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Applying Merleau-Ponty's Phenomenology of Perception to  
Maternal Well-Being in the First Twelve Months Following Birth

Anna Maria Bosco

*PhD*

Submitted in fulfilment of the requirements for the Degree of  
Doctor of Philosophy



School of Theology and Philosophy  
Fremantle Campus

February 2019

## **Declaration**

To the best of the candidate's knowledge, this thesis contains no material previously published by another person, except where due acknowledgement has been made.

This thesis is the candidate's own work and contains no material which has been accepted for the award of any other degree or diploma in any institution.

**Human Ethics** The research presented and reported in this thesis was conducted in accordance with the National Health and Medical Research Council National Statement on Ethical Conduct in Human Research (2007, updated 2018). The proposed research study received human research ethics approval from the University of Notre Dame Australia Human Research Ethics Committee (EC00418), Approval Number 013133F.

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**Anna Maria Bosco**

24th February 2019

## Abstract

Maternal emotional wellbeing is a deeply personal experience embodied through society; however previous literature examining emotional adaptation to motherhood has focussed on negative outcomes, risk factors and pathology. This perspective is limiting and objectifies a mother's experiences rather than exploring her being-in-the-world. In contrast to current conceptualisations, Maurice Merleau-Ponty's phenomenology of perception asserts a holistic view of the individual within the world, whereby the subjective body and the lived body are intertwined, and perception is a conversation between the body and the world. This conversation is how the mother embodies the world within her being, for example how she internalises the expectation of birth. When a mother's reality does not meet her ideal this can create emotional disequilibrium which the health system and mothers conceptualise as "disordered" (known as postnatal depression [PND]) rather than as being a normal fluctuation of mothering.

Therefore, the purpose of this phenomenological descriptive study was to describe mothers' perceptions of emotional wellbeing, and PND screening, in the first year postpartum by applying Merleau-Ponty's concepts of perception, the body and embodiment. In-depth interviews were conducted with 26 mothers who had identified themselves as either having or not having experienced PND. Giorgi's thematic analysis methodology was applied to explore the similarities and differences within the mothers' perceptions of their emotional wellbeing experiences. The study found that mothers misunderstand the spectrum of emotions they can experience and that this view is engendered by society's definitions of emotional wellbeing, motherhood and their identity as mothers. This leads mothers to conceal their feelings and not accept healthcare. The current ways of screening for emotional wellbeing misses mothers at risk. By conceptualising PND as a disorder, the health system makes it more difficult for mothers to get help.

The study results demonstrate compelling reasons for society and health care to change the way postpartum care is offered. Health professionals have an obligation to focus on promoting mothers' abilities to transition to motherhood, normalising rather than pathologising mothers' emotional responses and mothering behaviours.

Furthermore, the health system has a duty to prioritise maternal care as a separate entity rather than the mother being perceived as an extension of her baby. The study provides Australian and international health care professionals with further guidance and recommendations to ensure mothers have the best experience of motherhood thereby safeguarding their emotional wellbeing.

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## Abbreviations

<b>PND</b>	Postnatal depression
<b>EPDS</b>	Edinburgh postnatal depression scale
<b>PPD</b>	Postpartal depression
<b>DSM</b>	Diagnostic and statistical manual of mental disorders

# Chapter 1

## Introduction

*“The world is not what I think, but what I live through. I am open to the world, I have no doubt that I am in communication with it, but I do not possess it; it is inexhaustible”*

(Merleau-Ponty, *Phenomenology of Perception*, 1962, xviii-xix).

The first twelve months following birth presents mothers with numerous physical, emotional and social challenges that may be both welcomed and unwelcomed. Irrespective of whether situations are welcomed or not, mothers recognise that in order to adapt and adjust to situations at hand, they need to be aware of and understand their own emotions. However, some of these challenges can place the woman’s emotional wellbeing at risk. Emotional wellbeing is a subjective experience embodied through society. It is a feeling(s), a tension, a balance, premised on a continuum of possibilities. Currently, both Western society and scholarly literature tends to conceptualise disequilibrium within mothers’ emotional wellbeing in terms of postnatal depression (PND) including examining its antecedents, possible consequences, treatment and management plans. Western society’s social expectations suggest that the experience of motherhood in the first twelve months is continuously happy and easy. Historically, maternal emotional responses deviating from this expectation have been medicalised, and thus objectified, suggesting that mothers with PND are not able to function and put their baby at risk in daily life.

However, this conceptualisation limits the wide scope of reasons for a mother’s emotional wellbeing. Conceptualising PND does not consider the unpredictability of the everyday situation, the physiological and emotional variations of mother and baby, preconditioning of social influences of mothering, nor the expectations of mother and/or family. Furthermore, Western society socialises mothers to believe that any disruption to this wellbeing and having PND is inherently a negative experience, that it is associated with self-harm and harm directed to a baby, and indeed any emotion that suggests a non-adaptation to their new situation is considered unfavourable.

However, maintaining a sense of perspective cannot be imposed by another - it must be felt, and thus lived, by the mother. With mothering comes a constant questioning of whether mothering behaviours are acceptable and appropriate for the baby. This sense of having to adapt and live very much in the present, whilst still maintaining a focus on the future is a constantly creative process; there is a challenge in anticipating the needs of those around you in order for (your) life to continue its flow with mutually harmonious outcomes. The emotional wellbeing disequilibrium felt by mothers which Western society may medicalise as PND may instead be an inherent part of the shifting process from woman to mother. If we understand this shift as a natural flow of adaption we would better facilitate support for mothers' emotional wellbeing.

Therefore, the intent of this thesis is to apply Maurice Merleau-Ponty's phenomenology of perception to mothers' emotional wellbeing in the first year postpartum, using his concepts of perception, the body and embodiment, thereby understanding the breadth and variation of the mothers' interpretations of their own emotional wellbeing and adjustments to motherhood. The thesis demonstrates that mothers' experiences of emotional wellbeing are founded in ambiguity and unpredictability. It takes the position that experiencing a range of emotions, including PND, are ways of living in the world and the study aims to analyse the similarities and differences in the mothers' perceptions of their wellbeing, their embodiment of wellbeing and their bodily experiences during the first year of motherhood. The thesis progresses in three stages, with phenomenology threaded throughout. The first stage provides background information to a phenomenological framework for understanding maternal emotional wellbeing in the first year postpartum. It also highlights key aspects of Merleau-Ponty's phenomenology and its relevance in understanding maternal emotions during that period. The second stage draws on phenomenology as a research method, with particular reference to how this study applies descriptive phenomenology. The third stage of the thesis unites the first two stages into a phenomenological description of the lived experience of having or not having experienced PND. The third stage is orientated toward understanding how emotional wellbeing, including PND, can be utilised as a means of supporting mothers in the first twelve months postpartum.

## 1.1 Background

While every pregnancy, birth and first year postpartum is unique, the natural course of being pregnant and giving birth is to some extent a pre-determined process whereby a woman conceives, her body changes and adapts to facilitate the growth and birth of a new life. This physical and psychological capacity is a phenomenon that is taken for granted or is seemingly absorbed in the transition from non-pregnant to pregnant state. The process (of pregnancy) is predictable in its unfolding, yet it is steeped in ambiguity as a woman cannot predict how she will respond physiologically or emotionally to the pregnancy, birth or the postpartum period. Mothering in the first year postpartum is influenced by prior experience, genetics and conditioning drawn from social influences and culture. The experience of early mothering is unique; it can be simultaneously natural, simple, complex, complicated, predictable or unpredictable. Even though a mother knows what *should* happen, it does not necessarily mean that it *will happen*; for example, listening to anecdotal accounts or reading from textbooks will give her some insight into what to expect, but these sources will never be able to fully inform her of the sensations and intimate details of her imminent experiences. Neither will she know what to expect from her experiences of breastfeeding over the course of twelve months when a change from very regular feeds to intermittent feeds occurs, due to the changing needs of the baby or of her own circumstances.

The importance of understanding the everyday experiences, such as the daily demands of mothering, the pressures experienced, the routines established, the creation of a positive habit for baby growth and development, plus the development of personal habit, all contribute to a mother's perceptions of her own emotional wellbeing. The phenomena of being emotionally well or having PND in the first twelve months are experiences of life and ways of living in the world. Maurice Merleau-Ponty's phenomenology of perception, in particular his conception of embodiment (the biological/physical/mental body and the lived body), is uniquely suited to describing emotional wellbeing experiences as lived by the mother, the meanings attached to their emotional responses and general coping and adaptation in daily life. Merleau-Ponty (1962) describes embodiment as a person's being-in-the-world. This means that people's actions and experiences are one; the physical body and its physiological systems are all components contributing to its makeup. The sympathetic and parasympathetic nervous systems' roles in sensing and responding to the environment

are critical processes becoming activated in response to perception (Valle & Halling, 1989). In fearful or stressful situations the person may manifest an increase in heart rate or blood pressure, yet the individual is able to exercise active control in selecting what the senses receive, and what they choose to focus on. This embodied response promotes an adaptive reply to the immediate and on-going changing environment; a process of dynamic negotiation is undertaken by the individual. For example, a mother who is unable to settle her crying baby undertakes a series of routines in order to eliminate possible physical reasons for the baby's crying. Chapter 2 of the thesis further explores the significance of perception, the body and embodiment, and briefly explores the development of the medical gaze as related to PND.

Scientific investigations over the last fifty years have sought to identify the antecedents, triggers and predictors of PND, focussing on hypothesis formulation to explain and account for these variables. The investigations have promoted a linear temporality in order to explain cause/effect relationships. Furthermore, phenomena in empirical studies are reduced and quantified in order to be observed and measured. However, for PND, it is not plausible to apply experimental processes to understand why variables affect it. Despite this, scientific investigations exploring causation have resulted in a wide range of antecedents being linked with PND. This is further discussed in Chapter 3. In addition, confusion arises when measurement of a phenomenon is undertaken if an exact definition of the phenomenon is not clear. As Michael Lewis (1972) argues,

*because of the unwillingness to deal with introspective description, investigators have been forced to define state in terms of organism behaviour, which they believe accurately reflects some underlying condition...definition start with state...giving way to taxonomy, [and] replaced by measurement of specific behaviours (p. 96).*

In order to better understand mothers and their experiences of PND (or emotional wellbeing generally) study approaches that complement human experience and human behaviour are more appropriate. For example, PND is a phenomenon that can occur for a mother at any time from the birth of her baby. The *Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013)* defines the measurement period for PND from birth to 12 months, however mothers can experience PND beyond this time, at any stage along this time continuum

and with varying degrees of intensity. Therefore, considering emotional wellbeing, and all its variances, as a way of living is a far more useful framework than taking account of such variances as potential illness. Chapter 2 of the thesis continues exploring the measurement processes of PND.

Pregnancy and childbirth, which are generally recognised as normal life events, seem to have become mechanical processes where the focus is on physiological management (Liamputtong, 2007). The health care provider concurrently undertakes ongoing monitoring and care of the unborn foetus and the pregnancy. Thus, the changing worlds of science, technology, economics and accountability feature far more prominently during the antenatal period than the postpartum period. In applying Merleau-Ponty's concept of body (biological/physical body and lived body) to maternal identity, it is as if the obvious visibility of a pregnant woman's body is transformed into the invisible postpartum body. The woman has changed from being physiologically unified with the unborn baby to a discrete relationship as mother and baby following birth. Despite this physical separation, she remains connected with her baby in her role of mothering through the tasks of nurturing and caring.

The visible pregnant body evokes social and medical attention from the world regardless of the mixed emotions a mother may feel at the prospect of motherhood. In the postpartum period, her body morphs into another function where she no longer functions as a carrier of life but she is her own body. She may or may not fulfil her bodily potential to breastfeed or nurture the baby, or may not realise the physical demands of time and energy required to care for the baby and her family; she may rank her own needs last. The body schema becomes altered from accommodating the baby first within and then externally to herself yet within her close environment, thus extending her body schema. Whilst a mother's senses and actions are activated, there may be no awareness, permission or emotional space and time to gauge her new stance in her world that develops progressively. She may or may not be given the opportunity to express what she feels, and is expected by necessity to embrace her next new situation while not necessarily having reconciled or understood the previous experience (for example, the birth). That is, she is in constant motion caring for her baby and in order to cope she may inhibit or suppress her own emotions. It may be that she will remain attached to the social ideal of being the perfect mother by having the perfect birth or the perfect postnatal experience. Such notions suggest that women



judge that 'right' or 'wrong' experiences exist in birth and the first year postpartum, that is for example, that they can have the right/perfect birth(ing experience) or the wrong postnatal support. However, it is more likely that situations present with experiences that are simultaneously 'right and wrong', 'good and bad' or 'positive and negative'. Situations, as they unfold, are neutral in a way that the body experiences them, yet the bodily feeling in response to that experience is not neutral,<sup>1</sup> bodily responses and reactions are presupposed by one's world. This being-in-the-world reflects Merleau-Ponty's phenomenology of perception.

The experience of PND is described as an unexpected negative expression of feeling detached or separated from her baby or a feeling of being overwhelmed, feeling 'worn out' and a feeling that she cannot control - a 'slipping into'. In contrast, a woman who feels emotionally well focuses on the baby and her-self as one, rather than dwelling on unexpected emotions or expressions that solely relate either to herself or her baby. For Merleau-Ponty, perceptual experience comes from the body *itself* that is to feel a certain way about something is to perceive it in that way.<sup>2</sup> So, a mother who *feels* fatigue will perceive herself to be fatigued, just as a mother who *feels* that she has PND will perceive herself to have PND. However, there is a complexity in perceiving oneself to have PND and then having this state confirmed and medicalised by a clinical diagnosis. These perceptions of PND and emotional wellbeing fall within both a social/cultural model of health where PND/emotional wellbeing is identified by environmental and social factors, as well as a biomedical model of illness (Coates, Ayers, & de Visser, 2014; Regus, 2007; Shaikh & Kauppi, 2015; Shaw 2013).<sup>3</sup> Understandably, the formality of a PND clinical diagnosis can be confronting to the mother by the very nature of reaching that diagnosis, whereas a self-diagnosis of the

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<sup>1</sup> Merleau-Ponty in *Phenomenology of Perception* differentiates between the ideas of *for itself* and the *in itself*. He says that "perception takes place in a situation of generality and is presented to us anonymously; my perception, even when seen from inside, expresses a given situation: I can see blue because I am *sensitive* to colours, whereas personal acts create a situation: I am a mathematician because I have decided to be one. So, if I wanted to render precisely the perceptual experience, I ought to say that *one perceives* in me, and not that I perceive" (Merleau-Ponty, 2002, p. 250).

<sup>2</sup> Merleau-Ponty says that "sensation can be anonymous only because it is incomplete. The person who sees and the one who touches is not exactly myself, because the visible and the tangible worlds are not the world in its entirety. When I see an object, I always feel that there is a portion of being beyond what I see at this moment, not only as regards visible being, but also as regards what is tangible or audible" (Merleau-Ponty 2002, p. 251).

<sup>3</sup> Aho (2008) discusses how medicalisation in psychiatry has shifted the focus of interpreting the everyday emotional suffering and behaviour from a normal phenomenon to a medical condition. This shift in foundation suggests a likely entry point for which women's emotional experiences in the postpartum are made to believe they are abnormal.

condition seems less threatening, partly because there is still an element of doubt to having PND and the possibility of managing it without others knowing about it.

Several authors have argued that the basis of self-diagnosis or self-labelling occurs as a consequence of PND's vague definition (Aho, 2008; Chrisler, 2011; Chrisler & Johnston-Robeldo, 2002;; Nicolson, 1991; Shaikh & Kauppi, 2015). This is further explained in relation to how women see in themselves *aspects* of the characteristics by which PND is represented. It is in this way they substantiate and construct their own perceptions of their experiences. They attribute their feelings and behaviours to having PND. The key social assumptions in Western society are that in motherhood a mother has control over her body and life, will enjoy motherhood and will automatically adjust to a new lifestyle (Shaik & Kauppi, 2015). This scenario is promoted by society and therefore expected by mothers. However, there is an equal likelihood of a woman having to face variations and unpredictability in her emotions. This scenario, however, is not promoted as being a healthy norm even though physiologically it can be an expected behaviour. Mothers, in the context of mothering, do not always account for responses such as irritability, anger or exhaustion as being a consequence of the 'job', rather they perceive themselves as showing signs of vulnerability and attribute this to having PND. Hence, they self-diagnose and emotional disequilibrium becomes disease.

In contrast to disequilibrium existing within a disease-based framework, understanding emotional wellbeing in the postpartum period through the lens of Merleau-Ponty's concept of embodiment highlights the complexity of mothers' passages through time and space. Their transition involves ongoing physical and emotional changes, and continual adjustment and adaptation to their new lifestyle. It is the impact of sociocultural norms that lead mothers to develop expectations of themselves in their adjustment to motherhood (Mason, Rice, & Records, 2005). This adjustment is multifaceted in that it encompasses learning a new life for self, and literally, for a new baby, evolving into a new lived world, accommodating family and societal expectations and values all within a finite period of twelve months. This time period cannot fully capture the daily experience and the coping required to meet these demands.

Often the ideals of personal goals and motivations are challenged by reality. For example, the current *Australian National Breastfeeding Strategy: 2019 and Beyond* recommend that "breastfeeding provides mothers and babies with many benefits and is

a key contributor to lifelong health...and recommend exclusive breastfeeding of infants to around six months of age” (Australian Government Department of Health, 2019, para. 1). In practical measures, this means about 8 to 12 breast feeds per day, for 6 months. Logistically, this representation of the physical demands on, and expectations for, a new mother can be overwhelming, particularly when the realisation dawns that breastfeeding is merely *one* of the many daily tasks to which she must attend. Adjusting and adapting to motherhood and the needs of a baby are characterised by fluctuations of 'good days' and 'bad days'. 'Good days' occur when the baby is well, sleeps and the mother has opportunity to rest and care for herself. 'Bad days' are those when the baby does not settle, does not sleep and requires a lot of attention so that the opportunity for her own self-care is not readily available. In the latter, she may be fraught with fatigue and may doubt her capacity to mother. As Eric Matthews (2006) states of Merleau-Ponty,

*we experience...[our body] ...and those of other people, not as bits of machinery, but as the expression of a human person...of being-in-the-world...[and] interacting with and finding significance in the objects and people in the surrounding environment...[influenced by] the structures of the human body (p. 194).*

Thus, this relationship of being-in-the-world is a reciprocal taking up and letting go of emotions in relation to her actions of attending to the baby. A mother's embodied response to a changing environment, such as the baby crying, is to form new patterns of behaviour that evolve into habits. This adaptation is ongoing and a continued re-adaptation to the changing environment is evident allowing the flow of the orders of the body. Adapting and re-adapting is beneficial for self-preservation but not always evident in times of stress and uncertainty. Situations of continual distress can counteract physiological mechanisms, such as the parasympathetic nervous system whose role is to automatically rebalance the body's physiological responses (Trimble & George, 2010). A hypervigilant state inhibits the formation of coping processes as mothers focus on haphazard solutions rather than noticing patterns of behaviour in the changing environment. This means that it becomes more difficult for her to establish routines when her world is immediate and unpredictable. Whilst this is also representative of the formation of habit, it is considered an unproductive habit.

Merleau-Ponty discusses "the acquisition of habit as a rearrangement and renewal of the body schema... [which] brings together...component actions, reactions

and 'stimuli' is not... [an] external process of association" (p. 164). He argues that habit is evidenced in motor significance, which gives the body its intentionality. He cites the example of the woman with the feather in her hat, and how the hat and feather become an extension of her body schema so that she can protect and prevent it from being damaged. Likewise, a mother who attends to the needs of her baby at night negotiates her immediate surroundings in the dark by feeling, remembering and sensing her space. In time, she becomes attuned to her baby's needs and her own body responses and is able to anticipate and act on those signals. In this way, she responds to her baby by establishing a habit. The formulation of habit contributes positively to emotional wellbeing when actions and reactions become intuitive; this automatic response gives confidence and certainty in behaviour. When actions and reactions are ambiguous or out of flow, they can create a sense of helplessness, estrangement or impossibility, as uncertainty becomes heightened. In order to continue exploring these concepts, this thesis will now discuss Merleau-Ponty's ideas of perception, the body and embodiment and how they could be applied to mothers' emotional wellbeing.

## **1.2 Merleau-Ponty – An Introduction**

This thesis's central argument is that current conceptualisations of PND minimise the significant factors of perception, the body and embodiment. Furthermore, social expectations engender the idea that normal emotional disequilibrium related to a mother's experience in the first 12 months postpartum is abnormal, unwanted and unwelcomed. Merleau-Ponty's philosophy provides a salient perspective on perception, the body and embodiment to create a richer understanding of mothers' emotional experiences and transition to motherhood. Merleau-Ponty refers to the body as being comprised of three orders, which encompass the corporeal, the lived world and the social-cultural aspects. His conception of the body is holistic in nature so that each of the orders interrelates and present a unified being. The basis on which a person resonates with the world is understood as an intertwining of the person and the world.

This fundamental position is considered to be the body-subject, a person's unique imprint in the world.<sup>4</sup>

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<sup>4</sup> Ben Simpson in *Merleau-Ponty and Theology* highlights Merleau-Ponty's conceptions of the three orders: the physical, the living, and the mental/social. He says that the three orders are enmeshed, interrelated and founded within each other. See pages 12 – 17 of his text.

Merleau-Ponty differentiates the corporeal elements of the body and shows the first order of the body as being an integrated system, comprising physiology and matter (whilst reflective of the internal environment) as the outward appearance of being in the world. The internal environment functions automatically, to maintain its own equilibrium and stability in response to external influences of its environment. The self-regulation of the body, through complex feedback mechanisms, ensures its physiological and neurological balance to ensure health and wellbeing (Moore, Dalley, & Agur, 2018). This order is directed by laws of nature that can be measured and observed. For example, a woman's birth progress is assessed by the strength of uterine contractions that are influenced by multiple factors, including and not exclusive to the position of the baby in utero. Uterine contractions are directed by the sympathetic hormones of the body, the hormones over which a woman has no conscious control. She simply responds to pain. This order is also evident in milk production where for lactation to occur the hormones oestrogen and progesterone are required to fall to a suitable level for the production of prolactin. These hormonal feedback systems that are initiated by the body are functions of the body independent of conscious control. Such processes, whether they relate to the contractility of the uterus and a woman's response and coping to this contractility, or the hormonal feedback mechanism required for breastfeeding are processes not independent of each other but react in response to the baby being born (Moore et al., 2018). The first order seeks to maintain stable bodily functions, where the body on the one hand has systems for dealing with stress, such as the fight or flight response, and on the other hand has properties by which it is able to conserve energy and self-regulate and maintains its own equilibrium within physiological processes (Moore et al., 2018).

In the second order, Merleau-Ponty describes the lived body as a dynamic interaction and existence of the person (subject) with the world. In this order, there is a constant adaptation and response, as well as expansion and contraction to the experience of living. The subject is active in synthesising or making sense of the world, or the experience of itself in the world (Simpson, 2014). The lived body, a first person experience, includes the physical/biological body as previously described where the body is the subject. By this Merleau-Ponty means that it is the body experience of the person as experienced by them-self. Havi Carel in her chapter in the *Phenomenology of Sociality* (2016) says that it is this order that gives light to illness as opposed to disease.

Such a notion proposes that women in the postpartum are sensitive to labels imposed on their feelings and responses which are suggestive of an altered interaction with themselves and their baby (Coates et al., 2014; Matthey, Barnett, Howie, & Kavanagh, 2003; O'Hara & McCabe, 2013). Scope, Booth, and Sutcliffe's (2012) systematic review of 116 papers from 1966-2008 found that group support provided a means for women to share their feelings and develop ways of coping, and was considered of value for women with PND. Groups were also seen as a mechanism for overcoming health seeking delay. This practice of peer sharing and exchange is an example of adapting to a new experience. Merleau-Ponty comments on the significance of adaptive coping as a mechanism for survival in one's (new) lived world. He illustrates this in his example of the grasshopper that has lost a leg. He explains that the grasshopper adjusts its other legs and body movements to compensate for the loss of one appendage in order to survive. The adaptive behaviour demonstrates bodily subjectivity. Whilst research has recommended peer social support to assist new mothers (Coates et al., 2014), there is presupposition in this that mothers will willingly and readily share their experiences/feelings with a peer group. Consideration must be given to the vulnerability of the participants who at any particular time may or may not be ready to disclose how they feel. Furthermore, to participate and disclose to a peer group who may hold differing social values may prevent the mother from engaging and may be counteractive to her wellbeing.

The second order represents the engagement of mother with her world; mothers' bodily subjectivity can be both observed and expressed by them-selves, and there is great variation in the depth and breadth of such experience and adaptation. This order is where Merleau-Ponty's idea of mutual dependency of subject and the world (environment) is highlighted. For understanding to occur, the subject must be considered in relation to the world she takes up. Her reactions are reflective of the way she perceives items in her environment to be significant and of the value she places on them. Therefore, in the case of a mother who seeks the support of her friendship circle she looks to them to help her maintain the status within the group. If this does not occur, she (by necessity) adapts and establishes a new circle. Adapting to the demands of her baby requires an openness to accept change and to relinquish the restrictions of being in control. This can be observed with breastfeeding, where it is normal for a new born baby to feed between eight to twelve times within a 24 hour period. A mother is

not able to predict the physical and emotional consequences that this feeding routine will have on herself within one 24 hour period, let alone this routine as an ongoing requirement of attending to her baby, thus creating disequilibrium.

The third order is the human order, and relates to the mind and the social cultural context. Within this order, the subjectivity and identity of self exists in relation to others, as others exist true to their own existence and in relation to me (the self) (Merleau-Ponty, 2002; Simpson, 2014). This sense of experience that is within and outside of the person has a fluidity that allows aspects of the world to inform the person. It could almost be conceived as the cellular wall of existence, where osmotic pressures govern the molecules that enter or exist in its sphere. This permeation of interrelated experience is cross-cultural and non-determinate. The world as an indeterminate and dynamic existence reflects the indeterminate and dynamic subjective identity of the person. It could be argued that the world is perceived as both safe and protective, or as a place of alienation and hostility. For a new mother, this means that she must rediscover herself in her own experience. Merleau-Ponty's third order holds significance for mothers in relation to their identity of being a mother, and in their experience of their own emotional wellbeing in mothering. The social(ly) constructed realities of mothers and mothering informs her and she embodies these categories in the way she expresses and experiences herself and her mothering. The social cultural values, behaviours and ideals of mothering, her being-in-the-world, the potential for choice, including the possibilities of having negative or detrimental experiences that affect her health and wellbeing are ever present in her world without her having to consciously look for them. The world reflects experiences; it is the judgements labelled as 'good' or 'bad' in relation to these experiences that determine how they are perceived and impacted. This requires her to open herself to possibilities of the world, and to herself. The fluidity of identity within the mother allows the filtration of social ideals from, and bonding with, her community. Where her identity is too fluid or too fixed there is no form to the content she filters and the potential for disengagement and disconnect from her community occurs. She is confronted with choice, for example to conform to the norms in her community, to self-preserve by temporarily disconnecting, or to find another community and rediscover her world. She questions her identity. Essentially, the individual exists and engages within their

own particular social/cultural context and it is through this context that norms, behaviours, values and mores are expressed.

Merleau-Ponty suggests that the fundamental premise of the three orders is their interrelated nature to form the whole. The whole comprises a mutual dependency of the three orders, not the whole as reflected by the sum of its parts. This suggests a complementary relationship between the orders where one is no more important than the other (Merleau-Ponty, 2002). This harmonising existence is an intertwining phenomenon. A woman pregnant with her unborn baby is a perfect example of the intertwining phenomena where each expresses the other's existence. While Merleau-Ponty suggests that the three orders are of equal importance to each other and whilst they relate to each other, they also hold value individually. The lower order presupposes the middle and higher order, and becomes the vehicle for the world because of its sensory capacity and intuitive interpretation of stimulus (Merleau-Ponty, 2002). The higher order is essential for transcendence to be possible since the higher order is the experience of life in the physical (Merleau-Ponty, 2002). An example of this is the stress a mother may feel when she is unsuccessful in comforting her unsettled baby. As she reworks the usual baby comfort strategies, she knows that her concerns are escalating and that she needs to take some action, but is uncertain of what to do. Her tensions build and whilst she may take a moment to reflect on her situation, she must refocus in order to reconcile the situation. Transformation, which is essential for the lived world, occurs when the self takes on new meaning. The higher order is part of the lower order; it exists to allow the authentic expression of the person. For example, irrespective of physical or intellectual capacity, the individual participates in life that is appropriate for her own existence. The higher order identifies with the lower order as a synergistic flow between the two; they are reciprocally engaged with each other, pregnant (full and life-giving) with their uniqueness (Merleau-Ponty, 2002).

This thesis contends that the basis of the three orders is to maintain flow in existence and that when the subject resists the natural rhythm of experiences, the self becomes unbalanced and one order dominates the others. This imbalance becomes manifest in the subject as she lives her beliefs and ideals of the lived world - *not* in the reality of the world (situation). Her state of being is altered and she is sad or depressed. Thus, to focus on reality means that the subject has to examine her self-beliefs and related behaviours. When a mother identifies with being emotionally well, irrespective



of the personal situation, she describes being free of inner conflicts, she feels in harmony with the world and with herself (and with the demands of mothering). Whether or not she experiences difficulty in her daily (and nightly) mothering role she focusses on responding to the present situation in which she is immersed. She lives perfectly within her moment; she does not dwell on the past nor anticipates the future. This experience of being-in-the-moment frees her of and from emotion and thought as she focuses on the tasks at hand required by *that* situation. She freely moves and responds to the demands, burdens and joys of the next situation. Irrespective of a mother's emotional wellbeing, all experiences are temporary states brought on by particular situations directly related to her and her mothering. Therefore, the holding on to particular experiences can have a detrimental effect on emotional wellbeing.

Merleau-Ponty's *Phenomenology of Perception* states that thinking exists in action in ways that the body understands its situation and its own possibilities, before investing attention to the action. That is, phenomenology is more than cognitive consciousness; it is an embodied existence with shared communication that precedes the basis of an approach of collective focus. With this understanding, he argues that the world and consciousness are mutually dependent parts of a whole. By this he means that the body (I) is part of the world and that the world is a continuation of its body. He argues that 'objective thought' is the dominant way of thinking about the world, and that because of this conceptual schemes pre-exist in the world. By examining the shortcomings of objective thought, Merleau-Ponty says it is possible to formulate a new conceptual frame of existential living. Applying this thought to the PND experience where a negative birth experience is considered to be an antecedent for PND, it holds that this generalisation cannot be made because, as research shows, not all women who have such an experience develop PND. The category of giving birth as a predictor for PND is simplifying the birthing process to the status of an object. Furthermore, accessibility of health information available through social resources promotes women's emotional wellbeing to be pathologised through reporting statistics, facts or data that objectifies PND. Merleau-Ponty's unique concept of the body taking on the role of both subject and object and being unified with the world, had not been fully explored by his peers although it is touched on by Jean Paul Sartre, Simone de Beauvoir, and Gabriel Marcel.

In the *Structure of Behaviour* (1963), Merleau-Ponty discusses the kinetic melody of the body, and that behaviour is integrated and synergistically flows within and through the body. For Merleau-Ponty, the body, both biological and lived, is whole; there may be component experiences or parts to the body, but these component parts do not define the whole. Only the whole can be whole. For example, an engine, whilst part of a car, is not recognised as a car. Likewise, the body exists as a whole; it functions and integrates itself and through itself for the purpose of being a subject in the world. In the situation when the subject is reacting to an expectation outside of herself and what is realistically possible, her expression of behaviours is manifested through the body and bodily language that is not purposefully expressed, a change in verbal tone and pitch of voice, or expression of emotion. As a result, do others in the world treat the subject as a fractured being? This judgement may cause more disharmony for the individual. Depression and PND behaviours show that social withdrawal and isolation are common manifestations of the individual (Coplan & Bowker, 2014; Mauthner, 1995; Ni & Siew Lin, 2011; Sikorski et al., 2018). Treatment therapies to minimise these isolating behaviours included the establishment and participation in community maternal social support groups, educating mothers about expected child development and community related mother and baby activities. These groups aim to foster individual behavioural engagement. Merleau-Ponty supports the scientific study of behaviour but only when an embodied perspective is taken (Spiegelberg, 1978).

As follows phenomenologically Merleau-Ponty believes the world reveals itself to the individual and the individual reveals herself to the world in a complementary and mutually dependent way. He says that this intertwining of self and the world is inseparable. Therefore Merleau-Ponty's ideas of the body and embodiment can give insight to mother's emotional responses in the first twelve months following birth. This is discussed in the following section.

### **1.3 Merleau-Ponty and Postnatal Depression**

Benoist and Cathebras (1993) argue that the emergence of the biological body, as an object of science, has resulted in isolating the body from the subject's experience. A woman with PND may report a variety of physical and emotional disturbances which include sadness, fatigue, insomnia, appetite changes, reduced

libido, crying episodes, anxiety, irritability and non-coping (Beck, 2008; Leahy-Warren & McCarthy, 2007). She could exist and experience an altered perception of herself within her own world; and perceive her world differently to others; she lives and experiences *her* world not *the* world of others. Consequently, the woman lives within what others ascribe to her and of her and in this way she shapes and re-shapes her thinking and behaviour.

However, Merleau-Ponty argued that identity is perpetually embodied, in this sense it is both historical and contemporary, and it is shaped by the cultural and social contexts of society and thus can be variable (Murphy, 2008). From a PND perspective, this is important as perceptions of self as a woman and a mother are historically embedded in social and cultural contexts. The dynamic changes of history, expectation, transition, experience of motherhood and changing norms can lead to an acceptance that experiencing emotional upheaval and disequilibrium such as PND is a 'new normal' experience, adding another dimension of complexity that is not always beneficial to the self. That is, it introduces a new aspect that the individual might need to make meaning of and causes confusion in relating herself to the world. Merleau-Ponty's view highlights that existence is characterised by an intertwining between subject and world, and that existence precedes meaning.

Merleau-Ponty's conception of body, lived and biological, is of particular relevance to postnatal women given the physical, physiological and emotional re-adjustments and new beginnings required following childbirth. To Merleau-Ponty, the body is both subject and object, and the central focus of the body in the lived experience is to make meaning of the engagement of the body with the world. The experience of 'body as subject' is influenced by self and others in relation to language, motion, change and action on an interpersonal level and thus is situated in the world. The subject senses and perceives in their own world and the world of others at a particular place and time, and from a precise perspective. As Merleau-Ponty (2002) states - to be within the world is to be an object: either a physical or a material object.

In contrast to biomedical frameworks, according to Merleau-Ponty illness reveals itself as an absence of proper function of the objective body and as changed access to the world. In essence, what one projects, anticipates and does in the world is altered and the sense of oneself changes (Merleau-Ponty, 2002). The body

accommodates to this change and forms different habits and projections of being-in-the-world that continues with a different but engaged presence in the world. This mechanistic element of body and change then becomes one's lived experience of the world, a constant negotiation and re-negotiation of the self within the world, which occurs as a result of perception (Merleau-Ponty, 2002).

For women who suffer with PND their being-in-the-world alters. How they negotiate change and interpret ambiguity can be manifested as suspended or inhibited intention and thus altered responses in action or non-action. Merleau-Ponty refers to this as motor intentionality, where intention is fundamental to understanding, because this act of doing establishes our relationship to the world (Marshall, 2008). Essentially, intention and meaning merge into movement or action (Marshall, 2008; Merleau-Ponty, 2002). Merleau-Ponty sees intentionality as a consciousness of a world already present to which one is continually directed, and asserts that the world cannot be possessed or embraced.

The expectation of a mother who has recently given birth is that her world will change. This altered world will present with ambiguities and undefined situations, that is, she is aware that things will change but she is not sure how, why or when. Consequently, as a mother, she knows that she will perform her responsibilities as needed and wanted and she hopes that she will anticipate the needs of her baby. However, she will not be able to actualise these beliefs until she progresses into the mothering role. She recognises that the mothering role will require her to distinguish between the practical daily ambiguities of attending to the baby as well as managing her personal responses to her own needs. A mother's responses to the expected ambiguities reflect her flexibility in prioritising, coping and adapting to a new situation and may manifest in her emotional wellbeing. The complexity of integrating tasks and roles is a determinant of a mother's adaptation. For a mother adapting to evolving situations enables her to reprioritise her tasks and to take a 'big picture' approach to her day. This eventually manifests as emotional wellbeing. Alternatively, a mother who is unable to integrate tasks risks being overwhelmed as each discrete task becomes her focus, rather than understanding that all tasks will intertwine and evolve. Coping with ambiguity and adapting to evolving situations may influence behaviours that in turn influence self-belief and identity.

Merleau-Ponty proposed that meaningful reflection only occurs after action that subsequently influences the self in being-in-the world. Accordingly, the experience of being-in-the-world gives opportunity for self-transcendence (Merleau-Ponty, 2002). When PND is experienced the process of reflective existence does not take place; a woman's experience of being-in-the-world is overwhelmingly negative and a spiralling out of control is often reported (Beck, 2008). In such circumstances, the capacity for self-awareness is compromised. It is as if an independent thought or person is necessary to guide and support her progress into the immediate and short term. This situation of disembodiment is manifested through the expression of emotions.

In an attempt to safeguard emotional wellbeing in the first 12 months postpartum, historical and contemporary health knowledge and research outcomes reveal the complexities and struggles of new mothers' experiences. The plethora of research and the social awareness and acceptance of PND contributes to the idea that it is likely new mothers will succumb to this condition. Thus, it appears that for health professionals, the best means for determining mothers at risk of PND is to focus on screening their recent negative emotions rather than focusing on happy moods and experiences, further conceptualising emotional disequilibrium as inherently disordered and undesirable. Viewing emotional disequilibrium/PND, as disordered and undesirable is problematical for the mother and the health care professional in the screening process, where PND is observed as an object rather than Merleau-Ponty's perspective of an embodied experience.

#### **1.4 Screening and Maternal Emotional Wellbeing**

Saxby Pridmore in her chapter the "Medicalisation (Psychiatricization) of Distress" (2018) describes the medicalisation of daily life, whereby 'normal' human behaviour and experience are reframed as medical conditions; for example, smoking is referred to as nicotine dependence or shyness as social anxiety disorder. He draws attention to claims that birth and death have become medicalised. In light of Shaw's (2013) insights on the medicalisation of birth and midwifery as resistance, we are reminded of the importance of safeguarding women's journeys in the postpartum year. When attention is focussed solely on screening for emotional wellbeing, we risk objectifying and changing what are normal behaviours into pathological disordered ones. Shaw refers to Bergeron (2007) who argues that "when the normality of

childbirth changes and birth becomes an event to be medically managed, a woman's confidence in her ability to give birth naturally risks being lost" (p. 528). Many competing and complex factors contribute to the pros and cons of medicalising birth, yet key to this argument is ensuring that women (and their babies) are the central focus of care. Similarly when women's experiences in the postpartum year are limited to the assessment of maternal mood in terms of disorder (Matthey, Della-Vedova, & Agostini, 2017), we draw away from the relevance of whole life by dissecting features of her life as discrete entities rather than seeing herself as a whole. Matthey et al. (2017) draw attention to the limitations of the questions within the Edinburgh Postnatal Depression Scale (EPDS) and the range of possible explanations for responses. The limitations and cautionary notes of using the EPDS in screening processes are discussed further in Chapter 2 in relation to theoretical perspectives and Chapter 3 in relation to research outcomes for health.

Physical and psychological screening processes, such as the EPDS are designed to determine emotional wellbeing; however, they may generate feelings of vulnerability for some women. There are fundamental problems associated with psychiatric (mental health) assessments that measure parameters such as emotional wellbeing (Aho, 2008; Davis, Pearlstein, Stuart, O'Hara, & Zlotnick, 2013; Jablensky, 2016; Mann & Gilbody, 2011; Matthey, 2010; Matthey & Agostini, 2017; Morstyn, 2013). Problems include the absence of objective biological measures and the use of behavioural measures derived from psychometric scales as a substitute for biological measures. In addition, the statistical score that is applied to the psychometric tests does not take into account an individual's interpretation of the questions, but rather focuses on the statistical significance. This can create uncertain data (Davis et al., 2013; Matthey & Agostini, 2017; Morstyn, 2013). As Morstyn (2013) espoused "when two patients mark an item the same way on a psychometric test, this behaviour may have many vastly different underlying 'true' meanings, but will be scored the same for statistical analysis" (p. 312). In contrast, adopting a phenomenological perspective would *explore* the difference between the two responses. In a scenario where two mothers with vastly different contextual settings and histories score an equal answer to a question such as "In the past 7 days I have been able to laugh and see the funny side of things", their reasons for doing so would be based on very different experiences whilst recalling vastly different scenarios. Therefore, using Merleau-Ponty's

conceptualisations of an embodied self in the world can give greater insight to the lived daily experience of mothers to understanding mothers' experiences of emotional disequilibrium within the first 12 months and reframe emotional wellbeing in terms of strengths rather than disorder.

Matthey (2010) critically questions the prevalence rates of PND and the percentage of women deemed high risk following screening as a result of both the methods applied during screening and the inherent properties of the EPDS. Reporting probable depression by a cut-off score (in this case the EPDS cut-off is 13) is misleading as the positive predictive value is only 50%. This suggests that the odds of a high score on the EPDS is not necessarily reflective of depression, it is *probable* or *likely* depression rather than a definitive outcome. Secondly, using a single administration of the scale versus conducting a second administration two weeks later to ascertain the validity of the reading and to differentiate whether the emotional state is transient or enduring is not always evidenced in data. Thirdly, the properties of the EPDS do not discriminate between somatic symptoms that are mood related and those which reflect a general adjustment to motherhood. This leads to inflated reporting. After applying Bayes Theorem, others have also questioned the validity of the positive predictive value of the EPDS (Milgrom, Mendelsohn, & Gemmill, 2010). Therefore, it appears that the EPDS's current predominance as a method of ascertaining emotional wellbeing is unjustified and also leads us away from a true understanding of mothers' emotional wellbeing.

Marianna Szabó in her chapter on conceptual issues in abnormal psychology (2016) argues that whilst perceptions of normal and abnormal behaviours may be obvious to people within society, it is difficult to explain or quantify these differences. Often such judgements are based on a range of factors including personal values, prior experience and belief of appropriate behaviour for *that* situation. Defining a boundary between normal and abnormal behaviour is subjective to the woman, the environment and her situation. For example, a new mother may perceive herself to be abnormal because she feels awkward in talking to her baby. This awkwardness may relate to her personality or her beliefs and comfort levels in knowing how to relate to the baby, for example, using 'baby speak' versus 'adult speak' as recommended by the latest trends in child development. Another example of a mother perceiving herself to have abnormal emotion and behaviour is the recognition of her feelings of anger with the people around her. She is unable to recognise that the anger may be compounded by her tiredness and

inability to express her needs. In fact, these behaviours are normal responses yet the mother deems them as abnormal because she perceives the behaviour as being uncharacteristic of her usual personality/values or as being mismatched to what she has read, seen or heard about motherhood. A personal interpretation of normal versus abnormal behaviour is different to a medical definition. Szabo proposes that the elements - statistical rarity, deviance or norm violation, distress and dysfunction should be considered if differentiating between normal and abnormal behaviour. As a consequence of reading, seeing and hearing about what to expect from birth and mothering a woman judges her life in mirror to this information. If she perceives herself as not meeting these behaviours she may believe that her behaviour is abnormal or disordered, rather than as an inherent part of the transition from woman to mother.

Therefore, this thesis seeks to describe and analyse the perceptions of mothers' emotional wellbeing from a Merleau-Pontian perspective. For women who perceived themselves to have experienced PND was their being-in-the-world altered? Exploring PND and general emotional wellbeing from a phenomenological perspective moves away from conceptualising feelings and behaviours as disordered, as the majority of PND research literature does, and involves revealing the motivations and realities that a mother has of herself as a person and as a mother. The sense of being, growing and becoming are processes of mothering and may be understood from an existential perspective. In the first year postpartum, a mother's experience involves changes in daily life, changes that are integral to her identity and her being-in-the-world. She shifts her focus from a woman to a mother and baby, which means that she has a change in her relationship with the world. Descriptions, in the thesis, of perceptions and experiences of having or not having PND have applied Merleau-Ponty's themes of the body and embodiment. Included in this are altered bodily experiences; the range, breadth and depth of emotions; sense of agency and self; the experience of time; and relationships with others.

## **1.5 Summary of the Research Aims and Questions**

This thesis applies Merleau-Ponty's phenomenology of perception to the emotional wellbeing of mothers in their first year postpartum. The study involved mothers who perceived themselves to have been affected, or not, with PND in the first year following the birth of their baby. The overall aim of the study was to analyse the



sameness and difference in the mothers' perception of their wellbeing, their embodiment of wellbeing and their bodily experiences during the first year of motherhood. The specific aims of the study were to explain:

1. The differences between and within mothers who had and had not experienced PND.
2. The differences in the cultural and social perceptions of self and the self as a mother between mothers who had and had not experienced PND.
3. Mothers' perceptions and experiences of PND identified through the use of the commonly used screening tool, the Edinburgh Postnatal Depression Scale (EPDS).

## **1.6 Summary of the Chapters**

### **Chapter 2**

In order to provide a salient context for the study, Chapter 2 outlines the philosophy of Merleau-Ponty's phenomenology of perception. This is preceded by an exploration of Edmund Husserl's phenomenology since his contributions significantly informed Merleau-Ponty's phenomenology of perception. Merleau-Ponty's exploration of the body as an embodied agent is critical to understanding subjectivity and being in the world. This is followed by a justification for applying Merleau-Ponty's phenomenology in favour of applying the work of Simone de Beauvoir.

### **Chapter 3**

This chapter provides a detailed overview of discussion papers and research in relation to PND. This discussion includes consideration of women's emotional wellbeing and general postpartum adjustment experienced following childbirth. A review of the literature reveals that although a significant promotion of studies have endeavoured to explore the depth and extent of emotions and how they relate to the experience of PND, this disorder remains undetermined.

### **Chapter 4**

This chapter presents a description of the study design and discussion of phenomenology as a research method. The study's aims and objectives are outlined, as are the methods and procedures related to recruitment, data collection methods and ethical procedures. Data analysis using Giorgi's descriptive phenomenological method, which is premised on Merleau-Ponty's phenomenology, is described and explained.

## **Chapter 5**

Presented in this chapter are the personal biographies of the study participants. The stories provide the circumstances of the first 12 months following the birth, and the women's belief of why they had, or had not, experienced PND.

## **Chapter 6**

This chapter presents a detailed view of the data analysis process and the development of the themes and the steps undertaken to achieve this. It illustrates the processes of how rigor and trustworthiness of the data were ensured. Represented are the steps of descriptive phenomenology using the methods of Giorgi and Spiegelberg. These steps and processes of applying Merleau-Ponty's phenomenology of perception are outlined, and representation of this is included in the chapter. The development of the study themes is provided which gives insight to the researcher's decision-making trail.

## **Chapter 7**

This chapter explores the results and discussion of maternal embodiment and motor intentionality of mothers who had and had not perceived themselves to have PND in the first 12 months postpartum. The discussion involves Merleau-Ponty's philosophy of embodiment, the scientific literature and the participants' reflections. The chapter reveals the ambiguous nature of the body in health and illness.

## **Chapter 8**

Chapter 8 gives the results and discussion of the EPDS, which is the screening method applied to ascertain a woman's emotional wellbeing in the postpartum period. References are made to the sociological critique of method and measurement by Aaron Cicourel, and more contemporary research.

## **Chapter 9**

This chapter discusses the implications of the findings and makes recommendations for the practice setting. A general conclusion completes the thesis.

## Chapter 2

### Theoretical Framework

#### 2.1 Introduction to the chapter

This chapter sets the scene for understanding phenomenology and provides the framework for this study. Using phenomenology to understand mothers' emotional wellbeing in the first year postpartum can provide insight to better support their transition and adaptation to mothering. Phenomenology is the study and philosophy of the lived world, lived body and lived existence. Merleau-Ponty's phenomenology of perception is significant to mothers and health professionals to investigating mothers' emotional wellbeing as he discusses the active taking up of the world and the ways in which this occurs. Therefore, he says perception, a bodily experience, both enables one to inform and comprehend the world. Yet the concerns that one has is not necessarily based on science or rules, rather on ones experiences and feelings – where we interpret and substitute feeling in perception. If something *feels right* it is undertaken, if it *feels wrong* it is avoided. The use of feelings to determine action is both subjective and objective. Motivations and feelings may be driven by behaviours.

The fundamental challenge of understanding maternal wellbeing is that emotional wellbeing is interpreted as an objective measure of her engagement with the world. This perception of engagement is not a standard process for everyone, and presupposes that people can make unique, independent choices in their adaptations to life events. However, adaption is not always perceived as an episode or process of moving forward (in life): it is sometimes experienced as maintaining the status quo, or indeed perceived as a resistance or reversal of cultural norms.

Therefore, this chapter argues that emotional wellbeing and identifying with PND, is a bodily experience, and can be explained by Merleau-Ponty's phenomenology. The theoretical underpinning of Merleau-Ponty's phenomenology is informed by Edmund Husserl and this chapter contends that the exploration of emotional wellbeing goes beyond the idea of emotion, that to experience the world through our body is to live. PND has traditionally been explored through the feminine body. This chapter also argues why Merleau-Ponty's phenomenology, and not Simone

de Beauvoir's philosophy of the feminine body, offers a suitable approach for this study and acts as an appropriate explanation.

The social shaping of emotional wellbeing is influenced by science, medicine and measurement. This chapter argues that these historical guides and concepts have contributed to knowledge and the development of health and emotional wellbeing. However, these have also negatively influenced perception of emotional wellbeing. Whilst conflicting ideas and experiences can lead to ambiguity, for some the living with tension or uncertainty is an unsatisfactory and unhappy situation. This has significant relevance in the discussion of emotional wellbeing in the transition and adaptation to motherhood as perceptions of emotional wellbeing are influenced by self-imposed health and social norms and expectations. When maternal norms and expectations are not achieved this can create emotional disequilibrium and disorder (which mothers conceptualise as PND) rather than as being a normal fluctuation of mothering.

## **2.2 Phenomenology, Edmund Husserl and Maurice Merleau-Ponty**

Phenomenology is derived from two Greek words *phainomenon* (phenomenon meaning an appearance) and *logos* (meaning reason or word). Phenomenon "is a reasoned inquiry which discovers the inherent essences of appearances; while appearances are anything of which one is conscious...[m]oreover, an appearance is manifestation of the essence of that of which is the appearance" (Stewart & Mikunas, 1974, p. 3). Phenomenology makes no assumptions about what is or is not real; it begins with the content of consciousness as valid data for investigation (Stewart & Mikunas, 1974). The premise of phenomenological philosophy is that traditional tasks of philosophy are honoured, there are no preconceived notions of philosophy, the intentionality of consciousness, and the unification of subject and object (Stewart & Mikunas, 1974).

There is no single school or philosophy of phenomenology. Herbert Spiegelberg in *The Phenomenological Movement: A Historical Account* (1978) refers to phenomenology as a movement rather than a rigid discipline. The forerunner of the phenomenological movement was Franz Brentano (1838 – 1917) "who pioneered methods and attitudes which fed into the phenomenological movement principally through Edmund Husserl" (Luft & Overgaard, 2012, p. 17). The second movement,

also referred to as the German phase, was principally led by Edmund Husserl, and had a collective focus on methodology. Martin Heidegger was a student of Husserl in this German phase. The third movement, the French phase, was concerned with the significance of the body and the social world or social history (Luft & Overgaard, 2012; Spiegelberg, 1978). French phenomenology is generally referred to as 'existential phenomenology' where the focus is largely on human existence or various experiences of the being of 'subjectivity' (Reynolds, 2012).

Edmund Husserl is considered the founder of 20<sup>th</sup> century phenomenology and is responsible for establishing phenomenology as a movement (Spiegelberg, 1978). Husserl's phenomenology reinforced the requirement of philosophy to be authentic and without presuppositions. He argued that for this to occur, all judgements related to those presuppositions were required to be suspended. This, he referred to as suspending the 'natural attitude' to the philosophical attitude and termed this as the 'phenomenological reduction'. Employing the phenomenological reduction, Husserl disassembled complex problems to their basic forms, and eliminated previous prejudice about the world. In doing so, only the essential elements were revealed which led to an understanding of the phenomenon of consciousness (Stewart & Mikunas, 1974). Husserl followed with a phenomenological epoché where a suspension of judgement and previously held beliefs was undertaken. In this phase presuppositions were questioned until they could be validated. The core of the epoché was to suspend beliefs while focussing on the content of consciousness (thinking), namely the phenomena that gives rise to the description of the essence and relationships of the phenomena (Stewart & Mikunas, 1974). Husserl also applied the practice of '*bracketing*' to suspend thought while investigating the larger context of the inquiry (Stewart & Mikunas, 1974). The three processes of phenomenology, namely reduction, epoché and bracketing are fluid and not mutually exclusive. Husserl argued that one cannot bracket everything; even after the epoché is attended to, something still remains – that is the ego. The ego he termed the 'transcendental consciousness where it is neither subjective nor objective but unified' (Stewart & Mikunas, 1974). The distancing of the philosopher from themselves and the assumptions of the world allows for the phenomena to be precisely observed.

Husserl regards intentionality as an activity of consciousness by giving attention to an object. That is, the conscious mind which is always directing its

consciousness toward what it is conscious of, and supports the concept that intentionality of consciousness is a unified process tied to the world of experience (Stewart & Mikunas, 1974). In short, intentionality signifies that the world (or object) is already given and revealed in every thought or experience. Thus, intentionality is in a sense all about overcoming the *subject-object* divide. For Husserl, consciousness is unified, but he acknowledges the distinction between thinking and the idea of thinking. Husserl's philosophy that phenomenology 'return to the things themselves' required that human "experience be taken in its own right as it shows itself and as one is conscious of it" (Stewart & Mikunas, 1974, p. 22). This systematic investigation of the content of consciousness may relate to such things as values, affective states, desires, moods, feelings or any other thing of which one is aware.

Husserl describes the activity of consciousness, as mental perception, intelligence or thought, and is termed *noesis*; whilst *noema* is the essence to which this mental activity is correlated, that is, content that is perceived, a perception, a thought (Stewart & Mikunas, 1974). Stewart and Mikunas (1974) argue the relevance of the noetic-noematic (the adjective forms of noesis and noema) structure of consciousness is that it forms the basis of the unified human experience. One recognises that Husserl's initial approach to phenomenology substantially changed over his lifetime. Merleau-Ponty's *Phenomenology of Perception* developed from Husserl's early phenomenology where Husserl sought to overcome the subject-object divide (Moran, 2012).

However, in analysing Husserl's phenomenological reduction Merleau-Ponty argues that a complete reduction is not possible and rather favoured Eugene Fink's perspective of reduction

*when he spoke of 'wonder' in the face of the world. Reflection does not withdraw from the world towards the unit of consciousness as the world's basis; it steps back to watch the forms of transcendence fly up like sparks from a fire... Our reflections are carried out in the temporal flux on which we are trying to seize...there is no thought that embraces all our thought. (Merleau-Ponty, 2002, p. xv)*

In addition, Merleau-Ponty's phenomenology of perception questions the understanding of consciousness, the world and their relationship. He argues that the world is not reducible to its parts (that is, a subject and object exist separately) or

causally determined, but rather the world and consciousness are mutually dependent parts of one whole. Merleau-Ponty departed from Husserl's phenomenology in relation to the maintaining a focus on the phenomenon, rather than drawing attention to the ego. As previously identified, Husserl's phenomenology in its deliberation reveals the transcending ego. Merleau-Ponty perceives the presence or absence of existential meaning as a matter of transition and degree, rather than absolute presence or absolute absence (Spiegelberg, 1978). Existentialism accounts for the struggle between reason and life, and it is through the presence of opposing positions of reality that existence is defined. For example contingency versus necessity and adversity versus meaning (Spiegelberg, 1978). This standpoint suggests that a fluidity of self and the world is in existence and that an interaction of presence occurs constantly and without interruption. It is the transition from one aspect to another which is of importance, not the outcome of whether it is perceived as good or bad. Ultimately, Merleau-Ponty concerns himself with process rather than the product.

In the *Primacy of Perception*, Merleau-Ponty argues that perception is the background for science and philosophy. He says that the "experience of perception is our presence at the moment when things, truths, values are constituted for us...that it teaches us the true conditions of objectivity itself; that it summons us to the tasks of knowledge and action" (p. 25) Thus, phenomenology provides a means for understanding sensation as a foundation for human knowledge and culture. Science accounts for an aspect of perception; philosophy accounts for cultural phenomena that pertain to predictive or judgemental truths, to history, language and art (Spiegelberg, 1978).

In *The Phenomenology of Perception* and *The Structure of Behaviour* Merleau-Ponty's investigations could not justify the relationship between particular sciences (the fields of biology and psychology) and consciousness and nature (Merleau-Ponty, 2002; Spiegelberg, 1978). It was from Husserl's idea of the 'life world' as it bridged both science and philosophy that formed a basis for Merleau-Ponty's existential phenomenology. Furthermore, the implication of the social world on Merleau-Ponty's thinking grew from his immersion in living in and during World War II. This experience reinforced his ideas of the importance and relevance of history and co-existing within the world (Spiegelberg, 1978).

Merleau-Ponty asserts phenomenology to be a practice that can be recognised as a thought or style and exists as a movement; and is within each person as each person exists as a unified being (Merleau-Ponty, 2002, p. xx). Merleau-Ponty's phenomenology claims that,

*perception is not a science of the world, [nor] an act, a deliberate taking up of a position; [but rather] is the background from which all acts stand out, and is presupposed by them. The world is not an object such that I have in my possession the law of its making; it is the natural setting of, and field for, all my thoughts and all my explicit perceptions. Truth does not 'inhabit' only 'the inner man', or more accurately, there is no inner man, man is in the world, and only in the world does he know himself. (p. xi-xii)*

His unique view is that we perceive the world through the body, thus understanding human nature is possible as influences that 'attach' to the body from the world can be examined. It is in this process of examination that reality can be revealed. In this way Merleau-Ponty sees existence as more than a dualistic interaction between thought and things, as he describes that seeing the world as an entrance into the lived world is a process that engages three orders which are the physical, the living and the mental/social/cultural (Simpson, 2014). These orders are a unified presence, rather than individual components that exist separately in the one body. The orders signify the link of the body to the world and the world to the body. Merleau-Ponty describes the higher – invisible order relating to the lower – visible order with the subject within its material body engaging with the world and participating in that life as an interaction by which the material body takes on the meaning of that experience and thus becomes the order of the living body (Merleau-Ponty, 2002). For example, society believes that birth is a rite of passage, yet the experience and the meaning for each woman in each birth is different and depends on her own experience of engaging with the world at that moment/time of her own existence. The relationship between the orders provides a foundation for existence, where the higher order transcends the lower order through mutual engagement. This reciprocity reflects situations holistically integrated within the world and evidenced by 'giving and taking' or 'immersion and diversion' (Merleau-Ponty, 2002). Accordingly, existence is ambiguous and experience within the world ambivalent. This interwoven reality is revealed in the dynamic relationship



of the mind and body, where they exist ‘for-itself’ and ‘in-itself’ evolving to and in response to the world (Merleau-Ponty, 2002).

Understanding the inter-relationship of the orders is significant because it gives relevance to the connection that the orders have with each other rather than considering each of them to be independent, isolated and discrete. It is as if together they can solve a situation because their capacity to take a global perspective of it gives a richer option to understanding it. This enables adaptation because focus is not given to a singular order but rather taking the whole into consideration. The inability to globally accommodate and reflect on a situation means that the viewpoint is one dimensional as it focuses on a single order. This focus, by excluding the other orders, causes the situation to seem intensified or magnified thus resulting in disequilibrium. That is when isolating a situation it becomes more important in its isolation than in context to the whole situation. For example, mothers, rather than appreciating that feeling fatigued and overwhelmed are expected responses to motherhood isolate these states and consider them to be unmanageable and abnormal. By repeating these thoughts and behaviours they maintain a single order perspective and they interpret their situation to be pathological. A conscious interruption is required for adjustment or re-equilibrium. This understanding of the equilibrium of the three orders is often under-acknowledged in relation to mothers’ emotional wellbeing both in terms of the research literature and the health care system.

Despite commonalities, Merleau-Ponty’s phenomenological description also departs from Husserl’s phenomenology. Merleau-Ponty sees that Husserl’s phenomenological reduction reveals the unplanned flow of the lived world, and given that the person and lived world interact dynamically, this reduction holds validity for Merleau-Ponty. According to Husserl, “the eidetic reduction is the way from existence to essence” (Spiegelberg, 1978, p. 534). In contrast, Merleau-Ponty views this aspect of the reduction as a process rather than an outcome. As Merleau-Ponty’s focus is on the situation, the eidetic reduction is an attempt to capture facts of the experience before moderating the subjective state or thoughts (Spiegelberg, 1978).

Therefore, Merleau-Ponty’s phenomenology of perception is a useful way in which to examine a mother’s perception of her emotional wellbeing in the first 12 months postpartum and the relevance to the presence or absence of PND. This is

particularly useful as maternal emotional wellbeing has traditionally been investigated from a scientific and illness perspective. Whilst this exploration has attempted to acknowledge PND it has exposed a widespread range of possible symptoms, causes and understanding implying that there is a solution to the problem. It is not a simple problem that can be solved. Merleau-Ponty's holistic view of perception would bring a new understanding and approach that living with PND or emotional wellbeing generally is adaptive process that is worthy of exploration. Maternal wellbeing, including PND, is experienced and recognised as a bodily emotion - a felt sense of living in the world - also significant in the transition to motherhood. Yet transition to motherhood also embraces her physical and social body, and thus her adaption to being a mother. Mothers' perceptions and responses to motherhood and parenting are shaped by social and cultural influences, as discussed in chapter 3. Taking a Merleau-Pontian phenomenological approach to make sense of mothers' perceptions of their emotional wellbeing gives opportunity for a holistic view to be taken in order to overcome the deficits in scientific research. Giving voice to the mothers' experience allows health professionals and society to interact with empathy and understanding to the needs of mothers in the first 12 months of giving birth.

### **2.3 Maurice Merleau-Ponty's and Simone de Beauvoir's Perceptions of the Body**

While not the focus, this thesis acknowledges the substantial contribution of female philosophers and feminist writers to early mothering (and mothering in general). Hird (2007) in her article the "Corporeal Generosity of Maternity" highlights the ambivalent relationship feminism has had with maternity. Olkowski and Weiss (2006) in *Feminist Interpretations of Maurice Merleau-Ponty* defend the validity of his conception of the body in relation to feminist thinking. Therefore, this thesis is an opportunity to consider whether Merleau-Ponty's phenomenology of perception can contribute to understanding women's experience (embodiment) of emotional wellbeing in the first 12 months postpartum. Both Merleau-Ponty and Simone de Beauvoir use "the body as a basis for being". However, their approaches to understanding the body have both similarities and differences.

The body, from a Merleau-Pontian perspective, serves as a basis for being because it presumes familiarity and comfort. In PND, and indeed maternal emotional

wellbeing in the first year postpartum, a bodily focus on both recognising, and being recognised as having symptoms, behaviours and responses which typify PND or emotional wellbeing generally is experienced through the body. Bodily sensations (somatic symptoms) in response to experience can be further recognised through their patterned response and it is the potential within this patterned occurrence that a mother self-observes and thus finds means of regulating her emotions and responses. Studies demonstrate that there is ambiguity in the recognition of somatic symptoms in depression (Kapfhammer, 2006). Furthermore, symptoms of PND have also been under recognised and misunderstood by both the mother and the health professional despite ongoing and regular contact (Jarrett, 2017). A study by Habel, Feeley, Hayton, Bell, and Zerkowitz (2015) demonstrated that there are also perceptual differences between men and women in recognising and attributing symptoms of PND. Importantly, symptoms such as fatigue and interrupted sleeping are common to pregnancy, parenting and PND. Therefore, when the health professional (by referring to the *DSM*) and the mother (through social knowledge and norms) ascribe these manifestations as either PND or normal motherhood their judgement adds to the ambiguity of understanding the symptoms in context to the situation. In discriminating the validity of somatic symptoms as indicators of depression in pregnancy, Nylén, Williamson, O'Hara, Watson, and Engeldinger (2013) showed that symptoms are present and recognisable in women who have or have not experienced a normal pregnancy. Matthey and Ross-Hamid (2011) also argue that using *DSM* symptom criteria to diagnose depression in pregnancy are “over-estimated due to the natural occurrence of many of the symptoms as a result of the pregnancy” (p. 546). That is, there is real risk of over pathologising motherhood based on the presence of somatic symptoms alone and this significance was discussed in Chapter 1.

Comfort equates to an absence of discomfort from bodily sensations (somatic symptoms). In emotional wellbeing the presence of somatic symptoms, such as fatigue and fluctuating moods, suggests discomfort. There is no standard way a mother copes with this and thus she adjusts her daily experience accordingly. From Merleau-Ponty's perspective bodily sensations (somatic symptoms), behaviour and a mother's responses are simultaneously connected and related to her both as a person and mother in *that* situation (*moment*) of experience as well as her adjustment and response to mothering in general. However, living with discomfort also requires adjustment and

can create emotional disequilibrium. This may risk the mother's behaviour being labelled as a disorder rather than it being recognised as her adaptive response which compensates for the disequilibrium.

Adapting, physically and emotionally, to the postpartum period involves the body. In Merleau-Ponty's phenomenology of the body, the body is purposeful and lived inherently in the world. It is the fundamental basis for human experience, and is the foundation for being in-the-world (Merleau-Ponty, 2002). Merleau-Ponty promotes the view that perception is the interrelated connection between the human self, the sensing (corporeal) body and the being-in-the-world. Therefore, embodied consciousness is the intertwining relationship of the body subject and the world. Whilst he argues that changes in the corporeal body affect one's self, he does not engage in discussion that a person's gender is of significance; he argues a gender neutral perspective.

De Beauvoir, on the other hand, argues a gendered perspective of the body, and considers that as a result of the biological and social functions of the female body, women have become confined and restricted because of their body, unlike men (de Beauvoir, 1953). Whilst the challenges and demands that a woman experiences in the first 12 months of mothering are unique to the individual, there are societal ideals she aspires to in her mothering. These are arbitrary ideals by which a mother measures the self, the process of adaptation and personal identity of being 'an acceptable' mother (that is, society dictates the norms of mothering). De Beauvoir argues that "one is not born a woman - one becomes a woman" (p. 295). This analogy of becoming is evident in motherhood. However, Merleau-Ponty also subscribes to the view of becoming and says, "there is no inner man, man is in the world and only in the world does he know himself" (p. xii). By this he means that self-identity comes into being through our engagement with the world, a constant resonance of one with the other. This is a dynamic process.

Nevertheless, both Merleau-Ponty and de Beauvoir agree that social and cultural practices dynamically influence interactions and situated choices and accomplishments. From de Beauvoir's perspective, biology and culture are important; however adapting to motherhood involves more than a biological process. Merleau-Ponty acknowledges this and endorses a co-construction of self with the world, and in this way he considers the integration of human identity and worldly understanding to

transform the body. Merleau-Ponty, through his conception of embodiment, in particular the three orders of the body and the maintaining of equilibrium, are fundamental to understanding the experience of emotional wellbeing in the postpartum period. This, understanding that disequilibrium does not have to suggest pathology or illness (PND). Merleau-Ponty argues that a holistic approach encourages the understanding that the body is dynamic, complex and ambiguous rather than discrete parts that contribute to the whole. Whilst he appreciates that the scientific view has value, Merleau-Ponty argues that it does not fully explain the lived experience as subject and object are not unified.

In *The Second Sex*, de Beauvoir (1953) discusses the implicit inferiority of women and highlights that *woman* is defined and referenced to man *not* to woman; and in this way exists as the other. She argues that it is ‘man’ that defines what it means to be human. De Beauvoir advances that ‘she’ is incidental and non-essential to man, whereas man is perceived to be the subject, the absolute and the norm. It is because of this relational existence of female to male that the world judges a woman’s validity, worth and agency (Fullbrook & Fullbrook, 1998). Yet Kruks in her chapter “Merleau-Ponty and the Problem of Difference in Feminism”, in *Feminist Interpretations of Merleau-Ponty* (2006) argues that whilst his theory of embodied subjectivity is criticised by feminists for being a generic body, she says that while presented as male “the sexism is not...constitutive of his theory...[and thus does not] preclude his work from being creatively taken up for feminist ends” (p. 27). The three orders do not reside in a particular gendered body but rather have the capacity to integrate and transcend the body as there is no bias toward sexuality. As such then Kruks argues that Merleau-Ponty’s embodied subjectivity “offer[s] *potentialities* for communication and harmonious intersubjectivity, [and]...is also a site of antagonisms and conflicts...by exploring the tensions of general *and* particular experiences, of communication and conflict...we may find important guides to thinking about the [situated] lives of women” (p. 28). In this unique way the body exists dynamically with the world. Merleau-Ponty terms this unique existence as the intentional arc and it is this dynamic state that fosters the body to be active and acquires skills. The active state of the body and its skilful integration in its environment form the basis of creating the ‘body memory’; this embodiment is complete and whole and not simply a storage of mental representations (Merleau-Ponty, 2002). It is the basis of these stored body experiences

that encompass both the biological body and the lived body, which acts as the conduit in how one resonates and responds with situations in the world. As a corollary to this, Merleau-Ponty fosters the view that skill acquisition occurs at the point of need. He terms this as general grip, meaning the body consciously works towards discriminating sensations and responding to situations that occur, in order to function and exist in the world as a skilled person (Merleau-Ponty, 2002).

Although Merleau-Ponty and de Beauvoir both agree that it is impossible to consider the body as an object, de Beauvoir contradicts this view by suggesting that the female form is obstructed by gender socialisation (de Beauvoir, 1953; Fullbrook & Fullbrook, 1998). Merleau-Ponty's analysis of the body shows the capacity and adaptability of it-self, compared to de Beauvoir's embodiment where embodiment is inscribed from the gender perspective as a basis for becoming woman (Fullbrook & Fullbrook, 1998).

In *The Second Sex*, de Beauvoir (1953) regards maternity as a one-sided imposition on the mother. Specifically, in the chapters "Data from Biology" and "Mother" she argues that in pregnancy foetal autonomy overrides maternal autonomy because the primary purpose of pregnancy is to ensure reproduction of the species. She argues that a woman loses the control of her own body in pregnancy because of the physiological demands on it, whilst the unborn baby simultaneously exists parasitically within her. This biological view diminishes the maternal embodiment and suggests that a mother is disempowered both from the social world and her own body (Fullbrook & Fullbrook, 1998). In contrast, Merleau-Ponty in *Phenomenology of Perception*, conceives that the body has capacity to 'open up' and 'expand', that it is an integrated system between the body and the world. When a mother's autonomy is challenged by, for example the baby's behaviour or needs, she may perceive herself to be judged by her response particularly if it is uncharacteristic of her nature/being. From the lens of de Beauvoir, such uncharacteristic behaviour may be attributed to her not having choice and her decisions being superimposed on by another. Being faced with the ambiguity of her situation, she worries she is going to be labelled as having a mental illness, such as PND, which she perceives to be a stigma formed by personal and societal views. On the other hand Merleau-Ponty would see this situation as being a new adjustment, an opening up of possibilities that focus on integrating her and her baby into a new normal. Merleau-Ponty's view of the body may suggest that emotional

wellbeing which is considered to be at 'disequilibrium' should not to be perceived as a deficit but rather as an opportunity to rebalance and establish a new equilibrium from where adjustment may take place.

Nevertheless, Merleau-Ponty and de Beauvoir both argue for the ambiguity and indeterminacy of the world. De Beauvoir argues that human actions taken up in existence do not dismiss or reduce the ambiguity and indeterminacy experienced in the world, but rather assign meaning to human actions enabling them to *live* with ambiguity (Fullbrook & Fullbrook, 1998). In contrast, Merleau-Ponty investigates the bodily importance of indeterminacy through the concept of reversibility, when the constant mutual interaction between the subjective body and the lived world is experienced. It is through this interaction that the subjective body becomes the point of view in the world (Merleau-Ponty, 2002). In *Sense and Non-Sense*, Merleau-Ponty reasons that all involvement in the world is ambiguous and both affirms and restricts personal freedom: it is in the aspect of choosing to undertake something that not choosing is realised, and simultaneously excluded as a possibility. He says,

*the undertaking to do a certain thing means both that it would be possible for me not to do it and that I exclude this possibility" ... [and that] my involvement in nature and history is likewise a limitation of my view on the world and yet the only way for me to approach the world, know it and do something in it. (p. 73)*

It is in this way that "the relationship of being in which the subject is his body, his world and his situation, [occurs] by ...exchange" (pp. 71-73). For him, "ambiguity is essential to human existence, and everything that we live or think always has several senses" (Merleau-Ponty, 2002, p. 172).

In reality, both Merleau-Ponty and de Beauvoir hold importance and significance to this thesis. However, it is not pertinent in this thesis to fully discuss de Beauvoir's extensive contributions to feminist thinking and practice, and so a snapshot has been presented in the above discussion. Using Merleau-Ponty's view allows a holistic consideration of a mother's experience of emotional wellbeing, central to her situation rather than simply isolating the presence of emotion. It is the interrelationship of emotion and situation that enables understanding of, rather than a judgement of, wellbeing. *She and her situation just are.* Merleau-Ponty's phenomenology of

perception ensures that the woman is considered a whole person in context to herself and the world (that is, her baby, her community and society) and in this way adopts a feminist approach. His approach is deeply consistent with feminist accounts and also provides an awareness that has been lacking to mothers' experience of emotional wellbeing in relation to disequilibrium.

## **2.4 Perception**

The central argument within this present study is that perception, the body and embodiment are significant factors in a woman's experience of mothering in the first twelve months postpartum. In the *Primacy of Perception* (1964), Merleau-Ponty described his intention to re-establish the unity of the mind and body, and the body in the world. His unique conception of the body taking on the role of both subject and object and being unified with the world, had not been fully explored by his peers (Jean Paul Sartre, de Beauvoir, Albert Camus) when his work was published. The key to understanding his philosophy is provided by his definitions and perspectives on the body. Merleau-Ponty differentiates the three orders as discussed in Chapter 1.

Perception is the means by which the person has cognitive contact with the world, and is made likely by a range of physical factors (the brain, sense organs, and the nervous systems); and is available and possible through the first person experience and inaccessible from a third person perspective (Merleau-Ponty, 2002). For Merleau-Ponty, perception is an active bodily process that enables the person to see, hear and feel, yet he argues that perception is greater than the sensory perception possible through the body. He maintains that whilst the senses reveal detail, this detail does not constitute the completeness of the object (or the situation). What is perceived is a whole unit not the individual sense data per se. Therefore, it is in the perception of the whole of the object that the individual forms an interpretation of the object/situation. Significantly, he says that perception is neither complete nor perfect. Perception is influenced by and through the world in multiple factors including sensory, motor and affective behaviours, our principles, beliefs, attitudes, motives and judgements. Thus, perception is experienced entirely through the body in relation to the world and we formulate our "perceived world" (Merleau-Ponty, 2002, p. 5). Understanding human nature is made possible by understanding perception. Examining the influences that 'attach' the body to the world reveals a factual world.



In the *Primacy of Perception*, Merleau-Ponty establishes that perception is the person's first encounter with reality and as a corollary language and reasoning assign meaning to that encounter. Importantly he says that perception is foundational to experience because of its primal innate nature (that experience precedes meaning), and it is in perception that responses are expressed to that reality. Yet he also notes perception is bound to a certain perspective, which is premised to a particular time and place, and hence limited in its scope. It is because of this that it is not reasonable to hold the first perception as the absolute truth. This is of critical importance for mothers' emotional wellbeing whereby mothers may misunderstand their perceptions of their bodily symptoms and so may stereotype these to represent PND. It is essential for mothers to have opportunities to develop, discuss and progress their initial perceptions of emotional wellbeing, illness or adjustment in the postpartum. Merleau-Ponty comments on the evolving nature of perception that is it is neither fixed nor determinate, but rather is always in context to experience that is informed and informs the world in which you live. He says,

*the experience of perception is our present at the moment when things, truths, values are constituted for us; that perception is a nascent logos; that it teaches us, outside all dogmatism, the true conditions of objectivity itself; that it summons us to the tasks of knowledge and action. It is not a question of reducing human knowledge to sensation, but of assisting at the birth of this knowledge, to make it as sensible as the sensible, to recover the consciousness of rationality. (Merleau-Ponty, 2002, p. xv)*

In perception, Merleau-Ponty highlights how physical objects can exist to us even though we may not fully 'see' the entire object. In the *Phenomenology of Perception* he gives the examples of a 'cube' or the front of body; in both these examples he claims that we can see one dimension or side of the object but we know the other dimensions of the cube or the back of the body exist even though it is not observed. Objects can hold both present and absent features and still remain true; this introduces his ideas of ambiguity and ambivalence. He uses examples from Gestalt psychology to illustrate ambiguity in relation to when a subject maintains two distinct images of an object or being that are not yet recognised to be the same. He illustrates this when an image is directly observed and seen/noted; when the observer shifts the focus of their gaze a different image is observed within the same image. Classically,

these have been represented as the old woman/young woman image, or duck/rabbit image. In the *Collected Works of Aron Gurwitsch (1901-1973): Volume III: The Field of Consciousness: Theme, Thematic Field, and Margin*, Gurwitsch (2010) when discussing sameness, says that from the phenomenal point of view there is no identity. Moreover, because of the blurring of background and figure, purposeful gaze is required when inspection for a particular object is sought. Merleau-Ponty explains that it is the ocular fixation that records the impression and the brain then makes sense of what is meaningful for the subject (Fisher, 2015).<sup>5</sup> The brain organises sensory elements, filters and groups information processes and analyses situations to determine responses; the transmission of visual stimulus and the interaction of the different parts of the brain influence perception and recognition (Harrison, 2015). Harrison further explains that each cerebral hemisphere whilst specialised is complementary in how they process cognition. A shift of gaze is required to observe the different image. It is a purposeful movement of the eye that initially requires effort or intention, but when distinguished/recognised, that is grasped, it becomes inherent and natural to the observer. In *The Visible and Invisible* (1969) Merleau-Ponty refers to the subjects' unity of observation – that being the seen and unseen. It could be argued that from a Merleau-Pontian perspective that more than the body (physical body) is required to shift a gaze. That is, together with being in the world, a subject's understanding of her motivations, her appraisal of situations to consider her capabilities, her self-awareness, her prior experiences, her patterns of behaviour and her preparation and transition for being a mother all contribute to *her* shifting the gaze. This shifting of the gaze is not time dependent. Engaging in reflective discussion may reveal where the major focus of that gaze is. For example, a mother's gaze will be either on herself or on her baby; it is not possible for her to simultaneously focus on both. In emotional wellbeing she may be able to shift the gaze between herself and her baby as required, that is, she is flexible and accommodating to the demands of the situation. In maternal emotional disequilibrium this gaze is fixed on either the baby or herself, which limits her flexibility to engage with her situation.

For Merleau-Ponty, perception encompasses both subjectivity and the objectivity of an experience, of its inner feel and its intentional grip on the world. He

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<sup>5</sup> Taken from Alden L. Fisher (2015) translated version of *Merleau-Ponty's The Structure of Behaviour*.

explains that the Gestalt principles of foreground and background as part of the perceptual process are unified within experience. In experience we do not separate and perceive only components of the world that are relevant to the context. Rather, all components of foreground and background are distinguishable, regardless of whether they are relevant to the experience. Thus, experience is constituted and co-constituted by our foreground and background. Our background horizon gives a depth of capacity and context to our perception; our foreground is the present most obvious to us. The foreground and background horizons provide *our grip* on the world. If we focus too narrowly (that is, focus on the figure without context to the background), our orientation is lost. Likewise, if we focus on the background we also lose our orientation in perception. In such situations we often remark ‘we have lost perspective’ of the situation (Merleau-Ponty, 2002). We are then thrown into confusion and lose our grip on the world. Of significance to this study is that Merleau-Ponty argues that perception and action are linked, and that you cannot perceive without acting nor can you act without perceiving. Thus perception and as a consequence bodily action, together express bodily intentionality.

## 2.5 Motor Intentionality

In the *Phenomenology of Perception*, Merleau-Ponty discusses the relationship of the body to the world and its ‘mutual existence’, where the body is part of the whole, and the whole is part of the body. It is within this relationship of the self with the world that the world becomes available to the self. The taking up of the world is not necessarily consciously thought of, it is absorbed in embodiment. Merleau-Ponty describes motor intentionality as being “the natural and ante-predicative unity of the world and of our life, being apparent in our desires, our evaluations and in the landscape we see” (p. xx). That is, we are intertwined with the world, where our actions (and thoughts) equally shape and are shaped by the world. Bodily intentionality reflects the connectedness of perceptions to the world (Carman, 2008).

Merleau-Ponty says that our actions generate our lived world as, and because, we are drawn through it. He continues to say that our bodily intentions and capabilities are expressed in response to our perceived world. The perceived world includes the immediate, imminent and possible situations (worlds) of the ‘I can’. Merleau-Ponty’s three orders of the body presented in Chapter 1 refer to the sense of distinguishing

between the body as being biological, physiological or objective; and lived, phenomenal, or subjective. The reality, he argues, is that the body is one and the same taking on both forms simultaneously and existing as a being-in-the-world. This embodiment is integrated, resonant, dynamic and evident in subjectivity. He says that our being-in-the-world is orientated to a world of possible actions and gestures. Classic examples of motor or operative intentionality provided by Merleau-Ponty are those of gesturing, pointing, grasping and facial responses. An example of this in maternal emotional wellbeing could relate to a mother grasping or relating the meaning of her baby's cries; her own crying or using gestures to show tears running down one's face; externally placing hands on her breasts when talking about the difficulties of breastfeeding; lowered or raised auditory level and tone of the voice as an indicator moods such as shame, embarrassment, frustration or anger. Motor intentionality is an embodied experience and response with another or something in the world (Merleau- Ponty, 2002).

Merleau-Ponty discusses a range of neurological deficits which may exist. These deficits occur when, for example, a person is unable to physically 'gesture' on request, but has inherent knowledge of what is required to perform that task.<sup>6</sup> The task of 'I can' is not bodily possible. He further explains motor or operative intentionality through the intentional arc as a background that influences our behaviour. It is prior experience or conditioning affecting actions and responses which are purpose-driven. The world provides the means to satisfy the purpose we seek. In essence, we are informed by our purposes and external availability. Let us take an example of a baby crying in hunger. In this case the cry is purpose-driven; the baby itself is the driver and the mother's response is to determine the cause of the cry. In terms of intentionality the baby is object-driven in that it knows from prior experience that the mother will respond and satisfy its needs "agency, control, object-directedness, and the ability to act on behavioural impulses as central features of early social cognition and the development of a sense of self" (Williams, 1997, p. 30).

In *The Phenomenology of Perception*, Merleau-Ponty emphasises our sense of coherence and continuity with the world. My world is not only that which is obvious; it encompasses the abstract, the foreseen and unforeseen, events and experiences of myself and others as separates, but also as an interwoven one. The

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<sup>6</sup> Merleau-Ponty gives a number of examples of neurological deficit states including apraxia p. 161; praktognosia p. 162; Schneider p. 156.

world is also the necessary other - those who inhabit you, as one in space and time. The world is also the situation I find myself in; a physical reality that influences, and by necessity, changes my gaze. Merleau-Ponty refers to this reciprocity between the subject and the world as the ‘intentional arc’,

*the life of consciousness – cognitive life, the life of desire, or perceptual life – is subtended by an ‘intentional arc’ which projects round about us our past, our future, our human setting, our physical, ideological, and our moral situation, or rather which results in our being situated in all these respects. It is this intentional arc that brings about the unity of the senses, of intelligence, of sensibility and motility. (Merleau-Ponty, 2002, p. 157)*

“In illness the intentional arc goes limp, and the subject’s grasp of the world (all her projects and acts - [the mothering project and breastfeeding]) is altered” (Merleau-Ponty, 2002, p. 157). The intentional arc of a woman with a prior experience of depression could encompass personal experiences of depressive symptoms, ways of coping and possibly a beginning understanding of her patterns of responses when feeling vulnerable. The intentional arc allows the normal subject to spontaneously grasp the world, and a communion between world and subject exist in perception. Lengthy processes of clarification of understanding are not required by the subject as she intuits the world with ease. Yet hidden and overt movement of ideals and reality between subject and her world can create a complexity that needs to be distinguished, but is not pathological in nature. The intentional arc allows for such movement and discernment of paradox.

Cerbone (2008) discusses Merleau-Ponty’s concept of grip in literal and figurative contexts. He gives the example of, “in my hands ([as] literal) and when I ‘get a grip’ on things and situations, putting things in order, getting things under control, and optimizing my perceptual access ([as] figurative)” (p. 129). Attaining grip is essential for coping and mastery within a situation and/or environment. When being-in-the-world feels like a natural existence, grip itself is an intuitive response that occurs spontaneously - that is, attention is not focussed upon it. For example, a mother who is comfortable and confident in her maternal role does not think about *being a mother* – *she is a mother*. She adjusts her responses to get a grip on the situation: she moves into the space of her baby in order to know her baby better.

Zeedyk (1996) reasons that infant intentionality in relation to goal directed behaviours (e.g. trying to gain mother's attention) gives insight to the child's needs, capacity for intersubjectivity and is behaviourally object-directed. Infants and mothers use a turn-taking style of communication which is goal-driven by the infant,<sup>7</sup> and with response by the mother. Zeedyk draws on Merleau-Ponty's operative intentionality as a means of demonstrating that bodily intentionality, through motility, is a consequence of engagement with the world, and for an infant this occurs prior to thought. Classic behaviours Merleau-Ponty discusses in relation to motility include grasping, pointing, communications with gestures or words. Merleau-Ponty says,

*movement is not thought about movement, and bodily space is not space thought of or represented. Each voluntary movement takes place in a setting, against a background which is determined by the movement itself....We perform our movements in a space which is not "empty" or unrelated to them.... (p. 159)*

Embodiment is having a holistic view of the person within the world. It is about the world we inhabit, the ownership we manifest, the connections and relationships that participate with us in our existence. Our engagement with the world is evident in the daily choices and practices we undertake, the interactions we have with others. Embodiment is also how we understand ourselves and others in their passage of time. The subject communicates her being in the world through emotion, expression and gestures, reciprocity and mutuality. We have developed patterns of behaviour to situations which give us clues as to how one is coping with life. As Drew Leder discusses in *The Absent Body* (1990),

*I receive the surrounding world through my eyes, my ears, my hands. The structure of my perceptual organs shapes that which I apprehend. And it is via bodily means that I am capable of responding. My legs carry me toward a desired goal seen across the distance. My hands reach out to take up tools, reconstructing the natural surroundings into an abode uniquely suited to my*

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<sup>7</sup> Zeedyk illustrates classic exchange of communication between mother and baby: "A standard exchange begins with one partner eliciting the attention of the other, perhaps through positive affect or a vocalisation, and the partner responding by returning the gaze. The dyad then engages in a period of mutual gaze, with the mother speaking to the infant and the infant typically exhibiting animated behaviour such as cooing, body movements, or intensifying facial expressions. The interaction continues in a coordinated, synchronised fashion, with participants taking alternating turns until the exchange is terminated, often by the infant turning his or her attention away from the mother. The exchange resumes when the infant reorients to the mother" (p. 426).

*body. My actions are motivated by emotions, needs, desires that well up from a corporeal self. Relations with others are based upon our mutuality of gaze and touch, our speech, our resonances of feeling and perspective...the body plays its formative role (p. 1).*

Benoist and Cathebras (1993) argue that the emergence of the biological body, as an object of science, has resulted in isolating the body from the subject's experience. For example, a woman with PND can report a variety of physical and emotional disturbances which include sadness, fatigue, insomnia, appetite changes, reduced libido, episodes of crying, anxiety, irritability and non-coping (Beck, 2008; Leahy-Warren & McCarthy, 2007). She can exist and experience an altered perception of herself within her own world; and perceives her world differently to others; lives and experiences *her* world not *the* world of others. This woman lives within what others ascribe to her and of her; and in this way she shapes her thinking and behaviour.

Merleau-Ponty contends that identity is perpetually embodied, it is informed by personal and social-cultural dimensions, rather than it being static (Murphy, 2008). From a PND perspective this is important as conception of self as women and mothering is historically embedded in social and cultural elements of living. The dynamic changes of history, expectation, transition, experience of motherhood and changing norms can lead to an acceptance that experiencing dysfunction, such as postnatal depression, is the 'new normal'. In this sense Merleau-Ponty highlighted that existence is characterised by an intertwining between subject and world, and it is important that existence precedes meaning.

Merleau-Ponty's conception of body, lived and biological, is of particular relevance for postnatal women given the physical, physiological and emotional re-adjustments and new beginnings required following childbirth. To Merleau-Ponty the body is understood to be a subject and an object, and the central focus of the body in the lived experience is independent of the objectifying function of the body. The 'body as a subject's' experience is influenced by self and others in relation to language, motion, change and action on an interpersonal level, and is situated in the world. The subject senses and perceives in their own world and the world of others at a particular place and time, and from a precise perspective. As Merleau-Ponty (2002) states, to be within the world is to be an object: either a physical or a material object.

Illness reveals itself as an altered function of the objective body and as changed access to the world (Merleau-Ponty, 2002). In essence, what one projects, anticipates and does in the world is altered and the sense of oneself changes. Yet the body accommodates to this change and forms different habits and projections of being-in-the-world which continues a different but engaged presence in the world (Merleau-Ponty, 2002). This mechanistic element of body and change then becomes one's lived experience of the world, a constant negotiation and re-negotiation of the self within the world which occurs as a result of perception (Merleau-Ponty, 2002).

For a woman who may suffer with PND, her being-in-the-world changes. How she negotiates change and interprets ambiguity can manifest as suspended or inhibited intention, this can alter her response to action. Merleau-Ponty refers to this as motor intentionality, where intention is fundamental to understanding, because this act of doing establishes our relationship to the world (Marshall, 2008). Intention and meaning merge into movement or action (Marshall, 2008; Merleau-Ponty, 2002; Morris, 2008).

Merleau-Ponty sees intentionality as a consciousness of a world already present to which one is continually directed, and asserts that the world cannot be possessed or embraced, and is premised in ambiguity and indeterminacy. Similarly, a woman's world after the birth of her child is like this; there is no finite end. As a mother, she lives from one moment to the next and while she can intellectually anticipate the needs of her child. This intellectualising (idealisation/imagination) does not necessarily assure a satisfactory outcome. In order to function as a mother she must distinguish the ambiguities and confusions that may present daily as well as manage her responses in dealing with such uncertainties. Unpredictability of self and the baby's need, limited information affects her understanding, complexity and ambiguity result in uncertainty in her own behaviours and identity. Merleau-Ponty proposed that meaningful reflection only occurs after action, which may influence how one engages in the world, which is being-in-the-world. Thus, the experience of being-in-the-world gives opportunity for self-transcendence of perceived human problems (Merleau-Ponty, 2002). When PND is experienced, this process of reflective existence may not take place as a mother is trying to cope; a mother's experience of being-in-the-world is overwhelmingly negative and a spiralling out of control is often reported (Beck, 2008). In such circumstances the capacity to, and of, self-agency is compromised.



Merleau-Ponty asserts that the body is simultaneously habitual and ‘in the moment’. The habitual component implies that the body has the capacity to store a body memory and thus in behaviour can draw on this when responding in the world or a situation. The ‘in the moment’ component has an inherent knowledge of the habitual body and is capable of both supporting and/or varying the responses required from the environment. The ‘in the moment’ layer draws on consciousness. Both the habitual and present body have the capacity to evoke emotion, and that this evocation is not superimposed by physiology. He says that, “to feel emotion is to be involved in a situation which one is not managing to face and from which, nevertheless, one does not want to escape” (Merleau-Ponty, 2002, p. 99). This stance affirms the dynamic state of being-in-the-world where fluidity between the three orders helps to maintain an equilibrium in maternal emotional wellbeing rather than pathologising the disequilibrium.

Merleau-Ponty suggests that the formulation of habits is achieved through a process of renewal and reworking of the body schema,<sup>8</sup> and not necessarily only the physical repetition of movement or action. “The acquisition of a habit is indeed the grasping of a significance... [and is] the motor grasping of a motor significance (Merleau-Ponty, 2002, p. 165). It is the sensory memory that generates and guides the acquisition of habit. Consciousness plays a part in establishing a habit which when formed can be replaced by unconsciousness to continue with the habit or choice to further develop or change the habit. He posits that all “habits are motor and perceptual... [that] between explicit perception and actual movement...sets boundaries to our field of vision and our field of action” (Merleau-Ponty, 2002, p.175). Merleau-Ponty uses examples of dancing, driving a car, and typing as the formation of motor habits. The development of a habit may also recognise a prop as an extension of the body; for example, a lady with a feather in her hat and the blind man with a stick. From a maternal perspective, is a baby an extension of a mother’s body or a prop? Are the habits that she forms attributed to the baby and her together in the world, or the baby and her in the world as separates? For a mother either of these situations are possible and both can represent adaptation. Her adaptation to motherhood may be influenced by observation of other mothers (since childhood), formation of daily habits (historical and new), cultural practices and social values where some of these

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<sup>8</sup> Merleau-Ponty contends that body schema is more than physiological associations and/or a sensing form within the world. He believes that the body schema is the point at which a foreground/background perspective is possible and essential for perception.

influences are given greater attention than others. The formation of habits is valuable as it provides body memory and familiarity which can lead to comfort and confidence. As motherhood is fraught with ambiguities and unpredictability the presence of habits facilitates adaptive coping and thus promotes emotional wellbeing. The absence therefore of established habits can cause a disequilibrium that is overwhelming and perceived as contributing to emotional ill health.

Things or props that offer an extension to our body, and which are performed repeatedly form a habit, which become expressions of being-in-the-world. As Merleau-Ponty says, “to get used to a hat, a car or a stick is to be transplanted into them, or conversely, to incorporate them into the bulk of our own body. Habits express our power of dilating our being-in-the-world, or changing our existence by appropriating fresh instruments” (Merleau-Ponty, 2002, p. 166). As analogy the baby offers an extension to the maternal body which expands her visibility and influences her being and other people’s being- in-the- world. A mother could be afforded privileges that a woman without a baby may not receive. For example, a woman with a pram arriving late to a bus stop may be assisted to mount the bus over a woman without a baby. In this situation the baby become a prop as a mother is recognised as a mother by others. The same mother might be in a situation in her own home where she is attending to domestic responsibilities while holding the baby in her arms. Since there is no one there to recognise her, the baby is no longer classed a prop as a mother proceeds to carry out her tasks. However, the multiple items needed to facilitate the baby’s physical movements or needs, for example a pram, cot, feeding chairs are props as they enhance the visibility of the baby. The prop enhances the meaning and interaction of the mother-baby relationship. A mother’s being-in-the-world, her physical body, her emotional wellbeing and her sense of maternal responsibility have redefined her and readily and easily integrate the items into her life without seeing the props as incumbent items in being a mother. Props available to mothers allow the establishment of rituals that can promote wellbeing. For example, going for a daily walk with the baby facilitates her establishing and maintaining a routine for wellbeing. The style of props can reflect social trends however the functionality of the prop remains the same. The props can give mothers a sense of security when they perceive to possess the right props.

Merleau-Ponty's phenomenology of perception and embodiment hold significant relevance for understanding women's experience, or non-experience of PND.

His key concepts of body as subject and object have considerable merit in understanding the impact of illness and thus the implications for care. Intentionality is explored as an operative functionality, not simply as a thought process. However, the question remains can bodily responses be measured?

## 2.6 Intersubjectivity: Mother and Baby, Mother and Others

In the *Phenomenology of Perception*, Merleau-Ponty discusses intersubjectivity as the relation and experience one has of oneself with others, as they exist and participate in a shared social world.<sup>9</sup> This sharing occurs simultaneously through bodily existence and cultural life. For Merleau-Ponty, the world is filled with the other(s) and this shared presence provides opportunities for establishing common sense meanings, and the shaping of ideas in society. It is in this sense of being-in-the-world with others that his ideas of reciprocity and mutuality are informed. Alfred Schütz (2004) says “the experience of the other involves a reciprocal relationship: in experiencing the other I experience concurrently his experience of me” (pp. 168- 169).<sup>10</sup>

Unique to motherhood is the intersubjective relationship of mother to baby. Investigations of maternal-infant relationships have been formed from a number of theoretical perspectives including but not limited to intersubjectivity (Merleau-Ponty, 2002; Stern, 1995, 2004), empathic emotional attunement (Kurzweil, 2012), attachment and object relations, and bonding (Bowlby, 1970, 1988; Schlauch, 2016),<sup>11</sup> and the mutual regulation of emotions between mother and baby (Tronick, 1989). The most obvious example of intersubjectivity in motherhood is the relationship of mother

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<sup>9</sup> Intersubjectivity has also been referenced as interpersonal and intercorporeal. It is really dependent on the discipline focus as to how the term is applied. For example, psychodynamic theorists use the term interpersonal rather than intersubjective.

<sup>10</sup> For a full explanation of this see Schütz, A. (2004). Chapter 29. The Problem of transcendental intersubjectivity in Husserl. In Moran, D. & Embree, L.E. (Eds.). *Phenomenology, Critical Concepts of Philosophy*.

<sup>11</sup> Chris Schlauch in his article titled Readings of Winnicott, comments on Winnicott’s theory of holding (and being held) and holding onto in relation to maternal and infant relationship comments on ‘holding’ as a spectrum of processes involved in maternal-infant exchanges and engagement. It includes the physical holding of the infant by the parents and the broader environmental and spatial dimensions of daily life. The significance of these are reflected in maternal empathy: where the mother instinctively protects her baby. Maternal empathy establishes emotional stability for the baby, and the two develop ways of interacting with each other. Winnicott explored attunement theory which led to the idea of the good enough mother whereby the concept of getting things right most of the time versus one hundred percent of the time was a more reasonable expectation of mothering. However, mothers’ contemporary expectations of parenting are that they have to get mothering right 100% of the time in order to be a good enough parent. The ideas of the holding environment and the good enough mother are important foundations in ensuring a secure base for infant development.

with baby. Yet contemporary health care also focusses on a mother's other significant relationships in relation to her role of mothering, for example with her partner, family, friends and health professionals. As a concept a mother who is comfortable and confident in her maternal role does not think about *being a mother – she is a mother*. Yet a mother who lacks confidence, may have negative experiences, may feel negative emotions which may lead to a disconnection in herself and in her mothering role. She attends to the task of mothering but does not feel she *is* a mother. A postnatally depressed mother can experience a loss of identity (Baraitser, 2008; Matthey, 2010; Matthey & Agostini, 2017), ambivalence about motherhood and feel challenged about her competence and confidence in the role which can be pathologised as disorder (von Mohr, Mayes, & Rutherford, 2017). Research has validated the concern around a mother's negative adaption to motherhood and how this impacts on her relationship with her baby, her capacity to mother and the impacts of negative adjustment to baby wellbeing (Friedman, Beebe, Jaffe, Ross, & Triggs, 2010; Schlauch, 2016; Stern, 1995, 2004; Weinberg & Tronick, 1998). The social construction of motherhood and the risk factors for PND are discussed in Chapter 3.

Whilst Husserl sees intersubjectivity as an experience that relates the self to others, Dan Zahavi in *Phenomenology Critical Concepts in Philosophy* (2004) argues of Husserl that one only really has direct access to one's own mind and that access to

the mind of another is through bodily behaviour. He says that this is predicated on the position of "*argument for analogy*" whereby the experiences of one's one body and response, and all of its causal influences and associations, are inferred from one's own bodily experience. Zahavi says that we associate feelings with experiences and cites the example of when I am burnt by hot water and the associated feeling of pain, which gives rise to screaming; I subsequently appreciate the experience and response of others in the same situation. Yet it is not possible for one person to experience every physical/emotional event and be able to respond from her own experience perspective. Zahavi does argue that this is then achieved through empathy where a person can appreciate the position of the other through understanding that person's perspective and uses evidence from similar experiences. In the context of a woman's experience of birth, her story is understood and empathised by other women who have given birth. They share the varied experiences of pregnancy and birth, understand that *birth* pain is different to other physical pain, and are bonded with each other because of their shared

similar physical journey and appreciated by those who have not had a birth experience. The ability to empathise is an intersubjective quality and premised on perception of understanding another. This position is supported by Natalie Depraz in her chapter the Husserlian theory of intersubjectivity as alterology in *Phenomenology Critical Concepts in Philosophy* (2012) who suggests that in considering maternal intersubjectivity “we cannot directly know another’s understanding, we are all always constrained to understand others through our own perceptions” (p. 151). Furthermore, relating with others gives context to one’s own experience.

Zahavi maintains that Husserl’s *argument for analogy* is predicated on two influences, cognitive capacity and similarity of experience and that empathy is derived from either thought and/or personal experience. So from the perspective of health care, opportunities for empathic conversations cannot be underestimated and the responsibility can be shared by family, friends and community members. Genuine empathic communication with a mother may contribute to her emotional wellbeing. Whilst Merleau-Ponty supports Husserl’s *argument for analogy* he believes that there are limitations to it. These limitations relate to each person’s unique and personal being-in-the-world to which genetics, conditioning and social modelling may also contribute. Furthermore, a mother may receive empathetic support with good intentions yet this alone is not enough to sustain her emotional wellbeing or her ongoing growth in motherhood.

Merleau-Pontian intersubjectivity takes account of the subject and the object. He discusses this unique relationship in terms of

*‘double sensation’*: when I touch my right hand with my left, my right hand, as an object, has the strange property of being able to feel too...the two hands are never simultaneously in the relationship and touching to each other. When I press my two hands together, it is not a matter of two sensations felt together as one perceives two objects placed side by side, but of an ambiguous set up in which both hands can alternate the roles of ‘touching’ and being ‘touched’ .... (p. 106).

It is the uniqueness of bodily behaviour that Merleau-Ponty discusses as being significant in perception and intersubjectivity. He draws on the ambiguity of the body as uses the bodily concepts of mutuality, reciprocity, and adaption hold relevance, and the de Beauvoir perspective of power imbalances in the intersubjective experience.

In considering the relationship of mother and baby, in the *Primacy of Perception* he discusses the child's relation with others and highlights that despite there being firstly evidence of bodily behaviour such as facial expression, the meaning of this behaviour is determined by subsequent development. He writes that,

at a very early age children are sensitive to facial expression, e.g. the smile. How could that be possible if, in order to arrive at an understanding of the global meaning of the smile and to learn that the smile is a fair indication of a benevolent feeling... (p. 115).

Zahavi's claim that the similarity influence is based on understanding the intersubjective experience with references to social understanding, which may or may not be taken from a personal experience. This aligns with Husserl's discussion of the 'natural attitude' or the 'common sense' also known as the 'communal sense' as being a societal baseline of understanding, appreciating, empathising with another. It is from this baseline that social norms, knowledge, practices, interactions and comparisons may arise. A mother gauges her own emotions as being an appropriate response to her baby or her situation from the natural attitude. When she believes she does not fit into the normal parameter of happiness or being bonded with baby she does not necessarily express this explicitly. She silently compares her own responses with those of friends and family and questions whether her own perceptions are valid or not. Despite what she may be thinking or feeling she still interacts with those around her, whilst concealing her emotions. This concealment of negative emotion may be her way of containing her feelings so she can attend to the demands of daily life and thus 'feel normal'; it may also be an indicator of disorder.

It is in *Sense and Non Sense* (1964) that Merleau-Ponty draws attention to the idea that emotions "are not psychic facts hidden at the bottom of another's consciousness: they are types of behaviour or styles of conduct which are visible from the outside. They exist *on* this face or *in* those gestures, not hidden behind them" (pp. 52-53). He continues to argue that,

*psychology did not begin to develop until the day it gave up the distinction between mind and body, when it abandoned the two correlative methods of interior observation and physiological psychology... emotion is not a psychic, internal factor but rather a variation in our relations with others*

*and the world which is expressed in our bodily attitude, we cannot say that only the signs of love or anger are given to the outside observer and that we understand others indirectly by interpreting these signs: we have to say that others are directly manifest to us as behaviour. (p. 53)*

Zahavi claims that Merleau-Ponty's account of intersubjectivity holds significance for understanding embodied existence. He says,

*we begin from the recognition that our perception of the other's bodily presence is unlike our perception of physical things. The other is given in his or her bodily presence as a lived body, a body that is actively engaged in the world. (p. 183)*

In summary, Merleau-Ponty shifts the emphasis from the knowledge of experiencing others to the daily lived experiences of a shared world. He contends that shared experience is reciprocal and mutual, and that self-recognition is a distinct process of the other. It is in the *Phenomenology of Perception* that Merleau-Ponty discusses intersubjectivity as being the relation and experience one has of and with others, as they exist and participate in a shared social world. This sharing occurs simultaneously through the body and world. The established process of becoming maternal requires a mother to engage in healthcare. Processes of monitoring physical and emotional wellbeing are well established.

## **2.7 Measurement and the Edinburgh Postnatal Depression Scale (EPDS)**

Healthcare professionals are concerned about mothers' emotional wellbeing and currently endorse the use of the Edinburgh Postnatal Depression Scale (EPDS) as a means of measuring emotional wellbeing in the perinatal period. Chapter 3 discusses the scientific research associated with the use of the EPDS.

Applying Husserl's concept of the natural attitude to the usefulness of the EPDS may challenge the validity of both the scoring procedure and the method of its administration. Aaron Cicourel, an ethnomethodologist, in *Measurement and Methods* (1964) aims to examine critically the foundations of method and measurement in

sociology.<sup>12,13</sup> His premise is that social science research can only be valid if embedded within a social cultural linguistic context. He proposes that for social process to be measured an understanding of social relevance and meaning is necessary. He posits that social meaning is communicated through ordinary language in every day conversation that is authentic to its audience. Social cultural nuances and interactions, that is, Husserl's natural attitude, are required to gather information. What is spoken and unspoken needs to be taken into account when analysing data that relate to the social world, its measurement and reporting. He says that when we attempt to reason the literal measurement of social acts and assign numerical properties to these systems of measurement one must "use linguistic and non-linguistic meanings [such as gestures] that cannot be taken for granted and must be viewed as objects of study" (p. 14). Then, in measurement one needs to take account of implicit meanings demonstrated through social interaction that are obviously present but not necessarily acknowledged as pertinent to the actual content of the items being measured. Given the complexity of social interactions, it is important to focus on the measures to be reported on and to elicit the gathered (possible) meanings these measures may hold for the individual (Pellegrini, 2013). Behavioural and bodily interactions are significant indicators that should be taken account of as they can substantiate or negate subjective responses. For example, a mother can deny having PND through an overall reported low score, or she can express verbally and/or shake her head to indicate an affirmative response or not. For Cicourel (1964) the latter verbal and motor expression would not be sufficient in drawing judgement of findings from social interaction and indeed could be judged as irrelevant. Anthony Pellegrini (2013) notes that one must be careful with what one judges as irrelevant interactional content as the risk of discarding information could skew the authenticity of what is being expressed. That is, responses to questions or categories must be read as a representation of the whole person not simply the words expressed.

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<sup>12</sup> Cicourel proposes that "much of the work on measurement in sociology has been in social psychology and demography; and the development or use of mathematical systems for describing small group interaction, measuring attitudes, and analysing demographic data" (p. 10).

<sup>13</sup> According to Anthony Elliott and Charles Lemert (2014) Cicourel an ethnomethodologist placed importance on the reporting of social interactions irrespective of the lens through which it is viewed. He explores situated structures of society much like other phenomenologists such as Garfinkel; and suggests the analysis of social situations is predicated on interpretation within the general social context, social action thus follows language practices and social rules. See Elliot and Lemert for a fuller explanation.



As a corollary to this, Cicourel (1964) asserts that sociological theory is not sufficiently explicit to specify appropriate measurement structures and that as a result arbitrarily chosen categories are selected as the basis for measurement. He terms this arbitrary selection of measurement imposed on categories as measurement by fiat. The consequence of such imposition of method (and measurement) forces inappropriate or unsuitable relationships and result in untrue understandings of theory and data (Cicourel, 1964).<sup>14</sup> Cicourel (1964) says “the fact that we cannot demonstrate a precise or warranted correspondence between existing measurement systems and...must establish the link by fiat, means we cannot...take research procedures and...the conclusions based on them for granted (p. 18).<sup>15</sup> He further argues that measures are imposed on concepts arbitrarily. These aspects of arbitrary measures, concepts and multiple ambiguities counter the belief that the EPDS can reveal authentic responses. Numerical measurement processes expose that opinion may be the basis for responding to items, rather than objective parameters. This subjective response is only pertinent to one’s own situation, it is not collectively shared. The absence of measureable objective items and the broad scope of the possible responses in the EPDS contribute to the ambiguity of the resulting outcomes. This is discussed further in chapters 3, 8 and 9 of the thesis.

Cicourel (1964) further argues that attempting to measure qualitative data against quantitative measures will not give relevant results. The interview, thus, becomes the means for ensuring validity and relevancy of results. Problematically, unless interviews are scripted there runs the risk of many other unexpected variables influencing the discussion; thus outcomes of the interview process are variable. Potential flaws in the EPDS data collection process occur when it is used as a quantitative approach only. Furthermore, when the interview process seeks to clarify data in a qualitative way, the interview per se can influence the outcome. As discussed

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<sup>14</sup> Cicourel (1964) says “the ‘rules’ used for assigning significance to objects and events and their properties should be the same, i.e., the language systems should be in some kind of correspondence with each other. But in sociological discourse the ‘rules’ are seldom explicit even though there is a concern for precise definition and operational criteria...the ‘rules’ governing the use of language and the meanings conveyed by linguistic and non-linguistic utterances and gestures are unclear and remain an almost untouched problem for empirical research. If the ‘rules’ governing the use of language to describe objects and events in everyday life and in sociological discourse are unclear, then the assignment of numerals or numbers to the properties of objects and events according to some relatively congruent set of rules will also reflect a lack of clarity” (p. 15).

<sup>15</sup> “Fixed-choice questions asked of respondents are designed to elicit common-sense meanings from the subject and also to provide an automatic basis for generating responses that will fit into two or multivalued categories” (p. 22).

in the previous section on intersubjectivity the very nature of human interaction in the interview has an effect on its delivery and the responses. In the absence of behavioural measures within the EPDS, the truth judgement/response cannot be validated and is taken only at face value. An appropriate validation of the use of self-report measures is effective when it is observed in context, for example in a clinical environment. Dodd-McCue and Tartaglia (2010) highlight the issues and limitations of self-report data. In particular, social desirability implicates the individual wanting to fit in with society's norms and thereby presenting herself in a favourable light; compared with acquiescence where the respondent is in general agreement with the measures (Dodd-McCue & Tartaglia, 2010). The halo effect and midpoint response style are additional sources of bias in self-report measures (Dodd-McCue & Tartaglia, 2010). These self-report response biases are relevant issues in the EPDS because the EPDS is wholly reliant on self-reporting.

Smith and Atkinson (2016) continue to argue the relevancy of Cicourel's (1964) concepts for the present day, asserting that the imposition of categories and giving concreteness to indicators and variables do not necessarily add clarity to the issues of measurement and interviewing. Thus measurement becomes a process of classification from which categories are socially constructed and become the basis for social norms (Smith & Atkinson, 2016). Smith and Atkinson validate Bowker and Star's (1999) analysis of diagnostic categories in the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association as contributing significantly to the sociology of measurement. This leads into the need to explore the link between medicine and the screening process. The challenge in this exploration is to ensure that the normal experience is not interpreted as being abnormal or a pathology as reflected by the *DSM*. Of critical importance in this situation is to maintain a holistic perspective of wellness rather than isolating discrete issues that are deemed unfavourable, unwanted, or abnormal.

Michel Foucault in *The Birth of the Clinic* (1975) explored the rise of medicine as becoming a structured institution where the clinic (hospital) became the place where diagnosis and treatment of illness was established. It was in this context that the *medical gaze* became a powerful institution, with prestige and influence. The emergence of hospitals served the purpose of developing medical knowledge and prowess. The centralising of the sick and diseased provided objects of study for the

medical profession (Foucault, 1975). Concurrently, the regulation of medical education and training during the 18<sup>th</sup> century resulted in qualifications through university study. This formal recognition of standards ensured that only persons having medical education would be able to practice medicine (Foucault, 1975). These two significant reforms in health care established power within the medical field.

Pre nineteenth century the human body was analysed in a post-mortem state. It was from this perspective that investigative medicine derived its knowledge (Foucault, 1975). The body in this process was objectified as flesh. In the nineteenth century, however, Foucault reflected on the relationship of disease and illness, where the living body was seen as a potential space for disease as opposed to the post-mortem body. It was in this context that Foucault argued that symptoms and manifestations of illness were superimposed on the body. This relationship was reflected in terms of the body's anatomical structure and tissue where illness formed in the body. Foucault termed this as "the space of the configuration of the disease" and "the space of localization" (p. 3). For example, the presence of cancer cells located in a uterus is an entity within itself and then a diagnosis of cancer of the uterus follows. Foucault recognises 'diagnosis of disease as being a feature of nineteenth-century medicine. He says "at the Edinburgh clinic students kept a record of the diagnosis made, of the state of the patient at every visit and of the medicines taken during the day" (p. 62).

The medical profession expanded its jurisdiction of care to include the well individual and the ability to influence society by promoting health as a lifestyle. Foucault outlines how medicine shifted from a purely curative focus to incorporate the wellness of the being. It was this shift that established social norms and behaviours within society. The medical profession "assumes a normative posture, which authorises it not only to distribute advice as to healthy life, but also to dictate the standards for physical and moral relations of the individual and of the society in which [s]he lives" (p. 34).

In the eighteenth and nineteenth centuries medicine and the clinics were re-organised and re-classified; initially intended as a means of teaching medical practice as opposed to scientific study. Foucault posits that "the clinic was probably the first attempt to order a science on the exercise and decisions of the gaze" (p. 89). He further contends that,

*the medical gaze was organised in a new way. First, it was no longer the gaze of any observer, but that of a doctor supported and justified by an institution, that of a doctor endowed with the power of decision and intervention. Moreover, it was a gaze that was not bound but the narrow grid of structure (form, arrangement, number, size), but rather could and should grasp colours, variation, tiny anomalies, always receptive to the deviant. Finally, it was a gaze that was not content to observe what was self-evident; it must make it possible to outline chances and risks; it was calculating. (p. 89).*

However, it is clear that taking a linear approach to analysing the lived and social experience of motherhood does not reflect the ambiguity and complexity of the mother's world. Such an approach gives a naïve impression of assessing the complexity of maternal emotional wellbeing.

## **2.8 Summary**

Whilst phenomenology explores the lived worlds, it is acknowledged that there are various schools of thought each of which provide an insight and perspective of lived experience. Husserl's phenomenology influenced Merleau-Ponty who further developed the concepts of perception, the body and embodiment existentially. Merleau-Ponty argued that Husserl's phenomenological reduction was not possible because we are embedded in the world and thus it is not possible to separate ourselves from the world. Merleau-Ponty proposed that perception is the basis for understanding – it is in that moment of perceiving that truth is revealed. He says that it is in the moment of the gestalt that when things are lived and experienced, the wonder of living is revealed. Being-in-the-world implies that we exist in the world and the world co-exists with us. He said that perception

*is a deliberate taking up of the world – I take the world up now in whatever form it exists in and go from there...and it is within that perception and that moment that reflects the truth of what I know and do... (p. xi-xii).*

Merleau-Ponty's phenomenology of perception takes a bodily approach, where the biological and the lived body are viewed as one. Whilst he takes a non-gendered perspective of the body, his approach is feminist. De Beauvoir argues that the feminine body because of biology and maternity is disenfranchised, as are her emotions.

Whilst Merleau-Ponty does not specifically address biology and maternity or emotion in detail he argues these in terms of bodily capacity and ambiguity. He contends that mechanistic physiology alone cannot explain the ambiguity of one's body, and cites the example of Schneider the amputee and his experiences of phantom pain. From this follows the ambiguity of maternal emotions that can be experienced in pregnancy and the postpartum period. Understanding and appreciating maternal emotional wellbeing must involve the consideration of a mother's experiences *in toto*. The manner in which a mother takes up her (the) world is individually unique; she constantly adapts and responds to her world reflecting her embodiment. Her embodied approach to mothering is influenced by her relationship with her baby and others around her. Adaptation to motherhood is measured by assessing her emotional wellbeing.

Measurement in general may lead to understanding social norms but can lead to inappropriate labelling of a mother's health and wellbeing. Measurement is argued to be of importance, yet the basis of measurement is not always explored. The arbitrary nature of measurement is not fully understood by some health professionals. To overcome some of these limitations the concept of validity and reliability of measurement is required. Measurement tools may not necessarily capture the complexity of social existence.

This chapter has provided a background to this thesis, and Merleau-Ponty phenomenology of perception and the body and embodiment. The meaningful relationship a mother has with her world considers both her experience of herself in mothering and also the influence she derives from society. Thus, her perceptions of emotional wellbeing are revealed as she makes sense of her experiences and situations in which she is immersed. This immersive experience becomes her, it shapes her thinking, beliefs, and motivations of her-self, her identity and her mothering. This intertwined experience of being-in-the-world is premised on Merleau-Ponty's three orders of the body which promote the thinking that maintaining an equilibrium fosters the holistic view. The problem with this arises when the EPDS alone is used to measure maternal emotional wellbeing as the scale does not necessarily reveal the presence or absence of PND symptoms. Chapter 3 discusses the transition to motherhood, the historical context of PND, mood disorders and their symptoms in the postpartum period, instruments and screening for PND, and models and scientific approaches employed to investigate PND.

## Chapter 3

### Postnatal Depression Literature Review

This chapter details an overview of research and discussion papers in relation to PND in order to provide a historical and scientific understanding of current practices. This discussion considers mother's emotional wellbeing and general postpartum adjustment experienced following childbirth. Fundamentally, all mothers experience some level of transition to parenthood. Since the experience of childbearing and childbirth is unique to the person, essentially it is the breadth of emotions and responses which provide insight about the adjustment and experiences. A review of the literature reveals that although a significant number of studies have explored the depth and extent of maternal postpartum emotions and how they relate to the experience of PND, the aetiology of the disorder remains undetermined. This chapter presents the historical context of PND and mood disorders in the postpartum period. The discussion will include a review of the measurement tools and processes used to screen and predict those at risk of PND and their validity and an exploration of key research outcomes relating to possible antecedents of the condition.

#### 3.1 Introduction

PND is not a new phenomenon. Reports of this distressing disorder exist from the 15<sup>th</sup> century, yet a precise definition remains elusive. The available research shows a determination to identify women at risk of, or who have been diagnosed with, PND following childbirth. However despite such research, findings from these studies have not been effective in reducing the prevalence rate and it is this fact over time that has generated further concern (Bilszta, Gu, Meyer, & Buist, 2008; Brooks et al., 2009; Buist et al., 2008; Cox, Murray, & Chapman, 1993; Klainin & Arthur, 2009; Leahy-Warren & McCarthy, 2007; Söderquist, Wijma, Thorbert, & Wijma, 2009; Tannous, Gigante, Fuchs, & Busnello, 2008).

Research and in-depth analysis has identified numerous antecedents which have been proposed to contribute to the development of PND. However, the manifestations of symptoms and signs, the screening processes and impacts on women

demonstrate the ambiguous nature of PND. It would seem that the condition is even more complex than the diagnostic framework suggests. In an effort to substantiate the nature of PND, research has explored the significant parameters of this disorder. These include processes for the identification of symptoms and signs (Cox, Holden, & Sagovsky, 1987; Davis, Cross, & Lind, 2008), antecedents which influence the development of PND (Beck, 2001, 2002; Cox et al., 1987) and a variety of treatment and management interventions (Beck, 2002; Grote & Bledsoe, 2007; Knudson-Martin & Silverstein, 2009; Vasterling, 2003). The wide dimensions of past and current research have validated that PND is a multifaceted psychological disorder with no definitive cause. The array of recognised risk factors used to diagnose PND continues to proliferate, which suggests an inconclusive set of criteria for diagnosis. Furthermore, there is a tendency within the contemporary literature and current practice to place an emphasis on the prevalence rates of PND, rather than on incidence rates.<sup>16</sup> Prevalence rates inform the number and burden of disease in specific population at specific times as compared to incidence rate which informs the risk of disease/illness (Ward, 2013).<sup>17</sup> Determining incidence of PND would require a clear indication of the risks associated with the illness, as will be discussed further in the chapter, the antecedents are not clear and vary.

### **3.2 Transition to Motherhood**

According to Benedek (1956) motherhood is a developmental process for women experiencing the childbearing stage of life. Such a transition involves changes in physical, emotional and/or self-identity states or phases. All mothers experience some level of transition from single entity to motherhood, and this may be experienced from the time of conception, irrespective of the duration of the pregnancy and its outcome. The transition to motherhood affects most aspects of a woman's life ranging from her identity, relationships with her baby, partner, family and relevant others, her physical, mental and emotional health (Avan, Richter, Ramchandani, Norris, & Stein, 2010; Gauthier, Guay, Sénécal, & Pierce, 2010; Greenberg, Clair, & Ladge, 2016;

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<sup>16</sup> Brockington 1996 reports an incident rate of 4/1000 women.

<sup>17</sup> Michael Ward defines "prevalence as a measure of the burden of disease in a population in a given location and at a particular time, as represented in a count of the number of people affected... Incidence rates represent the number of new cases of disease among the number of susceptible persons in a given location and over a particular span of time. The primary value of incidence rates is in studies of disease aetiology, by comparing how the rates vary among different subgroups or with different exposures" (p. 1241)

Spitzmueller & Matthews, 2016; Vejar, Madison-Colmore, & Ter Maat, 2006). Whilst motherhood is recognised as a stressful life event, it is also the opportunity for a woman to explore another dimension of herself and to exploit change and uncertainty (Greenberg et al., 2016; Nicolson, Fox, & Heffernan, 2010). Nicolson et al. posit that a pregnant woman, because of her visible state, becomes subject to public scrutiny. In contrast a postnatal woman's physical state is not noticeable and therefore becomes invisible. Pregnant visibility is magnified by medical gaze. Pregnancy becomes 'public property'. This situation is generally welcomed by the woman in her transition to motherhood because of the attention afforded to her. However, if a pregnancy is not progressing as expected, she has no control over this public gaze and the attention is not welcomed by her<sup>18</sup> (de Vitry-Smith, 2011; de Vitry-Smith, Dietsch, & Bonner, 2013). In these circumstances the transition to motherhood is not a pleasant one and the experience may be daunting (Nicolson et al., 2010).

The intensified medical surveillance which has resulted from increased biomedical knowledge and technical expertise has altered the psychology of pregnancy and motherhood (Nicolson et al., 2010). Consequently, this medical surveillance intends to pre-empt possible intervention which in turn alerts the mother to increased risk and possible consequences. Thinking of the EPDS, this does not always work to the benefit of the mother and may cause unnecessary anxiety because of the ambiguity of the situation. This observation of medical surveillance aligns with Foucault's (1975) *Birth of the Clinic* and the clinical (medical) gaze discussed in the previous chapter. Women may welcome this gaze because it provides assurance that the pregnancy is progressing. But when a deviation from the norm arises, involving either the mother or baby, this situation presents a complexity that the mother was not expecting and which can negatively impact her emotional wellbeing. Attention to her initial and ongoing emotional needs become imperatives for care but these are often missed.

Maternal role attainment is a complicated process that is learned, yet becoming a mother is a dynamic and evolving experience, not a state that is attained (Rubin, 1984). Adaptation to motherhood, and maternal functioning,<sup>19</sup> is evident when

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<sup>18</sup> de-Vitry Smith's study investigated women's experience of foetal anomaly that was incompatible with life.

<sup>19</sup> Barking (2010) posits that seven functional domains (social support, self-care, psychological well-being, infant care, mother-child interaction, management and adjustment) comprise maternal functioning.



the responsibilities of infant care are combined with women's existing responsibilities (Barkin & Wisner, 2013). For women, the importance of maternal agency is realised as they strive to individually influence their own lives, and co-support other mothers. Erik Erikson's psychosocial adaptation framework and John Bowlby's seminal work on mother infant attachment provide a context to understand the mother's roles and responses to bond with her new baby. The importance of a close and enduring bond a mother has for her child has been extensively discussed and documented in the literature (Bowlby, 1979, 1988). According to Bowlby, the mother establishes and provides a physical, emotional and social source of trust and security for the baby, whilst the baby simultaneously identifies its mother as a source of trust and security (Applegate, 1997; Barkin & Wisner, 2013; Bowlby, 1979).

Maternal attainment is explored by Sarah Ruddick (1980) who posits that successful mothering is the outcome of care and deliberate maternal thinking and practice. She states that:

*maternal is a social category and that a mother's thought [is]- the intellectual capacities she develops, the judgments she makes, the metaphysical attitudes she assumes, the values she affirms...to describe the capacities, judgments...attitudes, and values of maternal thought does not presume maternal achievement. It is to describe a conception of achievement, the end to which maternal efforts are directed. (p. 24).*

For others, however, maternal identity are the internal feelings a woman holds; she is conscious of the relationship of competence and essential knowledge and understanding of her own child (Rubin, 1984). Maternal identity is realised when a woman births her baby; she may query her lack of competency, but she wholeheartedly knows that the responsibility of mothering the baby lies with her. Verbiest, Tully, Simpson, and Steube (2018) argue that the first twelve weeks postpartum - referred to as the fourth trimester is a critical time for mothers' transition and that more structured engagement and time should be given to assist mothers in their role transition at this time. These researchers undertook a fourth trimester project which was premised on social justice framework that supported mothers through education and discussion as they transitioned to their mothering role. The program focussed on maternal health and wellbeing and involved a combination of webinars, and small and large group interactions. The focus of this project was advocating for mothers

emotional and physical wellbeing, and fostering a satisfying transition to the new role of motherhood. The current Australian health care context pays little attention to the postpartum period. That is, once discharged from hospital a health assessment is conducted at the sixth week postpartum visit, the mother is considered to have returned to her pre-pregnant state and the assumption is made that she no longer needs physical care. Her transition and adjustment to mothering is left to her immersion into society. As childbearing and parenting are considered normal developmental milestones, perhaps assumptions are made that mothers may advocate for themselves and seek health care when required. This is in contrast to a baby/child who is considered vulnerable and as the state holds health care responsibilities, this is attended to through the child health clinic.<sup>20</sup>

### **3.3 Historical Context of PND**

Emotional distress in the postpartum period has been reported since the 15<sup>th</sup> century. Historians should be credited with providing detailed accounts and dialogue of postnatal distress which have provided the framework for present day research. Brockington (1996) cites de Castelo Branco who, in the 15<sup>th</sup> century and Castro in the 16<sup>th</sup> century described a woman's distress and melancholia for several months following childbirth. Platter in the 16<sup>th</sup> century also described a recurrent situation in which a woman was so distressed following childbirth that she had attempted suicide (cited in Brockington, 1996). Whilst such women were not recognised as having PND at that time, the exhibited behaviour led to the diagnosis of insanity. Up until 1950 women exhibiting similar behaviour were often committed to an asylum where tragically many remained until their death. Historically, asylums were institutions of incarceration rather than of care. McGregor-Robertson (1904) recognised that first-time mothers were more often affected by severe emotional distress and proposed that "insanity may occur during the child-bearing period, during labour, or after delivery" (p. 517). With the increased understanding of mental health such asylums were systematically abolished. Currently, mothers who experience a severe mental illness or psychosis following birth, and throughout the first year postpartum, should be cared for in specialist psychiatric mother and baby units. However, this ideal is not always

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<sup>20</sup> In Australia child health clinics are governed through state health policies: Department of Health, Government of Western Australia. 2019. *Community Child Health Program*. Retrieved from [https://healthywa.wa.gov.au/Articles/A\\_E/Community-Child-Health-Program](https://healthywa.wa.gov.au/Articles/A_E/Community-Child-Health-Program)

possible given issues arising with bed shortages, the limited availability of facilities and healthcare funding. Current perinatal health recommendations advocate that mother and baby remain together when in psychiatric care.<sup>21</sup> Maintaining the maternal-infant relationship is important to minimise the mother's distress, and facilitate bonding and attachment for both mother and baby. This practise of unifying mother and baby in all situations upholds Bowlby's seminal work on bonding and attachment as previously discussed.

McGregor-Roberston (1904) postulated that there was a hereditary component related to the psychological disturbances and that these women had a possible tendency to suicide. Since then a number of studies have supported findings of a relationship between psychological disturbances and family history (Forty, Jones, Macgregor, & Caesar, 2006; Friedman, 2009; Spinelli, 2009). Puerperal psychosis, the severest form psychological distress is a significant risk of maternal suicide or infant harm.

Pitt, an obstetrician in London in 1968, observed postpartum women and identified that some demonstrated behaviour of atypical depression. To validate this observation he undertook a study which involved 33 women. Findings showed that of the 33 participants, 20% ( $n = 6$ ) had PND. A follow up study found that in a population of 305 childbearing women "atypical postnatal depression" was found to be at a rate of 10.8%. Pitt's work was instrumental in beginning to understand PND and thereby defined a common mood disorder following childbirth. This common mood is 'the blues' often referred to as 'the third day blues'. He considered PND to be a state which "lies between the extreme of severe puerperal depression, with the risk of suicide and infanticide, and the trivial weepiness of 'the blues', much less dramatic than the former, yet decidedly more disabling than the other" (Pitt, 1968, p. 1325).

The aforementioned perceptions and descriptions of PND throughout history have established the lived experience of women's distressed states, describing physical and psychological impacts of the illness. While some studies of PND have used a phenomenological approach (Beck, 1994, 2002; Leung, Arthur, & Martinson, 2005), to date an extensive review of the literature has not revealed any study which has examined PND from a bodily perspective (body/subject). As Benoist and Cathebras

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<sup>21</sup> These are located at: Centre of Perinatal Excellence. 2017. *Mental Health Care in the Perinatal Period, Australian Clinical Practice Guideline*. Retrieved from <http://cope.org.au/wp-content/uploads/2017/10/Final-COPE-Perinatal-Mental-Health-Guideline.pdf>

(1993) assert it is “the association between body and person, more than the image of the body itself, which could be seen as the fundamental basis of body language which is expressed through social interaction or illness” (p. 857). In simple terms, Merleau-Ponty’s philosophy unifies the body that is the ‘lived body’ is a holistic self which is mind and body, and the ‘lived world’ is the social cultural aspect. He says that this unification gives an emphasis to subjectivity, and that the lived body is not an object in the world but is the subject's own point of view on the world. The body is the knowing subject and there is no “separation between the experiencing of the ‘I’ and the body as one lives it” (Merleau-Ponty, 2002, p. xiv). In this way ‘the subjective’ is related to the world we are conscious of (Matthews, 2006). The relationship of mind-body and Merleau-Ponty’s description of embodied consciousness is fundamental in further understanding the current research in relation to PND.

Whilst considerable research has been conducted to clarify what is, and what causes PND, a review of these studies conveys the impression that the diagnosis of PND appears relatively straightforward whereas in reality it is much more complex. An in-depth critique of the research, taking account of the antecedents of PND, behavioural manifestations, screening and impacts of the diagnosis implies that the diagnosis of PND is more compounding than the *DSM-IV* (American Psychiatric Association, 1994) suggests. In an attempt to understand PND, research has explored the significant parameters of this disorder; such as processes for the identification of symptoms and signs of PND (Cox et al., 1987; Davis et al., 2013; Dennis & Ross, 2006; Vik, Aass, Willumsen, & Hafting, 2009; Zelkowitz et al., 2008) and antecedents which could influence the development of PND (Beck, 2001, 2002; Boyce & Hickey, 2005; Cox et al., 1987; Davis et al., 2013; Johnstone, Boyce, Hickey, Morris-Yates, & Harris 2001; Josefsson, Larsson, Sydsjö, & Nylander, 2007; O'Hara & McCabe, 2013; Verkerk, Denollet, vanHeck, vanSon, & Pope 2005) and treatment and management interventions (Beck, 2002; Buultjens, Robinson, & Liamputtong, 2008; Grote & Bledsoe, 2007; Knudson-Martin & Silverstein, 2009; O'Hara & McCabe, 2013; Turner, Chew-Graham, Folkes, & Sharp, 2010). These studies clearly illustrate that PND is a complex psychological disorder and that the salient antecedents to identify

those at risk for PND have grown exponentially as a means to arrive at a diagnosis.<sup>22</sup> Regardless of these many safety nets, multiple women go undiagnosed.

The preceding literature shows the plethora of research that has been conducted since the 1980s. It was the worldwide concern of PND, and the developing areas of midwifery and obstetric health care practices that influenced the National Health and Medical Research Council in Australia to commission the first systematic review into PND in the year 2000. This foundational research review was important in establishing a direction for identifying risk and screening processes for PND. In 2008 the first Australian National Perinatal Initiative through Beyond Blue was established.<sup>23</sup> The launching of the Perinatal Initiative was important in establishing the perinatal period as a timeframe that addresses both the antepartum and postpartum period. In 2011 the first Perinatal Clinical Practice Guideline was disseminated for national health care practice through Beyond Blue. Beyond Blue is an Australian organisation committed to ensuring optimum mental health across the population. It ensures that all people regardless of their community have access to support in all areas of communication. Following this in 2013 the Centre of Perinatal Excellence (COPE) arose from Beyond Blue. COPE was established as a dedicated resource organisation to specifically support parental emotional wellbeing. COPE has both consumer and health care provider capacity, they published the 2018 mental health care in the perinatal period Australian clinical practice guidelines recommended for healthcare professionals.

### **3.4 Mood Disorders in the Postpartum Period**

There are three types of mood disorders which manifest at different times in the postnatal period. The first disorder, the 'maternity blues', is also referred to as the

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<sup>22</sup> According to the Australian Bureau of Statistics. (2010). *Births, Australia (No. 3301.0)*. Retrieved from <http://www.abs.gov.au/ausstats/abs@.nsf/lookup/3301.0Media%20Release12010> the Australian Institute of Health and Welfare (AIHW) reported a total of 297 900 births. According to the AIHW (2010) data from the Australian National Infant Feeding Survey, one in five mothers of children aged 24 months or less were diagnosed with depression. Of these, 56,000 women were diagnosed with depression during their pregnancy and up to the child's first year" (p.vi). This represents an incidence rate of 1.8/1000 compared with Brockington (1996) who reported an incidence of 4/1000 women (Brockington, 1996).

<sup>23</sup> The Australian Government Department of Health. 2019. *Framework for the national perinatal depression initiative 2008-09 to 2012-13*. Retrieved from: <http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-f-perinat>

third day blues or the postpartum blues. The second is postnatal depression (PND), and the third and most severe mood disorder is puerperal psychosis. All three disorders are discrete, do not affect all women, and are determined by time of occurrence, clinical presentation and clinical picture (Beyond Blue, 2011; COPE, 2018).

### **3.4.1 The maternity blues**

The maternity blues is considered a normal reaction to childbirth and may occur three to five days post birth and affects 70-80% of women (Beck, 2001; Bick, Bick, MacArthur, & Winter, 2009; Nicolson, 2006; Pope & National Health and Medical Research Council [NHMRC], 2000). This transient state is characterised by tearfulness, irritability, anxiety and a labile mood. These self-limiting responses are indicative of normal adjustment to childbirth. Generally, the maternity blues is transient and considered to be of minor importance. However, Cox et al. (1993) warned that a serious episode may be a predictor of PND. Whilst the maternity blues is considered a transient state, research has suggested a possible link to PND. The National Health and Medical Research Council (NHMRC, 2000) systematic review of literature on PND to 1999 found that severe maternity blues (particularly in women who had reported symptoms which had continued for longer than two weeks) is a probable risk factor for PND.

A quantitative study by Adewuya (2006) involving African women ( $N = 582$ ) explored early onset mood changes and the correlation with PND. The scales used to measure maternal mood were the Maternity Blues Scale (MBS) and the EPDS. The scales were administered on day five postpartum and at the end of weeks four and eight. Face to face interviews were conducted on all women using the Schedule for Affective Disorders and Schizophrenia at the end of weeks four and eight of the postpartum period. The scores of the MBS and the EPDS at day five postpartum reliably predicted PND at the end of weeks four and eight. Of the 582 women, 146 had maternity blues, 43 (29.5%) were diagnosed with PND at four weeks and 64 (43.8%) were diagnosed with PND at eight weeks. A low score on the MBS did not protect against a diagnosis of PND; eight (2.4%) women were diagnosed with PND at four weeks compared with 14 (4.2%) at eight weeks. Findings from the study revealed that the experience of maternity blues is not a final indicator of whether or not a diagnosis of PND will eventuate.

A subsequent study investigating the relationship between maternity blues and PND was undertaken by Taniguchi (2007). A mixed method study was conducted and involved 45 women born and raised in Japan who birthed in Hawaii (USA). The investigation focussed on the mental health of women who had experienced childbirth and its impact on women living in a foreign country. Results showed that 62% of these women experienced the maternity blues and 31% experienced PND. The author reported a significant finding ( $p < 0.05$ ) between mothers who had experienced maternity blues with progression to PND. Although it was acknowledged that whilst the findings were significant, limitations such as a small sample size, no comparison group and the measurement of stress factors associated with birthing in a foreign country, may have influenced the study outcomes.

### **3.4.2 Puerperal psychosis**

Puerperal psychosis is a serious depressive state which affects from 1 in 500 to 1 in 1000 mothers per live births. The onset is rapid usually within two to four weeks post birth (American Psychiatric Association, 2000; Beyond Blue, 2011, COPE, 2018; Nicolson, 2006). Women affected with puerperal psychosis may manifest distorted thinking through hallucinations, delusions, altered thoughts, confused speech and altered behaviour. Women with a previous diagnosis of other mental disorders such as bipolar disorder, schizophrenia or schizoaffective disorders are at increased risk of developing PND and psychosis (Beyond Blue, 2011, COPE, 2018; Nicolson, 2006). Management of puerperal psychosis is dependent on the severity of symptoms, with recommended hospitalisation and a prescription of a range of treatments including medications (antidepressants and/or neuroleptics), electroconvulsive therapy and community support when discharged home (Bick et al., 2009; Blum, 2007; Nicolson, 2006). The severe consequences of puerperal psychosis reinforces the importance of monitoring women who have a predisposition to developing mental disorders in the postpartum period and ensuring that early screening processes are in place to support women in their transition to motherhood.

### **3.4.3 Postnatal depression**

The *DSM* defines PND is an abnormal mood disturbance that may occur in women within a year after childbirth (*DSM-IV*; American Psychiatric Association, 1994). Contemporary diagnostic tools used to diagnose PND are based on the

international Classification of Disease, Tenth Revision (ICD-10) and the *DSM-IV* which consider the presence, number, severity and duration of a cluster of symptoms.<sup>24</sup> The *DSM-IV* identifies PND as a distinct diagnosis, and is listed as one of the five specifiers to identify the depressive mood disorders diagnoses. PND is assigned the specifier “with postpartum onset” specifying the occurrence of this disturbance within four weeks of childbirth (*DSM-IV*; American Psychiatric Association, 1994). The experience of PND clinically is similar to general depression (Brockington, 1996; O’Hara & McCabe, 2013) but key differences are in the number, type and severity of reported somatic and depressive symptoms (NHMRC, 1999; O’Hara & McCabe, 2013). The postpartum specifier added to the *DSM-IV* acknowledged motherhood as a stressful event.

Regardless of the historical nature or contemporary classification of PND, the physical and/or psychological manifestations of depression reflect Merleau-Ponty’s concept of embodiment as a means of informing perception/awareness. According to Merleau-Ponty, embodiment pertains to identifying the body as a biological (holistic) body and as a ‘phenomenal body’ which is the lived body in the world. Much research, debate and discussion has centred on the biological body. Benoist and Cathebras (1993) argued that the emergence of the biological body, as an object of science, has resulted in isolating the body from the subject’s experience. The aforementioned statement implies that *my* body is *my* lived experience (Merleau-Ponty, 2002). This factor becomes important for a woman as the basis of self-diagnosis relates to the symptoms she manifests. A diagnosis of PND is either assigned by the woman herself or prescribed.

The literature has reported a wide variation in the time of the onset of PND. Typical time periods are, for example, the first six weeks after childbirth (Ballard et al., 1992; Watson et al., 1984), the first 3 months (Cox et al., 1993; Kumar & Robson, 1984; O’Hara, 1984); the first 6 months (Cox et al, 1982; Kumar & Robson, 1984), and within the first 12 months (Kumar & Robson, 1984; Cooper et al., 1988). There is consensus that, irrespective of its onset, PND occurs within the first 12 months

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<sup>24</sup> PND is predicated on the general diagnosis of depression in the *DSM-IV*. Depression is recognised as experiencing at least two weeks of depressed mood or loss of interest or enjoyment in daily life; with the presence of any four of the following states: “a change in appetite or weight, sleep and psychomotor activity; decreased energy; feelings of worthlessness or guilt; difficulty thinking, concentrating, or making decisions; recurrent thoughts of death or suicidal ideation, plans or attempts” (*DSM-IV*; American Psychiatric Association, 1994, p. 320).



postpartum (Pope & NHMRC, 2000). However this thesis also contends that a cut off at 12 months is not biologically plausible.

A wide variation in the prevalence rates of PND is also reported. Brockington (1996) reviewed and identified a variety of definitions, thresholds and measures for PND that had been carried out at different time intervals in studies conducted in 15 countries. Leahy-Warren and McCarthy (2007) conducted a review of research studies on PND and found a wide range of prevalence in the published papers from 4.4 – 73.7%. Howell, (2009) conducted a similar review and found that 50% of postpartum women reported experiencing depressive symptoms postpartum. International studies have shown prevalence rates of 5.6% in Sweden (Söderquist et al., 2009), 5% -36.7% in Southern Brazil (Tannous et al., 2008), 14 – 17.7% in Turkey (Kirpinar, Gozum, & Pasinlioglu, 2009), 5.4% in the US (O’Hara & Swain, 1996) and more recently in the US 13% -19% (O’Hara & McCabe, 2013). These aforementioned studies clearly identify that the true prevalence of PND is unknown, possibly influenced by cultural variables and the adoption of various methods of measuring emotional wellbeing.

An Australian study reported by Buist et al. (2008) identified a range of prevalence of 5.6% – 15.5%; similarly a study conducted by Brooks et al. (2009) found the range to be 6% - 9%. The Australian NHMRC systematic review in 2011 confirmed this variation of prevalence of mental health disorders in the perinatal period and suggested that results vary depending on the study parameters; “the definition and measurement of disorder (e.g. screening tool or diagnostic interview; cut-off score used) and whether point or period prevalence is reported” (p. xiv). Hahn-Holbrook, Cornwell-Hinrichs, and Anaya’s (2018) undertook a systematic review, meta-analysis, and meta-regression of 291 studies from 56 countries to investigate the economic and health predictors of national PND prevalence. Results showed that the global prevalence of PND was greater than previously believed. A global pooled prevalence of 17.7% is presented. Of the twenty-three studies analysed from Australia the depression prevalence was deemed 9.1%-57.5%.

Given the range of varied prevalence rates in the research literature, it is possible that such variations are a result of different types of study designs and methodological problems associated with sample groups; for example non-representative samples, poor matching of comparison groups, selection bias, invalid

recruitment of control groups, demographic characteristics and small sample sizes may skew results (Beck, 1992; Brockington, 1996; Pope & NHMRC, 2000; Han-Holbrook et al., 2018). Cicourel's discussions regarding the appropriateness and validity of method and measurement raised in the previous chapter can also be considered as possible explanations for such varying prevalence rates. If indeed international and national data collection methods are to be analysed, one would expect at the very least that an agreed tool and method were applied. Furthermore, such a tool would also be compliant with validity and reliability measures. Given the social acceptability of mental health care and the National Mental Health Strategy, the awareness and knowledge of mental health needs has vastly influenced people's perceptions. One might surmise that Merleau-Ponty conception of perception could challenge the prevalence rates as they reinforce the social awareness and perception that PND is an increasing and continuing problem. Husserl's ideas of the natural attitude may influence contemporary thinking in some way, such things as popular culture, the media, and social awareness generally, health campaigns and cultural expectations are sources from where social norms can be generated. These then become the natural attitude from and for the social world. Merleau-Ponty says that the social world is already in existence, and the self is independent of the world. It is in the relationship of the self with the world where meaning is derived which influences action. The reciprocal and mutual interaction of self and the world co-constitutes one and the other. It is these elements that contribute and further influence how the individual responds to the natural attitude (norms). Linking this idea back to emotional wellbeing, one would need to identify and examine norms that impact mothering experiences. This is discussed in the findings in Chapters 7 and 8, and in Chapter 9 discussion and conclusion.

### **3.5 Symptoms of PND**

PND symptoms may be divided into emotional, cognitive, physical and behavioural components (NHMRC, 1999; Nicolson, 2006). Using such separations of mind and body in trying to understand PND contradicts Merleau-Ponty's concept of embodiment. In Merleau-Ponty terms we must look at the whole person, not a dissection of elements present in the person. The most commonly reported emotional symptoms include irritability, anger, loss of interest, guilt, and diminished pleasure in usual activities. Cognitive symptoms include difficulty concentrating or thinking,

difficulty making decisions and recurrent thoughts of death or suicide. Commonly reported physical symptoms include fatigue, sleep disturbance (too much or too little) lethargy, and significant weight or appetite, loss or gain. Behavioural symptoms can include crying or impaired social and occupational functioning (Centre of Perinatal Excellence [COPE], 2017; Pope & NHMRC, 2000; Nicolson, 2006). Psychomotor retardation or agitation is a general symptom of depression not generally observed in PND. Women with PND will usually identify with emotional aspects of these symptoms whilst also exhibiting physical, behavioural and cognitive aspects. However, they do not always recognise that these manifestations are related and connected to PND.

### **3.6 Instruments and Screening for PND**

In the 1970s and 1980s a number of instruments were developed to measure PND. These included the Beck Depression Inventory (BDI), the General Health Questionnaire (GHQ), the Anxiety and Depression Self-report Scale SADS and the Clinical Interview Schedule. These scales were administered by a psychologist or psychiatrist. However, the midwife and child health nurse (CHN) who were the primary carers of postnatal women were excluded from assessing women for psychological wellbeing. Significantly, these scales lacked specificity and sensitivity for PND, face validity and some of the somatic items were likely to be influenced by physiological factors; and thus were limited in identifying PND in childbearing women (Brockington, 1996; Cox & Holden, 1994, 2003). For example, a number of the items in the BDI were often reported by women who were not depressed; such as irritability, feeling unattractive, insomnia and fatigue (Brockington, 1996; Pope & NHMRC, 2000). The SADS was modified as a means of differentiating depressive symptoms in pregnancy and the postpartum, and whilst a comprehensive assessment tool, it was lengthy and impractical in most clinical settings. These tools are no longer used in to assess PND. The Clinical Interview Schedule was a standardised psychiatric interview for use by psychiatrists in community settings for assessing depression (Goldberg, Cooper, Eastwood, Kedward, & Shepherd, 1970). Clemmens, Driscoll, and Beck (2004) noted two more reasons for the difficulty with self-reporting instruments to measure PND: firstly, the sensitivity of screening tools and the symptom focus, and

secondly, the clinicians' understanding and awareness of the overall impact of the screening tool focus on PND.

Cox et al. (1987) endeavoured to overcome the deficits of existing scales and developed the Edinburgh Postnatal Depression Scale (EPDS) to screen for PND in primary care settings. In these settings health professionals such as midwives and child health nurses administered the scale at designated time periods in the antenatal and postnatal phases.<sup>25</sup> Since its development the EPDS has been globally accepted and translated into many languages including, Thai, Chinese, Spanish, Taiwanese, Japanese, Italian, African, Maltese, Hungarian, French, and Indian languages. The EPDS has become the worldwide dominant screening tool for PND. Primarily, Cox and Holden (1994, 2003) had designed the EPDS as an interim screening tool and did not anticipate the worldwide interest and reception of its use and implementation. Part of its attraction was that it could be used by midwives and child health nurses. Principally, Cox and Holden designed the EPDS as a *screening tool*. Nonetheless, it became interpreted as a *diagnostic tool* by the population it serves. Cox and Holden (1994) commented that the EPDS was “a self-report scale and could not fully measure the severity and personal impact of a depressive disorder which follows childbirth; the EPDS was designed as a screening questionnaire to identify possible depression in a clinical setting” (p. 118). Mandy (1998) reported that the premise on which the EPDS should be administered has been misunderstood. This has resulted in the scale being labelled as a diagnostic tool rather than its original intent as an ‘identification of the presence of depressive symptoms’ secondary to screening.

Currently, PND is formally diagnosed by a psychiatrist, psychologist or a general practitioner. Midwives and child health nurses apply protocols of assessment by combining health and wellbeing of a mother as well as undertaking psychosocial assessment their processes of engagement foster communication and exploration of maternal health needs.<sup>26</sup> Cox and Holden (1994) also argued that to completely understand PND socio-cultural variables associated with childbirth attitudes and parenting processes are essential. Being simple to use Cox and Holden (1994)

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<sup>25</sup> 10 The NHMRC and the WA Department of Health recommend that screening be undertaken within the last four weeks of pregnancy, at two weeks and eight months postpartum.

<sup>26</sup> NHMRC protocols and policy as above.

advocated that EPDS screening should be acceptable and simple to complete, even those who do not regard themselves as unwell.

The EPDS is a self-report questionnaire which originally had 13 items, later reduced to ten. As a screening instrument the tool has been validated for use with postpartum women in community samples and found to have a specificity of 95.7%, a sensitivity of 67.7% and a positive predictive value of 67.7%. The wide use of this scale has proved its validity and reliability as a screening instrument, and is recognised for being “sensitive to changes in the severity of depression over time” (Cox & Holden, 1994, p. 118). The scale asks that the respondent consider the feelings experienced in the previous seven days. Response to each item is by a Likert style response scale of 0 to 3. Originally, a cut off score of 10 was recommended as a reliable indicator of depressive symptoms in the postpartum period. However, it is again stressed that the survey was never meant as a diagnostic instrument (Cox et al., 1987).

Since the introduction of the EPDS, subtle changes have been made to the continuum of scoring. Baker-Ericzen (2008) applied a cut-off score of 10 as indicators of depressive symptoms. Whilst Bilszsta et al. (2008a) applied a score of 12 to indicate depressive symptoms, Buist et al. (2008b) used a cut off score more than 9 as a moderate likelihood of depression and more than 12 as a high likelihood of depression. In contrast, (Bowen, Stewart, Baetz, & Muhajarine, 2009) defined depression as a score of 13 or greater. This variation in scoring and the subsequent outcomes of varied definitions of what constitutes minor, moderate or high likelihood of depression have bestowed doubt on the true prevalence rates of depressive symptoms in the postpartum period. The complexity of diagnosing PND is clearly evident.

Despite the authors insistence that the EPDS was never meant to be a diagnostic instrument it has been globally accepted by midwives and nurses as the essential tool to assess for the presence of PND. A plethora of studies have used the EPDS, however, few studies have critiqued its use in practice. Dennis and Ross (2006) conducted a population-based study to determine whether true- and false-positive screen scores could be distinguished during the early postpartum period amongst childbearing women ( $N = 594$ ). Findings from the study showed a false-positive rate (nearly 50%) of women with EPDS scores greater than 9 at one week no longer screened positive for probable depression at eight weeks postpartum. From this

outcome, Denis and Ross suggested that the presence of known risks factors, in particular antenatal depression, and vulnerable personality, history of postnatal depression, low self-esteem, perceived stress and lack of social support, were reasons for differentiating results amongst those women with persistent depressive symptoms versus remitting depression. Migrant women were also included within the group since many do not have family members close by and so can have persistent postnatal depression symptoms (Ahmed, Stewart, Teng, Wahoush, & Gagnon, 2008). These researchers emphasised that it was essential to understand a woman's biological and psychosocial risk for PND, as this could assist health professionals to identify those at risk and early symptoms of depression. Milgrom and Gemmill (2014) argued the shortcomings of the EPDS in the practice setting but recognised that universal screening does benefit mothers. Furthermore, the incorporation of a referral pathway and health care professional training, the EPDS can assist mothers in their first year postpartum.

The current National Perinatal Mental Health guideline (2017) make recommendations on screening and management processes for women's emotional wellbeing following the birth of a baby.<sup>27</sup> The guidelines specifically recommend the use of the EPDS for mothers and fathers at predetermined time periods; and other additional assessment tools for mother and baby. In the development of these recommendations for care they have accessed other credible sources such as the United Kingdom (UK) National Institute for Health and Clinical Excellence (NICE) guidelines, Antenatal and Postnatal Mental Health (NICE, 2018):

*The UK National Institute for Health and Clinical Excellence guidelines, Antenatal and Postnatal Mental Health (NICE 2018) recommend that all health professionals seek to detect women with depression using two 'Woolley' questions, which ask about their mood and interest or pleasure in activities during the past month. They differ from these Guidelines in that they do not recommend routine use of the Edinburgh Postnatal Depression Scale (EPDS) (although they allow use of this tool as an adjunct); they do not recommend a broader routine psychosocial assessment, nor do they make recommendations on the infant's wellbeing in any specific way. In*

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<sup>27</sup> The 2017 COPE National Mental Health guideline make recommendations about screening and management processes: Centre of Perinatal Excellence. 2017. *Mental Health Care in the Perinatal Period, Australian Clinical Practice Guideline*. Retrieved from <http://cope.org.au/wp-content/uploads/2017/10/Final-COPE-Perinatal-Mental-Health-Guideline.pdf>. The previous Beyond Blue Perinatal Mental Health Clinical Practice guideline 2011 mandated screening and monitoring processes. As previously indicated COPE transitioned from Beyond Blue in 2013.

*summary the NICE guidelines have focussed on the prediction of maternal mental illness and the detection of depression, rather than taking a broader, more systemic approach to assessment of mother, infant and family. (p. xiii)*

Based on research findings there is a trend of new fathers also being diagnosed with PND (Beyond Blue, 2011; COPE, 2018; Edward, Castle, Mills, Davis, & Casey, 2015; Price, 2018). The question of how risk has been determined suggests that *previously established health care knowledge* is being revised by social cultural trends and newly established norms. Merleau-Ponty's concept of being-in-the-world and embodiment will account for the male experience of PND, while de Beauvoir's ideas of biology and maternity would dispel the diagnosis. As discussed in Chapter 2 the applicability of Merleau-Ponty's phenomenology to understanding PND has merit.

Brealey et al. (2010) conducted a systematic review to identify, analyse and synthesise evidence concerning the acceptability to women and healthcare professionals of screening for PND. The review included both qualitative and quantitative studies and examined the EPDS for its method of administration, the relationship between women and healthcare professionals in this administration, the competency and training of the health professional in its administration, the difficulty women experienced in answering questions in sufficient depth, the influence of cultural and ethnic origin in responding to the EPDS and whether screening is acceptable. The authors reported that it was difficult to generalise the systematic review findings due to the limitations associated with individual study design, methods and sample selections. Despite this limitation, an important theme to emerge was the need to ensure a comfortable and trusting environment for the woman so that she could respond honestly. This reality is not always achieved in the practice setting.

As discussed in chapter 2, Cicourel's (1964) important contribution of the need for building rapport in interview settings is of significance when related to the screening process for PND. Given that there are varied settings in which the EPDS is being administered, it is at the discretion of the health care provider as to how such a process can be integrated into the appointment or consultation. In the Child Health setting, the Department of Health recommends the time periods and process for this care requirement. Whilst a GP has much more autonomy during a health care consultation, health care protocols and recommended care pathways are still in place. It would be

beneficial to the mother if a more streamlined process for her health care was in place; one that would address a security and context for transitioning and adapting to the maternal role. As previously indicated in the Australian context there is the National Perinatal Mental Health guideline in place to support mothers. An imperative of this is ensuring that the health professional is sufficiently skilled to commence and facilitate the screening process in such a way that the mother is empowered and participates in an active constructive conversation. It cannot be assumed that since the guideline is in place it will be followed by the health professional. If this is carried out effectively, the mother's engagement in the screening process is purposeful and she is active within the process, thus she feels a part of the process of care allowing her to be *in-the-world* not simply an observer or passive participant. According to Merleau-Ponty's concept of embodiment and the three orders a mother experiences a natural flow or equilibrium as she resonates with her situation. If disequilibrium is noted during the screening process it can be addressed at the point of need.

### **3.7 Models of PND: Recognised Risk Factors for PND**

The causes of PND are not known, but several theories have been researched and discussed in the literature. It is believed that an interaction between biological, psychological and social factors *increase the likelihood* of developing PND rather than arguing a causal link between these factors and PND (NHMRC, 1999). Researchers have implemented systematic reviews as a means of identifying the risk factors for PND (Beck, 1992, 1993, 2001, & 2008; Brockington, 1996; COPE, 2017; Pope & NHMRC 2000). The identification of risk factors has had a bi-fold response: it has been useful for its clarity and direction yet has caused uncertainty in making the diagnosis of PND difficult and, at times, blurred. The antecedents, symptoms and signs identified in the research literature give the impression that all childbearing women could be identified with risk factors and therefore all have the potential to develop depressive symptoms postpartum. Currently the Australian Institute of Health and Welfare (AIHW) is seeking to develop a range of nationally agreed indicators pertinent



to maternal and perinatal information, inclusive of routine data collection for antenatal depression and PND.<sup>28</sup>

Investigations into the antecedents of PND have focussed on medical, sociological, cultural, psychological and biological factors. It is interesting to note that over time only a few antecedents have been confirmed as strong indicators for PND (Beck, 1996; Brockington, 1996; COPE, 2017; Pope & NHMRC, 2000). Taking a more sociological and somatic perspective, Beck reviewed only nursing research studies and concluded there was very little difference in non-confirmed risk factors for PND. In contrast, Brockington (1996) adopted a more medicalised framework and categorised the antecedents, for example, by psycho-obstetric factors. He also used historical literature (from as early as the 15<sup>th</sup> century) which was presented in the form of short narratives that describe situations where women manifested symptoms of PND. Whilst the ambiguous meaning of these antecedents continue, Merleau-Ponty describes this ambiguity as being “the essence of the human experience, and everything we live or think has several meanings....critically nothing has one perennial meaning” (Priest, 1998, p. 96).

The Australian NHMRC (1999) systematic review of published literature aimed at establishing a risk framework for early identification of PND, and ensuring appropriate treatment and planning services for all childbearing women. Furthermore, it recommended that useful and cost effective universal strategies be applied for women at increased risk. The NHMRC (1999) systematic review established risk factors in categories of ‘confirmed’, ‘probable’ or ‘possible’.<sup>29</sup> Whilst this review did not isolate biological factors from psychological or social factors, the biological experience was evidenced in each of these categories. Unique to this guideline was the

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<sup>28</sup> Australian Government Australian Institute of Health and Welfare. *Australia's health 2016*. Retrieved from <https://www.aihw.gov.au/reports/australias-health/australias-health-2016/contents/chapter-5-health-of-population-groups>

<sup>29</sup> Pope's (1999) systematic review revealed the following factors as “confirmed risk factors” for PND personal history of depression, depression during pregnancy, difficulties in the marital relationship, lack of support and stressful life events. Probable risk factors were family history of psychopathology, single parenthood, severe maternity blues, personality characteristics, negative cognitive style, birth experiences and obstetric complication, partner's level of depression, infant health, temperament and behavioural problems, genetic vulnerability and neurotransmitters. Possible risk factors were thyroid dysfunction, hormonal changes, early discharge from hospital, premature delivery, breastfeeding, poor relationship with parents, bereavement, maternal age, parity, cultural issues, Aboriginality, living in rural and remote areas, difficulty adjusting to parenthood, childhood sexual abuse and physical illness (pp. 2-3).

establishment of ‘possible protective factors’<sup>30</sup> for PND which are generally not discussed in the literature. The categories described above were linked to biological, psychological and social interactions.

Both the COPE Australian mental health care in the perinatal period (2018) and the Beyond Blue first perinatal clinical practice guideline (2011) adopt a biopsychosocial model to PND and which are focussed on supporting women experiencing PND symptoms. Psychosocial support (non-directive counselling and peer support) is initiated for those women with psychosocial risk factors and mild depressive symptoms, whilst those women with mild to moderate depressive symptoms are referred to psychosocial support or a range of psychological therapies depending on the presenting symptoms or the range of mild to moderate symptoms presented.<sup>31</sup>

### **3.7.1 Characterising PND from the biological perspective.**

Due to contradictory study findings, it has been contested that hormonal and biological factors play a role in the manifestation of PND. Yim et al. (2015) conducted a systematic review of biological and psychosocial predictors for postpartal depression (PPD) and as part of this review examined studies of the endocrine, immune/inflammatory, and genetic predictors for PPD. The endocrine studies were examined for predictability in relation to reproductive, stress, and thyroid hormones and found that:

*the empirical evidence does not support a role for oestrogen or progesterone withdrawal in the development of PPD symptoms, but studies have not tested moderators of biological vulnerability such as a history of depression or life stress...conclusions about prolactin and testosterone are limited by the paucity of available studies, but a small but fairly consistent literature links lower perinatal oxytocin to more PPD symptoms....the majority of studies on postpartum stress hormones yielded null findings...and studies examining inflammatory processes in the context of PPD have yielded inconsistent results. (p. 108).*

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<sup>30</sup> The protective factors described in Pope’s systematic review “include optimism and self-esteem, a good marital relationship, increased availability of social support, and adequate preparation for the physical and psychosocial changes of parenthood” (p. 3.).

<sup>31</sup> Psychological therapies include cognitive behavioural therapy, psychodynamic therapy, interpersonal therapy, maternal-infant psychotherapy (NHMRC, 2011).

Findings from a systematic review of the thyroid studies which tested the links between thyroid antibodies or hormones and PPD symptoms showed inconsistent and varied results between the studies. Furthermore, outcomes of the systematic review by Yim et al. recommended that “thyroid markers should not be studied in isolation, but rather in interaction with closely-related biological factors, most prominently estrogen” (p. 106). Additionally, the complexity of the genetic associations of PND were also investigated and Yim et al. commented that “there is no definitive answer as to whether the short or long allele of the *5-HTTLPR* is associated with PPD risk and under which conditions” (p. 114).

The abovementioned studies validate and reflect the range of personal experiences that mothers discuss when expressing beliefs about the biological basis of PND (Nicolson, 1991, 2006; Nicolson et al., 2010). Some women believe that the emotion they experience is directly related to hormones, whilst others deny this association (Nicolson, 1991, 2006; Nicolson et al., 2010). Explanations of hormonal adjustment in the postpartum are generally and readily given, with good intention, by health professionals, friends, and mothers with similar experiences.

### **3.7.2 Characterising PND from a psychosocial perspective.**

In the course of normal childbirth there is usually a plethora of events that may contribute to changes in personal behaviours, which may or may not be associated with PND. These events include coping, adapting to birth events, establishing a relationship with a new baby, and maintaining ongoing relationships with the partner, family and health professionals. Childbirth, in a psychosocial context, is considered a life-changing event and therefore stressful (Nicolson, 1991). PND features in this because the mother can feel powerless to control the stressful situation or unable to adapt/respond to childbirth events (Chan et al., 2002). According to Ball (1994), the psychosocial continuum model of PND demonstrates a whole spectrum of emotional reactions to motherhood. The continuum shows a variety of emotions from euphoria to happy to extreme sadness/depression; and coping mechanisms from well-adjusted to calmly-adjusted to unable to cope. A major focus of this approach is to ensure that relationships are equitable and supportive of the events and changes in life following the birth of a baby (Mauthner, 1995, 2002; O'Hara & Swain 1996; Romito, 1990; Yim et al., 2015).

Risk factors highlighted in this area are deficits in, omissions of or unsupported partnerships (Mauthner, 1995, 2002; O'Hara & Swain, 1996; Romito, 1990).

Stressful life events during pregnancy and the postpartum have been historically cited as contributors to PND (Pope & NHMRC, 2000; O'Hara & Swain, 1996). Some examples of these psychosocial stressors include pregnancy-related events such as predispositions to coping and resilience, social stress related to poverty or job insecurity (O'Hara & Swain, 1996). Yim et al. (2015) systematic review in relation to the biological and psychosocial predictors of PPD found mixed evidence that, in controlled studies, PPD was preceded by stressful life events.<sup>32</sup> The above researchers found that the type, severity and time of occurrence of major life events, such as stress, chronic strains, work demands, financial stress and parenting stress are relevant to the manifestation of PPD.

A further psychosocial identifier is the quality of interpersonal relationships with her partner and mother, and to some extent her family and friends, prior to the birthing experience. Yim et al. (2015) found that healthy, high quality relationships and social support protected against PPD, whilst mothers living in conflict and socially unsupportive relationships were at greater risk of manifesting PPD.

Psychological models applicable to PND include cognitive behavioural, learned helplessness, and self-control models (O'Hara & McCabe, 2013). From a cognitive perspective, women with PND have negative views of themselves, the world and their future (Beck, 2002; Haynes, 2017). The learned helplessness model suggests that past or present negative events lead to expectation of future failure and helplessness, and it is this cycle which can contribute to depressive symptoms (Abramson et al., 1978). Researchers have identified particular cognitive traits with PND. The most common factors have been personality type such as perfectionism, previous history of depression or anxiety, negative attributional style and low self-worth (Whitton & Appleby, 1996), low emotional regulation and poor maternal competency.

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<sup>32</sup> PPD – postpartum depression is the American terminology of PND.

### **3.7.3 Characterising PND from a childbirth and postpartum perspective**

As previously stated, the *DSM-IV* specifies that the onset of PND occurs from four weeks postpartum. This time frame excludes the childbirth period which, in reality, is an important event. In psychosocial terms childbirth, therefore, is a stressful life event and in biological terms it encompasses a range of hormonal and bodily experiences that are often outside the woman's control. Together, these risk factors, plus the waiting period of the *DSM-IV*, presents a scenario for PND and/or positive postpartum adjustment which must be delicately observed and recognised in order to maximise positive outcomes for the mother.

A number of risk factors relating to childbirth experience have been linked with PND. These include traumatic birth, unfulfilled expectations of the birth, loss of control in decision-making relating to birth, unexpected medical interventions, and unexpected pain. For many women the desire to have a natural birth is paramount to how she perceives herself as a woman and mother. For others the quest of natural childbirth is not a badge that defines who she is (Westall & Liamputtong, 2011)

Physical recovery from childbirth also impacts on emotional and physical wellbeing. Current child birthing practices encourage early discharge from hospital which can have both positive and negative consequences. A vulnerable mother who has minimal mothering experience and despite having participated in antenatal care and education, may feel a tenuous link to the health sector (Westall & Liamputtong, 2011); the opportunity for follow-up education or follow-up care is dependent on the type of birth she experienced and her length of stay in hospital. Adjustment to motherhood is complicated by unexpected hospitalisation, for either the mother or the baby, secondary to the birth process, can further negatively impact emotional and physical wellbeing (Westall & Liamputtong, 2011).

Childbirth is recognised as a risk due to unknown, unpredictable and uncertain outcomes regardless of the preparation and planning applied across all sectors. This risk may or may not materialise, and during this period stress and coping behaviours are counter-balanced by anticipation and joy/excitement. This complex time is recognised as a stressful life event, irrespective of whether the stress experienced is 'good' or 'bad' (Yim et al., 2015). Whilst there are current healthcare guidelines directing the health professional in relation to screening, support and

management of mothers at risk of PND and other mental health conditions, this is not always translated in healthcare practices. This omission is significant for those mothers at real risk of PND. Mothers, in turn, focus on their own health and wellbeing as best as they can with the purpose to provide optimal baby care.

No birth risks were identified in O'Hara and McCabe's (2013) review of PND's current status and future directions. Bahadoran, Orizi, and Safari (2014) meta-analysis of eighteen studies investigating the role of delivery mode in PND found a medium risk between the two; although the role of moderating variables was not taken account in the meta-analysis. These findings are in contrast to Bell and Andersson's (2016) systematic review that found a significant association between women's postnatal perspective of their birth experience and PND. They identified common themes in the assessment of women's birth experience which included "qualities of interaction between women and their caregivers, including confidence/trust, respect/privacy, and feeling safe/nurtured/supported" (p. 120). The researchers argue that satisfaction with the birth experience is a complex construct, this is supported by the literature.<sup>33</sup> Lambert, Etsane, Bergh, Pattinson, and van den Broeks' (2018) descriptive phenomenological study found that women feel alone and unsupported in their birth experience. Moreover, there is mutual distrust between woman and health care provider, and health care providers do not believe and support women in their birth care choices. The third significant theme is that health care professionals adopt a procedural rather than person-centred approach to care and this approach distresses mothers throughout their experience.

#### **3.7.4 Breastfeeding and PND**

The relationship between breastfeeding difficulties and PND has been highlighted in the literature for some time. Pope and the NHMRC's (2000) systematic review of scientific literature to 1999 described the causal link between breastfeeding difficulties and PND. Dennis and McQueen's (2009) systematic review of 49 research studies found that mothers with PND early in the postpartum period were at risk for negative feeding outcomes. These included shorter breastfeeding duration, increased breastfeeding difficulties, and decreased levels of breastfeeding self-efficacy.

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<sup>33</sup> Hodnett, 2002; Waldenstrom et al., 2004; Public Health Agency of Canada, 2009; Britton, 2012; Hildingsson, 2013 (cited in Anderson & Bell, 2013).

Similarly Dias and Figueiredo (2015) systematic review of 48 studies in the literature on breastfeeding and depression found that almost all the studies demonstrated an association between shorter breastfeeding duration and PND. They also found that PND predicts and is predicted by breastfeeding cessation. In a subsequent systematic and meta-analysis conducted by Chowdhury et al. (2015) breastfeeding and maternal health outcomes found no further relationship between breastfeeding and PND. Similarly, Brown, Rance, and Bennett's (2016) correlational study of 217 mothers found a negative correlation between duration of breastfeeding and the EPDS score. In addition, a lower score was found to be associated with a longer breastfeeding experience. Pope and Mazmanian (2016) suggest that the relationship between breastfeeding and PND is not clear. In their review paper they highlight methodological differences of past research studies relating to PND and breastfeeding intention, initiation and duration. They argue that because of the methodological differences between studies it was difficult to draw conclusions about the relationship between PND and breastfeeding and that prospective or longitudinal studies may provide greater insight to this conundrum. Embodying motherhood is challenging as a mother is constantly faced with pressure relating to the social norms of breastfeeding or not, breastfeeding in the public domain and with the physical challenges relating to breastfeeding. All of this creates disequilibrium for the mother when she finds herself outside the norm. This disequilibrium highlights the need to be aware of Merleau-Ponty's phenomenology of perception, and that there are multiple ways for a mother to be in the world. There is no one right way to be in the world, rather she adapts (her body) to the situation she faces.

### **3.8 A Qualitative Approach to Explaining Women's Experience of Postnatal Depression**

Qualitative studies have sought to understand a woman's subjective experiences of PND using a variety of methodologies including grounded theory, phenomenology, naturalistic inquiry and feminist perspective. An in-depth search of the research literature did not reveal any studies which had used Merleau-Ponty to explore PND.

Beck (2001, 2002) studied PND using both quantitative and qualitative approaches. A meta-analysis of various qualitative methodologies resulted in Beck's

description of 11 themes which related to the lived experience of PND. These themes included: unbearable loneliness; contemplating death as providing hope; obsessively thinking about being a bad mother; fear that a normal life will never be possible; life is empty of all previous interests and goals; suffocating guilt over thoughts of harming their infants; mental fogginess; envisioning self as a robot, just going through the motions; feelings on the edge of insanity due to uncontrollable anxiety; loss of control of emotions; and overwhelming feelings of insecurity and the need to be mothered. These themes seem somewhat extreme, one questions the level of psychological distress the sample experienced.

Beck (1992) identified that the instruments used to assess women's postnatal mental health status failed to detect depression. In 1993, using a Heideggerian phenomenological approach involving a sample of seven women, Beck endeavoured to capture a more accurate picture of the experiences of PND. Findings from the study identified that loss of control was reported as feeling "teetering on the edge of insanity which refers to walking the fine line between sanity and insanity" (p. 42). Beck (1993) described women's coping with PND as a four stage process: Stage 1, *encountering terror*, which is the women's experience of PND; (horrifying anxiety attacks, relentless obsessive thinking, and enveloping fogginess); Stage 2, *dying of self*, which describes the alarming sense of unreality, isolating oneself, and finally contemplating and attempting self-destruction. Stage 3, *struggling to survive*, strategies used by the women, such as praying for relief and seeking solace which the women used to gain support. Stage 4, *regaining control*, the unpredictable transition to wellness, mourning of lost time and feeling guarded in recovery (Beck, 1993). These interesting concepts explain the variation of experiences and stages that mothers may have with PND. Not all mothers have such an awareness, but given that these study participants were drawn from a postnatal depression support group, it is not surprising that such clarity is evident.

A qualitative study by Mauthner (1999) involving 40 women explored their experiences of motherhood and postpartum depression. Findings showed the participants experienced high and extreme anxiety and panic. These emotions are significant given the interconnectedness of anxiety and depression. One might suggest that this finding may be related to the confusion associated with the lack of separating anxiety from depression. Moreover, according to Knudson-Martin and Silverstein (2009) this finding might also relate to the practice of labelling women with depression



rather than the expressed state of anxiety. Nonetheless, one must be cautious as it is recognised that anxiety, if not managed correctly, may lead to depression.

Beck (2002) conducted a meta-analysis of 18 qualitative studies investigating PND between 1990 and 1999. This meta-analysis revealed four perspectives of PND. Firstly, incongruity between expectations and reality of motherhood; secondly, spiralling downward [of mood]; thirdly, pervasive loss and, lastly, making gains. This analysis enabled Beck to establish a theoretical perspective of PND which may guide the development of appropriate interventions for health professionals. Similarly but distinctly different, Mollard's (2014) qualitative meta-synthesis and theory of postpartum depression involved an examination of 12 studies. Using Noblit and Hare's model of ethnography Mollard discovered four themes common to all of these studies. These included a crushed maternal role expectation, going into hiding, loss of sense of self, and intense feelings of vulnerability. Mollard argued that each of four processes that postpartal women experience are exacerbated by practical life concerns. Merleau-Ponty would suggest that a mother in this situation is not at one with her world, and that she is resisting the events/situation around her. Thus she is blocking her resonance with the world, and thus not adapting to the situations she is in. The maternal world is perceived as looming and threatening and one which she cannot control. This understanding is supported by Roseth, Binder, and Malt (2011) ( $N = 4$ ) descriptive phenomenological study which explored mothers ways of living with a diagnosis of PND. Findings were analysed in relation to a number of theorists (Fuchs, Van den Berg, Heidegger and Merleau-Ponty) and explored dimension of psychopathology and the existential perspective. The findings of the four participants revealed two essential structures of living with PND which influenced treatment programs.

An interpretative phenomenological study by Hall (2006) ( $N = 10$ ) sought to explore women's experiences and perceptions following diagnosis of PND. Findings showed that women reported difficulty in admitting to others, including family and health professionals, how they felt and perceived that no one would appreciate their feelings/situation. The women reported being afraid of the consequences of disclosing their real feelings and were concerned that they would be admitted to a psychiatric unit, or that their baby would be taken from them. Of concern was that whilst these women admitted to having depressive symptoms at the time of completion of the EPDS, they falsely reported their responses to protect themselves from the possible judgements of

the health professional. Despite this finding, the women reported that they still wanted to receive help even though they could not ask for help (Hall, 2006). According to Merleau-Ponty, this trust (reliance and confidence in the truth) is integral to the self. However, a childbearing woman may transfer this trust to the carer, thereby causing a displacement of trust such that the woman feels “let down” when expectations are not fulfilled. Findings from Armstrong and Small (2010) reflect the outcome of Hall’s study. Armstrong and Small (2010) also used a multi-method approach including a postal survey and in-depth interviews. Results revealed that for some women the EPDS proved a barrier to accessing support and referral, thereby suggesting they may be embarrassed or feel stigmas associate themselves with mental health care.

Merleau-Ponty claimed that the self is embedded in the lived world which dynamically embraces the cultural aspects of the self. However, this factor was not considered in a phenomenological study by Leung et al. (2005) which involved 11 Chinese women living in Australia diagnosed with PND. Both multiparous and primiparous<sup>34</sup> women in the study reported major postpartum stress associated with parenting competence, the expectation-experience gap, baby-minder arrangements, childcare demands, and conflict with culture and tradition. These findings are of importance as the meaning and an association of one’s world is derived from the culture in which they are raised (Crotty; 1996; Merleau-Ponty, 2002). Therefore, it is important to ascertain how such meanings influence action and behaviour when the person experiences such events.

To completely understand PND it is essential to consider the associated socio-cultural variables in relation to childbirth attitudes and parenting processes (Cox & Holden, 1994). While the focus of Leung et al.’s (2005) study did not necessarily report women’s experiences, the authors described women’s responses in each of the themes as feelings of frustration, failing, being challenged, anxious and obsessing over particular concerns. These results concur with Knudson-Martin and Silverstein (2009) grounded theory meta-analysis of qualitative studies on PND. This analysis revealed that women reported feeling progressive despair and isolation in their role as a mother and that they were unable to express their negative emotions associated with

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<sup>34</sup> Multiparous refers to a woman who has given birth to more than one baby, primiparous refers to a woman who has given birth to one baby (Gray, Smith, & Homer, 2009). Current research finds that both multiparous and primiparous women experience PND.

motherhood. As a result of this self-imposed silencing, women experienced being overwhelmed with feelings of incompetence and as such focussed on self-preservation rather than maintaining connections with others. Similarly Highet, Stevenson, Purtell, and Coe's (2014) grounded theory study found that in the transition to motherhood frustration, loss and dissatisfactions with pregnancy and motherhood were commonly experienced by mothers with anxiety and depression in the perinatal period.

A qualitative study by Everingham, Heading, and Connor (2006) involving six Australian couples explored the new mothers' experience of PND. The study found that women needed to be understood by their partner in order for them to indirectly understand themselves and that the normative assumptions of 'a good mother' influenced their identity. Similarly, Homewood, Tweed, Cree, and Crossley (2009) highlight a five step process of psychological adaption of a mother with PND, in relation to her identity and her capacity to mother her baby. Merleau-Ponty argued that identity is perpetually embodied, historical, dependent and a changeable frame of reference. Therefore, studies that explore maternal wellbeing from Merleau-Ponty's may reveal the contemporary norms and assumptions that shape a mother's identity, her self-awareness and her self-understanding irrespective of her emotional wellbeing.

The literature suggests that some postnatal women, although not realising they are ill, seek care complaining of fatigue, irritability and a range of other somatic disturbances, and consequently are diagnosed with postnatal depression (Armstrong & Small, 2010; Hall, 2006; Haynes, 2017; Mauthner, 1999). This scenario is both interesting and concerning, as women's subjective experiences of their own health is translated to become "objective phenomena". For other women, a diagnosis of PND was beneficial since an "actual" diagnosis is reported to give comfort to women, a realisation that they are not alone in their mothering experience (Armstrong & Small, 2010; Beck, 2001, 2002). However, diagnosis does not amount to a cure, or identification of the time span for the symptoms to be experienced and overcome.

Disclosure of symptoms of PND is difficult for mothers who suffer with the condition. It influences their interactions, when health care is accessed, self-and health professional referral patterns. McLoughlin's (2013) literature review of eight qualitative studies from 2003-2013 showed that lack of knowledge of PND symptoms, not wanting to be perceived as a bad mother, the public versus private beliefs about

attending to emotions, concealment of their PND for fear of stigma and being subjected to labelling and moralising views of others. McLoughlin suggests that mothers feel a range of cognitive emotions such as shame, guilt and fear; PND is perceived as a weakness. Button, Thornton, Lee, Shakespeare, and Ayers (2017) conducted a meta-synthesis of 24 qualitative studies and determined that identifying a problem, the influence of healthcare professionals and stigma are common themes that influence health seeking behaviours when emotional distress is experienced by mothers. Similarly, Hadfield and Wittkowski's (2017) systematic review and thematic synthesis of the seventeen qualitative studies determined that women found the process of seeking help difficult; barriers to seeking and accepting support and valued aspects of support. Grissette, Spratling, and Aycock (2018) argue that barriers to health seeking are associated with misunderstandings of the perceived severity of PND and that factors such as knowledge, screening, and stigma are some of the factors which delay mothers from accessing appropriate health care.

The problems experienced biologically by the body intentionally change the lived experience of the ill person. Merleau-Ponty's premise of intentionality is framed as a bodily intentionality and holds significant relevance to understand the adjustments women make and respond to when adapting to the birth of their baby and the possibility of experiencing or not experiencing PND. That is, they find and enact ways of moving forward bodily. Mothering in contemporary Australian society is complex, the social pressures of being a good mother remains ever present. The preceding literature review has highlighted that prevalence rates of PND can be as high as 50% in the maternal population. The current screening method of employing only one tool is not sufficient to measure and incorporate all aspects of a mother's emotional wellbeing. The ambiguity of the definition of PND and the wide criteria of bodily symptoms or experience presents difficulty in accurately accounting for the mother's needs. The emphasis of research and care on causation alone does not equip mothers with living within a range of varied emotions they may encounter in the first year postpartum. Furthermore, the changing demographic representation of Australian mothers, the influence of migration and the co-existence of sub-cultures within the Australian culture creates ambiguity and complexities that are not easily accounted for. The development of governmental policies that promote emotional and physical wellbeing both for the maternal population (and baby), and the general population currently, and

for the future is at the forefront of progressing the Australian lifestyle. The need for ongoing health information is ever present. The attention to the needs of the physical body are obvious when one is faced with illness or when adjusting and adapting to the developmental milestones from conception to death. Emotional wellbeing in motherhood has historically only focussed on the negative emotions and the negative behaviours that occur. This bias has shaped mothers to be vigilant about the possibility of ‘contracting PND’ instead of focussing on emotions and behaviours that reinforce adaption and coping.

### **3.9 Summary**

A critical review of the literature highlights the lack of consensus regarding the onset, antecedents, symptoms and signs of PND. Possible explanations for the variations in the onset of symptoms/diagnosis and prevalence rates may be related to the study design and selection of sample groups. Other methodological issues in studies conducted in PND include non-representative samples, recruitment and poor matching of comparison/control groups, selection bias, demographic characteristics and small sample groups (Brockington, 1996; Pope & NHMRC, 2000).

A Merleau-Pontian interpretation of the inconsistent prevalence rates found in this research is that PND is an increasing and continuing predicament. The generated research reinforces the construction and re-construction of scientific knowledge and intervention associated with such phenomena (Matthews, 2006). It could be argued, therefore, that the abundance of scientific knowledge already generated supports the social prominence and cultural expectation of PND. It is possible that future exploration of the phenomena may be unclear and undefined.

Independent of the historical classification of contemporary PND, the physical and/or psychological manifestations of depression should be evaluated/understood through Merleau-Ponty’s concept of embodiment as a means of informing perception/awareness. According to Merleau-Ponty, embodiment pertains firstly to identify the body as an ‘objective state’ or physiological unit; and secondly, as a ‘phenomenal body’ which is to understand the body as an experience. This means my (or your) body as I (or you) experience (Merleau-Ponty, 2002). This philosophy becomes critically important for women who have been assigned a self or prescribed

diagnosis of PND, as much research, debate and discussion has centred on the biological body. Benoist and Cathebras (1993) argue that the emergence of the biological body, as an object of science, has resulted in isolating the body from the subject experience. From the perspective of PND this relates to research, its prevalence, the signs and symptoms manifesting the illness, and the instrumentation which measure the extent of the condition. Over the past decade there has been a proliferation in the predictors and antecedents of PND, probably in an attempt to understand it on every level.

It was regular practice in the 1980s for a woman to remain in hospital for six days after childbirth and this care was continued by the community nurse for up to 10 home visits. Women who had a caesarean birth were hospitalised for 7-10 days and followed up with home visits. In the 1990s changing trends in international and national obstetric and midwifery care, coupled with financial constraints, encouraged shorter hospital stays and fewer home visits for all childbirth outcomes. Currently, women who have a spontaneous vaginal delivery, are encouraged to leave hospital within six hours and up to 48 hours following childbirth. Women who have a caesarean birth are likely to be discharged within two to four days, if both the mother and baby are well. Western Australia (WA) practised a similar format and the Visiting Midwife Service was introduced to better support early discharge from hospital. This service allows the community midwife to visit the women in their home up to 10 days post childbirth, with the number and spacing of visits calculated on a needs basis. On discharge from hospital care and/or home visit care, mother and baby return to the care of their General Practitioner (GP) and a CHN who oversee the care of children from 0-5 years. It is recommended that all women and babies undertake a postnatal six-week check and continue timely follow-up visits at the Child Health Clinic. The responsibility for this continuity of care and related assessments rests with the woman. Thus, there is real possibility for missed detection and missed diagnosis of PND and/or psychosis when women (at risk) do not attend regular check-ups and monitoring. It is also known that women do not to seek medical help for depression (Cox, 1983; Knudson-Martin & Silverstein, 2009; Vidler, 2005). These factors may contribute to misrepresentation of the prevalence rates of PND (in the literature).

The social pressures women experience during pregnancy and subsequently the birth continue in the postpartum period as the focus shifts from the mother as a physical

state of carrying or bearing a baby, to a physical state of being separate to her baby but still being wholly responsible for the new life. Thus, the objectification of mother continues in the postpartum period, albeit in a very different way. For example, some women feel compelled to breastfeed, not because they wish to but because they feel pressured by society to do so (Homewood et al., 2009; Meeussen & Van Laar, 2018).

Mauthner (2002) argues that PND manifests when the mother realises the sharp contrast of her idealised constructions with the reality of motherhood. This view may be supported by the absence of a supportive partner or social environment. Merleau-Ponty's phenomenology may assist to comprehend the importance of understanding embodiment distinguishing between the 'objective body' and the phenomenal body (self). There is limited understanding of the self, other than the self's world, and its relationship to the world is dependent upon the body. Cultural and social prejudice influence one's sense of self. Trusting reality and the judgement of caregivers can be a challenge for mothers, but according to Merleau-Ponty, this trust, reliance and confidence in the truth is integral to the self. It is with concepts that in mind that the present study was conducted. The following chapter explores the study's methodology, the aims, design, description of the study, data collection procedures, data analysis and process of trustworthiness and rigour, and the ethical procedures applied.

## Chapter 4

### Methodology

#### 4.1 Introduction

This chapter presents a description of the study design and a discussion of phenomenology as a research method. The study aims and objectives are outlined, as are the methods and procedures related to recruitment, data collection and ethical procedures. Data analysis using Giorgi's descriptive phenomenological method, which is premised on Merleau-Ponty's phenomenology, is described and explained. Research studies using descriptive phenomenological theory, Merleau-Ponty, and method (Giorgi) is scarce.

#### 4.2 The Method: Overview

Research methods are described as procedures, techniques and processes for gathering and analysing data in a study. Streubert and Carpenter (2011) argue that the practice of using qualitative methods to study human phenomena is grounded in human values, culture and relationships. As a consequence, the researcher uses individual and methodological steps in descriptive research, in particular phenomenology, to analyse data to locate meanings in a text (Streubert & Carpenter, 2011). A variety of steps to analyse qualitative research is available and includes methods by Colaizzi (1978), Giorgi (1985), Paterson and Zderad (1976), van Kaam (1966), and van Manen (1990). There is no singular accepted method of data analysis in phenomenology; the essential premise for selection by the researcher is that it underpins the philosophical standpoint of the study. Thus, the method selected for this study is Giorgi's (1985) four methodological steps to assist the exploration of women's experiences of having, or not, postnatal depression in the first 12 months following the birth of their babies.

#### 4.3 Study Design

This is a descriptive phenomenological study which utilised Merleau-Ponty's *Phenomenology of Perception* to explore the experiences of women who had or did not have PND. Phenomenology aims to describe phenomena, or the appearances of things,



as accurately as possible, while remaining true to the facts presented; thus understanding the experiences of participants from within the lived world perspective (social/cultural) (Corbin & Strauss, 2008; Giorgi, 1985; Leininger, 1985; Liamputtong, 2013; Streubert & Carpenter, 2011). Phenomenology enables the creation of themes to describe the participants' perspective rather than using predefined categories (Corbin & Strauss, 2008; Giorgi, 1985; Leininger, 1985; Liamputtong, 2013; Streubert & Carpenter, 2011). Using descriptive phenomenology as a research tool is an appropriate approach to provide a deeper understanding of human experience through description, context, meaning and patterns of participant responses (Liamputtong, 2013). Qualitative research is applied to reveal deeper understanding of an individual's personal and social reality taking a holistic and process focused approach serves to downplay causal models in research (Hesse-Biber & Leavy, 2006). Qualitative research is a method often used within nursing and midwifery research.

The ethical procedures relating to recruitment and selection process of participants are explored later in the chapter. Principles of beneficence, non-maleficence, autonomy and justice were incorporated both in the advertising of the study and in the conduct of interviews and management of data.

#### **4.4 Aim of Study**

The overall aim of this study was to explore whether Merleau-Ponty's concept of perception, the body and embodiment was a valid framework to analyse women's experiences of having or not having PND. Secondly, whether using an embodied-social-subject perspective to understand mother's experiences in the first 12 months postpartum led to an understanding of emotional wellbeing.

The specific aims were:

1. To describe and compare the differences between and within mothers who had and had not experienced PND.
2. To describe and compare the differences in the cultural and social perceptions of self and the self as a mother between those who had and had not experienced PND.
3. To describe the mothers' perceptions and experiences of current methods of screening for PND.

## **4.5 Description of study**

The four steps of Giorgi (1985) provide a platform for an investigation such as this one. While the steps as outlined below appear linear, some reversing and forward movement was noted by the researcher in the exploration of mother's perception of having or not having experienced PND. In addition, the research questions were constantly kept in mind by the researcher to ensure that the methods of responding to the data were appropriate. The four steps taken were the sense of the whole, discrimination of meaning units, transformation of participant's everyday expressions and synthesis of transformed meaning units into a consistent expression. Each of the four steps will be discussed below:

### **4.5.1 Sense of the whole**

This first step involved a simple reading of the transcripts and the ability to understand the language of the describer. Multiple readings were often required for lengthy transcribed interviews. In this stage the general sense grasped after the reading of the text was not interrogated nor made explicit in any way (Giorgi, 1985). This first step involved the formulation of the research questions, "What is the experience of mothers having PND or not?", and "What were the cultural and social perceptions of self and the self as a mother between the two groups?" to describe the women's perceptions and experiences of current methods of screening for PND. Throughout the data analysis the researcher continually referred to the research questions to ensure that they were addressed. This process was constant throughout the research process.

### **4.5.2 Discrimination of Meaning units (within a Psychological Perspective)**

Giorgi (1985) states it is not possible to analyse a whole text description simultaneously; it is more productive to break it down into manageable units. The second part of this step is ensuring that a psychological analysis is maintained, and that transitions in meaning in the description (transcript) are noted so that all meaning units can be compiled. In this stage it is important that the discriminations (transitions in meaning) are noted before any further examination of the description is undertaken. According to Giorgi the researcher must work within the assumptions of reality revealed at the time of data analysis. Consequently, units, structures or themes are applied to allow understanding of having or not having PND (Corbin & Strauss, 2008).

As part of this second step, statements, words and/or phrases are selected while re-reading or listening to the audiotaped interviews (Corbin & Strauss, 2008). These selected statements, words, and/or phrases formulate the beginning elements of sub-themes and themes pertinent to emotional wellbeing and PND.

#### **4.5.3 Transformation of Subjects Everyday Expressions**

In this third step transformation of the meaning involves a process of reflection and imaginative variation. According to Giorgi (1985) within this step a tension exists between the specifics of the concrete situation and the general categories suggested by the description. Therefore, the intent of this step “is to arrive at the general category by *going through* the concrete expressions and not by abstraction or formalization, which are selected according to the criteria accepted” (Giorgi, 1985, p. 17). This step is important in explaining the particular [psychological] aspects in a depth appropriate for understanding the events. Transformation occurs when intersubjective elements of giving and receiving are illustrated. This form is evidenced in the interactions, experiences, thought feelings and attitudes expressed by the participants in the study. From a Merleau-Pontian perspective, this format is important as language and expression are fundamental aspects of perception. Chapter 5 outlines the events and circumstances that led to participants developing PND and the situations of those participants who did not experience PND. Chapter 7 highlights the themes and how they were established. Then presented in Chapter 7 is a discussion of the themes.

#### **4.5.4 Synthesis of transformed meaning units into a consistent expression**

In this fourth step, as in the three previous steps, the researcher’s focus of remaining true to the phenomena of interest (and thus remaining true to the participants) is maintained. In the final stage the transformed meaning units are synthesised into a consistent statement regarding the experience. In essence, the researcher is discriminating the essential elements of the process so that a consistent description of the structure of the event is generated. It is possible to generate a specific situated structure as well as a general structure, depending on the number of participants. Importantly, this step must ensure that all transformed meaning units are accounted for, and should be implicitly contained in the general description. This foundation then acts as a base that other researchers may confirm or critique. Trustworthiness and rigour of data analysis is discussed further in the chapter.

## **4.6 Participants**

Participants for the study were women who had birthed within the past five years. Purposive sampling was initially undertaken to recruit participants. The researcher then used snowballing, a common sampling technique used in qualitative research. Snowballing is where the sample is extended by asking participants to recommend others for interviewing (Polit & Beck, 2018; Streubert & Carpenter, 2011). In general, women with young children are acquainted with other mothers and after the initial recruitment of participants the snowball sampling technique was utilised to identify additional participants. This technique led to the inclusion of women from various geographical suburbs in the Perth metropolitan area. Once the prospective participant made contact with the researcher, the researcher explained the study in greater detail and assessed the woman's suitability by using the inclusion and exclusion criteria.

In total, twenty six participants were recruited to the study, this qualified as saturation of the data. In phenomenological research it is common to have a small purposive sample of participants who have lived the phenomena of interest. Sample size is determined by the data and continues until saturation is obtained; that is, when the collected data no longer reveals new information, and no new codes or themes emerge (Polit & Beck, 2018; Streubert & Carpenter, 2011). In relation to the total number ( $N = 26$ ) participants, eight perceived themselves to have experienced PND, two perceived themselves to 'not cope' and 16 perceived themselves to be emotionally well throughout the first 12 months following their baby's birth.

### **4.6.1 Inclusion Criteria**

Women were eligible for inclusion to the study if they met the following criteria:

- had birthed a live baby who, at the time of the study, was a minimum of 12 months of age and less than six years; were at least 18 years of age;
- were English speaking;
- either had or had not experienced PND in the first 12 months of childbirth;
- at the time of the study were coping with their current circumstances; and
- were willing to discuss their experience of the first 12 months following the birth of their baby.

#### **4.6.2 Exclusion Criteria**

Women were excluded from the study if they met the following criteria:

- did not birth a live baby;
- were less than 18 years of age;
- reported a history of major mental illness;
- were currently diagnosed with PND and undergoing treatment with prescribed medications and/or counselling, and
- were not English speaking.

The exclusion criteria were applied to safeguard the welfare of women where discussion of prior experiences could have triggered unexpected emotions and increased their vulnerability and/or exacerbated feelings of depression, anxiety or other emotions. It is acknowledged that women under the age of 18 can experience PND. However, the challenges of teenage pregnancy could compound the transition to motherhood. Women who did not qualify for the study based on the above exclusion criteria were thanked for their interest and their interviewee status was not pursued. If a participant satisfactorily met the inclusion criteria, she was provided with an information letter and invited to take part in a focus group or a one-on-one interview, or both.

#### **4.7 The Recruitment Process**

Several methods were used to recruit participants including personal invitation, flyers, and snowballing.

A flyer was designed which detailed the purpose of the study and the researcher's contact information (Appendix A). The flyer was displayed in community centres, libraries, community houses and playgroup venues. It invited the participation of interested women, whether or not they had experienced PND, to engage in an interview for research purposes. The researcher liaised with the manager of each venue to obtain permission to display the flyer and to adhere to required processes to advertise the study. In one venue the manager invited the researcher to share information via a personal interface with prospective participants. Other venues displayed the flyer on a designated noticeboard and another venue offered to circulate the flyer to a wider audience via the Centre's Facebook page. Several participants sought permission from the researcher to circulate the flyer within their own Facebook/business networks.

## **4.8 Data Collection**

Focus group interviews and individual in-depth interviews are recognised as valid methods of data collection in phenomenological research (Connelly, 2015; Liamputtong, 2013). Focus group interviews were selected to provide the opportunity for individual participants to share their experiences of the first 12 months of being a mothers. The discussion points generated within focus groups may trigger ideas not previously considered by the participant (Connelly, 2015). Individual interviews allow for exploration of experiences at a deeper level that may not be revealed in a focus group interview (Liamputtong (2013). Each data collection method is discussed below in detail.

### **4.8.1 Focus group interview process**

The researcher commenced data collection by conducting interviews with focus groups. This approach produced active and helpful participation between group members while they explored and examined their experiences of being a mother in the first 12 months following the birth of their baby. This emphasis on interaction and synergy between the group participants is recognised as generating rich explanations of the phenomena (Connelly, 2015; Liamputtong, 2013; Polit & Beck, 2018).

Ideally, it is recommended that 7 to 10 participants form a focus group. However, a smaller number of participants is permitted in particular situations (Liamputtong, 2013). Given the sensitivity and personal nature of the current research study, five participants per focus group was deemed an appropriate size. Regardless of this consideration, not all participants invited to a focus group attended.

Planning for focus group interviews included contacting the participants to ascertain a mutually agreeable date and time. Generally, the participants of each focus group were known to each other. Prior to the focus groups and interviews, participants were provided with a plain English statement which outlined the study's purpose and methods (Appendix B). The groups elected to meet at one of the participant's home as this location was convenient and familiar to all of them. Participants had their children playing in a nearby room where the interview was being conducted; the children wandered in and out of the room. The venue was conducive to a flowing discussion,

and all participants felt comfortable and safe to relate their stories or experiences. The researcher provided refreshments for the participants and their children.

There were challenges associated with arranging the focus group interviews. Originally, the researcher had planned five focus group interviews; however, only two were conducted. The other three group interviews were subsequently cancelled as participants were reluctant to participate in group sharing sessions with unfamiliar participants. Others did not attend the planned focus group interviews for reasons such as personal or children's ill health, personal responsibility and discomfort in group sharing. Liamputtong (2013) discusses the benefits and difficulties associated with focus group interviews when conducting research. Some benefits include the opportunity to share experiences, scaffold their ideas, and consider aspects of their mothering. The difficulties may include the hesitation of sharing personal information for and fear of being negatively judged by focus group participants.

Interviewing at both focus group used the same format. The participants were thanked for sharing their time and experiences in this study. The focus of the study was reiterated and the women were invited to raise any questions or concerns they may have had prior to the commencement of the interview. Written consent was obtained (Appendix C) and collection of demographic information was completed prior to the audiotaping of the interview (Appendix D). The demographic survey included information about age, type of birth and pain relief methods for the birth, number of pregnancies, number and ages of children, educational level, marital status and employment history prior to and following the birth of the baby. On completion of this step, a digital recorder was introduced and used to audiotape the discussion.

Questions generated from a review of the literature in relation to PND were used. As the focus of the study related to the women's experience in the first 12 months postpartum, a range of questions were used to give context to the depth and breadth of the women's experience. A series of interview questions were used as a guide to invite discussion and exploration of their experiences (Appendix E). However, the data was allowed to flow in a conversational manner rather than a directed process. Silence was maintained by the researcher to enable the participants to think about and express their views (Liamputtong, 2013).

The focus group interviews were permissive and non-critical; all participants engaged in conversation and they invited each other to speak when they felt a participant had a particular story to share, or if a group member had been quiet. At other times, the researcher facilitated discussion between members.

Responses from the focus groups were reviewed to validate and formulate additional questions to be used for the one-to-one interviews. All participants of the focus groups were offered the opportunity to engage in a follow-up individual interview where the participant could elaborate on her initial responses. Only one participant agreed to a follow-up interview.

#### **4.8.2 Individual interview process**

According to Liamputtong (2013) individual in-depth interviewing is a privilege for the researcher. It involves the sharing of particular experiences, both comfortable and uncomfortable, and can evoke emotions that can surprise participants and the researcher. Interviews involve the sharing and co-construction of participant biographies, between interviewer and interviewee, where meanings are continually constructed and reconstructed, and participants also relate description of pre-existing narratives (Liamputtong, 2013). Actively listening to the content of discussion, taking note of emotions, ensuring the participant's voice is central in the interview, and ensuring a flow in conversation (interview process) are some important interviewing techniques that were applied (Liamputtong, 2013).

A similar process was applied to the arrangement of the individual interviews. Generally, the interviews were conducted in the participant's home at a mutually suitable date and time. At the time of interview the purpose of the study was clarified and any concerns the participant had were discussed and clarified. Written consent was obtained and collection of demographic information was completed prior to audio recording the interview. The interview commenced with a broad question of inquiry such as, "How did you feel being pregnant?" and, "How did you feel in the first 12 months following the birth of your baby?" The interview was semi-structured and focussed on participants giving rich descriptions of their experience in the first 12 months following the birth of their baby. Supportive prompts or probing questions were also used as part of the interview process. According to Liamputtong (2013), a probe is a follow-up question that aims to prompt information to extend information



from the original response. A probe is neutral and does not bias the participant in a particular way. An example is, “Tell me more about...”.

Interviews took approximately one hour to complete or lasted until the participant had nothing further to say. Each interview was recorded and transcribed verbatim. A second interview was arranged with two participants to further explore some of the experiences triggered by the initial interview. The second interviews lasted 30 – 45 minutes. One participant communicated additional information via email to the researcher.

To safeguard the participant’s emotional wellbeing, a safety plan and process for management of distress was established and approved by the University Research and Ethics Committee prior to the commencement of the study. In the event that a participant became distressed, the interview would be discontinued and the safety plan implemented (Appendix F). No interviews were suspended and neither was the safety plan initiated during the interview process.

Six participants became emotional and cried during the interview. The interview was suspended until the participants recovered their composure. These women were given the opportunity to talk about their tearful reactions and made to feel comfortable to complete the interview. The women expressed surprise at their own reactions to the questions. Of these six participants, four perceived themselves to be emotionally well in the first year postpartum and two perceived themselves to have experienced PND.

At the conclusion of the interviews, six participants expressed that it was comforting to be able to talk about their 12 month experience as they had never previously shared this information with anyone. Another 10 participants expressed they had never been asked about their emotional and physical state or experience of their first 12 months postpartum. The interviews were concluded when the conversation around the guiding questions were completed. The participant was invited to make further comment about her experience and the interview concluded when the participant had nothing further to say.

## **4.9 Organisation of the Data**

Hesse-Biber and Leavy (2006) suggest that while there are steps to consider in the analysis of the data, the procedures may alter depending on the situation. Concepts and themes that emerge from interviews is where data analysis starts. The process of data analysis is to capture patterns, themes, categories and new ideas to better understand a phenomenon (Giorgi, 1985). The interviews were transcribed verbatim, after which the researcher simultaneously listened to the audio tape and re-read the transcript; this was to meditate on the given data. This important step served to identify nuances, emotions and emphasised points from the participant that could not be identified by simply reading the transcript. Emerging nuances, emotions and emphasised points were then noted on the transcript. Identifying characteristics, such as children's names related to the participant or the health care institution were also amended on the transcript. At the end of the interview the researcher made notes in relation to the interview process, particular responses, emotions, body language or the participant's tone of voice. This was important information as it guided the decision trail in the development of themes.

## **4.10 Analysis**

Phenomenological analysis seeks to uncover the fundamental structures of certain phenomena by analysing situations (Leininger, 1985). In particular, analysis clarifies the meaning and essence of lived experience for a particular group of individuals who may be familiar with a specific phenomenon. Giorgi's (1985) four steps of phenomenological data analysis provided a necessary guidance to the phenomenological method. Giorgi's method is premised on Merleau-Ponty's phenomenology of perception provides insight to the participants' lived experience of perception, body, and embodiment; with a specific focus of his three orders of the body (mind, body, world) was used to interpret the data.

The process of reading, re-reading, and listening to the audio tapes cannot be underestimated. Transcripts were initially grouped according to ideas and the participant's words or phrases. Examples of key words included the birth experience, somatic and bodily experiences in the 12 months, breastfeeding experiences and adjustments required to better support the baby. This coding resulted in the data being

dissected to follow key words that were repeated in the transcript and then reassembled to uncover the sequencing of the phenomena. Grouping the data in this way enabled the formulation of concepts, themes and subthemes (Strauss & Corbin, 1990).

#### **4.11 Descriptive Analysis**

Descriptive analysis followed Giorgi (1985) and Spiegelberg (1978) processes of descriptive analysis. Spiegelberg uses a three step process to descriptive phenomenology of intuiting, analysing and describing phenomena as a means of engaging in perceptions of lived experience. This three step process aligns with Giorgi's four step method, but it was Spiegelberg's first step of intuiting the data that resonated with the researcher, Giorgi used the term 'indwelling' for this step. Van Manen's (1990) method of separating thematic statements was also applied to the descriptive and structural analysis stage. Van Manen's (1990) approach uses a variety of approaches to interrogate the text for thematic development; these being a line-by-line approach (detailed analysis), sentence(s) approach (holistic analysis) and a selective approach.

The data were initially grouped using van Manen's approach to enable a description of the responses by highlighting the pertinent text. These responses were emboldened and served as a basis for maintaining a clear description of the participants' reflections. Significant statements were organised into concepts, and then grouped into subthemes to search for meaning within each experience. This process was achieved by reading and re-reading the transcripts to locate the essence of the experience. It was important at this stage to stay close to the data and to ensure that any formulated meanings arose from the data and not from another source. In staying 'true' to the data, the research process ensured that the participants' voices told the story of their experience. This was achieved by incorporating the participant's own language and expression into the formulated meanings, and thus adhering to descriptive phenomenological methods (Giorgi, 1985; Spiegelberg, 1978).

#### **4.12 Themes**

Subthemes were combined into theme clusters and a specific description or statement was written for each experience. This process required a constant re-examination of the theme structure and concepts which generated themes. To establish

validity, the theme clusters were reviewed by the researcher's supervisors. A list of themes emerged for each participant experience, and the analysis of theme clusters was compared with the original transcripts (Giorgi, 1985).

A final description was then generated for each of the participants. As part of this process the themes, memos/notes and reflections compiled during data collection and data analysis were incorporated into the final description. At the completion of this stage the final descriptions for each of the participants who had, or had not, experienced PND were compared and analysed. It was in these final analyses that the phenomenon and structure of the having or not having PND was generated.

#### **4.13 Trustworthiness and Rigor of Study Findings**

Streubert and Carpenter (2011) deliberate on the issues of trustworthiness and rigour of qualitative studies and methods. The application of appropriate procedures and processes of rigor to data ensures the science of research method is maintained. Other qualitative experts, such as Strauss and Corbin (1990) and Morse (2015), discuss procedures of validation, when developing data coding structures as important, but do not necessarily mention trustworthiness. According to Hesse-Biber and Leavy (2006) validity is a process of being confident that the reader accepts that the researcher correctly reflected the results. For Guba and Lincoln (1989) and Morse (2015) it is trustworthiness that takes the place of truth. Additional criteria of credibility, transferability, dependability and confirmability were processes applied in the data analysis to ensure that the final descriptions and themes were reflective of the data (Liamputtong, 2013).

According to Polit and Beck (2018), Giorgi's method of data analysis relies on research and it is not appropriate to validate findings by returning the transcript to the participant or to use external judges to validate the analysis. As mentioned earlier by Cicourel using purposive interviewing requires the interviewer to be engaged and active in the interview process. The researcher reviewed and cross-checked themes to ensure that duplication and miscoding did not occur. Additionally, an independent coder familiar with the research process was given five randomly selected interviews for review of coding. This person was not involved in the study or the development of

the coding system. Text nodes difficult to code were discussed with the researcher's supervisors. Chapter 5 highlights the process of coding.

Data were entered into NVivo 11 qualitative data software. This software was used to manage the data and to assist the researcher to identify concepts, create memos and identify themes and patterns within the data (Liamputtong, 2013). Memos were written at the end of each of the interviews. These contained impressions, thoughts and experiences of participants gathered in each of the interviews, and any conclusions or impressions that were revealed at the time. These accounts were important steps for the researcher as the interview was the first step of data analysis. As the researcher further engaged in data analysis, coding and the development of themes, these memos continued and became an audit trail for decision-making regarding the data as the study progressed. The researcher maintained memos and journals as standard processes in qualitative research (Liamputtong, 2013).

#### **4.14 Ethical procedures**

Given the possible vulnerability of the participants, a submission for full ethics approval was made to The University of Notre Dame Human Research Ethics Committee. In response, a condition was imposed on the researcher to complete a First Aid Mental Health Training course ahead of commencing the data collection. This two day training was conducted by the Association of Relatives and Friends of the Mentally Ill (ARAFMI), an organisation which offers Mental Health Carers support services in Perth WA.

Prior to the focus groups and interviews, participants were provided with a plain English statement (Appendix B) which outlined the study's purpose and methods. Participants were made aware that their participation was on a voluntary basis and that they could withdraw their consent and participation at any stage of the study. Assurance was given that confidentiality and anonymity of information would be maintained and that no one would be identified in the thesis or any report in relation to this study (Polit & Beck, 2018) (Appendix C). On agreeing to participate in the study the women were asked to read the information sheet and sign the form of Informed Consent (Appendix C). These documents were delivered either in person or as an attachment by email.

The focus groups and interviews were audio taped and transcribed verbatim. Only the researcher's supervisors had access to the data. All electronic audio and data were secured in a password protected computer known only to the researcher. To safeguard anonymity the participants were allocated a code. Tapes and transcripts of the interviews and a list of participants' names, and allocated codes and consent forms were stored in separate locked drawers in the researcher's office. In accordance with the National Health and Medical Research Ethics requirements, transcripts and audio tapes will be destroyed five years after completion of the study.

#### **4.15 Summary**

This chapter discussed the descriptive research methodology that was applied in this study. Information on the data collection processes and data analysis was gathered to compare themes from the responses of participating women who talked about their experience of having or not having PND symptoms in the 12 months following childbirth. Also, the chapter discussed the research design, the participants and ethical procedures related to the study. Data from 26 mothers were collected through semi-structured in-depth interviews. Data were analysed following the principles of descriptive phenomenology, including a 4-step process of reading and re-reading transcripts and identifying significant statements, arranging the significant statements into logical themes, clustering themes and developing subthemes and comparing the final theme list with the transcripts. Processes to ensure rigour and trustworthiness of the data, which aligned with qualitative research methods, were applied. The following chapter presents and examines the results of the study.

## Chapter 5

### The Participants

#### 5.1 Introduction

Whilst all participants provided rich information of their experiences in the first 12 months following the birth of their babies, in this chapter 15 of the 26 participant's personal biographies are presented. This selection was made to avoid unnecessary replication of information. The biographies begin with eight participants who perceived that they had experienced PND and when they felt their symptoms of PND manifested. This is followed by two participants who experienced 'not coping' or had an episode of depression which occurred in the first 12 months post birth and which was not necessarily related to their mothering or their baby. The final five biographies are of participants who perceived themselves to be emotionally well. The background information of all 26 participants is presented in Table 5.1, and further demographic data is available in Appendix G.

#### 5.2 The Participants

##### *Participant 1 (PND from the birth of the baby)*

P1, a first time mother, had a supportive husband and her mother lived with them. P1 was pleased to be pregnant but felt that she rejected her baby following a protracted labour. She became disheartened as her labour and breastfeeding experiences did not meet with her expectations, despite managing to breastfeed for three months. When she undertook the EPDS screen at her first child health appointment, she understood that she was confirmed as having PND, and was referred to another health professional for ongoing support which she did not pursue as she believed she ought to heal herself. She attended a mothers' group made up of mothers from her own cultural background and returned to part-time work at six months postpartum. She explained that her sense of wellbeing started to improve after she stopped breastfeeding. When she attended a 14 month child health appointment, her EPDS score was found to be reduced.

*Participant 20 (PND from the birth of the baby)*

P20 was not formally diagnosed with PND. However, following an unplanned caesarean birth she believed she suffered from it. Since childhood, P20 had always wanted to be a mother and had witnessed other women's normal birth experiences. Her personal experience of a caesarean birth was negative. When her baby was born it was placed on her outstretched arm, she could not safely secure the baby with her other arm and felt the baby would fall, so she asked her husband to hold the baby. When she returned to the ward the baby had already been bathed by the staff, whilst she breastfed the baby she did not feel a bond with her. The unfolding of her unexpected birth outcome and the care experiences with her baby were extremely disappointing for P20. She also felt unable to engage with visitors, experienced tiredness and episodes of crying. The early stages of motherhood was a blur. P20 believed that not being able to feel, touch, bathe and hold her newborn soon after birth significantly impacted on her wellbeing. She subsequently had three further babies by natural birth. P20 judged herself with the final birth in that she had achieved the birth experience she'd missed the first time [with the final birth].

*Participant 14 (PND from the birth of the baby)*

P14 is married with three children. Her first pregnancy and birth, in Kenya, was problem-free. With her second baby she experienced a protracted labour, which ended with an emergency caesarean birth followed by a reluctance to bond with the baby. She believed that she had PND from the birth. On returning home from hospital, P14 found it difficult to cope with a baby and toddler whilst also recovering from her surgery. Although she had limited family and friends available to support her she confided to a friend that she was having difficulty coping. The friend, a peer mother, offered regular emotional and practical support. When P14 discovered she was pregnant with her third baby she invited her aunt from Kenya to visit and stay to support her through the pregnancy, birth and to assist with her other children. With this support her final pregnancy and birth were problem-free.

*Participant 23 (PND early in the postpartum period, a preterm birth)*

P23 is married with twins. P23 and her husband migrated from India and had not yet established a social network. Whilst the pregnancy was welcomed and presented no problems, the experience and expectations of managing twins was



unknown since there was no family history of multiple pregnancy. At 33 weeks gestation she was admitted to hospital and had to undergo an emergency caesarean birth. Due to prematurity the babies were transferred to the neonatal nursery within the hospital. Fortunately, twin one was well and presented as a term baby. However, twin number two had breathing difficulties which required the support of a ventilator for a short time. On reflection, P23 realised that her limited knowledge about her preterm babies exacerbated her anxiety in relation to their care. She was discharged from hospital leaving the babies in the Neonatal Unit (NU). P23's depression began while the babies were in the NU. P23's parents arrived from India to support her and her husband. She, with their support, managed the care of the twins and both babies developed well. The babies required medical interventions at 8 and 11 months, at which time P23 recognised a re-emergence of her anxiety. Being socially isolated and having no driver's licence she was dependent on public transport to attend appointments in the first 12 months postpartum.

*Participant 6 (PND in the postpartum period)*

P6 is married and has a supportive husband and family. Her first pregnancy ended in a miscarriage and consequently she was reluctant to be excited or to share the news of her new (second) pregnancy. The pregnancy and birth were problem-free. Following the birth P6 felt disconnected from her former friends who had not yet had children and she missed the socialisation of life before the baby. Subsequently, she joined a mother's group which was established at the child health clinic; she felt the group was supportive and she has maintained close friendships with members of the group. P6 found the unpredictability of motherhood challenging. Prior to motherhood she was a proactive problem-solver in her workplace. She felt that her baby did not like her and at three months noticed she struggled with establishing routines for her baby. She thought her PND began at about five months postpartum but did not seek any support. On a particularly difficult day, and in desperation, she reached out to her older sister to let her know that she was not coping. With the support of her older sister she began to feel better about understanding and managing her baby; this was at between 6 and 7 months postpartum. At the end of the first 12 months she said that she wished she had been able to relax and enjoy her first year postpartum.

*Participant 8 (PND in the postpartum period)*

P8 has two children, a supportive husband and parents with whom they lived during the pregnancy and birth. Her first mothering experience was joyful and easy. Following the birth of her second baby P8 experienced difficulties coping with her sick baby and suppressed emotional feelings as she did not want her baby and toddler to see and remember her crying in front of them. Her assessment was that he was a 'sickie baby'. This baby (P8B) vomited between 10 and 15 times per day and she believed that the vomiting was related to something she was or was not doing. She kept a diary to work out what was happening. She said she bonded emotionally with the baby. It was after a period of time that she sought help for the baby. A subsequent paediatric visit led to an understanding of the baby's condition and that the vomiting should self-resolve. It was sometime after this appointment that she sought help for herself. Her GP responded to her with empathy and commenced anti-depressant treatment for her PND. She and her husband remained socially active throughout the 12 months. As a result of this experience she said that she would encourage new mothers to seek help if feeling depressed, and avoid thinking that a stigma is associated with the diagnosis of PND.

*Participant 15 (PND at 9 month postpartum)*

P15 has two children, a supportive husband and parents who live close by. She revealed that as an adolescent she experienced anxiety and depression, and her emotional wellbeing deteriorated following a miscarriage with her first pregnancy. On becoming pregnant with her second baby she was reluctant to bond for fear of another loss. P15 experienced a successful homebirth and bonded immediately with the baby. However at 9 months postpartum she became unexpectedly pregnant and experienced depression. She commenced her third pregnancy with the familiar care provided by a homebirth midwife, and during pregnancy care a high score on the EPDS screen was noted. P15 negotiated with the midwife to ensure that her husband was to provide all necessary emotional care so that she could have a home birth again, thereby avoiding a referral to another health professional. Her emotions were labile with the first baby, and with the second she experienced less fluctuations but deeper depression. She was surprised that she had happy days during the second PND experience. She said that when her mood was low she would avoid contact with her friends. P15 maintained a bond with both babies and attributed her PND to the financial pressures she and her husband were experiencing.

*Participant 25 (A diagnosis of difficulty adapting to motherhood - a delayed onset of PND)*

P25 has two children. Her husband was diagnosed with cancer when 36 weeks pregnant with their first baby. She had a difficult birth experience and the baby was taken to the neonatal unit soon after the birth. P25 stayed with the baby in the neonatal unit with the medical staff's support. On discharge, P25, her husband and the baby lived with her mother while their house was being built. The shared accommodation was adequate but stressful as P25 took conscious steps to ensure the baby fitted in with her mother's routines. She said that to stop the baby crying she breastfed him nearly every hour, day and night, resulting in sleep deprivation. She also avoided contact with the child health nurse and her GP. Some 16-18 months later, when her husband's cancer treatment had finished, she presented to her GP who immediately referred her to her psychiatrist, was hospitalised for a few weeks during which time she was assessed as having difficulty adapting to motherhood. She believed she had PND which was delayed in onset, but felt it was not diagnosed as PND because the assessment fell outside of the 12 months screening period. Following discharge from psychiatric care, she remedied her breast feeding routines and established her own sleep patterns and self-care. During the second pregnancy and birth, at a time when her husband remained well, she focussed on preparing for and having an enjoyable birth experience. She did not experience PND with her second baby. It was at the conclusion of her interview that she also shared that she had a complex mental health history and has worked on looking after herself and her family. She said she was a deeply reflective person and practiced it daily.

*Participant 7 (An episode of depression)*

P7 is married, has two children, a supportive family and a strong social network. P7 had an emergency caesarean birth with P7A, bonded successfully and enjoyed being a mother. At about 2 months postpartum she self-diagnosed depression rather than PND based on the criteria that she had bonded with her baby. She felt that her depression was triggered by having to cope with family and friends visiting from overseas. She managed her emotions by retreating from contact with the visitors. Thereby she successfully returned to her usual happy self. She did not experience PND with the second baby.

*Participant 19 (Not coping)*

P19 has three children and is a successful business owner working from home. P19 experienced a single anxiety attack whilst in hospital with her second baby. With her third baby she experienced anxiety for about 10 weeks postpartum. Her mother was particularly supportive during this period. P19 gave an example of self-management as she felt she was not coping she would lie on the couch and wait while everyone else continued their activities as normal. She found it difficult to cope with family commitments when her usual support network went overseas. She expressed fatigue, low energy and mood swings at this time. She said her feelings of not coping were because she missed her regular support network.

*Participant 3 (Not coping)*

P3 is happily married with three children. She had an unplanned caesarean following a protracted first labour. On day 3 she was to be discharged from hospital, at a time that she was not yet confident about breastfeeding. The midwife, who understood her distress, decided to prioritise providing care over attending a unit meeting in order to support and educate the mother and husband. This was gratefully received. With the second planned caesarean birth she felt more confident and assertive in being able to negotiate what she did and did not want that particular birth experience. With the third baby, however, she had difficulty coping with a school age child, a toddler and breastfeeding a baby. She mentioned that in addition to her usual support network being absent she felt particularly isolated on the occasion that those around her were celebrating the Melbourne Cup. She said when asked to complete the EPDS with the third baby she said she reflected on her personal coping and emotional wellbeing without discussing or mentioning these with the child health nurse.

*Participant 2 (Emotionally well)*

P2 is married with two children. Having Crohn's Disease, P2 was carefully monitored throughout each pregnancy. In her first pregnancy an elective caesarean birth was recommended and gratefully accepted. She was relieved to not have to make the birth choice herself. Despite the planned approaches both births were very difficult; she experienced significant blood loss and the postpartum pain relief was complicated by her underlying medical condition. She unsuccessfully attempted to breastfeed the first baby, and later discovered a family history of this. She experienced a very difficult second pregnancy and was fearful that she might not bond with the baby. This was not

the case. P2 was well organised and established sound sleeping, feeding and play routines early in the postpartum period. Following both births, her mother travelled from overseas and spent one month with her and her husband to support her/them in any way she could.

*Participant 16 (Emotionally well)*

P16 is married with four children, has a supportive husband, family and friends. She has successfully integrated family, work and social life by establishing sound routines around her professional career which involves caring for children with disabilities. She said whilst her fourth pregnancy was unplanned, given her age, she and her husband did not declare the pregnancy until they were assured that the baby did not have any genetic abnormalities. The first 12 months postpartum were busy yet manageable and she appreciates that her own children were blessed with good health.

*Participant 24 (Emotionally well)*

P24 is married with two children and has a supportive husband. Her husband was employed on a temporary work visa, which did not provide access to Medicare. Thus at 34 weeks gestation P24 returned to her country of origin to birth. Her husband followed some time later. There, P24 participated in traditional birthing and postpartum cultural practices. On return to Australia there were thus no follow-up visits for assessment of health and wellbeing of mother and baby. She said that “she felt she had no choice but to cope” in the first year postpartum and thus took the onus upon herself to do so (successfully).

*Participant 4 (Emotionally well)*

P4 is married with three children and has a supportive husband who worked in a fly in and fly out work arrangement. The first two babies were born in birth centres in eastern Australia; and the third in a birthing centre in Western Australia. The third birth experience left P4 feeling “like she was pushed out of the nest” to cope on her own. She was not provided with any follow-up mother/baby health care visits; nor was she advised of the WA child health support system. She recognised she needed to use her prior mothering experiences to support the successful integration of her newborn into family life. She focussed on establishing a good rapport between the older children and the baby.

The demographic profile of all the participants follows:

Table 5.1

*Demographic profile of all participants*

<b>Participant number</b>	<b>Emotionally well</b>	<b>Not coping</b>	<b>Experienced PND</b>	<b>Pregnancy PND/Not coping occurred</b>	<b>Type of birth</b>	<b>Place of birth</b>	<b>Number of children discussed at interview</b>
<b>1</b>			yes	First baby	Vacuum Birth	Hospital	<b>1</b>
<b>2</b>	yes				Planned Caesarean birth	Hospital	<b>2</b>
<b>3</b>		yes		Second baby	Unplanned caesarean then planned caesarean	Hospital	<b>2</b>
<b>4</b>	yes				Normal (Vaginal birth)	Birth centre	<b>2</b>
<b>5</b>	yes				Normal (Vaginal birth)	Hospital	<b>1</b>
<b>6</b>			yes	First baby	Normal (Vaginal birth)	Hospital	<b>1</b>
<b>7</b>			yes	First baby	Unplanned caesarean then planned caesarean	Hospital	<b>2</b>
<b>8</b>			yes	Second baby	Normal (Vaginal birth)	Hospital	<b>1</b>
<b>9</b>	yes				Normal (Vaginal birth)	Home Birth	<b>2</b>
<b>10</b>	yes				Normal (Vaginal birth)	Hospital	<b>2</b>
<b>11</b>	yes				Normal (Vaginal birth)	Hospital	<b>1</b>
<b>12</b>	yes				Normal (Vaginal birth)	Hospital	<b>1</b>
<b>13</b>	yes				Normal (Vaginal birth)	Hospital	<b>1</b>
<b>14</b>			yes	Second baby	Unplanned caesarean then planned caesarean		<b>2</b>

<b>Participant number</b>	<b>Emotionally well</b>	<b>Not coping</b>	<b>Experienced PND</b>	<b>Pregnancy PND/Not coping occurred</b>	<b>Type of birth</b>	<b>Place of birth</b>	<b>Number of children discussed at interview</b>
15			yes	First and second	Normal (Vaginal birth)	Home birth	2
16	yes				Normal (Vaginal birth)	Hospital	2
17	yes				Normal (Vaginal birth)	Hospital	1
18	yes				Normal (Vaginal birth)	Hospital	2
19		yes		Second baby	Unplanned caesarean then planned caesarean	Hospital	2
20			yes	Second baby	Unplanned caesarean birth, then Vaginal birth after caesarean	Hospital	4
21	yes				Normal (Vaginal birth)	Hospital	2
22	yes				Unplanned caesarean then planned caesarean	Hospital	2
23			yes	First baby	Unplanned caesarean then planned caesarean		2 <sup>1+2</sup>
24	yes				Normal (Vaginal birth)	Hospital	1
25			yes	First baby	Normal (Vaginal birth)	Hospital	2
26	yes				<b>Normal (Vaginal birth)</b>	<b>Hospital</b>	1

### **5.3 Summary**

In summary the selected participants' biographies demonstrate and represent the vast and varying experiences mothers have in the first 12 months postpartum. These biographies show that whilst one mother may have had a particular antecedent for PND, for example, an unplanned or difficult birth, it does not necessarily follow that the antecedent predicates PND. The biographies show the very complex situations of new mothers, and that even if a mother has previously had a baby this should not influence or suggest that the health professional should modify their attention or care to her. Whilst it is implied that the health system and care provide mothers with choices and options relating to birth and the first postpartum year, the reality is that this does not always happen. This is further explored in the following chapter where the analysis of interviews is presented and discussed.



## **Chapter 6**

### **The Voices of Twenty six Women**

#### **6.1 Introduction**

This chapter presents a detailed review of the data analysis process and the development of the themes and the steps undertaken to achieve this. It illustrates the processes of how rigor and trustworthiness of the data were ensured. Represented are the steps of descriptive phenomenology using the methods of Giorgi and Spiegelberg. The steps and processes of applying Merleau-Ponty's phenomenology of perception (and as previously outlined in Chapter 2) are outlined, and representation of this is included in the chapter. The development of the study themes are provided, giving insight to the researcher's trail in decision-making.

#### **6.2 The Steps and Processes Used in this Thesis**

The use of Giorgi's and Spiegelberg's methods of interpreting descriptive data are appropriate sources for revealing consistent phenomenal patterns and themes under investigation. These methods also align with Merleau-Ponty's perception of horizons (perspective). The descriptive accounts given by the participants were reflected in a fluid style where they moved backwards and forwards in time while they recounted episodes and feelings which to them pinpointed milestones in their experience of motherhood. At these times the researcher noted that there were changes in the participants' behaviours, emotion and expressions when deeply personal experiences were revealed.

Merleau-Ponty states that to every experience we bring our prior history which may influence our judgements, assumptions and behaviours. In the case of the participants they contributed information about their personal experience. The researcher was mindful of maintaining a neutral voice in eliciting memories and experiences for the study. Throughout the interviews and data analysis the researcher ensured relevance in data collection by regular reflection and revisiting the study questions. Furthermore, the researcher maintained a journal which documented initial perceptions and responses to the participants' accounts. This process was helpful in focusing on the contribution and participation of the participant in order to keep the

voices authentic and true. The content produced an authentic voice of the participant. The researcher's behaviour and questioning techniques were professional and her knowledge of PND did not influence the direction of the interviews or the data.

Using Giorgi's first step of descriptive phenomenological analysis, the pure descriptions were analysed in multiple readings and key concepts and content identified. Following Giorgi's second step, these multiple readings led the researcher to apply and categorise the data into Merleau-Ponty's key concepts of perception, the biological body (self, self as mother, emotion, birthing, the thinking subject), the lived body (the social world), coping, habits, and others (baby, family, health professionals). This process focused on identifying significant statements which were subsequently discriminated into meaning units or key concepts. These steps ensured a consistent approach to understanding the data at a deeper level. Giorgi's third step of transforming the participants' expressions into psychological and body focused language included their comments on physical body, emotions, interactions, experiences, feelings and attitudes pertinent to the participants' experience of emotional wellbeing in motherhood in the first 12 months. This enabled the development of themes and sub themes. In Giorgi's final stage, the transformed meaning units were synthesised into a consistent statement regarding emotional wellbeing. In this step the researcher discriminated the essential elements of the process and a general description was generated for women who reported being emotionally well in the first 12 months. In addition, a specific situated structure was generated for participants who perceived themselves to have experienced PND.

### **6.3 Identifying Themes**

Van Manen (1990) uses three ways of identifying themes for analysis within a text. These include a detailed reading approach, the selective approach, and the holistic reading approach. The researcher applied all these methods over various and multiple readings of the data to support and identify the sub themes and themes.

It was appropriate to integrate the approaches of Giorgi and van Manen in the readings of the data. Careful detailed reading, as suggested by van Manen, required a careful examination of the transcriptions to identify key words, concepts and clusters of sentences. Using the selective approach, pertinent participants' statements were identified and tabulated into sub themes. An example of this method is given below:

*I'm glad we've done it now because they play so well together and everything, but it was very very challenging at the time, trying to deal with, you know, a newborn and all the issues that you have there. (P22, did not experience PND)*

This significant statement, selected in the initial analysis, became linked to key words of **being challenged** which led to the concept of **accepting and having to cope**. This statement highlights that the participant acknowledged her difficulty in caring for a baby and a toddler very close in age. Her reflection of this time helped her to recognise and appreciate her current situation and the benefits that this challenge had brought. In the final analysis, this selected statement became part of a sub theme, **Coping with the demands of motherhood** and the theme, **Adapting (and Transitioning) to Motherhood (Maintaining Perspective: that is identifying as self as person and self as Mother (Embodying Change). (Being visible)**

In the preliminary analysis, the significant statement by P23, who perceived herself to have experienced PND, the words of **being challenged** led to the concept of **self-perceived not coping**. It later became part of the subtheme **coping with the demands of motherhood** and the theme **Interrupted Adaptation (delayed transition) to Motherhood**.

*It was a shock but then I didn't know the hard work behind it and the challenges behind twins" ... I think every day was a new day with new things happening, something new happening. Once when we thought, for the first few days, maybe 4 or 5 days we'd say oh we have got a routine and we used to follow that routine. On the sixth or the seventh day there was something new happening with the boys. (P22, experienced PND)*

When examining the written text the researcher searched for significant statements and key linking words between the transcripts that identified similar and consistent meanings so they could be aligned to indicate the concepts, subthemes and themes. This process was a challenging one as it was fundamental to ensure that the participants' voice was upheld over the researcher's perspective of the reading. This aspect of having to judge the relevance of selected statements is acknowledged by van Manen (1990) and Giorgi (1985).

The researcher engaged in a holistic reading approach numerous times in order to validate the understandings of the data. The significant statements were also re-examined to gauge whether or not the themes were still reflected in this analysis. For example, when examining the data for participants' experiences of other people, the data showed the overwhelming personal support the participants received from their partner, family members and peers which contrasted with the minimal support shown to the mother by the health professionals during health care visits. The theme that evolved from participants' comments on the health care experience was their consistent sense of **"Being Invisible"** where the focus and attention was directed at the baby, not at the mother and baby as a unit, or at the mother as a relevant other. The following examples came from participants who had perceived themselves to experience PND and those who had not:

*It's not just about the baby, the mother's the main person... definitely...yeah I'll be honest. But I didn't ring again or say anything... I'll be honest yeah, because this will help other people. (P2, did not experience PND)*

***I found the GP easier to talk to than her [the child health nurse]. She was very good with the children. For the chat I'm feeling like this I found it easier to talk to the doctor. He was family doctor for a long time. He knew. He knew. (P8, experienced PND)***

*It was never explicitly, you know, would you like to do an EPDS, no you're fine ok it was just kind of how you going, ok good, didn't bring it out kind of thing and **I wasn't until yeah her 8 month check where I was with a child health nurse who I didn't know that she actually just automatically did it and we don't actually have to do it at 8 months. We routinely do them at 6 to 8 weeks and at 3 to 4 months and we will sometimes do them at 8 months if there's been a high one previously or if they haven't been done or whatever and she just, this particular nurse just [did it] routinely. (P9, did not experience PND)***

*Probably if I had that screening offered, someone would have realized that I was struggling in that time, but I didn't get that, because I went through the public way, so I don't think, I didn't get that. And the only other time is when you go to the six-week visit, but the doctor focuses more on the baby, and not so much you. (P14, did experience PND)*

The experience of **feeling less important than the baby** was a sub-theme to the theme **Being visible** that arose in the holistic reading approach.

Table 6.1

*Representing the early analysis, with P22 and P23 as examples*

Significant statements (from transcript)	Concept and linking key words
<p><b>I'm glad we've done it now</b> because they play so well together and everything, but it was very very <b>challenging at the time</b>, trying to deal with, you know, a newborn and all the issues that you have there. (P22, did not experience PND).</p>	<p><b>Coping</b> Positive emotions: <b>Motherhood is work</b> Being challenged during the 12 months Acceptance of the situation <b>Maintaining Perspective</b> A temporary state which requires immediate adjustment and which will pass</p>
<p>It was a shock but then <b>I didn't know the hard work</b> behind it and the challenges behind twins. (P23, experienced PND)</p>	<p><b>Motherhood is work</b> Unaware of the demands of motherhood</p>
<p><b>I think every day was a new day</b> with new things happening, something new happening. Once when we thought, for the first few days, maybe 4 or 5 days we'd say oh <b>we have got a routine</b> and we used to follow that routine. On the sixth or the seventh day there was something new happening with the boys. (P23, experienced PND).</p>	<p><b>Self-perceived not coping</b> Feeling unprepared/New experiences cannot be predicted <b>Developing confidence in recognising establishing routines</b> Recognising patterns and routine <b>Not Coping</b> Feeling challenged /unprepared with unpredictable change</p>

Significant statements (from transcript)	Concept and linking key words
<p>He was obviously too young you had to make sure that she was safe all the time and <b>I couldn't leave her</b> where he could get to her and things like that, without supervision. Um so showering was like okay, "<b>you sit on the bed and right you sit right here where I can see you</b>". (P22, did not experience PND)</p>	<p><b>Coping</b>  <b>Ensuring safety</b>  Strategies of daily routines</p>
<p><b>I've got a lot more support</b> in that regard. For both the children, yes he was home for both the children, so <b>I was really really lucky</b> and yeh he is an involved dad. um she would only sleep for one sleep cycle. (P22, did not experience PND)</p>	<p><b>Coping and Support</b>  Practical support on-hand  Sharing Responsibilities</p>
<p>Sleeping was a bit hard as well. But then night time what, what we used to do is, bed time was quick. So if they go to bed around 7.30 <b>I used to have a nice quick shower</b>, my mum used to cook something fresh. <b>We used to eat together, then 10.30 was a feed</b> then we all, <b>I used to go straight to bed</b> then they used to wake up around 2.30, 3 o'clock so that sleep used to... (P23, experienced PND)</p>	<p><b>Coping and Support</b>  Practical support on-hand  <b>Self-caring</b>  Taking care of self</p>
<p><b>I would give her a feed at 7 o'clock and then go to bed</b>, and um he would do whatever he could to give me a good chunk of sleep until about 11. <b>I'd get up and do the next feed, and I would do whatever I could to give him chunk of sleep.</b> (P22, did not experience PND)</p>	<p><b>Coping and Support</b>  Practical support on-hand  Sharing  <b>Nurturing others</b>  Responsibilities  <b>Self-caring</b>  Taking care of self</p>

## **6.4 Summary**

This chapter provided an outline of the processes and methods involved in data analysis. The process for the development of the themes was described. The processes of ensuring rigor and trustworthiness of the data were explained. The development of the study themes were provided giving insight to the researcher's decision-making trail, thereby allowing the following chapter to explore maternal postpartum embodiment.

## Chapter 7

### Embodiment – Maternal Postpartum Embodiment

#### 7.1 Introduction

This chapter, begins with a consideration of embodiment from Merleau-Ponty's perspective and explores the spectrum of emotional wellbeing that mothers experienced in their first 12 months following the birth of their baby. The similarities and differences between mothers who had and had not perceived themselves to have experienced PND will be discussed. The continuum encompasses a mother's experience at the birth, infant feeding and her adaptation to mothering. Specifically, adaptation refers to the range of emotions experienced in the postpartum year and her associated coping responses. Importantly, Merleau-Ponty's discussion on habit is a relevant element of her coping structure. Merleau-Ponty's concept of being-in-the-world is explored through relationships with significant others. In this context significant others include the baby, partners and family members, health professionals and social networks. Whilst the outline presented appears in a sequential frame, her being and living are governed by simultaneous, interactive and intertwined realities. Thus, the reader should consider this interconnectedness in the reading of the chapter.

#### 7.2 Merleau-Ponty's Embodiment: The Body (In) and the World

Embodiment, according to Merleau-Ponty (2012), is how we live in and experience the world through our bodies; it is the body schema that provides the essence for us to feel our way in the world. He says

*the theory of the body schema is, implicitly a theory of perception. We have relearned to feel our body; we have found underneath the objective and detached knowledge of the body that other knowledge which we have of it in virtue of its always being with us and of the fact that we are our body...we are in the world through our body...we perceive the world with our body.*  
(p. 239)



Our being-in-the-world is evidenced in our perceptions, emotions, language, and movement in space and time. Embodiment is the simultaneous awareness of the self, the body as it is experienced and lived, and the world with which it relates and from which it shapes daily life. Thus, the self, the body, and the world are intertwined.

The body is a complex and sophisticated organism that manifests as the functional, practical, mechanical structure that negotiates with the world. For Merleau-Ponty the body is more than a physiological being; it is not simply an object in the world. He contends that the body, as a mechanical structure, has both internal and external mechanisms that sense the world. The internal mechanisms inform the sensing and awareness of the external environment or Being-in-the-world. Whilst the external mechanisms are the observed responses of being-in-the-world and to which the dynamic state of involvement and evolvment of “our tasks, our cares, our situation, [and] our familiar horizons” are situated (Merleau-Ponty, 2002, p. 94). He says,

*the body is the vehicle of being in the world, and to have a body... is to be intervolved in a definite environment, to identify oneself with certain projects and be continually committed to them”...[and that] I am conscious of my body via the world, that it is the unperceived term in the centre of the world toward which all objects turn their face, it is true for the same reason that my body is the pivot of the world. (Merleau-Ponty, 2002, p. 94).*

## **7.3 The Body as a Subject**

### **7.3.1 Spatiality**

Merleau-Ponty says that we experience our body as a subject, not an object. Our body, like objects in the world, takes up space. However, it takes up space differently to objects because of its integrated and unified way. The body as subject is perceived as a whole, not as a series of parts that are related and interconnected. For example, my hand does not exist separately from my body, it is part of my body. In contrast, objects in the world exist separately from other objects and whilst they take up space, near or far, together they may be associated with each other because of distance (space) without being interconnected with each other; they are discrete in their function and presence. They exist independently of each other. The body is an organised whole; it does not exist independently of its parts and Merleau-Ponty argues, it is because of this unified presence that awareness of the body is perceived through the *body schema*.

### 7.3.2 Body schema

Merleau-Ponty interprets the body schema as a cognitive system that is within the body, which one understands from the first person experience by how it is felt, sensed and gauged from within the person. The body schema provides proprioceptive and kinaesthetic knowledge of the body which gives the body its motor awareness and understanding of its capacity. For example, we know intuitively and subconsciously that our body is held up by the back/spine yet to we do not have to be continually aware of this. To confirm its presence we can access it indirectly by looking through a mirror or we can feel its presence by pressing it against an object (for example, when we lean on a wall – we feel our back against the wall).

A significant issue arose in the translation from French to English of Merleau-Ponty's work pertaining to the concept of body schema (Carman, 2008; Gallagher, 1986; Paillard, 2005). The terminology 'body schema' (*schéma corporel*) was misrepresented as 'body image' (Gallagher, 1986). Gallagher (1986) comments that body image is a third person perspective of the body and understood from an external perspective, as for example, as one looks at something, as one appears to others, as one interacts with others. It is a sensory view of how the self is imagined to be or acts that is gauged, and influenced from and by the world. This may be demonstrated by the perceptions of a sufferer with anorexia who sees an obese body and not an anorexic body when seeing the self on an image in the mirror. Body image can be clarified as one's perceptions, beliefs and attitudes of one's body, whilst body schema is an understanding of one's sensory-motor capacities that control movement and posture (Gallagher, 1986). Specifically for this thesis body schema and body image refer to both the mothers' perceptions, beliefs and attitudes to maternal embodiment, and their bodily responses and their adaptation to mothering.

As discussed in the previous section, both these body representations (body schema and body image) hold relevance for the maternal subject. Body schema reflects direct emotion, physical movement and capacity, while the latter is a subject informed by the world that, apprehends and takes up activities, actions and beliefs of the world. It is in the using of the term body image that a dynamic relationship between a subject and the world is evident. Merleau-Ponty's view of embodiment gives a context for

understanding the significance of mothers' perceptions of their body schema with regards to their postpartum experience.

Merleau-Ponty points out that neurophysiological states interfere with bodily self-awareness and body schema,<sup>35</sup> and as a result an alteration in recognising the self occurs. Carruthers (2008) claims that

*possessing a sense of embodiment is necessary for being capable of self-recognition...and cannot be used in isolation by a subject to tell whether the actions they see in the mirror are their own...[and that]..[t]o know whether the action one sees has anything to do with oneself one must also possess a sense of agency. That is, one must possess a sense that one initiates, controls and ends the actions one performs. (p. 1303).*

Carruther's ideas of self-recognition may be understood by Merleau-Ponty's classic example cited in the *Phenomenology of Perception* of Schneider where he examines the presence of phantom limb pain as self-recognition. In this situation the confines of the body schema are curiously experienced, the sense of a unified whole remains in existence for the subject event, though a limb is absent. That is, his body schema feels phantom pain. Here Merleau-Ponty alludes to the sensory and motor capacities of the body, but it is in the *Structure of Behaviour* that this aspect of body schema is further detailed, where he argues that the integrated or coordinated and control or inhibition elements of neural circuits become visible when normal or pathological behaviour is manifest. These circuits are essential for both thought and language, but also lay foundations for adaptation and learning that are essential for human development. This may be evidenced by the phenomenon that a 3-4 month baby is engaged by the moving object in front of her without knowledge or understanding that the moving object is indeed her hand.

Merleau-Ponty does not provide any specific discussion on maternal body schema either during pregnancy or the postpartum period. He does, however, present an argument for the development of infant body schema as something that happens to the infant following birth. The very nature of drawing attention to the infant body schema implies a mother-baby relationship and schema. That is, whilst the body schema identifies with the individual, the baby because of its early stage of

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<sup>35</sup> Merleau-Ponty specifically refers to the condition of anosognosia.

development is dependent on the mother and in the absence of a mother is reliant on a pseudo-mother. Conversely, the mother's body schema re-adapts to accommodate the needs of the baby and herself.

Interestingly, Merleau-Ponty's theory of body schema begins from birth compared to Lymer (2011) who suggests that infant body schema begins in utero at which point the mother responds with her own body schema. The study accepts that the maternal body (through genetics, nutrition and physiology) enables the unborn baby to develop its body schema. The uterine environment provides the space and capacity for the growth and movement of the foetal body schema. Lymer (2011) explains that the pregnant maternal body accommodates the developing foetus and that the two exist reciprocally in and for each other, and because of this the maternal body schema experiences incremental and constant change. She states that "one of the most characteristic aspects of embodiment in pregnancy is the manner in which the [maternal] body schema is constantly changing and shifting" (p. 132). The outward appearance of the body and the negotiations she makes are a reminder of her focus to the developing baby. As she grows outward in pregnant embodiment her sense of self and her capabilities transform.

### **7.3.3 Situational space – emotion as space**

As we saw above in the discussion of the intertwining of maternal and foetal schema, and also how a baby perceives its hand to be a moving object separate from itself, there is the sense in which the spatiality of the body can be seen as different to the spatiality of objects. Merleau-Ponty points out that the body is the first point from which all objects are subsequently positioned; that is my body is 'here' and all other positions are judged to be 'there'. He says that the body acts as an anchor and gives context to the tasks to be faced and from which experience is interpreted. In this way, the body is recognised as the first point of reference. The meanings we ascribe to objects that are experienced in space are associated with and derived from the body. Thus embodiment for Merleau-Ponty is the subjective experience immersed through the bodily (object) experience; we experience ourselves both as subjects as well as objects.

It is through terms such as 'beside', 'underneath', 'in front' or 'behind' that orientated space gives form to the objects. It is the 'here' and directedness of the body that allows for relationship to external objects and thus space to be established,

described or intuited. Emotional space, whilst not directly discussed by Merleau-Ponty, is an important element of situated space.

Merleau-Ponty discusses emotions and feelings<sup>36</sup> in his discussions of sexuality and the expressiveness of the body. He says, “if then we want to bring to light the birth of being for us, we must finally look at that of our experience which clearly has significance and reality only for us, and that is our affective life” (Merleau-Ponty, 2002, p. 178). He argues that affectivity is not a property of the body; but rather a dimension of experience. If experience and affect do not correlate increased ambiguity may result; in a mother this may lead to PND. To illustrate how experience informs affectivity and/or emotion he gives the example of, “a girl whose mother has forbidden her to see again the young man with whom she is in love, cannot sleep, loses her appetite and finally the use of speech” (Merleau-Ponty, 2002, p. 185). This example shows the physical responses that the young woman experiences as a result of her emotional state. He says, “bodily existence which runs through me, yet does so independently of me, is only the barest raw material of a genuine presence in the world. . . .that personal existence is the taking up and manifestation of a being in a given situation” (Merleau-Ponty, 2002, p. 192). Emotions and feelings are familiar and accessible to all people, and while they manifest in the same way, they differ in how they use their body and patterning to react. To further explain Merleau-Ponty writes,

*the fact is that the behaviour associated with anger or love is not the same in a Japanese and an Occidental. Or, to be more precise, the difference of behaviour corresponds to a difference in the emotions themselves. It is not only the gesture which is contingent in relation to the body's organisation, it is the manner itself in which we meet the situation and live it. The angry Japanese smiles, the westerner goes red and stamps his foot or else goes pale and hisses his words. It is not enough for two conscious subjects to have the same organs and nervous system for the same emotions to produce in both the same signs. What is important is how they use their bodies, the simultaneous patterning of body and world in emotion. (Merleau-Ponty, 2002, p. 219).*

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<sup>36</sup> Specifically the emotions and feelings Merleau-Ponty refers to include desire and love, pleasure and pain, satisfaction, fear (p. 186), resentment (p. 189), shame and immodesty (193).

Merleau-Ponty suggests that words, emotion, things, behaviours for example are “no more natural, and no less conventional, to shout in anger or to kiss in love than to call a table ‘a table’. Feelings and passionate conduct are invented like words” (p. 220). This suggests that emotions such as shame and fear are learned and possibly conditioned through society.<sup>37</sup> Culture and prior experiences may influence our responses to situations. Women are told it is a positive thing to be a mother, but what happens if a woman does not feel that? Expectant mothers are informed that PND is a possibility following birth. They have knowledge of the language and symptoms of PND but not necessarily the complex understanding of its manifestation. The terminology and expectation of PND may become the natural attitude and social norm. The individual bodily feeling is a subjective interpretation of the natural attitude. A woman may recognise her bodily state or feeling of PND. When Merleau-Ponty discusses the mutual relationship of the natural attitude and perception he conveys the significance of the social and cultural context, and how the individual assimilates in society.

Sue Cataldi’s (1993) book *Emotion, Depth and Flesh* expands Merleau-Ponty’s work on affect and emotion. Her work focuses on developing the connection between emotion and depth, with her central claim being that “perceived and emotional depths are interrelated and

*phenomenologically, our sense of ‘self’ is that we are simultaneously open to and closed off from others; simultaneously intermingled with and distanced from them...[and] our lived experience of the world is that we belong to it or are of it, but are not it. (Cataldi, 1993, p. 28).*

It could be argued that some new mothers feel they are ‘in motherhood’ but not ‘of motherhood’ and this distinction of their ‘state of being’ and how they experience their own state of being, is relative to the defined or objectified state. That is, reality versus the ideal.

Cataldi’s (1993) discussion defines particular emotions with linguistic distinctions to demonstrate the cluster or spectrum of the emotional state. Rather than naming emotions generically (for example, ‘liking’ versus ‘love’), she recognises them as a continuum of varying depths such as ‘liking, admiration, infatuation, excitement,

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<sup>37</sup> Conditioned responses are ‘recognised attributes or behaviours’ for some mental health states (Barkway, 2013). For example, a prior history of depression predisposes a mother to PND

love'. Another example is 'irritation, anger, rage, blind rage'. She also distinguishes between emotions arising from personal experience and those which are understood through the social world. Emotions in the social world convey common understanding and interpretation, and also invoke empathic responses. The appreciating and understanding of emotions in others is recognised through empathy. The possibility for empathy was discussed in Chapter 2. Cataldi (1993) differentiates between the first person experience and meaning attributed to emotion versus the third person experience of attending to the emotion through factors such as empathy, attitude, cognition and perception.

Cataldi (1993) makes reference to dislike, loathing and hatred being on a continuum of emotional depth. Her linguistic distinctions show,

*a complex vocabulary for [example] sadness. We may feel glum, dismal, dissatisfied, distressed, disappointed, dejected, depressed, sorry, sorrowful, despondent, miserable, wretched, melancholy, nostalgic, hurt, bitter, 'broken-hearted', grim, distraught, grievous, mournful, tormented, in agony, anguished or in despair; they are felt as a continuum. Many of these emotions may be deep-rooted, and some are deeper than others. We construct sorrow and despair, for example, as engulfing being deeper than just feeling sad or glum. In depression, for example, we experience a 'darkening' of our world'. (p. 8-9).*

For a mother with PND it may be difficult as she tries to separate how she personally feels and how she shows her feelings to, or for, her baby. As such a mother is mindful that she does not want her baby (or others including small children) to see her unhappiness or tears. Therefore, she displays a pretence of happiness, and in essence she masks her emotion. This emotional masking toward a baby or young child is different to that of masking for adults. Mothers are concerned with protecting their children from future painful memories. It could be argued that in protecting her children she is protecting herself for the future. Thus, her intention in the immediate and future are her children, and her future self. From a mother's perspective, memories are situated in the future but created in the present.

Cataldi (1993) proposes that it is the perceived depth of emotion within a situation which governs a personal response. She explains that when one experiences deep emotion, a moral and cognitive component exists. In the experience of anger,

recognised as a deep emotion, a perceptual belief of being deliberately wronged or harmed is held, and the person moves toward the source of the anger to 'do' something about the situation. In comparison, in superficial emotion such as irritation, there is no moral or cognitive dimension to the situation and therefore no response to the emotion. The resolution is a movement away from the source of irritation. In PND, a woman has to account for her emotions, so the hyper magnification that is given to her state does not always reflect her complete situation. She has in reality been disembodied, and her emotion seen separate and not related to her lived situation.

Cataldi (1993) also explains that emotional depth exists spatially and temporally, although it is the spatial dimension that is prominent in the explanation of the experience of some emotions. Elements mentioned are dimensions of distance, breadth and height, position (on top of, in front and behind) and colour. Thus, experiences can be 'suffocating', 'palpable', 'far away' or 'dark'. For Cataldi, the temporal dimension pertains only to deep emotions, such as 'in-love' versus being 'in-liking'. Merleau-Ponty does not talk about emotions as such but he addresses the lived body as an expressive body. For him a body is not born with emotion but develops as a subject is exposed to experience; that is, given the duality of a lived experience and being-in-the-world may create emotion. Merleau-Ponty in the *Primacy of Perception* (1964) says that we look to and for the body's "expressive gestures...[to give] sufficient signs of emotional states [they] have a univocal meaning only with respect to the situation which they underline and punctuate. But like phonemes, which have no meaning by themselves, expressive gestures have a diacritical value: they announce the constitution of a symbolical system capable of redesigning an infinite number of situations [and] are a first language (Merleau-Ponty, 1964, p. 7). This is a significant observation in regards to mother-baby relationships as mothers learn to read and understand the baby's communication through their emotive state. For example, crying is a classic demonstration of baby's discomfort while society generally associates crying with emotional distress. In reality, the body's expressive capacity gives off signals; those signs are indicative of states of being, like happiness, discomfort, pain, being uncomfortable, annoyed, or sick.



## 7.4 Theme 1: Emotional wellbeing which is reflected through the body

The first theme, **emotional wellbeing which is reflected through the body** (discriminating between having or not having experienced PND), involves three sub-themes - the rhythms of my body, the expression of emotions and coping with an unexpected reality. The themes and subthemes are discussed below.

The theme of emotional wellbeing which is reflected through the body relates to how mothers discriminate emotions and particular signs (somatic symptoms) experienced through the physical body as reflections of the lived world where social ideals are portrayed and normalised by women. When a mother encounters a conflicting reality she can experience unwelcomed and unanticipated emotions. This phenomenon is realised at critical times that coincide with birth and when the pressures and tensions of being a new mother are felt. For a mother PND is experienced privately; she tends to mask her true feelings. This may, or may not, influence her interactions with her baby and other children. In this study it is noted that when emotional distress becomes so overwhelming the participants choose to allow another caregiver to nurture the baby and attend to its needs while they allowed themselves time to be alone. In reality, these women do not feel a connectedness with their baby. On the other hand other participants who felt this overwhelming sense of distress chose to embrace their feelings in another way. They consciously made a decision to compartmentalise their distress and did not reveal any untoward feelings. These women became aware of their body language and how this may have translated to the baby/children. As a protective behaviour they suppressed their feelings of sadness, distress, hopelessness or such moods that may give the impression of maternal unhappiness. The participants were aware of their outward bodily expressions, such as crying and expressing anger, however they were not always successful in suppressing it. Furthermore, they were mindful to keep such feelings private as a means of self- preservation and protection of others:

*I think for [P8A] the older one, I kept on a brave face you know I didn't want to be sad because I didn't want him to pick up on I was sad. There was a false, I tried to bravado face for him because I didn't want him to relate to this baby to me being sad all the time. That's how I saw it [crying silently in the interview]. (P8, experienced PND)*

In the postpartum period for the mother, being emotionally well meant that a range and depth of emotions were experienced and the participants were comfortable to express them. They felt comfortable to cry when they needed to cry or to express anger when feeling angry. In social circles there is a tendency to avoid the acknowledgement and display of anger as this emotion is seen as socially unacceptable, however, these women were able to assign a reason for their anger. Similarly for crying, they could justify their expression. They were responsive to the baby's needs and were happy to fulfil this aspect of mothering and accepted that unexpected interruptions occurred.

Social preparation for birth and parenting generally focuses on positive and happy experiences. The contrast of these expectations which collided with the reality of unexpected, unhappy and unfulfilled physical and emotional bodily elements aggrieved those who perceived they experienced PND. An example of this is when the realisation that the unfulfilled situation cannot be undone; as is in the case of the birth which cannot be physically re-visited. It may be replayed emotionally which can cause distress due to the mismatched idealistic expectation with the reality. As much as a woman wants to have a unique experience, the safety and wellbeing of the baby takes precedence over her wishes for a planned idealistic experience. Which, of course according to social expectations, is the 'right' process to follow.

#### **7.4.1 Subtheme 1.1: The Rhythms of the Body**

The natural rhythms of the body have undulating highs and lows, which are normalised to the point of being indistinguishable and accepted as part of expected behaviour. Women who perceived that they had PND were able to discriminate that their emotional responses did not reach the peak and troughs of the expected body rhythm, but rather they experienced a flattening and protraction of their emotions. This levelling out of emotion influenced their general adjustment and adaptation to their transition to motherhood. Coping with an unexpected reality is discussed further into this chapter. Women who perceived that they were emotionally well were able to accept the cyclic rhythm of their body and understood that any distress experienced would be transient.

Recognised symptoms of PND include interrupted sleep patterns, fatigue, altered nutrition and unexpected weight gain or loss. These symptoms are not exclusive

to PND and are expected parameters of parenthood in the first 12 months. Therefore when reflecting on somatic symptoms an association of these with PND is not definitive and in reality mothers did not assign these as symptoms of emotional disturbance. The women focussed, generally, on the demonstration of overt emotional behaviours, such as crying, shouting and expressing anger. That is, mothers in this study ascribed emotion and emotional behaviours, in favour of physical symptoms, to PND. Prior conditioning, information and expectations related to emotional states in birth, parenthood and PND influence the self-awareness of those particular emotions. For example, when reflecting on evidence of crying or humour they could readily identify with those situations because they were pre-informed about expecting these behaviours. Yet if asked to identify times of being frustrated or bored such situations could not be readily identified in this context because they were not associated with PND.

Tiredness, fatigue, decreased energy levels and sleep deprivation are common and expected in early motherhood. The same symptoms are generally investigated in PND, however, these bodily manifestations are neither exclusive to motherhood nor to PND. In motherhood, these symptoms are assumed to be related to caring for the ongoing physical needs of the baby. Whilst the majority of participants in this study expressed that they had experienced these symptoms, as would be expected in motherhood, the symptoms were indiscriminate across both groups. For example, there were reports of tiredness, sleep deprivation, and decreased energy levels from all participants regardless of whether or not they identified with having experienced PND. Fatigue, whilst not defined, was related to the cyclical care and physical demands of the baby such as the night time care and feeding. Interestingly, synonyms such as 'exhaustion', 'weariness', 'being worn out' were not mentioned yet those who referred to those feelings referred to them as being 'fatigue'. These latter terms imply a desire to give up or not able to continue in this role. The temporary nature of tiredness, having reduced energy, fatigue and sleep deprivation suggest that these states will be remedied in time when specific attention is giving to them.

The participants who reported experiencing tiredness, fatigue, sleep deprivation or low energy did not attribute these symptoms to having or not having PND but rather as a manifestation of daily mothering. The participants revealed that they had an awareness of their own limitations, responses and vulnerabilities and they realised they were prioritising and readjusting personal expectations in favour of the

physical demands of a baby. The following participants recognised that tiredness is a function of mothering:

*being tired I guess it was knowing my limitations. I thought I can't do this by myself I thought I could. That only human came into my head, you know trying to work it all out. And I was started to be gentler [on myself]. (P3 experienced non-coping)*

*I just remember like I was exhausted after his, like after him being a baby because I was just physically tired from holding him and he cried a lot so he wouldn't go to anyone else. (P26 emotionally well)*

Tiredness was a result of sleep deprivation and physical exertion related to caring for the baby and maintaining family life. Establishing baby sleep routines was seen as a positive foundation for maternal wellbeing because it enabled predictability and structure for baby and maternal health as the following statements show:

*So both my babies have slept through, well [P2B] was even earlier than [P2A], she was nine weeks and he was seven weeks, my mum was still with [us] ... I've had 12 hrs sleep. My [husband name] will tell anyone [researcher name], that's the truth. P2B's never had us up. (P2 emotionally well)*

*Sleep deprive, that's what I think. Even though my child, children sleep through very well I still am very tired and that's the only thing I can think of. Always tired. Yeah like I'm either, either you know when they go to bed I'm either folding washing or doing stuff so always, always up late trying to fix, you know trying to do stuff for them. (P21 emotionally well)*

The participants attributed tiredness to being an expected part of mothering. They did not identify it as being symptomatic of PND:

*...there's some days you think I'm just going through the motions here because you're so tired. And you know maybe you haven't had a good night's sleep or you know somebody's been up half the night and I remember one time they, when all of them were sick with some gastro thing and we were using up all the sheets in the house and all the towels and it was just constant. (P4, emotionally well)*

Somatic symptoms of PND manifest as body aches (muscle and joints), physical pain (headaches, backache) or discomforts (such as nausea). Such symptoms may also be associated with general illness or influenza. However, when a mother experiences these symptoms she does not necessarily relate them to PND. Participants who felt emotionally well and also those who perceived themselves as not emotionally well, reported somatic experiences of pain which were attributed to physical complications of recovery from the birth experience. Again there was no discrepancy between the groups experiencing pain and the presence or absence of PND.

One could question whether the physical sensations experienced in the postpartum such as tiredness, muscle pain, or headache for example is the heightened awareness that the mother has of her body and its physical needs. The physical ailments indicate possible deficits in the body that she should attend to for its wellbeing, for example, exercise, diet, water consumption, being in the outdoors. Embodiment exists without conscious awareness.

#### **7.4.2 Subtheme 1.2: The expression of emotions**

There were no predictable and consistent emotional behaviours that either group commented on experiencing. Notably, participants who reported as being emotionally well recognised their body rhythms and emotions as cyclical and with which they identified as being part of their normal behaviour. This range included peaks and lows of happiness, sadness, anger, frustration, and fear. To participants, being emotional meant being demonstrative in their reactions to a situation. Participants who had perceived themselves to have PND reported to have had a more flat lined or blunted daily and prolonged emotional response. Participants noticed they had pronounced tensions that were manifested externally. The major emotions that were commented on included anger, unhappiness, sadness and frustration. The notable difference between the groups, even in their experience of the same emotions, was the significance of the duration and the depth of emotion. Those who were emotionally well commented that they knew their anger or frustration would have an end point, and this knowledge helped them to cope and not hang onto that emotion. Conversely, participants who expressed feeling postnatally depressed were unable to understand that the feeling of hopelessness would pass. In their feelings of being overwhelmed they lost their sense of perspective and sense of coping and retreated into survival behaviours.

Generally, episodes of anger were directed at family members, usually partners, in response to frustrating situations and tiredness. However, expressing anger toward the baby or young children was generally recognised as an indicator of not coping, being at risk for PND and of vulnerability. Participants who reported being emotionally well did not focus on their feelings, emotional outbursts or their general wellbeing but rather on the baby or the tasks at hand. They experienced a general sense of happiness and wellbeing. Participants who reported feeling PND commented on prolonged feelings of hopelessness, despair, sadness and depression. These participants felt the palpability of their emotions:

*Mmm it was very clear that I was very unhappy. Yeah it was very clear that I was angry or like moody all the time. I snap at my husband all the time and I just want to stay away from him [the baby] all the time. So I think it suddenly feel much better after I stop breastfeeding. And I, I stopped giving myself so much pressure that I need to produce lots of milk for him. (P1, experienced PND)*

*You know I spiral with my anxiety and when I start doing that you know the mental spiralling isn't happening all the way through the day but in between the mental spiralling I'm just, I just can't cope, I can't do stuff, I can't get stuff done. I feel like I can't, I feel like I can't connect with the kids and I can't connect with [husband], like I feel really isolated. And then I'll start to get weepy if I get particularly bad or I'll be getting really angry. I'll get really angry with [husband], you're not listening, [and] you're not understanding that kind of anger coming out of a real frustration that somehow he isn't fixing this. (P15, experienced depression)*

The negative emotions mothers' experienced related to the pressures they felt in their mothering at that particular time. Feeling isolated in their mothering and their own emotional despair they would look to their partner for some support. However, they were not able to articulate the support they required from their partner.

### **7.4.3 Subtheme 1.3: Coping with an unexpected reality**

Women who had a close friend with PND used this experience to monitor their own emotional wellbeing. Despite having numerous medical problems which compounded the pregnancy and birth experience, a participant used her close friend's experience of PND as a benchmark to judge her own emotional wellbeing

*I've got a friend in New Zealand who had a traumatic birth and she had really bad post-natal depression after and I'm just thinking like now, I think all of it makes a big difference, I mean I can't say it can be everything but I'm just thinking now talking aloud to you, I could have probably been a [a candidate for PND]... I'm someone who is a perfectionist, to have that choice more or less, took away from me was huge, but I had a brilliant obstetrician who couldn't have supported me more, and a good specialist. And the gastroenterologist, she's a lady too I think that's crucial, it's got to be because it really helped me. (P2, emotionally well)*

*Epecially [friend 1] the girlfriend of mine who had postnatal depression. Talking to her when she had postnatal depression was really shocking the things that she'd say about her son and made me really sad so. And knowing that I never said anything like that kind of made me feel, that knowing that I wasn't, I wasn't like that. So yeah she was my, she was my little guide. (P21, emotionally well)*

*But I wasn't you know, I mean you're still on the, you know in that first one, with that first one you're still on the verge of crying all the time because you're just emotionally drained and. So I don't know whether that was a sign type thing and like being quite nervous with going up there and like you know and you just you know like P26A was a cat napper and I couldn't get him 'cause he was, he had such a headache from the whole birthing thing it took him ages to get over that and they just never got him on a good pattern. (P26, emotionally well)*

On the pathway to the confinement the mother formulates her ideal birth plan which integrates her expectations and aspirations for her own birth experience and breast feeding. Yet the realities of coping with the labour (pain, pain relief, the muscular forces of labour, and birth) which results in physical exhaustion is not a consideration of the ideal. Equally important are the situations where choice is replaced by imposed health/medical interventions. Women, irrespective of their emotional well-being, faced this situation of not having their plan fulfilled. The difference between the women who perceived themselves to be emotionally well versus those who perceived themselves with PND was in their adaptation to the situation, the reconciliation and readiness to progress their personal state. For example, those who felt more vulnerable had a more difficult time of letting go of the event over which they were forced to relinquish control. Others

were more able to move forward and to focus and prioritise on immediate and future goals, care and time.

Strategies to deal with reality such as establishing daily routines, coping and adaptive behaviours were easier to cultivate for some mothers than others. Notably, all mothers demonstrated capacity to recognise the baby as an individual and to take responsibility for the baby's safety and wellbeing. Personal self-care was not as consistent and predictable as to that for the baby, for example, the more vulnerable women tended to minimise attention to themselves and focussed attention on mothering the baby. Mothers who were emotionally well noticed they practiced self-care and balanced their daily activities with social and family interactions. The emotionally vulnerable women felt the priority of their attention should be drawn to the baby and not to themselves. Regardless of the imbalance of self as person and self as mother, each exercised choice in how she managed her situation.

Mothers who were emotionally well were aware and adapted to the needs of their baby and themselves and demonstrated absorbed coping behaviours. Absorbed coping behaviours showed their mastery of motherhood and that they were perceptive and flexible in their adaptability. Mastery is transferable because situations are unique hence there is a need for ongoing flexibility and adaptability. The baby is the unique situational being that evolves, maturing in growth and development; and as a corollary of this the mother also evolves. Mothers with strong emotional wellbeing recognize that the physical demands of the baby/or situation are finite and as a result do not dwell on particular situations and focus their attention on the baby. However, mothers who are not emotionally strong doubt that difficult and unexpected situations will end and consequently find it challenging to adapt their behaviours. As multiple scenarios present themselves with little or no adaptation the mother finds it more difficult and overwhelming to control and cope with the situation. A sense of helplessness prevails, and acting on her feelings of despair to seek a solution to her trapped situation, she must choose to seek a circuit breaker. This circuit breaker is a means of self-preservation or protection and can take the form of seeking and acting on advice, changing routines and behaviours, and engaging with relevant practical support. The circuit breaker interrupts the repeated unhelpful cycle and helps to establish new pathways and behaviours.



Mothers who identified with having experienced PND early in their motherhood experienced reported to have done so in a number of different ways. For example, they described particular events or situations that they had encountered early in motherhood, recognised feelings toward their newborn or felt they did not bond with their baby. However, mothers who experienced PND further during the postpartum year (at 3-5 months and 7-9 months) said they did feel bonded with their baby, yet still self-diagnosed with PND. Mothers who struggled with their emotional wellbeing experienced multiple ongoing situations that were difficult for them to resolve. For some this was reflected in particular expressions of their maternal body schema which is commented on below.

## **7.5 Theme 2: Expressions of Maternal Body Schema**

Scheuneman (2012) discusses the physical transformation of the pregnant body as being a physical state that is apparent to the woman and the bystander. The noticeable changes include skin changes such as chloasma, growth of the breasts, puffiness of the limbs, a rounded or oval shaped abdomen and the possible change of gait. Scheuneman (2012) also argues that despite the physical adaptation the bystander is not aware of probable and possible psychological impacts that these changes bring about.

Interestingly, in this study, the mothers who experienced uncomplicated and uneventful pregnancies commented on their feelings of positivity and happiness. They looked forward to the imminent birth. They embraced a change in their body schema and normalised their adaptation to this. This is reinforced by the following comments

*I found out I was pregnant I was over the moon just I had never experienced that kind of sense of, I don't know like I was just floating, like I don't know looking down from above kind of thing it was really amazing. (P10, emotionally well)*

*I had a really good pregnancy...at times I forgot I was pregnant in a way. Not forgot but...I mean towards the end I felt a bit tired. But other than that, yeah no it was, I haven't minded being pregnant both times. Yeah my experience has been pretty good I think, but I didn't really put on too much weight... I still kept active. Yeah I think I did the things that I used to do...I had pretty good experiences. (P13, emotionally well)*

In contrast, mothers who had a difficult pregnancy or who had previously experienced a miscarriage recalled more specific details with focus on the unexpected, unpleasant and emotionally challenging events. These events occurred and stemmed from pregnancy, with no predictable end date to the situation. The commonly held belief was that on reaching a certain milestone the situation would clarify or recede:

*So I had this, had this devastating sense of miscarriage isn't just the first 3 months. It's, stillbirth is you know right up until you think your baby's in your arms you can lose your child. (P15, experienced PND)*

*I did have actually a lot a much more difficult pregnancy with my son, I was on Zofran [antiemetic medication] during that pregnancy and it was, I had extreme nausea and vomiting until the end. I was pretty anaemic and so that actually when I say I wasn't so worried about the birth, but I was... it was, it was an extremely difficult pregnancy. (P2, emotionally well)*

Equally significant were the situations where mothers found themselves pregnant unexpectedly. Mothers and their partners realised that they faced decisions about their future and family thus exposing their vulnerabilities. It was a time of conscious adaptation to pregnancy and family life. The concerns related to maternal age and potential foetal abnormality, financial hardship, working/family life and consideration of their life plans. The couple faced readjustment of a familiar body schema:

*I guess [P16D's], actually no [P16D's] for the first 12 weeks was a bit scary 'cause it was an unplanned pregnancy and I was 39 I was terrified that you that she'd have some chromosomal abnormality. So I, and I didn't not, I didn't tell anybody this time. (P16, emotionally well)*

The body schema is made of both visible and invisible parts. The bystander sees the visible body schema of a pregnant woman. The invisible includes emotions and experiences which are individual or unique and are often kept purposefully private. During birth the maternal body schema is both visible and invisible. The obvious visibility is the birthing process, however there are some aspects of this process that are selectively visible to others, such as in the dilation of the cervix. Her invisible body schema encompasses the physical pain she experiences with uterine contractions, the physical adjustments she may make in response to the pain, and emotional responses

to fatigue, pain or distress within the birthing process. The latter element may be influenced by her self-image and reactions to interactions with others with dissimilar values. Mothers in the study commented:

*The labour went on for more than 36 hours and it was painful and I [had] planned not to have any epidural. I say no epidural but it was too painful so I had to have epidural. (P1, experienced PND)*

After birth the visible changes to the maternal body schema extend over a period of time from immediately after the birth towards breastfeeding and to physical recovery from the birth. Furthermore, the maternal body schema encompasses the senses and active responses to the baby as a separate being to herself. In this early period the mother and baby begin to know, understand and respond to each other's separateness and their body schemas adapt accordingly. Examples of this adaptation of the maternal/baby body schemas is observed with breastfeeding, as the baby's body moulds itself into the mother's contours and its mouth latches to the breast; or in the situation of the baby mirroring the mother's facial expressions as she engages in a deliberate conversation bounded by touch and proximity. The mother uses her body to initiate communication with her baby by talking, holding, touching and having skin-to-skin contact. Together they establish a pattern of engagement which involves, but is not exclusive to talking, touching, feeding and playing. In the example of the mother and baby being separated from each other by being in different locations, it is observed that both have innate knowledge of the other. That is, the body schemas respond to the needs of the other in the baby crying in hunger while simultaneously the mother's breast engorges ready for feeding. The mother's body schema becomes absorbed into the baby's body schema as her primary consideration is the baby's development. This marks her transition to an invisible body schema.

At times, incidental conversations with health professionals and other people sharing their prior experience, influence a mother's perception of her body schema. Observations by others impact a mother's sense of being noticed or understood (visible) versus being judged or misunderstood (invisible). The mother experiences her maternal body schema occurs prior to the birth, during the birth and the early postpartum period. She is very aware of the limitations of her body schema, as in not being able to control

its manifestations such as burning pain, but she has not control her body. The body is perceived to have innate self-protective functions,

*it was probably about 2 weeks before he was born and you know you run around crazy trying to get everything organised and then 2 weeks before he was born my body just stopped. Like my legs and my feet were just, it was like they were burning and I couldn't actually walk, I had to just sit there with my feet up the whole time and it was like my body was saying you have to slow down. I remember that like 2 weeks I just couldn't do anything. (P6, experienced PND)*

A woman's awareness and reaction to her own body experience may at times mismatch the observations held by the health professional who is attending to her. This mismatch is compounded by her personal ideals and the resulting conflict of accepting her bodily response. The experience of the first birth implies that the body schema and body memory for that situation has not yet occurred and therefore a woman relies on knowledge – hers and that shared by others - of what a woman's body is capable of, and her trust for her own body to embrace this capacity. She is fearful of travelling into unknown experiences, and is reliant on the health professional to guide her. Her vulnerability becomes apparent when the other (health professional) does not affirm her capacity or her decisions. Interestingly, partners and family members were consistently supportive and affirming

*As a first time mum labouring, not getting very far very quickly, obviously 'cause first time and to have you know the negative talk of [of the obstetrician challenging the midwife], 'oh the baby's never going to fit out of that pelvis and oh that's not a 7 centimetre dilation that's 4'. It knocks you quite, it knocks you down really quickly. (P20, experienced PND)*

*I didn't have enough milk, and I asked for a bottle but was told no [by the midwife]. (P1, experienced PND)*

In contrast, a mother may also reconcile the capabilities of her body by focussing on situations within her control, by respecting and accepting the recommendations of others (health professionals) and accepting the limitations of her body and her situation. The early phases of the postpartum period were strongly associated, by memory, with the experience of bodily limitations. That is,

conversations and recollections often referred to the difficulties or unexpected challenges that a mother had experienced as a consequence of the birth. For a mother undergoing a second or subsequent birth, her recollections focussed on circumventing future physical problems which had been experienced on prior occasions.

*The body thing I think I was already wibbly, I didn't get stretchmarks cos I think am already stretchy so that didn't really bother me that much yeh. To be honest yeh. The pelvis and the womb. the pelvis didn't work I couldn't deliver but at least the boobs worked for breastfeeding, that was my thing (laughing) I was malfunctioned down there (laughing) but I tried to deliver normally (laughing). (P7, experienced an episode of depression)*

*I guess the main thing for me with my body was that...it affected me with the breastfeeding...I have also ulcerative colitis that's why my specialist recommended the caesareans and with my son I did have a flare up in the hospital... I had to have special pain killers, that all affected my system so in that regard that was really really difficult [emphasis on really difficult] ...I tried to just get on with it. So I did do as much as I could I was changing nappies. I actually did more, I was determined to do more for him than [I was able to] for my little girl because I knew that what, how I'd had felt before [not being able to do the immediate newborn care]. It did affect me a bit, but when you know and I tried to see the positives - like my [husband name] changed the first nappy and but with my son with us probably not having any more children I, for my own positivity in mind I really pushed would myself even more, probably a bit too much and it probably effected my Crohn's [disease] but. (P3, emotionally well)*

*So when I was looking at birthing P22B I spoke to the obstetrician and said what do you recommend; and he said if you want to go for a VBAC [vaginal birth after caesarean] I'll support you in that. I was like "what are the chances that she is going to get stuck, you know?" "He said probably pretty good" (laugh). Because your pelvis is your pelvis, and your kids head just not going to go. So I said let's not go through that again. I think some women feel strongly that natural birth is some sort of badge of honour I don't feel that way (speaks in quieter tone)...the baby ... That's it so I decided quite early on to go for an elective caesarean with her. (P22, emotionally well)*

it was day three time to go home, because that's what they do there, and then the midwives come each day after for three days. And I was definitely not ready after the birth that I had, after 12 hours of labour, no pain relief, um and then they brought it on with oxytocin. That was like for 12 hours. Then having to have the non-elective

caesarean. So this nurse, she was Spanish, and it was time to go home she was discharging me and she said my coordinator wants us all for this meeting and I have to go. And I said to her, I just - I can't breastfeed and I said to her um and you know also just very tired and in a lot of pain, and the medication on board, the tears rolled down

*{finger action showing tears rolling down her face} and she just looked at me and said "I'm going to close this door and I'm not going to go to that meeting." And she stayed with me, and it was probably three quarters of an hour and taught me and because I knew that she sacrificed of, you know she had someone in a higher role telling her that she needed to go. It just changed my attitude going home. (P2, experienced not coping)*

In the postpartum period the mother's awareness of her body may be drawn from an experience of pain: breastfeeding, muscle pain that has no pathological basis, the presence of pain that reflects infection, from discomfort of her weighted body, and/or from a changed body configuration

*the first night [mum] brought P9A to me in bed you know for feeds... and she went out and got me a nipple shield when I was struggling with feeding and things like that. (P9, emotionally well)*

*I also had another eventful birth (changes tone)...it was incredibly painful. I thought I had just like bumped my coccyx, but every time I sat down and of course when you breastfeeding it hurt all the time... She must have only maybe for week six weeks old. It happened right on the tail of it so I had to go and have surgery (giggling softly). I remember being in such pain... she would only breastfeed she wouldn't take a bottle. And um they gave me a shot of morphine it didn't even touch the sides. I was still in so much pain. The pain was way, way worse than my Caesarean pain. It was incredibly painful. So I had surgery for it. And I remember waking up from the surgery and it was still painful. (P22, emotionally well)*

When pain is evident a mother discerns the basis of her pain to determine whether or not it needs investigation. Her immediate assumption is that the pain is birth related, and given the transient nature of birth she then assumes that her pain is also transient and will resolve itself. However, this is not always the case. Given that an individual has her own threshold of tolerance of pain or distress, she may live with the ambiguity of not knowing the source of the pain, however there comes a time when

she reaches her own limitation and recognises that she needs help. A mother's belief that the situation of pain or distress will improve without intervention suggests that she will tolerate symptoms and prolong seeking help. Alternatively, when the pain or distress becomes more frequent, intense or prolonged her tolerance changes and her belief is that she can no longer live with the ambiguous situation of pain. Her resolution to seek clarity involves seeking help and support.

The postpartum maternal body evolves to a new normal. It takes the maternal reproductive body approximately 6 weeks to return to its pre-pregnant state, this does not mean that it goes back to a state of never being pregnant. Her body schema is forever changed to acknowledge this experience of pregnancy. However, the transient pregnant body returns to a bodily state of familiarity. That is she no longer carries a baby in utero and from an external perspective there is no evidence to show she has given birth.

Societal values influence a mother's perception of her physical appearance and body image. A focus on a healthy lifestyle is a constant reminder for her to be attentive to her own body self. Western social values focus on physically healthy bodies that are within favourable norms. For example, the NHMRC recommends that attention should be paid to maternal nutrition, body weight and body mass index as measures of actual and predictive maternal and baby wellbeing.<sup>38</sup> Mothers expressed a preoccupation with body weight and their goal to lose the extra weight gained during pregnancy. This transition is easier for some than others and something that needs to be worked at rather than simply happening. In the case of assuming that body weight would 'fall off' implies a sense of naivety and not knowing one's body. For mothers who did not have to consciously 'work on' getting back to their pre-baby body felt fortunate about this? The quest for physical wellbeing is highly desired however the journey to achieving this is varied

*So during that confinement a lot of people say oh that's the best time, like for a lot of Chinese friends say that's the best time to lose all your weight and le-le-le. So again like you know that's the pressure there and that didn't happen so. I plan and it didn't happen again. I think the weight problem is, has been lingering for the first 12 months. Yeah it's always like oh I have to lose weight, I have to lose weight yeah for the first 12 months. Even now like*

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<sup>38</sup> Australian Government Australian Institute of Health and Welfare. *Australia's health 2016*. Retrieved from <https://www.aihw.gov.au/reports/australias-health/australias-health-2016/contents/chapter-5-health-of-population-groups>

*you know it doesn't yeah. Mmm I think weight is the big issue. (P1, experienced PND)*

*With P17A like I said I was quite young so I feel in terms of like my body and everything I just felt like I went back to normal. Had, like I felt quite fit straight away... With P17B I did notice that it was like different. Like even I had like quite bad contractions after having him but I've heard with your second one that it takes you know a while for your uterus to contract a bit more and then just even you know I suppose on a physical level with my you know stomach and that took longer to go back to normal with the second. I felt like I didn't you know lose my weight as quickly with him. (P17, emotionally well)*

*With P18A I was back to my pre-pregnancy size within 6 weeks and with P18B within 3 [months]... I don't have any stretch marks, I didn't get, have any like episiotomies or anything with my labours so I'm pretty much back to normal. My skin's probably the worst thing... with the changing of hormones with the pregnancy and breastfeeding. (P18, emotionally well)*

*Just that it changes, that it's not the same. You know you might get back to the same numbers on the scale as you were beforehand but you don't have the same body anymore, it's different and for me I was really ok with that I think. (P9, emotionally well)*

*...in the first 12 months you're a bit up and down for sure, because then you don't feel good about yourself either because your body might not be back to the way you want it, or you know, yeh. But otherwise.... I'm probably heavier now than I was when I had her, so I'm just not good post [caesarean]. (P19, experienced not coping)*

A commonly held belief for the mother is the need to lose her baby weight gained during pregnancy. However, there are many reasons for a mother's motivation to achieve this. The knowledge that body weight may influence the health and wellbeing of future pregnancies was significant. There is a realisation that having the same pre-pregnant weight does not mean it is the same body shape I've always been quite an active person playing sports and stuff so yeah getting my body, well because I didn't have to go full term either I didn't get that big as much as what I am now. So



yeah. Yeah I was very keen to get my body back and I think with the, like with not having to go to work I was able to do that. (P5, emotionally well)

*It's funny I was a lot more healthy with [P7B], with [P7A] I was heavier when I got pregnant. I was over 100 kg when I had by the time I had him. Um and I've got gestational diabetes, so it was a kind of a bit of a wake-up call. So when I had between pregnancies I'd lost a lot of weight and I didn't get gestational diabetes with [P7B]. So it was a real big achievement for me because I'd really really really tried hard to be healthy and I was walking him I was walking him everywhere to the park um and then when I had [P7B] I went back to Weight Watchers when she was three weeks old. (P7, experienced an episode of depression)*

*I tend to lose baby weight fairly quickly but there's this little bit that just, that hasn't gone in the 12 years since I started having babies. So I think that's more of a body change thing than a. I got back into playing netball fairly soon afterwards so I just got back into doing my normal things. (P20, experienced PND)*

In summary, maternal expressions of maternal body schema were identified through self-awareness and adapting to a change in the maternal body from pregnancy through to the postpartum year. The mothers' self-awareness of her body originated from changes in the physical and emotional states, ranging from comfort to discomfort. The recognition of the impact of her body was influenced by her own expectations and those of society.

## **7.6 Theme 3: Embodying Motherhood**

The third theme, **embodying motherhood**, involves the idealisation and reality of the mother's birth experience and her transition to motherhood, her relationship with her baby (infant feeding and her body and her mental representation) and her self-perception.

### **7.6.1 Subtheme 3.1: The idealisation and reality of the birth experience**

Social preparation for birth and parenting generally focus on positive and happy experiences. In the Australian public health context within the antenatal period mothers are encouraged to consider the type of birth experience they *would like*

(emphasis added), this provides a degree of choice, control and self-empowerment in their own experience.<sup>39</sup> Subsequently, they plan and prepare for the birth in some cases attending birth preparation classes, reading relevant literature, socialising with other mothers and becoming informed about the birth experience. This is irrespective of whether it is a first or subsequent birth.

Mothers tend to aspire to achieve a perfect birth, that is one where they follow the predicted pathway of labour (for example, breaking the waters, commencing labour pains), labour with little difficulty, experience a relatively short length of labour overall, and able to birth the baby with ease. Unfortunately women often have a misconception of birth due to social, media and written influences. Their interpretation of the perfect birth consists of a spontaneous onset of labour, minimal pain that is self-managed, a short labour resulting in a natural (vaginal) birth and an instant bond with their baby. This type of experience enables an easier transition and adaption to the postpartum period. In most cases a mother enjoys the next stage of her life as a mother without restrictions because she experienced the birth she planned for. Unless mothers have a prior birth experience to relate to, the journey is a virtual unknown. Whilst they can mentally and physically prepare themselves for the unfolding of the birth sequence, each birth is unique and individual to each mother on every occasion.

The reality of the situation is that mothers have expectations of themselves in the birth experience, of being able to cope with uterine contractions, physical discomfort and fatigue of the birthing process. Even in diligent preparation for the birth there is limited knowledge of how the birth will progress, and of not being able to control bodily functions such as cervical dilatation and uterine contractions. There is a sense of a woman having to comply with her body, trusting the expertise of the caregiver to facilitate their birth plan. Mothers perceive their bodies as malfunctioning when natural childbirth is not fulfilled. The aspiration for natural childbirth is still held as an ideal. When reality does not fit the ideal this places mothers in a delicate state of vulnerability as these participants describe:

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<sup>39</sup> This process is achieved through the Hand Held Record, a document that records a woman's social, psychological, medical/surgical and obstetric history, screening processes including the EPDS, alcohol and smoking habits, and domestic violence screening. The partner health status is also recorded in the document. The hand held record documents the health and wellbeing of pregnant mother and unborn baby at each antenatal visit. The document includes a section titled the birth plan and it is in this way that the woman is encouraged to consider what may be possible in the forthcoming birth.

*I think immediately after the birth, because the pregnancy happened so fast I didn't have that preparation. Like I, I had the feeling that everything will be fine you know. I planned that I will have a very short labour. I planned everything but everything didn't happen. The labour went on for more than 36 hours and it was painful and I planned not to have any epidural. I say no epidural but it was too painful so I had to have epidural. And after the birth I actually went into depression because it was, it was not planned, like very sudden. And it took some time for me to have that connection with my baby. (P1, experienced PND)*

*I was so confident that I'd have a normal birth, I didn't plan for someone to come over and help me, and then I ended up having an emergency caesarean and then after the birth it was the worst, because I could not believe the pain of a caesarean. And so I struggled. I think I was on the brink of depression for my second, because of my caesarean and coping with that, being all alone, and just having my husband here. He was working full time, so when he would go to work and I'd be alone with my son and my sore self and the baby. (P14, experienced PND)*

*I had the obstetrician who was taking her patients for the weekend come in and literally just look at me and go oh a child is never fitting out that pelvis. From across the room. Hadn't assessed me, hadn't examined me, hadn't done anything and that was the first blow and then she also examined and said no, I think those midwives want to say you're [cervix is] 7 centimetres, you're only 4 [centimetres], I think you need a [caesarean] section. And that was so and 'cause she was the first grandchild on both sides, so everyone was really excited, everyone was, it was a whole big thing and to say yeah ok I'll have the section and to be wheeled off and to sit and to wait, 'cause it was a Saturday so they had to call the staff in and then to have her born and taken over to someone else and it's all very clinical and not what I wanted. And I can, I play her birth story in my head all the time and I was sad, I cried. I cried and the obstetrician who did the section said I hope they're happy tears and it was like actually they're not. I was crying while it was happening. 'Cause it wasn't what I wanted. (P20, experienced PND)*

*The pelvis and the womb. The pelvis didn't work I couldn't deliver but at least the boobs worked for breastfeeding, that was my thing I was malfunctioned down there but I tried to deliver normally. (P7, experienced an episode of depression)*

The examples above indicate how easy it is for a woman's choice and control within the birth process to be compromised, thus making the woman feel invisible, fading into the background and submitting to the dictates of the caregivers. Due to the overriding judgement of the obstetrician or midwife, the mother's birth plan may be negated thus reducing her ability to challenge the status quo and maintain some authority over her body in this situation. In some cases the mother's vulnerability is compounded because the midwife who advocates for her would not be willing to challenge the obstetrician's decision made about her physical body and the changes to her birth plan. More open discussion with the mother in these situations would eliminate some of these problems or disappointments. Sometimes mothers feel a sense of aloneness which is exaggerated due to the time constraints of organizational requirements.

Not all women who have a change in birth plans experience PND. However in some cases the changing situation may result in a feeling of vulnerability and for some mothers this may be a defining point for which PND is identified. Although not all traumatic birth experiences are followed by PND. As was described by the participants:

*I didn't really have much [choice], you know they said they could risk it but then they told me the scenario that my specialist had had and the obstetrician had had about experiences with delivering somebody. She was really upfront and honest, I really trusted her, I just thought I want what's safest for my baby and for me in the end and she was just, it wasn't like I think that plays a big part now speaking to you [researcher name] because I've got a friend...who had a traumatic birth and she had really bad post-natal depression after and I'm just thinking like now, I think all of it makes a big difference, I mean I can't say it can be everything but I'm just thinking now talking aloud to you, I could have probably been a [candidate for PND]. I'm someone who is a perfectionist, to have that choice more or less, took away from me was huge. (P2, did not experience PND)*

Unforeseen and unpredictable circumstances may alter women's birth plans. In these situations personal choice is removed as medical intervention is required for the safety of the mother and unborn baby, as in for example cases of pre-eclampsia and breech presentation. Where there are planned caesarean births the mother is still apprehensive because of the unpredictable and inherent risks associated with surgical childbirth. Mothers seek to hang on to as much of the natural as possible within a planned intervention. For them not being able to experience natural childbirth in its

purest form is disappointing, as experiencing natural childbirth is perceived as a status symbol of womanhood.

*I had an elective caesarean due to medical reasons... I think I was very fortunate that I'd accepted that the choice had been taken from me to have a caesarean... I would have liked to have a natural birth... I wasn't so daunted by having an operation as I was the first time. (P2, emotionally well)*

*So when I was looking at birthing [P22B] I spoke to the obstetrician and said what do you recommend; and he said if you want to go for a VBAC I'll support you in that. I was like "what are the chances that she is going to get stuck, you know", he said probably pretty good. Because your pelvis is your pelvis, and your kid's head just not going to go. So I said let's not go through that again. I think some women feel strongly that natural birth is some sort of badge of honour I don't feel that way... That's it so I decided quite early on to go for an elective caesar[ean] with her. (P22, emotionally well)*

Following the labour and birth experience, a mother's next focus is the reality of caring for her baby. This new reality involves physical and emotional changes and adaptations that may not be foreseen. Nurturing and nourishing her baby are her focus.

### **7.6.2 Subtheme 3.2: Nurturing and nourishing her baby.**

Healthcare professionals encourage breast feeding as the preferred option for infant feeding. This is based on the scientific understandings of the health benefits to the baby, which also promotes maternal attachment to the baby. Society plays a part in idealising breastfeeding as the norm and, like the perfect birth, mothers aspire to meet these perceived standards. In Australia, breastfeeding is regarded as the physiological norm. The National Health and Medical Research Council (NHMRC) (2015) recommend exclusive breastfeeding, for six months and to continue breastfeeding for 12-24 months, or as long as possible, following the introduction of solid foods. Society presents breastfeeding as a romantic representation of motherhood making it appear easy and natural for women. The connection between mother and baby is unique and memorable. As participants said

*When you're breastfeeding he's looking into your eyes and you're looking into his and he's playing with his toes... It's just magical (P14, experienced PND)*

*I remember saying with [P16D] oh well I'm not going to feed her long, I'm sick of this breastfeeding but I think I breastfed her to 14, 15 months...so [P16A] was a year and then [P16B] was 13 months and then [P16C] was 14 months. You know so every child went probably a little bit, yeah a little bit longer Yeah I don't know, maybe it's just I always do the right thing...this is what you do. I tend to go oh that's, that's what you do. (P16, emotionally well)*

In their social education mothers recognise natural childbirth and breastfeeding as positive outcomes of reaching motherhood, and when either of these events is unmet their focus turns to the successful event. However, some mothers do not achieve either of these events and do not achieve their own perception of the successful mother. Not all mothers are able to breastfeed, and therefore are compelled to feed the baby using formula milk. This inability to breastfeed has a negative impact on mothers' emotions and feelings of being pressured, isolated and unsupported by the health professional, who persistently promotes breast feeding. Self-belief and identifying a positive outcome of the situation helped to moderate feelings of guilt about not being able to breastfeed. Rather than dwelling on deficits and limitations of the situation being proactive and future focussed provided a measure of comfort. This solution was generated from within her, not a platitude expressed by others. Prior personal experiences, maternal self-knowledge and action, and applying mothering instincts helped to inform confidence in mothering

*...I planned to breastfeed for my baby. And I say I'm going to breastfeed for a year, you know I planned for that. But it didn't happen immediately and I couldn't, you know I couldn't produce any milk and I had bad experience in the hospital because my baby was crying because he, he's hungry for the first two nights and the second night the nurse realised that the baby is not settling. So she offered to give him formula and he slept and after that I asked if you know they can give him formula, they refused so I say I'm coming home. (P1, experienced PND)*

*The one thing that impacted was that I wasn't able to breastfeed um but I guess I viewed it as my husband being more hands-on is that we were both, would have been our first-born we then worked as a team and that he got to bond more with my little girl as well. (P2, emotionally well)*

*I expressed for [P18A] in the beginning for the first two months before we went onto formula but that just got too inconvenient really. [P18B], breast milk never seemed to satisfy him totally and by the end of the day I was completely depleted, so formula at that night time before he went to bed was from necessity. But we had planned to do that anyway after the success with [P18A] and it made him sleep much better at night as well which was part of his night time issues too I think that he just, breast milk was not satisfying enough for him. But I did predominantly breastfeed him he just would have top ups of formula as well. (P18, emotionally well)*

*I wasn't able to [breastfeed], so I did breastfeed when he was up in hospital I expressed milk and took it up so but when I brought him home he was still too little to keep my milk regular. So my milk decreased and then of course that was probably the only stressful, major stressful time for me that I wasn't able to breastfeed or keep breastfeeding. So yeah with assurances from my nurse like just put him on the bottle and then everyone's happy and you're not stressed and disheartened... there's so much emphasis on breastfeeding that you do feel guilty that you can't. (P5, emotionally well)*

Whilst social and health recommendations promote breastfeeding there is still hesitancy or difficulty for mothers to breast feed in public. Reasons offered range from baby demands, parent needs, desire to feel in control, to feel comfortable in social situations, and to allow others to bond with the baby. In these circumstances a woman's embodiment in being a mother is challenged by the attitudes of society and through the actions of the people involved (for examples, extended family or social circle) and the behaviour of the baby. As much as a mother wants to embody her essence of being a mother she is constantly faced with issues that compromise her desire or wishes to be the best model of herself

*[P6A] was breastfed until about 6 months and he ended up getting, he was never a very easy eater, he was just fussy on the boob. You know he'd kick his legs and kick his arms and he'd come off and on, so when I was out, out of the house if we were at the shops or in a restaurant or at friend's house he just made it difficult. You know I had a cover on but with arms kicking and it being the heat of summer as well it was just hard. (P6, experienced PND)*

*They were predominantly breast but we did have bottle feeds. Initially with [P18A] we were going to give them a bottle at the end of the day so that when people baby sat him they would be able to put him to bed which was, never*

*happened...when we were out, not that I have any issues with breastfeeding in public. And have done it myself when I've needed to. But when it was a planned outing I would plan and take formula. It was just more convenient for me and often when we were going out it was with people who would like to bond with him and feed him as well so. (P18, emotionally well)*

The positive benefits of breastfeeding for mother and baby are distinct and varied. There is an associated thought that feeling emotionally and physically drained is related to breastfeeding and by not engaging in breastfeeding a mother's emotions may settle sooner. Equally, the ebb and flow of maternal hormones is perceived to be evidence of good mothering thereby leading to personal satisfaction in that role. Breastfeeding and the accompanying hormonal changes are perceived to contribute positively to embodying motherhood

*My emotions started to settle about two weeks after I came home. It was pretty... Yeah, it wasn't too bad. Like so a week in hospital, two weeks at home but then like I said mum then went two weeks after that and then I got really weepy again. Maybe because I wasn't breastfeeding and all of that, that's why I might have settled down a bit quicker. (P2, emotionally well)*

*I'm very like pro breastfeeding and you know with all your hormones and oxytocin and things like that so I don't know whether you put it down to that or but I've always felt quite vibrant after having children. (P17, emotionally well)*

*I took a breastfeeding win because I didn't think I was going to be able to because mum couldn't so I thought oh well I'll just be like my mum and I won't be able to. And breastfeeding for me came so easily and even in the hospital I begged for reassurance that it was good and I had the lac consultant just look at me go yeah you two are fine. I'm like oh ok great, ok that's fantastic. (P20, experienced PND)*

Other factors that contributed to unexpected physical and emotional impacts, whilst breastfeeding, related to the practical challenges in maintaining a balanced family life. Despite dealing with concurrent mothering responsibilities and their physical fatigue and wellbeing, mothers remained committed to breastfeeding their babies.

*I breastfed [P7B] as much as possible I think to about 10 months. And that was quite hard to breastfeed her and to keep a 22 month old child occupied.*



*I remember it being very frantic very busy and being very tired and I was very very emotional. (P7, experienced an episode of depression)*

*The first three months were pretty difficult but I'm lucky because I had my mum and my sister would drop off the kids for me and it took a bit of the load off so I'm really lucky in that aspect. What was difficult was because I wasn't feeling 100%, still getting up in the morning you know, caring for a new born, just getting into you know, the breastfeeding and then I stopped that. You know just getting kind of the first teething problems you often have when they're that age. Then she started to sleep through I think after about four months and things started to get a little bit better, we started to get a routine happening. (P19, experienced not coping)*

The physical problems associated with breastfeeding were not personally anticipated, and if faced with this situation mothers responded with physical and emotional reserves to uphold and achieve their goal of breastfeeding for as long as possible. Although education about breast care is commonly available it is often only accessed when a complication arise. A particular breastfeeding complication may be predicted where a characteristic manifestation occurs during breastfeeding, for example if the baby does not attach to the breast correctly, then the mother's nipples can crack, bleed and there is potential risk of mastitis. This is in contrast to more unusual problems that could occur such as the oversensitivity of sensation that results from the baby's suckling. The overstimulation of her body challenges her capacity to mother because her own ideal of breastfeeding is interrupted. This challenges the romantic ideal of breastfeeding. Adhering to personal, social and health ideals encourages resourcefulness in finding alternative sources of breast milk. As some of the participants commented:

*...breastfeeding was hard, cracked nipples and soreness and mastitis over and over again, and you've got to learn as you go and go with your gut instincts of just 'this isn't right, let's try something else' but you're not thinking straight half the times when you're sleep deprived. But we managed. I think perseverance and I grew up with a bit of that in my parents and I pushed and pushed for it, and breastfeeding became easy. So about the five month mark we were on track. (P3, experienced not coping)*

*I really, really struggled with that 'cause in my ideal world that I had imagined before I had [P15A] I was planning to breastfeed 'til at least 2*

*years old. I was going to do, do extended feeding. I really wanted to have that bond for as long as possible. And so then at 9 months of age to start, for breastfeeding to start being a really negative experience for me was devastating. I was just so heartbroken. I was like but you need to keep feeding. So I was pushing through the pain, I was doing my meditation while she was feeding to keep me from feeling really angry. The feeding aversion was the worst, 'cause I could deal with the pain and I'd been dealing with the pain and then at about, when I was about 3 months pregnant the feeding aversion set in and I was like why, the feelings were so intense and so aggressive every time she feeding it was like I wanted to push her away, I don't want her to touch me. Every time she touched me it was like my skin was crawling and it was just awful. And at first I was like what the hell is wrong with me. Cause I'd never heard of feeding aversion. (P15, experienced PND)*

*I had milk coming from 3 different women to continue giving her [the baby]. 'Cause I never wanted to give her any formula so I continued giving her expressed milk from all my friends to top her up while my milk was dwindling. And then when, when she was, she must have been about 10 months I started giving her watered down cow's milk as well. Because it's a pretty big ask to keep asking your friends for express milk and she was happy with that. (P15, experienced PND)*

Discriminating the problems associated with breastfeeding may be challenging for mothers and there is a need to resolve the issues as they present. Seeking and harnessing support to achieve progressive goals and establishing self-belief that the situation is temporary are important measures to ensure continuity of breastfeeding. As much as a mother wants to embody the essence of being a mother she is constantly faced with issues that compromise her desires. Establishing self-belief and gaining confidence in mothering behaviours may be learned and conditioning may be negated. Affirmations by health professionals may contribute to grounding this self-belief. Participants commented:

*I know it's going to seem really hard to you know to don't give the breastfeeding away straight away I think that's a real big thing that people do. It's so hard those first few weeks sometimes and you, and you get through that 'cause you can't really see the wood for the trees sometimes and I think you need somebody that's giving you good clear advice, this is what you need to do to get through these first few weeks and then they do*

*get better. Sort at 6 weeks it gets better, then at 12 weeks it gets better. So just to have small goals. Get them to 6 weeks, get them to 12 weeks and then they'll sleep a little bit longer and breastfeeding will become easier for most people and then you can move forward from there. (P16, emotionally well)*

*I took a breastfeeding win because I didn't think I was going to be able to because mum couldn't so I thought oh well I'll just be like my mum and I won't be able to. And breastfeeding for me came so easily and even in the hospital I begged for reassurance that it was good and I had the lac[tation] consultant just look at me go yeah you two are fine. I'm like oh ok great, ok that's fantastic. (P20, experienced PND)*

*I'm the oldest [daughter] yeah, and she couldn't breastfeed and I breastfeed very easily. I could feed an African nation. And she would always be a bit umm. Oh why don't I just give them a bottle? Oh no mum it's alright I'll just, I'll feed. And she'll be like oh. Like she was almost a bit put off that I was breastfeeding. (P20, experienced PND)*

It is a useful strategy for a mother to learn what best practice is so that she is well equipped for the mothering role, in this case breast feeding. Equally as helpful for mothering is acknowledging that a situation such as distress is not helpful to herself or the baby. Consequently the decision to cease breastfeeding should be made for the benefit of all involved without the feeling of guilt. Participants commented:

*Yeah I tried for about 2 weeks I tried expressing, if I can't breastfeed I will just express. And yeah I gave up after 2 weeks it was just too hard. You know I'd be feeding [P6A] then cleaning bottles, sterilising bottles, pumping again and I just felt like I was all day just dairy cow. And it was kind of occupying my life and so after 2 weeks I gave it up. (P6, experienced PND)*

*It was, it was but we figured it out that it was dairy and as soon as we took him off, soon as I stopped breastfeeding it was easy. He, he sorted himself out. I just got him on [allaxapro] which is allergy milk. And he was amazing after that. Yes. He I had to stop at 3 months because it was just too hard, just in case I ate something that wasn't, didn't have dairy in it or something, like diet coke has dairy in it. Yeah it's got dairy solids. So, yeah so I had a coke and I was like oh what's going on. I had stopped all my dairy and then he arced up for 2 days afterwards. So I stopped breastfeeding him and it was easier, since then it was easy. (P21, emotionally well)*

*I don't have any milk. So it took me long time to have that. I think about a week then the milk start coming. But it didn't come as like flowing it just a bit by bit and I try so hard. I take so hard, I pump regularly but still it doesn't happen.... I tried my best to breastfeed him for about 3 months. Plus the formula. (P1, experienced PND)*

Despite the NHMRC (2015) breast feeding recommendations value judgements are still displayed within our community and in society. Negative comments about breast feeding by respected community members including health professionals and family members may impact self-belief or one's value system. Being given conflicting advice may undermine maternal confidence and skill. Assumptions are made that breast fed babies have a certain look, and health care providers advocate breastfeeding over bottle feeding, without consideration of individual circumstances. As some participants commented:

*I remember breastfeeding in the doctor's clinic in the waiting room with [P10A] and he was 8 months and my doctor, the doctor who I went to only for [P10A], he's not my personal one, I was shocked 'cause he came out to the waiting room and said oh isn't he too old for that... I found that every midwife told me a different thing about breastfeeding. (P10, emotionally well) but the breastfeeding didn't work out for me and that was something I just had to live with now. (P2, emotional well)*

*I visited my best friend who had a baby six months after me...and the midwife walked in the room and said to me, "oh you can tell she's a breast fed baby' and I just said...she wasn't breastfed and she just walked straight out." That happened to me [researcher name] that really happened to me. (P2, emotionally well)*

The realisation that society dictates what a mother's experience should be is a turning point for the woman who acknowledges that her body does not conform to society's dictates. Her body is still able to function as a female, as a mother, and her involvement in the world is still as an authentic mother. Some participants commented:

*I just look at my babies and they're healthy and that's all that matters [researcher name] really in the end. I would have, that would have been nice to have a natural birth and to breastfeed but it's probably was hard for someone who's a perfectionist. But I won't probably cry now because I... (P2, emotionally well)*

*I don't think I had any expectations because I had never really thought about the actual practicalities of motherhood. And you know I'd never thought what breastfeeding will be like. Breastfeeding wasn't even something that entered my mind until you know I fell pregnant I suppose and I hadn't really thought motherhood through it was just something that felt natural to me. (P4, emotionally well)*

The physical and emotional experiences of preparing for birth, giving birth and breastfeeding are unique to each woman. It is the uniqueness of each of her experiences that guides her adaptation and authentication to motherhood. She should thus be encouraged to see herself holistically whilst recognising societal influences on her perceptions of motherhood.

### **7.6.3 Subtheme 3.3: Bonding with the baby – an extension of the maternal body schema**

Maternal embodiment involves physiological and affective bonds that commence in utero. It is the physiological bond and the development in the uterine environment that influences foetal body schema. The foetus is dependent on maternal physiology for existence, yet this physiological bond can have a detrimental effect on maternal physiology, as in cases of pre-eclampsia and placenta praevia. Medicine and technology have provided considerable knowledge about the developing foetus and the possible impacts on the maternal body schema. This progress has facilitated mothers (and fathers) to bond earlier with the unborn baby. Ultrasound for example, enables the baby to be visualised, the graphic and precise details make its presence more real. This visual reality promotes another level for a mother to bond with her baby (Øyen & Aune, 2016). Lymer (2011) illustrates how the pregnant body accommodates itself to the growing foetus/baby and in this way facilitates foetal body schema, but this is a highly subjective assumption since there is no knowledge or evidence that a baby in utero has thought or has knowledge of its body. However, the basis of infant having knowledge of its own body schema is judged through the maternal environment rather than it being identified with its own subjectivity. Lymer argues that the baby can assess and interact in its environment and react according to its own needs within that environment. This is not possible given that it reacts to the environment and changes within it through its senses; it does not necessarily recognise those changes as positive or negative to itself. This recognition is imposed by the

mother or caregivers as an interpretation of their own experience. When born, the baby responds to the mother in an object directed way as Zeedyk (1996) suggests: infant intentionality in relation to goal directed behaviours (e.g. trying to gain mother's attention) which gives insight to the baby's needs, capacity for relating with others and is behaviourally object-directed. For example, a baby cries when hungry. That is, infants and mothers use a turn-taking style of communication which is goal-driven by the baby,<sup>40</sup> and with response by the mother. Infant communication is a reactive process by the baby driven by its physiological needs. Lymer suggests that the timing of the development of foetal-maternal communication occurs when the foetus is sufficiently developed that it feels the confinement of the uterine space. A mother's heightened awareness of the increasing size of her baby and her uterine expansion promotes her verbal and tactile communication through her body changes. Lymer's conceptualisation of maternal –foetal communication establishes that pregnancy for the mother is more than carrying the baby. She can potentially bond with her baby before birth. Merleau-Ponty, however, initially proposed that this bonding and communication occurred in the postpartum period.

A mother judges herself about her worthiness and when she does not measure up to her own standards she conceives her capacity to mother is diminished. A mother and baby bond is an emotional and physical relationship that she establishes from the birth. Her senses are heightened to those first moments of meeting her baby. This sensory expansion continues in the postpartum year. Bonding is a personal experience and whether or not it occurs and when it occurs cannot be predicted

Mothers in this study described the attachment to their baby as a bond or connection which they had established either during pregnancy, at the birth or at some time after the birth. They described the bond as feeling 'love' or 'being in love with the baby'. Whilst they had an expectation about bonding, having heard about it from other mothers or from societal values and healthcare, they did not always know how

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<sup>40</sup> Zeedyk illustrates classic exchange of communication between mother and baby: "A standard exchange begins with one partner eliciting the attention of the other, perhaps through positive affect or a vocalisation, and the partner responding by returning the gaze. The dyad then engages in a period of mutual gaze, with the mother speaking to the infant and the infant typically exhibiting animated behaviour such as cooing, body movements, or intensifying facial expressions. The interaction continues in a coordinated, synchronised fashion, with participants taking alternating turns until the exchange is terminated, often by the infant turning his or her attention away from the mother. The exchange resumes when the infant reorients to the mother".

they would recognise it. This recognition occurred with the reality of seeing and holding the baby. As a participant commented:

*So with [P5A] I felt ok, like yeah I didn't feel the love like I know a lot of other woman do so it wasn't until he actually came that I felt the real bond...I know you don't experience love until they're here like I think carrying this baby [pregnant with P5B] I know what I'm going to receive so I feel so much more attached [to] how I'm carrying now and feel so much more in love with the baby already. (P5, emotionally well)*

Having an instant feeling of love at the birth is perceived as the ideal experience of bonding. The realisation of this instant bond is affirming for the mother,

*It was just instant love as soon as she was born and you know I guess I just felt like very very fortunate that that I had all them feelings that I wanted to feel for her... (P2, emotionally well)*

Bonding was also referred to as a connection. The physicality of seeing and holding the baby was not a determinant for bonding. The awareness of not wanting to spend time with the baby was a critical realisation that all was not right with the mother. For her, the perception that bonding is an easy and natural endeavour was not realised. It was experienced as something that needed to be worked at and taking effort to establish. The delayed connection may take between days and months to establish and build upon. As daily life unfolds the mother may recognise her bond with the baby evidenced, for example, by feelings of missing the baby during her work day. As participants commented:

*I think it takes a lot of effort. It doesn't just happen that way, like it's not like oh like suddenly oh I love my baby. It's really an effort to really understand him...I really have to put effort to have that connection, it's not something that just happens. Mmm yeah because when you read article like you know mums they immediately when they give birth they love their baby, like is so, so fantasy like you know and again I thought you know I will have that love feeling to him immediately but yeah no... I spent time with him. So I have to put in effort to spend time with him and play with him. Understand him like you know even though he still hasn't speak yet but really understands and really see him as someone that I'm going to spend you know my life with him. (P1, experienced PND)*

*And woke all the time, every couple of hours or hour and breastfeeding wasn't happening right and you know every midwife told you something different and so that first kind of few month was so intense and I didn't bond with him straightaway... I didn't actually tell the girls for quite a while because I felt like oh I don't want to tell anyone that I don't already feel kind of this great bond for my baby but yeah so my experience was quite intense actually, that's why it was nice having an easy baby second time round... (P10, emotionally well)*

Bonding is a sensitive time and can be disrupted by difficult situations. Being overwhelmed with the demands and needs of the baby may skew the mother's perceptions and expectations of herself in dealing and coping with them. Knowing that bonding has a social and personal value makes it difficult for the mother when she does not experience a bond. Hence to disclose its absence feels, to her, like a taboo subject.

When complications of health and lifestyle occur during a subsequent pregnancy the mother worries about her own wellbeing and that her future lifestyle may be compromised. Her personal situation will not necessarily change with the birth of the baby. At this time she is pre-occupied with the problems of the future and focuses on those thoughts rather than maintaining a nurturing attention toward her baby. She fears that the feeling of disconnection she experiences with the baby in utero will continue after the birth. Already she is aware of what to expect both in the birth and in bonding with the baby and is concerned that her focus on herself with regards to her situation may detract from attention to the baby. At birth she is relieved to recognise that she feels an instant love with her baby. Participants commented:

*Because I was so upset I suppose in my pregnancy I was thinking, you know in my head I was thinking I'm just going to go straight back to work. Like I felt like I was almost going to be disconnected from him. However it's been just amazing, like I'm just so in love with him. Probably more so, I wouldn't say more so than what I was with my daughter but I think I'm just, I'm older now than what I was when I had my daughter as well and being the second I just enjoy him so much...I feel better than what I thought I would if that makes sense, yeah, yeah so. (P17, emotionally well)*

*It was an extremely difficult pregnancy. I felt guilty to my daughter, I didn't have the energy that I used to have and I was sick, I was still wrenching...and in that regard I did worry about how I would bond with my*



*baby because I had all these issues that I hadn't enjoyed the pregnancy. But again as soon as he was born, that maternal love and the same feelings I had for my daughter was just there, like with my son. (P2, emotionally well)*

Bonding is a process that involves the senses and occurs over a critical timeframe. For a mother with a prior experience of bonding at birth she has a formulated rhythm that should occur for her. For a first time mother who may not have experience to draw from, she still is aware and has expectations of herself and her baby. When a mother is not able to see or feel her baby she may experience disappointment. This disappointment may be compounded when the health professional provides physical care to the baby that the mother believes she should have given. This practical and physical care, when provided by the mother, are perceived to be important rites of passage in initiating the mother-baby relationship. A mother not being able to physically hold and be close with her baby following birth may impact the way she relates to the baby. As participants commented:

*You still want to have the fact that it comes out and you bond with it, well they place him on you so you can have that connection, just seeing that little person makes everything...but I didn't get that with the caesarean. (P14, experienced PND)*

*[Interviewer: "So they didn't put him on you?"] "No they didn't, they just, I just saw him, like they took him out and I saw him from a distance, they showed me and he was alright and they took him away and they took me away, and that was quite distressing, I should say the second one had everything wrong with it, the birthing was just not a very good experience. (P14, experienced PND)*

*I think it was because she was, I didn't have her, I didn't. It was that you know and the first time I got her she was all bundled up, you know that beautiful little papoosie bundle. So I couldn't smell her and I couldn't touch her bits and look at her and then the next time I saw her she was clean. So it was, whereas with the boys they were up on me and I could you know count finger tips and when [P20C] was born, [P20C's] got a beautiful big birth mark on his thigh and my first thought, I can still see him coming out and I thought he's got a bruise on his leg. He hadn't and then I always say, my husband and I it's our little running joke, we go that's how we know you're ours because that was your mark so we knew that you were ours and he*

*thinks that's hilarious. But I never had that, you know that tactile-ness with her. The first time I did she was clean, she wasn't, she didn't smell like me, she didn't smell like and I think that's what it was. (P20, experienced PND)*

The presumption that bonding requires thought and planning overrides the simple behaviours of the baby being born from the mother and placed on her skin. The belief that bonding is a complicated process and bound by duty supersedes the naturalness of the engagement. One participant commented:

*I had two very difficult births, after they were born, I just wanted to sleep, I didn't want to bond with the baby, at that moment. I just wanted to hold the baby so I could just get a bit of rest. (P14, experienced PND)*

The realisation that bonding is a natural and ordinary process that is assumed within the duty of mothering may be disappointing for the mother who had a prior experience of being instantly bonded with her baby at birth. The love and infatuation she felt for her baby grew daily. A mother expects to have the same feelings of connectedness and awe in her subsequent births and when this is not realised she questions the success of her bonding with the new baby. She reasons that the demands of daily life may interfere with her quality of bonding. Participants commented:

*I found after [P9B] was born it was a bit more challenging, just mainly logistically I think, just trying to work out how to manage two. And I think it took me longer to bond with him than it did with [P9A]. And that made me more anxious about things because I felt like, you know I was so in love with her so quickly and it wasn't the same with him, it wasn't as instant and overwhelming and so that wasn't quite as pleasant. But it's still been, you know overall very positive and very good memories of that first yeah.... I can remember with [P9A] thinking, at about a couple of months old thinking wow I thought I was so in love with her when she was born but I am even more in love with her now and it just seems to be getting more and more, the more I know her and the more she develops and the more character she kinds of shows me of who she is I love her more and more and I remember being around that same stage, around about that kind of 6 week mark when they are crying the most and all that kind of thing. With [P9B] and I can't remember, I think maybe my husband had to go away for work or something, there was just a few things and I was quite teary and he was crying lots and thinking, you know thinking back to what that time was like with [P9A] and how infatuated I was and thinking why don't I feel that same level of you*

*know lovey-doviness as what I did last time and even though I didn't not love him, I definitely was attached and I did love him but just wasn't as overwhelming. It was like yeah but I've got to get on with you know, got to get through the day kind of thing and... (P9, emotionally well)*

For some mothers bonding is not a natural process and becomes a deliberate, conscious activity. She needs to think and plan on how to know her baby without a prescribed timeline pressuring her. The belief that bonding will eventually occur, in its own time, helps her to accommodate her feelings. She has helped herself to rationalise her situation, by recognising her baby's health and personality, and acknowledging the importance of bonding with her baby for a lifelong purpose.

*I spent time with him. So I have to put in effort to spend time with him and play with him. Understand him like you know even though he still hasn't speak yet but really understands and really see him as someone that I'm going to spend you know my life with him. And to really appreciate that he's a healthy baby. And he doesn't, you know I realise that he doesn't really give me a lot of problem. Yeah and that again is like you know I'm thinking about myself again and I, in my mind I just want him to be happy boy. Yeah I try my best to make sure that he's happy. (P1, experienced PND)*

For some mothers breastfeeding is a means to enhance bonding and to prolong the connection of mother and baby. This exclusive relationship is empowering and affirms the mother's role as the primary caregiver. When the baby starts to have control over breastfeeding by weaning or refusing the breast the mother has to rethink her role in satisfying the needs of her baby. The exclusivity of her bond ceases but her connection evolves to include other sources in the nourishment of the baby. This process of change may be confronting for the mother as there is a conflict between what she assumed would occur and what was realised. She is forced to accept circumstances in which she has no control. She perceives that the bond with her baby is challenged,

*In my ideal world that I had imagined before I had [P15A] I was planning to breastfeed 'til at least 2 years old. I was going to do, do extended feeding. I really wanted to have that bond for as long as possible. And so then at 9 months of age to start, for breastfeeding to start being a really negative experience for me was devastating. I was just so heartbroken. I was like but you need to keep feeding... the intensity with which I wanted it to be just me and her. I bonded really, really strongly with her and I didn't share, I really*

*didn't share. She wasn't allowed to be babysat, I didn't go out without her.  
(P15, experienced PND)*

Generally, feeding the baby is considered an opportunity to bond with the baby. In those situations where the mother is unable to breastfeed she relinquishes the privilege of an exclusive relationship with her baby. The mother compromises her exclusivity to allow her partner or significant others the opportunity to bond with her baby,

*I wasn't able to breastfeed um [small sigh] but I guess I viewed it my husband being more hands-on is that we were both, would have been our first-born we then worked as a team and that he got to bond more with my little girl as well. (P2, emotionally well)*

Mothers also recognize the rite of passage of fatherhood and accept that sometimes being unable to undertake an aspect of motherhood, for example breastfeeding, provides an opportunity for her partner's involvement.

## **7.7 Summary**

This chapter relates Merleau-Ponty's concept of body schema to maternal embodiment in pregnancy, birth and the postpartum periods. In each of these stages the maternal body schema changes and adapts to ensure the physiological needs of the baby are met. This maternal embodied response and adaptation are experienced both biologically by the individual body and through the world as a lived body.

From the conversations with the mothers who had experienced a 'normal pregnancy', free of medical and physical complications, it was found that they had a general feeling of happiness and wellbeing. When talking about their pregnancies they did not dwell on or point out particular incidents of their pregnant states. They commented on noticing when the baby kicked in utero without being specific about the details surrounding this. In contrast mothers who, in pregnancy, experienced emotional and/or physical stress seemed to be more aware of their body schema by being able to recall specific details with regards to stressful or uncomfortable situations. Perhaps this heightened their sensitivity to their body schema to allow them to recall the particular details. It is possible that being aware of one's body schema is a consequence of physical discomfort. Adapting to physical discomfort is dynamic and unpredictable yet purposeful in allowing the body to rebalance and re-establish the flow of daily life. The

situation of perceiving one's wellbeing as being a threat (for example, anticipation of a stillbirth or the ill health of baby in utero) presents a complex response where adaptation and re-establishment of the flow of daily life is not automatic. In these circumstances a mother's awareness of her body schema would be even more heightened and her sense of vigilance would impact her perception and adaptation.

Giving birth is a physical event that is always remembered and recalled by mothers regardless of the mode of birth or its associated complexity. With a rapidly changing body schema, to which she must adapt, she has to give herself over to her body and allow it to continue its process. She has no conscious control of interrupting or changing this flow and so accepts and adapts to *her* situation. A mother who resists the flow or cannot adapt to the physical demands of the situation may manifest her emotions through her body schema. It becomes more complex when a mother is faced with cumulative physical challenges to her body schema (for example, having an unplanned delivery mode, hours of labour, epidural against your will, the physical tearing and stretching during delivery). Health professionals in consultation with the woman respond to the immediate needs of her body schema.

Following the birth, the maternal body adapts yet again physiologically to accommodate the needs of the baby. Mothers commented either on feeling generally happy or were able to recall specific details of challenges that they had experienced in the postpartum period in hospital. Interestingly, mothers who experienced challenges took longer to adapt to the situation, and to understand their body schema. For example a mother who was not successful in initiating breastfeeding in hospital accepted this and adapted her methods to bottle feed which as a consequence enable all family members to experience and nurture the baby. This contrasted with a mother who struggled to breastfeed in hospital and at home despite the physical distress and discomfort this brought her. She adapted by goal setting and persevering to meet her values.

It seems that a mother is more aware of her body schema when she experiences discomfort, distress, challenge and/or unfamiliarity. Physical and mental coping with uncertainty and ambiguity either in herself or her baby can challenge her emotional wellbeing. Situations that are unfamiliar to her can compromise her engagement or willingness to engage in everyday tasks. Despite her self-awareness and self-regulation being altered, it's not until she reaches her own emotional limits

that she reaches out for support and advice in order to re-establish her equilibrium and re-balance her energy and focus.

Re-establishing equilibrium requires purposeful action, and is influenced by habit and rituals. As a woman she has established rituals, as a new mother irrespective of the number of times she has birthed a baby, she requires to establish new habits and new rituals to accommodate the expansion of her life. Her baby also requires the establishment of routines to foster a healthy development. Finding the balance between self-care and being a mother is a challenging situation she finds herself in. The synergy of herself and her baby is unique each time she births, attending to herself, her identify and her role is the multifaceted nature of mothering. When these boundaries of existence fade out, her disequilibrium becomes apparent.

In relation to birthing, mothers feel social pressure to birth naturally and without intervention as this is suggested to be the 'ideal badge' of motherhood. However, important to the birth process is for mothers to feel and know that they are partners with the health professionals in the delivery of their baby. Partnership is evident when mothers are provided with choices and options that health professionals know would best suit her situation. Thus, a positive experience can result from unplanned birth interventions when a mother feels informed, respected and in control of her outcome.

## Chapter 8

### Women's Perceptions and Experiences of PND Screening

This chapter discusses that whilst the intention of the Edinburgh Postnatal Depression Scale (EPDS) is to gauge mothers' emotional self-assessment, several inconsistencies in this intent emerged from the participants' discussions. Three themes emerged from the discussions with the participants. The first theme that emerged related to the participant's experience of an inconsistent approach to its administration. The second theme determined that participants felt supported or unsupported in the screening process. The third theme was that participants questioned the purpose, validity and need for the EPDS.

#### 8.1 Theme 1: An inconsistent experience in screening for postnatal depression

Whilst there are recommended guidelines for the administration of the EPDS in the postpartum year, the actual practice was not consistently applied and varied considerably amongst a wide range of clinic settings. These variations include the timeframes of screening, their frequency, and the time intervals between screenings. Time frames of screening varied from mid pregnancy to 8-months post birth, with some mothers not being screened at all. An inconsistent approach by the child health nurse in the delivery of the EPDS is also demonstrated. Participants commented:

*That's why I said every time you go for an appointment they went through that survey. (P13, emotionally well)*

*Yeah every time I went for a meeting with [P12A], with [P12B] I remember always having to answer these questions and I thought God how many more times, but I mean it's for... (P12, emotionally well)*

*For both of mine I only had to answer them twice, are you sure you answered them more? (P10, emotionally well)*

In situations where mothers present as emotionally well and score within a norm indicating no risk of PND, the attention is redirected. Where there is a known

history of partner depression, PND screening shifts from the mother to the father. This challenges the dynamics of embodying motherhood, because it diminishes the attention from her body to his body and while this is a gallant and altruistic gesture it does not honour the maternal role and devalues her attention.

*There was a questionnaire that I filled out with [P18A], I don't want to get my nurse in trouble...but I never got given one for [P18B]. It became quite clear that I was not in any danger. Very early on. So it, I think I probably got glossed over a little bit which was fine with me, I didn't feel like there was any issues. I mean she asked every time how are you coping. And she could see that everything was. Going along great. They were probably more concerned about postnatal depression with my husband because he does actually suffer from depression so they were concerned about how he was going to cope probably a little more than myself. (P18, emotionally well)*

Attending to PND screening processes should be consistently applied by the health professional. Mothers may self-regulate their own emotions and may have an awareness of their partner's emotions. The skill required by the health professional in balancing the needs of the mother, partner and baby may be challenging.

## **8.2 Theme 2: Feeling supported or unsupported in the screening process**

The tool was appreciated as a method of being able to self-assess their emotional status and confirm it. In this way the screening process was seen to be successful by some participants, whose feelings were validated and their score suggested having, or not, PND symptoms. Participants commented:

*I suspected that I wasn't happy and then they, you know how they go through the questionnaire and they say I do have a higher branch of depression..... I think the last time that I went to they actually say that you improve a bit. Yeah so I think it gradually I realised that I actually got lots of help. (P1, experienced PND)*

*I was actually anxious about doing it [the EPDS] because I was worried that I could be depressed and hiding it cause I hide very well. And I was worried that I was actually hiding it. But yeah it's scary to go to there and know that you could have it when you think everything's ok. Yeah but yeah so the screen was fine. (P21, emotionally well)*



Participants with high EPDS scores were recommended to seek further care, such as counselling with specialised counsellors, psychologists or with their general practitioner. Thus, for participants, acting on the recommendations was a personal choice. For the child health nurse, passing on information relating to ongoing care, is consistent with the COPE Clinical Practice Guidelines (2018). As participants commented:

*They recommend me to go for counselling...but I didn't. I thought yeah it's, yeah I didn't go for counselling I say I'll deal with it on my own first.... they do recommend a service that I can go to but I say no [I] should be alright.... (P1, experienced PND)*

*The child health nurse ...encouraged me to go to the GP... I found the GP easier to talk to than her [child health nurse]. She was very good with the children. For the chat I'm feeling like this I found it easier to talk to the doctor. He was family doctor for a long time. (P8, experienced PND)*

A shortcoming of the EPDS is that no strategy for ensuring that the recommended follow-up care actually occurs. To assume that a person with such vulnerability will follow the recommendation independently falls short of a positive outcome. Health professionals offer advice and choice to those they serve, and are aware that individuals should not be forced to take up recommended care. The problem lies in that there is no feedback mechanism to know whether or not a person has sought support or intervention and so it becomes easier for the person at risk to slip through the safety net.

Participants described the administration of the EPDS as a checklist, or tick-box exercise with no probing or opportunity to explain or draw on experiences, neither to clarify questions or answers. Their experiences of undertaking the screen were that it was an impersonal exercise, which had a depersonalised clinical feel about it. It was generally administered during the child health visit with the child health nurse. Participants felt that the child health nurse's primary focus was on the EPDS score rather than on the content of the items and eliciting information about their feelings, recent emotions, personal wellbeing and coping:

*Yeah they give you a check list, and you just tick it and they give you the score and that was it...it was just like a tick in the box. There was no*

*exploratory offer or nothing and. Like I didn't get top scores on that and I don't know if anybody would but I think if you pass whatever the marks are they never said " how you feeling with that one because you never said like. (P2, emotionally well)*

Participants commented that they did not consider the child health appointment as an appropriate time and venue for raising maternal concerns of wellbeing elicited from the EPDS. Confusion arose where the mother was asked to express her judgement about her wellbeing at a time and place that is supposedly devoted to the attention of the baby and its development. This ambiguous context of care presents another layer of misperception for the participants. Furthermore, to be confronted by having to complete the EPDS was further disconcerting. One would consider whether mothers were mentally/emotionally prepared to respond to the screen, and whether they were prepared to be truthful. This sense of not knowing that the EPDS needed to be completed and when it was to be completed, caused resentment with its repeated administration in some participants. Completing the screen in isolation from the follow-up discussion compounded the participants' dissatisfaction; it seemed also that there was no consequence to undertaking the screen.

*It's like taking the focus off the baby and bringing it on you. I don't think I'd feel right to raise that to anyone, but then, maybe other people feel that way so maybe could be another reason why people don't discuss it, and that's why it probably should be up to the child health nurse. I mean they might be under resourced or funded but I've had two now and both... I'm not saying she wasn't a nice person; the person was nice but just the something with it. Tick the box and you go... I don't, I definitely think it's more for the baby, which is fine but there's not much time, it doesn't seem like there's enough. (P3, emotionally well)*

*It was never explicitly you know would you like to do an EPDS, no you're fine ok it was just kind of how you going, ok good, didn't bring it out kind of thing and I wasn't until yeah her 8 month check where I was with a child health nurse who I didn't know that she actually just automatically did it and we don't actually have to do it at 8 months. We routinely do them at 6 to 8 weeks and at 3 to 4 months and we will sometimes do them at 8 months if there's been a high one previously or if they haven't been done or whatever and she just, this particular nurse just routinely. (P9, did not experience PND)*

*Probably if I had that screening offered, someone would have realized that I was struggling in that time, but I didn't get that, because I went through the public way, so I don't think, I didn't get that. And the only other time is when you go to the six-week visit, but the doctor focuses more on the baby, and not so much you. (P14, did experience PND)*

Cicourel (1964) points out that errors may occur in the interviewing process, primarily as a result of misinterpreted intention of the participant to the interviewer in relation to the process and the questions directed within the interview. This aligns with the mothers' response to the EPDS screen and the screening process conducted by the health professional. Cicourel also challenges the validity and reliability of such screening methods because they do not represent a true value, and that this value cannot be verified in any way. Mann and Gilbody (2011) conducted a rapid review of the literature to determine the validity of 2 case finding questions (2CFQ) for PND detection and found that whilst the 2CFQ was a useful screen to dismiss PND the high rate of false positive responses was misleading and resulted in unnecessary follow-up care.

### **8.3 Theme 3: Questioning the purpose, validity and need for the EPDS**

Participants questioned the validity and purpose of the EPDS, that is, was it for the benefit of the mother or was it solely a survey for governmental reporting? This uncertainty and ambiguity about the EPDS score and its consequence influenced the mothers' responses and attention to an honest and complete screen. As participants commented:

*What happens if you... do you answer... do they come and support you or is it literally just a survey... So it's not for statistics? (P13, emotionally well)*

*Did I just think it was probably done in, oh just fill in? You know like, so if I really was depressed I don't know how comfortable cause you can do the test and you could fudge it if you wanted to. You know if you didn't want people to know you're depressed that'd be quite easy to do that so I wonder, yeah I wonder how honest. It's really about you feeling comfortable to tell your health professional that's how you're feeling I think. (P16, emotionally well)*

Participants commented that the questions on the EPDS were broad and superficial. The questions did not address personal or parenting behaviours, and were not contextualised to the postnatal period of the mother's relationship with her baby.

Also commented was the screen did not serve as a basis for discussion about the mother's experience and emotions. The focus and attention was on the screen and its score, not the person and her needs. Participants stated:

*They're just asking if you were, cried about things or... They're very, I feel like they're very, they're not in depth though, like I don't think they're in depth to find out if you are, you could be having a bad week and you could be, yeah so I think they need to ask better questions that's what I thought. Well even like asking about harming your children, something like that because there's nothing in those questions about that it's just asking about your, how you're going. It's not asking about your children and how, no questions about yeah harming your child or how you're feeling with your child. It's are you having a bad day, the, so yeah I think questions like yeah calming your child and more in depth about your children more so about yourself. (P21, emotionally well)*

*There was no exploratory offer or nothing and. Like I didn't get top scores on that and I don't know if anybody would but I think if you pass whatever the marks are they never said "How you feeling with that one because you never said like.." no. (P2, emotionally well)*

The conflicting nature of some of the questions was exposed where some participants noted the extreme of the questions which range from laughter and humour to self-harm. The question of determining self-harm in the presence of someone who is vulnerable and emotional was perceived as being unfitting at this time and context. The intensity of that item had a suggestive tone that might foreshadow a consequence, where a participant who was particularly sensitive could be affected. Safeguarding emotional wellbeing requires more than an immediate judgement on a screen. Participants stated:

*I don't know if I had it with all of them, probably, I probably did but I remember, I remember answering some questions about whether I had ever been depressed. And some quite confronting questions and that's probably why I remember it 'cause I remember thinking I've never tried to kill myself why, you know why, have I ever thought about killing myself, why would they even ask me that. You know when you're pregnant your hormones are probably all over the place anyway. (P4 emotionally well)*

*I remember thinking some of them were a bit odd but thinking they must be there for a reason. (P7 emotionally well)*

Participants noted that the opportunity for genuine engagement was missed. When a conversation happens to clarify meaning behind given responses, in this case the EPDS, a more honest and authentic expression is promoted. Relevant feelings, emotions and behaviours are validated and this allows a more specific account of what the person is experiencing. Bearing in mind that the mother will most likely be 'interviewed' by a different CHN at each visit, integration of an interactive approach would offer a unique opportunity for each mother to validate her responses and contextualise her situation at each visit. Giving the EPDS an extra layer of voice would foster a relationship and support network with the CHN and health setting, whilst also assisting the mother to identify personal triggers and behaviours of which to become aware during vulnerable times. The EPDS when used in partnership with discussion is a suitable filter for screening for maternal emotional wellbeing.

*Well even like asking about harming your children, something like that because there's nothing in those questions about that it's just asking about your, how you're going. It's not asking about your children and how, no questions about yeah harming your child or how you're feeling with your child. It's are you having a bad day, so yeah I think questions like yeah calming your child and more in depth about your children more so about yourself. (P21, emotionally well)*

*The questions are confronting, that is so confronting. Because quite often you'll gosh, no never. But that 7 days I mean really it should be have you ever because that's more indicative of where that person is as opposed to just that last 7 days. Because I think over a life time, and I know a life time's a long time but if they've ever had a thought where they've not been ok with themselves well that should be enough of an alarm bell to go ok this person probably needs just a little bit more care and comfort because anything can happen, anything can happen and you can have a nice clear EPDS score and 3 weeks later they could drown their child because it doesn't take. I mean I had a child that didn't sleep ever and there were many times that even as a 2 year old I would hold him to his bed and look him dead in the eyes and go I need to walk away, not that I'd ever condone it but I can understand how some people get to a point where they just want to go. And you know you don't know what's going on. (P20, experienced PND)*

There is an acceptance that pregnancy and the postpartum period are an emotionally charged time, and the range of emotions is wide and varied, where on

some days a mother may feel more emotional than other days. Thus, emotional fluctuations impacted on the screening scores (outcomes). Whilst their responses were authentic at the time of completing the EPDS, some questioned the validity of whether the EPDS could actually identify whether they were at risk of PND or had appropriate coping. The participants commented how their present emotional state may influence their responses on the EPDS,

*I would have probably, you know the whole coping thing, all those questions would have been answered differently, depending on also on what day. You know I don't know how well those survey things go because it depends on what day you get the person, you know how they're feeling I suppose. (P19, experienced non-coping)*

*'Cause even the pre-birth one [EPDS], again you might have had a great week or you might have you know your granddad might have died that week. It doesn't mean that, you know you're not any more likely to get postnatal depression. Yeah ok I cried a lot this week 'cause my granddad died. But it doesn't, doesn't give you the option to, not that you should be explaining it but it doesn't give you that kind of, you know it is a snapshot of 7 days and I do understand why. But sometimes you need it to be a little bit more. You need to delve into the questions a little bit more. You know go down you go 0, 1, 0, 1, 0, 2, 3 every now and again if you're really unlucky but when, you know as a clinician marking it you don't think to go oh you know, why did they put that and I always question the ones that are 0, 0, 0, 0, 'cause like ok no one's that happy seriously. So although I do love it as a tool, I do love it as a tool I think it needs something different done to it. (P20, experienced PND)*

Undertaking the screening was a challenge when feeling emotional. Appearing happy and coping at the CHN visit was important to the mother so in order to invite probing questions which might reveal her vulnerability. The mother, therefore, downplayed the outcome of the screen and was able to hide her true emotions which the total score of the screen did not reveal. She did not believe the child health nurse had a right to know her deep feelings. She felt this aspect of her being to be a deeply personal one, which she wanted to protect and nurture with significant people of her choosing. For others, undertaking the EPDS offered time for personal reflection, where mothers were prompted to consider their feelings and gauge their own emotional wellbeing. This was done privately and information was not

necessarily shared with the child health nurse or midwife. In attending to her own self-assessment a mother could avoid being labelled by the system. While they recognised they had some emotional tendencies the mothers were reluctant to align what they were feeling with a pre-constructed criterion of depression. This could have reflected mothers' disembodiment,

*I remember filling out the postnatal depression things and I guess I was sort of [hesitating speech] borderline. I didn't feel depressed but a lot of the things were "oh yeh I am crying uncontrollably but I didn't necessarily feel sad, it was just I didn't have control over it. So you know I might just be sitting here having a normal conversation with you and then [motions crying] tears would start and I would say I'm really sorry about this I'm fine. But I didn't feel sad. (P22, emotionally well)*

*You do actually think where you're at and make you take stock and stop because you're always so busy. Especially if you've got more than one, you're too busy caring for a new born and then a two year old, but when you've got this in front of you and these questions, it's quite confronting, like so I would... for me I did answer it honestly and... By the time I did it I probably would have moved through a lot so I was being honest but she never asked me anything about the things where I was under. (P2, emotionally well)*

Yet mothers were aware that they masked their emotions during the screening process. They avoided answering the questions honestly, they suppressed their emotions to themselves as well as others, and they made an effort to join a social circle that facilitated engagement with others. The process of suppressing their own emotions created confusion and anxiety in their personal self-evaluation. That is, they feared being diagnosed with depression

*I was actually anxious about doing it [taking the EPDS] because I was worried that I could be depressed and hiding it 'cause I hide very well. And I was worried that I was actually hiding it. But yeah it's scary to go to there and know that you could have it [depression] when you think everything's ok. Yeah but yeah so the screen was fine. Yeah even to myself at times. So I hide everything really well but yeah just worrying that you there's days when I do have a bad day, is it actually depression or is it just having a bad. Yeah so it's just having a bad day. Just having a bad day. (P21, emotionally well)*

Participants with health professional backgrounds experienced difficulty in several ways. It was presumed that having a professional background in health would equip one to self-assess their own emotional wellbeing and ask for help if needed.

Consequently, the screening process was not always undertaken for these participants. A further assumption that having a professional background in health would prevent one from developing PND. The participants suggested that the child health nurse administering the test could have been intimidated by the mother and her responses, and thus the mother was treated as a professional rather than as a mother which resulted in an uncomfortable interaction. Mothers who are health professionals were also aware that health records are permanent, and did not want a record that put them in an unfavourable light, as this information can be accessed by others. A record of depression can impact on future life, travel and income protection insurance (Beyond Blue, 2011; COPE, 2018)

*I don't know what impression I was giving the child health nurse at that stage and I could, that's probably nothing to do with the original question but that's really annoyed me and I don't know what to do about it 'cause I want it taken off the system. I'm sure I didn't say that. I would have never have said I'm not, I would never refuse to do something I would have probably said, she might have said do you feel that you need to do it and maybe you shouldn't ever say that to a person. So I think what my experience is sometimes it's very awkward for the child health nurse to ask those questions particularly if they that they know you're in that field. (P16, emotionally well)*

*With [P9A] I was not, I didn't do an EPDS until she was 8 months old... The midwife antenatally said there's an EPDS here and she said we'll probably, at the first visit she said we'll probably do you know these a couple of times throughout the pregnancy. I think she might have said if you want to fill one out before you come to an appointment you can and we'll both do it there kind of thing. But she never, like she asked me how I was going. And I guess she knew you know what I did as a job and that kind of thing and expected that I would say if I needed to. (P9, emotionally well)*

Developing a sincere rapport with your caregiver is of primary importance particularly when mothers are disclosing very personal information to a health professional. As a result of general discussion with the child health nurse, and not the



screening process per se, more authentic information was shared by the participant. Therefore this participant was encouraged to seek assistance from her general medical practitioner for ongoing professional support. She had a unique rapport with her general medical practitioner whose nurturing manner and open communication allowed her to disclose her feelings. Her emotional state while fragile was dealt with in a kind and personal way. As opposed to another participant who also sought care from her general medical practitioner but had to convince her of her fragility, vulnerability, and had to advocate for herself to seek additional care. She was heard but not listened to. Another participant commented on the ability of her general medical practitioner to sensitively initiate an inquiry about her emotional wellbeing while attending to her children's health needs, was a thoughtful approach which she welcomed. The demonstration of compassion by the general medical practitioner revealed a deep understanding of the role of the mother, and her emotional wellbeing; the inquiry into her personal health provided a forum for her to be heard

*My GP [general medical practitioner] is very good, she, she knows me. So yeah she kind of, like the last time I saw her she said I was feeling, she could tell I was feeling a bit flat. But though she picked up on that but besides that no. (P21, emotionally well)*

*For [P3C], she's very good actually, she'll sit with you in a 10 minute consult, if I take one of the kids with a sore ear or something. But she'll ask about the family and what's going on, so she does that with every visit. And the form she was excellent she said there are days you can have that are low, that's normal...she was saying that it was okay to ask for help, yeh, so that was good. (P3, experienced non-coping)*

Another aspect that questions the validity of the EPDS is that not all mothers are screened for PND. Some mothers are not entitled to attend child health visits at all because their temporary visa status disallows Medicare benefits. Other mothers choose not to attend and direct their care needs with the GP only. A judgement of the presence or absence of PND is made by the GP as opposed to undertaking the EPDS screening. This puts into question the necessity of utilising or not the EPDS.

Cicourel (1964) suggests that interviewing is a process of social interaction, and that the outcomes of the social interaction are a result of the exchange between the interviewer and participant. The interviewer seeks to develop a rapport with the

participant to foster a situation where they feel comfortable to reveal honest responses. He says that the interviewer needs to present herself naturally, that is be free of judgement and adopt active listening techniques of paraphrasing, clarifying and confirming the expressions made by the participants. The interviewer attempts to present an informal conversation type interview rather than a clinical approach that is delivered from a script. The development of rapport was commented on by participants.

Cicourel (1964) says that while attempting to adopt an open and friendly dialogue the naturalness of the situation is altered. By the very nature of trying to be friendly, sincere and cheerful, the interview becomes compromised. The attempt to communicate in a positive way sets a precedence to the participants and presents an unintentional bias. This suggests to the participants that they should mirror this response and be similarly friendly and cheerful which thus removes the naturalness of the interviewing situation. So participants do not necessarily reveal their true situation but rather feel compelled to respond in a certain manner. He says “the more the interviewer attempts to sustain a relationship with the subject which he feels will reveal valid responses, the more he feels the interview is ‘successful’ ” (p. 77).

The approach of the interviewer is to maintain a therapeutic process, and the objective of the communication is to respond to the cues and reactions of the participant. The interviewer, while actively engaging is also reading the tone and mood of the subject, and ensuring that a continued exchange occurs. Cicourel (1964) also comments that a responsibility of the interviewer is also to capture information that is not spoken. At face value, the subject is reciprocally engaged and responding to the interviewer, however they have choice as to how they want to benefit from the therapeutic process. While the intention of the interviewer is to be non-judgemental the subject is judgmental with respect to their own dignity as they determine what they wish to reveal. Furthermore, the subject is assessing the interviewer and the interviewer must demonstrate a relaxed interest in the participant (Cicourel, 1964). However, the relationship between subject and interviewer is not reciprocal and leaves the interview situation as a complex one.

## **8.4 Summary**

Gauging emotional wellbeing is more than the completion of a PND screen. There are inconsistencies in the EPDS: the inconsistent approach to its administration in that not all participants were afforded the opportunity to engage in the EPDS in the first 12 months postpartum. A second concern related to the perception of whether the mothers felt that the EPDS screening process supported their emotional wellbeing or not. The third concern raised by the participants related to questioning the purpose, process and timing of administration of the screen, the influence of a sensitive and compassionate health care provider, the importance that rapport has for women when disclosing their emotional wellbeing and the need for its administration. Our society would do well to review the purpose, process and procedures surrounding the EPDS, for Australian mothers. Further research into alternative PND screening methods and tools is necessary, as well as the processes of educating and training health professionals to understand the necessity of engaging women with rapport. This is discussed further in Chapter 9.

## Chapter 9

### Discussion and Conclusions

#### 9.1 Introduction

The historical context surrounding mothers' emotional well-being in the first year postpartum has been recognized and well documented in the literature. As mentioned earlier, reports of mothers' emotional distress have been documented since the 15<sup>th</sup> century. In the 19<sup>th</sup> century perinatal psychiatry was founded by Jeanne Etienne Esquirol and Louis Victor Marce. McGregor-Robertson (1904) noted that first time mothers were more affected by severe emotional distress and proposed that "insanity may occur during the childbearing period, labour or after delivery" (p. 517). In the 1960's Hamilton (1962) and Paffenbarger (1964) began investigating mothers' emotional responses to childbirth; Pitt (1968) observed atypical depression in mothers in the postpartum period and consequently termed the phrase 'postnatal depression' (PND). In 1987 Cox et al. developed and validated The Edinburgh Postnatal Depression Scale (EPDS) as a screening tool specifically to be used for the mother in the postpartum period. Then in 1994 the American Psychiatric Association's *DSM-IV* classified PND as a psychiatric disturbance and defined its occurrence as being within 4 weeks of giving birth to 12 months postpartum.

Since the 1960s a plethora of research in PND has been conducted on understanding its aetiology, identifying antecedents, predicting mothers at-risk, establishing screening methods, and formulating interventions and treatment pathways. The historical background highlights the immense complexity and ambiguity of predicting PND and in supporting mothers regardless of whether or not they experience the condition. Despite all the research, a succinct definition of PND has not been established, mainly due to the personal and unique nature of adjusting to motherhood; each experience of motherhood cannot be replicated by the same or a different mother. Thus, a strict definition will either be so broad that it overlaps with other conditions, or be so narrow that it will miss identifying mothers at true risk. There is no consistent criterion and manifestation of symptoms and signs.

Motherhood is a socially constructed experience that involves physical and psychological adaptation to each situation. Existentially it is an experience that has been enriched by cultural diversity that has shaped and influenced maternal behaviours worldwide. Mothers adapt and adjust to the needs of their baby; for some this is an experience that feels natural and easy whilst for others is a process of learning which takes time. There is no prescribed way to adapt emotionally to motherhood. Significant research attention has been directed to the possible consequences to mothers' negative emotional behaviours and feelings toward the baby and the impact this may have on the wellbeing of the baby. Whilst it is possible to experience negative reactions to motherhood when such situations are evident, the dominant viewpoint taken by society is through the lens of pathologising motherhood, rather like a maternal illness deficit model. A more supportive approach would be to adopt a model of strengths-based and resilience-building so that a focus could be given to the normalcy of transitioning to motherhood.

This thesis reviews the application of Merleau-Ponty's phenomenology of perception as a means to understanding maternal emotional wellbeing in the first year following birth. An exploration of perception per se is essential to bring to light that human experience is a continual development and engagement of the individual within society and the interpretation mothers' place on the events that unfold in their experience. Perception is guided by our sensory experience, cognitive knowledge, emotional intelligence and social-cultural understandings. Merleau-Ponty describes embodiment as the body taking part in the world. Having a baby and becoming a mother is seen as a social and personal milestone, which requires the mother to accept responsibility for her baby, while concurrently maintaining a sense of identity and also being aware that she must adapt and transition to a new sense of self. Her pathway to motherhood is not linear, rather it is a progressive unfolding of layers of possibilities. Merleau-Ponty's concept of being-in-the-world is premised in mutuality, dynamic resonance and are interconnected. One is constant flow finding equilibrium within itself and within its participation in the world. Embodying flow requires awareness, an openness and acceptance of what is possible, and is gauged by action and response. Adaptation is noted as the change of behaviour required by the individual within the situation. Measuring emotional wellbeing and adaptation in the first 12 months of

mothering is ambiguous and complex. The mother maintains her role as a mother regardless of the degree of ambiguity of emotional wellbeing.

Adjustment to mothering is measured by personal standards and medical guidelines. Whilst the guidelines are used to identify those mothers at risk of PND, the diagnostic criteria along with the multiple symptoms possibly creates confusion. Mothers who identify with having PND symptoms do not necessarily seek a clinical diagnosis. Their self-diagnoses gives comfort to their feeling of distress. Several questions arise when a mother self-diagnoses; what is the perceived benefit of the label? Why won't she seek help to clarify her condition? Does the PND she feels warrant medical attention? To whom does she declare her feelings or beliefs of PND? Is her expression of emotion a cry for help?

Whatever disclosures mothers give in relation to their experiences of emotional wellbeing in motherhood, their disclosure is their reality. Their perceptions and understandings of what PND may or may not be relevant as they are attending and responding to their own feelings. Their experience of mothering is personal and whilst others may seek to support them, the ultimate responsibilities and decisions of mothering are theirs. The realities of a changing self invites reflection which allows the mother to consider herself within their own situation. Consideration is not idle thought as much as it is about finding a way forward for herself. In navigating the possibilities of what is, what can go wrong, what can go right, what is known and unknown are complexities and ambiguities of daily life that cannot be predicted nor always be interpreted. Merleau-Ponty says that "another will never exist for us as we exist for ourselves" (p. 457).

There are discrepancies between the experience described by the mothers in this study and the criteria used to diagnose PND using the *DSM-5* diagnostic criteria. The *DSM-5* specifies criteria such as depressed mood and loss of pleasure in activities occurring every day for most of the day. Mothers in the study however, did not mention that a depressed mood for them was enduring. The *DSM-5* criterion that states '*of diminished ability to make decisions*' was also felt by mothers who had feelings of being overwhelmed and unable to discriminate their mothering situation. The sense of impaired mastery of recent situations or events, with the added complexity of dealing with the immediate and contemplating the future, altogether contributed to their

diminished ability to formulate mothering routines and habits. However, whilst a mother's coping may be an indicator of PND a true diagnosis as per the *DSM-5* requires that a number of significant criteria are simultaneously present. The existential feeling and experience of PND may differ from the clinical definition. Socially what seems to have developed is that mothers have become conditioned to expect emotional difficulties in the first year postpartum, which may then become. The feelings involved in role transitions are not balanced with recognising the positive achievements made during that transition, neither is there credit given to the adaptive coping strategies that mothers develop within their situations. It seems that society has turned PND into a condition which parents must expect to experience.

## **9.2 Mothers' experiences of emotional wellbeing and PND in the first year postpartum**

In this study mothers who regarded themselves as emotionally well experienced a range of emotions. They were more flexible in whether or not they dwelled on particular events or emotions at the time and over time. In their daily mothering they focussed on being in the moment and living the experience rather than trying to control it. They embraced the challenges presented rather than feeling defeated by them. They were forward thinking and did not regret or replay situations in their mind. They remembered that it was the general business of the first year postpartum, rather than the discrete milestones and events, that was significant to them. In this sense Merleau-Ponty's concept of embodiment was a continual process of adaptive coping. When the mothers' sense of self consistently resonated with their lived daily experience, they felt happiness, a connection with their purpose and were able to attend to the daily experience. Merleau-Ponty expressed the phenomenon of body orders. He suggested that the body and mind are one; integrated within its own entity and in complete harmony and co-existence without separation from the world. The body orders of Merleau-Ponty's phenomenology were displayed in the flow of the mothers' daily experience. There was a balance of familiar and unfamiliar, a balance of comfort and discomfort, and the balance of trial and error was a learning endeavour rather than of a competitive nature. For these mothers the world was within reach. This contrasted with the perception of a mother with PND who felt disconnected and unfamiliar with her world.

Drawn from the interviews in this study, the central experiences of PND are described by the mothers as a feeling of low mood, helplessness, insecurity and uncertainty of themselves within their own mothering experience. Their perceptions were drawn from the challenges they experienced in unwanted and unanticipated situations. The mothers experienced a range of emotions with dominance in the negative dimension and which persisted for some time. Some mothers recognised their PND retrospectively. However, they were not always clear about the onset and end point, unless it was linked to a definite event or milestone such as the birth of the baby or breastfeeding.

Other mothers recognised a gradual slipping of mood and they attributed feelings of being overwhelmed to the continual demands of mothering. They felt unable to interrupt or stop the slipping into PND. This sense of helplessness and uncertainty prevailed. Significantly, this study shows that mothers in this situation had a bodily awareness of their emotional state and linked that feeling with their motherhood state and assumed that it was PND. As a consequence to naming their feeling as PND mothers felt they could own it and better understand themselves and commence recovery from the distress they felt; they were then able to structure a self-care/self-management plan.

From Merleau-Ponty's perspective embodying motherhood was a period of mothers' assessing and adjusting to their place in the world. For mothers in the study who experienced PND Merleau-Ponty would consider this a disconnect of the three orders of the body and a resistance to the flow of being in the world. The ambiguity within their situations obscured their take on the world that is they were reacting to. They were threatened by the immediate situation rather than embracing the experience as a time of growth. It was not possible to gain perspective (of their overall emotional state) until they had adapted to that situation. They were dealing with issues, and thus, their emotions, on linearly, or step by step, and this limited their perspective. As a result, they were viewing their situation from a narrow lens, rather than seeing their experience from a broader field and having confidence that in the scheme of things life would evolve with hope. Mothers who had experienced PND were unable to tolerate ambiguity. Living with ambiguity is not time dependent.



As is demonstrated in the study, and in comparison, with contemporary literature and the social media, the experience of PND is changeable and influenced by time, context and social situation. For mothers in this study identifying with PND was challenging as the typical features presented of it, along with typical antecedents, are the parameters with which they identify. Whilst this is true for them, in reality they are typically observing singular and discrete parameters. The parameters that are less obvious to them, but are indeed present, is where the challenge lies as the mothers are aware that something is wrong but cannot articulate this precisely. It becomes their physical manifestation that ‘speaks’ – their tears are tears about something. In the study mothers who perceived themselves as emotionally well, appreciated that daily life was not without its challenges; they did not expect a smooth journey. They were focussed on attending to mothering and integrating themselves with daily life in general.

Merleau-Ponty’s exploration of the body and embodiment gives opportunity for mothers to reflect on their own mothering experiences. The tears, the challenges, the despair they feel all are deeply personal to them and only they can create solutions. How their bodies react and respond to their difficulties and how they express their emotions are personal and unique.

The findings of this study are supported by Highet et al. (2014) whose qualitative grounded theory study highlighted that the mothers’ experience of PND were from a loss of sense of self and frustration. A loss of sense of self was developed from the maternal bodily changes established in pregnancy, progressed through the postpartum period and considered the adjustments required to accommodate the needs of the baby. Frustration experienced in the perinatal period related to negative experiences of pregnancy, infant difficulties related to care and partner disagreement. Highet et al. (2014) study findings emphasise that some of the mothers had negative feelings towards their experiences of motherhood. This is contrasted with the findings of the current thesis where mothers did not express a preoccupation with the physicality of pregnancy and motherhood nor with problematic partner relationships. Mollard’s (2014) qualitative meta synthesis put forward a suggestion that PND is a sequenced process which begins with crushed maternal expectations, and progresses to a mother ‘going into hiding’, her loss of sense of self and this results in intense vulnerability. This study identifies that the challenges mothers recognised were based on reconciling the unmet and physical realities of their birth experience and

breastfeeding, not feeling supported by health professionals, not being secure in their mothering skills, being overwhelmed by the physical demands of the baby, the uncertainty of the immediate future and being worn down by daily life activities. The mothers found that these factors by themselves were manageable, however when a number of them occurred simultaneously their moods and coping strategies were tested and contributed to self-doubt and uncertainty. A mother in this heightened state of self-awareness questions herself (her sense of self) and her self-efficacy. Her being in the world is a fragmented and vulnerable presence, in a state of disharmony, not in synchronicity with herself. She disembodies herself further to cope with the physical demands of her situation. As Merleau-Ponty would suggest this is a disruption of the three orders of the body (mind, body, and world). He would say that despite this appearance of disruption, this forced opening up to experience, although challenging, allows her to grow. Her integrity and purpose remain.

### **9.3 Validating perceptions of emotional wellbeing – the role of the body in perception.**

The study results show that measuring emotional wellbeing is largely a personal process which mothers assessed within themselves. The degree of their perceived vulnerability lay in their feelings toward their babies along with their own perceived satisfaction of themselves in their birth and breastfeeding journeys. How they integrated the activities of mothering involved not only addressing the tasks of mothering, but also how they expanded and developed their own sense of self. This development of self within a community of other mothers was an important source of strength for them. They valued younger mothers who had contemporary knowledge and practices, rather than older mothers (grandmothers) whose advice may have been outdated. They felt they could not compare their own experiences with those of another generation. Yet the wisdom of the older mother was something that they appreciated in the context of not ‘interfering’ with decisions about the baby, and in recognising the supportive role the older woman played in general family life. Mothers recognised that the experience and wisdom of the older mother was important in providing a context of what ‘normal mothers do’. The older mother seemed to provide a background security when needed. This valuing of a present generation of sharing the same experience (of giving birth) as opposed to the value placed on the older maternal

figures within a family unit is an interesting notion and worth exploring through a perceptual lens. What (preconceived) beliefs lie within mothers that lead them to perceive that current lifestyle is a valid source of reason? Perhaps it is the perception that contemporary society and lifestyle dictates better practice and a shared experience, rather than seeking counsel of ones whom may have faced the same feelings of inadequacy during a time gone by. Perhaps the perception is that a new personal experience cannot be understood by one who may have had a similar experience in another time context?

The perception of positive coping may be understood in physiological terms through the homeostatic mechanisms of the body. When the body is in harmony mothers do not think about their body, it is in automatic perceptive action. Mothers adjust their mothering activities to that which is the most important at the time. In this study mothers measured their emotional wellbeing in response to the presence or absence of particular feelings or emotions, the presence of particular manifestations and the feeling they felt toward their baby. Their balanced perceptions gave clarity to their emotional wellbeing. This is supported by Verbiest et al. (2018) who elevated mother's voices for improved patient-centred postpartum care in the 4th trimester project. Mothers engaged in a minimum of 13 interactions, a combination of online and face to face meetings with the health professional about all aspects of the postpartum experience from the mother and baby perspective. Topics included managing sleep and night-time parenting to body weight and body image.

In the current study mothers who identified with having PND were mindful of their feelings and behaviours and some, in order to deflect attention from their vulnerability, focussed great attention on the baby (and toddler), rather than on themselves, at that time. Their wish was to leave a positive impression of themselves on the baby and others. In this, in order to cope, they made an effort to suppress or mask their distress. Their motivation was to present a positive demeanour to their baby and to the outside world to provide a fair opportunity for optimal growth and development. Social awareness of PND highlights that mothers with PND are at risk of neglecting their baby. This study showed that mothers with PND did not neglect their babies, in fact they felt strongly bonded to them. Grissette et al. (2018) suggest that perceived susceptibility and perceived severity of PND symptoms, together and separately are significant factors in perception of the benefits and barriers to seeking

help. From Merleau-Ponty's perspective indicators of susceptibility and severity are associated with the body and shows that mothers have an awareness of their physical capabilities and are able to judge the level of support they require. Perception of vulnerability to PND plays a significant role in the way mothers respond to their feelings. Hadfield and Wittkowski's (2017) qualitative systematic review of women's experiences of seeking and receiving support for PND highlight that mothers engage in a systematic process of help-seeking and that voluntary self-referral has better outcomes than referrals made by health professionals. Perception of stigma remains a significant barrier to seeking support for PND (Button et al., 2017; Grissette et al., 2018; Hadfield & Wittkowski, 2017).

Mothers who self-identified with PND and pursued a clinical diagnosis recognised their need for medical support because their feelings were interfering with their mothering. Whilst this process was independent of the EPDS, the mothers felt understood and respected and trusted the judgements of the medical practitioner. A consistent theme in Hadfield and Wittkowski (2017) systematic review of 17 qualitative studies drew out that a valued relationship with the healthcare professional was significant to recovery.

In this study mothers perceived their state of emotional wellbeing through the lens of self-reflection. Having undergone this introspective analysis they gauged their level of vulnerability within their mothering role against their own beliefs and values, how they felt toward their baby and the physical challenges they endured. The timing and context of reflection were significant to this. Time and context of reflection were significant elements influenced by events and the physical demands of that event, such as the birth which involves physical and emotional parameters that are shaped by social influences.

#### **9.4 Mother's perceptions and experiences of PND identified through the use of the EPDS.**

The adoption of universal screening for PND was intended to improve detection rates of mothers at risk of developing PND. This study shows that mothers have limited participation in PND screening, not all mothers were offered the screen, and not all mothers wished to participate in screening. Mothers felt conflicted and uncomfortable about attending to their own emotional wellbeing in appointments that

were designated as child health assessments. Furthermore the time constraints of appointments did not allow a mother to fully disclose her emotional situation. The mothers felt that a focus on completing a questionnaire and being give a score was inappropriate; they felt they were being ‘tested’ on their mothering abilities not on their emotional wellbeing. The process of engaging in this was believed to be for health reporting requirements and not for them personally.

Whilst the EPDS screening is for PND risk it assesses both anxiety and depression, as other emotions are considered that emphasise depression. The total score reflects a risk but not a diagnosis of PND. The women in the study considered that the questions were not in context to motherhood, nor were they discussed in the child health appointment. The mothers did not disclose their true feelings at administration of the EPDS to the child health nurse. Some mothers downplayed their emotional responses by alerting the child health nurse to their fragile state after the completion of the screen. Some mothers relied on the EPDS score to confirm their suspicions of having PND. This scenario was complex: they felt validated that their suspicions were well founded but this also provoked anxiety. The EPDS as a screening tool for perinatal anxiety has also been investigated by researchers (Swalm, Brooks, Doherty, Nathan, & Jacques, 2010).

The EPDS only captures some emotions whilst others such as anger are not considered. In the study mothers who said they had PND, manifested as crying, expressions of anger, feelings of isolation and disconnection from their peers. These symptoms and signs align with the *DSM-5* diagnostic criteria. The mothers who did not have PND also experienced some of these manifestations without progressing to a depressive state.

The EPDS is an adequate screen provided that the user is compliant with the requirements such as review in 2 weeks’ time, repeat of the EPDS after 2 weeks and referral to psychological or psychiatric services. Unfortunately, providing maternal emotional care is inadequately funded to allow these requirements to occur. This is further complicated by the falling numbers of privately insured mothers. The significance of health professional interaction with the mother cannot be underestimated. An inductive approach to health care appointments ensures that the focus of care remains mother-centred rather than a perception that the appointment is

to facilitate the collection of data for statistical purposes. Mother-centred care ensures that the mother is supported throughout her first 12 months after giving birth.

The questions in the EPDS are not connected to a theme and are discrete from each other. In some of the items the content creates confusion in what is being measured. The content varies making a judgement between emotion and/or cognitive process and/or behaviour. Furthermore the content directs superficial responses towards an assumed norm, there is no qualification for the response given. The assumption is that happiness is categorical and thus by default so too is PND. That is, it is an 'either/or' situation. This subjectivity implies an ambiguous judgement of outcome.

Participants aspire to an ideal or belief that may or may not have been reached. In some of the items of the questionnaire there are two concepts that could be rated and the emphasis can be weighted either way by the subject responding to the question. The judgement made on the question is an arbitrary response. For example, 'I have felt scared or panicky for no good reason'. Ambiguity also exists in terminology and people's use of vocabulary may not be consistent in meaning, for example the word 'coping' can hold varying meaning, coping for one mother might mean being up to date with home duties as compared to another mother who may hold coping to be 'I can't stand this pressure of being the perfect mother and I want out'. Thus the item question in the EPDS 'Things have been getting on top of me' can relate to managing a physical situation only, emotional situation only or both. Essentially nine of the ten items seek to grasp an emotion on a singular inquiry, the final item seeks a judgement on intention to self-harm and sets it in isolation to the previous items. The emotional state of the person is judged according to the placement of an arbitrary numerical value. The questions would better serve as the basis of discussion, based on the cultural and social settings from which the participants derive, but because they were taken at face value they resulted only in a score being given which cannot reflect a cultural and social implication. Further, the score, while it is a number remains arbitrary and influences whether discussion is undertaken or not and the person taking the screen can be dismissed if the score is high or low indicating functioning well. In reality the score does not reflect the truth or the affective component of the individual. The content varies making a judgement between emotion and/or cognitive process and/or behaviour. Furthermore the content directs superficial responses towards an assumed norm, there is no qualification for the response given.

Despite the limitations of the EPDS it is universally adopted and thus researchers are focussing on ensuring that health professionals have adequate training in administering the questionnaire (El-Den et al., 2015; Milgrom & Gemmill 2014). Milgrom and Gemmill discuss the implications of the EPDS scoring and the probability of PND developing, this is a very different perception to the commonly held view of the EPDS, that is, that it will identify those at risk of PND. These authors acknowledge that it will take many research years to develop an appropriate evidence based for PND screening and thus agree that it is better to use a tool such as the EPDS that will serve some of the population. If the tool is considered inadequate what can the Health System offer as a substitute? Will a personal interview improve the situation at all?

## **9.5 Dispelling the myths of the antecedents of PND.**

Predicting PND using recognised (reported in the literature and practice) antecedents, (such as birth experience, breast feeding difficulties, previous history of depression, poor social support) is not definitive. Birth and breastfeeding difficulties were common experiences to mothers whether or not they had experienced PND. Mothers who had a prior history of depression had developed a sense of awareness with regard to factors which they knew to influence their mood. Consequently they were responsive to their own emotional or physical needs. All mothers were supported by their partners and families throughout birth and the first year postpartum (and beyond). All mothers developed a sustaining and enduring peer network.

Theoretical and research literature suggests that particular antecedents (for example, birth method, planned or unplanned birth outcomes) are associated with PND. However, these antecedents also manifest in mothers who do not experience PND. Whilst there may be similarities in the physical/physiological/psychological experiences of the mother in particular situations, the differences lie in mothers' unique engagement with the world. Such differences are explained through embodiment, and influenced by particular aspects of the social setting. The social world is replete with inherent values that affect the individual. Privately a mother compares her lived experience with others who hold the same experience or emotion as herself. She seeks to understand her own emotions through the actions and interactions of other mothers (with their babies). A self-judgement of having or not having PND needs to be examined in terms of social understandings, comparison and

perceived risk in relation to emotional wellbeing in the first 12 months following birth. Mothers because of particular experiences (for example, birth and breastfeeding) perceive themselves as having experienced the 'recognised' risks of PND. The focus of their responses are influenced by social perceptions. This is evidenced by sociological theories and research on mothering, where mothers express beliefs and perceptions of their transition into motherhood and identify with labels of being a good mother versus a bad mother based on their judgements from society. Such concepts of labelling exist in the world and mothers who may experience vulnerability are reluctant to disclose this vulnerability for fear of stigma and carrying a lifelong label of having a mental illness. To them, being assigned a label of PND makes them feel they have failed (as a mother). This impacts a number of issues including, honesty to self, honesty to others, seeking support, confidence and their engagement with others outside their family unit. A mother formulates her beliefs from the world, that is, she formulates her ideas of what PND is from the stories she hears, things she reads, the conversations she has with others, and what she observes in other mothers, and develops a sensitivity to her feelings and responses which becomes her foundation for noticing similar or different behaviours in herself.

The findings of the study showed that mothers, irrespective of whether they had PND or not, experienced challenging situations and circumstances that related to the birth experience. These included unplanned and unexpected birth outcomes and a difficult birth. Some research has demonstrated that there is no association between the type of birth and risk of PND (Bell et al., 2016; Bahadoran et al., 2014; Faisal-Cury & Menezes, 2018). However, Bell and Andersson's (2016) systematic review on the birth experience as a predictor for women's postnatal depression suggests that a negative birth experience may contribute to PND. A negative birth experience was perceived to be associated with the extreme physicality of the birth experience and included a prolonged labour and an unexpected outcome, intense unrelenting and unexpected labour pain, fatigue and weariness and being required to give attention and care to the baby while being exhausted. The findings of this thesis are supported by Waldenstrom and Schytt's (2009) study which identified that mothers with a negative birth experience remember specific details of the events.

In this study (and in relation to the birth experience) the notable differences between mothers who had or did not experience PND centred on the care and attention



directed to them during the birth event. Mothers who experienced PND commented that their wishes and decisions were not taken into account at the birth event, they did not feel fully informed and listened to by staff and that health professionals did not provide positive personal support. In contrast, mothers who did not experience PND commented that they were treated as an active participant who could determine and negotiate in their own processes of care. In this they felt they had been respected, recognised and acknowledged dually as individuals and partners in care. This finding is supported by Hildingsson's (2013) study which identified factors that led to women's satisfaction in the birth experience, and thus did not lead to PND were support, active participation in decision making, and feeling respected and nurtured. For the mothers who experienced an unexpected, unplanned and difficult birth experience and identified with having PND they commented on their unmet expectations of the birth experience. Hildingsson's (2015) study draws on the antenatal expectations and how closely these align with their fulfilment of the birth. Furthermore, Lambert et al.'s (2018) study exploring mothers' experiences during labour and birth demonstrated that mothers felt alone and unsupported in their birth experience. Whilst the healthcare professionals have an understanding of quality health care delivery the women did not experience this during their labour and birth experience.

Breastfeeding difficulties are also reported in the literature as a predictor of PND. The findings in this study that both mothers who did and did not perceive themselves to have PND experienced breastfeeding difficulties. For the emotionally well mother mothers who experienced breastfeeding difficulties and were unable to breastfeed easily decided very early in the postpartum period to switch to bottle feeding. These mothers saw this change as an opportunity for all family members to be involved in baby care. Critically, for the mothers with PND who persisted with breastfeeding experienced ongoing difficulties and required ongoing support for the duration of the time of breastfeeding. The cessation of PND was when they made a decision to stop breastfeeding. Some mothers with PND accessed breastfeeding support at the time they sought medical care for their own emotional health. Other mothers with PND experienced no difficulties with breastfeeding and recognised themselves for this achievement. The recognition of this achievement was not enough to balance out their previous disappointments. Dias and Figuerido's (2015) systematic review on breastfeeding and depression shows an association between these factors

but recommends further research in this area. Negative social influences on public breastfeeding prevail and whilst there is legislation permitting public breastfeeding, in the study mothers were mindful about facilitating others to bond with their baby and in fact mothers who breastfed choose to bottle feed in public.

In this study all mothers had a supportive partner and family. The lack of maternal support, and the absence of a quality partner relationship are consistently recognised in the literature and health setting as a risk for PND. This study finding is atypical of the research literature.

Prior history of depression is regarded as a significant risk factor for PND in the literature. In this study some mothers with a prior history of depression experienced PND whilst others did not. The mothers who regarded themselves as emotionally well took account of the patterns of their emotions and used them as a point of reflection. They were aware that their low feeling and withdrawal from others was a temporary state. The mothers who experienced PND accepted that this may be a likely outcome because of their prior history, these mothers reflected an indication of risk on the EPDS. In this instance Milgrom et al. (2010) account of scoring and the probability of depression concur.

Health professionals have accepted recommendations from research literature as predictors of PND. This approach is limiting as it assumes a one size fits all approach rather than considering a holistic individualised lens. When the antecedents are presented as categories there is risk of presenting a disembodied interpretation of mothers' wellbeing. A holistic view on the other hand would consider a unified intertwined view that is individually based. Mothers would seek and receive care that is relevant to their situation and not one that is a generalised approach that cannot be adapted to suit them.

## **9.6 Summary**

For the mothers in this study PND and emotional wellbeing were determined by their own responses to situations they had experienced. For some, a self-diagnosis of PND named and validated their own feelings and perceptions of coping and thus they self-managed. For others, a clinical diagnosis of PND was accessed when they saw no improvement in their own mood and their situation do not seem to be

improving. These mothers sought medical care essential for emotional recovery. All mothers, irrespective of their emotional wellbeing, were able to recognise and respond to their personal level of situational tolerance; their threshold of intolerance motivated their actions to re-adjust and rebalance their experience.

Mothers recognised within themselves particular signs and manifestations of PND. These included crying, repressed and expressed anger (toward self and others), a low mood and being worn down by their situation. Mothers judged themselves not to have PND based on their feeling toward their baby. That is, when they enjoyed the baby and had a positive relationship with her, mothers judged their situation as a normal adjustment to mothering.

All mothers irrespective of emotional wellbeing, whether self-diagnosed with PND or not coping, clinically diagnosed with PND or emotionally well, had a positive regard for their baby. Mothers who had experienced PND expressed that they had never had any thoughts or actions of wanting to hurt or harm the baby or themselves. All mothers had an unconditional expectation to bond with their baby at birth. For mothers who experienced PND the absence of this bond was magnified and complicated by unwanted events.

Mothers who had reported feeling anger felt they were disempowered by their situation and felt they did not have a voice in directing the situation. They sometimes felt that their choices were taken from them. Other mothers identify with a woman suffering with PND through her self-imposed isolation. The disconnect is a subtle disengagement on an emotional level, not necessarily embodying the withdrawal by physically isolating herself from social events, although some mothers may have done this too.

Emotional wellbeing involves self-awareness, self-knowledge, social awareness and social knowledge. Self-awareness and self-reflection are recognising differences and feelings within oneself; it is both a revealing time and transforming time of growth. She may not realise the pressure she is placing on herself or be aware of her feelings. There is no timeframe for her understanding. It seems that a self-diagnosis of PND acknowledged the mothers' discontent at facing a situation that happened 'to them', and by giving their story a voice they recognised there was hope of recovery. By attributing that feeling to PND, knowing that others had lived it,

provided her with her own hope that she could transcend the distress she felt. She maintained her intentions to be a good mother. Without a clinical diagnosis of PND she keeps a part of herself invisible to the world, she presents an outward appearance of coping while inwardly vulnerable. It is as if she perceives herself as performing two distinct roles, one of what the world sees and one of what she feels. She is not able to make a change.

## **9.7 Conclusions**

Viewing maternal embodiment through the lens of Merleau-Ponty gives an understanding of the experiences of mothers' adaption to motherhood. Appreciating that motherhood requires daily adaption is important for the mother and her baby. The sense of getting to know oneself in a new role, as well as understanding the developmental needs of a new baby may be both a beautiful and enriching experience as it may be despairing and overwhelming. Understanding maternal emotional wellbeing requires a holistic viewpoint. An examination of the self-in-the-world and the world-in-the-self provides such a viewpoint. The resonance of self-and-the-world (society) highlight for the mother the reality of becoming a mother. Her bodily experience and lived experience are shaped by societal norms and expectations. The constant shaping and reshaping of mothering is a dynamic process for the individual mother and the world (society). The responsibility of society is to foster a constructive understanding of mothering rather than highlighting the mental health risks of having a baby.

Predicting PND using recognised (reported in the literature and practice) antecedents, (such as type of birth, breast feeding difficulties, previous history of depression, poor social support) is not definitive. Birth and breastfeeding challenges were common experiences to mothers whether or not they had experienced PND. Mothers who had a prior history of depression had developed a sense of awareness with regard to factors which they knew to influence their mood. Consequently they were responsive to their own emotional or physical needs. All mothers were supported by their partners and families throughout birth and the first year postpartum (and beyond). All mothers developed a sustaining and enduring peer network. Therefore, it cannot be said that these factors predict PND.

Mothers defined their PND as an emotional reaction to circumstances that were unplanned, unexpected and difficult and that were unrelenting. They felt helpless, insecure and uncertain of themselves within their mothering role and believed it was something they had to overcome. The study suggests that there are vulnerable phases for mothers in the first year postpartum and that to promote adjustment and adaptation to her situation a reciprocal interaction between health professional and the mother exists. The focus of care should always be humanistic and attentive to the mother's (and baby's) needs. There must be opportunity for discussion, acknowledgement of feelings, coping, and maternal capability which encompasses knowing herself and her baby. Therefore, the modern PND should be regarded as an opinion a mother places on herself, not a universally accepted concise phenomenon.

Mothers who experienced PND did not base their self-diagnosis on the results of the EPDS screen. In universal screening for PND mothers take account of the numerical score rather than the descriptive indicators of wellness. Whilst it is assumed that all mothers are offered the screen at designated times in the first year postpartum many in this research reported they had not been offered this. The EDPS needs to be reinvented.

Universal screening for maternal wellbeing should be predicated on discussion and authentic interaction between healthcare provider and mother, not simply a data collection tool to satisfy health statistics. Furthermore dedicated time, separate to the child health visit, should be invested in this process.

### **9.7.1 Recommendations for practice**

The results of this research put forward the following recommendations for practice, that:

1. Health professionals should focus on promoting mothers abilities to transition to motherhood. It is important to normalise rather than pathologise maternal emotional responses and mothering behaviours.
2. Mothers are encouraged to consult with their general practitioner, midwife, or child-health nurse regarding their health needs, for example emotional well-being or parenting requirements throughout the first year postpartum.

3. Health professionals (midwives, obstetricians, general practitioners, paediatricians, and child health nurses) should actively listen to the needs of the mother and provide appropriate support and education regarding transition to mothering. Health professionals must ensure that they engage and interact respectfully and positively without preconceived assumptions with all mothers as whole people rather than only a screening process.
4. Care and education, equivalent to that provided in the antenatal period, is also provided in the postnatal 12 months.
5. In the first year postpartum, a meaningful conversation, between mother and health professional, about emotional wellbeing and transitioning to motherhood occurs concurrently with the completion of the EPDS screen. This will give mothers an opportunity to reflect on their situations and to promote discussion.
6. Websites, such as the Centre for Perinatal Excellence (COPE), Beyond Blue and raisingchildren.net.au, which discuss and promote support for parental adaptation, continue to be widely publicised and available to mothers. This should include the use of multilingual resources.
7. Positive antenatal and postnatal education should include the discussion on the range of emotional responses mothers may experience in the first year postpartum.
8. A balanced emotional perspective of motherhood should be provided to future generations through health education programs in schools.
9. The antenatal care provider should inform mothers in greater detail of the physical preparation for and the demands of the labour, birth and recovery. As each birth is unique it is important for mothers to understand the physicality of labour and birth, and the unpredictability of each event.
10. Mothers should be co-collaborators in their own care decisions so that when mothers encounter unexpected or unwanted birth and breastfeeding challenges they are able to share in decision making regarding their own health care plan. For example, women who undergo unplanned caesarean section or challenges in breast feeding should benefit from being supported to make suitable choices for mother/baby wellbeing.

11. Mothers should be given an opportunity to debrief their birth experience with the health care professional attending the birth, prior to discharge from care. This may occur between the periods of birth and 6 weeks postpartum depending on their health care provider and the mother's birth experience.
12. The EPDS screening process should ensure that mothers whose scores are at risk are followed up with a referral to a health profession (GP, psychologist or counsellor) and that the process is tracked to ensure that the referral takes place.

### **9.7.2 Recommendations for research**

The following recommendations for further research are:

1. An exploration of factors and/or interventions that support mothers in coping with unexpected and unplanned birth events.
2. An exploration of exercise and/or intervention programs to improve mother's physical wellbeing in the antenatal period to better prepare them to cope with the physical aspects of the birth itself and the transitions in the postpartum period.
3. Enhancing health professional training and supervision of the EPDS to ensure that communication is compassionate, culturally sensitive, and non-judgmental.
4. A comparative trial of different screening tools for assessing emotional wellbeing in the postpartum 12 months is undertaken.

*Tell me and I will forget  
Show me and I may remember  
Involve me and I will understand*

(Confucius)

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## APPENDICES

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# Appendix A

## Advertising the Study

### Seeking Mothers Who Have Given Birth Twelve Months Ago and Within the Last Six Years



**My name is Anna Bosco and I am currently undertaking a PhD study through the University of Notre Dame Fremantle, School of Philosophy and Theology.**

I'm interested in postnatal natal depression and would like to talk with women who have had a baby no less than 12 months ago but no more than 6 years ago. As part of this study I am very interested to speak with women who may have experienced Postnatal depression (PND) or not in the first 12 months following the birth of your baby.

**The information could help future women in their role as a mother.**

#### **Are you interested?**

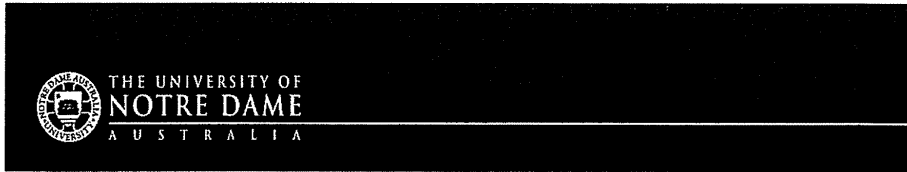
To talk about your experiences you will be invited to participate in a focus group or individual interview.

#### **Want to know more?**

Please contact me, Anna Bosco on 041 772 1878 or  
Email at 20114153@nd.edu.au

# Appendix B

## Information Sheet



### Information Sheet to Prospective Participants

Dear Participant,

My name is Anna Bosco and I thank you for your interest. This study is being conducted as part of my Doctor of Philosophy thesis at the University of Notre Dame Australia

#### What is the study about?

This research is designed to gather information about women, who either experienced or did not experience postnatal depressive symptoms. The experience of pregnancy, childbirth and childrearing can be a different experience for every mother. I am interested in the experiences of women who have given birth to a baby 12 months and within the last six years. The purpose of the study is to describe the experience of women who may or may not have experienced postnatal depressive symptoms following the birth of a baby.

#### What would I have to do?

You have the choice of participating in a focus group interview with other mothers to talk about your experiences or on your own with me. As part of my study I plan to conduct two group interviews with women who *have had* PND symptoms and two group interviews with women who *have not* experienced PND symptoms. Within these specific groups you will be invited to discuss your experiences of PND, or not experiencing PND. The focus group interview will take approximately 1 hour and will be tape recorded.

Prior to the focus group you will be asked to complete a survey which will ask some information regarding your age, number of children etc. If you volunteer to take part in a one on one interview this will provide you with the opportunity to expand on your discussion in the focus group. This will also be tape recorded.

#### Will all the information remain confidential?

Please be assured that confidentiality will be maintained at all times. The audiotapes and information collected will be stored in a secure place. Only myself and my supervisors will have access to this information. Participation in this research is entirely your choice and you can withdraw at any time.

- o Before starting the focus group/one-on-one interview you will need to read and sign a consent form indicating your willingness to participate.
- o Only myself and my University Supervisors  
\_\_\_\_\_ will have access to the data. You can contact either of these supervisors if you wish.
- o You will not be identified in any report or publication related to the study.
- o A number will be assigned to your details so that I will be the only person who will know your actual name.
- o The tapes and transcripts related to the focus group and interviews will be stored in a locked cupboard in the researcher's office.
- o All tapes and transcripts will be password protected in the researcher's computer. All tapes and transcripts will be destroyed on completion of the study

**What if I need to bring my child with me?**

It would be advisable if you could ask a family member or friend to care for your child whilst you are involved with the focus group or interview so that you can commit fully to the sessions. If this is not possible the intended venue will be safe and secure for the children. Refreshments will be provided, however please state if your child is not allowed or perhaps allergic to certain foods or drinks. Please bring your child's favorite toy and I will provide crayons, paper etc. The one-on-one interview can be conducted at a location convenient to you including your home.

**Are there any risks and benefits of participating in the study?**

- o This study will further contribute to knowledge and practice of healthcare professionals to understand the strategies women use to manage their postnatal experience. It will assist other women preparing for the birth of their baby.
- o If during the interview you feel uncomfortable or distressed during the group session I will take every opportunity to speak with you quietly on your own after the session. But if you wish to leave the session you are able to do so. A safe, compassionate supportive environment will be provided.

**What will happen to the information collected?**

- o Results from this study will be used to inform midwifery health care practices and help others mothers to develop coping strategies and to enhance well-being following the birth of a baby.

- Results may be published in scholarly journals or project reports or presented at conferences. Again, please be assured that you will not be identified in any of these publications.

**Has the study had official clearance?**

Yes it has. This research has clearance from the Human Research Ethics Committee (approval reference 013133F) of the University of Notre Dame Australia, Fremantle. Should you have any enquiries regarding the ethics of this research, you may contact me on the following email:

- [20114153@nd.edu.au](mailto:20114153@nd.edu.au) or phone 9266 2204 (office hours) or 041 772 1878 (after hours)

or Academic Supervisors:

- Dr Richard Hamilton at email [richard.hamilton@nd.edu.au](mailto:richard.hamilton@nd.edu.au) or telephone 9433 0139 (office hours)
- Dr Catherine Ward at email [catherine.ward@nd.edu.au](mailto:catherine.ward@nd.edu.au) or telephone 9433 2249 (office hours),

If participants have any complaint regarding the manner in which a research project is undertaken, it should be directed to the Executive Officer of the Human Research Ethics Committee, Research Office, The University of Notre Dame Australia, PO Box 1225 Fremantle WA 6959, phone (08)94330964, [research@nd.edu.au](mailto:research@nd.edu.au)

Thank you in anticipation of your time in participating in this study.

Anna Maria Bosco  
PhD Candidate  
The University of Notre Dame Australia

# Appendix C

## Consent



**Perception, the body and embodiment, applying Merleau-Ponty's philosophy to unravel the conundrum of postnatal depression**

### INFORMED CONSENT FORM

I, *(participant's name)* \_\_\_\_\_ hereby agree to being voluntary participant in the above research project.

- I have read and understood the Information Sheet about this project and any questions have been answered to my satisfaction. I understand that this consent form will be retained by the researcher.
- I understand that I may withdraw from participating in the project at any time without prejudice.
- I understand that I will be audio-taped.
- I understand that all information gathered by the researcher by tape recording and transcript will be treated as strictly confidential, except in instances of legal requirements such as court subpoenas, freedom of information requests, or mandated reporting by some professionals.
- Whilst the research involves small sample sizes I understand that a code will be ascribed to all participants to ensure that the risk of identification is minimized.
- I understand that the protocol adopted by the University Of Notre Dame Australia Human Research Ethics Committee for the protection of privacy will be adhered to and relevant sections of the *Privacy Act* are available at <http://www.nhmrc.gov.au/>
- I agree that any research data gathered for the study may be published provided my name or other identifying information is not disclosed.

<b>PARTICIPANTS SIGNATURE</b>		<b>DATE:</b>	
<b>RESEARCHER'S FULL NAME:</b>	STUDENT: ANNA MARIA BOSCO (SUPERVISOR: DR RICHARD HAMILTON, DR CATHERINE WARD)	<b>DATE:</b>	
<b>RESEARCHER'S SIGNATURE:</b>		<b>DATE:</b>	

*If participants have any complaint regarding the manner in which a research project is conducted, it should be directed to the Executive Officer of the Human Research Ethics Committee, Research Office, The University of Notre Dame Australia, PO Box 1225 Fremantle WA 6959, phone (08) 9433 0964.*

# Appendix D

## Demographic Survey



Please respond to the following questions by ticking the box or writing your response in the space provided.

The information you present will remain anonymous and confidential, an identifying code will be assigned to this questionnaire.

1. What is your current age?

- 1. 20 years or
- 2. 21-25 years
- 3. 26-30 years
- 4. 31-35 years
- 5. 36-40 years
- 6. over 41 years

2. Can you describe the type of birthing/delivery experience you had?

- 1. Normal delivery (vaginal)
- 2. An elective caesarean section
- 3. An emergency caesarean
- 4. A forceps delivery
- 5. A vacuum extraction
- 6. Other: \_\_\_\_\_

3. Did you have any pain relief during childbirth?

- 1. Yes
- 2. No

What type of pain relief did you have?

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4. How many times have you been pregnant (including miscarriages)?

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5. How many children do you have now?

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6. What is the age of your child/children now?

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7. What level of education did you complete?

- 1. High School  go to question 9
- 2. TAFE qualification  go to question 9
- 3. University degree  go to question 8

8. What is your marital/partnership status?

- 1. Married
- 2. Single
- 3. De-facto
- 4. Other: \_\_\_\_\_

9. What is your employment?

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10. What is your role?

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11. Which sector do (did) you work in?

- 1. Public
- 2. Private
- 3. Voluntary
- 4. Other: \_\_\_\_\_

12. Do you work (now):

- 1. Full-time
- 2. Part-time
- 3. Don't work

13. If you are employed outside the home, how old was your child when you returned to work?

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14. Any other comments

End of questionnaire  
Thank you for your assistance your support is greatly appreciated.



## Appendix E

### Interview Questions

Category	Participants who did not experience PND	Participants who did experience PND
<b>First 12 months</b>	How did you feel being pregnant?	How did you feel being pregnant?
	How did you feel in the first 12 months following the birth of your baby?	How did you feel in the first 12 months following the birth of your baby?
	Have you always wanted to have a baby and be a mother?	Have you always wanted to have a baby and be a mother?
	Did reality meet expectations?	Did reality meet expectations?
<b>Coping and emotions</b>	Describe how you coped with life after you had your baby?	Describe how you coped with life after you had your baby?
	Did you always feel happy during the first 12 months?	Did you always feel sad during the first 12 months?
	Did anything make you feel sad?	Did anything make you feel happy?
	What did you do for yourself as a person, rather than for your partner and children?	What did you do for yourself as a person, rather than for your partner and children?
<b>Screening process</b>	How did you feel about the screening process for PND?	How did you feel about the screening process for PND?
<b>Social and cultural</b>	Do you think your cultural background or social circumstances were an influence? How?	Do you think your cultural background or social circumstances were an influence? How?
	Did you engage in activities to meet other mothers?	Did you engage in activities to meet other mothers?
<b>Work</b>	Did you work before your baby was born?	Did you work before your baby was born?
	Do you miss work?	Do you miss work?

## **Appendix F**

### **Managing Emotional Distress Arising in the Interview Process Management Plan**

1. Immediately cease the interview;
2. The researcher is to provide a safe, compassionate environment and allow the participant to express her feelings of distress;
3. Recognise any judgments or thoughts that may be troubling the participant, acknowledging her distress and inquire as to whether any actions could be undertaken by the participant or the researcher;
4. With permission, the researcher is to contact a friend or family member of the participant and the researcher is to share her concerns with the woman and to establish an immediate and ongoing point of contact for the participant;
5. Provide information relating to:
  - 24 hour telephone counselling numbers;
  - 24 hour crisis care services;
  - Mental health services of the nearest emergency department
  - GP support
6. The researcher is to conduct a follow-up phone call within 24 hours of the ceased interview to ensure an appropriate health follow up appointment is arranged by the participant, and a further follow-up appointment in three days following this, if required.

## Appendix G

### Participant Demographic Profile

This appendix presents the demographic information for all participants in the study ( $N = 26$ ). The information presented includes age, type of birth experience, methods of pain relief in childbirth, number of pregnancies and number of babies birthed, education level, previous employment, and age of infant when a return to work was initiated. Some of the items within the questionnaire were open-ended questions, however not all participants responded to these items. Missing data is reported as ‘99’.

Demographic data gathered for the whole group who participated in an interview was used to give a background perspective of the women’s childbearing history and birthing experiences ( $N = 26$ ). Table G.1 shows the age ranges of the participants. Results show a cluster of participants between the ages of 31 – 35 years and 36 – 40 years.

Table G.1  
*Frequency and percentage of participants in each age group*

<b>Age bracket</b>	<b>Frequency</b>	<b>Percent</b>
26-30 years	3	11.5
31-35 years	9	34.6
36-40 years	9	34.6
over 41 years	5	19.2
<b>Total</b>	<b>26</b>	<b>100.0</b>

There was an equal majority (34.6 %) of women in the 31 – 35 years and the 36 – 40 years age bracket, 19.2% reported being over 41 years of age, whilst 11.5% were in the 26 – 30 years. The frequency in the age brackets may have been a result of snowballing techniques where participants would have invited friends who by coincidence were the same age. This was not planned. This higher age bracket may also be indicative that women are more willing and more comfortable to share their stories than younger counterparts.

Table G.2

*Frequency and percentage of type of birthing experience reported overall type of birth for all participants*

<b>Type of Birth</b>	<b>Frequency*</b>	<b>Percent</b>
Normal delivery (vaginal delivery)	19	73.0
Emergency caesarean birth	7	26.9
Elective caesarean birth	5	19.2
Vacuum birth	2	7.7
<b>Total</b>	<b>33</b>	<b>126.8</b>

\* some participants had two children they discussed in the interview

The majority of women had a vaginal delivery (VD) (73%), followed by 26.9% of participants who had an emergency caesarean birth and 19.2% having an elective caesarean birth. Two participants had vacuum birth (7.7%). Of the women who had an emergency caesarean birth, five had elective caesarean births in their subsequent childbirth experience, and one had vaginal birth. One of the women who had an emergency caesarean birth had twins, while another participant who had a VD delivered a preterm baby.

Table G.3

*Frequency and percentage of pain relief during childbirth*

<b>Pain Relief</b>	<b>Frequency</b>	<b>Percent</b>
Yes	20	76.9
No	6	23.1
<b>Total</b>	<b>26</b>	<b>100.0</b>

The majority (76.9%) of the participants had pain relief during childbirth. Twenty three percent of participants did not use any prescribed methods of pain relief.

Table G.4

*Frequency and percentage of types of pain relief used during childbirth*

<b>Type of Pain Relief</b>	<b>Frequency</b>	<b>Percent</b>
Epidural	15	57.7
Pethidine injection	1	3.8
Gas	1	3.8
Range of pharmacology's	1	3.8
Non pharmacological	3	11.5
Missing	5	19.2
<b>Total</b>	<b>26</b>	<b>100.0</b>

More than half of the participants (57.7%) had an epidural administered during childbirth, 11.5% of the participants used non-pharmacological methods of pain relief including hypnobirthing, water birth, TENS machine and breathing techniques. Three individual participants reported needing only a pain injection, gas or a combination of these methods.

Table G.5

*Frequency and percentage of number of pregnancies (including miscarriages)*

<b>Number of pregnancies</b>	<b>Frequency</b>	<b>Percent</b>
1	2	7.7
2	8	30.8
3	12	46.1
4	2	7.7
5	1	3.8
7	1	3.8
<b>Total</b>	<b>26</b>	<b>100.0</b>

Two of the participants had only one pregnancy. Ten participants (38.5%) experienced a pregnancy loss (miscarriage). Of these 10, one participant had experienced two pregnancy losses, and two participants had experienced three pregnancy losses. Of these participants who had experienced a pregnancy loss, only one of these participants identified having experienced PND symptoms. This participant experienced her first pregnancy loss with her first pregnancy.

Table G.6  
*Frequency and percentage of number of times babies birthed*

<b>Number of babies</b>	<b>Frequency</b>	<b>Percent</b>
1	4*	15.3
2	14	53.8
3	6	23.0
4	2	7.7
<b>Total</b>	<b>26</b>	<b>100.0</b>

Three of the participants were first time mothers having birthed a single baby, one of the three first time mothers had given birth to twin babies. Two of the participants (7.7%) had birthed their baby overseas, in their country of origin. One of these two participants was temporarily residing in Perth WA with her husband who was employed on a 457 visa. For this woman (and couple) it was too expensive to birth her baby in Perth and thus decided to return to her country of origin and returned to Perth 6 weeks following the birth.

In total the participants had birthed 59 children, the average age of the children was four years, median age was 4.4 years, and the mode was one year. The baby age distribution of all children was <6 months to 12 years. Those participants who had toddlers and a baby less than 12 months at the time of interview were not asked about their baby less than 12 months of age.

Fourteen participants had a University qualification (53.8%), 7 (26.9%) had a technical and further education qualification, and 5 (19.2%) had a high school certificate. Twenty-two participants (84.6%) were married, one (3.8%) defacto and three (11.5%) did not report a marital status.

Twenty participants reported being employed in a professional capacity (77%), 6 (235) identified as being stay at home mothers. Those employed came from a variety of professions including, nursing, audiologists, marketing, book keeping/finance and administration, project work and research. Eleven participants were employed in the public sector (42.3), 14 (53.8%) in the private sector and one (3.8%) not for profit sector. Two (7.7%) were employed on a full-time basis, the majority worked part time (n = 12, 46.1%), while 10 (38.5%) were stay at home mums. One participant (3.8%) was employed on casual basis, and one (3.8%) was currently on maternity leave.

Fourteen participants returned to work (53.8%) compared with 12 participants who never did (46.1%). Of the participants who returned to work on average they returned to work approximately 12 months following the birth of their baby. The range of time of return to work was from the birth of the baby to 3.5 years following the birth.

## References

- Ahmed, A., Stewart, D., Teng, L., Wahoush, O., & Gagnon, A. (2008). Experiences of immigrant new mothers with symptoms of depression. *Archives of Women's Mental Health, 11*(4), 295-393. <https://doi.org/10.1007/s00737-008-0025-6>
- Aho, K. (2008). Medicalising mental health: A phenomenological alternative. *Journal of Medical Humanity, 29*, 243-259. <https://doi.org/10.1007/s10912-008-9065-1>
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- American Psychiatric Association. (2013). *The diagnostic and statistical manual of mental disorders* (5th ed). Washington, DC: Author.
- Applegate, J. S. (1997). The holding environment: An organizing metaphor for social work theory and practice. *Smith College Studies in Social Work, 68*(1), 7-29. <https://doi.org/10.1080/00377319709517514>
- Australian Bureau of Statistics. (2010). *Births, Australia* (No. 3301.0). Retrieved from <http://www.abs.gov.au/ausstats/>
- Australian Government Australian Institute of Health and Welfare. (2016). *Australia's health 2016*. Retrieved from <https://www.aihw.gov.au/reports/australias-health/australias-health-2016/contents/chapter-5-health-of-population-groups>
- Australian Government Department of Health. (2019). *Breastfeeding*. Retrieved from <http://www.health.gov.au/internet/main/publishing.nsf/Content/health-publth-strateg-brfeed-index.htm>
- Avan, B., Richter, L. M., Ramchandani, P. G., Norris, S. A., & Stein, A. (2010). Maternal postnatal depression and children's growth and behaviour during the early years of life: Exploring the interaction between physical and mental health. *Archives of Disease in Childhood, 95*(9), 690-695. <https://doi.org/10.1136/adc.2009.164848>
- Bahadoran, P., Oreizi, H., & Safari, S. (2014). Meta-analysis of the role of delivery mode in postpartum depression (Iran 1997-2011). *Journal of Education and Health Promotion, 3*, 118-196. <https://doi.org/10.4103/2277-9531.145924>
- Baraitser, L. (2008). Mum's the word: Intersubjectivity, alterity, and the maternal subject. *Studies in Gender and Sexuality, 9*(1), 86-110. <https://doi.org/10.1080/15240650701759524>.



- Barkin, J. L., & Wisner, K. L. (2013). The role of maternal self-care in new motherhood. *Midwifery*, *29*(9), 1050-1055. <https://doi.org/10.1016/j.midw.2012.10.001>
- Beck, C. T. (1992). The lived experience of postpartum depression: A phenomenological study. *Nursing Research*, *41*, 166-170. <https://doi.org/10.1097/00006199-199205000-00008>
- Beck, C. T. (1993). Teetering on the edge: A substantive theory of depression. *Nursing Research*, *42*(1), 42-48. <https://doi.org/10.1097/00006199-199301000-00008>
- Beck, C. T. (1994). Women's temporal experiences during the delivery process: A phenomenological study. *International Journal of Nursing Studies*, *31*(3), 245-252. [https://doi.org/10.1016/0020-7489\(94\)90050-7](https://doi.org/10.1016/0020-7489(94)90050-7)
- Beck, C. T. (2001). Predictors of postpartum depression: An update. *Nursing Research*, *50*(5), 275-285. <https://doi.org/10.1097/00006199-200109000-00004>
- Beck, C. T. (2002). Postpartum depression: A metasynthesis. *Qualitative Health Research*, *12*(4), 453-472. <https://doi.org/10.1177/104973202129120016>
- Beck, C. T. (2008). State of the science on postpartum depression: What nurse researchers have contributed—part 1. *MCN, American Journal of Maternal Child Nursing*, *33*(2), 121-126. <https://doi.org/10.1097/01.NMC.0000313421.97236.c>
- Bell, A. F., & Andersson, E. (2016). The birth experience and women's postnatal depression: A systematic review. *Midwifery*, *39*, 112-123. <https://doi.org/10.1016/j.midw.2016.04.014>
- Bell, A., Carter, C., Davis, J., Golding, J., Adejumo, O., Pyra, M., . . . Rubin, L. (2016). Childbirth and symptoms of postpartum depression and anxiety: A prospective birth cohort study. *Archives of Women's Mental Health*, *19*(2), 219-227. <https://doi.org/10.1007/s00737-015-0555-7>
- Benedek, T. (1956). Psychobiological aspects of mothering. *American Journal of Orthopsychiatry*, *26*(2), 272-278. <https://doi.org/10.1111/j.1939-0025.1956.tb06176.x>
- Benoist, J., & Cathebras, P. (1993). The body: From an immateriality to another. *Social Science and Medicine*, *36*(7), 857-865. [https://doi.org/10.1016/0277-9536\(93\)90078-I](https://doi.org/10.1016/0277-9536(93)90078-I)

- Beyond Blue. (2011). *Clinical practice guidelines. Depression and related disorders - anxiety, bipolar disorder and puerperal psychosis - in the perinatal period. A guideline for primary care health professionals*. Retrieved from <https://cope.org.au/wp-content/uploads/2013/12/Perinatal-Mental-Health-Clinical-Practice-Guidelines.pdf>
- Bilszta, J. L., Gu, Y. Z., Meyer, D., & Buist, A. E. (2008). A geographic comparison of the prevalence and risk factors for postnatal depression in an Australian population. *Australian and New Zealand Journal of Public Health, 32*(5), 424-430. <https://doi.org/10.1111/j.1753-6405.2008.00274.x>
- Bowen, A., Stewart, N., Baetz, M., & Muhajarine, N. (2009). Antenatal depression in socially high-risk women in Canada. *Journal of Epidemiology and Community Health, 63*(5), 414-416. <https://doi.org/10.1136/jech.2008.078832>
- Bowker, G. C., & Star, S. L. (1999). *Sorting things out: Classification and its consequences*. Cambridge, MA: The MIT Press.
- Bowlby, J. (1970). *Separation, anxiety and anger*. London, England: Hogarth.
- Bowlby, J. (1979). *The making and breaking of affectional bonds*. London, England: Tavistock Publications.
- Bowlby, J. (1988). Developmental psychiatry comes of age. *The American Journal of Psychiatry, 145*(1), 1-10. <https://doi.org/10.1176/ajp.145.1.1>
- Boyce, P., & Hickey, A. (2005). Psychosocial risk factors to major depression after childbirth. *Social Psychiatry and Psychiatric Epidemiology, 40*(8), 605-612. <https://doi.org/10.1007/s00127-005-0931-0>
- Brockington, I. F. (1996). *Motherhood and mental health*. New York, NY: Oxford University Press.
- Brooks, J., Nathan, E., Speelman, C., Swalm, D., Jacques, A., & Doherty, D. (2009). Tailoring screening protocols for perinatal depression: Prevalence of high risk across obstetric services in Western Australia. *Archives of Women's Mental Health, 12*(2), 105-112. <https://doi.org/10.1007/s00737-009-0048-7>.
- Brown, A., Rance, J., & Bennett, P. (2015). Understanding the relationship between breastfeeding and postnatal depression: The role of pain and physical difficulties. *Journal of Advanced Nursing, 72*(2), 273-282. <https://doi.org/10.1111/jan.12832>

- Buist, A. E., Austin, M. P., Hayes, B. A., Speelman, C., Bilszta, J. L., Gemmill, A. W., & Milgrom, J. (2008). Postnatal mental health of women giving birth in Australia 2002–2004: Findings from the Beyond Blue national postnatal depression program. *Australian and New Zealand Journal of Psychiatry*, *42*(1), 66-73. <https://doi.org/10.1080/00048670701732749>
- Button, S., Thornton, A., Lee, S., Shakespeare, J., & Ayers, S. (2017). Seeking help for perinatal psychological distress: A meta-synthesis of women's experiences. *British Journal of General Practice*, *67*(663), e692-e698. <https://doi.org/10.3399/bjgp17X692549>
- Buultjens, M., Robinson, P., & Liamputtong, P. (2008). A holistic programme for mothers with postnatal depression: Pilot study. *Journal of Advanced Nursing*, *63*(2), 181-188. <https://doi.org/10.1111/j.1365-2648.2008.04692.x>
- Carel, H. (2016). If I had to live like you, I think I'd kill myself: Social dimensions of the experience of illness. In T. Szanto & D. Moran (Eds.), *Phenomenology of sociality: Discovering the we* (pp. 173-186). New York, NY: Routledge.
- Carman, T. (2008). *Merleau-Ponty*. London, England: Routledge.
- Cataldi, S. L. (1993). *Emotion, depth and flesh: A study of sensitive space. Reflections of Merleau-Ponty's philosophy of embodiment*. Albany, NY: State University of New York Press.
- Centre of Perinatal Excellence. (2017). *Mental health care in the perinatal period, Australian clinical practice guideline*. Retrieved from <http://cope.org.au/wp-content/uploads/2017/10/Final-COPE-Perinatal-Mental-Health-Guideline.pdf>
- Cerbone, D. R. (2008). Perception. In R. Diprose & J. Reynolds (Eds.), *Merleau-Ponty. Key concepts* (pp. 121-131). Stocksfield, England: Acumen.
- Chowdhury, R., Sinha, B., Sankar, M. J., Taneja, S., Bhandari, N., Rollins, N., & Bahl, R. (2015). Breastfeeding and maternal health outcomes: A systematic review and meta-analysis. *Acta Paediatrica*, *104*, 96-113. <https://doi.org/10.1111/apa.13102>
- Chrisler, J. C. (2011). Feminist psychology and the body problem: Sexuality, physical appearance and mental health. *Psychology of Women Quarterly*, *35*(4), 648-654. <https://doi.org/10.1177/0361684311426688>
- Chrisler, J. C., & Johnston-Robledo, I. (2002). Raging hormones? Feminist perspectives on premenstrual syndrome and postpartum depression. In M. Ballou & L. S. Brown (Eds.), *Rethinking mental health and disorder: Feminist perspectives* (pp. 174-197). New York, NY: Guildford Press.

- Cicourel, A. V. (1964). *Method and measurement in sociology*. New York, NY: Free Press of Glencoe.
- Coates, R., Ayer, S., & de Visser, R. (2014). Women's experiences of postnatal distress: A qualitative study. *BMC Pregnancy & Childbirth, 14*, 359-373. <https://doi.org/10.1186/1471-2393-14-359>
- Connelly, L. M. (2015). Focus groups. *Medsurg Nursing, 24*(5), 369-370. Retrieved from <https://www.medsurnursing.net/archives/15sep/369.pdf>
- Coplan, R. J., & Bowker, J. C. (2014). All alone; Multiple perspectives on the study of solitude. In R. Coplan & J. C. Bowker (Eds.), *The handbook of solitude: A psychological perspective on social isolation, social withdrawal, and being alone* (pp. 3-13). Oxford, England: Wiley-Blackwell.
- Corbin, J. M., & Strauss, A. L. (2008). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (3rd ed.). Thousand Oaks, CA: Sage Publications, Inc.
- Cox, J., & Holden, J. (1994). Perinatal psychiatry: use and misuse of the Edinburgh postnatal depression scale. London: Gaskell.
- Cox, J., Holden, J. (2003). Perinatal mental health: A guide to the Edinburgh postnatal depression scale (EPDS). London: Gaskell.
- Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *The British Journal of Psychiatry, 150*(6), 782-786. <https://doi.org/10.1192/bjp.150.6.782>
- Cox, J. L., Murray, D., & Chapman, G. (1993). A controlled study of the onset, duration and prevalence of postnatal depression. *The British Journal of Psychiatry, 163*(1), 27-31. <https://doi.org/10.1192/bjp.163.1.27>
- Davis, K., Pearlstein, T., Stuart, S., O'Hara, M., & Zlotnick, C. (2013). Analysis of brief screening tools for the detection of postpartum depression: Comparisons of the PRAMS 6-item instrument, PHQ-9, and structured interviews. *Archives of Women's Mental Health, 16*(4), 271-277. <https://doi.org/10.1007/s00737-013-0345-z>
- Davis, S., Cross, J., & Lind, B. K. (2008). Exploring the postpartum adjustment questionnaire as a predictor of postpartum depression. *Journal of Obstetric, Gynecologic & Neonatal Nursing, 37*(6), 622-630. <https://doi.org/10.1111/j.1552-6909.2008.00286.x>
- de Beauvoir, S. (1953). *The second sex* (H. M. Parshley, Trans.). London, England: Random House. (Original work published 1949)

- Dennis, C. L., & McQueen, K. (2009). The relationship between infant-feeding outcomes and postpartum depression: A qualitative systematic review. *Pediatrics, 123*(4), e736-e751. <https://doi.org/10.1542/peds.2008-1629>.
- Dennis, C. L., & Ross, L. E. (2006). Depressive symptomatology in the immediate postnatal period: Identifying maternal characteristics related to true- and false-positive screening scores. *Canadian Journal of Psychiatry, 51*(5), 265-273. <https://doi.org/10.1177/070674370605100501>
- Department of Health, Government of Western Australia. (2019). *Community child health program*. Retrieved from [https://healthywa.wa.gov.au/Articles/A\\_E/Community-Child-Health-Program](https://healthywa.wa.gov.au/Articles/A_E/Community-Child-Health-Program)
- Depraz, N. (2012). The Husserlian theory of intersubjectivity as alterology. In D. Moran & L. E. Embree (Eds.), *Phenomenology. Critical concepts in philosophy* (Vol. II, pp. 201-214). London, England: Routledge.
- de Vitry Smith, S. (2011). Taking hold of a tenuous future: Couples experiences of continuing pregnancy following diagnosis of a serious or lethal fetal anomaly. *Women and Birth, 24*, S4-S4. <https://doi.org/10.1016/j.wombi.2011.07.031>
- de Vitry Smith, S., Dietsch, E., & Bonner, A. (2013). Pregnancy as public property: The experience of couples following diagnosis of a foetal anomaly. *Women and Birth, 26*(1), 76-81. <https://doi.org/10.1016/j.wombi.2012.05.003>
- Dias, C. C., & Figueiredo, B. (2015). Breastfeeding and depression: A systematic review of the literature. *Journal of Affective Disorders, 171*, 142-154. <https://doi.org/10.1016/j.jad.2014.09.022>
- Dodd-McCue, D., & Tartaglia, A. (2010). Self-report response bias: Learning how to live with its diagnosis in chaplaincy research. *Chaplaincy Today, 26*(1), 2-8. <https://doi.org/10.1080/10999183.2010.10767394>
- Edward, K. L., Castle, D., Mills, C., Davis, L., & Casey, J. (2015). Integrated review of paternal depression. *The American Journal of Men's Health, 9*(1), 26-34. <https://doi.org/10.1177/1557988314526614>
- Elliot, A., & Lemert, C. (2014). *Introduction to contemporary social theory*. New York, NY: Routledge.
- Faisal-Cury, A. & Menezes, P. R. (2018). Type of delivery is not associated with maternal depression. *Archives of Women's Mental Health*. Advance online publication. <https://doi.org/10.1007/s00737-018-0923-1>
- Fisher, A. (2015). *The structure of behavior by Maurice Merleau-Ponty*. Pittsburgh, PA: Duquesne University Press.

- Forty, L., Jones, L., Macgregor, S., & Caesar, S. (2006). Familiarity of postpartum depression in unipolar disorder: Results of a family study. *The American Journal of Psychiatry*, *163*(9), 1549-1553. <https://doi.org/10.1176/ajp.2006.163.9.1549>
- Foucault, M. (1975). *The birth of the clinic: An archaeology of medical perception* (A. M. Sheridan Smith, Trans.). New York, NY: Vintage Books. (Original work published 1975).
- Friedman, D., Beebe, B., Jaffe, J., Ross, D., & Triggs, S. (2010). Microanalysis of 4-month infant vocal affect qualities and maternal postpartum depression. *Clinical Social Work Journal*, *38*(1), 8-16. <https://doi.org/10.1007/s10615-010-0261-x>
- Friedman, S. H. (2009). Postpartum mood disorders: Genetic progress and treatment paradigms. *The American Journal of Psychiatry*, *166*(11), 1201-1204. <https://doi.org/10.1176/appi.ajp.2009.09081185>
- Fullbrook, E., & Fullbrook, K. (1998). *Simone de Beauvoir: A critical introduction*. New York, NY: Polity Press.
- Gallagher, S. (1986). Body image and body schema: A conceptual clarification. *Journal of Mind and Behavior*, *7*, 541-554. Retrieved from <https://www.jstor.org/stable/43853233>
- Gauthier, L., Guay, F., Sénécal, C., & Pierce, T. (2010). Women's depressive symptoms during the transition to motherhood: The role of competence, relatedness, and autonomy. *Journal of Health Psychology*, *15*(8), 1145-1156. <https://doi.org/10.1177/1359105310364170>
- Giorgi, A. (1985). Sketch of a psychological phenomenological method. In A. Giorgi (Ed.), *Phenomenology and psychological research* (pp. 8-22). Pittsburgh, PA: Duquesne University Press.
- Goldberg, D. P., Cooper, B., Eastwood, M. R., Kedward, H. B., & Shepherd, M. (1970). A standardized psychiatric interview for use in community surveys. *British Journal of Preventative and Social Medicine*, *24*(1), 18-23. <https://doi.org/10.1136/jech.24.1.18>
- Greenberg, D. N., Clair, J. A., & Ladge, J. (2016). Identity and the transition to motherhood: Navigating existing, temporary, and anticipatory identities. In C. Spitzmueller & R. Matthews (Eds.), *Research perspectives on work and the transition to motherhood* (pp. 33-55). [https://doi.org/10.1007/978-3-319-41121-7\\_3](https://doi.org/10.1007/978-3-319-41121-7_3)
- Grissette, B. G., Spratling, R., & Aycock, D. M. (2018). Barriers to help-seeking behaviour among women with postpartum depression. *Journal of Obstetric, Gynaecologic, and Neonatal Nursing*, *47*(6), 812-819. <https://doi.org/10.1016/j.jogn.2018.09.006>

- Grote, N. K., & Bledsoe, S. E. (2007). Predicting postpartum depressive symptoms in new mothers: The role of optimism and stress frequency during pregnancy. *Health & Social Work, 32*(2), 107-188. <https://doi.org/10.1093/hsw/32.2.107>
- Guba, E., & Lincoln, Y. (1989). *Fourth generation evaluation*. Newbury Park, CA: Sage.
- Gurwitsch, A. (2010). Some principles of Gestalt psychology. In A. Gurwitsch & R. M. Zaner (Eds.), *The collected works of Aron Gurwitsch (1901-1973): Volume III: The field of consciousness: Theme, thematic field and margin* (pp. 85-148). <https://doi.org/10.1007/978-90-481-3346-8>
- Habel, C., Feeley, N., Hayton, B., Bell, L., & Zelkowitz, P. (2015). Causes of women's postnatal depression symptoms: Men's and women's perceptions. *Midwifery, 31*(7), 728-734. <https://doi.org/10.1016/j.midw.2015.03.007>
- Hadfield, H., & Wittkowski, A. (2017). Women's experiences of seeking and receiving psychological and psychosocial interventions for postpartum depression: A systematic review and thematic synthesis of the qualitative literature. *Journal of Midwifery and Women's Health, 62*(6), 723-736. <https://doi.org/10.1111/jmwh.12669>
- Hahn-Holbrook, J., Cornwell-Hinrichs, T., & Anaya, I. (2018). Economic and health predictors of national postpartum depression prevalence: A systematic review, meta-analysis, and meta-regression of 291 studies from 56 countries. *Frontiers in Psychiatry, 8*, 1-23. <https://doi.org/10.3389/fpsy.2017.00248>
- Hamilton, J. (1962). *Postpartum psychiatric problems*. Saint Louis, MO: CV Mosby.
- Harrison, D. W. (2015). *Brain asymmetry and neural systems: Foundations in clinical neuroscience and neuropsychology*. <https://doi.org/10.1007/978-3-319-13069-9>
- Haynes, E. (2017). Listening to the voices of women suffering perinatal psychological distress. *Transactional Analysis Journal, 47*(2), 126-137. <https://doi.org/10.1177/0362153717691977>
- Hesse-Biber, S. N., & Leavy, P. (2006). *The practice of qualitative research*. Thousand Oaks, CA: SAGE Publications.
- Highet, N., Stevenson, A. L., Purtell, C., & Coo, S. (2014). Qualitative insights into women's personal experiences of perinatal depression and anxiety. *Women and Birth, 27*(3), 179-184. <https://doi.org/10.1016/j.wombi.2014.003>
- Hildingsson, I. (2015). Women's birth expectations, are they fulfilled? Findings from a longitudinal cohort Swedish study. *Women and Birth, 28*(2), e7-e18. <https://doi.org/10.1016/j.wombi.2015.01.011>

- Hird, M. (2007). The corporeal generosity of maternity. *Body & Society*, 13(1), 1-20.  
<https://doi.org/10.1177/1357034X07074760>
- Homeward, E., Tweed, A., Cree, M., & Crossley, J. (2009). Becoming occluded: The transition to motherhood of women with postnatal depression. *Qualitative Research in Psychology*, 6(4), 313-329.  
<https://doi.org/10.1080/14780880802473860>
- Jablensky, A. (2016). Psychiatric classifications: Validity and utility. *World Psychiatry*, 15, 26-31. <https://doi.org/10.1002/wps.20284>
- Jarrett, P. M. (2017). How do women's self-report symptoms impact on identification of perinatal mental health problems? *The Journal of Mental Health Training, Education and Practice*, 12(3), 173-187. <https://doi.org/10.1108/JMHTEP-06-2016-0029>
- Johnstone, S. J., Boyce, P. M., Hickey, A. R., Morris-Yates, A. D., & Harris, M. G. (2001). Obstetric risk factors for postnatal depression in urban and rural community samples. *Australian and New Zealand Journal of Psychiatry*, 35(1), 69-74. <https://doi.org/10.1046/j.1440-1614.2001.00862.x>
- Josefsson, A., Larsson, C., Sydsjö, G. & Nylander, P. O. (2007). Temperament and character in women with postpartum depression. *Archives of Women's Mental Health*, 10(1), 3-7. <https://doi.org/10.1007/s00739-006>
- Kapfhammer, H-P. (2006). Somatic symptoms in depression. *Dialogues in Clinical Neuroscience*, 8(2), 227-239. Retrieved from <https://www.dialogues-cns.org/wp-content/uploads/issues/08/DialoguesClinNeurosci-8-227.pdf>
- Klainin, P., & Arthur, D. G. (2009). Postpartum depression in asian cultures: A literature review. *International Journal of Nursing Studies*, 46(10), 1355-1373.  
<https://doi.org/10.1016/j.ijnurstu.2009.02.012>
- Knudson-Martin, C., & Silverstein, R. (2009). Suffering in silence: A qualitative meta-data-analysis of postpartum depression. *Journal of Marital and Family Therapy*, 35(2), 145-158. <https://doi.org/10.1111/j.1752-0606.2009.00112.x>
- Kruks, S. (2006). Merleau-Ponty and the problem of difference in feminism. In D. Olkowski & G. Weiss (Eds.), *Feminist interpretations of Maurice Merleau-Ponty* (pp. 25-48). University Park, PA: Pennsylvania State University Press.
- Kurzweil, S. (2012). Psychodynamic therapy for depression in women with infants and young children. *American Journal of Psychotherapy*, 66(2), 181-199.  
<https://doi.org/10.1176/appi.psychotherapy.2012.66.2.181>



- Lambert, J., Etsane, E., Bergh, A-M., Pattinson, R., & van den Broek, N. (2018). I thought they were going to handle me like a queen but they didn't: A qualitative study exploring the quality of care provided to women at the time of birth. *Midwifery*, 62, 256-263. <https://doi.org/10.1016/j.midw.2018.04.007>
- Leahy-Warren, P., & McCarthy, G. (2007). Postnatal depression: Prevalence, mother's perspectives, and treatments. *Archives of Psychiatric Nursing*, 21(2), 91-100. <https://doi.org/10.1016/j.apnu.2006.10.006>
- Leder, D. (1990). *The absent body*. Chicago, IL: University Chicago Press.
- Leininger, M. (1985). Nature, rationale, and importance of qualitative research methods in nursing. In M. Leininger (Ed.), *Qualitative research methods in nursing* (pp. 1-25). Orlando, FL: Grune & Stratton.
- Leung, S., Arthur, D. G., & Martinson, I. (2005). Stress in women with postpartum depression: A phenomenological study. *Journal of Advanced Nursing*, 51(4), 353-360. <https://doi.org/10.1111/j.1365-2648.2005.03506.x>
- Lewis, M. (1972). State as an infant environment interaction: An analysis of mother-infant interaction as a function of sex. *Merrill-Palmer Quarterly of Behaviour and Development*, 18(2), 95-121. Retrieved from <https://www.jstor.org/stable/23083965>
- Liamputtong, P. (2007). Situated reproduction, procreation and motherhood within a crosscultural context: An introduction. In P. Liamputtong (Ed.), *Reproduction, childbearing, and motherhood: A cross-cultural perspective* (pp. 3-34). New York, NY: Nova Science.
- Liamputtong, P. (2013). *Qualitative research methods* (4th ed.). South Melbourne, Australia: Oxford University Press.
- Luft, S., & Overgaard, S. (2012). Introduction. In S. Luft & S. Overgaard (Eds.), *The Routledge companion to phenomenology* (pp. 1-14). New York, NY: Routledge.
- Lymer, J. (2011). Merleau-Ponty and the maternal-foetal relation. *Parrhesia: A Journal of Critical Philosophy*, 13, 126-143. Retrieved from [http://parrhesiajournal.org/parrhesia13/parrhesia13\\_lymer.pdf](http://parrhesiajournal.org/parrhesia13/parrhesia13_lymer.pdf)
- Mann, R., & Gilbody, S. (2011). Validity of two case finding questions to detect postnatal depression: A review of diagnostic accuracy. *Journal of Affective Disorders*, 133(3), 388-397. <https://doi.org/10.1016/j.jad.11.015>
- Marshall, G. J. (2008). *A guide to Merleau-Ponty's Phenomenology of Perception*. Milwaukee, WI: Marquette University Press.

- Mason, W., Rice, M., & Records, K. (2005). The lived experience of postpartum depression in a psychiatric population. *Perspectives in Psychiatric Care*, 41(2), 52-61. <https://doi.org/10.1111/j.1744-6163.2005.00011.x>
- Matthews, E. (2006). *Merleau-Ponty: A guide for the perplexed*. London, England: Continuum International Publishing Group.
- Matthey, S. (2010). Are we overpathologising motherhood? *Journal of Affective Disorders*, 120(1), 263-266. <https://doi.org/10.1016/j.jad.2009.05.004>
- Matthey, S., & Agostini, F. (2017). Using the Edinburgh Postnatal Depression Scale for women and men - some cautionary thoughts. *Archives of Women's Mental Health*, 20(2), 345-354. <https://doi.org/10.1007/s00737-016-0710-9>
- Matthey, S., Barnett, B., Howie, P., & Kavanagh, D. J. (2003). Diagnosing postpartum depression in mothers and fathers: Whatever happened to anxiety? *Journal of Affective Disorders*, 74, 139-157. [https://doi.org/10.1016/S0165-0327\(02\)00012-5](https://doi.org/10.1016/S0165-0327(02)00012-5)
- Matthey, S., Della-Vedova, A. M., & Agostini, F. (2017). The Edinburgh Postnatal Depression Scale in routine screening: Errors and cautionary advice. *American Journal of Obstetrics and Gynecology*, 216, 424-424. <https://doi.org/10.1016/j.ajog.2016.11.1020>
- Matthey, S., & Ross-Hamid, C. (2011). The validity of DSM symptoms for depression and anxiety disorders during pregnancy. *Journal of Affective Disorders*, 133(3), 546-552. <https://doi.org/10.1016/j.jad.2011.05.004>
- Mauthner, N.S. (2002). *The darkest days of my life: Stories of postpartum depression*. Cambridge: Harvard University Press
- Mauthner, N. (1995). Postnatal depression: The significance of social contacts between mothers. *Women's Studies International Forum*, 18(3), 311-323. [https://doi.org/10.1016/0277-5395\(95\)80075-Z](https://doi.org/10.1016/0277-5395(95)80075-Z)
- McGregor-Robertson, J. (1904). *The household physician* (Vol. 2). London, England: The Gresham Publishing Company.
- Meeussen, L., & Van Laar, C. (2018). Feeling pressure to be a perfect mother relates to parental burnout and career ambitions. *Frontiers in Psychology*, 9, 1-13. <https://doi.org/10.3389/fpsyg.2018.02113>
- Merleau-Ponty, M. (1962). *The phenomenology of perception*. New York, NY: Routledge Classics.
- Merleau-Ponty, M. (1964). *Sense and non-sense*. Evanston, IL: Northwestern University Press.

- Merleau-Ponty, M. (2002). *Phenomenology of perception* (C. Smith, Trans.). London, England: Routledge. (Original work published 1945)
- Milgrom, J., & Gemmill, A. W. (2014). Screening for perinatal depression. *Best Practice & Research Clinical Obstetrics and Gynaecology*, 28, 13-23. <https://doi.org/10.1016/j.bpobgyn.2013.08.014>
- Milgrom, J., Mendelsohn, J., & Gemmill, A. W. (2010). Does postnatal depression screening work? Throwing out the bathwater, keeping the baby. *Journal of Affective Disorders*, 132(3), 301-310. <https://doi.org/10.1016/j.jad.2010.09.031>
- Mollard, E. (2014). A qualitative meta-synthesis and theory of postpartum depression. *Issues in Mental Health Nursing*, 35(9), 656-663. <https://doi.org/10.3109/01612840.2014.893044>
- Moore, K. L., Dalley, A. F., & Agur, A. M. (2018). *Clinically oriented anatomy* (8th ed.). Philadelphia, PA: Wolters Kluwer.
- Moran, D. (2012). Edmund Husserl. In S. Luft & S. Overgaard (Eds.), *The Routledge companion to phenomenology* (pp. 28-39). New York, NY: Routledge.
- Morris, D. (2008). Body. In R. Diprose & J. Reynolds (Eds.), *Merleau-Ponty. Key concepts* (pp. 111-120). Stocksfield, England: Acumen.
- Morse, J. M. (2015). Critical analysis of strategies for determining rigour in qualitative inquiry. *Qualitative Health Research*, 25(9), 1212-1222. <https://doi.org/10.1177/1049732315588501>
- Morstyn, R. (2013). Escaping the behavioural spin of evidence-based psychiatry: Merleau-Ponty's ontology of truth. *Australasian Psychiatry*, 21(4), 311-314. <https://doi.org/10.1177/1039856213486216>
- Murphy, A. (2008). Feminism and race theory. In R. Diprose & J. Reynolds (Eds.), *Merleau-Ponty. Key concepts* (pp. 197-206). Stocksfield, England: Acumen.
- Ni, P. K. & Siew Lin, S. K. (2011). The role of family and friends in providing social support towards enhancing the wellbeing of postpartum women: A comprehensive systematic review. *JBIS Library of Systematic Reviews*, 9(10), 313-370. <https://doi.org/10.11124/jbisrir-2011-94>
- National Institute for Health and Care Excellence. (2014). *Antenatal and postnatal mental health: Clinical management and service guidance* (NICE Clinical Guideline No. CG192). Retrieved from <https://www.nice.org.uk/guidance/cg192>

- Nicolson, P. (1991). Explanations of postnatal depression: Structuring knowledge of female psychology. *Research on Language and Social Interaction*, 25(1), 75-96. <https://doi.org/10.1080/08351819109389358>
- Nicolson, P. (2006). *Postnatal depression: Psychology, science and the transition to motherhood*. London, England: Routledge.
- Nicolson, P., Fox, R., & Heffernan, K. (2010). Constructions of pregnant and postnatal embodiment across three generations: Mothers', daughters' and others' experiences of the transition to motherhood. *Journal of Health Psychology*, 15(4), 575-585. <https://doi.org/10.1177/1359105309355341>
- Nylen, K. J., Williamson, J. A., O'Hara, M. W., Watson, D., & Engeldinger, J. (2013). Validity of somatic symptoms as indicators of depression in pregnancy. *Archives of Women's Mental Health*, 16(3), 203-210. <https://doi.org/10.1007/s00737-013-0334-2>
- O'Hara, M. W., & McCabe, J. E. (2013). Postpartum depression: Current status and future directions. *Annual Review of Clinical Psychology*, 9, 379-407. <https://doi.org/10.1146/annurev-clinpsy-050212-185612>
- O'Hara, M. W., & Swain, A. M. (1996). Rates and risk of postpartum depression- a meta-analysis. *International Review of Psychiatry*, 8(1), 37-54. <https://doi.org/10.3109/0954026909037816>
- Øyen, L., & Aune, I. (2016). Viewing the unborn baby - pregnant women's expectations, attitudes and experiences regarding fetal ultrasound examination. *Sexual and Reproductive Healthcare*, 7, 8-13. <https://doi.org/10.1016/j.srhc.2015.10.003>
- Paffenbarger, R. S. (1964). Epidemiological aspects of parapatum illness. *British Journal of Preventative and Social Medicine*, 18(4), 189-194. <https://doi.org/10.1136/jech.18.4.189>
- Paillard, J. (2005). Vectorial versus configural encoding of body space. A neural basis for a distinction between body schema and body image. In H. De Preester & V. Knockaert (Eds), *Body image and body schema* (pp. 89–109). <https://doi.org/10.1075/aicr.62.07pai>
- Paterson, J. G., & Zderad, L. T. (1976). *Humanistic nursing*. New York, NY: Wiley.
- Pellegrini, A. D. (2013). *Observing children in their natural worlds: A methodological primer* (3rd ed.). New York, NY: Psychology Press.
- Pitt, B. (1968). Atypical depression following childbirth. *British Journal of Psychiatry*, 114, 1325-1335. <https://doi.org/10.1192/bjp.114.516.1325>

- Pope, C. J., & Mazmanian, D. (2016). Breastfeeding and postpartum depression: An overview and methodological recommendation for future research. *Depression Research and Treatment*, 2016, 1-9. <https://doi.org/10.1155/2016/47653100>
- Pope, S., & National Health and Medical Research Council. (2000). *Postnatal depression: A systematic review of scientific literature to 1999* (Cat No. WH29-WH30). Canberra, Australia: National Health & Medical Research Council.
- Polit, D. F., & Beck, C. T. (2018). *Essentials of nursing research: Appraising evidence for nursing practice* (9th ed.). Philadelphia, PA: Wolters Kluwer Health.
- Price, R. (2018). A project to support fathers with postnatal depression. *Journal of Health Visiting*, 6(8), 380-386. <https://doi.org/10.12968/johv.2018.6.8.380>
- Pridmore, S. (2018). Chapter 32. Medicalization (psychiatricization) of distress. In *Download of Psychiatry*. Retrieved from <https://eprints.utas.edu.au/287/557/Chapter%2032.%20Medicalization.pdf>
- Priest, S. (1998). *Merleau-Ponty*. New York, NY: Routledge.
- Regus, P. (2007). *The emerging medicalisation of postpartum depression: Tightening the boundaries of motherhood* (Doctoral dissertation). Retrieved from [http://scholarworks.gsu.edu/sociology\\_theses/16](http://scholarworks.gsu.edu/sociology_theses/16)
- Reynolds, J. (2012). Existentialism. In S. Luft & S. Overgaard (Eds.), *The Routledge companion to phenomenology* (pp. 485-495). New York, NY: Routledge.
- Roseth, I., Binder, P., & Malt, U. F. (2011). Two ways of living through postpartum depression. *Journal of Phenomenological Psychology*, 42(2), 174-194. <https://doi.org/10.1163/156916211X599753>
- Rubin, R. (1984). *Maternal identity and the maternal experience*. New York, NY: Springer Pub. Co.
- Ruddick, S. (1980). Maternal thinking. *Feminist Studies*, 6(2), 342-367. <https://doi.org/10.2307/3177749>
- Scheuneman, B. (2012). Creating life, giving birth and learning to die. In S. Lintott & M. Sander-Staudt (Eds.), *Philosophical inquiries into pregnancy, childbirth and mothering* (pp. 165-177). New York, NY: Routledge.
- Schlauch, C.R. (2016). Readings of Winnicott. *Pastoral Psychology*, 65, 255-281. <https://doi.org/10.1007/s11089-015-0682-0>.
- Schütz, A. (2004). The problem of transcendental intersubjectivity in Husserl. In D. Moran & L. E. Embree (Eds.), *Phenomenology: Critical concepts in philosophy* (Vol. II, pp. 143-178). London, England: Routledge.

- Scope, A., Booth, A., & Sutcliffe, E. (2012). Women's perceptions and experiences of group cognitive behaviour therapy and other group interventions for postnatal depression: A qualitative synthesis. *Journal of Advanced Nursing*, 68(9), 1909-1919. <https://doi.org/10.1111/j.1365-2648.2012.05954.x>
- Shaikh, A., & Kauppi, C. (2015). Postpartum depression: Deconstructing the label through a social constructions lens. *Social Work in Mental Health*, 13(5), 459-480. <https://doi.org/10.1080/15332985.2014.943456>
- Shaw, J. C. (2013). The medicalisation of birth and midwifery as resistance. *Health Care for Women International*, 34(6), 522-536. <https://doi.org/10.1080/07399332.2012.736569>
- Sikorski, C., Lakhanpaul, M., Benton, L., Martin, J., Costello, A. & Heys, M. (2018). Could postnatal women's groups be used to improve outcomes for mothers and children in high-income countries? A systematic review. *Maternal & Childhealth Journal*, 22(12), 1698-1712. <https://doi.org/10.1007/s10995-018-2606-y>
- Simpson, C. B. (2014). *Merleau-Ponty and theology*. London, England: Bloomsbury.
- Smith, R. J., & Atkinson, P. (2016). Method and measurement in sociology, fifty years on. *International Journal of Social Research Methodology*, 19(1), 99-110. <https://doi.org/10.1080/13645579.2015.1068010>
- Söderquist, J., Wijma, B., Thorbert, G., & Wijma, K. (2009). Risk factors in pregnancy for post-traumatic stress and depression after childbirth. *BJOG: An International Journal of Obstetrics & Gynaecology*, 116(5), 672-680. <https://doi.org/10.1111/j.1471-0528.2008.02083.x>
- Spiegelberg, H. (1978). *The phenomenological movement: A historical introduction* (2nd ed.). The Hague, Netherlands: Martinus Nijhoff.
- Spinelli, M. (2009). Postpartum psychosis: Detection of risk and management. *The American Journal of Psychiatry*, 166(4), 405-408. <https://doi.org/10.1176/appi.ajp.2008.0812189908>.
- Spitzmueller, C., & Matthews, R. A. (2016). Work and the transition to motherhood: Introduction. In C. Spitzmueller & R. A. Matthews (Eds.), *Research perspectives on work and the transition to motherhood* (pp. 1-8). London, England: Springer. [https://doi.org/10.1007/978-3-319-41121-7\\_3](https://doi.org/10.1007/978-3-319-41121-7_3)
- Stern, D. N. (1995). *The motherhood constellation: A unified view of parent-infant psychotherapy*. New York, NY: Basicbooks.
- Stern, D. N. (2004). *The present day moment in psychotherapy and everyday life*. London, England: W.W. Norton.

- Stewart, D., & Mikunas, A. (1974). *Exploring phenomenology: A guide to the field and its literature*. Chicago, IL: American Library Association.
- Strauss, A. L. & Corbin, J. M. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage.
- Streubert, H., & Carpenter, D. R. (2011). *Qualitative research in nursing : Advancing the humanistic imperative* (5th ed.). Philadelphia, PA: Wolters Kluwer Health.
- Swalm, D., Brooks, J., Doherty, D., Nathan, E., & Jacques, A. (2010). Using the Edinburgh Postnatal Depression Scale to screen for perinatal anxiety. *Archives of Women's Mental Health*, 13(6), 515-522. <https://doi.org/10.1007/s00737-010-0170-6>
- Szabó, M. (2016). Conceptual issues in abnormal psychology. In E. Rieger (Ed.), *Abnormal psychology: Leading researcher perspectives* (3rd ed., pp. 1-42). North Ryde, Australia: McGraw-Hill Education.
- Tannous, L., Gigante, L. P., Fuchs, S. C., & Busnello, E. D. (2008). Postnatal depression in Southern Brazil: Prevalence and its demographic and socioeconomic determinants. *BMC Psychiatry*, 8, 1-8. <https://doi.org/10.1186/1471-244X-8-1>
- Trimble, M. R., & George, M. S. (2010). *Biological psychiatry* (3rd ed.). Chichester, England: Wiley-Blackwell.
- Tronick, E. (1989). Emotions and emotional communication in infants. *American Psychologist*, 44(2), 112-119. <https://doi.org/10.1037/0003-066X.44.2.112>
- Turner, K. M., Chew-Graham, C., Folkes, L., & Sharp, D. (2010). Women's experiences of health visitor delivered listening visits as a treatment for postnatal depression: A qualitative study. *Patient Education and Counselling*, 78(2), 234-239. <https://doi.org/10.1016/j.pec.2009.05.022>
- Valle, R. S., & Halling, S. (1989). *Existential-phenomenological perspectives: Exploring the breadth of human experience: With a special section on transpersonal psychology*. New York, NY: Plenum Press.
- Vasterling, V. (2003). Body and language: Butler, Merleau-Ponty and Lyotard on the speaking embodied subject. *International Journal of Philosophical Studies*, 11(2), 205-223. <https://doi.org/10.1080/0967255032000074190>

- Vejar, C. M., Madison-Colmore, O. D., & Ter Maat, M. B. (2006). Understanding the transition from career to fulltime motherhood: A qualitative study. *The American Journal of Family Therapy*, *34*(1), 17-31. <https://doi.org/10.1080/01926180500301352>
- Verbiest, S., Tully, K., Simpson, M., & Stuebe, A. (2018). Elevating mothers' voices: Recommendations for improved patient-centered postpartum. *Journal of Behavioural Medicine*, *41*, 577-590. <https://doi.org/10.1007/s10865-018-9961-4>
- Verkerk, G. J., Denollet, J., vanHeck, G. L., vanSon, M., & Pope, V. (2005). Personality factors as determinants of depression in postpartum women: A prospective 1-year follow-up study. *Psychosomatic Medicine*, *67*(4), 632-637. <https://doi.org/10.1097/01.psy.0000170832.14718.98>
- Vik, K., Aass, I. M., Willumsen, A. B., & Hafting, M. (2009). It's about focusing on the mother's mental health: Screening for postnatal depression seen from the health visitors' perspective-a qualitative study. *Scandinavian Journal of Public Health*, *37*(3), 239-45. <https://doi.org/10.1177/1403494808100275>
- von Mohr, M., Mayes, L. C., & Rutherford, H. J. (2017). The transition to motherhood: Psychoanalysis and neuroscience perspectives. *The Psychoanalytic Study of the Child*, *70*(1), 154-173. <https://doi.org/10.1080/00797308.2016.1277905>
- Ward, M. M. (2013). Estimating disease prevalence and incidence using administrative data: Some assembly required. *Journal of Rheumatology*, *40*(8), 1241-1243. <https://doi.org/10.3899/jrheum.130675>
- Weinberg, M. K. & Tronick, E. Z. (1998). Emotional characteristics of infants associated with maternal depression and anxiety. *Paediatrics*, *102*(5), 1298-1304. Retrieved from [https://pediatrics.aappublications.org/content/102/Supplement\\_E1/1298](https://pediatrics.aappublications.org/content/102/Supplement_E1/1298)
- Westall, C. & Liamputtong, P. (2011). *Motherhood and postnatal depression*. Dordrecht: Springer Netherlands.
- Zahavi, D. (2004). Beyond empathy: Phenomenological approaches to intersubjectivity. In D. Moran & L. E. Embree (Eds.), *Phenomenology: Critical concepts in philosophy* (Vol. II, pp. 179-200). London, England: Routledge.
- Zeedyk, S. M. (1996). Developmental accounts of intentionality: Toward integration. *Developmental Review*, *16*(4), 416-461. <http://doi.org/10.1006/drev.1996.0018>
- Zelkowitz, P., Saucier, J., Wang, T., Katofsky, L., Valenzuela, M., & Westreich, R. (2008). Stability and change in depressive symptoms from pregnancy to two months postpartum in childbearing immigrant women. *Archives of Women's Mental Health*, *11*(1), 1-11. <https://doi.org/10.1007/s00737-008-0219-y>