- An emphasis on the life-or-death nature of childbirth;
- An interpretation of intense physical pain and psychological suffering within a religious framework that presumed women to be responsible for original sin;
- Relatively poor physical health coupled with a focus on day-to-day survival that did not necessarily consider any aspect of psychological wellbeing”.

Littlewood and McHugh (1997, p. 9), explain that “Psychological disorders frequently went unacknowledged unless they showed themselves in severely disturbed behaviour, and then it would be considered as evidence of demonic possession”.

Scientific thought began to change gradually, but the idea of mental illness being associated with the devil remained until later on in the 19th century, when two French psychiatrists of this time, Marce and Esquirol actually identified for the first time a puerperal mental illness (Cox, 1986 cited in Adcock, 1993). However it was not until about the turn of the 20th Century as reported by Adcock (1993, p. 704) that “the concept of demonology was destroyed due to advances in psychopathology”. Mental illness due to brain pathology was the school of thought that followed until a new theory emerged which proposed that mental illness might be caused by psychological rather than organic factors (Coleman, 1972, cited in Adcock, 1993). However, it now appears from the contemporary literature that PND is attributed to a variety of aetiologies which are thought to include a combination of biochemical, psychological, socio-economic, cultural, spiritual and physical factors, including the birth experience (Raphael-Left, 1991 cited in Adcock, 1993).

One of the early studies on PND (Pitt, 1968, p. 1327-1328) described postnatal depression as:

Tearfulness, despondency, feelings of inadequacy and inability to cope, particularly with the baby.... Guilt and self-reproach over not loving or caring enough for the baby... excessive anxiety over the baby which was not justified by the baby's health..... Unusual irritability was common, adding to feelings of guilt.... impaired concentration and memory, and undue fatigue and ready exhaustion were frequent, so that mothers could barely deal with their babies, let alone look after the rest of the family and cope with housework and shopping.... Anorexia was present with remarkable consistency, and sleep disturbance, over and above the inevitable with a new baby, were reported by a third of the patients.

This description of PND remains mostly unchanged today, with reference to Dalton's (1980) definition most commonly recognised. Dalton (in Littlewood & McHugh, 1997) defines PND as the first psychiatric illness occurring after childbirth and she breaks it into three interrelated but potentially separate psychological conditions.

The first condition is that of postpartum blues otherwise known as 'The Baby Blues' which is very common and occurs around the third day after birth. It is thought to be due to fluctuating hormone levels that result from the third stage of labour with the expulsion of the placenta and also the influx of the hormones of lactation with the establishment of lactation at about the third day after childbirth. Dalton describes this as an emotional disturbance that only lasts for a few days and is not considered to be a psychiatric condition. The symptoms include tearfulness for no apparent reason, various degrees of anxiety especially related to coping with the responsibility of a new baby, fatigue, sleep disturbance and poor appetite.

The second condition identified by Dalton is moderate to severe PND which she explains can occur as a gradual onset from the postnatal blues or can occur at any time up to approximately six months postnatally and it is much the same as moderate to severe depression experienced at any other time of a person's life such as anxiety, tearfulness, confusion, obsessional thoughts, irritability, fatigue, insomnia, fear of harming the baby and loss of interest in sexual activity.

The third condition is that of puerperal psychosis. The onset of this condition, usually sudden and within the early postpartum period, is characterised by severe behavioural changes with psychotic symptoms such as auditory and/or visual hallucinations. Puerperal psychosis is serious and requires hospitalisation, however it is comparatively rare.

The Mental Health Foundation of New Zealand (1999) defines PND as also consisting of the three types of depression described above. However, for the purpose of this study the focus is on the second condition identified by Dalton.

More recently however, research has identified another stage known as 'the pinks' which occurs soon after birth (White 2005, p.58). The 'pinks' are described by White as "euphoria (ecstasy, joy, jubilation, rapture, excitement, exhilaration) and elation (delight, exultation, high spirits, pride)" and are triggered by the release of endorphins following labour. The baby blues as described in Dalton's earlier definition (1980) follow the 'pinks' for around 85 per cent of new mothers (White, 2005, p.61). "In these cases, mothers experience a dysphoric stage that follows an earlier 'pink' euphoric stage".

Incidence and Prevalence of PND

Incidence is defined by the Macmillan English Dictionary (Rundell, 2006, p.725), as the number of cases of an illness or a medical condition in a particular place, group, or situation. Therefore, incidence refers to the actual occurrence of PND in the community. The **incidence** of disease is defined as the number of *new* cases of disease occurring in a population during a defined time interval.

Prevalence is defined by the Macmillan English Dictionary (Rundell, 2006, p.1116), as the fact that something is prevalent: the prevalence of lung cancer among the local population. Prevalent refers to it being very common in a particular place or among a particular group, such as depression in women following childbirth. In other words, prevalence is the high number of cases of a disease present in a statistical population at a specified time.

Depression following childbirth (PND) is considered the most common complication of the postpartum period and is believed to affect between 10 to 20 per cent of women (Miller, 2002). However the literature concerning the statistical occurrence of PND is conflicting which is thought to be due to the difficulties associated with its detection and the various use of screening tools. For example, the Marce Society (in Littlewood & McHugh, 1997, p.21) report the incidence as follows:

Postpartum blues	8 in 10 women
Moderate/severe depression	2 in 10 women
Puerperal psychosis	2 in 3000 women

O'Hara and Swain, (1996) report that approximately 13 per cent of postpartum women are affected by PND and that it is resistant to conventional treatment. They describe PND as characterised by tearfulness, mood swings, despondency, feelings of inadequacy and inability to cope with the care of the baby. Feelings of guilt about the birth and guilt about their performance as a mother are also common experiences (Berggren-Clive, 1998; Nalepka & Coblenz, 1995).

Most of the literature describes the slow insidious onset of PND which often goes unrecognised, resulting in only a minority of women who suffer from it actually seeking professional help (Littlewood & McHugh, 1997). It would appear that women are reluctant to discuss their feelings perhaps because of their own beliefs, or society's expectations of motherhood as a joyful and happy time for women (Beck, 2001). An unrealistic expectation of motherhood can increase a woman's feelings of unhappiness, hopelessness and isolation with symptoms worsening before she seeks help (Ugarriza, 1997). Many women feel a great relief from having a diagnosis given to their distress and feelings of hopelessness. It in some way provides them with a justification for what they see as their inadequacies or inability to cope. However in other cases a diagnosis can hinder the recovery because postnatal depression is considered a mental health disorder and a stigma is still attached to mental health disorders (Littlewood & McHugh, 1997).

In an early study of PND by Cox, Connor and Kendell (1982), 13 of the 101 women they interviewed had a marked depressive illness, and the majority of these women had not been recognised as having PND. These women had gone untreated despite home visits from health visitors and also general practitioner (GP) awareness of the patient's state. This was a problem also recognised in a New Zealand Study carried out by McGill, Burrows, Holland, Langer and Sweet (1995). This latter study showed that 20 per cent of women had symptoms of depression following childbirth and that a considerable number of the women with depression were not recognised as having it.

There is considerable data available on the prevalence of PND and the factors affecting the prevalence, for example a 1998 pilot study carried out by Johnson, Martin and Milgrom, (cited in Milgrom, et al., 1999, p.242) “revealed a much higher prevalence rate of PND (31.6%) in a rural community compared to (17.6%) in an urban community.”

However some disagreement in the literature exists as to whether depression is more frequent in the months after childbirth compared to the general population. Cox, Murray and Chapman (1993) found that the incidence of depression was similar to that of the general population, although women were at greater risk of depression shortly after childbirth, with a threefold higher rate of onset of depression within five weeks of childbirth. Pop, Essed, De Geus, Van Son and Komproe (1993) found that women had the highest incidence of depression at ten weeks postpartum, and Nott (1987) reported that the highest incidence of new cases of depression occurred between the third and the ninth month postpartum.

Depending on the criteria used, and the methodology of the research studies, about 10-20 per cent of women suffer from some degree of clinical depression in the first year after childbirth. Lower rates of depression (7%) were found if the criterion for depression was seeking psychiatric help (Dalton, 1971). If a formal questionnaire or interview was used rates of up to 20% were found, and over 30% of postpartum women were described as depressed when the criterion was ‘emotional problems’ assessed by obstetricians (Gordon, Kapostinis & Gordon 1965). These differences are still apparent today depending on the sample and how depression is defined (Kendall – Tackett, 2005).

Screening for PND

In recent years, a standardised form of assessment has been used for detecting depression in postnatal women. Usually these are standardised psychiatric interviews such as the Goldberg Standardised Psychiatric interview (Cox et al. 1993), and the Structured Clinical Interview (SCID), used in conjunction with questionnaires or screening tests such

as the Pitt Depression and Anxiety Questionnaire (PDAQ) (Tonge, 1986), Beck's Depression Inventory (BDI) (Tamminen, 1988), the Research Diagnostic Criteria (RDC) (Pop, et al. 1993) or the Edinburgh Postnatal Depression Scale (EPDS) (Cooper, Murray and Stein, 1993). Currently, the EPDS is the most commonly used PND screening tool. Recently however, Beck and Gable (2000) have developed a new measure for screening postnatal depression known as the Postpartum Depression Screening Scale (PDSS) which is far broader than the EPDS and these are discussed below.

It is important to note here that these questionnaires are screening instruments, not diagnostic tools and therefore they may only be used to support the clinical findings. The use of conventional screening tools to support the diagnosis of depression in the postpartum period can be misleading, as concentration on somatic symptoms such as difficulty sleeping, tiredness and weight change may not relate to depression in this situation since weight change, tiredness and sleep problems can be associated with the normal postpartum period. The EPDS was devised to take these factors into account, and to be acceptable to both women and health professionals. It is quick to complete and score, and explores ten statements relating to symptoms of depression, each with four possible responses. Women are asked to underline the one that comes closest to how they have felt during the past week. The items are then scored 0 to 3 and are totalled to give an overall score. A score of 12 or more indicates the likelihood of depression, but not the severity. However, the EPDS has been translated into many different languages and the cut-off point for scoring has been lowered to 9 or 10 for some, such as the French, Chinese, Japanese and Swedish language versions to allow for the difference in translation and cultural interpretations of the condition (Cox & Holden, 2003). In addition, clinical judgement must be used to assess women who may be depressed according to the results of this screening scale. Another possible disadvantage of this screening scale is that women are not given the opportunity to describe their symptoms or feelings more fully in the questionnaire, although it does give them an opportunity to speak about their feelings, and it can prompt health professionals to question their symptoms in more depth (Holden, 1991).

The Postpartum Depression Screening Scale (PDSS)

Rather than merely screening for depressive symptoms, the PDSS screens for additional symptoms such as loneliness, irritability and loss of concentration (Henshaw & Elliott, 2005). The PDSS (Beck & Gable 2000) is:

A 35 item self-report instrument that assesses the following dimensions:

- Sleeping/eating disturbances
- Anxiety/insecurity
- Emotional lability
- Cognitive impairment
- Loss of self
- Guilt/shame
- Contemplating harming oneself.

Each dimension is composed of five items with a response ranging from strongly disagree (1) to strongly agree (5). Women are asked to respond to the questionnaire regarding how they have felt over the past two weeks (Henshaw & Elliott, 2005, p. 134):

In completing this scale they are asked to circle the answer that best describes how they have been feeling over the past two weeks. Because all items are negatively worded, agreement with an item constitutes endorsement of a psychological distress. Higher scores on the PDSS indicate higher levels of postpartum distress. Total scores on the PDSS range from 35 to 175.

This new screening scale is designed as a self report scale to be used with women in the first year postnatally, and is currently being used by some practitioners in screening women for PND in the United States of America.

Consequences of PND

It is necessary to understand the consequences of PND in order to understand the recovery process as it is experienced by the individual, because each woman's experience of PND is different. It is also important to recognise effects that maternal depression may have on the infant and other members of the family in order to provide appropriate interventions.

In a study by Beck (1993), she describes PND as a debilitating mood disorder that wears away at the delight of new mothers. In some cases, this can leave women to contemplate suicide as the only way out of their misery. However, the consequences of this illness can have long-lasting effects on the entire family. Husbands and partners are often invisible victims of PND as there is a lack of services providing support to them (Harberger, Berchtold, & Honikman, 1992). Evidence is accumulating that PND not only has an adverse effect on maternal/infant interaction during the first year of life (Beck, 1995), but may also have long-term effects on children over the age of one year (Murray & Cooper, 1997).

A Christchurch, New Zealand pilot study of women with postnatal depression conducted by McGill, et al. showed that:

Some degree of postnatal depression is found in 20% of women after childbirth. It has also shown that the incidence of depression in their partners is about the same. Under these circumstances 20% of parental relationships are likely to be "at risk", 6-9 months after the birth. What this means in terms of family unhappiness and subsequent separation or divorce is unknown. It is speculated that the personality and behavioural changes in a woman which are associated with PND, may be a contributory cause of depression in her partner and deterioration in the partner relationship.

Depression after childbirth is often referred to in the literature as ‘the hidden disorder of motherhood’, because it is so commonly masked by women with newborn infants. This masking of symptoms is also referred to as the ‘mask of motherhood’ by Susan Maushart (1999) in her book of the same name where she dispels the myth of the serene mother and attacks what she views as lies served to new parents that hide the realities of parenthood. In a more local context, both Arlene Goss and Liz Gunn admit to hiding their symptoms in Goss’s book (1998) *Beyond the Baby Blues: Overcoming Postnatal Distress in New Zealand*.

There is growing evidence that PND has an adverse impact on the quality of the early mother/infant relationship and on the course of child socio-emotional development (Murray & Cooper, 2003). Milgrom et al. (1999, p. 2) acknowledge that:

One of the most striking features of PND is the impact it has, not only on the woman, but also on her infant and her partner. The difficulties that arise in these relationships, often triggered by the depressive episode, mean that the adverse effects of PND may persist even after resolution of maternal symptoms.

As previously noted the DSM – IV criteria recognises PND as a general depression or major depressive disorder with postpartum onset (American Psychiatric Association, Diagnostic and statistical manual of mental disorders DSM-IV, 1994). In this context, the depression is considered to have the same affect on the individual and her family as it would have at any other time in a person’s life. It is therefore understandable that this serious mental health disorder at such an important and demanding time in a person’s life will have a huge impact on a new mother, her infant and her family, not to mention the community and in particular the health service.

Elliott (1989) explains how “depression affects the sufferer’s behaviour, particularly social behaviour. The postnatal period is of special, unrepeatable significance

in the mother's developing relationship with her child. It is not surprising; therefore, that depression in the postnatal period has special consequences not shared by depression at other times" (p. 879). She states that:

Depression after childbirth may:

1. Fundamentally and enduringly undermine a women's self-esteem, particularly her confidence in her ability to be a 'good enough' mother;
2. Be a permanent and well-remembered source of regret, since women describe having 'missed the first year' of their child's life;
3. Delay the development of mother/infant attachment and mutually satisfying interactive behaviours;
4. Lead to long-term effects on the child's behaviour or cognitive ability, as well as the mother/child relationship if the mother's 'withdrawal' is not adequately compensated for by the father or other suitable persons;
5. Lead to marital stress and, if this remains unresolved, eventually divorce.

Much is written about the negative consequences of PND but very little about the positive, such as personal growth which must be profound given such a life changing experience. Bishop (1999, p. 103) writes:

Through PND, I have learnt about the value of love in my life, of friendship and of inner strength. Whilst PND is hell and I never want to go through it again, I would not have missed it for the world. We have a beautiful son, I have learnt so much about myself, my husband and I have reassessed our lives and relationship and we have made wonderful friends. Also, the completion of this book was made possible by my own suffering.

White (2005) also details the positive consequences which can arise from the PND experience. The experience of one father, Paul, whose wife had PND is particularly uplifting. Paul explains (p. 112):

I think postnatal depression has helped me to see the real me.
It has shown just how much patience I really do have and that I
can just keep on keeping on. It's evidence of the depth of my
love [for Tina] because I have carried on.

Such descriptions of recovery from PND that details the positive consequences such an upheaval can create, make the Mental Health Commission (2000) definition of recovery as a 'journey' ring true.

Experiences of PND

Depression is a painful and debilitating condition at any time; it attacks the will — the will to look on the positive side or to take any positive action to change your outlook or circumstances. Most women find themselves unable to seek help. Cox et al. (1987) suggests that they probably don't feel that it is acceptable to be feeling the way that they are feeling because motherhood is portrayed as a joyful and fulfilling time in a woman's life and they may also fear being labelled as 'mentally ill'.

Although each woman has a different experience of PND, there are many common feelings such as: a total loss of enjoyment of life, helplessness and despair, isolation, severe fatigue, irritability and guilt, loss of appetite and sleep disturbance, anxiety and panic attacks, difficulty or inability to cope with the care of an infant and the demands of motherhood, a real sense of failure and sometimes thoughts of suicide or even homicide (Beck, 1992; Bishop, 1999).

The cause is not fully understood and is thought to be due to a variety of factors including; sudden hormonal changes following childbirth, psychosocial problems, trauma or difficult birth, lack of support, history of depression or mental health disorder, relationship problems with partner and childhood experiences. Whatever the cause, the effects can be devastating not only on the mother but on the infant, the partner and other members of the family.

Diagnosis of PND is complicated by the fact that every woman's experience is different; symptoms of PND may be dramatic and severe or prolonged and recurrent. They may experience symptoms immediately or soon after the birth or not until months afterwards.

Bishop (1999, p. 14-25) provides quotes in her book *Postnatal Depression: Families in Turmoil* of the different experiences of PND as described by the women themselves, for example:

- I felt as though my world had fallen apart. Everything looked bleak and there seemed no chance of the PND ever getting better.
- I was in a constant state of worry about myself and the baby and had frequent panic attacks.
- I had suddenly developed a fear of social contact and yet I was afraid of being alone and at home.
- I felt as though I were going mad, and that I just simply couldn't cope.
- I was always tired, but couldn't sleep, I desperately needed sleep but was simply too wound up to relax.
- I spent a lot of time in useless activities and by the end of the day would look around me and find that I had actually achieved nothing.
- People around me saw the baby was dressed and clean and I was presentable, they would often comment on how capable I was, but inside I was dying.

- I believed I had gone mad. I felt disconnected from everything around me, and I seemed to be in a world of my own.
- I believed that the depression was my fault.
- I remember feeling so guilty about what my family were going through when I was depressed, and how hard it was for them.
- I wanted to end my life – suicide looked like the only option. I had a plan of how I was going to kill the kids and myself. I tried to commit suicide a number of times. The world would be better off without me.

Current Treatment of PND – Advantages and Disadvantages

There have been only limited studies of treatment approaches specifically developed for PND. Both prospective and retrospective studies of PND have largely concentrated on the identification of maternal risk factors. Although useful, such studies fail to provide any assistance for those mothers who are currently suffering from PND or who have not been recognised by health professionals as having PND. Cox et al. (1982), and Whitten, Warner and Appleby (1996), all state that early identification and early intervention by health professionals is essential for these women. Once PND has been identified, it may require some encouragement before a woman will engage in treatment, as evidence suggests women are reluctant to accept a diagnosis of PND and often regard their symptoms as not severe enough to be labelled as depression (Whitten, et al., 1996). They are therefore reluctant to accept treatment. Frequently, women hold strong beliefs that prevent them from accepting treatment which can include denial, shame, myths about motherhood and social expectations. They feel that they should be able to cope, often dismissing their feelings as a result of having had a bad day (Milgrom, et al., 1999).

Medication

Antidepressant medication remains the main-stay of treatment for moderate to severe PND. Miller (2002, p. 763) states:

While there are no absolute contraindications to using particular antidepressant medications during pregnancy or lactation, there is also no specific Food and Drug Administration approval for use of any antidepressant medication during pregnancy or lactation. Most guidelines advise the use of antidepressants that have been systematically studied in humans, such as the tricyclic group or the selective serotonin reuptake inhibitor (SSRI) group of antidepressants.

Both of these antidepressant groups are known for their efficacy in the treatment of depression, however they do not offer a quick-fix and are required to be taken on a daily basis for some time even after symptoms have subsided in order to reduce the possibility of relapse. As there are certain risks with all medication, the literature indicates that medication should never be the first choice of treatment and should only be considered when alternative treatment or social support is inadequate. Relevant literature notes that the side effects of the medication can be uncomfortable for the mother such as drowsiness, dry mouth, and nausea. There has also been some association with crying, sleep disturbance, vomiting and watery stools in nursing infants of mothers on antidepressant medication (Lester, Cucca, Andreozzi, Flanagan and Oh, 1993). Some women will refuse to consider medication out of concern for the effect it might have on their unborn child or their nursing infant.

More recent clinical information regarding the use of one of the SSRIs, paroxetine hydrochloride (Aropax) in pregnancy was provided by GlaxoSmithKline (2005) to all health professionals. This followed a retrospective epidemiological study of major congenital malformations in infants born to women taking antidepressants during the first

trimester of pregnancy. Preliminary results suggested that a possible increase in the risk of birth abnormalities was associated with the use of Aropax as compared to other antidepressants. The type of abnormalities seen were reflective of those in the general population, the most common of these were cardiovascular mainly that of ventricular septal defects (GlaxoSmithKline, 2005).

As stated by GlaxoSmithKline (2005) these preliminary results differ from previous epidemiological studies, making it difficult to conclude whether a causal relationship exists. However, it is an important consideration when faced with the need to prescribe antidepressant medication during the first trimester of pregnancy. There is also the need for health professionals to respect the wishes of a mother who refuses medication during pregnancy and lactation and to offer alternative therapy as discussed below.

Cognitive-behavioural therapy and interpersonal psychotherapy have demonstrated efficacy in treating PND (O'Hara, Stuart, Gorman & Wenzel, 2000).

Cognitive Behavioural Therapy (CBT)

Cognitive behavioural therapy (CBT) is an effective form of treatment for depression and is conducted by a trained therapist. It is helpful in challenging erroneous cognition such as the way a patient perceives themselves, motherhood, relationships, expectations, the environment and the future. As Meager and Milgrom, (1996, p. 853) explain it is extremely useful in “demonstrating the relationship between negative thinking and subsequent feelings/behaviours”. This therapy provides strategies for dealing with these negative thoughts and ways of developing more realistic and positive thinking.

Interpersonal Therapy

Couples intervention can improve the mental health of both the woman and her partner (Misri, Kostaras, Fox, & Kostaras, 2000). For women whose depression has

interfered with attachment to the infant, parenting, coaching or infant massage can improve this relationship (Onozawa, Glover, Adams, et al., 2001).

Self-Help Groups

Self-help groups such as Postnatal and Antenatal Distress Support Groups can be very helpful for women with depression either during pregnancy or in the postnatal period by providing them with support and education (Farmer, 1995). For many women this has been their saving grace as they learn that they are not alone, it is not their fault and they will recover.

Listening

Listening therapy has been extremely valuable as demonstrated by this study where women spoke about the therapeutic value of telling their story. Women with PND or those who have experienced PND have received great comfort from telling their story and having their feelings validated (White, 2005). I have also found in my work as a Maternal Mental Health Clinician that in some cases women require no further treatment or input from our service following a session of telling their story and having it listened to and validated. Telephone counselling is also a very good option for women with PND; this can sometimes be provided in the community by the coordinator of the PND support group or a qualified counsellor from a community agency with a special interest in maternal mental health, as it is in the community where I work.

Electroconvulsive Therapy

Electroconvulsive therapy (ECT) can be an effective treatment for depression and can work more rapidly than medication (Raty-Vohsen, 1982 cited in Miller, 2002). Side

effects of ECT include memory loss. ECT can be the treatment of choice when symptoms are very severe and require a more prompt response than can be achieved with the introduction of medication.

Hormonal Therapies

Interventions currently under study for efficacy include regional transcranial magnetic stimulation, sleep deprivation, and oestrogen. Oestrogen therapy has been found to be effective for some women, however the contraindications include risk factors for breast cancer, hypercoagulability, and pregnancy (Gregoire, Kumar, Everfill, Henderson & Studd, 1996).

Eye-Movement Desensitisation and Reprocessing (EMDR)

This is a relatively new form of treatment, mainly used in cases where women have experienced a traumatic birthing experience and are suffering from a condition known as post-traumatic stress disorder (PTSD). As White (2005, p. 132) explains “No one is sure how EMDR works. It is possible that it follows a similar process to acupuncture and ‘unblocks’ the brain’s information processing system.” It is also possible that it helps in some way to restructure the memory. There is only vague evidence related to the effectiveness of EMDR, however, many people have experienced success from the use of this therapy (White, 2005).

Preventative Treatment

Preventative approaches to treatment of PND include regular screening of women during pregnancy with tools such as the previously discussed EPDS and PDSS and the provision of early intervention (Cox & Holden, 1994; Henshaw & Elliott, 2005). Early identification of antenatal psychosocial risk factors has also received some attention in the research literature (Wilson, Reid, Midmer, Biringer, Carroll & Stewart, 1996). Psycho-education and social support provided during pregnancy and continued for some time post-partum has been found to reduce the prevalence of PND (Elliott, Sanjack, & Leverton, 1988). Prevention of PND may not always be possible, however education and support can minimise the effects of PND on the woman, her infant and her family.

Recovery

There is limited research on recovery related to PND. The research that exists mainly refers to general recovery from both physical and more chronic types of mental illness. The literature available on recovery from mental illness is not specifically related to PND and there is only a sparse amount on depression generally, which mainly focuses on recovery from chronic mental disorders such as schizophrenia. Moreover, such research frequently considers maintenance of the symptoms rather than focussing on recovery.

Models of Illness: Explanatory Model vs. Biomedical Model

In 2002, Ugarriza published a study of 30 women living in Miami, Florida who self-identified with PND from 1997 through 2000 (Ugarriza, 2002). Using the Kleinman explanatory model of illness, Ugarriza found that their beliefs about PND and its treatment contrasted with the biomedical model of PND. The explanatory model of PND presented by this group of mothers differed significantly from the DSM-IV diagnostic criteria for PND as Ugarriza, (2002, p. 233) explains:

First, the symptoms came in phases and were unrelated to length of time since delivery. Women would experience the symptoms, feel relieved for a while, and then re-experience the symptoms. Feeling bad, feeling better, then feeling bad again was a frequent complaint. This fluctuation of symptoms and their unrelated relationship to length of time from delivery differs significantly from descriptions of DSM-IV criteria which indicates sustained symptoms for at least a 2-week period.

The mothers in Ugarriza's study all suggested more public education and support for new mothers to prevent and treat the disorder.

As mentioned in Chapter 1, there is a lack of literature focussing on recovery from PND. This current research aims to address the gap by listening to women's stories and by documenting the factors which assisted in or which hindered their recovery.

Chapter Three

Study Design and Method

As PND is a unique and a personal experience for the individual, only a qualitative approach would be able to reflect the very essence of this experience as it is for a woman. Qualitative research is about understanding the meaning of the phenomenon for the individual experiencing the phenomenon. Qualitative research methods are systematic modes of inquiry oriented toward understanding humans in ways which acknowledge holistically the nature of their interactions with themselves and with their surroundings (Benoliel, 1984). The qualitative paradigm provides an opportunity for the researcher to empathise and in so doing, to describe the perspective of the participants from an empirical foundation (Patton, 2002). Max Weber is widely regarded as having brought the idea of empathy into social science in order to achieve a proper understanding of the feelings of people in a social-cultural realm (Patton, 2002).

The main objective within a qualitative study is to examine and describe phenomena as they are consciously experienced by the individual (Beck, 1992). It is without theories and is as free as possible from unexamined preconceptions and presuppositions (Spiegelberg, 1975).

Qualitative study therefore requires us to place our usual understandings aside and have a fresh look at things. It can be creative, exciting, fun and challenging but also at times it can be disturbing or even painful for the researcher because they care deeply about their work and find profound and satisfying meaning in their studies (Spiegelberg, 1975).

Often inductive in approach, qualitative methods focus on the perspectives of the participants in their own settings. Using such an approach the researcher attempts to understand the participant's reality within whatever context it arises (Field & Morse, 1985). Whilst acknowledging that each participant is a complex whole, interacting in a background of further complexities, the participants are viewed as authors of their own experiences, creators of themselves by their existential choices, and definers of their own reality (Oiler, 1982).

This perspective helps to make sense of the complexity of human experience and avoids a reductionist approach that often occurs in quantitative research through recognising that "individuals are not always reducible and measurable objects that exist independently of their historical, social and cultural contexts" (Duffy, 1987, p. 132).

There are three types of data collection within the qualitative paradigm: in-depth open-ended interviews, direct observation and the study of written materials (Patton, 2002). In this study, the first of these data collection categories has been employed whereby in-depth interviews were used to gain a rich and extensive collection of information. The method of data collection will be discussed in greater depth later in this chapter. Briefly however, interviews "yield direct quotations from people about their experiences, opinions, feelings, and knowledge" which was most appropriate for the purposes of this study (Patton, 2002, p. 4).

I considered it essential to hear from the women themselves, how it was for them having depression following childbirth and what they found helpful or a hindrance to their recovery. Having worked in the field of women's health for the past 20 years and having established the Specialist Maternal Mental Health Clinician position in the Wanganui region in 1998, I became aware that women's description of positive and negative factors affecting their recovery was absent from the literature. By hearing their stories and having their voices heard through this study, I hope that a more in depth understanding of PND will be gained and preventative measures can be put in place.

Thematic Analysis

Thematic analysis is way of seeing. Often, what one sees through thematic analysis does not appear to others, even if they are observing the same information, events, or situations. To others, if they agree with the insight, the insight appears almost magical. If they are empowered by the insight, it appears visionary. If they disagree with the insight, it appears delusionary. Observation precedes understanding (Boyatzis, 1998, p. 1).

Within the qualitative paradigm, thematic analysis is a method of analysis which acts as an encoder of information by coding thematic lists, complex thematic models, causally-related indicators and requirements or a mixture of these (Boyatzis, 1998). By analysing a set of data, core patterns may be found which the researcher can then group into major themes for further analysis (Patton, 2002). In applying thematic analysis to nursing research, Morse (1991) limits themes to 'thematic moments' which she considers helpful focal points rather than the essence of an experience. However, Morse's explanation overlooks the value of thematic analysis as a method in which patterns, and thus themes, may be drawn from complex data and applied to nursing research.

As described by Boyatzis (1998), a theme is a pattern found in the information that can describe, organise and interpret the information as within the particular phenomenon. A theme may be identified as underlying the phenomenon. These themes can either be generated inductively from the raw information or be generated deductively from theory or prior research.

Thematic analysis consists of various purposes (which can overlap) that are used as a way of:

- Seeing
- Making sense out of seemingly unrelated material
- Analyzing qualitative information
- Systematically observing a person, an interaction, a group, a situation, an organisation, or a culture
- Converting qualitative information into quantitative data (Boyatzis, 1998 p. 4).

This study has utilised the first three of these purposes of thematic analysis. With these purposes in mind, data has been analyzed using Colaizzi's (1978) procedural thematic framework which includes a number of steps:

1. The transcription of interviews verbatim;
2. The extraction of significant phrases;
3. The formulation of meanings from those phrases;
4. The generation of themes from those phrases;
5. The description of experience from analysis of themes, and
6. The return of research to the original source to ensure its validity.

Thematic analysis was particularly suited to this study because experiences of PND and recovery from it as described by the women in the study were very similar in many respects and analysis of the transcripts based on the words of the participants formed several common thematic patterns from which the three major themes emerged. Personal knowing is frequently enhanced through the use of poetry, literature or even art, and story telling as described by Younger, (1990, p. 42) can be used as an endeavor to "more truly understand '[the person]' and his world as if I were inside it".

Design

The study design has taken the form of in-depth interviews using open-ended questions as prompts for the women to tell their stories and carried out by the researcher. The interviews were audiotaped. A total of eight interviews were carried out in the Wanganui area. The researcher observed the subjects while they responded to the questions as this usually leads to more information (Massey, 1995).

Taping rather than writing full notes during the interviews in order to observe the participants is a useful qualitative research technique because it allows for the exploration of a wide variety of phenomena. Broadly, following Colaizzi's thematic analysis framework, the interviews were then transcribed verbatim and the transcribed interviews were then sent back to participants to ensure the validity of data recorded during each interview. Whilst Colaizzi (1978) recommends returning the research to the participants as the final step of his framework, this study undertook this phase as the second step in order to ensure that the data was valid before it was analysed. Next, all of the participant quotes from the interviews were taken and meanings were formulated from each quote. Then, those with similar meanings were grouped together according to similarity of representation. Following this step, the groups of quotes from the various participants were examined and reflected upon as a whole in order to determine common themes from the sets of phrases. Finally, those major themes were analysed to describe the participants' experience of PND.

Participant Selection

Participants were recruited through flyers placed in local health services, Plunket rooms and the Plunket Karatane family centre, with an invitation for women who had experienced PND to take part in the study (see Appendix 3). Contact details were included in the invitation and women who were interested in participating in the study made contact themselves with the researcher. Participants were included in the study following assessment by telephone to ensure that they met the criteria, for example: had been

diagnosed with PND by a doctor, had recovered or were in the process of recovery. Women were excluded if they:

- Had had a miscarriage, abortion or stillbirth within the past 12 months;
- Were experiencing psychotic symptoms that are likely to interfere with their comprehension of the project;
- Were experiencing any acute or chronic symptoms that were severe enough to cause them to experience any distress as a result of participating in the study;
- Had any cognitive impairment that would make it difficult or impossible for them to participate in the study and/or
- Had any form of problem that could interfere or prevent them from freely giving their written and verbal consent to participate in the research.

Women who made contact were given further information by telephone and a written information sheet and consent form was posted to them (see Appendix 1 and 2 for information sheet and consent form respectively). Participants were given the choice of having an individual interview or participating in a focus group and both of these processes were fully explained. All of the participants in this study chose to have individual interviews. The consent form was signed by the participant and witnessed at the first meeting with the researcher. Contact details have been deleted from the appendices.

Ethical and Legal Issues

This research has conformed to the guidelines prepared by Massey University Human Ethics Committee for the preparation and undertaking of research involving human subjects. The New Zealand Nurses' Organisation Code of Ethics and the New Zealand Health Research Council (1997) Guidelines on Ethics in Health Care Research were used to guide the researcher throughout this study. In addition the research has upheld the Code of Consumer Rights as defined by the Health and Disability Commissioner's Office.

The participants of this research are considered to be a vulnerable population for two reasons, firstly, they may be either pregnant or newly delivered and breastfeeding and secondly, PND is considered a psychiatric condition which often carries considerable social stigma and a presumption of incompetence in some spheres of decision making. Every effort was made to ensure that this research does not further stigmatise participants or cause any further emotional distress. Particular care was taken to ensure that participants experienced no duress, or pressure to participate, and that the principles of informed consent were adhered to. If the participant appeared to be experiencing undue stress, they were asked if they wished to continue and were further informed of their right to withdraw from the study and have their data destroyed in their presence. However, no participants withdrew from this study.

Ethics Approval

Approval was obtained through the Massey University Ethics Committee and the Manawatu—Whanganui, District Health Boards' (DHB) Ethics Committee prior to undertaking the research project.

Informed Consent

Informed consent was obtained from all participants in the study, ensuring that they were competent and had the ability to understand information about the proposed research. Participants were made aware that they could withdraw from the study at any time without the need for an explanation and that all data pertaining to them would be destroyed on request.

All data including audiotapes was identified by code number only and stored in a locked filing cabinet. A master list, linking names to code numbers, was stored securely in a locked filing cabinet separate from the research data and was made available only to the researcher and the research supervisor. Results of the research have been written in aggregate form and in a manner which should preclude identification of participants.

After the research proposal had received approval from the appropriate DHB and University ethics committees, women who had responded to the advertisements, had met the criteria to take part in the study and had signed the informed consent sheet were interviewed.

Data Collection

The interviews took place in a private location of the participant's choice of their own home, the Plunket Karatane Family Centre or the Community Mental Health Service. The interviews were scheduled for a time that was convenient to both the participant and the researcher. Each interview was audiotaped and took between 1-2 hours to complete.

At the conclusion of each interview, the tape was transcribed and edited so that it read coherently. The transcript was then sent to each participant for her to edit to a standard with which she was happy. This process was very long and drawn out with some major difficulties experienced such as waiting for the return of the edited transcripts so as to complete the final drafts.

The interviews were designed to be as open-ended as possible in order to be able to explore the richness of each woman's story of her experience with PND. The researcher was aware of the pitfalls of using open-ended questions. As Foddy (1993) explains, it is common practice to use follow up 'probes' which can often turn open ended questions into closed ones. He also believes that open-ended questions do not always reflect the participant's level of knowledge because of the nature of the questions asked and the risk that important issues may only be remembered after the interview. The researcher's attempt to overcome this problem was to provide the participants with a prompt sheet to ponder over and make notes a few days to a week prior to the interviews taking place.

Interview Guide

The basic question asked was “Looking back on your experience of dealing with PND, what factors assisted you and what hindered your recovery?” To achieve the goals of gaining an understanding from the women’s perspective and gaining material from the interviews that was information rich, a guide was constructed with five specific questions:

1. What was it like for you having postnatal depression?
2. What sort of things helped or are helping you recover?
3. What sort of things hindered your recovery?
4. What advice would you give to other women and their families experiencing depression after childbirth?
5. Do you have any suggestions to improve the health service for women with postnatal depression?

These questions are based on the belief that the people experiencing the phenomenon are reservoirs of knowledge related to their experiences, and when interviewed will contribute the information that is deemed to be ‘rich’. As Patton states (1990, p.181), “These are cases from which one can learn a great deal about matters of importance”.

The prompts or guiding questions assisted the participants to tell their stories within the framework of the study aims, however it was not unusual for the women to deviate along pathways that they wanted to talk about. This is the nature of story-telling and highlights what is of importance to the individuals.

The result of the collective data is a narrative description of the participants’ experience, from which the key themes emerged. Emphasis was placed on studying and documenting what the women knew how they felt, how they dealt with it, what helped and what hindered their recovery.

Data Analysis

As Boyatzis (1998) outlines, thematic analysis can take a number of forms. He notes that a directly observable theme may be established from the data or an underlying theme may be analysed from the phenomenon. More specifically, thematic analysis allows for common themes to be taken from raw data or deduced from theory and previous study in conjunction with the data. Rather than identifying a theme at the manifest level, the researcher in this study followed the latter form of thematic analysis outlined by Boyatzis (1998) and analyzed the participant interviews for an underlying theme at the latent level. As a result of such analysis, patterns were initially identified which were then grouped into common codes. Following this coding, three major themes emerged from the analysis of the coded patterns, which will be presented in the next chapter.

Credibility/Trustworthiness

Qualitative methods have had a rough time gaining acceptance in the mainstream of social and behavioral science research. One of the major reasons has been the lack of methods for bridging or translating between the worlds of qualitative and quantitative research. In addition, the rich tapestry of information in qualitative sources has often eluded or intimidated researchers (Boyatzis, 1998, p vi).

In the above quote, Boyatzis describes qualitative and quantitative research as existing in different worlds. Indeed, the focus of qualitative research lies in the process of enquiry while the focus of quantitative research is found in measurement (Patton, 2002). While the two paradigms can be mutually complementary, there is a greater level of skill required in qualitative research (Patton, 2002). Qualitative analysis largely relies on the methodology employed and the skill, understanding and integrity of the researcher. As a result, qualitative research relies on the unquantifiable values of credibility and

trustworthiness whilst quantitative research depends on the more easily confirmable attributes of reliability and validity.

In order to ensure the research demonstrated the previously described qualitative attributes of credibility and trustworthiness, the analysis was returned to the participants and they were asked if it truly described their experience and whether the findings resonated with them. Whilst one participant made some minor changes to the text of her transcribed interview which was acknowledged by the researcher, all of the participants in the study agreed that it faithfully described their experience and resonated with them. Following these eight interviews data saturation was reached.

In summary, the nature of this study fitted well within the qualitative paradigm as the experiences for women with PND are not able to be mathematically quantified and indeed, should not be minimised to such calculable analysis. Within the qualitative paradigm of enquiry, thematic analysis provided a fitting methodology with which to analyze the data. Colaizzi's (1978) procedural steps of thematic analysis provided a framework from which to identify patterns and subsequent themes from the interview data thus enabling the emergence of three credible major themes.

Chapter Four

Findings

Study Participants

The study consisted of eight participants. These participants were all white middle-class women who had experienced PND and had either recovered or were recovering from the condition. The age range was 20 to 42 with a median age of 38 years. Two of the women had experienced their last episode of PND more than 15 years ago. Both of these women had experienced PND twice, with their first and second child. One of the women had five children and two women had four children. All of these women had experienced PND more than once. Two women had two children and three women had only one child. Five of the participants had experienced PND in the last year or two. Seven out of the eight women were educated to tertiary level and all of the women with more than one child had experienced PND at least twice, but it was frequently not recognised the first time and in some cases had gone on until it was finally diagnosed with the second child.

During the analysis, three major themes emerged which impacted greatly on the women's experience of PND and their recovery from PND:

1. Knowledge
2. Early recognition
3. Acceptance

Each theme will be examined under separate headings, the women's feelings will be described, how society views the condition, and how the emerging theme contributed to the

hindrance of recovery from postnatal depression or the recovery process itself will be explicated. At the end of each section, recommendations for addressing the implications arising from each theme will be provided. However, in-depth recommendations spanning across the three themes will be discussed in more detail in Chapter 6.

Knowledge

To be conscious that you are ignorant is a great step to knowledge

Benjamin Disraeli, Sybil, (1926)

Knowledge is intangible, thus, knowledge or conversely, a lack of knowledge of PND (i.e. how much a person knows or does not know), is difficult to measure. Lara Bishop (1999, p. 10) writes:

One of the hardest things about PND is that we can't see it... This may be particularly difficult for those who are caring for the person with PND. However, PND is a very real illness and the earlier it is recognised and treated, the more quickly a woman is likely to recover.

Depression following childbirth has frequently been described as the 'hidden disease' because it is not easily recognised by health professionals or society and women themselves feel the need to hide their feelings. Diagnosis is further complicated by the fact that every woman's experience of PND is different.

There is a general lack of knowledge about PND by society. Motherhood is portrayed as one of the most fulfilling experiences of a woman's life, and therefore a woman goes into it with high expectations. Women's feelings are also heightened during pregnancy and childbirth as their emotions in part are subject to hormonal influences and in

part to major life changes, including identity transitions to being a mother, and relationships with their partners and significant others.

Feelings:

All of the women in this study spoke of feeling a failure, especially as a mother. They felt as though everyone else was coping with a new baby except themselves, so there must be something seriously wrong with them.

Some of the common feelings expressed by the women in this study were expressed in colourful metaphors depicting being in the dark:

LW – "... a big deep hole, never able to reach the top of it... just feeling like that all the time, under a cloud"

RJ – "... like a big black hole pretty much."

SP – "...you feel like there's no light at the end of the tunnel, and it's the way you're going to always be from now on."

Others related to a sense of emptiness, loneliness, and lack of emotion:

LW – "... no feelings, empty, numb, to the extent I didn't understand what was happening... my whole world fell apart... a major thing, is just feeling so lonely, not being able to understand what's happening but also, you're just so alone out there where I can distinctly remember going down the town one day, and looking at people, and thinking, why are they all smiling when I feel so sad, and it's a real ...isolation."

SP – "... very lonely and isolated"

A number felt scared of going crazy, becoming obsessive or concerned about hurting their babies:

SP – "I had... thoughts...of stabbing the children and also thoughts of driving off a cliff and having to consciously, make sure that I didn't do that."

DW – "I didn't want anyone to think I was not feeling right, and I didn't want to admit it myself."

RJ – "I ...had two emotions: anger, yelling, screaming, throwing things, breaking things; or crying. That was it."

The most common feeling expressed however was related to guilt and shame at believing they were failures. The fear and hopelessness felt was overwhelming.

SW – "They would have thought I was a failure, that's all I've basically thought all the way through, that it was all my fault, and there's something majorly wrong with me and I was not a good mother and I shouldn't have had kids."

BG – "I wanted to hide it from people because I didn't want everyone to know I was a failure."

IL – "...it ...made me feel guilty."

SH – "I felt...worthless, I wasn't going anywhere, and I couldn't ever do anything."

Beck (1992) in her article *The Lived Experience of Postpartum Depression* supports the patterns of dark imagery, loneliness, fear of harming (self or child) and an over-arching sense of guilt found in the women's stories as quoted above. Beck explains (p.166):

Postpartum depression was a living nightmare filled with uncontrollable anxiety attacks, consuming guilt, and obsessive thinking. Mothers contemplated not only harming themselves but also their infants. The mothers were enveloped in loneliness and the quality of their lives was further compromised by a lack of emotions and all previous interests. Fear that their lives would never return to normal was all-encompassing.

These feelings seem to be directly related to, or exacerbated by, a lack of knowledge of PND by the women themselves, by their health professionals and by society. In my experience of working and studying in the field of maternal mental health, knowledge increases awareness and acceptance of PND which leads to early recognition, treatment and recovery. Certainly a lack of knowledge was closely related to hindering the women's recovery as the women demonstrated in these interviews.

Hindrances to Recovery:

The women in the study felt that a lack of knowledge was a hindrance to their recovery because they didn't know what was happening to them. They didn't know anything about PND and were frightened and powerless to know what to do to help their situation. They described feeling shame and guilt because they were not coping or feeling happy as they believed a woman is supposed to feel when they have had a baby. As Cox (1986, p.11) states "Indeed it is this culturally-sanctioned belief that a mother should be happy after childbirth that may exacerbate further her already low self-esteem, and so perpetuate or even initiate a more serious depressive illness."

Women who did attempt to explain what they were experiencing to partners, other family members, friends or even health professionals found that their pleas for help and understanding often fell on deaf ears. Their concerns were dismissed when they were told to get on with life, not to worry and that things would get easier. This made them feel even more inadequate and more of a failure than they were already feeling. They began to isolate themselves, since they no longer felt comfortable around others or they would put on a front and pretend they were feeling good and coping well.

Some of the common hindrances as stated by the women in this study related to a lack of education for both themselves and for health professionals as to the nature of PND:

BG [when asked what hindered her recovery] – “...the attitude of the doctor ... I felt like a freak.”

IL – “And they [health professionals] still pushed me to breastfeed.”

RJ – “I think that the professionals need to all do a course in post natal depression.”

LW – “I distinctly remember seeing this lady psychiatrist at one stage and her saying to me, oh no you're not depressed, you've got makeup on...you know, those sort of things, and it was like, I was just wasting my time basically and getting worse....”

SH – “I... didn't know anything about it, nothing had been discussed about post natal depression.”

Another hindrance related to knowledge was a general ignorance by society (including family and friends) as to the nature of PND. This came through most clearly in the women's interviews where they discussed society's unrealistic expectations of motherhood.

SP – "...it's society's messages that need to change, but that's education too."

LW – "with a mental illness, you don't see it, so people don't [know],...I had even close relatives saying, 'why can't she pull herself out of it? She's got a lovely home, she's got a lovely husband, she's got a lovely baby, everything, so why can't, [she] ...get a grip of it?' sort of thing, and it isn't like that..."

SH – "...more education of the public I suppose [is needed]."

Linked to society and the women's lack of knowledge was the resultant need for the women to mask their feelings in the face of the stigma that attaches to PND as a mental illness.

SH – "I haven't told them that I was feeling really depressed... I didn't tell them about the tearfulness and being upset."

SP – "So when she came by, the house was all tidy and I looked like I was coping, I told her I was coping." (Referring to the midwife)

IL – "[There is] stigma... Women are supposed to cope, and I think most of us have this image of motherhood, that ... we're just going to have this wonderful baby, and it's all going to be happy, ... and they're going to eat and sleep..."

Due to this lack of knowledge and the consequent masking of symptoms by the women to make it appear to themselves and to the outside world as though they were coping, women did not receive the support they needed to begin the journey to recovery.

SP [describing a lack of support from her husband] – “[He] didn't recognise that need for me to have that rest... he made it out that I was just wanting a maid or a servant to do the work for me... he didn't even see the need for me to have a couple of hours a week to myself.”

SH – “The sort of thing that hindered my recovery the first time, was the negative feedback from family...about depression and "you don't need any antidepressants"...“don't go on antidepressants, they're addictive”.”

Broadly, the pattern above demonstrates that a lack of knowledge was a major hindrance to recovery from PND for the women in this study. As shown by the above quotes, this lack of knowledge manifested itself in a number of ways. The first of these was a lack of knowledge on the part of the women themselves, followed by a lack of knowledge by health professionals as to the nature of PND. The gap in professional knowledge meant that professionals were slow to recognise PND, thus allowing the suffering to continue further. It could be suggested that the lack of knowledge by society

can be found here also, as evidenced by the way that government is not alerted to the needs of women with PND. However, early recognition will be discussed later in this Chapter as the second major theme. An unrealistic expectation of motherhood was the second way in which a pattern emerged showing a lack of knowledge about PND. Linked to this was the way in which women masked their symptoms in order to conform to these unrealistic expectations and appear as though they were coping well. Finally, the culmination of this knowledge deficit resulted in women not receiving the support they required.

Depression following childbirth is more common than many of the other complications such as pre-eclampsia, gestational diabetes and premature labour yet from my experience it receives much less attention in the medical and midwifery literature. However, as Leopold and Zoschnick (1997, p. 5) state: “Although both academics and researchers have recently increased the focus on PND, this condition remains a frequently overlooked and under-diagnosed illness despite its potentially devastating consequences”.

In addition, although the media has recently shone the spotlight on PND and interestingly, may have succeeded in removing some of the stigma attached to women’s suffering, a great deal of misinformation still exists which further supports the central theme of knowledge being integral to recovery from PND. This was evidenced by comments made in May 2005 by American actor Tom Cruise who criticised fellow actress Brooke Shields for taking medication as treatment for PND. As a member of the Church of Scientology, Cruise believes in treating PND with high doses of vitamins rather than prescribed medication, and said in a televised interview “These drugs are dangerous. I have actually helped people come off them...When you talk about postpartum depression you can take people today, women, and what you do is you use vitamins” (Sunday Times Online, 29 May 2005). Shields who had recently authored *Down Came the Rain: A Mother’s Story of Depression and Recovery* documenting her struggle and recovery from PND (2005) contested Cruise by commenting, “Tom Cruise’s comments are irresponsible and dangerous... [he] should... let women who are experiencing postpartum depression decide what treatment options are best for them” (Sunday Times Online, 29 May 2005).

The women in this study had regular contact with health professionals yet their distress was not recognised so they continued to suffer in silence. This lack of understanding and awareness keeps the stigma associated with PND or indeed any mental illness very much alive. It causes a delay in treatment, prolongs the illness, and makes recovery a long and slow process.

Beck and Gable, (2000, p. 272) wrote:

It is estimated that 400,000 mothers in the United States experience this postpartum mood disorder each year, most often 6 to 8 months after delivery (Kleiman & Raskin, 1994). Only a small proportion of these women, however are identified by health professionals as depressed. Hearn, Iliff, Jones, Kirby, Ormiston, Parr, Rout and Wardman, (1998) reported that up to 50% of all cases go undetected. England, Ballard, and George (1994) reported that the longer the delay from onset of postpartum depression to the beginning of adequate antidepressant/psychological interventions, the longer the duration of this mood disorder, which typically lasts more than 6 months. This finding emphasises the need for early diagnosis and treatment of postpartum depression.

Given an approximate number of 60,000 births in New Zealand per year and a conservative incidence of 10% with PND, then 6,000 New Zealand women would suffer from PND each year (Statistics New Zealand, 2006). If the above quote from Beck and Gable is correct, then the numbers could be as high as 12,000 women suffering from PND in New Zealand each year.

If lack of knowledge is a hindrance to recovery therefore the opposite must apply, which means knowledge is a major factor in assisting recovery.

Assistance with Recovery:

The women in this current study supported the notion that knowledge and education has played an important role in their recovery. Many women hadn't known that help was available and they isolated themselves not realising that there were others going through the same experiences.

SP – "...it's going to take time to recover... and learning, see it's education of course, getting that knowledge... learning to tell myself it's okay not to be the perfect mother".

DW – "If I knew then what I know now..."

SH – "The second time it helped me recover because I knew what it was.... And I knew I could get the help, and I knew what I was dealing with. So it never got as bad..."

SP also makes note of the work of the specialist maternal mental health service in the region: "I had also caught up with Maternal Health workers here, there was a professional service that dealt solely in that area, whereas when I first had it [PND], I don't think the actual Maternal Mental Health, was available".

Many of the women commented that professional support was very helpful in their recovery. As indicated by the quotes below, this professional support could take the form of medication or it could be by way of support groups.

SH - "It [the greatest help] was the combination of his [a doctor's] support ...and the medication, definitely... I knew the

medication was going to make me feel better from my previous experience with it”.

IL – “I went back to the doctor and changed my medication,’ I got put on Aropax, which was wonderful (laughs)...[I recovered] once I started on Aropax.”

RJ – “She [referring to a Family Support Centre worker] actually made the effort to reach out there, asked me how things were going, how she could help me...[I] ended up going to the postnatal depression support group, I think it was like a course”.

SP – “The support group was really good... I remember one woman that came to the group, she'd been an executive and was having difficulties hanging out the washing, and it was reassuring to her to know that we all had those feelings of panic when you go into the supermarket and we'd all left piles of groceries in the trolley and not been able to cope and just left them, ... [it was good] knowing there's other women going through that...”

Another pattern of recovery that emerged also related to support but this support came from family and friends. Understanding, and thus, knowledge of PND by family and friends have helped lead to recovery. Occasionally, as in the case of IL, those family members have learnt about PND because other family members had experienced the condition.

LW – “...obviously a lot of family support I had [helped me to recover].”

IL – “Friends and talking about it actually [helped me to recover]... he [my husband] literally just stepped in and took over... and she (his mother) had postnatal depression”.

RW – “...a friend of mine said to me one day... "Look, whether you like it or not, you have to look after this kid, so we all understand your depression and stuff" ... I started doing things like leaving the house a lot, like up in the morning, having a shower, getting us fed and dressed, packing us a lunch and going to a friend's house for the day...”

Knowledge is therefore a prerequisite to recovery, and lack of knowledge is a hindrance. Knowledge is required by health professionals, society and those families experiencing PND before the journey towards recovery can begin. Knowledge about PND by health professionals and society will reduce the stigma and ensure early recognition, appropriate intervention and recovery. It is possible that in many cases PND could be prevented with appropriate support and understanding of the stressors and emotional upheaval associated with motherhood.

Barbara Carper (1978) has identified four key patterns of knowing. In her seminal work *Fundamental Patterns of Knowing in Nursing*, she distinguishes these four patterns according to type of meaning as:

1. empirics, the science of nursing
 2. esthetics, the art of nursing
 3. the component of a personal knowledge in nursing
 4. ethics, the component of moral knowledge in nursing
- (Carper, 1978, p. 14).

These four concepts can be extrapolated beyond nursing and are a useful addition to this discussion about ‘knowledge.’

Empirics as described by Carper, is a pattern of scientific knowing although it does not exhibit the same level of explanation characteristic of a scientific paradigm. It is nonetheless a highly recognised and valued form of knowing within the professional field of nursing and also fits comfortably within this study as science clearly underpins the condition of PND as providing evidence of its multi-factual causality.

Aesthetics recognises the creative process of discovery, Carper (1978, p. 17) explains that “aesthetics involves the active transformation of ...behaviour into a perception of what is significant in it - that is, what need is being expressed by the behaviour.”

The most complex of the four patterns, that of personal knowledge, is ideally suited to a condition such as PND. An element of personal knowledge is striving to ‘know the self’ rather than to simply ‘know *about* the self’ (Carper, 1978, p. 18). White (1995) expands on Carper’s analysis by noting that creative endeavours such as art, poetry and story-telling can enhance personal knowing assisting greater understanding of self/other person. White’s expansion is particularly relevant here where story-telling provides a key to understanding women’s experience of PND and forms the backbone to this research. Later in this chapter, a poem of one woman’s experience of PND demonstrates the enhanced understanding gained by this more holistic pattern of knowing.

The final pattern of knowing, the moral component, focuses on the treatment of illness (Carper, 1978). Maternal mental health services are particularly affected by this pattern of knowing. As with other areas of mental health, often the clients in maternal mental health are vulnerable and in some cases, lack the capacity to make decisions for themselves. Further, the stigma attached to mental illness requires heightened awareness of this pattern of knowing. A further moral complicator within the field is the fact that there is sometimes a second patient who is either silent (in the case of the unborn child) or who is also unable to make choices relating to their own well-being (in the case of the infant). It is precisely because of these complications that the moral component is especially significant to this

study and can lead the women who suffer PND to consider themselves immoral people because they sometimes 'feel' like harming themselves or their babies.

Carper's (1978) patterns of knowing support the sentiments expressed by the women in this study that there is a need for greater knowledge of PND to ensure early and appropriate intervention and recovery. Yet it is well documented that PND often goes unrecognised and is grossly under-diagnosed (Kendall-Tackett, 2005; McGill et al., 1998).

This means there is a knowledge deficit in this area by health professionals, the women themselves and society.

The Women's Recommendations:

The women in this study were asked what recommendations they would like to provide to improve the health services for women during pregnancy and following childbirth. The responses all focussed on the need to increase knowledge about PND and the reality of having a baby.

As these participants experienced a lack of knowledge at the hand of health professionals, many recommended further education in the professional field so that those working in the health arena understand PND, are able to recognise the symptoms and provide the appropriate support as a result, including referral to PND support groups which came highly recommended.

BG – "I felt really let down, by the health professionals, like when I took [child] for her 6 week check.... I spent the whole appointment crying, and not once did he ask me what was wrong, or if I was okay....[referring to PND Support Group] I think the biggest ...thing is people who will listen and understand and be supportive, ... [and] having a health professional who you can connect with.."

RJ – “I think that the professionals need to all do a course in post natal depression.”

SH – “How all parts of the health sector [need to be] ...aware of it...so no matter where you are... working in health, being aware that that [PND] could be a problem for women and even years after...”

IL [referring to the EPDS as a screening tool] – “...I think the doctors need to be educated...because ... I did a test, he... sat me down and I had to ...answer the questions, and things like that, which was really good, and I think they need to do [that].”

DW – “It [a screening tool] would have [identified PND] and it might have pushed the right buttons.”

SW – “...the whole mental, well the whole hospital system seems to be under the impression that women... should cope with everything, so you don't want to admit that you've got a failing, because obviously even the health system thinks that you should be able to cope... [home help] would [benefit], because you won't get so far behind with everything when you first get home...they still send you home with no home help which is what happened with [child].”

LW – “..... very impressed to see the Post Natal Support Group...being in a support group is very important, there was none available [for me] as I've said I must say the Plunket family groups, [name of Plunket nurse] was absolutely

wonderful to me [and the Plunket Karitane Family Centre].
They were [all]...very good.”

The second recommendation to emerge was that women felt that their own lack of knowledge about PND hindered their recovery. Women requested greater education about PND generally so that they could recognise the symptoms in themselves. Unrealistic expectations of motherhood meant that women were unaware of the potential emotional upheaval of what is a common complication of childbirth. Many recommended the inclusion of education about PND in antenatal classes. Specifically they (and their partners) wanted to know how to recognise PND, where to seek advice and support in the community and what professional services were available.

RJ – “More education, I think at an earlier stage. I think the biggest downfall at the moment in the health system is, that you do antenatal classes that are completely focused on the birth, then your baby's born and you go, well what do I do now, oh my God, I know everything about C sections and epidurals that I didn't have, but what do I do now....I think that they should talk about post natal depression at an antenatal class so that women recognise the signs a hell of a lot sooner than they do.”

LW – “I think ante-natal classes, need definitely to be made aware of it [PND], I had antenatal classes, and I never knew a thing about post natal depression...so you could understand if...things start going wrong, what is happening to me, is this normal or is it not, or do you just plod on... I think ante-natal groups, need almost a session on [PND] to cover the ‘what ifs’ [and] scenarios”

SH – "... definitely mention it during antenatal, I can't remember [PND] being mentioned in my antenatal classes."

SP – "...even in the antenatal courses, they don't even talk about it."

SW – "...they don't really tell you anything about post natal depression. If you'd known what the signs were... everyone knows about you get the 3 day blues, that's about all you ever hear about, the 3 day blues and that's it..."

A third recommendation resulting from a feeling that ignorance and lack of knowledge by friends, family and society hindered recovery was that this could be remedied with greater education.

SP – "...it's society's messages that need to change, but that's education too."

IL [in referring also to a gap on the part of health professionals] –
"I think the debate about breast feeding needs to be toned down a bit... when I tried to find information about bottle feeding, there was none...I got very angry when I heard the debate that they'd thought of even taking Treasurers magazines off the maternity ward because they were advertising ... I think... just because you see someone bottle feeding, or formula, it's not going to make you bottle feed, ... I think the system definitely has to look at that. I mean in today's society we needsupport, for both ... and for me I think the system let me down that I didn't get ..."

SH – “Educating yourself around it, having people around you that are understanding about postnatal depression, you don't need the negative people...”

BW – “I wondered whether the health services can do anything to support and educate the partners.”

These recommendations indicate a need for greater knowledge about PND in three areas: for the professionals, for women, and for family, friends and society generally. Where there is a general lack of knowledge in these three areas, women feel afraid (as they do not know what is happening to themselves), they feel unsupported (as health services seem unaware of their suffering) and they mask their symptoms (as society, friends and family who generally lack knowledge of PND present with negative attitudes and the women feel stigmatised). Where this knowledge was present, the participants reported that knowing what they were experiencing, having professional support and the support of family and friends was a key helpful factor in their recovery. Women were particularly grateful for experienced professional assistance where it was available.

This three-pronged pattern of a knowledge-deficit found in this study is also noted by Milgrom, et al. (1999, p. 2) who explain:

Childbirth is viewed by society as a joyful event, not only in Westernised countries but also in other cultures. It is a time for celebration, fulfilment and hope. The common experience is very often in stark contrast to this idealised image, with a daunting number of women experiencing symptoms of depression. Instead of the expected tranquillity, many women struggle with: the new set of demands a baby brings, for which they have inadequate preparation and support; the loss of order and routine; the sleepless nights; the changes in their role, including career decisions; the relationship with their partner;

and their partner's possible adjustment difficulties to parenting, or his absence due to work demands or relationship breakdown.

This unrealistic image by society must be changed if there is going to be a difference made for women's health and the health of their family.

Early Recognition

The second major theme that emerged from this study was early recognition as a critical component for a mother's journey towards recovery.

Early recognition is essential because without prompt assessment of PND support and treatment, many women suffer endless months, even years, and that can have a negative impact on the health and wellbeing of their entire family (Beck & Gable, 2000). Research has identified the need for health professionals and society to be more informed and aware of this serious illness and its consequences (Beck & Gable, 2000). Thus there is an inherent link between knowledge and early recognition.

It is well established that early recognition and treatment is an essential component of recovery in all illnesses, none more worthy than that of women with PND given the potential devastating consequences of such an illness. In a study of thirty women with PND, in Miami-Dade County, Florida, Ugarriza (2002) asked what the best treatment would be for PND. Twenty-five (83%) of the women made statements centred on the notion that if they had been better educated and knowledgeable about PND they would have been able to cope better and recover more quickly. The women in this present study also recognised the importance of early recognition of PND and the role that they themselves played in that, such as talking about their feelings and not putting on a front.

Unfortunately women appear to be blaming themselves whereas health professionals working in the area of women's health should take the responsibility for early recognition, which may be partly explained by lack of knowledge but has greater

implications around not valuing postnatal nursing or midwifery care with possibly too much emphasis on 'normalising' birth and failing to be perceptive.

The clinical skills required to determine the presence or absence of PND can usually be acquired during supervised undergraduate or postgraduate training or from a post-qualifying refresher course for primary care health professionals (Cox & Holden, 2003). However, in New Zealand there has been a perception that postgraduate training especially in midwifery, is not necessary and/or that midwives, who work in independent practice do not have time or the capacity for in-service development (anecdotal comments). To understand PND requires more than a seminar or workshop. For example women with PND who have fixed delusional ideas of guilt or self-blame congruent with their depressed mood should be identified as having severe depression. "It is very important to identify this group of women early in primary care because of their increased risk of self-harm. They may require treatment with antidepressant medication and they do require immediate referral to a specialist team" (Cox & Holden, 2003, p. 11).

It has been well documented in the literature (Taylor & Littlewood, 1994; Hearn et al., 1998) that detection rates of PND do not actually reflect rates of PND. Taylor found in a study looking at the risk factors, identification and effects of PND that 80% of women had neither sought nor received medical help. It is possible, however, as suggested by the participants in this current study, that women would not wish to be identified as not coping with motherhood, or would not wish to be perceived as inadequate or as a failure.

Cox (1986) found it ironic that, although women had regular contact with health professionals in the postnatal period, PND was rarely detected. He believed that it was possible some primary care workers such as midwives and other health workers feel out of their depth with a perceived mental health disorder even if it was detected. Beck and Gable (2000) also enforced that an issue exists due to low detection rate for PND by health professionals.

Early recognition is vital although it can also be a dilemma. There is a dichotomy between the relief a diagnosis gives and the stigma that a diagnosis of PND can promote. Women's feelings about early recognition are therefore often ambiguous and can include anger, hope, guilt or confusion.

Feelings:

The first pattern to emerge was that many of the participants reported feeling guilty, ashamed, as though they had failed and that they would be judged by others.

BG – “Okay, probably failure would [be] the word that summed it up...it felt like a failure... I felt like a failure...”

SP – “I felt like a failure all the time. It was a nightmare that never seemed to end... very incapable... of achieving things, especially on a day to day basis, a total loss of sense of self, just not knowing who I was...”

SW – “... I just felt like a useless parent basically... I felt like a failure... I felt like a failure and that everyone else could cope but I couldn't...”

Such stigmatisation is reflected in their comments above and continues in the quotes below which indicate the resulting actions taken by the women as a consequence of their feelings. They masked their symptoms and isolated themselves. As a result, some women either did not seek help at all for their condition or delayed seeking help, making early recognition of PND impossible.

BG – “...it was very isolating because I wanted to hide it from people because I didn't want everyone to know I was a failure. ... so ...I isolated myself in the way of just not

being real to people I guess because I was pretending that I was okay, I was well and truly into it, even before I went to see my doctor.”

SP – “... but I kept those thoughts [of harming the child] very quiet. I didn't tell anyone about them for a long time... I was putting on a big front you see ...when she [the midwife] came by, the house was all tidy and I looked like I was coping, I told her I was coping.”

SW – “.... when you think you're a failure, you don't want to get help anyway, because then other people might think you're a failure as well.”

DO – “I didn't want anyone to think I was not feeling right, and I didn't want to admit it myself ... I covered it up...”

In describing the failure of the health services to recognise PND, commonly the women interpreted the question about feelings to mean statements of opinion rather than descriptions of their emotional response. Accordingly, these will be discussed in the hindrances section below.

Postnatal emotional difficulties and mood disorders is an area of women's health that needs urgent attention because early recognition and early intervention is crucial to the health of women, their families and the future generation. As indicated by the patterns above, women felt shame, guilt and failure— feelings which caused them to isolate themselves and to mask their symptoms as they were afraid others would find out how they were feeling and would see them as failures also (Farmer, 1995; Maushart, 1999; Goss, 1998). Such masking might mean that health professionals were unable to recognise their symptoms, however the quotes above show that regardless of whether or not women masked their feelings, health professionals generally remained slow to recognise PND.

Hindrances to early recognition appear to have much to do with a lack of knowledge about PND by health professionals, women themselves and society as well as the stigma resulting from negative attitudes about mental illness. It is also affected by unrealistic expectations of motherhood held by the above three groups.

Hindrances to recovery:

Masking the symptoms of PND (as quoted in the feelings section above) due to the stigma from society created a hindrance to early recognition by women themselves and by professionals. This fear and masking led to an increase in anxiety and depression with the women isolating themselves even more and hiding their feelings, putting on a front and pretending that all was well, even to the health professionals with whom they had frequent contact. As explained by Kendall-Tackett (2005, p. 129) who reports that:

As many as 50 percent of cases are not identified (Beck & Gable, 2001; Cooper & Murray, 1998). In a study of 1,102 new mothers (MacLennan, Wilson, & Taylor, 1996), only 49 percent of women with serious depression sought help for it. In another study health care providers did not identify almost half of the depressed mothers even though they made an average of fourteen health care visits each (Hearn et al., 1998).

In retrospect, some women were angry at the health professionals for a failure to recognise they were suffering from PND at an early stage. Even if they had previously suffered from PND and so recognised their own symptoms and could seek help accordingly, at times such help was not forthcoming from health services. These women felt frustrated at services that failed to meet their needs thus hindering their recovery.

BG – “I felt really let down, by the health professionals, like when
I took [child] for her 6 week check, so she was second one

[child with which I had PND], and I spent the whole appointment crying, and not once did he ask me what was wrong, or if I was okay...and ...it had started 2 weeks before that ...and he [the doctor] ignored that, and I left there with not having been asked [how I was feeling].”

IL – “I went to my doctor, and I said, look I don't think ... it's my personality, I'd kept up the façade for everyone...and he said “Oh you're just like a normal tired mother”... so I walked out feeling even worse then... I mean [not having the PND recognised meant]... I lost 6 months...of my ‘life.’”

Lanzi, Pascoe, Keltner, Landasman and Ramsey, (1999, p. 801) state that:

Symptoms of PND pose several risks to families. In moderate to severe cases of the illness, women have sleep disturbances, agitation and appetite changes. In addition, suicidal thoughts, thoughts of harming the children or indifference toward the baby are not uncommon. Without prompt assessment and treatment for the mother, babies can be at high risk for developmental delays, neglect, abuse or cognitive behavioural difficulties later in life.

As Lanzi, et al. (1999) demonstrate above, the risks of delayed assessment and treatment are clear, yet detection rates for PND remain low (Webster, Margo, Pritchard, Creedy & East, 2003). As previously discussed around 50 per cent of all cases of PND are undiagnosed and yet around 13 per cent of all mothers are affected by this condition (Beck & Gable, 2001). Hearn et al. (1998) supports this finding in their study of 176 postnatal mothers, where nearly half of the mothers that were depressed had not been recognised as such despite an average of 14 follow up contacts with health professionals. Others, such as

Holden (1996), reported a non-detection rate of 60 percent despite visits to the mothers by health professionals on a weekly basis.

The comments by the participants in the section above on their feelings that they were slow to seek professional help (and sometimes did not seek help at all) are supported by the literature. One study indicates that a shocking 51 per cent of women who reported feeling seriously depressed did not seek professional help at all (Beck & Gable, 2001). Other than women masking their symptoms (as in the quotes on feelings above) due to shame, health professionals are not recognising PND when women do seek professional help. There appears to be a number of reasons for this (such as professionals dismissing women as being blue, early discharge rates and lack of screening tools usage) and the participants interviewed in this study also mention these are a hindrance to their recovery (as they do not enable early recognition). The literature supports their stories. Goss (1998, p. 14) writes of her own experience of visiting a doctor when she was suffering from PND:

He was a complete stranger, but I was so desperate I burst into tears in his office and told him I couldn't cope with the asthma, that I just couldn't cope at all. The doctor recommended the Asthma Society. There was absolutely no understanding or compassion in his eyes. I went out feeling stupid, like I had wasted his time. I was so embarrassed I never visited him again.

IL – "I was happy in hospital but the minute we went to go home [things changed]."

SW – "... Umm what else hindered – not wanting to tell people, not really understanding what the symptoms were, because they [health professionals] don't really tell you what to look out for."

Hindrances to early recognition appear to be due to a lack of information/knowledge by health professionals, and their lack of skills in the use of tools such as the EPDS. This

highlights the need for more education and adequate training in this area of health within the undergraduate programme for nurses and also for midwives.

Early recognition is essential in preventing the long-term consequences of PND on the mother, her infant, partner, other members of the family and the community (Beck, 2001). Thus another major hindrance is related to society's unrealistic expectation of motherhood and the lack of support for all new mothers in the community, which encourages mothers to 'mask' their symptoms and hampers early recognition.

Assistance with Recovery:

Early recognition of PND was identified by all the women in this study as giving them hope and reassurance of recovery. By having a diagnosis they could give some meaning to the dreadful feelings of hopelessness, guilt, shame, isolation, failure, inadequacy, loss of self and enjoyment of life, fatigue from sleep deprivation and obsessive thoughts that seemed to consume their every day. They could get the support and treatment they so desperately needed. However, much of this acknowledgement was in retrospect with many women either not seeking help at that time or not being recognised by health professionals as requiring help. As a result, their comments about early recognition will be discussed in the recommendations section below.

For those women who had previously experienced PND, their prior knowledge and understanding of the condition enabled them to recognise the symptoms and know where to seek help. As a result, these women sought help early to prevent a more major illness and in so doing, reduced the impact of the illness on themselves, their infants, partners and other members of their family.

Common statements from the women in this study related directly to early recognition made mention of their previous experience of PND, in some cases assisting

them to recognise their symptoms at an early stage. Women also attributed well-trained professionals with recognising the symptoms and referring them for further help:

SP – “The midwife I had, was older and more experienced, and picked up very quickly, what was going on, and so she made the referral to the Maternity Ward.”

SH – “I think for my first one, what helped me was having that GP that really sort of had an understanding about it, and ... he was willing to discuss things, and ...give me the facts about it, rather than all this other, old wives tales...”

SH – “The second time was when I was in another town and that doctor had diagnosed my first lot of depression... It wasn't as scary as the first time because I knew.. several years later, when I moved to this new town, I went to the doctor, and said how was I feeling, and he said you're depressed... when I spoke with the doctor, he said to me "Have you been on it before, [medication] and I said "Yes", that I hadn't been on it for long, he said "Why did you go off it" and I told him, and he said "What were they doing, trying to kill you" (laughs), and he said people don't understand, and we had a good chat about it... So then when I went on it after my daughter was born, and I got the same symptoms, the doctor said to me, it must be biological.... I think it was quicker because I went and got help straightaway, I knew the medication was going to make me feel better from my previous experience with it....The second time it helped me recover because I knew what it was....And I knew I could get the help, and I knew what I was dealing with. So it never got as bad...”

However, one woman told her story of over-zealous professionals expecting her to get PND because she had experienced the condition before. She was continuously asked if she was depressed whilst still in the maternity unit and was segregated from other patients due to this expectation. Such an experience can be related back to Carper's fourth type of knowledge (moral knowing) where this value was ignored and her privacy was violated. She explains:

LW – "... [I] had the baby, was taken downstairs, in those days I think we were upstairs, taken downstairs, put into a room with three other people, to have a nurse come in and say to me, "oh we've just looked at your notes, and would you like to be in a room of your own because you've had post natal depression?"

Recommendations:

In direct relationship to this theme, all of the participants again strongly recommended that more information be provided during antenatal classes so they could recognise what is happening to them and seek early diagnosis and treatment. Whilst the women noted that early recognition helped recovery, many could only comment in retrospect that early recognition would have been key to recovery from PND.

DW – [when asked what advice she would give to other women]
"Knowing that you have it, recognising it...and talking to someone, you know, Plunket [helps with recovery]..."

SP – "See I recognise [PND] now too, I had it after my 2nd child as well....[after my] 3rd, 4th and 5th [children], yeah, definitely after my 2nd because I can recognise the symptoms now... especially the feeling of going crazy, you know, and losing touch with reality... If you could have that knowledge, and

that reassurance, that this was a clinical condition, but early detection and, like with the Plunket nurses...And anyone can have early contact, during pregnancy, because I was really bad during pregnancy as well...I think a good trained professional [would ask the right questions and]... should be able to pick it up, or could, not should, you know, if they are trained and educated.”

RJ – “I think that they should talk about post natal depression at an antenatal class so that women recognise the signs a hell of a lot sooner than they do.”

SW – “I’m pretty sure, I was depressed while I was pregnant [and when asked if knowledge may have made me seek help at an earlier stage]...Yeah, and I didn’t actually, wasn’t actually the one that [sought] help.”

LW – [in relation to] “...early recognition... I think antenatal classes, need definitely to be made aware of it, I had antenatal classes, and I never knew a thing about post natal depression [antenatal classes on PND would have been a benefit]... so you could understand if, say things start going wrong, what is happening to me, is this normal or is it not, or do you just plod on, but I think ante-natal groups, need almost a session on [PND].”

As explained by Arlene Goss (1998, p.43):

Some PND sufferers have complained about the quality of the antenatal education they have received. They 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 to discussing PND is often minimal. This could partly be because, not so long ago, some health professionals believed that if they talked about PND in antenatal classes the pregnant mothers were more likely to suffer from it. Thankfully, that misconception has been cleared up and antenatal education should now include at least a mention of the symptoms of PND, often backed up with a pamphlet or photocopied notes, and contact numbers of support groups.

She suggests that information be provided on both the normal adjustment to parenthood and the specific postnatal illnesses including where and how to find help. Like the women who participated in this study, she places particular emphasis on the need for such education to be provided in antenatal classes.

White (2005) further enforces this gap in the health service by advising new mothers that whilst being hugely beneficial, antenatal classes focus mostly on the birthing process and on keeping healthy throughout pregnancy. As in this present study, she notes that many couples comment that they wished the classes had prepared them emotionally for the adjustment to parenthood.

Research has identified support as a critical component to promote a mother's journey toward recovery. In addition to medication and psychological therapy, women with PND require significant physical and emotional support. If new mothers were provided with adequate physical and emotional support, PND could possibly be prevented. If those experiencing symptoms of PND were identified early and treated early there would more likely be a speedy recovery without the long-term consequences of PND on the woman and her family (as discussed in Chapter Two).

Swinburne (2002) reports that the Royal College of Psychiatrists recommend that all health authorities identify a consultant with a special interest in maternal mental health and establish a multidisciplinary team, so that all women with PND who require specialist care could have access to a consultant and other mental health professionals who have a special interest in this special field of mental health. They also recommend that mother and baby units be established that serve several health areas within a region.

In conclusion it is clear that knowledge and the need for early recognition are interconnected. Both the health professionals and the women in the childbearing population lack knowledge about PND and the result is a lack of early recognition. Health professionals are not focusing enough attention on the emotional moods related to childbirth, often brushing them off as 'normal'. Consequently women put off seeking help believing they should be coping. As has been shown in this section, both the women in this study and the research literature have made recommendations linking knowledge with early recognition.

Acceptance

Unfortunately, as with any mental illness, acceptance can be difficult, especially since motherhood is considered to be a joyous and happy time in a woman's life. As Bishop reports (1999, p.10): "Many new mothers are reluctant to come forward and talk about how they are feeling. Some hide behind a smile and pretend in public that everything is going well. They may fall to pieces in the privacy of their own home."

This reluctance to seek help, or for many women the awareness that help is available, has been identified in this study as a major hindrance to recovery. Acceptance is not only an issue for the person experiencing PND, it is also a problem for health professionals and society that needs to be recognised and addressed.

The following poem as an introduction to PND by Milgrom, et al. (1999) describes one woman's experience and also demonstrates quite clearly the lack of acceptance of this illness.

Listening

On the outside looking in
You see a smile and all is well
Yet if you look a little closer
You'd see the pain in which I dwell.

You ask me how I am
But the truth you do not seek
For if I show you my pain
You do not let me speak.

On the inside looking out
I see the joy in others lives
I wonder where my joy has gone
Its absence hurts my eyes.

Through the haze I see the days go by
And I watch my child grow
I fear my acts will scar her
Or is she just too young to know

My child is so precious to me
The most beautiful thing I've seen
I love her more than life itself
And yet sometimes I'm so mean.

I don't know why I get so angry
When her cries are just her speech
She does not deserve my anger

Or my attitude of defeat.

You tell me she's a good baby
Don't you think I already know?
Your words just drive the pain harder
When all I want is to let go.

Why are you so scared to hear
The truth behind my smile?
I need for you to understand
To listen for a while.

It is the illness that I suffer
A bad person I am not
As a mother I do my very best
I give it everything I've got.

In time I will be well again
But for now I need you here
For a shoulder just to cry on
Or an understanding ear.

Sherry Hardy 30 May 1996

Client of the Austin & Repatriation Medical Centre

Infant Clinic

Feelings:

The first common pattern of feelings related to a lack of acceptance of PND was by the women themselves. When exploring the feelings experienced by women with PND such as inadequacy, mood swings, tearfulness, self-blame, inability to cope, hopelessness, exhaustion, isolation, anxiety with panic attacks, obsessive thoughts, guilt and shame it is not that hard to see how acceptance would be difficult for a new mother. As the comments below will demonstrate, women, in some cases, appeared to believe that PND was not a 'genuine illness' and rather saw their symptoms as an indicator of their own failure. The process of accepting that PND was a condition and that they were suffering from this condition was a difficult process for many who had to confess to masking symptoms to professionals, family and friends. As discussed earlier, such acceptance can be a double-edged sword: by letting the world know they are not coping, the participants suffered the potential social stigma PND carries, and was seen by some as a public admission of failure.

SP – “And also, having to come to acceptance in myself, that this was an illness, a genuine illness...that needed treatment, and it wasn't something that I could, you know any work I did on myself as far as trying to become a better mother, wasn't going to help...I needed help, so the minute you accept that and start realising...”

IL – “I went to my doctor, and I said, look I don't think ... it's [not] my personality, I'd kept up the façade for everyone...and he said “Oh you're just like a normal tired mother”... so I walked out feeling even worse then... I mean [not having the PND recognised meant]... I lost 6 months..of my life.”

RJ – “I became quite good at pretending that everything was okay, you know, even at like Plunket visits and stuff like that. I

managed to hide it even from the Plunket nurse that I had postnatal depression... it was embarrassing [because]...it makes you feel like you're a nut... ...I think the more able you are to cognitively think about it, the worse it becomes, because you'd be thinking your head off, this is what it is, and this is what needs to happen to get me better, but you know, your mind plays tricks on you, and you kind of get, not an ego, but a thing in you that fights it, you're going, whatever. Even when my doctor said to me, "What's going on?" it was like, "I'm not taking drugs, no I'm not." It kind of goes through these big denials and then you try and coax them into thinking, I think that it's a lot harder to deal with, I didn't blame the baby, I blamed myself."

DW – "I went back to work, and I... couldn't cope, it had completely gone out of the window, and I couldn't cope with the slightest amount of stress.... and it wasn't right, and I went to my doctor ... and thought, no I'm not depressed, you know...I went back to... part time work, but I had to throw it in because I just couldn't do it,... I felt sad, yeah I was tearful [I masked it]... Because I [thought it was]... a weakness I suppose, giving in to it... admitting it."

Even now some women continue to hide the fact they had PND:

SW – "Well my sister knows, I never really actually told Mum and Dad... [when asked why] ...Just ashamed I suppose, I don't know, I feel like a failure."

The second common pattern that emerged was lack of acceptance on the part of health professionals. The women felt frustrated by the lack of acceptance of PND by health

professionals and were left with nowhere to turn for the help they so desperately needed, this contributed to their feelings of shame and guilt.

In some cases, many did not lend PND the legitimacy it deserves and refused to admit women were suffering from anything more serious than the tiredness of a new mother. The quote above from IL illustrates this perfectly, where, after admitting she had been masking her symptoms (and accepting she had PND in herself), her health professional minimised her feelings by dismissing her as feeling “just like a normal tired mother”.

BG – [in relation to a Doctor focussing on the baby and ignoring the mother crying] “that encouraged me to hide it more really, I think, because it felt like it was unacceptable.”

SW – “...the whole hospital system seems to be under the impression that women, well, they should cope with everything, so you don't want to admit that you've got a failing, because obviously even the health systems thinks that you should be able to cope...”

Acceptance for women suffering from PND is hindered by their own and society's belief that childbirth is a special time in a woman's life, one that brings much joy and happiness. Henshaw and Elliott, (2005) found that women were also very aware of not wanting to be labelled as depressed, seen as a bad mother or risk having their baby taken away.

Hindrances to recovery:

Unfortunately, the stigma associated with having depression or for that matter any mental illness, remains a barrier (a hindrance) to acceptance therefore delaying treatment, extending the illness and severely prolonging recovery. A degree of depression following childbirth is probably experienced by all mothers at some time. However, the onset of a full-blown PND is insidious and is frequently resistant to conventional treatment (McGill, 1994). Women with PND often minimise the condition by ignoring or denying symptoms and choosing not to seek help due to their own feelings about failure and to societal stigma (Affonso, Lovett, Paul, & Sheptak, 1990; Kendall-Tackett & Kantor, 1993; Ugarriza, 1997).

The conflicting professional and societal understandings of PND, along with the possibility of depressed mothers minimising their symptoms, suffering in silence, and being unaccepting of their illness and their need for help, can play a major role in the disorder going undetected and untreated (Ugarriza, 1997). According to Beck (2001), the social stigma associated with PND often influences mothers not to accept that they have PND.

The pattern of quotes in the feelings section of this third theme reflects a need for health professionals, society and mothers themselves to change the way they view motherhood (or for that matter parenthood) and to recognise it as a difficult time in family life rather than the polished unrealistic way in which it is portrayed today which acts as a hindrance to recovery. The media play an important role here as they succeed in romanticising childbirth and motherhood on the cover of glossy women's magazines portraying unrealistic images on motherhood for weekly public digestion. Acceptance is the first and most important step towards recovery.

Assistance with Recovery:

To accept that things are not right and that they need help can be most difficult for women with PND. They frequently think they are the only one feeling that way and can sometimes hide it for quite some time.

Admitting that they need help and seeking treatment for PND can be a daunting experience (Bishop, 1999), however the sooner treatment begins the quicker recovery occurs. What is required before acceptance is possible is knowledge, and early recognition. Knowing that there is such a condition; that it is very common, it is not their fault, that they are not alone, that help is available, where to get help and that they will recover; are essential ingredients.

Similar to the statements in the recovery section of the early recognition theme, those women (such as SP and SH) who accepted that they were suffering from PND were the ones who sought help (which came from their own early recognition of their symptoms and followed with their own acceptance that they needed treatment to recover). Some of these women were suffering from PND for the second time and thus, this process was faster than with others.

In some cases, as in the recovery section of the early recognition theme, even though women recognised and accepted that they had PND, professionals at times, failed to recognise and then to accept that they needed treatment (such as with BG and SW). This has been discussed in the sections above on feelings and hindrances to acceptance.

There is copious literature on the possible causes and risk factors for PND and recommendations according to various theoretical approaches of which there are four main theories: psychoanalytical, cognitive, learned reinforcement and biological (James, 1998). The women in this study were not using theories, they made recommendations relating to acceptance from personal experience and their voices are strong.

Recommendations:

Beck (2002a) found that expectations played a large role in PND at several different levels and she reports that both mothers and the health professionals who care for them still believe that motherhood brings total fulfilment to a woman's life. Motherhood can be wonderful for some, but quite the opposite for others. If we go into motherhood with such high expectations without acknowledging the difficulties, we set standards that are impossible to meet and set women up to fail (Kendall-Tackett, 2005). Women would then see themselves as a failure or inadequate as a mother and feel too ashamed to discuss or confide in others, because they saw themselves as abnormal mothers and thought that no one else could feel the way they do.

This study has thoroughly confirmed the beliefs of the women who took part and Beck's findings on expectations. Most recommendations from the women in this study relating to acceptance focussed on making sure women stopped hiding their symptoms.

LW – "Don't be afraid to admit, life is not right, I think that's the biggest thing, I've had people ring me since I've had post natal depression, not a lot, but odd people who have known that I've had it, and earlier on actually, not so much of late obviously. I think there's a real stigma out there that I'm not coping so therefore I'm not a good mother, and so on and so forth...Get help as soon as you feel things aren't going right, immediately, talk, don't hide it, and talk to people about it, who understand, ...if you come across people that don't understand, ...that's not the people you should be talking to."

DW – "...talking to someone, you know, Plunket."

SP – "...don't hide it....seek help."

RJ – “I think [don’t]... hide it, that's probably the biggest one, don't hide it. Talk, if you possibly can about what's going on, because you're bound to find someone who's going to help you, or someone who understands what you mean, especially with other mothers, and stuff like that.”

Other recommendations relating to acceptance were more varied. For example one woman (IL) wanted health professionals to accept that breast-feeding was not always the best option, particularly for women suffering from PND as she was and finding the pressure to breastfeed to be too much.

The key theme of acceptance, as indicated earlier, comes first from a lack of knowledge on the part of women, professionals and society about PND, second, from a failure of these groups to recognise the symptoms early. The consequence of these two themes as shown by the literature and the participant’s comments above, is that women do not accept they have an illness and professionals and society are unaccepting of mental illness (e.g. PND) in general. There is recently an attempt by the Mental Health Foundation of New Zealand to address this issue by portraying well-known people dealing with mental illness in a television advertisement –“know me before you judge me”.

Conclusion

This chapter on findings demonstrates the credibility and trustworthiness of a vigorous qualitative study. Using thematic analysis of the data, it is noted how patterns emerged which formed the three major themes. Each theme has been explored and discussed under its specific heading using research literature to emphasise implications and consequences. Table 1 (page 89) illustrates the patterns as they emerged in response to the questions and shows how these patterns grouped themselves into major themes.

These three themes will be united and synthesised in the concluding chapter to summarise what factors assisted and what hindered recovery from PND. The findings of

the research will be used to inform and transform clinical practice for health professionals, those in a position to influence health policy, and educators. Recommendations will also be made for further research.

Table 1: Summary of Findings

Question areas	Knowledge	Early Recognition	Acceptance
Feelings	Colourful metaphors, felt in the dark (dark imagery)	Felt like a failure	Lack of acceptance of PND by women themselves
	Sense of emptiness, loneliness, felt numb	Tried to mask feelings and symptoms so other people didn't see them as a failure	Lack of acceptance of PND by health pros and society (though society is not mentioned as much)
	Scared of going crazy, harming child		
	Most common: guilt, shame, fear, feeling of failure		
Hindrances	Lack of knowledge for women and health professionals	Felt frustrated with health professionals who didn't recognise PND	This lack of acceptance by three areas is due to societal stigma which hinders
	Lack of knowledge by society	Did not recognise themselves what was wrong	
	Because of this stigma, women masked feelings		
Recovery	Professional support, knowledge of professionals helped recovery	Well-trained professionals and women's prior experience of PND led to early recognition	Women admit that accepting they have PND leads to recovery. Usually 2 nd time sufferers do.
	Family and friends knowledge/understanding helped recovery		
	Women's own knowledge helped recovery		
Recommendations	Need education for health professionals and services	Most recommended education for themselves to help recognise PND	Professionals need to accept women have PND (as a legitimate illness)
	Women need education themselves on PND		Women shouldn't be afraid to admit/accept they have PND
	Family/friends and society need education too		

Chapter Five

Discussion

The main focus of research to date has been on signs and symptoms of PND, screening tools, treatment approaches, risk factors and effects on the mother and baby, undertaken by clinical practitioners and academic researchers. The aim of this qualitative study was to explore with women their experience of PND with an emphasis on what factors assisted them and what hindered their recovery and to hear their voice.

Eight women took part in the study and were individually interviewed using open-ended questions as prompts. What was most interesting to the researcher was their need to tell their stories. One woman talked about her first experience with PND as though it had happened only yesterday, but for this particular woman it was actually 21 years ago. Hearing from the women themselves what factors either assisted or hindered their recovery puts a new perspective on PND.

Using interviews under the qualitative research paradigm and thematic analysis of the data obtained from these interviews, patterns emerged in response to questions related to feelings, hindrances to recovery, assistance to recovery and recommendations. These patterns clustered into three major themes: **Knowledge, Early recognition** and **Acceptance**. All three themes, and the patterns within them, were closely woven together, each influencing the other and having a major effect on the woman's experience of PND and her recovery as set out in Table 1 (page 89) and as described next.

Knowledge

Feelings

Whilst the first pattern within feelings that emerged (in which women depicted their feelings with dark imagery) could fit within any one of the themes, it sat most comfortably within the theme of knowledge. Implicit in this placement is the researcher's assumption that feelings of *being in the dark* result initially from a lack of knowledge. The second pattern tied in with both the first pattern and with the theme of knowledge generally, where women described feeling a sense of loneliness and emptiness. Linked to these first two patterns, women's lack of knowledge about PND resulted in them feeling as though they were going crazy and may even harm their child. This third pattern emerged only as a result of the first two patterns where women did not understand what was happening to them and further, did not realise there were others suffering alongside them.

Most commonly, feelings of guilt, shame, fear and of being a failure were all-encompassing. The women felt like a failure because they had stopped coping. They had stopped coping because they thought they were going crazy. They thought this because their loneliness and dark feelings meant they didn't realise, as discussed above, what was happening to them and that they weren't the only ones to whom this was happening. The linkages here are clear, women's lack of knowledge meant that their feelings escalated out of control and exacerbated their symptoms of PND.

Hindrances to recovery

Whilst the responses to the question on feelings focused solely on how the women themselves felt, the response concerning hindrances to recovery revealed a lack of knowledge on the part of health professionals and society generally. Even when women developed the courage to seek help from health professionals, they were frequently met with a further lack of knowledge where they least expected to find it. A lack of knowledge for the women themselves and for health professionals was considered to be a major

hindrance to their recovery. The women did not know what was wrong with them and health professionals did not know or recognise what was wrong with them either. As a result, the women wrongly blamed themselves thinking that they were a failure or a bad mother, so wouldn't talk to anyone about the way they were feeling in fear of being recognised in this light. Secondly, they also felt shame about not coping and the stigma of having a mental illness, and were also unaware that help was available or from where to seek help. The final pattern to emerge was a lack of knowledge by society about PND. This was a hindrance to recovery because they had no support, and further this lack of knowledge was frequently demonstrated by negative attitudes which made women feel worse when they most expected support. Negative attitudes as a result of a lack of knowledge meant that women were ashamed of how they felt. The stigma attached to PND was a further hindrance for these women because they preferred to hide their illness and mask their feelings rather than be stigmatised or thought of as a failure by society.

Assistance with recovery

Conversely, patterns emerged to demonstrate that the opposite was also true. Where women, health professionals and society had knowledge and understanding of PND, this assisted recovery by providing the necessary personal and professional support, thus setting women on the journey to recovery.

Family and friends who were aware of PND and who were understanding and supportive were identified by the women as being helpful in their recovery. Knowledge about PND by the women themselves was also a factor identified as helpful to their recovery. Those women in the study who had learnt about PND because of a previous experience were able to recognise the symptoms early and seek appropriate help.

Recommendations

Within the theme of knowledge, three patterns emerged by way of participant recommendations to tackle this knowledge deficit. Each of these three patterns related to education. All of the women in this study recommended that education about PND be provided to all health professionals and agencies or services working in the health field. In addition, they recommended more education be provided for women about PND and about caring for a newborn baby. Specifically, emphasis was placed on the need for more education about the reality of parenthood in the antenatal classes. They also recommended that family friends and society in general be educated about PND.

This study has identified a three-pronged knowledge deficit in that there is a general lack of knowledge about PND by women, health professionals and society.

Early Recognition

Feelings

Within this theme, feelings expressed related to lack of early recognition. Within this section, the first pattern to emerge was that the participants felt like a failure and did not want others to know how they were feeling for fear they would also see them as such. The second pattern of feelings resulted from the first: women's feeling of failure meant that they masked their feelings and symptoms.

Hindrances to recovery

Again, the main hindrance to recovery expressed by these women was that of not being recognised early by health professionals as having PND. Another major hindrance was not recognising themselves that things were not right and that they might have PND. This lack of early recognition prevented women from seeking help and from talking to

others about how they felt. For those that did, the lack of early recognition on the part of health professionals provided a major hindrance to recovery.

Assistance with recovery

Conversely again, the women in this study explained that what did help in early recognition was having prior knowledge through a previous experience of PND, or having a mature, well-trained health professional who recognised the signs and asked the appropriate questions, resulting in early recognition thus making recovery possible through appropriate treatment and support.

Recommendations

Most recommendations related to early recognition linked in with the first theme of knowledge to help women recognise the symptoms of PND and further education for health professionals with an emphasis on the importance of early recognition.

Acceptance

Feelings

Here, the need for self-acceptance emerged as a major pattern. The participants in this study all recognised a lack of acceptance of PND in themselves due to feelings of failure and also due to the stigma associated with PND being a mental health disorder. Another reason for their lack of acceptance was misplaced belief that motherhood was meant to be a happy time and it was not acceptable to feel the way they were feeling at this time in their life.

The participants reported a lack of acceptance of PND by health professionals and explained how their feelings often fell on deaf ears, or were brushed off or completely ignored even when obvious distress was apparent. The women described feeling let-down

and frustrated by the lack of acceptance of PND by health professionals. Interestingly, there is relatively little mention of women's feelings relating to a lack of acceptance on the part of society, yet this could be impliedly covered by women's acknowledgement of the stigma attached to PND.

Hindrances to recovery

The women identified lack of acceptance in three areas: by the women themselves, by health professionals and by society, as a hindrance to recovery. A pattern also emerged whereby the women linked the lack of acceptance in all three areas to societal stigma (about which they had been relatively quiet when talking about feelings, yet here it emerged as a clear hindrance to recovery).

Assistance with recovery

Again, conversely, a lack of acceptance is seen as a helpful factor in recovery. The participants recognised that they needed to accept that they had PND before the journey to recovery could begin. Acceptance was easier for those who were second-time sufferers. Women in the study admitted that accepting that they had PND was the beginning of the journey towards their recovery.

Recommendations

Recommendations related to acceptance were that health professionals need to accept that the women have PND and that it is a real illness requiring treatment like any other illness.

In addition, the participants recommended that women should not be afraid to admit they are not coping and accept PND as an illness requiring appropriate treatment like any other illness.

Gaps in the Health Care Service

The first and most important step should be to listen to what these women are saying and to take it seriously because the alternative is long-term suffering for families with a huge cost to society. The women in this study have identified quite clearly simple effective strategies that could possibly prevent PND or at the very least minimise its effect on the woman, the infant, the family and society.

The participants in this study have highlighted three fundamental gaps in the health care service provision for women and families. The gaps will first be listed briefly below before being discussed in more depth throughout this concluding chapter. Then, in the sixth chapter on recommendations, ways of plugging these gaps will be canvassed:

1. There is a *lack of education* about PND as a possible complication following childbirth. New parenthood and the postnatal period is accompanied by large-scale emotional upheaval. Having a baby necessitates a huge adjustment for the whole household especially the new parents. The reality of childbirth and parenting for parents to be, health professionals and society is ignored in what little education exists as it focuses largely on the physical birth process.
2. Romantic media hype about birth and motherhood in today's modern society gives a *false image and resulting expectation about motherhood*, so that women do not feel they are living up to this image or expectation. As a result, they feel inadequate as a mother leading to a sense of failure, combined with anxiety and depression and a strong need to hide these feelings/symptoms because of their shame and fear of others also seeing them as a failure.
3. *A lack of government support* for funding is needed to ensure that new parents are provided with the appropriate support to make certain that their emotional, physical and practical needs are being adequately met at this very crucial

time in the new family's life. Though once prevalent, *greater societal support is also needed* (including within the family).

Gap 1: Lack of Education (Knowledge is Power)

An important finding arising from this study is that the road to recovery could not begin until PND was recognised, and once recognised, it needed to be accepted. The earlier this process happened the sooner recovery occurred. However, before either of these processes could begin, knowledge about PND and motherhood is required, not only for the women themselves but for health professionals and society. Women need to know that it is very common, it is not their fault, they are not alone and they will recover.

Every woman in this study recommended that education on PND be more *out there* and at the very least be part of the antenatal education program. Women need education in order to recognise the symptoms, to know how and where to get the help, including strategies they can put into place before the birth to reduce the stress and anxiety afterwards. Partners also need to be informed so they can recognise a change in their partner and take appropriate action to reduce stress and ensure help be provided in whatever form is required. Women are also requesting that more realistic knowledge be made available about childbirth and motherhood.

Education about PND does not stop with the parents to be, it is needed for all health professionals - doctors, nurses, midwives, social workers and society as a whole. The stigma associated with this condition needs to be addressed, as PND should be seen as a possible complication of childbirth which women do recover from. (Or rather a disorder of society for lack of support and recognition of the trauma and stress associated with childbirth and motherhood).

Knowledge deficit was a major issue for the women in this study. It was extremely frightening not knowing what was happening to them. They all thought that they were not good mothers, and were unable to discuss their feelings in the fear that others would realise

this and see them as the failure that they believed they were. They continued to suffer in silence for months, even years before anyone recognised that they needed some help. Early recognition was not possible due to a lack of knowledge on the part of women, which prevented them from recognising their symptoms as something other than their own failure and seeking appropriate help.

Participant (SP) supported this idea of a knowledge deficit in her comment:

“...they don't really tell you what to look out for...they don't want to tell you in case you suddenly discover you've got the symptoms I think”.

In this current study all of the women interviewed experienced feelings of shame, failure, inadequacy and guilt with anxiety playing a major role. Goss (1998) identifies one reason for being out of touch with the reality of parenthood as lack of preparation and says becoming a parent is a major milestone in life, but many mothers and fathers in western society are totally unprepared – despite nine months warning. She states (p. 23):

Small nuclear families living in suburban isolation often do not provide girls or young women (or young men) with any practical, first-hand experience of babies. Ideally, preparation for such a huge responsibility as the nurture of another human being should begin in childhood and gradually follow into adolescence, as it used to when families were much bigger, and still does in cultures where extended families live together.

No one tells parents what *really* to expect in the first parenting months as Peters (1997, p. 53) explains:

Consider the simplest physical impact: sleep deprivation. Most people are aware that infants eat every three hours, but few know

what it means to wake from sleep every three hours, or even more often. Staying up for a week during final exams is nothing compared to months of interrupted sleep with an infant. The difference lies in walking around dizzy with fatigue, a permanent goofy smile on your face, and a numbing chill at the rim of your brain, where only one or two – instead of two dozen – thoughts now coexist. Sometimes you sink into unconsciousness – sitting on the rim of a bath tub, on the kitchen stool, on the couch.

With an infant you do not move through a day at your own pace. You cannot live your former life. You don't dine; you eat. You don't sleep; you nap. You don't stroll out of the house; you organise a mound of equipment and set off. Every move is punctuated by the baby's far more pressing need. In this earliest period, parents live to serve the house's new potentate, for that is absolutely what every infant is – shrieking for quicker service and inspiring fear in the hearts of his body servants.

Gap 2: Romantic Hype surrounding the Myth of Motherhood leads to False Expectations

Similarly, not only do women and others not know enough about motherhood, what they do know stems from largely incorrect romantic hype. The power of the media in today's society has meant that its pervasive influence displays expected stereotypes for members of a particular culture. Stereotypes of women and particularly mothers are depicted in all forms of media but particularly in advertising (Goss, 1998).

Goss, (1998, p. 25) describes these stereotypes below as:

The 'soft-focus mother'

She is always thin-looking and perfectly groomed, and usually aged about 30. She is often found changing her baby using the latest high-tech disposable nappy. The soft-focus mother is always totally absorbed in her baby, receives great satisfaction and fulfilment from every movement and noise the baby makes, and obviously loves her baby more than anything in the world – that's how all mothers feel isn't it? If you don't feel that way, there must be something wrong with you.

The baking mother

Goss explains that the soft-focus mother is one of the most prevalent stereotypes but there are others such as the 'baking mother', often found in the recipe pages of women's magazines. Alongside is a text that encourages mothers to involve their children in the delights of baking. Once again the photo of the 'baking mother' is totally unrealistic – showing a perfectly groomed mother and child, usually without aprons because there is no mess involved, and of course the final result is a culinary delight that even a chef would be proud of.

The super mum

Then there is the 'super-mum' who brings up perfect children, holds down two jobs and keeps a perfect house.

The romantic mother

The 'romantic mother' meets the demands of small children and still finds enough time and energy for walks along the beach, romantic dinners and nights of heated passion with her man.

The findings in the interviews also supported the stereotypical notion of a super-mum. As participant (SP) recalls her husband saying "You'd better clean up the washing, because the midwife's coming over..."

Depression during pregnancy and following childbirth does not fit comfortably within psychiatric or mental health disorders and cannot be considered the same as depression at any other time in a person's life because for one thing, at no other time in your life do you have such responsibility for the life of another human being. Yet, as the results of this study have identified, depression *is* a mental health disorder and it carries a stigma (which includes registering sufferers of PND as mental health clients which can be tracked electronically), hence making acceptance more difficult for women, especially at a time in their life that is supposed to be joyful, happy and fulfilling. The stigma attached to PND being a mental health disorder is identified in this study as contributing to the women's non-acceptance of the illness. By going to great extremes to hide their discomfort and to mask their symptoms, women actually became quite efficient at this disguise.

Some of the women in this study have suggested that maternal mental health service be attached to the maternity services, to lessen their feelings related to the stigma and make the service much more accessible to women during the postnatal period. However as a Maternal Mental Health Clinician, I am doubtful that this would be as effective in that area as it is within the mental health service because of the multidisciplinary component of PND being placed where it is currently. Further, I feel reluctant to consider this as a potential gap in the health care service because I see it as possibly providing support to the stigma. However, it does provide food for thought and could possibly be considered by the health service with government backing and financial support.

Reinforcing this maternal health recommendation, Elliot (1983) believed that PND could well be a realistic response to the life event of birth and the stress associated with the role of mother. If this is the case, then the above request to have it treated within the maternity or women's health division of health services would be the most appropriate approach.

In this current study of what helps and what hinders recovery from PND, as with many other studies, it has been found that PND frequently begins during pregnancy and that anxiety is always present (Bishop, 1999; Milgrom, et al. 1999). In fact, it is very probable that anxiety precipitates the depression and thus, if it was recognised as such and measures were put in place to reduce this anxiety, it could potentially prevent the depression. Some anxiety is normal and in fact necessary in order to prepare for the arrival of the baby and the responsibility that this involves. However, with so much emphasis on being a 'good' mother and numerous books and studies advising on what mothers must and must not do, say or feel in order to be a 'good' mother, anxiety is ever increasing and always present.

Peters (1997, p. 42) explains that emphasis on the mother-child relationship now dominates in the form of "attachment theory". This theory was originally developed in the fifties by a physician, John Bowlby (1982). Bowlby observed that children, who were separated from their mothers, either due to long periods in hospitals, or in orphanages, became severely depressed. Bowlby's theory draws from the notion that a child's sense of security and psychological well-being was entirely dependent on the mother as the primary nurturer who is ever present and always responsive. This could be seen as putting too much pressure on new mothers to be everything to their baby.

Further studies such as that of Mary Ainsworth (1969) have upheld Bowlby's theory on attachment. Ainsworth's longitudinal study on human infants in Baltimore first published in 1969 found three distinct patterns in the babies' reactions when separated and then reunited with their mothers, which she labelled securely, insecurely or anxiously attached. Ainsworth's findings marked the beginning of a critical shift in the way infancy

and child-rearing was perceived and the prolonged debate divides infancy researchers to this day. Since then, the field has been transformed, in the past twenty years infants and their mothers have been studied as never before. Researchers such as Margaret Mahler (1979) have very much kept alive the attachment debate with support for the work of Bowlby and Ainsworth. Further studies have continued to support the importance of early secure attachment in infants but have placed it in a less-pressurised light as stated below:

There is something simple and life-affirming in the attachment message – that the only thing your child needs in order to thrive emotionally is your emotional availability and responsiveness. You don't need to be rich or smart or talented or funny; you just have to be there, in both senses of the phrase. To your child, none of the rest matters, except inasmuch as it enables you to give of yourself. What's more, you don't have to be an outstanding mother, just – in Winnicott's famous phrase – a "good enough" mother (Karen 1990, p. 20).

This is the message that needs to be heard by mothers of today who seem to believe they have to be some kind of super Mum.

Unrealistic stereotypes did not just attach to new mothers. Unfortunately resentment towards the role that New Zealand fathers assume was apparent throughout this study, and this resentment may stem from the pressurised role of motherhood in society today. Yet fathers are also mentioned as deserving of support, which will be discussed more in the section on the third gap following.

A clear message from this study is that attitudes towards parenting need to change, so that parenting becomes a shared responsibility. It takes both parents to produce a child, therefore, it requires both parents to parent the child especially in the first year or so of its life.

Gap 3: Government and Societal Support of PND is needed

Drawing from the first two gaps, a need for greater support for mothers remains the most serious gap. The findings in this study support those of Kendall-Tackett who acknowledged the difficulty in diagnosing PND at an early stage: “the mothers themselves contribute to this dismal record in that they frequently go to great lengths to conceal their depression from health care providers, as well as friends and family” (Kendall-Tackett, 2005); Cooper and Murray (1998) narrow this approach to pin-point that the onus lies with health care providers who fail to identify this condition, even when mothers are in frequent contact with such providers. Yet when women do seek help it can be minimised, normalised or completely ignored as described by participant ‘BG’:

“I spent the whole [doctors] appointment crying, and not once did he ask me what was wrong, or if I was okay.”

Brooke Shields’ book *Down Came the Rain* (2005, p. 82) supports the lack of recognition by doctors of the illness. She explains how her Doctor responded to her tearful and distressed state at the six weeks postnatal check:

He said to trust him, that this feeling would pass and that many new mothers went through the baby blues. He explained that it had to do with the fact that out with the placenta went many of the hormones contributing to the sense of well-being felt during pregnancy. Once the hormones equalised I would start feeling better. He said the hormonal shifts that occur post natal are often a shock to women, but even his wife went through it, and it was very normal.

She, too, like many other women, decided to trust her doctor and thought that “maybe she was just another one of those emotional women who was making more out of it than necessary” (Shields, 2005, p. 82). She explains that she felt too ashamed to keep trying to convince her doctor that it was more serious than a hormonal imbalance.

There is an expectation that today's woman will step expertly into the motherhood role without preparation or a role model to look to for advice. As Goss (1998, p. 23), explains, many new mothers look back to the way they were reared by their own mothers for examples of how to behave. However, such an approach is flawed as time may have blurred the edges of a new mother's childhood memories (and there will be no hints at how to mother a small baby). Furthermore, new mothers who have come from abusive homes will have a poor role model to mimic and this may mean that they have no advice to guide them as to what good parenting practices would be, or at worst, may repeat old mistakes (Goss, 1998).

All new mothers go into their role of motherhood with a strong desire to be the best they can be. Many have sought out all the best literature on parenting and are setting themselves up to be super-mums. However, they will fail at this because such an over-hyped fantasy simply does not exist. Yet, popular best selling child-care books such as those by Penelope Leach, (1994) have played a major part in keeping the myth of motherhood very much alive. Leach, herself a professional "with a practical approach to child-rearing, made motherhood seem anything but old-fashioned" (Peters, 1997, p.22). Peters reports that Leach: "tells it like it is, or seems to, but she also absolutely – and with unflappable authority asserts what she believes to be the necessity of traditional, primary motherhood: that mothers should be 'ever-present, always responsive' to their babies, and she argues that female biology dictates such behaviour" (Peters, 1997, p. 22).

Our lives have changed so greatly as Peters (1997, p. 35) states:

So why hasn't motherhood adapted to our vastly changed lives?
Why is it that so many women feel guilty when they do not
measure up to an outdated mothering ideal? The answer lies in
the force of tradition, culture and personal upbringing, which
have taught women to subordinate their lives to their children. As
equal as women see themselves now, femininity is still defined in

terms of caring, acceptance and accommodation - not accomplishment. Motherhood, in contrast to fatherhood, still means providing for a child's essential psychological security and anchoring the family.

Likewise, community models prevalent in the child-rearing of yesteryear provided unconscious guides for new mothers who raised their children in more inclusive community groupings than today's mothers. Robert Putnam discusses this in his seminal book *Bowling Alone* (2000) which is based on the decline of the American Community. In it, Putnam explores how this decline in civil and social engagement has affected society in a way that affects us all as individuals. We are now going it alone without the support of others, such as groups, neighbours, friends, churches and families. The movement of women out of the home and into the workforce is as he puts it (p.194) "the most portentous social change of the last half century". He states (p.194) "Women who work outside the home doubled from fewer than one in three in the 1950s to nearly two in three in the 1990s." Prior to this shift, women were homemakers that he states (p.194) "invested heavily in social-capital formation". They devoted much of their time and energy in unpaid church activities, PTA activities and meetings, neighbourhood coffee meetings and visits with friends and relatives.

Putnam (2000) asks whether women's movement into the workforce as a result of the feminist revolution has contributed to the decline of social capital over the last generation. There has most definitely been a decline over recent years of social support provided by mothers getting together in the community in the form of mothers groups, play groups and the like, that their own mothers and grandmothers enjoyed. Putnam (2000, p.288) states that:

First, social capital allows citizens to resolve collective problems more easily... Second, social capital greases the wheels that allow communities to advance smoothly. Where people are trusting and trustworthy, and where they are subject to repeated

interactions with fellow citizens, every day business and social transactions are less costly... A third way in which social capital improves our lot is by widening our awareness of the many ways in which our fates are linked. People who have active and trusting connections to others - whether family members, friends, or fellow bowlers - develop or maintain character traits that are good for the rest of society.

Without such role models or community, there is little place to turn for new mothers in need of advice. As can be witnessed, this decline in communities today is evidenced by the lack of support available from other women in the community for new mothers and combines with a lack of support from health professionals, to create a serious gap which hinders recovery from PND and which requires addressing.

My mother

In looking back to my upbringing and its context, it is possible to see this notion of community even if it was within the family unit. I was one of a large family — my mother already had seven children when I was on the way. To further complicate matters, I was not arriving alone, there were two of us: ‘twins’. I often wondered how my mother must have felt when she found out that she was expecting twins after she had already had seven children. I very much wondered how she managed, but I soon learned that my older sisters took on the role of mother. This role did not do them any favours apart from hands-on experience with infants. They said it actually put them off having children of their own. They felt they had had enough of child-rearing by the time it came to having children. However, they did change their minds on this eventually, but limited their families to two children.

21st Century mothers

We can not compare motherhood today with that of our mothers or grandmothers. Life is so vastly different and not necessarily in a negative way. It is our attitude that makes it negative and the lack of community support as illustrated generally by Putnam (2000). In addition, in days past, women were given time to recover from childbirth, often remaining in the maternity unit for 14 days and first time mothers spent three or four days in a Karatane unit learning mother-craft. These options are no longer available to women.

New mothers today are discharged home with their new baby often within 24 hours and sometimes in the middle of the night. There is no recovery time from labour and childbirth and very little, if any, support once they get home. Many mothers are ill-prepared for motherhood (and in particular breastfeeding), the discomforts associated with childbirth, breastfeeding, mood fluctuations, demands of the new baby, including sleepless nights and extreme tiredness. Then there are the household chores and often the demands of other children and family members.

In addition, grandmothers of today are usually working and not so available for support and practical help, and the women in the neighbourhood are either extremely busy with their own children or are also working.

Peters (1997, p.24-25) concludes in her book titled *When Mothers Work: Loving Our Children Without Sacrificing Ourselves* that the mother as the primary caregiver and emotional centre being the best arrangement for the children and for the family as we have been so conditioned to believe is:

...most definitely... not the best arrangement. In fact, it may be among the least sensible child-rearing arrangements civilization has come up with thus far. I am not alone in this opinion. More

than two decades ago the sociologist Jessie Bernard wrote in *The Future of Motherhood*:

The way we institutionalise motherhood in our society — assigning sole responsibility for child care to the mother... is not only new and unique, but it is not even a good way for either women... or children. It may, in fact, be the worst. It is as though we had selected the worst features of all the ways motherhood is structured around the world and combined them to produce our current design.

This current study confirmed the notion that support (whether it be professional or that of family and friends) is a major requirement for new mothers. Along with emotional support, practical support (such as home help) was seen by the participants as even more of a requirement for new mothers. This should be a primary health initiative and be Government funded. Most of the women in the study (6/8) identified home help as a major factor assisting their recovery. It seems ridiculous that a woman has to wait until she has a diagnosis of PND before receiving this common-sense practical support that she so desperately needs.

Anecdotally, I have frequently heard fathers speak of 'baby-sitting' when their wife or partner is not at home and they are home alone with their baby or children. I always remind them that they are parenting, not baby-sitting. What does interest me, is that in contrast, I never hear mothers refer to their role as baby-sitting.

However, as indicated in the discussion on the second gap above, the women in this study identified that education and support for fathers was also lacking. Men equally find themselves unprepared for their new role, and are frequently on an emotional roller coaster after the birth of their child, so when their wife or partner has PND, it is easy to imagine the difficulties they are faced with. It has been described by some men as feeling as though

they have lost the woman they fell in love with and are living with an alien (Meighan, Davis, Thomas & Droppleman, 1999). White (2005, p. 41) states that "there needs to be an opportunity for individual support for men, similar to the way women are provided with maternity health-care services". She believes that "lack of any services, especially for paternal mental health, is an indictment on the value a country places on parenting".

The role of fatherhood has also changed from the control and discipline often associated with being a father in the past. "Today's expectations of a 'good' father are that he provides his family with financial support as well as warmth, love and affection and that he be a role-model of a 'good' father to his own sons, which includes showing respect and valuing the mothering role for his daughters and the family unit as a whole" (White, 2005, p. 43).

Richardson (1990, p. 2) links PND to the social context in which mothering occurs. She states:

There is the tremendous responsibility associated with looking after a young child which, because it is rarely shared and because society provides only limited support for carers, is less likely to produce feelings of self importance and self worth than it is of anxiety and stress.

So much time and effort has been spent studying the rights and wrongs of parenting that the needs and/or resources required of parents to enable them to carry out this important function has been completely overlooked. Instead of all of the information on how to be a good mother, the focus should be on providing ways to support, making motherhood a less stressful and a more enjoyable experience.

Sharing parenting from the start could be beneficial to both parents and the child. By both parents taking time off work after their baby is born, they will share the load and adapt to their new roles together, they both get to know their baby and their baby gets to

know and trust them both as primary caregivers. This way, parents will both recognise and understand the changes that occur to them, including the chemistry between them as a couple. Perhaps instead of the three months paid maternity leave the New Zealand Government has introduced, an automatic one to two month paid leave for both parents would be more appropriate and beneficial for the new family. However, this too may be unrealistic – some fathers are not supportive and would like to be paid for a holiday instead.

The great value of starting out parenting together, whether both continue to work part-time, both stay at home for a while, or both take leave consecutively is how much easier it is to maintain a relationship of equals (Peters, 1997, p. 54).

Conclusion

As the findings from this research have demonstrated, the women in the study were prevented from enjoying the experience of motherhood because of the devastating feelings associated with PND which lead them to isolate themselves and see themselves as inadequate or as a failure. They became frightened, fearing that they were going crazy and that they would never be the same again, they were afraid to talk to anyone about their feelings because of the stigma associated with PND and they had great difficulty accepting that they were suffering from PND. Lack of support was a major problem and also lack of knowledge about PND and where to get help from. This devastating condition affecting so many New Zealand mothers could possibly be prevented if shared parenting was encouraged as an accepted norm in New Zealand. These women would then have the emotional and practical support they so desperately need at this time in their lives.

Chapter Six

Conclusion

As the patterns emerged throughout this study to form the three major themes of knowledge, early recognition and acceptance, it became obvious that in order for me, as the researcher, to identify the gaps within the health service, it was important to recognise how the questions relating to feelings, hindrances to recovery, assistance to recovery and recommendations interacted with each other as they became so intensely intermingled and interrelated with one-another. Therefore, the recommendations from the women in the study are also intermingled and interrelated with one-another, each having impact on the other. This chapter concludes this thesis by offering recommendations to close the gaps identified within the health service.

Gap 1: Education

Firstly and most important, the government, health professionals, and society must listen to what the women are saying about their experience of PND and what factors assisted recovery and what hindered it. Those in the position to effect change can then focus on what women are saying about their experience of PND and what changes need to be made to prevent or at least reduce the devastating effects of this cruel, debilitating and soul-destroying illness that is so common in our society.

Specifically, there is a need for primary health services such as Plunket to move into educating new parents and/or parents to be, preferably in their own homes providing supportive hands-on teaching about how to care for their baby and to continue this service on a regular daily basis until the new mother is coping well and feeling confident in caring for her baby. Plunket Karatane Family centres are available in some areas, however, they are not meeting these needs, perhaps because the new mother is required to go to them and

this is not always possible, often because of lack of transport, lack of motivation due to PND or lack of organisation, which is very common with new motherhood.

As identified by this study, education on childbirth and parenting is a major requirement for society in general, health professionals and new parents, including the emotional upheaval for new parents and common complications such as PND, information on signs and symptoms, where to get help, what agencies and services are available in the community, and preventive measures such as extra support and practical help. With increased knowledge comes recognition and acceptance of this common complication following childbirth, thus removing the stigma so frequently attached to it, which, in turn, allows early intervention to take place and assists recovery, thus ensuring that a family's life remains intact and they become an asset to the community.

Gap 2: The Myth of Motherhood

Ignorance has created unrealistic expectations of motherhood leading to many women feeling inadequate and depressed as they struggle so hard to live up to the super-mother image. Motherhood needs to be seen as it is, not glossed over as some romantic unrealistic fantasy that it is not. Plugging this gap requires a great deal of accurate unhyped literature on motherhood, a focus on removing the stereotypical mother from the media and linked to the recommendation above, antenatal classes which focus on the realities of motherhood.

Nested within the idealised role of mothers is the stigma of mental illness and failure that attaches to PND. One of the women's recommendations suggested that maternal mental health services may be easier to access if situated within maternity services, yet as discussed, it is possible that seeking to place PND outside of this realm may further support the generalised stigma of mental illness.

Gap 3: The Need for Support

This study has provided confirmation of the research to date in identifying support as a critical component to promote a mother's journey toward recovery. In addition to medication and psychological therapy women with PND require significant physical and emotional support. Barriers to this support as discussed earlier can include the stigma of depression being a mental health problem, the absence of family support, a lack of availability of support in the community and cut-backs in health-care dollars, also ignorance related to the needs of new parents and PND in particular. Rural living can also pose additional barriers because of the lack of available resources in the area and long distance to travel for treatment, road conditions, transportation problems, long distance phone call costs and social isolation.

Shared parenting and its benefits have been discussed earlier and should be highlighted here. As we have seen throughout this study women have been conditioned to believe that it is their role alone to provide the emotional stability and physical wellbeing for the family no matter how impossible it is. The mother must work a 24-hour-a-day, seven-day-week, 52-weeks-a-year job and is expected to enjoy it.

Government needs to recognise the value of both parents sharing the parenting role, especially in the first 3 to 6 months of the infant's life, by providing paid parental leave for the mother and the father during this time. This will not only benefit the infant but will benefit both parents by providing them with the emotional and physical support of one another, as they adjust to their new roles together, both getting to know their new baby and their new baby getting to know and trust them both as primary caregivers.

Anxiety is a common symptom of PND and is frequently described by women as 'out-of-control' leading them to believe they are not good mothers. There is much that can be done to prevent or reduce anxiety. The first of these would be to have motherhood valued at the high status it so deserves, by society. The second would be to increase

knowledge by providing a high standard of education for all society, perhaps beginning in primary schools and continuing throughout secondary and tertiary educational facilities, with greater emphasis for education for those in the health services and parenting facilities.

Women need to be given the opportunity to recover from childbirth. This could be provided by maternity services such as giving them the opportunity to stay in the maternity unit after birth as long as required. Additionally, home-help could be provided when they do return home on an as-required basis for up to three months as described earlier in the fifth chapter. Research has found that PND is rare in those cultures that see childbirth as a significant rite of passage and place high status and value on the mother by recognising her need to be nurtured and cared for by the family and society as she recovers from childbirth and prepares for her new role as a mother (Littlewood & McHugh, 1997).

“Look after women and children to have a healthier society.” This was a headline in the health section of our local paper dated April 6 2005. The article titled “Make every mother and child count” by Lucy Dunlop (2005, p. 7) was the World Health Organisation’s (WHO) slogan for World Health Day April 7 2005. Perhaps the dictum should read “Look after parents and children to have a healthier society”. If the mother has the support she requires from the start, the family will thrive which will impact positively on society. “The global aim of World Health Day 2005 was to encourage everyone from individuals through to governments to take action to improve the health and wellbeing of mothers and children. Healthy mothers and children grow strong our communities.”

I strongly support the WHO slogan and hope the message is taken seriously by those in the position to effect change. Specific areas in which targeted government and other funding is required include:

- Practical home help to be provided for all mothers following childbirth for up to 6 months postnatally as required;

- Paid parental leave to be provided for both parents for three months after childbirth to enable them to learn parenting together and provide each other with emotional support;
- Infant health and development-trained health professionals to undertake home visits to teach parenting skills and to provide support to new parents following childbirth as required;
- Antenatal classes to be enhanced to provide education on the reality of parenting with emphasis on exhaustion, sleepless nights, emotional upheaval and the difficulty of crying/unsettled babies. A specific emphasis to be placed on providing in-depth education on PND as a common complication of childbirth with information on the following areas: signs and symptoms, preventative measures, community agencies and support groups as well as specialist services such as maternal mental health;
- Community-run PND support groups to be fully government-funded as these are often run by individual PND survivors and yet provide an indispensable help to mothers suffering from PND and can prevent further strain on the health budget;
- Education to be provided for health professionals (including Obstetricians, General Practitioners, Midwives, Nurses etc) about PND generally with a specific emphasis on screening for PND as routine antenatal and postnatal care. Emphasis also to be placed on the difficulties of adjustment to motherhood and treatment/support options available to those with PND including support groups and specialist services;
- Regular screening for early signs and symptoms of PND such as sleeplessness, anxiety and severe tiredness;
- Primary healthcare funding for an early intervention maternal mental health service for mild-moderate PND;
- Provide support and education for the father and include him in counselling and treatment;
- Funding to be provided for the establishment of more regional mother/baby units to treat those with severe PND requiring hospitalisation. For example, a unit could be established in Palmerston North to cater for the Manawatu-Wanganui District

Health Board area. Such units currently exist at some major urban centres in New Zealand such as Christchurch;

- Advertising via a range of media (television, radio, magazines and newspapers) about the realities of parenting in order to banish the myths of motherhood and increase awareness of PND as a common complication of childbirth and
- Support services to be made available to rural families including funding for these families to travel to urban centres for treatment.

This study has put things in better perspective for me, both as a researcher and as a health professional working in the field of maternal mental health. I feel that research to date has almost become saturated with its focus on signs and symptoms of PND, causes, risk factors and modes of treatment. It is now time to look more closely at prevention with a focus on education, early recognition and acceptance.

Limitations of this Study:

- Qualitative research cannot always be generalised;
- Age range of 20 to 42 could be considered a limitation;
- Two of the participants in this study had experienced their last episode of PND more than 15 years ago which could also be considered a limitation.

Areas for Further Research

This study has looked at what factors hindered and what factors helped women's recovery from PND. In doing this, it has identified three major themes, being: lack of knowledge, lack of early recognition and a lack of acceptance. All three of these factors hindered women's recovery from PND. Conversely, where these three themes did exist (i.e. where there was knowledge, early recognition and appropriate acceptance of PND), women found that these factors helped in their recovery. However this study could not answer every question relating to PND. In conducting this study, the researcher uncovered as many questions as answers. Those areas which are considered as deserving of further future research in order to gain a greater understanding of PND are listed briefly below:

- What is the relationship between anxiety and PND?
- What role does sleep deprivation play as a possible contributing cause of PND?
- If strategies are put in place to reduce stress and anxiety during pregnancy and the postnatal period would PND be prevented or at least reduced?
- Would treatment for PND be better suited to the needs of this group if the maternal mental health service was part of or attached to the maternity or women's health service? Or is this supporting the stigma of PND or mental health conditions?
- How effective are the existing maternal mental health services?
- What are the benefits of regular screening of all pregnant and postnatal women for PND by their midwives, doctors, Plunket nurses or health visitors?

- What are the benefits of having an early intervention maternal mental health service as part of the primary health services as discussed above?
- Further research should flip the question to look not at why women get PND but rather why some women do not.
- With the appropriate support during pregnancy and the postnatal period, is it possible to prevent the onset of PND?
- How frequently is chronic depression a result of untreated or poorly treated PND?

Conclusion

This study has broken new ground by highlighting women's view of their own journey to recovery. From this, a rare opportunity emerged to uncover what factors contributed to their recovery and what factors hindered their recovery. Gaps within the New Zealand Health Service were identified with recommendations on how to fill the gaps and improve the health and wellbeing of New Zealand parents and their families.

I feel extremely privileged to have been entrusted by the women in this study, hearing their stories and travelling back with them to the deep darkness of their depression, the difficulties they faced and the many hurdles they had to cross before finally beginning their journey to recovery.

Appendices

Appendix 1: Participant Information Sheet

Postnatal Depression

A Woman's Perspective:

What Factors Helped and What Hindered Recovery?

Invitation

I would like to invite you to participate in my research. I will be exploring your experience of recovering from postnatal depression. Participation is entirely voluntary and your free choice. If you do agree to take part you are free to withdraw from the study at any time, without having to give a reason. Non-participation will not affect any future care or treatment you currently receive. There will be no cost to you for taking part in this study. This information and consent form has been sent to you following your response by telephone and your request for further information. Please feel free to ring me with any further questions. Please send in the signed consent form if you are interested in being a participant.

What is the purpose of the study?

The research is part of my studies for a Master of Arts (Nursing). Its purpose is to explore with women their experience of recovering from postnatal depression, looking at what they found helpful and what hindered their recovery. It is anticipated that findings from this study will be potentially useful in identifying gaps within our health service. These gaps could then be addressed in a cost-effective way to reduce the impact of postnatal depression on the woman, the baby and the family.

When and where will the research be conducted?

Only after you have given consent to participate in the study, I will offer you the choice of an individual interview or to take part in a focus group. The time and place of the interviews and groups will be negotiated with you. If you choose an individual interview you do have the right to have a support person present.

What will happen during the study?

Interviews will be recorded by audiotape and written record. It will take between one and two hours, but I will be guided by you. The information you give will be transcribed and shown to you to give you the opportunity to edit it.

Privacy, confidentiality and safety

Information you provide will not have your name and you will not be identified in any reports resulting from this study. I will store all information safely in a locked filing cabinet in my home. All information obtained during the interviews will be available only to myself and Dr Gillian White who will be supervising this research. At the end of my study I will erase all tapes, shred transcripts and destroy all identifiable data.

I am concerned that women experience no ill-effects through participation in this project. You have the right not to answer questions and to have information wiped from the tape or the notes on request. If you feel distressed or uncomfortable at any time during the interview you have the right to stop the process at any time. If you want to talk to someone about anything which caused you to feel uncomfortable or need further support I will refer you to the appropriate service or discuss with you other avenues of support.

Those participating in focus groups have the right to withdraw from the study at any time up to a point, however you can state at any time that you don't wish for these comments to be documented or recorded. Focus group data is dependent on what others have said.

This project has been reviewed and approved by the Massey University Human Ethics Committee.

Appendix 2: Consent Form

Recovering From Postnatal Depression What Factors Helped and What Hindered?

I have read the information sheet about this study and any questions I have asked have been answered to my satisfaction. I agree to be involved in this project, knowing I have the right to withdraw at any time and have all information wiped from the tape or the notes. If I am participating in a focus group I have the right to withdraw up to a point, however I can state at any time that I don't wish for some of my comments to be documented or recorded and these will be removed or destroyed. I agree that information gathered for the purpose of the study may be published in aggregate form. Any information which could identify me will not be used. I am aware that if I decide to participate in an individual interview, I may choose to have a support person present during the process.

Name of Participant

Name of Witness

Signature of Participant

Signature of Witness

Date

Date

Appendix 3: Flyer



An invitation to women who have experienced PND

If you live in Wanganui or Palmerston North and you have recovered from postnatal depression (PND), I would like to invite you to participate in my research. I will be exploring with you your experience of PND, with an emphasis on what factors were helpful and what hindered your recovery. Information you provide will not have your name and you will not be identified in any reports resulting from the study.

Participation is entirely voluntary and your free choice although I will ask a few questions to assess your eligibility. If you are eligible and choose to take part you are free to withdraw from the study at any time with no questions asked. Non participation will not affect any future care or treatment you currently receive. There will be no cost to you for taking part in the study.

The research is part of my studies for a Master of Arts (Nursing) degree through Massey University. It is anticipated that findings from this study will be potentially useful in identifying gaps within our health service. These gaps could then be addressed in a cost-effective way to reduce the impact of PND on the woman, the baby and the family.

Appendix 4: Interview Question Set

1. What was it like for you having postnatal depression?
2. What sort of things helped you recover?
3. What sort of things hindered your recovery?
4. What advice would you give to other women and their families experiencing depression after childbirth?
5. Do you have any suggestions to improve the health service for women with postnatal depression?

Appendix 5: Permission from Publisher

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They have granted permission (though it seems they have granted it to me!) - see below.

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Dear Sir

I am completing a thesis on postnatal depression as partial fulfilment of a Master of Arts in Nursing at Massey University, New Zealand.

I would like to include the publication of the poem titled Listening, written by Sherri Hardy 30 May 1996, a client of the Austin & Repatriation Medical Centre Infant Clinic. Its on page 3 of the book- Treating Postnatal Depression, A Psychological Approach for Health Care Practitioners by Jeanette Milgrom, Paul R. Martin and Lisa M. Negri, (1999).

I would be most grateful for your permission to include this poem in my thesis to highlight the feelings experienced by women with postnatal depression and to support the findings from this study.

Yours sincerely

Alice Morton
62 Durievale Road
Wanganui
New Zealand

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