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What does it mean for a woman to be diagnosed with postnatal depression?

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What does it mean for a woman to be diagnosed with postnatal depression?

By

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Abstract

The research question “What does it mean for a woman to be diagnosed with postnatal depression?” indicates three main overlapping areas of investigation: women, including issues of gender, discourses around womanhood and the roles and expectations being a woman carries; diagnosis, which is the categorising of experiences deemed to be outside of what is considered normal and includes discourses around mental health and mental illness; and mothers, including expectations of mothers and motherhood. All of these areas interlink and are arguably socially and culturally specific. There is also an underlying concept of identity as a woman, a mother and a mentally ill person, both separately and as an intersection of the three. It is therefore an important area of investigation within counselling psychology, a discipline that concerns itself with subjective experience and is therefore well placed to interrogate the process of medicalised diagnoses. The social and cultural influence also suggests Charmaz’s constructivist grounded theory as the appropriate method as it uses ideas of social constructionism. In this study semi-structured interviews were carried out with eight women who believed they had been given a diagnosis of postnatal depression. They were asked about the circumstances leading up to their diagnosis and what they felt the impact was. These interviews were transcribed and analysed using a Grounded Theory methodology (Charmaz, e.g. 2006). A theory of how women view their experience of being diagnosed with postnatal depression, as well as how social factors influence the way the women make sense of this experience, is proposed. This theory takes the form of a process in which women described a dissonance between their expectations of motherhood and their lived experience. They understood this as a lack in themselves and as a result hid their struggles to a point at which they felt they could no longer avoid seeking professional help. The subsequent diagnosis of postnatal depression led to an opening of a dialogue around the difficulties they were experiencing as well as options of possible treatments. The implications of this process are discussed.

Ethical Approval Statement

The research for this project was submitted for ethics consideration under the reference PSYC 12/ 048 in the Department of Psychology and was approved under the procedures of the University of Roehampton's Ethics Committee on 1st August 2012.

CONTENTS

Introduction

This study is looking at the area of postnatal depression (PND). Postnatal depression (PND) is the common term for the experience of low mood and difficulty coping in the period after the birth of a child. As it is defined, it affects more than 100,000 women every year in England and Wales alone (Department of Health [D.O.H.], 2007; Office for National Statistics [O.N.S.], 2014), and due to concerns about side effects of antidepressants, particularly when breastfeeding, it might be expected that a significant number of these women will seek talking therapy treatments with therapists including counselling psychologists. There are several theories to explain PND including biological, social and psychological but these theories leave out the experiences of the woman herself. Counselling psychology, as a discipline, concerns itself with the subjective experience (British Psychological Society [BPS], 2011) and therefore this study is important to the field in terms of understanding both the subjective experience in general and with regard to a potential client group. This need to look at the woman's own experience was addressed by Nicolson (1998) who interviewed women in the U.K. about their postnatal experiences. She felt that what was being described as PND (in some cases) was a normal grief reaction to the losses, which she argued came from becoming a mother (whether for the first time, or with subsequent births). Nicolson also found that women distanced themselves from PND by explaining their experiences of low mood, for example, as being due to other external factors which were occurring at the time. This raises the question that if women are normally keen to distance themselves from PND, how is this impacted by 'experts' labelling the same experience with the very diagnosis they are trying to distance themselves from? Also, if PND is a normal grieving reaction to loss as Nicolson (1998) suggests, what is the impact of pathologising it as a mental disorder by giving it a diagnosis? These are the questions that this study will be examining.

Literature review

Definition of postnatal depression.

What is termed ‘postnatal depression’ (PND) in this study is formally defined in the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5) as depression which occurs within four weeks postnatally (American Psychiatric Association [A.P.A.], 2013). This means that the diagnostic criteria for one of the subtypes of depression as defined by the A.P.A. have to be met, which are: a depressed mood; loss of interest and pleasure, lasting for more than two weeks; psychomotor agitation; loss of appetite; not sleeping; a sense of worthlessness or guilt; poor concentration and suicidal ideation. Five of these symptoms would qualify as a major depressive episode. Other criteria are clinically significant distress and impairment in social functioning. In contrast the ICD-10 (World Health Organisation [W.H.O], 1992) has a separate category F53.0, which describes mild mental and behavioural disorders associated six weeks postnatally when the diagnostic criteria for affective disorders (mainly depression) is not met. It could be argued that the emphasis is on the affective disorder, and the fact that it occurs within a certain timeframe of giving birth is incidental. This would question whether it is important or useful to distinguish it as a separate disorder, rather than just treating the affective disorder irrespective of the coincidence of childbirth. It also doesn’t explain away the possibility that the depression pre-existed the birth, but symptoms were exacerbated by the experience not just of childbirth, but of parenting a newborn. The labelling of PND as a clinical depression is also challenged by Green (1998) who argues that the symptoms in fact form part of dysphoria. However as this study is investigating the process of being diagnosed with PND, it will use the definitions as set out in the diagnostic manuals. It will be borne in mind for the purposes of this study however that in doing so, the researcher is making no judgment as to whether PND is a distinct category of mental disorder, or indeed whether it is a mental disorder at all. It is also

worth noting at this point that other writers use the term PND as a description of negative emotional experiences subsequent to childbirth, without necessarily using it in a clinical sense. This study will use the same term when talking about this literature; however in using this term, this study does not intend to pathologise these experiences, and asks the reader to keep in mind the implications of the term.

PND is distinguished, both in the literature and also within this study, from 'baby blues', defined as transient low mood and weepiness with no impaired functioning and which affects 70 per cent of women in the first ten days after birth (A.P.A., 2013). PND is also distinguished from puerperal psychosis, in which the mother experiences psychotic symptoms such as hallucinations and paranoid delusions. This affects 1 in 1000 women and occurs within days/weeks of childbirth (Royal College of Psychiatrists, 2011).

Why study PND?

PND affects 10 to 15 per cent of women who have a baby, with the most serious illnesses developing six to eight weeks after birth (D.O.H., 2007). With 698,512 live births in England and Wales in 2013 (O.N.S., 2014) this could mean 104,777 women in England and Wales annually. This excludes cases of stillbirth and women living in other countries. Therefore PND, as it is currently defined, affects a lot of women globally, and perhaps significantly more than the official statistics suggest if we include women who do not seek help, as well as widening the definition to include mothers of stillborn babies.

The consequences of PND

There has been some research into the consequences of PND; it is argued as having implications for susceptibility to depression in later life (Holmes, 1993). This in turn has financial implications for a society like the UK in terms of the provision of NHS, as well as private, treatment for those with depression.

Reay, Matthey, Ellwood & Scott (2011) conducted a two-year follow up study comparing 98 mothers who were identified as being 'probably depressed' and a random sample of 101 mothers who scored as not depressed on the Edinburgh Postnatal Depression Scale (EPDS; Cox, Holden & Sagovsky, 1987). They found that the depressed mothers were more depressed, scoring higher on the EPDS, at the two-year follow up, and that this was associated with poorer relationships with their partners as well as poorer mother-infant bonding (as judged by objective measures that were sent to be completed) than the previously non-depressed group. These mothers were not diagnosed with PND, but the study indicates that perhaps depressive symptoms do have lasting impacts relationally between the mother and child, and also between the parents as partners. This study merely shows an association between factors; it does not say that one causes another, and it is equally possible that the factors interrelate. The finding of an association between depressive symptoms and a lower quality of maternal bonding long-term supports a finding by Moehler, Brunner, Wiebel, Reck & Resch (2006) who measured depression levels and quality of bonding at various intervals from 2 weeks to 14 months postnatally. They found that even mild or unrecognised maternal depressive symptoms during the first four months postnatally had a significant impact on maternal bonding at 14 months.

Thus, PND is an important area to understand as it affects a lot of people; not just the women but also their children, partner and society as a whole.

Perspectives on gender and motherhood.

Postnatal depression by definition is a gendered condition (Ussher, 1991) in that it is the experience of a mother who is generally identified as female. The concept of gender, and whether mother is synonymous with being female has been contested by writers such as Butler (2007), but to start it is important to look at how gender, or more specifically being female, is described and understood in the literature. How

females and femininity are described, viewed and understood will impact on how postnatal depression, a condition seen to affect primarily females, is in turn perceived and understood, both at a societal level but also by the women themselves who are identified as having the condition.

Feminist writers such as Irigaray (Whitford, 1991) challenge Freud's assumption that the differences in the development of male and female are both described under male parameters; the presence or absence of a penis, and de Beauvoir (1952) argues that Freud describes the female destiny by adapting that of the male. Therefore de Beauvoir argues that female is seen as a mutilated man. Also, the female identity is contingent on that of the male, rather than having an identity in their own right. This is similar to the Old Testament account of the creation of Eve from the rib of Adam; woman made from man. Irigaray argues that for true equality, women need to have an identity in their own right. The father can also be argued psychoanalytically to play a more active role in a child's development than the mother, both as the rival and potential punisher for boys, and not only an object of desire but also the potential provider of a child (and therefore a penis) for girls. It can also be argued that boys reach a resolution of their conflict and no longer harbour a castration anxiety, whereas there is no indication that girls resolve their 'penis envy', except perhaps by having a child of their own. Already this is hinting at an inequality between male and female, where male is seen as more active and an object of envy; Irigaray also argues that whilst there is mention of the phallus in psychoanalytic accounts, the separation of the child from the mother's womb is ignored. It could be argued that having a child highlights a woman's femininity and thus this lack of identity of the feminine, or envy of the masculine, is exacerbated, a result of which may be what becomes termed as PND.

In classical Freudian theory, girls have to give up their love and desire for the mother in favour of the father, which Irigaray argues uproots them from their identity as

women, and they also, in rejecting the mother, reject all women. Using Lacan's mirror stage model, Whitford (1991) argues that women lack a mirror for becoming women. This would again suggest a lack of identity for women. Irigaray goes further than this by arguing that by using the term penis envy, Freud describes women in terms of deficiency or atrophy, which mirrors de Beauvoir's argument of female being portrayed as a mutilated male. Linked with this lack of identity, Irigaray uses the analogy of the feminine as space, with masculinity as time and the logic of philosophical reason. In being such a space without boundary, women have no proper place but forever remain in motion according to Irigaray. She also argues that man deprives her of the chance to create a space for herself, by denying her the relationship with the spatial.

Kristeva (1980) distinguishes between the semiotic, as linked with the emotional, instinctual and poetic realm which she regards as feminine, with the symbolic which is a shared cultural meaning associated with law, structure and the masculine. By following this distinction and viewing the symbolic, such as language, as masculine, then any linguistic description of women could be argued as using male parameters. Boulous Walker (1998) maintains that the masculine imaginary imposes meanings onto women's bodies which deny women possible meanings of their own. She argues that femininity is semiotic, which is poetic writing rather than the masculine scientific writing that is more widely accepted as truth about meaning. However, she talks of the dangers of women speaking the semiotic, illustrated by writers such as Plath and Woolf who committed suicide; that in trying to speak for themselves, they step outside of the boundary into a boundless space that they cannot cope with because it is not understood and therefore they self-destruct. However, Brennan (1989, as cited in Doane & Hodges, 1992) argues that both seeing the symbolic as masculine and the semiotic as feminine uses clichés within psychoanalytic literature that should be challenged. Placing the semiotic as opposed to the symbolic also perpetuates the denial of a place for femininity other than in terms of the masculine. PND could be

argued to be an example of the feminine being defined in terms of the masculine language of science or psychiatry, which will be examined in more detail later. Thus, by being described in masculine terms, PND is an example of the feminine lacking a space of her own. Similarly it may also be a result of this lack of space which is highlighted by the act of having a child.

This approach also assumes categories of masculinity and femininity which is challenged by writers such as Butler (2007) who argue that gender is not some essentialist category, meaning that it is not something that you are, rather something that you do. She argues that gender is something that is performed, a social action, and this performance is determined by the social environment. Trying to universalise discourses of femininity, thereby creating a category of femininity, has done little for the benefit of women, which is supposed to be part of what the feminist approach has been trying to achieve (Doane & Hodges, 1992).

So if females, or women, are seen as somehow less than men, then women are in a position of less power and autonomy. If this power inequality is coupled with the lack of a sense of identity as described above, then women are more vulnerable to having meaning and identity imposed upon them, which is unlikely to reflect their true experience as it does not come from them. Also, the way in which that experience is described is going to be in terms of others' expectations. This study will look at postnatal depression as a possible example of this, by examining how this is described and understood, and how this matches with women's own experiences of what is termed postnatal depression. More specifically it will look at the concept of diagnosis as an example of the imposing of a meaning onto another's experience.

From women to mothers

Femininity is seen as either maternal or sexual (Nicolson, 1998), which are seen as mutually exclusive in society (Young, 2005), meaning that women who are perceived as maternal or a good mother cannot, or are not, seen as sexual or attractive and vice

versa. This may mean that once a woman becomes a mother, particularly a pregnant or new mother where the signs of motherhood are more visible, then they are no longer seen as sexual and they lose a part of the feminine identity they had previously. The paradox is that to become a mother, a woman must be sexual in engaging in the act of sex, and so being a mother belies the distinction of maternal versus sexual. Burr (2003) describes the prevailing discourses of femininity as being "nurturant, close to nature, emotional, negatively affected by their hormones, empathic and vulnerable" (p.75). This, she argues, lends women very much to the role of mothering. It also however gives a very narrow expectation of women and also of mothers that would be easy to infringe and therefore be seen as 'unfeminine' or 'non-maternal'. The fact that the only antonym for maternal is paternal may be an indication of how unfathomable this idea that a woman may not be maternal actually is. Motherhood can therefore be understood as a gender role in that it is an expectation of women to be motherly and therefore become mothers.

Burr (2003) also describes discourses of motherhood in terms of being a 'good' as opposed to a 'bad' mother. The dominant discourse of a 'good' mother, she argues, is one who stays at home when the children are little, and who puts their needs ahead of her own. Anything that deviates from this will therefore be seen as being a 'bad' mother. 'Bad' mothers may be the ones who go on to be diagnosed with postnatal depression, whether the definition of 'bad' matches Burr's or is the mother's or mental health professional's own. This is quite an idealised view of motherhood and a high expectation for a mother to live up to. There are, according to Ussher (1991), conflicting demands from the dual roles of working mothers and a feeling of isolation for those that stay at home. Adhering to this discourse of staying at home and putting the child's needs ahead of her own is likely to add to the feeling of isolation that Ussher describes and arguably could heighten the lack of identity of the mother as a person in her own right. Even with working mothers, they have a period of maternity leave which mean that they will stay at home for a period of time. As a social group,

mothers report higher rates of depression (Ussher, 1991), which may link with this. For a mother who is depressed, Ussher argues she can get drawn into a vicious spiral with a child who responds to the mother's negativity by becoming increasingly difficult in terms of his behaviour. This then makes the mother feel more unable to cope with the child's behaviour, making her more depressed.

Transition to motherhood

Having a baby leads to many changes for the mother, whether it is her first child or not. Some of these changes are physical, some psychological and some social. It should be noted here that different mothers will experience different changes to greater or lesser degrees, but we are looking here at the changes that are experienced, and the reaction to those changes, in what is considered a normal situation from pregnancy, through childbirth and postnatally. We will then look at what this so called 'normal' experience might mean for what is considered postnatal depression.

Pregnancy

Pregnancy is a time of great change, both physically and emotionally (e.g. Deans, 2007). For first-time mothers it represents a major transitional event (Brien, 2006). It can bring to the fore any issues which the mother-to-be hasn't had to think about, such as the relationship and/or presence of her own mother as a child (e.g. Raphael-Leff, 2003), as well as that of the father of the child and other significant parties (Deans, 2007). It is a time of great anxiety, both with regard to what the changes mean for her, and also whether the baby will be happy and healthy (Deans, 2007). She feels responsible for the life inside her, a responsibility which is confirmed by society (the media, medical professionals and friends and family) all telling her what she should be doing (Gross & Pattison, 2007), if indeed she even wants to continue with the pregnancy.

Pregnancy is often perceived as a taboo subject which people feel uncomfortable talking about (Gross & Pattison, 2007). Pregnancy is a visible marker of a woman's femininity (Gross & Pattison, 2007), and therefore serves to highlight the discourses around femininity, which Burr (2003) argues are dominantly around women being nurturing, emotional, negatively affected by their hormones and vulnerable. This highlighting of femininity was also described by Bailey (1999) who found that a new gendered identity developed as the pregnancy continued as women could no longer regard themselves as 'surrogate men' but had to acknowledge the physicality of their femininity. Socially, discourse on pregnancy focuses on the outcome of the pregnancy; the health and wellbeing of the baby; viewing the mother as somehow separate and merely a vessel to incubate this new life (Young, 2005). Any interventions therefore focus on the subsequent health and development of the baby in the main rather than the mother (Gross & Pattison, 2007). Socially as well there is an emphasis on caring for the baby; from encouraging a pregnant woman to sit down to making derogatory comments about a pregnant woman having a cigarette, a glass of wine or even a cup of coffee (Gross & Pattison, 2007). This could arguably lead to a sense of isolation for the mother-to-be, as well as an expectation that she should put the baby's needs before her own, and a loss of identity as a person in her own right, rather than solely as a mother-to-be. Deutsch, Ruble, Fleming, Brooks-Gunn & Stangor (1988) describe a process in which mothers actively construct a new identity for themselves by actively seeking information in anticipation of the birth of their first child. This new identity is then modified into self-conceptions with the use of direct experiences of childcare once the child arrives. So identity construction is a proactive process and one which is modified through experience.

In the UK, pregnancy has become a time where even a fit and healthy woman comes into regular contact with health professionals (Young, 2005); this has pathologised pregnancy to a medicalised (rather than a normal and healthy) condition, where normal changes associated with pregnancy become symptoms requiring treatment

(Young, 2005). The knowledge of the development of the pregnancy is controlled by medical instruments, which devalues the woman's own experience (Young, 2005); women may wait for confirmation of the pregnancy via a pregnancy test or an ultrasound scan for example. This medicalisation has also shifted the focus onto the physiological, endochrinological and neurological changes rather than psychological (Gross & Pattison, 2007), and also onto the pregnancy outcome rather than the mother's experience of her pregnancy (Gross & Pattison, 2007). The result of this arguably is that the mother is further ignored and isolated and her psychological needs not addressed, which may increase her risk of emotional disturbance, which may ultimately be classified as postnatal depression. This shift in focus to a medicalised condition also means that a mother's health has become secondary to that of her baby (Young, 2005), and this is paralleled by the attention of research in the field (Gross & Pattison, 2007). This forms part of the discourse that the pregnant woman is regarded as a vessel for the foetus (Gross & Pattison, 2007) and perpetuates the expectation that the baby's needs are more important, which may pervade into expectations of motherhood. In looking at women's narratives of their pregnancy, Smith (1994) found that in comparing accounts of pregnancy at the time and then retrospectively women modified their stories to produce self-enhancing personal accounts. They glossed over difficulties and emphasised growth and continuity of self. This helps to create a discourse in which pregnancy is seen as an overly positive experience, which can make it more difficult for other women who encounter difficulties in their own pregnancy which they therefore feel are outside of the norm. This could be argued to further perpetuate the occlusion of the woman's own needs and experience when these are outside of the expected norm.

Childbirth

An important event in the transition to motherhood is the experience of the birth itself. Kitzinger (2006) discusses the fact that birth is a traumatic experience, which in itself

is difficult, but also that this trauma is not openly discussed amongst women, which can lead to feelings of isolation and inadequacy that everyone else seems to be coping much better than they are. Thus women reconstruct their narratives of childbirth, which perpetuates this experience for other mothers that follow.

Part of this trauma may be from a lack of communication, which Baker, Choi, Henshaw & Tree (2005) found when interviewing mothers about their experiences of childbirth and maternity care. They found a lack of communication led to feelings of anger, fear, disappointment, distress, guilt and inadequacy. There was a feeling of power being taken away by this lack of communication, rather than the women giving up their power in favour of medical expertise. This links with the patriarchal medical model and the power differences between the mother and the medical 'expert', as the women's own knowledge (such as of their own bodies) was dismissed. One example where childbirth is particularly medicalised is in the case of Caesarean section. McAra-Couper, Jones & Smythe (2012) interviewed health professionals and focus groups of women and found multiple inherent power structures that determined choices; the choice is always situated in the context in which the women gave birth. Choice is constructed and shaped by discourses around the control and predictability of a medicalised intervention, the normalisation of surgery and an assumption of ease and convenience. There is also the influence of discourses of the gendering of women, and the authors argue that a culture of birth is created that calls into question the ability of the woman to give birth naturally. Tew (1985) argues that the coincidence of a lowering in perinatal mortality rate and an increase in hospital births led to an assumption that hospital births were safer. This would further endorse a perceived need for medical intervention in giving birth, even though Tew's interrogation of the statistics suggests that the perinatal mortality rate would have dropped even without this preference for hospital births.

Motherhood

Both during pregnancy and after childbirth, women are subjected to various discourses of how motherhood 'should' be and how they 'should' be as mothers. However it is only once the mother has her baby that she sees how these expectations match up, or not, to the actual experience. Choi, Henshaw, Baker & Tree (2005) conducted a qualitative study with new mums, both first time mothers and mothers who had existing children. They found a feeling of being unprepared, which differed from expectations from various myths of how motherhood 'should' be, leading to a sense of inadequacy which women overcompensated for by trying to be 'superwife', 'supermum' etc. With regard to infant behaviours however, Muscat, Thorpe & Obst (2012) found that parents generally have realistic expectations of, for example, sleeping or feeding patterns and if anything their expectations are more negative than in reality, possibly to protect against disappointment and depression.

These expectations determine the extent to which mothers access support. Knaark (2009) conducted a grounded theory study on postnatal emotional states and found an underlying theme of self-care. The extent to which mothers activated resources available to them was determined by beliefs of what mothers 'should' need, be or do. This demonstrates that broader discourses about what makes a good mother influences how women make use of resources that will help them in their self care. Greater distress or difficulties are also linked with a lack of such resources. Therefore a mother experiencing distress is likely to have fewer self-care resources available. If she feels inadequate or that she 'should' be able to cope on her own or be 'supermum' etc then she won't access what support she does have to assist her in her self care. Without this support it is possible that her distress may build to a point at which it becomes defined as PND.

The impact on partner relationships

Having a baby also impacts on the relationship between the parents, in those cases where the relationship continues. Lawrence, Rothman, Cobb & Rothman (2008) found that marital satisfaction declined more for parents than non-parents, though having a pregnancy that was planned offered some protection, particularly from the husband's perspective. A higher level of pre-pregnancy marital satisfaction was also found to be a protective factor. Ruble, Fleming, Hackel & Stangor (1988) looked cross-sectionally and longitudinally at married first-time mothers during late pregnancy and three periods postnatally and found that women reported less positive feelings towards their husbands postnatally than during pregnancy, and reported doing more housework and childcare than they expected. These violated expectations related to negative feelings concerning some parts of the relationship, rather than the core affective feeling of the relationship as a whole. Koivunen, Rothaupt & Wolfgram (2009) found an importance placed on husbands helping out with household tasks but also voicing an appreciation for women's contributions. Deutsch (2001) found that 75% of couples felt childcare was not split equally and that women generally worked longer hours than men when combining paid and household work. This was coupled with women having less input in important decisions in the home and having poorer mental health. Cox et al. (1999) found that marital dissatisfaction peaked at around twelve months postnatally. Medina, Lederhos & Lillis (2009) described the additional role of sleep loss in the postnatal decline of marital satisfaction in the child's first year.

Shapiro, Gottman & Carrere (2000) conducted a longitudinal study on newlyweds over six years and found that marital satisfaction declined more sharply for wives who became mothers than those who remained childless. This may indicate a negative impact of having a child on the relationship, or may relate to existing vulnerabilities in the relationship that are triggered by a stressful event such as childbirth. However,

despite this decline in satisfaction, any divorces that occurred in the study happened amongst the childless couples and so the couples that had children remained together. The satisfaction at the start of the marriage was found to be higher for women who subsequently became mothers. Whether marital satisfaction decreased or not was mediated by the husband's attitude towards his wife as well as an awareness of both the partner and the relationship on the part of both partners.

Looking further at the impact that having a baby has on the romantic relationship between the parents, Rupp, James, Ketterson, Sengelaub, Ditzen & Heiman (2013) suggest that a decrease in sexual desire postnatally is common, which may be due to lifestyle and peripheral physiological changes (lack of sleep, perineal soreness etc) but also hormone-mediated changes in neural responses to sexual and infant stimuli. They found that the hormone oxytocin (produced when breastfeeding and also when having sex) when given to women who had never had children led them to rate infant stimuli as arousing as postnatal women. They also found via fMRI that there was a decrease in the right amygdala activation in response to arousing stimuli postnatally, which wasn't affected by oxytocin. Thus oxytocin leads to infant stimuli becoming a source of arousal, but amygdala activity decreases postnatally which means a lowered response to arousing (including sexual) stimuli. Von Sydow (1999) in a metacontent analysis found that female sexual interest and coital activity decreases slightly in the first trimester of pregnancy, is variable in the second and declines sharply in the third. This is further reduced for several months postnatally compared with pregnancy levels, and most couples don't practise intercourse for two months post delivery. Glazener (1997) found that half the women studied had some problem with intercourse after birth, but only 7-13% expressed a need for help or advice. A lack of interest was particularly so if the mother was breastfeeding, which Glazener posited to be linked with hormone levels; either the progesterone-only pill which is generally prescribed for breastfeeding mothers, or with low androgen/testosterone levels, which in turn are linked with depressed mood.

Keizer, Dykstra and Poortman (2010) looked at the impact of changing hours at work and found that women who leave their jobs on becoming mothers showed a decrease in partner satisfaction. Men showed a decrease in partner satisfaction on becoming fathers. The negative effects were lessened when women increased their working hours on becoming mothers. This may relate to feelings of resentment resulting from changes in role, particularly when it is perceived to affect one partner rather than the other. If men generally show a dissatisfaction with their partners, then this will impact negatively on the relationship and therefore on the women as well. It also links with the ambivalence arising from the contradictory messages about intensive mothering versus shared parenting in that women who leave work may feel more expectation to fulfil the intensive mothering role or the more traditional gendered narrative. Resentment may arise for mothers who subscribe to a more shared-parenting philosophy.

Sevón (2012) found two competing narratives with regard to intensive versus shared parenting; a turbulent transformation narrative and a smooth transformation narrative. The smooth transformation incorporated willingness and effort from both parents to move from intensive mothering to shared parenting. The turbulent narrative by contrast consisted of an ambivalence from the contradictory cultural narratives of intensive mothering versus shared parenthood, as well as a feeling of a disruption in the mothers', but not fathers', lives. This illustrates the difficulty in negotiating the differing expectations of mothers. The study also indicates that a traditional gendered narrative supports the construction of a coherent identity as a mother and partner. This traditional gendered narrative however is again in contradiction to the shared parenting narrative, and the implication may be that by existing outside of this traditional gendered narrative that it would be difficult to establish a coherent identity for oneself.

Feeding the baby

One of the experiences that come with having a baby is the feeding of the baby, and there is some research that has been done on the impact of breastfeeding versus artificial feeding (as it is referred to in the literature, presumably to encompass both feeding from a bottle and a cup or other vessel). The word artificial does arguably imply some negative connotation, in that it is not natural and therefore not wholesome, and this links in with a pressure that new mothers feel to try breastfeeding as the best alternative (National Health Service [N.H.S], 2012). Berg-Cross, Berg-Cross & McGeehan (1979) found that breastfeeding mothers enjoyed feeding more and that they felt they were fulfilling their roles as women, which reinforced a positive self image. There was also some discussion about the level of arousal and how that links with the choice to breastfeed or artificially feed the baby; the suggestion is that artificial feeding is chosen to reduce the arousal that is caused by nursing the infant (a process which as we have seen may be mediated by the release of the hormone oxytocin), whereas mothers who breastfeed manage to maintain an optimal level of arousal through nursing. So a mother's ability to manage arousal may impact her choice on whether to breastfeed or not, and this ability to manage arousal may impact on her emotional response to being a mother more generally. There is also a suggestion in this study that artificial-feeding mothers may be more conservative and rigid in their expectations, which also might impact on their emotional responses to having a baby. Fleming, Ruble, Flett & Shaul (1988) found that mothers who reported themselves as more depressed were more likely to have started bottle feeding by three months. Schmied & Lupton (2001) argue that breastfeeding crosses the border between motherhood and sexuality. Linked to this crossover (between breastfeeding, motherhood and sexuality), Avery, Duckett & Frantzich (2000) found that it had a slightly negative impact on physiological aspects of sexuality (such as soreness of the nipples), but that it didn't greatly affect the sexual relationship with the partner as the authors hypothesised may be expected.

Schmied & Lupton (2001) found that whilst some women experienced breastfeeding as a harmonious, bonding experience, the majority struggled with the tension between the pro-breastfeeding rhetoric and the demands it places in reality. These included restricted activities, loss of self and agency, a change to their embodied experience of their breasts. They found a discourse of persevering through the discomfort, which undermined the sense of enjoyment and confidence in their mothering skills.

Costs of motherhood

Motherhood brings costs, but the need to adapt may also lead to personal growth (Tedeschi & Calhoun, 2004, as cited in Taubran-Ben-Ari et al, 2009). The experience of cost is stable from pregnancy to the postnatal period; what differs is whether that cost is perceived as a threat or a challenge (Taubran-Ben-Ari, Shlomo, Sivan & Dolizki, 2009). This is in turn linked with marital satisfaction and the level of both external and internal resources such as self esteem and attachment anxiety. Churchill and Davis (2010) found that mothers who had a realistic orientation in that they thought more about the negative possibilities during pregnancy had a greater reduction in depressive symptoms postnatally. This might indicate that women who are overly optimistic, or who avoid the negative possibilities are more at risk of developing postnatal depression.

The costs of mothering are arguably highlighted in the case of older mothers where they have a more established way of life prior to motherhood. In a study on older mothers (defined as women over the age of 30 years when having their first child), Shelton & Johnson (2006) found that waiting to have children had the benefit of being psychologically ready, but carried the cost of having to give up a single lifestyle and personal freedom leading to a desire to be something more. Whilst this study looked at older mothers, and it could be questioned whether 30 years of age constitutes an older mother at a time when some women are waiting until their forties to have

children, it could be argued that this same issue of cost and loss could be true for younger mothers as well. Shelton and Johnson also describe a period of integration, in which the loss and other aspects of motherhood are eventually reintegrated into their identity, although this also elicits unanticipated anger.

Postnatal moods and emotions

This current study is investigating the experience of postnatal depression and so it is important to look at emotions and moods postnatally. Fleming, Ruble, Flett & Shaul (1988) looked at self-report data from first-time mothers during pregnancy and at various intervals postnatally and found that self-reported mood states, particularly postnatal mood, accounted for a high proportion of the variance in maternal attitudes towards the infant. They also found that at one month and three months postnatally, depressed mothers showed less response to infant vocalisations and fewer affectionate contact behaviours, but that these differences were no longer apparent at sixteen months postnatally.

Fleming, Ruble, Flett & Van Wagner (1990) looked at how moods adjusted in first-time mothers and found that moods were consistent over time, but reported as being better at three and sixteen months postnatally than earlier. Positive feelings about the infant increased linearly, with positive feelings about the spouse showing a 'U'-shaped function, with the least positive feelings being at one and three months postnatally.

Goldstein, Diener & Mangelsdorf (1996) found that women who reported themselves as being more anxious and worried prenatally were rated as less expressive with their infants. This study also confirms other findings of less spousal support postnatally, as well as finding an increase in life stress postnatally. Interestingly, the study also found that a woman's prenatal satisfaction with the support from her own parents was negatively associated with maternal sensitivity, meaning that women are less sensitive to their baby's needs if they perceive good support from their own parents.

With regard to depressive symptoms postnatally, an increase in family-related goals during pregnancy and after childbirth predicted a decline in depressive symptoms, whereas an increase in self-focused goals predicted an increase in depressive symptoms (Salmela-Aro, Nurmi, Saisto & Halmesmaki, 2001). This relationship also happened in reverse in that an increase in depressive symptoms predicted a decline in the number of birth and family related goals as well as an increase in self-focused goals. It is worth noting that these studies were carried out in Finland, where the authors argue that gender roles are quite equal, perhaps more so than the UK.

Explanations of PND

There are various ways of understanding PND, a lot of which lie in various discourses around, or ways of describing, women and mothers. Discourses are not just abstract ideas but lead to expectations regarding how women should behave or react, which has implications in terms of how power is allocated within a given society between men and women (Burr, 2003).

The first of the discourses ties in very much with discourses of what (or how) a good mother should be. This in turn links in with discourses of femininity and perceptions of how women should be. Burr (2003) describes the prevailing discourses of femininity as being “nurturant, close to nature, emotional, negatively affected by their hormones, empathic and vulnerable” (p.75). This, she argues, is seen to lend women very much to the role of mothering. The aspect of being negatively affected by hormones also links with the medical discourse of PND as an illness caused by hormonal changes, and could be argued as meaning PND is expected from someone seen as feminine; it is feminine to suffer from PND, in the same way that it was seen as feminine for Victorian women to suffer with nerves.

Other discourses of PND are more biological or medical in nature and are based on a scientific viewpoint, in which Nicolson (1998) argues there is a prominent discourse of positivism and seeking an objective truth. This approach views PND as an illness

caused by hormonal fluctuations occurring after childbirth (e.g. Dalton, 1980). Pregnant and postnatal women are very much within the medical sphere in the UK, with input from midwives and health visitors as well as possibly GPs and obstetricians using various methods of antenatal screening (Gross and Pattison, 2007). Medical intervention in childbirth itself occurs in more than half of cases in England (Gross & Pattison, 2007, p.8). It could be argued, therefore, that women are exposed to a medicalised view from the early beginnings of their birth experience. Ussher (1991) describes these discourses around pregnancy, childbirth and the postnatal period as being patriarchal in the sense that the medical profession is by men, but also that the scientific language that pervades the medical setting is masculine. This means that the very understandings that are communicated about pregnancy and birth are in terms of the masculine, rather than the feminine that is being discussed. The power is thus given to the masculine and away from the mother herself.

A more sociological understanding may look at contextual factors such as the relationships and support network that the mother exists in. If there are problems in the relationship with the child's father for example, or if the mother has a lack of emotional or practical support from friends and families, this may contribute to a feeling of isolation in the mother which may trigger depressive symptoms. Also if there are financial pressures, particularly for example with a mother being on maternity leave and on reduced pay, this can also exacerbate depressive symptoms.

All of these stances, however, describe PND from the outside looking in and therefore do not take account of the perspective of the mother. An alternative view was proposed by Nicolson (1998) of what is termed PND being a normal reaction to the stress of childbirth and/or the transition to motherhood, as well as to a lack of emotional or practical support. Counselling psychology is concerned with subjective experience (BPS, 2011) and so it is important for this study to follow this stance in looking at mothers' own experiences. Several researchers have conducted such

studies. In her UK qualitative study of 24 women's postnatal experience, Nicolson (1998) found that a recurring theme was that of loss, which Nicolson describes as a paradox; motherhood being an event in which things are gained (the role of being a mother) and also lost (the loss of the woman's former self and her independence). This paradox is strengthened with subsequent births. Acknowledging the loss which comes with motherhood may liken the experience to that of bereavement, which (apart from cases of complicated grief) is regarded as a normal process and not pathologised in the way that PND currently is. Acknowledging the loss could therefore mean accepting the symptoms of PND as part of a normal birthing process, rather than as a mental illness requiring treatment.

Mental health, mental illness and diagnosis

The term 'postnatal depression' in using the word 'depression' classifies PND as a mental illness. The question of this study is what it means for a woman to be diagnosed with PND, and therefore it is important to examine the literature around what mental illness means, the discourses around it and how it is experienced by the people that are diagnosed with it.

The concept of mental health and mental illness is challenged by writers such as Foucault who claimed that madness was used as a way of excluding an undesirable facet of society (Foucault, 1967). By confining people that are mentally ill, Foucault argues that madness is manifested as non-being and is thereby suppressed. Nowadays the 'madness' that is confined is likely to be those classified as psychotic, rather than depressive, and Foucault describes melancholy (as a precursor to what is now commonly referred to as depression) as madness at the limits of its powerlessness. Szasz (1974) also challenges the concept of mental illness as being distinct from organic physical illness as well as claiming that mental illness is used to obscure and explain away problems in personal and social relationships. He saw mental illness as experiencing problems of living.

Diagnosis, as well as diagnostic categories, are historically and culturally defined (Kleinman, 1988; Parker, 1999) with mental illness only having a reality within a culture that recognises it as such (Foucault, 1962). Fee (2000) proposes a constructionist perspective that shifts the gaze to the cultural and political context surrounding mental illness. The discourses of mental illness are described, and indeed created, through the language of psychiatry as experience is recreated through an internalised psychiatric dialogue (Fee, 2000b). This is not to deny that a mental illness such as depression does not exist as an experience, but that describing it in psychiatric terms loses a lot of the complexity of the experience (Fee, 2000b). This language also then places value judgements on mental illnesses as something that can, and should, be fixed or cured in the striving for a 'healthy' self (Hewitt, Fraser & Berger, 2000). Kleinman (1988) argues that there is a bias in psychiatry against prevention and towards treatment, which is confounded, he argues, by the close relationship between drug treatments and psychiatric knowledge, as well as funding. Kleinman argues that an ideal would be an integration of social factors with psychobiological ones. Ussher (1991) argues that the realm of psychiatric medicine is a patriarchal system. This is relevant to this present study situated within counselling psychology as counselling and psychotherapy have gained in prominence as a result of the feminist involvement in them as alternatives to psychiatry (Parker, 1999). It is also relevant when considering PND as a gendered condition that is described in terms of the psychiatric, and therefore according to Ussher, patriarchal.

Rose and Thornicroft (2010) defined diagnosis as marking the point at which a formal status of psychiatric patient is conferred, which can lead to stigma, and often gives rise to a negative reaction on the part of the 'patient'. Illich (1976) argues that diagnosis brings dehumanisation, labelling, the pathologisation of many human activities and iatrogenesis in which the condition is brought about by giving it a name and definition, in a self-fulfilling prophecy. Acknowledging the dehumanising potential of a diagnosis, Laing (1969) argues that one needs to understand a person's

existential context in order to explore and understand, and presumably therefore 'treat', their madness.

The use of psychiatric labels is, however, argued to enable communication between professionals (Parker, 1999). Macaskill (1999) argues that using a psychiatric assessment within a psychotherapeutic approach allows the right treatment to be determined, and also provides a framework in which to conceptualise the difficulties, allowing access to knowledge which can empower the client. However, empowering someone is still operating from a position of power in that it is assuming the power is yours to be given to someone else. This framework is argued to be helpful in terms of giving 'patients' a sense of hope and feeling that they are not alone in experiencing their difficulties; if the condition has a name then ergo other people have experienced a similar thing. Macaskill also argues that a diagnostic framework leads to a reattribution away from a perceived moral or character weakness and thereby externalises the issues. It could also improve the therapeutic bond by increasing the client's confidence in the professional's knowledge and understanding of the issue. From the perspective of the therapist, Macaskill posits that such a framework could alert the therapist to potential common problems, particularly those that may jeopardise the therapeutic relationship or any concealed symptoms. He does also acknowledge that it can also lead to an abuse of power and an over-focus on the symptoms, thus invalidating the client's experience and rendering him more helpless.

There can be some variance with regard to how a mental health diagnosis is applied and therefore what the impact of that diagnosis is. Rose & Thornicroft (2010) found in their investigation of service user perspectives that diagnosis can be a process of negotiation, which includes the strengths or benefits of the diagnosis, or it can be the blunt allocation of a label. In the latter case, a person can be reduced to their diagnosis in that it is seen as their whole, which, the authors argue, has an effect on

the self although not as a passive victim as service users have strategies to deal with it.

There can be a discrepancy between the incidence of a mental illness when comparing clinical presentation with scores on a diagnostic measure. De la Espriella, Pingel & Falla (2010) looked at levels of PTSD amongst former guerilla and paramilitary soldiers in Columbia and found that whilst there was a lack of clinical presentation of PTSD in patients, a PTSD scale administered by a clinician showed a diagnosis of PTSD in 57% of patients. This may be due to a degree of priming, in which using a scale primes both the clinician and perhaps the patient to the possibility of PTSD symptoms being present, which in turn may lead to them being over reported. As this study was conducted in Columbia, it is also possible that there are cross cultural issues of the scale used not being culturally sensitive and therefore an invalid measure of PTSD symptoms.

Women and mental health

By using the term postnatal *depression* it is arguably defined as a mental illness. More women than men are diagnosed with, or meet the criteria for mental illness (Ussher, 1991; Health & Social Care Information Centre, 2009). Ussher (1991) claims that the concept of madness has been used to oppress women by organising and regulating practices, dating back to the burning of supposed witches in medieval times through to Victorian times and modern day; women are positioned as other and then labelled as mad if they step outside of the status quo. She argues also that psychiatry is a less recognised branch of medicine, and so to assert its authority it adheres more strongly to the positivist scientific method which Ussher describes as patriarchal and therefore not suited to women. Even in the field of psychological therapy, Ussher makes the point that there is a movement towards registration and professionalization (and more currently towards scientific evidence-based interventions) which perpetuates this positivist stance of mental health care. This is

particularly relevant in the field of counselling psychology which exists within this mental health sphere but which prioritises the subjective experience which could be argued to favour the feminine. Ussher discusses the impact of economic status in that women are significantly poorer than men; they earn less on average for doing the same job and they are more likely to work fewer paid hours in order to take on more responsibility for children, housework etc. Increased poverty is linked with greater prevalence of mental illness (Ussher, 1991), and relying on another for income gives rise to issues of power and dependence in that access to finance gives a certain degree of power over another. Ussher (1991) also talks about the burden of care placed upon women, in that they are expected to look after children, elderly relatives, sick relatives and the home via housework, and this has an impact on women's emotional wellbeing. So women are more exposed to the factors that increase the risk of mental illness because of the social position they occupy. Also the concept of mental illness can be argued to be used to regulate behaviour. Postnatal depression therefore, as a mental illness, could be another way of regulating the behaviour of women and mothers in that a woman who acts outside of the preconceived expectation of how mothers should be is diagnosed, or pathologised, as postnatally depressed. Van den Tillaart, Kurtz & Cash (2009) found that women diagnosed with mental health issues such as depression experienced personal and societal stigmatisation. This stigmatisation led to a sense of powerlessness, marginalised identity and a silencing of health concerns, which meant that women had difficulty accessing physical health services. Whilst not looking at PND specifically, this study does include depression, which shares the same diagnostic criteria as PND, and therefore some of the same experiences may apply. This current study is interested in the process of diagnosis, how women react to it and what the consequences of it are.

Depression and PND as a mental illness

Parker, Georgaca, Harper et al. (1995) claim that the concept of depression serves a societal function in that the focus is shifted to the individual rather than society. This means that by locating the problem in the individual this also removes the responsibility for change from society to the individual. Relating this to postnatal depression specifically, this means that social factors such as support available for new mothers as well as other measures that may impact on new parents both individually and as a couple, such as parental leave and benefits, can be ignored in favour of treating PND at an individual level. This can also have the arguable effect that the individual is pathologised rather than normalised as part of a society that does not give the right support to new parents.

The labelling of PND as a clinical depression is challenged by Green (1998) who argues that the symptoms in fact form part of dysphoria. This therefore denies PND as a mental health disorder.

Drennan (2009), in a theoretical article, describes how women report concerns about taking medication for postnatal distress due to the fear of being stigmatised, although in their randomised controlled trial, Turner, Sharp, Folkes et al. (2008) found that some women changed their attitudes to medication after talking to health professionals. This could mean that their fears were alleviated by this discussion, however it is unclear whether this change in attitude was because of being better informed, or whether the women merely went along with professional opinion. So there is a concern about stigmatisation which comes with both having a mental health diagnosis such as PND and also with taking psychological medication. This reluctance to take medication may be due in part to evidence that some antidepressants are found to transfer into breast milk (National Institute for Health and Clinical Excellence [NICE], 2007), which may be of concern to a breastfeeding mother. The NICE guidelines therefore recommend a lower threshold for non-drug

treatments, particularly psychological treatments, in cases of PND than for other mental disorders such as major depression.

Edinburgh Postnatal Depression Scale (EPDS)

In the UK, PND is screened for using the EPDS (Cox, Holden & Sagovsky, 1987) which is a ten-question questionnaire which asks mostly about mood compared to how women used to feel. It is designed to identify a mild depression that may develop into severe prolonged PND as a sustained depressive disorder in the first year of childbirth (Cox & Holden, 2003). When validated against Research Diagnostic Criteria (Spitzer et al, 1978) it showed a positive predictive value (Cox & Holden, 2003) and shows a different, but comparable sensitivity to other depression measures such as the Beck Depression Inventory (Beck, Ward, Mendelson, Mock & Erbaugh, 1961) and the Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983). However, there is also evidence that it measures not only depression but also anxiety during early pregnancy (Jomeen & Martin, 2005) and that this anxiety can exist in the absence of depressive disorders (Matthey, 2008). This challenges the validity of the EPDS as a screening tool for depression specifically. Small, Lumley, Yelland & Brown (2007) compared the performance of the EPDS with English-speaking and non-English speaking women living in Australia and found that it was a consistent measure with good construct validity and item endorsement by women. Another benefit of the scale is that it has raised awareness of the potential for PND amongst health professionals (Cox & Holden, 2003). It must be borne in mind, however, that it is a screening, rather than a diagnostic, tool.

Overall, what is labelled as PND intersects with discourses around gender, womanhood and motherhood as well as mental health, mental illness and diagnosis. All of these areas intersect with each other in terms of how women and mothers are viewed in society and how this impacts on discussions around mental health. This present study will investigate the phenomenon known as PND in terms of how the

woman's own understanding of her experiences is shaped both by the dialogues surrounding gender and motherhood as well as how far this is impacted by having this experience defined within mental health parameters. Thereby in asking what does it mean for a woman to be diagnosed with PND, this study will be asking not just what it means for her to have the experience that is labelled as PND within her social context, but also how far that experience, and the sense of her experience, is shaped by the diagnosis itself. More specifically the study will be asking women about the circumstances leading up to their diagnosis, in order to identify any contextual factors that may have contributed to the experience. Also it will ask the women what they felt the impact of the diagnosis was.

Methodology

Grounded theory for the present study

The question for this study is “What does it mean for a woman to be diagnosed with postnatal depression?” This study will therefore examine the impact of having a diagnosis of PND on the women themselves. This includes the individual in terms of looking at the meanings women ascribe to the concept of postnatal depression as an experience and a diagnosis. It will also look at how those meanings impact the way the women negotiate their actions in relation to others as well as how social factors influence these meanings and actions. Using a grounded theory approach allows the study to focus on both the individual and the social levels and how they interplay. Also, as the experience of PND is an area in which there is not a great deal of existing research, the creative and initially broad approach of grounded theory is argued here as useful. Grounded theory would also contribute findings and ideas to the research field that come from the women themselves, rather than health professionals, or researchers adding their own abstract interpretations (whilst still acknowledging the impact of the researcher herself on the findings). This gives a different perspective which would add to existing research, and which may give rise to ideas that would not have otherwise emerged.

Using the constructivist approach of Charmaz (2006) means acknowledging the role of the researcher in the negotiation of meanings for the participant. It will ask the questions of how and why the women attach meaning to their own, and others’, conduct. Grounded theory also allows for a wider sampling (initially) to allow ideas to emerge that otherwise may not with the homogenous sampling approach of other methodologies such as Interpretative Phenomenological Analysis (IPA; Smith, 1996). By not imposing pre-conceived sampling criteria at the outset, which would inevitably have to be informed by certain expectations, the approach is more open to what might, rather than what might be expected to, emerge.

The research question “What does it mean for a woman to be diagnosed with postnatal depression?” indicates three main overlapping areas of investigation. It indicates women, and so is looking at issues of gender, the discourses around gender and the roles and expectations being a particular gender carries. It explores diagnosis, which is the categorising of experiences deemed to be outside of what is considered normal. This includes the discourses around mental health and mental illness. The term ‘postnatal’ also indicates parents, primarily mothers, and so looks at expectations of mothers and motherhood both of the mothers themselves and of the society in which they exist. All of these areas link together and are all arguably socially and culturally specific. They also have an underlying concept of identity; how one identifies as a woman, a mother, a mentally ill person, both separately and as an intersection of the three. It is this social and cultural influence which also suggests Charmaz’s constructivist grounded theory as the appropriate method as it uses the ideas of social constructionism. This means it looks at how meanings are co-constructed or negotiated via interactions between people. This version of grounded theory therefore seeks to deconstruct concepts used by the researcher and participants, and widens the view to include the historical and cultural context (McLeod, 2001).

This constructivist approach is also consistent with the feminist position on interviewing women put forward by Oakley (1981) who emphasised the importance of validating women’s subjective experience as women and as people. She argued that to find out about people, thus achieving rich data, it is necessary to build a rapport, which requires a level of intimacy and a non-hierarchical relationship between the interviewer and the woman being interviewed. Oakley argues that this is particularly important when the research involves a woman interviewing other women, as is the case with the current study. One way this will be addressed in the present study this will be by conducting the interviews in a place in which the participants are familiar and comfortable, including their own homes if they so choose.

Another important aspect of Charmaz's grounded theory approach is that of reflexivity of the researcher, and being aware of the moral dimension of the research and the impact of the researcher's own experiences (McLeod, 2001). This will be addressed by the use of a reflexive journal throughout the research process, and a critical stance of what is said by the researcher in the interviews as much as by the participants.

Qualitative methods in psychological research

Scientific research in how it is conducted makes both ontological assumptions about what reality is as well as epistemological assumptions about how we gain knowledge of that reality. Psychological research has traditionally followed the realist ontology of the natural sciences in assuming an objective and 'real' truth to the world (Willig, 2008). This 'truth' can be known, according to this tradition, either by directly perceiving the world (a positivist epistemology), deriving knowledge through facts of experiences including experiments (an empiricist epistemology) or devising theories and hypotheses that can be tested and falsified (a hypethetico-deductivist epistemology) (Willig, 2008).

More recently there is a trend within counselling psychology towards research methods that are not rooted in this positivist tradition (Fassinger, 2005). These qualitative methods are rooted in a relativist ontology in assuming that rather than an objective truth there are a variety of interpretations that can be applied to the world. These methods are therefore concerned with finding meaning behind human experience and how we as human beings make sense of our world.

Choice and rationale of method of data analysis

Willig (2008) argues that three questions should be asked of a research methodology: What kind of knowledge does it aim to produce? What kinds of ontological assumptions does it make? How does it conceptualise the role of the researcher in the research process?

Previous research in this field has looked at the experience of women postnatally, and who have a diagnosis of PND (e.g. Beck, 1993). This study aims to build on that research by looking at the specific impact of the diagnosis and will do this by interviewing women, or in other words, looking at women's narratives of their experiences. Creating, and attending to, a narrative is an active and constructive process in which there are several levels at which aspects of practices and experiences are communicated (Mattingley & Garro, 2000). Examining these narratives could therefore be done in several ways. The research literature reviewed here shows the importance of identity as linked to the social discourses around femininity, womanhood and motherhood, as well as mental illness. It could therefore be useful to conduct a critical discourse analysis (Fairclough, 1989). This would examine the narrative construct to allow an exploration of the sociolinguistic rules regarding which discourses are allowed and which suppressed (Mattingly & Garro, 2000). While the current study is interested in the influences of social discourses, the focus of this study is the social processes of the postnatal experience and the diagnosis of this experience as PND. It will also look at how these processes occur within the context of the discourses as part of the wider environment. These areas of focus fit more with a grounded theory approach (Starks & Trinidad, 2007).

Another possible approach would be IPA (e.g. Smith, Flowers & Larkin, 2009). This approach would be concerned with how women experience and make sense of the phenomenon of PND in the context of their perinatal experience. This would be much more focused on the individual meanings arising from the individual experience. The current study is more concerned with this individual experience as part of a social process in terms of the actions taken by the women as a result of their experiences. This social focus is consistent with a grounded theory approach (Starks & Trinidad, 2007).

Grounded theory methodology

This study is following a grounded theory approach. This is a qualitative (in this case) and sociological approach which seeks to discover new ways of making sense of the social world, and to generate a theory to explain the phenomena being studied that is 'grounded', in other words arising from, the data (McLeod, 2001). It is an approach that was originally developed by Glaser & Strauss (1967) as a reaction against the dominant positivist tradition of the time. It was also a way of approaching sociological research in a systematic and qualitative way that moved beyond the descriptive level to something more analytical (Charmaz, 2006). As an approach it combined the principles of positivism and pragmatism, the latter of which views knowledge in terms of how it is and can be used rather than how accurate or representative it is per se. Pragmatism informs the ideas of symbolic interactionism (Blumer 1969). Symbolic interactionism looks at the meanings we have, which it argues are negotiated in our interactions with others and society, and influence how we act and respond, and is founded in a constructionist and interpretivist epistemology (Crotty, 1998).

Glaser and Strauss later diverged in their approaches to grounded theory with Glaser sticking with the more traditional method of grounding categories in the data, whilst Strauss moved the method more towards verification and technical procedures for identifying categories (Strauss & Corbin, 1990). Charmaz further developed these ideas to argue that a theory and data are not discovered, but that the researcher is part of the study and the data that is collected (Charmaz, 2006). Thus, according to Charmaz, data and theories are constructed through interactions both with participants but also our personal interactions past and present as well as our interactions with research practices. This assumes an interpretive epistemology in which data gathered is a construction, or interpretation, of reality.

Developing the theory itself occurs through a process of making tentative interpretations which are tested by gathering more data until new data fails to bring

new insight, which is described as the point of saturation (e.g. Charmaz, 2006). This study, more specifically, is using the constructivist grounded theory approach of Charmaz (2006) which builds on ideas from symbolic interactionism. Grounded theory, using these ideas, asks questions about the meanings participants attach to things, people or concepts such as postnatal depression, and how these meanings inform the actions the participants take. It also considers the interview process as one example of an interaction, with the researcher as an active player, in which these meanings are negotiated and modified.

Reliability and validity in qualitative research

Reliability and validity are concepts that are based within a realist ontological tradition in which they seek to quantify the extent to which research replicates its findings of an objective, static truth and is able to represent that truth (Madill, Jordan & Shirley, 2000). It can therefore be argued that reliability and validity have no place in qualitative research that ontologically denies such a truth. By viewing truth as subjective or even intersubjective, any findings from a qualitative study are not going to be replicable and are only valid for that given situation. However, it is challenged as to whether such concepts are important when qualitative research gives great depth of understanding. It is also argued that qualitative research has strengths in its own right that are different to that of quantitative but nonetheless valuable. It could be argued that trying to prove reliability and validity in qualitative research is trying to describe itself in the language of quantitative and thereby give silence to the language of qualitative itself, in much the same way as feminists argue that the feminine loses its place when described in the language of the masculine. Indeed it could be further argued that quantitative methods and its corresponding realist ontological position are an extension of the logic of the masculine position, whereas qualitative could be said to exist within the semiotic or the feminine space.

However, by widening the definitions of what constitutes validity and reliability, Willig (2008) argues that they can be redefined to suit the purposes of qualitative research. She defines validity as the extent to which the research describes, measures or explains what it aims to. This might be problematic in a grounded theory study in which, as the theory arises from the data, the end product may be far removed from anything previously considered by the researcher. However, it should still be adding to the knowledge of the phenomenon under scrutiny. One of the ways in which validity can be demonstrated according to Willig is through participant validation in which participants feedback on the findings. She also argues that the validity of a qualitative study is increased when the data is gathered in real-life settings, and when the researcher uses a process of reflexivity to identify her own assumptions and work to acknowledge them. Using the constructivist grounded theory methodology of Charmaz means actively using this reflexive process as it acknowledges the researcher's part in co-creating both the data which is collected as well as the product of any analysis. In this present study this was achieved by the use of a research journal, documenting any reactions of the researcher throughout the interview period and subsequent analysis. The researcher also reflected on her own position with regard to motherhood, womanhood and PND and acknowledged the potential impact of this on the subsequent data.

Henwood & Pidgeon (1992) propose seven attributes that characterise good qualitative research. Other authors have also proposed similar lists of criteria, but Henwood & Pidgeon's list was informed by grounded theory research and is therefore more relevant for this study. These attributes are: (1) the importance of fit, in terms of how well the categories that emerge in analysis fit the original data. (2) the integration of theory, in which the process of how the theory is formed and integrated is well explained and documented. (3) good reflexivity of the researcher. (4) a detailed documentation of what was done and why in terms of the procedure. (5) use of theoretical sampling to extend and modify the emerging theory and also negative

case analysis to explore cases that do not fit with the theory. (6) sensitivity to negotiated realities, meaning an attention to ways in which the research is interpreted by the participants, part of which may be use of participant validation of categories. (7) transferability, meaning the extent to which the theory can be extended beyond the specific context of the study which requires a full and detailed report of the contextual features of the study.

Reliability and validity in this study

This study is investigating the meaning of being diagnosed with PND and therefore specifies participants that have been diagnosed. The criterion is that they have been diagnosed since February 2007, as this is when the current NICE guidelines were published with regard to perinatal mental health (NICE, 2007). Therefore any professionals involved with participants at the time of their PND should have been operating within the same framework.

Interviews with the participants were carried out either at the participant's home or in a suitable place in the community that the participant was familiar with. This follows Willig's assertion that validity is increased when data is gathered in real-life settings (Willig, 2008). The choice of whether to meet at the participant's home or in the community was made by the participant herself. Following the interviews they were then transcribed and the transcripts were sent to the participants to verify that they were an accurate account of what was said.

Ethical considerations

The research for this study received approval from the University of Roehampton's Ethics Committee and also met the ethical criteria for the British Psychological Society (2010) and the Health & Care Professions Council (2012).

As the participants in the study were women who had been diagnosed with PND, one of the main considerations was their emotional wellbeing. It was possible that they

might be in psychological therapy as a result of their PND and so it was stipulated that anyone who was either in therapy or had completed within the last six months was excluded from the study. This was to safeguard any therapeutic process that the interview may have interfered with. Participants were made aware from the outset that the interviews would be asking questions about their experiences and that this may bring up difficult emotions for them. They were also informed that they could withdraw from the study at any point. At times during the interviews when participants did get upset, the researcher was sensitive to allow them to set the pace of how much they wanted to say and also whether they were OK to continue with the interview. At the end of the interview there was an opportunity to debrief about how it felt to talk about their experiences and also a list of support organisations was given if further support was needed subsequent to the interview.

As some of the interviews were conducted in the participant's own homes, as part of the overall risk assessment for the study, certain safety procedures were followed with regard to lone working. This included the researcher alerting someone when she arrived at the home and again when she left. An emergency procedure was in place should the researcher not have phoned by an agreed time.

The role and impact of the researcher

The constructivist approach of grounded theory acknowledges the role of the researcher in having an active part in how the research is carried out, the data that emerges and the subsequent analysis. For the present study, the researcher identifies as female, aged 32, and is a mother to a child who was aged four at the time the interviews were carried out. With regard to the researcher's own experience postnatally, she was not diagnosed with PND but could identify with a lot of the struggles described by women that have. She did not have the birthing experience that she wanted in that she had an elected caesarean because the baby was breach,

rather than the home birth she had wanted. She was able to breastfeed, which was painful for several weeks and was feeding the baby every two hours, day and night, which left her exhausted. Breastfeeding also meant that she was tied to the baby and unable to leave him for any prolonged period of time for several months. As someone trained and employed in mental health, PND was something the researcher was very aware of as a possibility but also something that she was keen to avoid, both in terms of the experience and also of the label. She attributed her low moods to the tiredness and adjustment to being a new and first-time mother, and whilst she felt quite detached emotionally from her baby at the beginning, she attributed this to the experience of the caesarean, in which she felt she was given a baby rather than had one, as well as the subsequent exhaustion. The researcher had a lot of support available locally from both her family and her husband.

With regard to the study, the reason why the researcher was so keen to investigate PND was partly from a personal interest of early motherhood, which was still quite current at the time of the study. There was also a growing interest in the discourses around women and what was expected of them, which mirrored some of the researcher's own dilemmas around being a mother and balancing that with a career, coupled with a tension with regard to gender roles. The researcher grew up in a family where the mother did stay at home and look after the children, but also where independence and ambition was prized. The researcher also has her own unease about mental health diagnosis and pathologising experiences and behaviours, but experiencing the tension of this against people being able to receive help and support when needed. As a trainee counselling psychologist, the researcher was encouraged by the discipline to be critical of the status quo and prize intersubjectivity, and was also involved in clinical practice which would impact on the way she approached an interview situation.

The participants

The question for this study is what it means for a woman to be diagnosed with PND. Therefore the participants were women who believed they had been diagnosed with PND, living in the South East of the UK. The South East of the UK has a large and diverse population in terms of factors such as class, ethnicity, race etc. Participants were recruited via advertisements placed on internet forums aimed at new mothers (such as Netmums and Mumsnet), as well as organisations that work with new mothers such as Homestart. Some participants were also recruited by recommendation of other participants, a process called nominated sampling (Morse, 2007).

23 women responded to the adverts, of which 20 met the criteria and were sent follow-up correspondence (via post or email) giving further details of the study, participant information and a consent form. 9 women responded and were booked in for interviews at a mutually convenient location, of which 8 were attended. The demographics of the women who attended interviews are detailed in Table 1. The 'relevant child' is the child whose birth was linked with the diagnosis of PND.

Table 1: The demographics of the participants

Participant	Age (at interview)	When diagnosed (time postnatally)	Age of relevant child at interview	Order of relevant child
Annie	37	9 weeks	3 months	2nd
Belinda	32	4 months	3 years	1st
Charlotte	27	9 months	3 years	1st
Daisy	39	4 months	4 years	1st
Emma	33	5 ½ months	10 months	1st
Fiona	31	3 ½ months	7 months	1st
Georgina	37	3 months	4 years	2nd
Hannah	32	13 months	3 years	2nd

The participants that attended interviews believed they had been given a diagnosis of PND subsequent to February 2007. They were also not currently, or within the six months prior to interview, attending psychological therapy. This was in order to safeguard their therapeutic process. The aim of this recruitment strategy was to ensure as far as possible that the experiences surrounding the diagnosis were recent and were related specifically to their postnatal experience. This in turn will arguably mean that the participants were more likely to give a fuller reflection of the experiences and circumstances of their postnatal period, which is important for obtaining rich data from the interviews. No other eligibility criteria were imposed.

For five of the eight participants, they were diagnosed with PND with their first child. For the remaining three their diagnosis was with their second child, although one of the mothers felt she had non-diagnosed PND with her first child as well. At the time of the interviews the mothers ranged from being three months to four years postnatal with the median average being two years. The diagnoses of PND was received between two months and thirteen months postnatally with the median average being four-and-a-half months postnatally. Each of the participants was allocated a pseudonym prior to the interview, the initial of which followed an alphabetical pattern. This was in order to protect their anonymity as far as possible.

Procedure

The data was gathered via semi-structured in-depth interviews lasting around 60 minutes, with some flexibility to extend in order to cover the area fully and allow for sufficiently rich data to emerge. The opening question of each interview was “Tell me about the circumstances which led to your diagnosis of postnatal depression”. This was to allow the women to have some choice with regard to what as well as how much detail they chose to disclose, and was sufficiently open so as to allow for the

women's' own understanding of what led to the diagnosis, rather than being led by the researcher. Subsequent questions were determined by what participants had said and were asked in order to clarify or expand on details. At some point during the interview, however, all participants were also asked how they felt being given a diagnosis impacted on things. Examples of further questions asked can be found in Appendix E.

Grounded theory methodology uses different sampling criteria at different stages of the research. Initially the study aimed to get as wide a range of participants as possible, in order to allow findings to emerge which are not restricted to one particular social group, and also to allow for any findings that may differ across social groups as these may warrant further investigation. This was achieved by advertising for participants in the variety of places mentioned, in order to recruit as wide a range of mothers as possible. In order for rich data, it is important to locate 'excellent participants' (Morse, 2007, p.234) which means that participants need to be an expert in the phenomenon being studied, have the time to share their story in a reflective manner, and are able to speak articulately about their experience. For this study, this means that the women were experts of their own experience of postnatal distress. During this initial stage, the interviews were transcribed and then coded using open coding. This means going through the transcript, line by line initially and writing all the possible actions and meanings being talked about, thereby looking at the content of what is being said and inferring what the woman was doing when she was saying it. Appendix F shows this process for the first interview with Annie. The transcripts, and corresponding codes, were coloured, with each participant being allocated a different colour of font. This was to allow a visual mapping of where the codes had come from and to ensure that as many participants as possible were represented in any codes. The transcript was then gone through section by section in order to identify the focused codes, the full list of which are detailed in Appendix G, with Appendix H showing an example of an emerging category with all of the codes colour coded

according to which participant they came from. Examples of codes from the present study include comparing aspects, resigning herself or protecting herself. This follows Strauss and Corbin (1990), who recommend defining categories by actions rather than abstractly. This stage was carried out after the first four interviews were conducted. Any initial codes that seemed to be talking about the same thing were then grouped together into more overlying categories, and the list of categories that emerged are detailed in Appendix H. During this process gaps and inconsistencies in understanding were shown, which gave rise to further questions about the data and what was said. Any questions or gaps in understanding that emerged then informed later sampling criteria, which is referred to as theoretical sampling (Charmaz, 2006). Any gaps also informed the questions that were asked of new participants. The initial coding stage was then repeated for subsequent interviews. This process of re-interviewing and asking increasingly specific questions, and re-categorising responses, continued until the point of saturation i.e. when new data failed to add new insight.

The emphasis for data collection using grounded theory is to obtain sufficiently rich data from the interviews (Charmaz, 2006). Therefore sample size is important. McLeod (2001) recommends a sample of between eight and twenty participants, claiming that too few is bordering on a case study and too many results in too much data to analyse fully with repetitive and redundant data. Charmaz, in her grounded theory study with chronically ill men (1994), used a sample size of twenty, however, other grounded theory studies within the field of psychotherapy have used smaller sample sizes of seven (e.g. Bolger, 1999). Grounded theory studies looking specifically at PND have used samples of nineteen (Abrams & Curran, 2009); twelve (Megel, Wilson, Bravo et al., 2011; Beck, 1993) and nine (Homewood, Tweed, Cree & Crossley, 2009). In line with this previous research in the field, the current study aimed for a sample size of fifteen to twenty participants, but found that saturation

occurred with eight participants. This meant that after eight interviews, no unique information or insights were given.

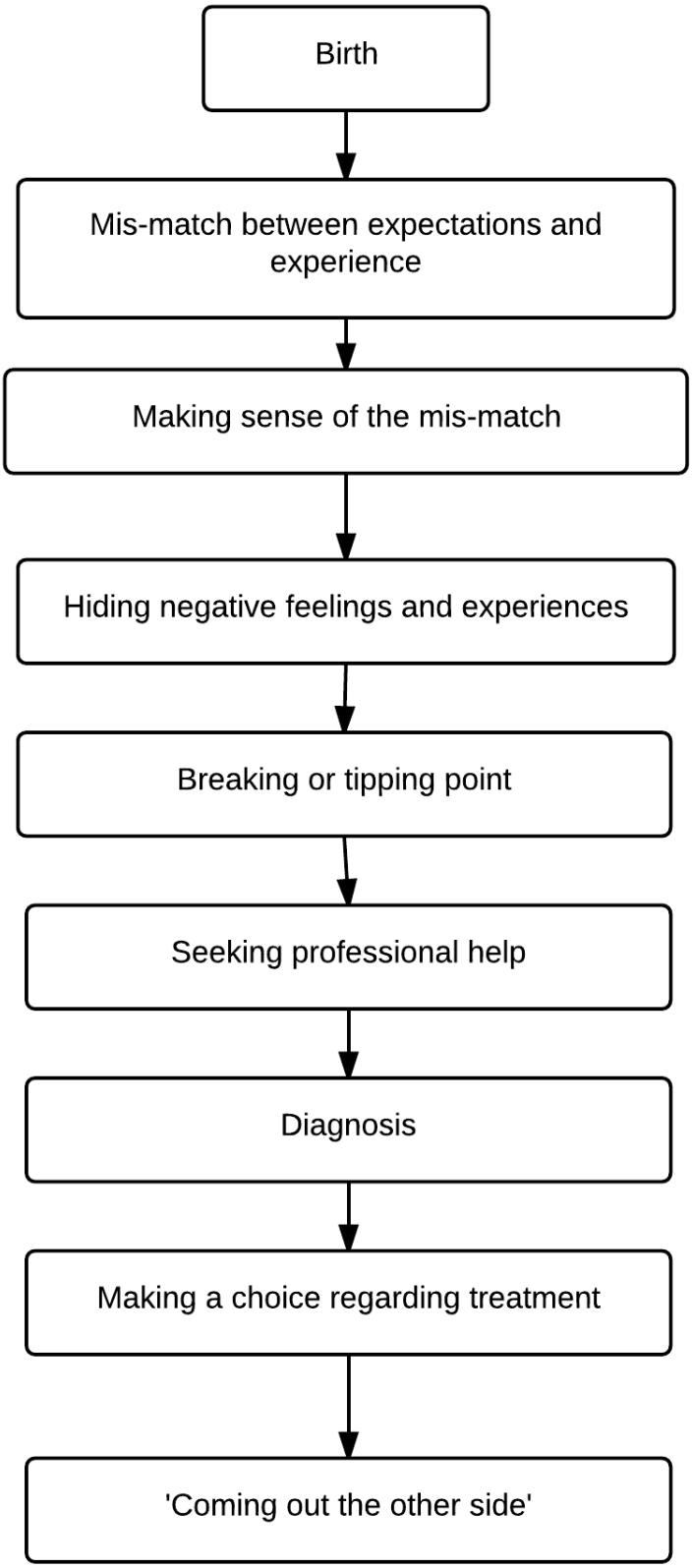
Analysis

PND as a process

When interviewed and asked to describe the circumstances which led to their being diagnosed with PND, the categories that emerge from what the women describe appear to follow a fairly consistent pattern or process which occurs postnatally. This process is illustrated in Figure 1. It is acknowledged that the process may start before having the baby, as far back as the mother's own childhood, but due to the research question focusing us postnatally, we pick up this process at the point of birth. Direct quotations from the interviews have been used to illustrate and support the formation of each stage of the process. Further quotations to support the themes can be found in Appendix J.

It should also be noted here that alongside this process is the presence and adequacy of professional support. This is not strictly a category with regard to what it means to have a diagnosis of PND but is something that is mentioned as part of the experience both leading up to the diagnosis as well as the experience post diagnosis. It forms part of the narrative as to why women feel they came to be diagnosed, and indeed professional input is a prerequisite for being given that diagnosis. The professional input at all stages is argued here to be relevant to the context of the process and the feelings that arise at each stage and subsequent stages. Thus professional support received in the earlier stages may well set the scene for feelings and experiences further down the line and so professional input at all stages is therefore worthy of discussion. It is also a point of interest for this study that all of the routine professional input comes from within the medical sphere.

Figure 1: PND as a process



Birth

Despite not being asked about the birth explicitly, all of the women included the birthing experience within their narrative. Some of the women described quite traumatic experiences linked with the birth, whilst others describe the birth as a positive experience.

The professional support at the time of the birth was not always talked about explicitly by the women during the interview, other than for Belinda who mentions a mis-diagnosis that was made. It was also not asked about explicitly as the focus of the research question was postnatally and the researcher was keen to allow the women to tell their own narrative of what they felt led to their diagnosis. However , despite the lack of explicit mention it is argued here that the input of professionals is still present in the background. An example of this is the case of Emma who believed that her baby would be born dead. How the information around the risks to her baby were conveyed to her, as well as whether her fear was recognised and acknowledged would arguably have impacted her birthing experience. She went on later to describe a debrief that she was able to have with the professionals to discuss her case, and an important outcome of that for her was that she was able to realise that the drop in the baby's heartbeat was not due to choices she made. The importance of this demonstrates that she was carrying a certain level of blame for what happened, which may have been averted if space had been made at the time to explain what was happening more fully.

It is also interesting to note that even mothers who did not suffer a traumatic birth still went on to be diagnosed with PND. This indicates that the birth is only part of the story. Following the birth, all the women describe some sort of subsequent mis-match in how things are experienced as opposed to how the women expected things to be for them as a mother.

Mis-match between expectations and experience

This first category of expectations can be further separated into three sub-categories: the expectations of motherhood, expectations of what constitutes a 'good' mother and the expectations the women have of themselves as mothers. All of these are sub-categories which emerged from the data.

Expectations of motherhood

Looking first at the expectations of motherhood, a common code that emerges from the data is the discourse that having a baby should be a wonderful, happy experience:

> ..because you're not meant to be depressed are you, when you've just had a baby, you're meant to be 'Look at my new baby, yay!'.
>
> - Georgina

> ...because I'm meant to be happy, I'm meant to be.. I'm meant to enjoy every moment..
>
> - Daisy

However, none of the women's experiences matched this 'wonderful' account; what comes out of the interviews is a sense that it should be wonderful but it is not for them. This gives rise to other feelings such as loneliness or fear:

> ..I find being a mu.. being a mother is.. er.. is just the loneliest.. I find it so lonely, because nobody around you, not even other mothers know.. er knows exactly how you feel...
>
> - Annie

> Yeah, it's just.. it's a lonely time I think. It can be a scary time.
>
> - Georgina

So what stops it being this 'wonderful' experience? Several of the mothers discussed how hard they found motherhood, some describing it as relentless, both physically and emotionally, and some saying how unprepared they were for this relentlessness:

> I don't think.. think anyone could ever put across, certainly I've never read it, about how actually it's just.. your whole world is turned upside down. Everyone thinks, you know, baby come along and life happens and you just get on... and I don't think anything really conveys quite, quite what happens when parenthood comes...
>
> - Hannah

This shows the dominance of the discourse of motherhood being wonderful in that the relentlessness, which doesn't fit this discourse, is not discussed. It is this silence which causes the women to be unprepared for it.

In describing where these expectations of motherhood come from, the women point to both peers and family members and also parenting books that make things sound much easier and straightforward than they are. The women described where these expectations come from:

> ..they [parenting books] don't tell you what to do if what they say doesn't work erm.... and they say, you know, all babies will do this, this this and this and I just.. and it didn't work.
>
> - Emma

> ...you read the books of 'Routines are really easy to get into and you can do this and do that' and I think maybe that's where some of it stems, you know, well OK the baby's going to sleep you know at 10 o'clock, 12 o'clock and 3 o'clock and bed at 7 kind of thing, so if they're sleeping then well I'll be able to hoover here and iron here and get husband's dinner ready here, but actually it doesn't happen...
>
> - Hannah

An area in which this struggle with the relentlessness became apparent was in relation to the partner, where the women expressed dissatisfaction at how the partner returned to his normal life, and had respite where they did not:

> ..I'm not off duty' I said 'you go to work' and I said, you know,' that's your.. your respite, that's your change, that's your something else', I said 'I haven't got a something else.'
>
> - Hannah

> ...my husband's life went back to normal straight away, to the point where he was almost sort of proving that he didn't have to change anything.
>
> - Daisy

> ...I think the transition from being quite a career-focused woman to being at home is quite a big transition erm, especially when your husband is still working and still in that.. career-focussed mindset...
>
> - Fiona

This may be merely seeing the contrast in what their partner can do highlighting their own lack of freedom. However, it might also be part of a wider struggle of the woman finding herself and her place within being a mother; a struggle between her identity as a mother and her old one prior to having children. All of the partners mentioned in the interviews were male, and so it may be something about gender differences that means that partners are not subject to the same restrictions postnatally. It may also be due to practical considerations such as women being solely responsible for certain tasks, for example if they are breastfeeding. There are also more social factors in that women are able to take parental leave of up to a year, whereas fathers are only entitled to two weeks, meaning that it is predominantly the women who stay at home with the baby. Either way, it still points to a struggle in the transition to being a mother.

Expectations of a 'good' mother

This second sub-category incorporates ideas of what a 'good' mother is in terms of both how she is as a person and what she does. One way in which the mothers in this study assess this is by judging herself against her peers. In this study assumptions emerge that other people are coping well and are relaxed about things with their babies, leading the mothers to feel inadequate if they feel they are not.

Alongside this is an assumption of judgement by their peers, either implicitly or explicitly meaning there is a sense of competition between mothers with regard to their baby's development or behaviour, with an accompanying feeling of lacking and not quite meeting the standard set:

> ..you look.. look at other people coping, what appear to be coping very well and you just used to get.. I used to get quite upset that I couldn't just be happy, you know.
>
> - Daisy

Linked with this is an expectation of certain 'motherly' tasks that they should do, which emerged from women expressing issues when these tasks were taken on by other people, particularly their partners; despite appreciating the efforts made to support them there is also a pervading sense that they should be the ones doing these tasks:

> I should be the one getting up doing it all, not trying to get myself out of bloody bed'
>
> - Charlotte

Belinda explains why this feels important for her:

> ..my husband had to look after him and he had to sort of take over, but I think again that affected the bonding because you bond through doing things for them don't you?
>
> - Belinda

So not only do they feel that they are the ones that should be doing the task, which suggests a pervading discourse of the role of either the woman or the mother in doing childcare tasks. Belinda's concern about the effect on bonding may partly explain this discourse in that it is not merely a practical thing about allocating tasks, but also a relational one in that it is seen to affect the mother-baby relationship. There is also a sense of guilt at not doing things. This is even when they can acknowledge the positives of their partner taking over, as in the case of Charlotte, and also when doing things with the baby causes a great deal of physical pain, as with Belinda. This guilt may have deeper roots tied in to thoughts about the relationship with their baby.

There was also an expectation expressed in the interviews by some that they shouldn't be depressed or that they should be coping better than they are. This links

in with ideas of identity in terms of the mother previously considering herself in a particular way:

> ...I like to feel that I'm informed, capable, erm, yeah and organised and that all fell to pieces..
>
> ...I was quite tearful one day and they said to me 'You need to speak to your health visitor, coz I don't think you're managing partic.. you know to cope with what's going on at the moment, you know, you're finding it hard' erm, and I just thought 'No, a stiff upper lip, I've always coped with everything, I'm always in control, I don't ask for help'.
>
> - Daisy

The implication is that that particular way of viewing herself previously, leads to expectations of being able to cope in a way that she does not feel is realised. There is also perhaps a sense of attempting to hold on to this concept of herself by not asking for help, perhaps trying to prove that she is still that strong, capable woman.

One interesting point that came out in the research interviews is that all the mothers at some point in the interview asserted their love for their baby.

> ..I mean I loved her.. there was no denying that, you know, I loved.. you know I loved her to bits, never resented her, anything like that, but I found it ever so hard to accept that overnight my life had changed regardless of whether I was ready or not.
>
> - Charlotte

> ...you know I wanted [baby]; he was, you know, love of my life and such when they come out, you know and adorable and beautiful and all those things...
>
> - Daisy

> ...like I said I had moments of wanting things to be different but not.. not not wanting either of us to be here.. yeah, that was definitely something I never felt so..
>
> - Emma

Whilst the researcher did not have any reason to doubt this sentiment from any of them, the fact that they felt the need to assert it is interesting. This need perhaps comes from a pervading sense that somehow being depressed postnatally is either expected to mean a lack of love for the baby, or a desire to do harm that the women want to discount. It could also be that, as a mother, it is important not only that they love their child but they are *seen* to love their child as part of fulfilling the expectations of being a 'good' mother.

Expectations of what constitutes a 'good' mother also links in with the concept of needs in that there was a sense that the women expected a 'good' mother to both be attuned to her baby's needs and also to put her baby's needs ahead of her own.

> ...I'm one of those people that puts other people before myself, um, and er obviously you're going to do that for your child anyway, but you know, push yourself aside all the time..
>
> - Daisy

The fact that Daisy uses the word ‘obviously’ implies that it is a given that a mother will do this. This shows the level of expectation which is so great it is not even questioned.

One area in which this negotiation between the needs of mother and baby became apparent is that of breastfeeding. The mothers in this study had their babies at a time when breastfeeding was encouraged as the best means of feeding babies and all of the mothers in this study started by breastfeeding their baby. Thus a category emerged from the data about a pressure to breastfeed.

Pressure to breastfeed

This is the pressure experienced by mothers to breastfeed, partly from a cultural drive that focuses on the benefits of breastfeeding, particularly for the baby. For some of the mothers, breastfeeding worked well but for others it was a struggle:

> I was struggling with the breastfeeding but felt like I had to continue...
>
> - Emma

Underlying these accounts is a sense of pressure which comes from themselves and their own desire to breastfeed but also reinforced by those around them, including their partner and health professionals. From what the mothers said in the interviews, it seems that a major driving force of this message comes from the health professionals who push breastfeeding to the extent that they neglect to support alternative feeding methods. When breastfeeding did not work well in the beginning there was a sense that professionals were intent on persevering with breastfeeding and trying to make it work, not allowing the women to change their minds and opt for bottles:

> ..I felt there was a real lack of support from midwives and health visitors, especially the health visitors, and I felt all they wanted to do was push you into continuing to breastfeed erm, when actually I don't think that was the right thing for me to do.
>
> - Fiona

The message that breastfeeding is best for baby is prevalent throughout these accounts and the women go to great lengths, and disadvantage in some cases, to adhere to this ideal. This inevitably links with expectations of a good mother, a link made explicitly by some:

> ..then I probably would have stopped, but because everyone I spoke to was basically making me feel like a bad mother for wanting.. for even questioning the fact whether I should continue.
>
> - Fiona

> they do they go.. make you feel like you're a terrible person to even consider not breastfeeding your child, so a lot of pressure is put on new mothers for that...
>
> - Georgina

Others did acknowledge the benefit of bottle-feeding:

> ...obviously it helped me a bit more if it wasn't just down to me to feed her all the time.
>
> - Charlotte

It also ties into the interplay between those expectations and the negotiation of needs. Thus mothers feel the need of the baby to be breastfed supersedes their needs for either comfort, time to do other things or even medication to help their mood:

> ...there could have been a mild antidepressant that did work with the breastfeeding, but yeah I just felt that I couldn't because I wanted [to breastfeed]..
>
> - Georgina

This demand was made even greater by the mother having to bottle-feed expressed milk. Breastfeeding is hugely emotive, and as some of the women express, there is a feeling of failing if you cannot breastfeed your baby.

Some women also hint at breastfeeding being used to make up for some other perceived lack. Here the mothers feel they are failing their babies in other areas, either by being a bad mother in general or by not loving their baby as they feel they should. Breastfeeding then represents an area in which they feel they can still be a good mother in one aspect:

> ...I just think it would have helped me bond with him if I could have just, you know, I couldn't do anything coz my pelvis was practically broken but at least I could sit there and breastfeed him; that was one thing that a mother can do, which I couldn't even do that, and it was just.. yeah, really sad really.
>
> - Belinda

Being unable to continue breastfeeding was suffered as a loss. This is a loss that the mother feels but being unable to nurse one's baby is also against the template of a

‘good’ mother which may add to any feelings of inadequacy or failure the mother may have. Therefore it is not just about the baby getting nutritional value but represents something much wider in terms of the relationship between mother and baby.

Mothers continuing with breastfeeding despite their struggles resulted in a level of anxiety in the mother and several of the women feel that this contributed to their depression. This was due to struggling with something that wasn’t working for them alongside the guilt of not being able to breastfeed as they wanted, or felt they should, as well as the ongoing stress of doing something they did not enjoy. There was also the possible negative impact on the baby picking up on the mother’s anxiety making feeding quite traumatic in cases. Even in cases where breastfeeding went well, it still meant that no-one else could take over the feeding, which was particularly an issue overnight as it meant that the mother had disturbed nights but did not have the opportunity for a night off to catch up on much-needed sleep. During the day it also meant that the mother was limited in her time away from baby, meaning she would have little time for herself.

The pressure to breastfeed comes from a societal pressure:

> ..I think the breastfeeding was a peer pressure from around.. outside influences made me feel ‘This is what you must do’ and obviously you then put it on yourself and you know it’s the right thing to do for your child...
>
> - Hannah

There was also pressure put upon themselves, in some cases as wanting to breastfeed as one thing they could do right for their baby. This does incorporate the

message that breastfeeding is a good thing for baby, which comes, at least in part, externally.

As well as the pressure from professionals came pressure from themselves in taking on the message that breastfeeding was best for baby. Interestingly, when describing the benefits of breastfeeding and explaining why they were so keen to try it and do their best to continue, the women focused on the benefits to the baby, particularly nutritionally or bonding with the baby. The benefits to the mother (of losing weight, helping the uterus to contract, protecting against cancers later in life or even the practical benefits of cost and convenience) did not seem of concern. Ironically breastfeeding is one of the preventative measures against PND (Borra, Iacovou & Sevilla, 2014), though obviously only when it works for mother and baby; when it doesn't then it may be one of the contributing factors. This indicates a link between expectations and needs in that a 'good' mother is expected to breastfeed her baby, even if this is putting her needs aside in favour of the baby. This negotiation of needs also manifests with regard to medication as few antidepressants are suitable when breastfeeding and so women often made a choice between taking medication and breastfeeding.

Expectations of themselves as mothers

The third sub-category of expectations is the women's own expectations of how they will be as mothers. This may be to do with their perceptions of themselves as people and therefore their expectations of themselves as mothers and how they would cope with the challenges of motherhood. This links in with another category of identity, which will be explored further on. One of the ways in which their expectations of themselves is demonstrated in the research interviews, when the women describe a process of questioning their previous sense of themselves.

> I didn't think it would affect me as much as it did, coz I've always been quite a strong person..
>
> - Charlotte

Thus they think of themselves as being strong, organised or someone who copes with things, and the subsequent doubt or confusion that results when they struggle implies that they had certain expectations of how they would manage motherhood. This can sometimes lead them to resist the fact that they are struggling.

Wider than the expectations around mothering, the women also talked about expectations around mothering alongside other tasks. Some expressed an expectation, that seemed to stem from their own beliefs, that they should be able to manage the baby as well as the household tasks. Hannah described it thus:

> ...my biggest thing was feeling like a failure if I wasn't doing what I should be doing, or coping... you're supposed to be superwoman and actually you're not a superwoman and nobody expects you to be, it's.. it's just what you've built up in your head...
>
> - Hannah

Another area in which this manifested is when negotiating being a mother with paid employment:

> ...I think it was mixed emotions as well ... I'd just gone back to work, she started not sleeping, I felt guilty for going to work... I wanted to go back to work, but I felt guilty about wanting to go back to work but I had to for my sanity really, and I've always been a very independent woman; I've always worked... not that I didn't want to stay at home with

> my child.. with, like, my daughter, but thinking 'Well, I should want to. I shouldn't want to be going back to work' but I had to for myself ...obviously she started not sleeping, which I think.. which was think.. I was thinking 'Is that something to do with me going?'
>
> - Charlotte

This would suggest a belief that as a mother she shouldn't want to go back to work and have time away from her baby, and indeed Charlotte is keen to assert that she did want to stay with her child despite wanting to work. This may link in with the assertions mentioned earlier in being seen to love one's child as part of being a good mother. This sense of herself as a mother as well as an individual brings ideas of identity. For Charlotte, working is an important part of her identity and so we move on to explore identity as a category.

Identity or sense of self

This category concerns those aspects that relate to the way in which the women see themselves as individuals. It is the sense of who they are in terms of personality traits and qualities, or lack thereof. It also includes their sense of themselves in relation to the experiences they have, in terms of how much they attribute responsibility for things that happen to external factors and how much they assume for themselves. This then affects their sense of agency in controlling events, how they judge themselves, and their ability to manage these events. It is also about how they perceive themselves within the frame of being a mother and also being a depressed mother.

One of the ways in which this manifests is in the sense of the baby being put before the mother, leading to a diminished space for the mother. This may link with a change of identity from an individual to being a mother; several women described a process of realising that they were no longer an individual but recognising that they had

become part of a unit in which the baby was not only a part but also the main focus. This happens practically in the mother having little 'me' time in favour of doing things for the baby, but also in interactions with others:

> ...I think it's.. sort of linked to a feeling I had that, erm.. a slight sense of invisibility once you'd had the baby, everyone was sort of all about the baby and, you know, a kind of.. but it..it's not that I felt invisible but it's just sort of like I was, you know, she was kind of 99% and I was just this tiny little 1% left at the end of the day, um.. as far as everyone was concerned, which was which was great but erm, you know, and obviously she's, you know, got to take priority now but erm, still sort of a sense of 'What about me?' It's my life that's changed as well..
>
> - Emma

This bias in attention towards the baby is also experienced from health professionals:

> ...Coz it does become all about how the baby is thriving and how.. if the baby is growing and putting weight on and there's very little done for the sort of health of the mother I don't think...
>
> - Fiona

This indicates a lack of space in which the mother exists as her own entity. On a practical level this makes it difficult for any issues the mother is experiencing to be recognised and acknowledged. It also means a lack of metaphorical space that the mother may need to negotiate her new identity, resulting in a diminished sense of self. The expectations of a good mother also come into play in the assumption, as described by Emma, that the baby *should* be the main focus. This also links with the prioritising of baby's needs as discussed previously. This negotiation of needs may be

what leads to the mixed emotions Charlotte describes at going back to work. Even when professionals do ask about the mother, this doesn't always serve to counteract this effect:

> ..it's a weird one because on the li.. on their list is..is that question 'And how's your mood?' but I felt they didn't really want to hear the answer. They.. I..I.. I feel like.. they have got tick boxes, and erm they..they have been told that postnatal depression is a big problem and.. and whatnot, but the caring's just not there...
>
> - Annie

Linked in with this idea of space is the allocation of time for herself as an individual, which several women describe as lacking in the early days of motherhood, but which several recognise the need for retrospectively. Even if the need is recognised, practical issues come into play as to whether it is feasible. Perhaps again there is something here about not being seen to be wanting. This again links with negotiating the mother's needs with those of the baby or the family. This negotiation of needs emerges as a category in its own right and interplays with expectations of a 'good' mother who, as discussed, puts her baby's needs ahead of her own.

This active prioritising of the baby has also been demonstrated with regard to breastfeeding. This is distinct from when Emma experienced other people focusing on the baby rather than her. However, in explaining that the baby needs to take priority, she is pushing her needs aside. Another example is when mothers describe putting their plans on hold for their babies, for example going back to work, taking up hobbies or taking some time either for themselves or as a couple. This may lead to feelings of guilt, as Charlotte described at wanting to return to work, or of resentment of a

partner's return to 'normality' in having some independent time as previously discussed.

Following this discussion of needs is how the mother's needs are met by the timing of support available. This may also form part of the mismatch in terms of the support the mothers expect and what they ultimately receive:

> ...as I say 10 days later you're still getting used to the fact that you've got a whole new being, that's.. it's still quite overwhelming with, you know.. so I don't think it's a fair judgement to do a postnatal review, a depressive review coz as I say, 3 months, 4 months down the line it's just worth having a discussion to see how we're doing
>
> - Hannah

Thus there seems to be a feeling that the early postnatal period was necessary to adapt to becoming a mother/parent and that any ongoing problems would not become apparent until later. Even when support is available it can be difficult to access:

> ...I know they say that you go in for the baby's weighing, you can always talk to the health visitors but, it's missing.. you've got a problem and you need to talk to somebody so to actually phone them up and say, or drop in and go to the weigh clinic and then saying that actually you do want a chat is really hard, whereas if somebody phones you, you're not instigating it, it's quite scary to have to take the lead on it and be able to take the opportunity to have to say.. 'Actually my hormones aren't.. or still aren't right'...
>
> - Hannah

This raises questions about how to make support more accessible in these later stages. This may mean, as several mothers suggest, having increased support and/or checks as standard at this time. It could also be about removing the barriers to women actively seeking the support. These barriers may be practical, for example in terms of location, or may be linked with issues around stigma at asking for help or admitting the struggle. This idea of stigma will be explored more fully when discussing how women make sense of the mismatch.

So there is an issue around the timing of support available but also more generally about the level of support and resources in terms of people being able to access them.

Making sense of the mismatch

So there is a mismatch between how things are expected to be and how they turn out. The expectations arise from the women's previous sense of themselves as individuals, which they project into how they expect to be as mothers. Expectations also come from discourses around how motherhood is, which are predominantly positive, as well as how a 'good' mother 'should' be. How things turn out is partially affected by the women's negotiation of their needs versus those of others, which is in turn affected by their sense of themselves and their needs as valid. So if the experience does not match what they expect, how do they make sense of that?

The dominant discourse is that motherhood is this wonderful, happy experience, and the mothers perceive those around them to be coping well with the demands of motherhood. A common way of making sense of it is that they are the only ones struggling with the experience and therefore it is some kind of lacking in themselves as to why they cannot cope when other people supposedly can.

> I just.. I felt I was the only one, that everybody else was fine and perfect, I was the only one that didn't feel that way.
>
> - Georgina

> ...but sort of felt, you know, coming back to that sense of inadequacy that I couldn't, you know, I wasn't having this, you know, experience of motherhood you're meant to have..
>
> - Emma

> ..makes me feel useless, absolutely useless and um.. a failure, a real failure.
>
> - Belinda

This shows the power and prevailing nature of the discourse of motherhood being perceived as a wonderful experience. The women assert this assumption as though it is fact and they judge themselves as lacking in some way when it doesn't happen for them. The feeling of failure that Belinda mentions is distinct from feeling like one has failed, and appears to refer to a more deep-rooted sense of being a failure as a mother and/or a person. This feeling may also be hinted at less directly in the example of Daisy struggling to reconcile her sense of herself as an organised, strong person who should be able to cope with the challenges of motherhood quite easily with the struggles she had with the demands of having a baby and the lack of control that she felt. Belinda and Emma explicitly link feelings of inadequacy or failure with this expectation, whereas others talk about their identity as a mother and how they perceive themselves in that role. Perhaps unsurprisingly, the women in this study do have thoughts that they are a bad mother in some way:

> I wanted to enjoy it, I wanted to enjoy him and I ended up, at some points hating him and hating being a mother and didn't think I was.. I shouldn't be a mother, I was like saying to mum 'I'm just not designed to do this', 'He deserves better than me'...
>
> - Fiona

> ...I don't know whether I'm just not cut out for.. for the role, and yet I also think I am, you know, I.. On.. in some ways I'm quite a good mother, but I just think I some.. I often hate doing it.
>
> - Annie

These ideas play into those surrounding the concept of silence, in which the negative side of motherhood is kept hidden and therefore not recognised as a normal part of the experience. They then feel that they are the only ones struggling, which can lead to other feelings such as isolation, inadequacy and guilt. This concept of silence is one which emerges from the data and comes into play at various stages of the process of becoming diagnosed with PND.

There is some retrospective rationalising of the situation:

> ... truthfully you don't know what goes on behind closed doors, how other people are coping...
>
> - Daisy

However, it is the subjective experience at the time that shapes the women's experiences and is therefore considered here.

Perhaps linked with this is the woman's identity as someone who is experiencing the struggles labelled as PND:

> ..and you're just feeling, yeah. An outsider.
>
> - Belinda

Alongside this is the concept of validation and the corresponding lack of validation which includes the categories of: not feeling understood; feeling guilty; not being how you 'should' be; feeling judged, especially as a bad mother. This then links in with the category of expectations of how a 'good' mother 'should' be.

There is also a link to the category of a diminishing sense of self where the experience of having what is later termed PND involves a doubting or questioning the woman's own sense of what is going on.

> ..I want someone to validate what's going on so that I feel like I'm not so alone with these feelings. Ah, it's difficult, it's difficult to get them out so that people can hear them...I'm talking rubbish...it feels like I'm talking in riddles.
>
> - Annie

This doubt in one's own perception of how things are relates to the category of relief at not 'going mad'. This relief implies a previous sense or fear that they were going mad, meaning they were interpreting their view of the world as faulty. It also relates to a sense of confusion as to what one's feelings are and not knowing one's own wants or needs. It may also link in with the dismissing of one's internal sense of things, for example by dismissing negative feelings as tiredness rather than acknowledging the

emotional struggle that later becomes apparent. This forms part of the lack of validation.

So one explanation of the mismatch between expectations and experience is a perceived failing or lack in themselves. Another obvious explanation is depression or PND. Some of the mothers were previously aware of depression, or PND specifically, as a possibility. How depression is perceived and understood beforehand affects how this plays into their understanding:

> ...you know when people are depressed you think maybe about them sitting at home crying all the time, or.. you know all the different things like not being able to get out of bed and stuff, but because I never really had any of that, I was purely, just thinking I was a bad mother...
>
> - Charlotte

So in ruling out depression as an explanation, Charlotte reverts to assuming responsibility as a bad mother. Other mothers do mention thinking they may be depressed but these thoughts become more apparent further along in the process.

Hiding negative feelings and experiences

This stage in the process also emerges as a category in its own right and encompasses situations in which the woman feels she needs to hide her experience and her feelings from those around her. Part of this may be linked to not having the language to adequately express how she is feeling:

> And it feels like what's under a lot of the stuff that's underlying it is sort of screaming out at me, but I can't, I can't express it, so what comes out

> is quite hurtful I think to the person that's listening, but it's the only way I can get it out.
>
> - Annie

Keeping silent is partly about protecting people, namely friends and family:

> I didn't feel comfortable admitting to my husband erm.. although I talk openly about.. to him now about it; at the time I'd be trying to hide.. I think I didn't want to be a burden on him...
>
> - Belinda

There is also something here about preserving the existing relationship. Some of the mothers had worries regarding their children:

> ...was worried about the impact I was having on [baby] coz clearly I didn't really want him to be around the negativity I sort of had..had around me ...
>
> - Fiona

> ...the other thing was, you don't want them to pick up on this wobbling wreck of a mother... I think, you speak to most mothers, whatever their trigger was, they were all, all of them at one point probably said they felt guilty for feeling that way, and didn't really want their child to see them crying or not coping, erm, coz they didn't want it to affect them...
>
> - Daisy

In these cases the women try to protect their children by trying to hide their negativity. Daisy is able to rationalise in hindsight that her baby wasn't adversely affected but still

acknowledges the fear at the time, both for her and other depressed mothers she met in her support group. Part of this rationalisation may be made possible by the fact that the interview took place several years after the event during which it is felt that any effects would have shown themselves. This wanting to protect also therefore links in with the category of needs, in which the woman's need for support is negated by the perceived need of others' protection.

Hiding their feelings and struggles also links in with the feeling amongst the mothers that they are the only ones struggling. This contributes to a sense of isolation, which some mothers add to by further isolating themselves either by not going out and interacting with other mothers for fear of being judged as failing, or by hiding how they are feeling from those around them.

> I think when I was really low I just didn't want to be around anybody and spent a lot of time in the house...
>
> - Fiona

> ...I didn't know who else to call; I didn't want to admit to anyone else, coz all my friends had babies around the same.. similar time, and I didn't want to ring them up and say, you know, coz they're coping, and I'm not...
>
> - Belinda

There is an assumption that other people will judge them for how they are feeling, or for the lacking they perceive in themselves:

> ..I don't really talk about my mood with.. with other mothers, because I don't.. I don't want people to judge me on that, I don't want people to

> think ‘Oh,’ you know ‘poor [baby], he’s having to deal with mother at home that’s got depression’ erm, and I don’t think.. I don.. I.. I feel like other mothers would discuss it and I don’t want to be a point of discussion.
>
> - Fiona

> Probably more the fear of being judged and being labelled..
>
> - Georgina

This is an assumption, but in some cases it becomes a reality that the woman is judged by those around her:

> ...when it got to being really bad, there was just like ‘Why why.. what have you..’ especially my mother, ‘what have you got to be depressed about? Erm, are you trying to say it’s something that we did when you were young?’ and it’s like ‘No’ and yeah even, like my mother was like, you know, ‘You’re not depressed, sort of pull yourself together, thousands of women feel like you..
>
> - Georgina

Some of the mothers expressed a wish to keep their feelings private, explaining that as why they didn’t want to share outside of their immediate family.

> ..I felt it was.. it’s a very private thing for me erm, and I’d hate.. I would still hate friends of mine to know now coz I think I’d still feel like I’d be seen as a bit of a failure when it came to surviving motherhood..
>
> - Fiona

This then links back to fear of judgement, feelings of being a failure and perhaps again a sense of shame:

> ...for the people that I don't know, I suppose like me that would have never ever thought.. and as well some people are ashamed aren't they? To admit it, or to say..
>
> - Charlotte

This taboo was understood in terms of other people not being able to cope with her negative feelings, but there was also a sense of PND somehow not being as you 'should' be, which links in with the category of expectations of a 'good' mother. This also links in with the category of silence in that this sense of failing in coping as she 'should' be is partly what leads her to hide how she's feeling from others, either from a fear of judgement or from a sense of shame. This perpetuates a silence around the negative experiences, which emerged as a category in the data.

Part of this silence is not wanting to admit they have a problem, as if somehow admitting it makes it more real. It could also be waiting for someone else to notice:

> ...if someone could just listen to what's ke.. being said and then sort of hear what's hurting, then perhaps they could say 'Look, let's just do this. Let me just do this for you. Let.. let me do this so that you can do that'
>
> - Annie

This hiding of their feelings also means a delay in asking for help. Alongside this is a lack of professional input postnatally that contributes to the hiding of the problems.

Breaking or Tipping point

So the women make sense of the experience not matching expectations in terms of them lacking as a person or as a mother. They therefore hide how they are feeling to protect loved ones from worrying about them and also to prevent people judging them for this lack. This occlusion of the struggles the woman is experiencing continues to a point at which the feelings and emotions can no longer be kept hidden, or they reach a level at which the woman feels the need to acknowledge that she needs help.

> ...nobody really knew how I was feeling inside until I got to the point where I couldn't hide that and crying came very very quickly because I was just feeling, erm, oh, depressed..
> ...when I couldn't cope any longer from hiding my emotion I just burst out crying in the middle of a weigh-in erm and they picked up on that...
>
> - Daisy

> ..by hiding my difficulties I felt I was protecting them but actually I was only... as [daughter] said in the car, you know..she was aware.. so that broke my heart knowing that she was more aware of me than actually anybody else was, erm, as I said, you know 'Mummy keeps crying.. I'm so sad because mummy keeps crying all the time' and I thought I've got to.. I'm affecting the kids and I thought I was protecting them but actually I'm not. If my 2 year old is coming out with this, whatever it takes I've got to do it...
>
> - Hannah

It is interesting that this tipping point often comes from either not being able to hide it any longer, or because of the impact on loved ones, particularly children. This would

suggest that if women were able to continue to hide it successfully, meaning that loved ones were not aware, then they would do so. The drive to seek help in these cases does not seem to come from a recognition of a need for the woman herself. In cases where there is a recognition of the mother's struggle being above what is considered normal, the children are younger at the time of the interview. It may therefore be that the experience is more immediate, with the accompanying feelings and negative process being more readily accessed. This may mean that the other mothers over time have, subconsciously, adapted their narrative in terms of the influence of their feelings on other people. This may indicate a still pervasive message that considering others is what mothers or women should do, and that seeking help or support for their PND may be seen as a negative, perhaps selfish, thing unless it cannot be helped or is for the good of those around them. This may link to ideas around permission and entitlement to receiving support that still bears out retrospectively, in that women do not feel entitled to seek support for their own needs. Therefore their narratives are reshaped, subconsciously, to be more in-line with what is deemed acceptable, by the discourses of what women and mothers should do or be.

Seeking professional help

This tipping point is the point at which the women in the study sought professional help. Some of the women had previously sought support, either emotional or practical, from their partner or family members. For others, this tipping point was the first time they made the approach for support, and it is interesting that invariably it is professional input that is sought at this point, either from the GP or the health visitor, rather than support from friends or family. It could be that these avenues have been exhausted already, and as mentioned some women had pursued this support. But nonetheless there does seem to be something about taking the struggle outside of

the immediate unit, perhaps looking for external validation or perhaps as an extension of the woman trying to resolve the struggle herself. It may also be part of the influence of the medical sphere that the woman has been subject to from the beginning of her pregnancy in that any problems, either during pregnancy or postnatally, should be rectified within the same sphere.

There is still a sense of the woman balancing her needs against those of others including family members or even other people who may need the same professional help:

> ..I'm a strong believer in thinking there are often people worse off than me, but you know I did have a couple of moments where I felt very very low...
>
> - Daisy

A category relating to the adequacy of professional help interplays at this point, both in terms of the support available and also the recognition of the woman's needs by health professionals.

The standard professional input was initially from a midwife, transferred to a health visitor after ten days postnatally, with a GP check at about 8 weeks. With regard to the help that is routinely available it was felt that there was a variation in the support available to different women, even within the same locality, and there was little continuity in terms of which professional one saw. There was also a feeling of lack of time in which to explore feelings, and more generally it was mentioned that women would feel more comfortable opening up in their own homes, with the same person that they have built up some relationship with.

> ...I think that in your home, you're much more likely to talk about something rather than actually having to go and take yourself to the doctors and then talk to a doctor who you don't really have a relationship with coz you see a different doctor every time.
>
> - Fiona

There is also further support that the women sought once they'd reached a point where they had to acknowledge they were not coping and needed help. This help came from health visitors, GPs and counsellors or other talking therapies. As the system exists, if a woman wants help then the onus is on her to approach a health visitor. For some they have access to a health visitor who persists with them:

> The health visitor...she just kept coming round and coming round, making me fill in those silly questionnaire forms...the health visitor, you know, kind of made a drama with it, that things weren't great, and if I didn't get help they weren't going to get any better coz I don't know how long I would have gone on without asking for help..
>
> - Georgina

Overall access to professional input was mixed, with some mothers finding it difficult being able to approach either professionals in general, or a perceived expert:

> ..I would have liked to have spoken to somebody who was more of a specialist in babies and new mothers who might have been able to help me more than a GP..
>
> - Fiona

Others described the process as quite positive once they had made the initial approach:

> .. [I] approached a health visitor with a concern and then just sort of broke down and then you sort of get referred on to your health visitor and from that point on, was.. had an appointment and was seen, it was efficient..
>
> - Daisy

Adequacy of professional support is not just about the services available; there is a significant role for professionals with regard to validation. Some of the mothers expressed feelings of being dismissed or of not being taken seriously by professionals, whilst others are appreciative of the professional that did recognise a problem and encouraged them to seek help or offered them support.

It was mentioned by some that they felt that when they talked to professionals their needs were not recognised and they felt reduced and not understood.

> I feel like they pay lip service to the fact they realise it is a significant problem but there's.. but there's nowhere to go with it unless you're prepared to take the medication.
>
> - Annie

So, in summary, the women reach a point at which they choose to seek professional help with how they are feeling. This help, at least initially, exists within the medical sphere and there appears to be wide variation in the experience of accessing it. There does, however, seem to be some consensus about wanting more support available, especially at a later period, such as three months, postnatally. There is also

an issue expressed regarding how support or services are made known, which may link to the concept of silence discussed earlier.

Diagnosis

This approach for support leads the professional to administer a screening for PND via the EPDS, which in the case of the women in this study leads to the professional ascribing the experience to PND. Following this 'diagnosis' is the women's immediate reaction, a common one of which is relief:

> ...that relief that it was, not that it was that, coz obviously it's not that I wanted it but as I say it was that it could be worked on and say I wasn't going mad, I wasn't a bad mother, it was perfectly normal when you are a new mother to go have so.. but yeah, I think that was more the relief that it was something and not just me thinking I was nuts.
>
> - Charlotte

Relief at not 'going mad' describes a process in which a woman is having negative feelings and experiences that she is struggling with but which she places inside of herself, doubting them as something that truly exists, yet at the same time knowing on some level that things are not how they should be.

> ...I didn't know what was going, I didn't know what I wanted...
>
> - Charlotte

> Yeah, it was.. I just kept thinking I was tired. I thought I'd be better when she sleeps better and I sort of focussed an awful lot of energy on trying to get her to sleep bit better ...
>
> - Emma

> ...and then when it hit.. when I got it later.. later down the line I was.. I think for me I was confused as to whether it was or whether it wasn't ..
>
> - Fiona

This may be because she feels she shouldn't be feeling this way or doesn't want to admit to feeling this way as this would mean acknowledging a failure in herself either as a person or as a mother. It may also be that the way she is feeling doesn't make sense to her, as she has no language for it. It does point to a dissonance between how the woman is feeling and experiencing things and her perceived reality; what she is feeling doesn't match what she either thinks she should be feeling or what she feels is rational. One solution to rectifying this dissonance is to assume that her feelings are wrong, in which case she needs to reinterpret them or rationalise them as going mad, being stupid, being hormonal etc. Another solution is to assume that the external reality, as she perceives it, is wrong.

Madness can be described as a dissonance between how you perceive the world and how the world 'really' exists. This sense of reality could come directly from your own perceptions and experiences, but if this was solely the case then there would be no feeling of dissonance; the reality would merely adapt according to the new experience. This therefore suggests that reality is, at least partly, co-created by external ideas of how things are. This input is more social, coming generally from the societal level, as well as more specifically from friends and family. As reality is thus co-constructed, adapting one's sense of reality becomes more complicated and requires external input to validate this new perception. One such way would be from an authority, such as a health professional. Therefore receiving a diagnosis of PND may be a way of an external input, that carries with it a sense of authority in the form of knowledge, training, experience etc, creating a space in which the dissonance can exist; having this condition meaning that your experience can be outside of what you

expect. There is also a sense of having one's own sense validated; it's not crazy and in the women's heads, it is something real that is actually wrong, which can be recognised and worked on. It is almost as if the women doubt that they are actually feeling the way they are, possibly because they are trying to distance themselves from it or needing to be told it's okay.

The phrase 'not going mad' may also point to a paradox in which receiving a mental health diagnosis actually said to the women that they weren't 'mad'. This may be a distinction between different mental health issues, namely depression and psychosis, and/or maybe have something to do with PND being a transient mental health problem that is situated within a specific time and event. This may then allow the diagnosis, and the condition, to be placed outside of the woman herself, such as 'It's not a fault of myself as a person, it's the fact that I've had a baby'. This in turn may link with ideas of identity, or sense of self in relation to what is labelled PND.
However, it is interesting that a lot of the women laugh when they talk about going mad, or being a bad person, which could be taken as a nervous laugh used to defend against the discomfort caused by the thought. It could therefore be that on some level, even retrospectively, part of them believes it.

Linked in with this may also be the relief of it having a name/label, which means that somebody knows what it is (or at least appears to), and more importantly that something can perhaps be done to manage it and make things better. The women also describe an opening up of the dialogue:

> I hadn't.. before I had the diagnosis, I hadn't really spoken to anyone else about it, it was only afterwards that I told people that I was on medication..

> ...the diagnosis sort of made it okay to say, you know, actually there's something not right, I'm not feeling right, this is what's happening, I suppose...
>
> - Emma

> ... it was at that point that he mentioned to his family that I was.. whereas up until that point he hadn't said a thing, you know.. his side of the family had no idea I wasn't coping, erm, but once I'd been diagnosed and I'd gone to get some help, he'd said to them, you know that I'd been diagnosed with PND...
>
> -Daisy

It could also be to do with the woman feeling strong enough to talk about difficult feelings, which she is more likely to either after time has passed or after she has received treatment, which she will not get until after the diagnosis.

> I do think I was more confident to speak to him [her partner] once my mood had lifted..
>
> - Fiona

The exception to this was Georgina who, as discussed earlier felt that there was a stigma attached to being depressed within her friends and family, and so even having a diagnosis made it difficult for her to talk about what was going on for her. She was, however, more prepared for the possibility of her friends that were having babies struggling and feeling depressed.

> ...it was just once I was kind of been diagnosed and put back on medication that I would kind of say, you know 'How, you know, how are

> things?' you know, kind of more of try and find out, you know how they were coping...
>
> - Georgina

She also had the ability to be open about her feelings in her support group.

Fiona felt that her diagnosis gave her partner some level of understanding and a language in which he could attempt to understand her experience, even if she felt it didn't exactly fit her specifically.

> ...I think initially probably when I spoke to my husband he wanted it to be 'Well this is the reason you're feeling low, or this is the reason' he wanted to be able to define it and I couldn't do that but then when it was titled PND for him, he was like 'Right, now I can go and find out the reasons and find out..' and he.. it almost gave him something to.. like the facts to be able to go and sit down and understand it rather than me just going 'I'm feeling really low. I feel really awful. I don't want to be a mother. I hate our child' I don't think that, for him, erm was reason enough.
>
> -Fiona

She did however still feel that she wanted to keep her depression as something private to her and her immediate family. This may be because she felt she had adequate support from her own mother or possibly because she still felt shame or fear of judgement.

Having a name or label also means that other people have suffered with it before, as something wouldn't have a pre-existing label otherwise. This may link with ideas around having a common language to talk about the experience in a way that others

will understand, but also counteracting the sense of not being the only one to have the experience as discussed previously.

This links to a process of opening up. All the women interviewed described being more open about their depression and negative experience after having a diagnosis:

> ...like now I'll openly say to people I've had postnatal depression because I think it's good to say that because if someone hears me say it.. For example, I said to a friend a few months ago I had postnatal depression and then she came up and said 'Oh, I've got it too, I'm on antidepressants'; if I hadn't brought that up freely she might not have talked to me about hers...
>
> - Belinda

> ...I didn't feel strong enough I think to talk about it, and to talk about the feelings, whereas now, I mean, my friends, a lot of my friends know now that I did have it...
>
> - Charlotte

There may also be something about who women choose to talk to and why: professionals, who may be perceived as knowledgeable and objective; another mother who may be expected to be able to empathise; or someone they have an intimate relationship with such as their partner, friend or family member.

The sense of validation may also be something to do with having their experience recognised by another, and therefore link to feelings of being understood by someone, contrasting with the category of feeling isolated as part of the experience. The majority of women describe wanting to be understood. The experiences of being

understood that are mentioned occur post-diagnosis, either in counselling, a peer support group, or a supportive family member, usually their mothers:

> I didn't speak to everyone about it, but like my mother I could actually go and talk and you know, and say things and not.. and not think that I'm being judged...
>
> - Charlotte

There may, however, be an importance placed on this other being viewed as expert, or experienced, knowledgeable etc, as opposed to a family member. Hannah, for example, made the point, and therefore perhaps placed importance on the fact, that her sister-in-law (who suggested PND) was a nurse and had medical training.

> ..I'd thought it for a while but it's one of those things I didn't want to admit it, so somebody actually saying it to me and somebody there that was actually knowledgeable in it saying 'Actually you need to go and see somebody'...
>
> - Hannah

This may therefore link with accessing professional support and a value placed on that knowledge or 'expertise'. But this is contrasted with feelings that one shouldn't be like this or needing help, and so there is still a conflict:

> Yeah, it was.. it was, you know, obviously I said it was a relief to have sort of offloaded it and have someone say this is what's actually wrong, but at the same time it was, you know, 'I shouldn't need to be taking this, but I do', it's all sort of a bit of a conflict of.. feeling I suppose as to why I should take it..

- Emma

This relief at something being done about it extends into a sense of hope for the future which links more widely with a category of opening up possibilities which emerges from the data.

Opening up of possibilities

This category describes the process in which receiving a diagnosis leads to both a sense of things becoming possible, such as getting help, feeling better, as well as the things that actually happen as a result.

> It's slightly less frightening as well, knowing that that's what it is and perhaps I can get help with it .
>
> - Annie

This includes identifying other issues that need addressing, such as relationship issues:

> ...getting as low as I did post, you know, postnatal, then makes you realise, or made me realise, erm what other things were missing, what other things I felt I needed to, to just be happier in myself...
>
> - Daisy

It also includes highlighting needs of the mother that aren't being met and identifying ways of coping that either are no longer appropriate or that need to be added to the current repertoire.

> ...but I've since, I've learned how to get out of it now, erm, and that's through studying... if I use my mind.. I'm always.. I'm always reading a text book, I'm always studying, and that is how I've learned to deal with it...
>
> - Belinda

> And it was off the back of support from other people and getting coping mechanisms...
>
> - Daisy

Receiving a diagnosis means some sort of external explanation of the woman's experience, which is then incorporated and integrated into the woman's own sense of what is going on for her and why. For example, whereas previously she may have viewed her situation as arising because she was a bad mother, or lacking in some way as a person, she may now externalise the reasons why she was struggling. Charlotte describes this process for her:

> ...after my counselling, when they stemmed it back to the sort of whirlwind of a year that we'd had; the birth.. coz I'd had an awful labour and birth, erm, and once I'd talked about it and realised I wasn't going mad, and it's very common for women to think the way that I did, erm, that I could sort of put it behind me and move on, and I totally changed; I totally changed my views of life then..
>
> - Charlotte

Daisy was able to recognise other issues that contributed to her struggle:

> ...getting the support from the group was.. was fantastic, erm, but I think ultimately, off the back of having a diagnosis of PND was erm.. still need.. it, basically within our.. I think we.. we've.. we then realised that maybe our relationship was not necessarily.. was one of the main triggers really coz we weren't communicating effectively.
>
> - Daisy

As a result of this 'diagnosis' the woman then has a choice of treatments, namely talking therapies, including groups, or medication. There is at this stage a process of negotiation of choosing which treatment, if any, are appropriate for her.

One of the things that women who subsequently receive talking therapy, either individually or as part of a peer support group, value is the space where they can say things and not be judged:

> ...it was through having group therapy and being able to say what you really needed to say or what you really were thinking, and not actually feeling judged at all, that makes.. that makes a diff.. that made a difference.
>
> - Daisy

> ...having a group of like 4 friends that I met through the erm CBT, it was.. they were the only ones that I could fully talk to and say how I was feeling, without the feeling of being judged or people giving you that look of 'Really?! You thought that?!'
>
> - Georgina

This shows the importance, and the impact, of having a non-judgmental space, and people to relate to.

There is also something about the diagnosis validating the woman's own needs, as contrasted with that of the baby. This may be a need for support as described by Annie:

> I think with my parents, my mother particularly, even with.. even with her it kind of validates that the extra effort that she's having to put in...
> ...if I'm going to be asking for that help, it's easier if I can say it's been recognised that I have postnatal depression rather than just 'I'm just really finding this hard work'.
>
> - Annie

This was due to feelings of guilt at asking her mother for practical help. It also suggests that the reason for requesting help needs to be either something external, or something validated externally, for it to be seen by others. Annie's internal sense of struggle was not enough. Another need is what one of the mothers referred to as 'me time', which can be taken to mean some time in which to be herself. Charlotte described the importance of her going back to work, which may link in with this. This links in with the category of hiding how one is feeling, whether this is done in order to protect friends and family from her feelings, or because she needs it to be really bad before she feels able, or has to, ask for help or time for herself. This hiding of her feelings is putting others before herself. This contrasts with the validation that she matters too. Thus there is an interplay between relief at being diagnosed, validation, having a language within which to discuss the experience, and needs.

Following a diagnosis the category of identity comes into play again in terms of the women's identity in relation to what is termed PND or her relationship to her identity as a mother who is struggling:

> ...it was a shock for me personally coz I never thought I would be a person that would have to deal with PND so, like as I say to me it was a big big shock, and a reality check really as to it can happen to anyone erm.. and I think it.. it makes sense when.. when I went to the counselling and they stemmed it back, because when you think of what actually each of these stages that we went through, even the counsellor said 'It's not surprising' and it's.. she said she's quite surprised that it took that long to come out erm.. so I don't know, I never saw myself as anything.. as any different to any other mother.
>
> - Charlotte

> ...it was just sometimes so bloody awful erm.. yeah.. coz I don't want to think of myself as a mother like that, who couldn't cope and felt so distraught and so anxious all the time...
>
> - Daisy

There is also the sense of finding oneself within the experience of what is termed PND; several women describe a feeling of being taken over by PND. Some mums compared it with their previous depression:

> ...I don't know with the postnatal. It doesn't seem as logical as the other two depressions, erm, it feels a bit.. I felt.. it sounds.. it sounds daft but I felt more like I was possessed like the other two I felt depressed, I still

> felt like I was me but I was depressed, but with the postnatal I felt like someone else was in my mind like I wasn't.. I wasn't me at all..
>
> - Belinda

> ...I think with PND I was a lot lower than I'd been with depression actually. I felt less able to cope with day to day tasks and day to day things than when I had depression previously... whereas now I was having to cope with the household, the baby..
> ..and also the feeling that you've got a baby that's relying on you for everything and you're feeling like this and it.. I felt so guilty that I was like this around [baby].
>
> - Fiona

So with PND there is an added dimension of having a baby to consider as well as the extra demands.

Thus, receiving a diagnosis starts off a process of validation. This includes a recognition by an external other of the struggles the woman experiences. This means a recognition of the fact that the woman is struggling and also the fact that she needs help and support. This links with the desire to be understood and be heard, but perhaps paradoxically without actually saying the words. This relates to the idea of attunement, in which a mother is intrinsically attuned to her child's needs and satisfies them at a stage where the child is unable to verbalise them. This lack of words may also be due to a fear of the reaction or due to a lack of an available language to adequately express how one feels. This links with the category of hiding how one is feeling or struggling; having the language or words for the experience somehow making it more real or valid, as something that exists rather than being imagined. Therefore, conversely, not having a language leads to it being silenced and hidden.

There may be a role for the process of normalisation as part of the validation experience. This includes normalising the experience and feelings, knowing that others feel similarly and also being able, at least to some degree, to make sense of the experience and where the feelings have arisen from. The research interview may have formed a part of this process, in that having to talk about their experiences as part of the interview may have contributed to the forming of a cohesive narrative. Linked with this idea of normalising are the categories of having an acceptability to how one is feeling and knowing it wasn't her fault.

Thus there is an interplay at this stage between validation and having a language which contributes to a sense of relief. This validation also applies to the negotiating of needs in which the woman's needs are validated, allowing her to seek support. Alongside this is having a language which allows a process of opening up about her experience to begin. An evolved sense of identity then emerges within this language.

Following this stage of diagnosis there is a decision-making process with regard to possible treatment.

Treatment

Making a choice regarding treatment

This category describes the thought process and the factors that women consider when deciding, following their diagnosis, whether or not to pursue medication as a treatment. One of the concerns expressed by some was the stigma around depression and medication, with medication as somehow cementing the label of being depressive, and the negative connotations that go with that:

> Yeah, it was sort of the stigma of needing, needing help erm, so, yeah, but you know, in the end I just sort of gave myself a stern talking to and took it. It was all fine, I've been taking them since.
>
> - Emma

Some felt the need to talk over a need for medication:

> I don't want to go on medication for myself, I just don't really feel like I want to do that, and before, and I've not got anything against it, but I just don't wanna do it. And I wanted to kind of see, I..I felt like if I could just talk and get it out, coz it's just all stuck in me the whole... So I wanna try that first.
>
> - Annie

Possibly linked with this is a desire to 'do it myself', i.e. without medication, which may suggest that taking medication would be giving in and therefore failing on some level:

> To me it felt like failure; if I took them then I really had.. succumbed to being, to having.. you know, real postnatal..I mean I know I had it, I just thought I had to get myself out of this rut...
>
> - Belinda

> I said 'Look I don't really want to do pills, coz taking pills for me is.. it's a failure and I know I'm not a failure but if you give me pills I'll feel like I've failed.'
>
> - Hannah

So there is some sort of stigma surrounding medication. With regard to this stigma, there was also inconsistencies expressed with regard to how they viewed others taking medication. There was a sense that it was alright for other people but not for themselves. This may be a genuine difference in how they perceived the issue, or it could be a reluctance to be seen by the interviewer as judging others.

Some indicated a feeling of using medication as a last resort, only when really necessary:

> Obviously after the counselling if I was still having these feelings, still feeling the way I was, then yeah, I would have had to go ask..
>
> - Charlotte

Other concerns were mentioned around becoming dependent on medication or concerns about possible side effects. In some instances these concerns were resolved after discussion with the GP or other professional:

> I think I really didn't want to go on to tablets, I didn't want to have to go onto drugs to control my mood but actually I think when I'd spoken to the doctor about it I felt much more reassured of going onto it and I will, in a few months come off it or wean myself off it and hopefully be OK again, I just needed a bit of an extra boost while things were really bad.
>
> - Fiona

Another factor is what the woman wants from her treatment. Part of the decision about what treatment to pursue was wanting a 'quick fix'.

> ...I know you can't have it but I just needed like a quick fix you know, something that just lifted me up a little bit erm.. but they explained that they could put me on antidepressants, the minimum would be 6 months, erm, they'd put you on a higher dose after that or something and then they start weaning.. weaning you off and all this..
>
> - Charlotte

Coupled with their views on medication, their views of other treatments, predominantly counselling, are also relevant to this decision process. For some they decided they did not want to 'dissect things' through counselling, thereby perhaps viewing medication as the quicker fix.

> ...I didn't feel like I necessarily needed it, or even wanted to, you know dissect all my life in such detail.
>
> - Emma

> ...I didn't really want counselling this time. I think if I had.. if I'd gone into it really wanting it I would have pushed the doctor or pushed him further. Erm, I think I felt that at the moment if I could just get something to lift my mood then I'd feel better able to cope and therefore it would be a cyclical thing...
>
> - Fiona

One factor that comes into play with this decision is weighing up between breastfeeding and whether medication is suitable if the woman intends to continue with breastfeeding. This could be seen as balancing the needs of the mother for support and treatment with the needs of the baby for optimum feeding. Thus a negotiation takes place:

> ...in hospital I remember erm asking the midwife could I.. would I now be able to take antidepressants and still breastfeeding and they were like 'No' and I was like 'OK' and in.. I think I'd made that decision that breastfeeding was more important for [baby] than taking the antidepressants would be for myself, coz I thought 'Well if.. OK the last 9 months haven't been great but I survived them so..' I was thinking 'well, I can.. I got through that and I can probably get through this now I've had the baby' ...
>
> - Georgina

The expectations of what constitutes a 'good' mother also come into play with this as to whose needs take precedence and also in terms of how it fits for a mother to be depressed in the first place. Receiving treatment further defines the mother as depressed, and if being depressed is seen as being a bad mother then this treatment may be resisted.

All women were constrained, to varying degrees, by which treatments were available. Two of the women were offered a support group, which they attended, two were put on the list, and subsequently received, counselling and all were offered medication with four of them ultimately taking it. Some were aware of long waiting lists for individual talking therapy:

> ...it was sort of, you know, we'll give medication a go and see how that goes, erm.. I did sort of think about going for counselling but er, you know the waiting list is so long on the NHS and um.. it.. I didn't feel like it..
>
> - Emma

> ...I'd been put down on the, I think it's called the sort of counselling list you can go on, but the waiting list was like 9 or 10 months? And I thought if you need counselling you need counselling now, not 9 months down the line. You know, they said you know, occasionally a slot comes up earlier but it is generally like a 9 month waiting list..
>
> - Hannah

Hannah then went on to pursue CBT treatment privately through her husband's healthcare plan. For some talking therapy was not even mentioned as an option:

> They didn't actually offer me counselling. He just offered me.. coz he actually said that he didn't think there was a point in counselling at the moment and just to see if this helped and then if.. if long term I wanted it, we could discuss it at a later date.
>
> - Fiona

> Yeah, [antidepressants] or nothing. But yeah coz I'd since, after.. when I went to the erm postnatal depression group, the other health visitors or midwives or whatever had said that I should have been referred to a 'Time to talk' when I was pregnant but nobody had kind of offered me that.
>
> - Georgina

Some mothers had to negotiate treatment against other needs and concerns such as physical health and mobility:

> Yeah so it was just like.. I really want the counselling, but I can't bear the pain anymore so I knew it, you know, so.. yeah. It was just trying to balance all the aspects of.. my health really.
>
> - Belinda

There is an issue of resourcing when it comes to help available. This choice of treatment therefore links in again with the adequacy of professional support available. Women that were able to attend for example a support group became aware that said group subsequently stopped due to lack of funding. Several mothers also expressed concerns about the waiting period, either to see someone and receive the diagnosis or for non-medicated support such as counselling or groups.

There might also be something about having a space to talk, with women finding it either in a support group or in counselling. Many women described the relentlessness of being a mother, which arguably leaves little time for discussing feelings. Having something like a group or counselling allocates a formal space in which such discussion is not just allowed but actively encouraged. In having this space and opening up this discussion, women find the normalisation of what they are feeling either by having it understood by a third party or by talking to others who are expressing similar experiences. This then leads to a sense of validation.

Some women did receive extra support, usually from health visitors, and all were appreciative of what help they did receive. It was consistently felt that more needed to be done with regard to rectifying a lack of health visitors.

‘Coming out the other side’

All but one of the interviews were conducted some time after the diagnosis during which time treatment was either significantly underway or completed, with the exception of a further one who didn’t undertake treatment. There was therefore, for all of the women, a sense of the accounts of PND being retrospective, with a sense of the experience as evolving, or the women having ‘come out the other side’, albeit to varying degrees.

> ...my life, as I say, has totally changed. I’ve accepted my life’s changed and I love my life now with my little girl...
>
> - Charlotte

This is meant in terms of mood being perceived as more manageable, and even where there are struggles the women feel better able to cope than they did before, or have more mechanisms in place to support themselves.

> ..it’s getting easier, I think I’m just getting.. I think the depression isn’t affecting me so much, because I’ve started to develop coping mechanisms to go with it...
> ...it just started to, as in I kind of started to get my sense of humour back and find some things funny, you know I wouldn’t cry constantly.
>
> - Belinda

Even Annie, who was still waiting for treatment at the time of the interview, felt a change after putting mechanisms in place:

> I feel better today than I have done since, ironically, as.. er.. since she came... I did something where I could actually focus in little pockets on

> something other than my life at the moment and how I feel at the moment, coz that's kind of depressing in itself... and I just feel.. clearer; I just feel like I've just done something different.
>
> ...I feel like I've sort of reconnected with myself a bit somewhere, erm.. I'm starting.. I feel like I, I can I can access my thoughts whereas before I just couldn't erm, and I just I sort of feel a bit more like me, which is quite nice.
>
> - Annie

There was also a sense of the women being more reflective about the experience, and rationalising or normalising things a lot more.

> ...feeling tired, feeling erm anxious; tired, anxious and low were the ways I mostly felt and as I say, it's now in hindsight people do feel like that, some people worse than others...
>
> - Daisy

> ...since I've been.. sort of been on medication I was very sort of rational about it and, you know, quite objective about various things..
>
> ..couldn't sort of see the bigger picture really erm, I didn't see that my needs were important as well as hers...
>
> - Emma

> ...I don't want people thinking I'm not a good mother to him erm, coz I am, and I know that now. I think initially I didn't feel like I was, but 7 months in I feel like I am a good mother now and I know him and I know what he needs when he needs it...
>
> - Fiona

This also links with the women viewing their experience as a point of learning for the future, either for themselves with any future children, or for any friends or family who may experience struggles after having children. Part of this is the women looking outward to supporting others who may go on to struggle after giving birth, and this was a major reason for the women getting involved in the research, in order to help other women and get more information out there. It also links with opening up of dialogue about PND as a result of the diagnosis, which is part of being given a language with which to describe it.

Through the interviews a process emerged in which the struggle started off as private to the woman herself, hiding it from those around her, to reaching a point where she felt she had to tell someone, ultimately a professional, and after receiving a diagnosis then having a language in which to explain to others how she was feeling. Part of this seems to be having the language, given to them by a professional, who may therefore be viewed as 'expert', but also perhaps in being able to talk about it in the past tense, as something that happened, rather than something that was happening.

Talking about one's experiences also links with talking about PND in general. There was a common feeling that not enough was known about PND, with regard to the symptoms, time frame, how common it was and also what help was available. There is something about this increased information about PND and the support available that opens up discussion in general and is linked with taking away the perceived taboo of it.

> ..and you're just feeling, yeah. An outsider. I think it's all about getting the taboo away from it really and just to make it a.. everyone know it's quite common.
>
> - Belinda

Part of this process is also the women looking outward, in terms of wanting to help other women who may be struggling. This includes their friends and family, but also women in the general public in terms of wanting things that would either help women in general who are struggling, such as more support, more discussion about PND, more information about support available etc.

> ...they're [colleagues] having babies at the moment, erm, and it's their first child, and I think.. it's..I think sometimes it's quite nice to have somebody; I wouldn't go to them and say 'Oh I think you've got PND' but it would probably be quite nice for them to have somebody who might recognise that little bit of behaviour that is, like, 'Would you like me to take the baby for an hour?' or 'Would you like me to come round and sit with you, or can I do anything for you?' and so, yeah.. erm, sometimes it's good to have experience, as negative as it can be, it teaches you, erm.. to help others as well.
>
> - Daisy

> No I don't think.. it just, trying to help women understand that, you know, there are so many things that can help you, it's just knowing about them and being able to talk about it, and organisations like Homestart that can help and people who are willing to listen, or.. yeah, just yeah willing to help.. with a problem and willing to talk really and

> get it out, and if you don't want to see a therapist then think about some friends that you might talk to...
>
> - Hannah

When asked during the debrief why they chose to participate in the study, all the women said that they wanted to help get more information out in the public arena in order to help anyone going through similar experiences to them. Some of this may be a part of a reparative process to make up in some way for their negative experience.

Despite this evolving experience a few of the women expressed surprise at how upset they got whilst talking about their experiences in the interview:

> I didn't think I'd get this upset, considering it was so long ago...
>
> - Charlotte

This may indicate that there is still a need for a space in which to process the experience, either as an ongoing thing or because not enough space was given at the time.

So, from the study, the experiences that become labelled as PND follow a process in which the woman goes from a position where she experiences a mismatch in both how she wants, and how she expects things to be, as a mother. This is impacted by her sense of herself both as a person and a potential mother as well as expectations placed on her by her own values and more socially with regard to how she should mother. She experiences this mismatch as a failing within herself, partly due to the silence that pervades the struggles other mothers are experiencing. She perpetuates this silence by keeping her struggles hidden from those around her both from fear of judgement and also to protect loved ones from worry. This continues until a tipping

point at which she cannot hide the feelings any longer, or she realises the impact on her loved ones, despite her efforts. This leads her to seek professional help, either from the health visitor or the GP, which leads to, in this case an informal, diagnosis of PND. Following this there is a sense of relief and hope that things will improve, and also a validation that her struggles were something real rather than imagined. There then begins a decision process about which treatment, if any, to pursue. There also is a process of opening up about the experience, firstly with immediate family and latterly with other women, though this latter dialogue appears to occur retrospectively, once the label of PND can be talked about in the past tense. There is also a subsequent process of reflection, of which the research interview may have been a part, in which the woman makes sense of the experience and thinks about how she would do things differently either in hindsight, or in preparation for any future children.

The interviews conducted as part of this investigation were asking women to talk about their past experiences. They are therefore inevitably retrospective accounts of their experience. The women were all at different stages postnatally as well, and so there is a variation in the time that had lapsed from the experience and the re-telling of it. It could be argued that this delay in time may cause the narrative to become altered, either through some details being forgotten or through details changing in terms of how salient they are at the time; what is experienced as uppermost at the time of the experience may be rationalised as something less significant. Conversely other details may gain in significance when women are further from the experience and able to notice things more widely, or are able to discuss the experience with others and incorporate the narratives of others. This is an especially pertinent point for this current study, as it has shown the opening up of such discussion with others, and it is inevitable that this will impact on a woman's recollection and understanding of the experience. Part of this discussion obviously occurs as part of the research interview itself, and the constructionist approach of this study acknowledges the role

of the interviewer, and the interview questions, on the subsequent dialogue. Thus the narrative is shaped, over time, by interaction and discussion with others, including the researcher herself. The more time that has elapsed would arguably mean more opportunity for this shaping. This does inevitably result in a different narrative than would be given closer to the time of the experience, and it could be argued that this makes the narrative less valid. It is argued here, however, that the shaping of the narrative by social interaction is exactly what the research is investigating; it is looking at PND within a social context. What it means for a woman to be diagnosed as postnatally depressed is not just what it means for her as an isolated individual, but as a person who exists within a social landscape of family, friends, other mothers and society as a whole. Perhaps then it is more valid when investigating this aspect of PND to have narratives that are so shaped by this landscape.

Part of the way in which it has perhaps been shaped is the discourse of mothers, or women, not seeking help or support. This was not mentioned explicitly as an expectation but it does seem to underlie the hiding of the feelings and the struggles. The expectation was made explicitly that mothers should be able to cope with motherhood, and the implication of this is that seeking help or support is in some way admitting a failure as a mother and perhaps as a woman. The fact that all of the women interviewed, in one way or another, chose to hide their struggle from those around them may indicate an underlying assumption that they should not ask for support. Looking at it another way, the fact that the women reported in the interviews that they waited until they couldn't manage any more on their own before seeking professional help may indicate that this was an important aspect not just of their experience at the time but also of their retrospective account. This would indicate that this discourse was still playing out within the interview in that the women didn't just wait at the time, they wanted to be seen as waiting until they had to do something, in a way saying "It wasn't my fault, I managed as best I could but (for one reason or another) I had to seek help". The reasons given were more in terms of not being able

to hold it in any longer, or the impact of other people around her. Thus even in choosing when to seek help the women still seem to be following a rule of putting others first and of managing by herself. Whether this is a rule for mothers or for women more generally it is hard to distinguish.

The women interviewed for this study exist as several people, or a person on multiple levels. They are, for example, individuals, but also mothers, sometimes wives or partners and also women. They are therefore subject to different rules and expectations on each of those levels.

Discussion

The findings of this study and what they mean

The question for this investigation was 'What does it mean for a woman to be diagnosed with postnatal depression?'. This could be investigated on several levels. Firstly there is the level of the woman herself as an individual. What does it mean for her to have the experience? How does she make sense of the fact that she struggles when she perceives that no-one else does? What does it then do to her understanding to have this experience recognised by an external other and given a name? It is at this level of the individual that the investigation was designed to focus, in order to give women a voice, that has been argued to have been lacking in the literature on PND. There is also the level of what it means socially, or societally, in terms of what it says about our society that women both have the experience but also then have this experienced labelled as PND. There is then the level of the immediate family unit of the woman, baby and possibly the baby's father in terms of what both the experience, and the labelling of it, means for them as a unit. Inevitably all levels interact with each other, so how the woman makes sense of things within herself is influenced by societal ideas or the input from friends and family around her, as well as her own individual history, such as a previous experience of depression. Therefore despite the focus on the level of the individual, the other levels are still present in the analysis.

From the data within the study, one answer to what it means for a woman to be diagnosed with postnatal depression is that it means that a woman moves along a kind of process, in which she starts by having a negative experience and struggling. She takes this upon herself as a failing within her and hides it from others, partly from a sense of shame and also from pressure to deal with things on her own. Knudson-Martin & Silverstein (2009) similarly found that failing to live up to cultural standards led to negative feelings that could not be voiced. This then is shown in this study to

build to a point at which she cannot keep it in any longer and she seeks professional support. This is consistent with McCarthy & McMahon (2008) who found that women reached a crisis point before seeking help, due to the stigma of being unable to cope and being seen as a bad mother. In this current study, the resulting diagnosis starts an almost reverse process in which the woman begins to open up about her struggle, receives support either professionally in the form of medication, counselling or a support group, or informally from friends and family. She begins to feel validated and the experience is taken, at least in part, out of herself as something more external rather than a failing in character. This again is supported by McCarthy & McMahon (2008) who found that talking was of primary importance in the recovery process, as well as Knudson-Martin & Silverstein (2009) who emphasised the importance of validation and reconnection with others in surviving the depression. The present study goes on to show that the woman's experience starts to improve and the dialogue opens further as part of the woman looking outward to helping other women who may be struggling. Agreeing to do the research interview appears to fit in with this latter part of the process. This opening up of dialogue may be due to several factors, one of which is having the language with which to describe the situation. It could also be that the women need a certain amount of time to be able to reflect and make sense of the experience in their own minds post-diagnosis before sharing it with others. This may link with what Charlotte describes as needing to be stronger in herself before being able to talk about quite powerful feelings. Another factor may be that it is easier to talk about it in the past tense, so the women are not only removed from it by time passing, but also in being able to place themselves outside of the condition by saying they *had*, rather than *have*, it. This may then link with ideas around resisting the negative aspects and not wanting to identify with it, which may have been part of what led these women to hide their struggles in the first place.

Part of this process of opening up a dialogue is attributed to the diagnosis coming with a language in which to discuss some of the feelings. For women who have experienced, and been diagnosed with, depression previously in their lives, they arguably already have some of this language available to them. However, all of the women, whether they had been previously diagnosed with depression or not, followed the pattern of hiding their struggle, suggesting that having the language already does not impact on openness to discussion. Similarly women without a previous diagnosis of depression described still knowing on some level that they had PND, merely needing to have that confirmed by a professional.

The women who had a previous diagnosis of depression all distinguished it from PND, describing PND as feeling more dark and more possessing in that they felt taken over by it. This is interesting in light of the fact that as a mental health diagnosis, PND shares the same diagnostic criteria as depression and yet it is experienced as a distinct condition.

There may also be a difference in how PND and depression are perceived. Women in the interviews talked about the stigma around discussing depression, and yet a discussion does open up, albeit retrospectively, about PND. This may point to a difference in how PND is perceived, possibly as a more permissible mental health issue in that it is tied to a specific event and is therefore considered transient and possibly not a fault in the woman herself. This may be the distinction between viewing it as something that is caused by having a baby and all the ensuing difficulties or as something that the woman is previously predisposed to but is triggered by the stresses of having a baby.

For the women in this study, the initial assessment for PND was conducted by a health professional, usually a health visitor, administering the Edinburgh Postnatal Depression Scale (EPDS), which is a screening, not a diagnostic, tool. The ‘diagnosis’ received was therefore not a diagnosis in the formal and mental health

sense, as this would require diagnostic measures administered by a psychiatrist. For the purposes of this study, the women's experiences are still valid as they believed themselves to be diagnosed. However, it is worth considering the possible impact of this lack of formal diagnosis. Part of the process that would normally occur with a mental health diagnosis would be lost, such as the formal meeting with a psychiatrist. This may remove some of the stigma of the condition as it is dealt with at a community, rather than psychiatric, level. This is perhaps part of what makes PND more permissible, or discussable, as a condition. This raises the question of whether mental health more generally would be less stigmatised and more open to discussion if it was dealt with more at this community level. However, depression is often dealt with at the level of the GP who administers antidepressants without consulting a psychiatrist, and yet depression is still not discussed. Therefore there may be something about PND being dealt with within an established contact network of health visitors. Despite the mother having to initiate contact with the health visitor, which the interviews indicated can be a difficult first step, to all appearances she could be discussing physical health or practical childcare issues which arguably carry less stigma. Is there something then about accessing help within the existing sphere of support that allows it more easily? Would having more standard psychological support therefore mean that women may find it easier to seek the help they need?

The next question then is whether a diagnosis is necessary. Could the positive outcomes such as support, open dialogue and hope happen without it? Receiving a diagnosis, even informally as in the case of the women in this study, starts a process of: opening up a dialogue; seeking and receiving support, both professionally and from friends or family; opening up possibilities and giving a sense of hope for the future. The question remains, however, whether this process would still be possible without the diagnosis. Is there a way in which a dialogue could be opened up and support be provided without necessarily having the label of PND? Taking the label of PND away would mean taking away the distinction between that experience and that

of other mothers who perhaps are not struggling to the same degree. This could arguably mean that it would not be recognised as something worthy or needing of support. However, it is argued here that perhaps by providing the support and the dialogue, not for PND per se but as part of a normal, standard matter of course, the same positive outcomes could be achieved without pathologising the experience as PND. It is possible that by acknowledging the struggles intrinsic to becoming a mother, indeed a parent, a dialogue could be opened within which women, and men, could share their experiences more widely. By opening up this dialogue it would become apparent, as many of the women in this study found, that these struggles are indeed part of the norm, albeit to varying degrees. By having more support as standard, perhaps things would not need to escalate to a breaking point at which mothers felt they could no longer cope, and instead have support on hand when it is needed, at whatever stage postnatally. The field of counselling psychology could play a major role in this, in being a form of psychological input for mothers, and indeed fathers, as standard. With the discipline's focus on the subjective experience it is arguably well-placed in providing not just support but validation of the individual experience.

Links with existing literature

Linking the experience of the women in this study with the diagnostic criteria, their 'symptoms' had lasted longer than the prescribed 4 weeks, more than 6 months in some cases. There is, however, a distinction between onset and diagnosis in terms of when 'symptoms' began and when the woman was diagnosed. This is particularly pertinent in this study where the women delayed in seeking help. It is therefore hard to pinpoint the onset as a result. There is some controversy as to whether PND is a condition distinct from depression. The comparisons made by women in this study between their experience of PND and their previous experience of depression suggest it is, but it is not recognised as such by new DSM-5.

Discourses of motherhood did emerge from the data in terms of what a 'good' mother should be, and these did seem to concur with Burr's (2003) example of a 'good' mother staying at home and putting the child's needs ahead of her own. From the data in this study this does seem to extend to putting others' needs ahead of her own as well, such as her partner or extended family. This may therefore be to do with discourses about being a woman more widely than a mother specifically; she may put the baby's needs ahead of her own not as part of her role as mother, but as part of her role as a woman. The sense of isolation that Ussher (1991) suggests results from this putting aside of her needs is also borne out in the data.

These present findings support those of Smith (1994) in that women adapt their accounts of their pregnancy retrospectively to narratives that were more self-enhancing and glossing over difficulties also bears out postnatally. Further, women whose accounts were more retrospective, in the sense that there was a greater delay between the experience and re-telling it in the interview, had narratives that were more self-sacrificing and more positive with regard to their relationship with their baby. This therefore arguably indicates the strength of the discourse that motherhood, including pregnancy, is a positive experience, contributing to the lack of space to discuss anything other, such as a negative experience or struggle. This then supports the silence around the trauma of childbirth found by Kitzinger (2006). This present study also suggests that this silence and narrative reconstruction extends postnatally, which is consistent with other existing research (McCarthy & McMahon, 2008; Knudson-Martin & Silverstein, 2009). This reconstruction of narrative is worthy of more investigation, in comparing narratives of women at various stages postnatally. Unfortunately this fell outside of the scope of the current investigation. Irigaray's (1991) ideas around the lack of space for the feminine to be expressed also come into play in that the hiding of the experience and distress postnatally, that emerged as a major theme here, could be argued to result from a lack of language in which to

express the feminine, or indeed a space in which the feminine could be expressed. That space would then be argued to have been given by the masculine, i.e. psychiatry and its language. This study furthers the work of Gross & Pattison (2007) in suggesting that the focus on the baby's wellbeing, rather than the mother's, extends postnatally. Similarly the medicalisation of pregnancy and the birthing process, at the expense of psychological support, extends postnatally in terms of the standard care available.

It could be argued that the mothers in this study had an optimistic view of motherhood, shaped by the positive discourses of how motherhood should be. According to Churchill & Davis (2010) this would place the mothers at increased risk of developing PND, and this would be borne out by the fact that the women in this study did go on to be diagnosed, albeit not formally by a psychiatrist. However, due to the focus of the study there is no comparative sample of mothers who were not diagnosed. Also, there were mothers in this study who had had other children prior to their diagnosis and therefore arguably would have more realistic expectations of motherhood but still went on to be diagnosed with PND. The themes that emerged from the data in this study replicate the findings of Choi, Henshaw, Baker & Tree (2005) who found that the expectations of motherhood did not match up to the experience. This led to feelings of inadequacy and a resulting sense of overcompensating that were similarly found in this study. This study furthered this investigation by assessing the impact of a professional diagnosis on these feelings of inadequacy. The diagnosis appears to remove the sense of failing from the woman herself to a place outside of her. Knaark's (2009) point that discourses around a 'good' mother influence how women make use of resources in their self care also bears out in this study in that women who assume that 'good' mothers can cope and therefore do not approach for support until they absolutely have to. This is also further supported by McCarthy & McMahon (2008).

Identity emerged as a theme in the data, with women caught in a limbo between their identity as an individual and their identity as a mother or mother-baby dyad. Identity was expressed more in terms of the dyad than as a triad with the father, which may link with the difficulties in the partner relationships expressed in this study. The findings that suggest a decrease in marital satisfaction are also touched on by the current investigation in that several of the mothers indicate a certain dissatisfaction with their partners and the supposed lack of impact on their lifestyles. Some of the women also touched on becoming aware of communication difficulties with their partners as a result of their postnatal struggles. As previous authors suggest (e.g. Lawrence et al., 2008; Shapiro et al., 2008), this may be due to the impact of having a child, or it could be that the stress of having a child exacerbates a pre-existing issue within the relationship. This was not a focus of the current study, however for the women who did point to issues within their relationship their feeling was the latter. The competing narratives put forward by Sevón (2012) of intensive versus shared parenting are also reiterated in this study in that the women in this study do seem to feel they should be doing all of the motherly tasks but paradoxically feeling their partners should be more involved. Again, however, this was not a focus of the current study although it does appear to form part of the process of postnatal distress.

Another area that emerged from the data of this study was around breastfeeding. All of the women in this study began by trying to breastfeed, and they described similar struggles to those detailed in Schmeid & Lupton (2001) in terms of negotiating the pro-breastfeeding rhetoric and the demands it places. The several women who persevered through the discomfort felt this may have been a contributing factor in the increase of postnatal distress and the development of what became termed PND.

The findings in this study support a more socio-psychological explanation of PND in that discourses around motherhood and how mothers 'should' be not only emerged from the data but also appear to be a significant factor in the process of being diagnosed with PND. The accompanying loss posited by Nicolson (1998) was acknowledged indirectly in the changes that the women underwent with regards to their hobbies, social circle, sense of identity and even time for herself. The lack of explicit acknowledgement of this sense of loss replicates Nicolson's finding of this loss being a silenced part of the experience. This study lends support to the idea that what is termed PND could be viewed as part of a normal struggle when acknowledging the contextual factors. It does also, however, acknowledge the importance of the validation that receiving a diagnosis brings. There is perhaps a middle ground in which the struggle could be validated as part of a normal postnatal process without the need for a formal label.

With regard to mental health, the women in this study were aware of a sense of stigma around mental illness, depression and needing support. Some of the mothers in the study actively fought this in denying or hiding their struggle.

What does this study add to the knowledge of the field of Counselling Psychology?

This study tells us something about the experience of what is termed PND from the perspective of the woman experiencing it. This is important to counselling psychology as one of the psychological therapies, and therefore to counselling psychologists who may come across women having this experience in their work. It adds a layer of understanding of, specifically, a potential client group, but also more widely about the possibility of negative experiences being kept hidden and the importance of allowing a space for dialogue of a person's experience. Where counselling psychology as a

discipline is uniquely placed within the realms of psychological therapy is its emphasis on the subjective experience and an awareness of the impact of socio-cultural factors on this experience. With regards to this study this means an acknowledgement of the potential impact of social dialogues both around mental health and depression, but also about expectations placed on women and mothers. These factors are important in the area of PND but also in other narratives that a counselling psychologist may come across in her client work.

This emphasis on subjective experience within counselling psychology also serves as a potential challenge to both the 'medical model' and what is termed 'mental health' and therefore by implication the 'process of diagnosis'. This study, therefore, with its examination of this very process fits well within the confines of the discipline and adds to its knowledge. It points to a social process of PND in which a perceived diagnosis paves the way to a dialogue about the struggles of the experience and a sense of validation for the individual.

Postnatally, women exist within a context in which there is access to health professionals that there may not be at other times. Therefore there is a system ready-established to identify and support, any difficulties that may arise in a way that may not happen in other areas of the health system. This is particularly pertinent with women for whom this is the first experience of psychological distress, as the systems in place for supporting postnatal women, regardless of their adequacy, could be argued to be more likely to noticing distress than when no such systems exist.

The findings of this study point to a lack of standard psychological support for new mothers. Women have contact with nurses and GPs, and whilst now under the Improving Access to Psychological Therapies scheme there is an option to self-refer for psychological treatment, the women in this study did not have that as an option and so were only able to access psychological therapy via their GP. Therefore medication was the first available treatment. However, this study illustrates the

importance of dialogue and a non-judgmental space in which to be heard and understood and so it is argued here that counselling psychology is ideally suited to play a role in the management of postnatal difficulties. It argues that an increase of psychological input would allow the opening up of a dialogue sooner, which would mean that women would have a space in which to discuss their experience. This space would mean that the struggles would not have to build to a breaking point before they are acknowledged and addressed, and may alleviate the struggle without any need for further support. A further point made by the study is the difficulty in accessing support, both in terms of availability, which varies across localities, but also in the women's struggle to initiate seeking support. Therefore it would be argued that any support should be offered as standard without women having to summon the courage to make the approach. Having psychological input as a standard part of postnatal care would acknowledge the role and potential impact of psychological factors on the postnatal experience. It would also mean that the experience would not have to be pathologised as beyond the norm before help was sought. This input therefore needs to occur at the time of the health visitor intervention, either as part of the initial home visits or as part of a drop-in service at the weigh-in clinics. The former is preferable as even with drop-in services, the onus is still on the women to make to approach for help, which this study has shown women find difficult.

What is the place of counselling psychology when it comes to treating what is termed PND, if indeed it requires treatment at all? Counselling psychology exists outside of the medical sphere so it could be argued that talking treatments are not the first choice considered. There is a need expressed by the women in this study for increased one-to-one contact. Health visitors are named as the people to have that contact with, but it is argued here that this contact could be further improved either by direct contact with a counselling psychologist, or with a health visitor who is trained and supported by a counselling psychologist. Having direct contact with a counselling psychologist would be preferable as it would have the effect of freeing up the time of

health visitors to focus solely on the physical health of mother and baby, whilst obviously being aware of any potential issues that they can then refer on to the psychological professional. However, it is accepted here than financial constraints may not allow this. Having counselling psychology input in whichever way would provide support not just for the mother but also the health visitor, who would be able to focus within his or her area of expertise but also have a highly trained professional colleague on which to draw on the more psychological aspects of which he or she may not be as well-versed. Indeed, it has been evidenced that training health visitors in approaches using cognitive-behavioural or person-centred principles to support mothers is also cost effective (Morrell, Warner, Slade, Dixon, Walters, Paley & Brugha, 2009). Counselling psychologists are well positioned to offer this training.

PND, as it is currently defined, is said to affect 10-15% of mothers. Therefore providing care as routine could be argued to be non-financially viable when it is not needed by 85% of the target population. It is argued here, however, that the 15% quoted prevalence is an under-estimate considering the lengths that the women in this study go to in order to cope without professional input. Anecdotally there were also several women who approached the researcher to take part in the study who weren't diagnosed, and therefore were excluded from the study, but still felt they had PND. This would suggest that there are a number of women experiencing the distress but without the label of PND. Also, it could be argued that postnatal distress is not a binary condition that is either PND or is not, but rather on a continuum on which women experience postnatal distress to varying degrees. Thus 15% may be the determined cut-off at what warrants a label, but there will be other women who are below 'cut-off' who may well benefit from increased psychological support as standard.

Limitations of this study

This study has interviewed women about their experiences; narrative accounts which are inevitably retrospective in nature. As part of this retrospective process, it is possible that a certain degree of reconstruction of the narrative has taken place. A possible example of this is regarding decisions the women have made with regard to their own self care and getting professional help with their struggle. The prominent narrative is that this was a 'good' decision in that it allowed them to talk about their struggle and thus 'get better'. However, it could be that this is partly a rationalisation of the decision they made in order to convince themselves they made the right one, thus protecting themselves from the possibility that they made the wrong one. Also, the nature of this research as a doctoral thesis means there has been a constraint of time, meaning the findings are limited within a snapshot of the sample. The fact that the sample has not been researched at different time points postnatally means the longitudinal validity of the sample cannot be determined. Had a more longitudinal approach been possible, it may have highlighted any process of rationalisation as it occurred over time.

Whilst this study gives an in-depth view of the postnatal experiences of the women who participated, the data gathered are not exhaustive of PND experience as the accounts given were in part determined by the questions that were asked of the women. There is also the fact that the women chose to participate in the study and therefore the sample was self-selected, which meant that it was not as representative as it could have been. For example the sample would not have included women who felt unable to talk about their experience, for instance because they did not feel they had the knowledge or understanding of it, or because it felt too painful. Agreeing to attend an interview to talk about the experience fits with the opening up of dialogue that this research suggests. However, if there were women for whom this did not

happen then they may not have come forward to be interviewed as they still may not have felt able to talk about their experience.

Reflexivity

The researcher identifies as female, aged 32, and is a mother to a child who was aged four at the time the interviews were carried out. This puts her at a similar age to the participants, with a child of a similar age to some of them. The fact that the researcher is a mother herself was not disclosed to the participants, although some of the comments made gave the impression that the majority of the participants assumed she was. Being of a similar age, and with an assumption that she was herself a mother, may have led the participants to be more open in what they talked about, if they assumed that they had some shared understanding with the researcher. Also the interviews being held in a real-life setting meant that they perhaps felt less formal, particularly in the participant's own homes. This also altered the power dynamic in which the researcher was there to ask questions and guide the interview but it was in the participant's own space, or at least somewhere familiar to them. Part of the aim of this was to allow them more of a sense of control in order to feel more relaxed and open. It was also to be sensitive to the fact that it was an emotional topic and allowed participants to control where they felt able to allow that emotion. There were times during interviews when the researcher was tempted to ask a therapeutic question, which would have been inappropriate outside of an ongoing therapeutic contact.

Whilst the participants would not have been aware of the researcher's history or views, although they may well have assumed she had experienced PND as a reason for conducting the study, this is the experience that the researcher brought into the interviews. Some of her experiences overlapped with experiences the participants were describing and her own views would inevitably impact on how that experience was understood and interpreted.

The researcher was keen to distance herself from any diagnosis of PND when having her baby and went into this investigation with a critical stance on mental health diagnosis. Prior to the interview stage the researcher was expecting perhaps more of a negative or mixed response to the diagnosis. It is then perhaps surprising that themes emerged which demonstrated the positive aspects of receiving a diagnosis and that overall the response of the women to their diagnosis was generally felt to be more positive than expected. This may indicate the strength of the language of mental health and the power of a diagnosis to open up possibilities of treatment, that these aspects emerged in spite of a potential bias against it.

The theme of opening up of a space and dialogue in which to express oneself is one that resonates with the researcher on both a personal level as an issue she herself has experienced but also professionally as a trainee counselling psychologist who tries to facilitate that space for clients. It resonated with the researcher during the interview stage which may be partly from it naturally emerging from what the participants said but also perhaps, in subsequent interviews, being looked for by the researcher. It was not, however, something that was anticipated by the researcher prior to the interviews, and therefore must have initially emerged from the interview process, both in terms of what the women said and how the researcher interpreted it.

Concluding remarks

This study looked at what it means for a woman to be diagnosed with PND. It therefore focused on the subjective experience of the woman, within her social context. It also looked at how discourses around gender, womanhood and motherhood played into her sense of that experience. Following Nicolson (1998) who found that women were keen to distance themselves from PND, this study asked how women experienced having that very label placed upon them. Also, assuming Nicolson is right in claiming that what is termed PND is in fact a normal grieving reaction to loss, this study looked at the impact of pathologising it.

This study found that the discourses surrounding women and mothers, particularly what is expected of a 'good' mother, were a significant part of the experience. It was these expectations that led women to feel that they were lacking, indeed failing, in some way by not reaching these prescribed standards. The expectation that they 'should' be able to cope led to them hiding the fact that they weren't. This meant there was a delay in seeking support, and may have actually meant that difficulties increased in a way that they might not have if support was given sooner. This hiding of their struggles may form part of what Nicolson (1998) found in women distancing themselves from the label of PND. However, despite this distancing, it seems from this study that having the label placed by an external 'expert' or authority led to a sense of relief and a means of placing the struggle in the context of a condition rather than a personal failing. On a practical level having the label opened doors with regard to treatment and support. It also meant that a dialogue was possible that perhaps wasn't before. It is not, however, conclusive that it is the label itself that is necessary for this to occur and this study posits that with increased psychological support as standard, in which counselling psychologists may play a part, the stigma of struggling with a new baby may be diminished. This in turn may open the dialogue surrounding

the struggles, which may diminish the sense of isolation that the women in this study indicated they felt and lead to the label of PND becoming irrelevant.

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Appendix A

Advertisement

Have you been recently diagnosed with postnatal depression?.

My name is Lisa Roddam and I am a student on the Counselling Psychology doctoral programme at the University of Roehampton. As part of my doctoral training I am conducting a research study with the title "What does it mean for a woman to be diagnosed with postnatal depression?". I have chosen this area as one that I feel there is a lack of understanding about. This research has had ethical approval from the University of Roehampton.

I am looking for women who have received a diagnosis of postnatal depression since February 2007 and would be willing to participate in an interview to talk about their experiences of this. Interviews will last approximately an hour and a half, and will take place at a location accessible to you (within the South East), including your home if this is more convenient. Interviews via Skype are also a possibility.

If you are interested in participating in this research, then please contact me on roddaml@roehampton.ac.uk or phone/text on 07928 156360 for more information. An interview can then be arranged once you have read all of the information.

Many thanks in advance for considering participating and I look forward to hearing from you.

Lisa.

Appendix B

Participant Information Sheet

Title of Research Project: What is the impact on women of having a diagnosis of postnatal depression?

Thank you for your interest in participating in my doctoral study on the experiences of women who are diagnosed with postnatal depression. This information sheet provides some details about the project in order to help you understand what it is about, why it is being conducted and what your participation will involve. This is so that you can make an informed decision about whether or not you would like to consent to participate.

The research will involve asking you questions about your postnatal experiences, and the circumstances which have led to your being diagnosed with postnatal depression in order that we might understand this experience better. I hope that this may lead to more discussion amongst professionals as to the experience of postnatal depression from the woman's own perspective and thereby improving the services available. Anything you say in the course of the interviews will be confidential in the sense that you won't be identified as having said the things that you say. In other words, all identifying details will be anonymised throughout the study. The exception to this would be if you said something that made me think that you or someone else was in danger of harm, in which case I would have to discuss with you how we (you and I) will manage that risk. This may include my passing on of information to appropriate agencies.

If you are currently in therapy for any reason, it is possible that the things we talk about as part of this interview may impact your therapy. It is therefore advised that you do not participate if you are currently in therapy or have finished therapy within the last six months.

Interviews will last approximately an hour and a half, and will be conducted at a venue in as convenient location as possible. It is possible that I may ask you questions that you haven't thought about before, and we may touch on some areas which are painful to think and talk about. You will be given the opportunity to ask me any questions, or discuss any concerns which come to mind for you, before agreeing to participate in the interview. You do not have to answer any questions that you do not want to, and you are free to stop the interview at any point should it feel too much for you. You will be debriefed fully at the end of the interview when I will ask you how you found it to participate. I will also provide you with information regarding sources of support should any difficult issues or feelings arise as a result of the interview.

Once you have consented to participate, you have the right to withdraw your consent and participation at any time. I will provide you with my contact details

and those of my Director of Studies (project supervisor), so that you may withdraw at any time, should you so desire. There will be no penalty for withdrawing your participation from the project and I will destroy any recordings or data related to you. However, please note that after one month from the interview the data from your interview will be combined with other interview data and analysed, and therefore will still be used in a collated form. Should you have any further questions that you would like answered, please contact me on: 07928 156360 or email: roddaml@roehampton.ac.uk. All data from your case will be stored under the participant code _____, so please quote this code when you contact me or my Director of Studies should you decide to withdraw.

I hope that this information is enough to give you some idea of whether you would like to participate in this research. Your participation will be invaluable and also much appreciated as it will allow new knowledge of women's own experiences and views being heard in the field of postnatal experience, as well as adding to our understanding of postnatal depression as a phenomenon. I thank you again for your time and interest.

Investigator Contact Details:

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Tel: 07928 156360

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However, if you would like to contact an independent party please contact the Head of Department (or you can also contact the Director of Studies).

Director of Studies Contact Details: **Head of Department Contact Details:**

Dr. Janek Dubowski Department of Psychology University of Roehampton, Whitelands College Holybourne Avenue LONDON SW15 4JD J.Dubowski@roehampton.ac.uk +44 (0) 20 8392 3214	Dr. Diane Bray Department of Psychology University of Roehampton, Whitelands College Holybourne Avenue LONDON SW15 4JD d.bray@roehampton.ac.uk +44 (0) 20 8392 3627

Appendix C

University of Roehampton London

ETHICS COMMITTEE

PARTICIPANT CONSENT FORM

Title of Research Project:

What is the impact on women of having a diagnosis of postnatal depression?

Brief Description of Research Project:

This is a doctoral research project which aims to interview 15-20 women and ask questions about their experiences during pregnancy, birth and the postnatal period. It will also be asking specifically about the circumstances surrounding a diagnosis of postnatal depression being given. Interviews will last approximately one hour and will take place in a location convenient to you. What is said during the interviews will be audio recorded and transcribed (by the investigator), and the transcripts will then be analysed through a coding system according to what themes emerge from what is said. These themes will then be used to build a theory of what it means to be diagnosed with postnatal depression that will be written up into a thesis and submitted for examination at the University.

Anything you say in the course of the interviews will be confidential in the sense that you won't be identified as having said the things that you say. In other words, all identifying details will be anonymised throughout the study. The exception to this would be if you said something that made me think that you or someone else was in danger of harm, in which case I would have to discuss with you how we (you and I) will manage that risk. This may include my passing on of information to appropriate agencies.

Once you have consented to participate, you have the right to withdraw your consent and participation at any time. I will provide you with my contact details and those of my Director of Studies (project supervisor), so that you may withdraw at any time, should you so desire. There will be no penalty for withdrawing your participation from the project and I will destroy any recordings or data related to you. However, please note that after one month from the interview the data from your interview will be combined with other interview data and analysed, and therefore will still be used in a collated form. Should you have any further questions that you would like answered,

please contact me on: 07928 156360 or email: roddaml@roehampton.ac.uk. All data from your case will be stored under the participant code _____, so please quote this code when you contact me or my Director of Studies should you decide to withdraw.

Investigator Contact Details:

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Consent Statement:

I agree to take part in this research, and am aware that I am free to withdraw at any point. I understand that the information I provide will be treated in confidence by the investigator and that my identity will be protected in the publication of any findings.

Name …….

Signature ……

Date ……

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However, if you would like to contact an independent party please contact the Head of Department (or you can also contact the Director of Studies.)

Director of Studies Contact Details:	**Head of Department Contact Details:**
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Appendix D

University of Roehampton London

Participant Debriefing Sheet

Title of Research Project: What is the impact on women of having a diagnosis of postnatal depression?

Thank you for your participation in my doctoral study on exploring the meaning of a diagnosis of postnatal depression. I hope that this study will add to the understanding of postnatal depression from the woman's point of view and will thereby help to improve the services available.

We may have talked about things which have brought up painful memories or feelings for you. This is why, at the end of the interview, I asked how you had found it to take part in the research and how you were feeling after the interview. If as a result of participating, you have experienced or are experiencing any difficulties that you are uncomfortable with, I have provided below some details of organisations that you can contact in order to get some support. I hope that these might be useful if issues have come up either during or after the interview that you would like to talk to someone about.

You can call Samaritans on 08457 909090 and talk to someone any time day or night; you don't have to be suicidal to call them, they are there just to listen for those that need it. If you feel that you would like to talk to someone about these issues in more detail, then either ask your GP to refer you for counselling, or you can seek private therapy. Accredited therapists can be found on www.bacp.co.uk or www.psychotherapy.org.uk .

If there are any questions or concerns that you have about the research and how your data will be used then please do not hesitate to contact either me (Tel: 07928 156360 or email: roddaml@roehampton.ac.uk) or my Director of Studies (Dr. Janek Dubowski, Tel: 020 8392 3214 or email: J.Dobowski@roehampton.ac.uk)

Even though the interview has taken place, you still have the right to withdraw your consent at any time. I have provided you with my contact details and those of my Director of Studies (project supervisor), so that you may withdraw at any time, should you so desire. There will be no penalty for withdrawing your participation from the project and I will destroy any recordings or data related to you. However, please note that after one month from the interview the data from your interview will be combined with other interview data and analysed, and therefore will still be used in a collated form. Should you have any further questions that you would like answered, please contact me on: 07928 156360 or email: roddaml@roehampton.ac.uk. All data from your case will be stored under the participant code _____, so please quote this

code when you contact me or my Director of Studies should you decide to withdraw.

All data will be stored securely and identified via a participant code (yours is _____) and any data used in the written research is anonymised, with all identifiable details (names, towns, workplaces etc) either removed entirely or given a pseudonym/alias.

In continuing with the research, it is possible that I may have more questions that I would like to ask you. If you would be willing for me to contact you again to arrange a further interview then please tick the box. Please note that this is entirely optional and that you can decline to attend the second interview should you agree but then change your mind at a later date.

I confirm that I am willing to be contacted again to arrange a further

interview. ☐

Signed _____ Date _____

Participant code: _____

Investigator Contact Details:

Lisa Roddam,
Department of Psychology,
University of Roehampton,
Whitelands College,
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Tel: 07928 156360

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However, if you would like to contact an independent party please contact the Head of Department (or you can also contact the Director of Studies).

Director of Studies Contact Details:	**Head of Department Contact Details:**
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Appendix E

Sample Interview Questions

As this is a grounded theory study, it is not possible to compile an absolutely comprehensive list of questions as what participants say in the early interviews will inform what questions are required for subsequent interviews, thus following a theoretical sampling strategy (Charmaz, 2006). However, all interviews will start with the same questions, and I have included a list of possible questions that may be asked subsequently.

Starting question:

- Can you tell me about the circumstances which have led to your diagnosis of postnatal depression?
- How did/do you feel about being given a diagnosis?

The following questions are suggestions as part of an aide memoire in the event of needing a prompt (please note that not all of these questions will be asked and they are not intended to be in any particular order nor intended as an exhaustive list):

- What led to you seeking professional help? Who did you seek this from?
- What help/treatment have you received? What help or treatment did you want (or would you want now)?
- What do you think your friends/family/children/partner think of your diagnosis?
- Can you tell me about your relationship with the baby's father?
- Have you been diagnosed with postnatal depression with previous babies?
- How does this experience compare?
- What did you know about postnatal depression already/ before you were diagnosed?
- What were your thoughts about postnatal depression prior to being diagnosed?
- Have these changed at all? If so, how?
- What would you say to a close friend or family member who was experiencing difficulty with a new baby?
- What expectations did you have about being a mother (this time/ first time)?
- How has your experience compared with those expectations?

- What ideas do you have about how a mother should be?
- Where do you think those ideas have come from?
- How do they compare with your reality?
- How would you describe yourself as a mother?
- How would you describe yourself as a partner?
- How would you describe yourself as a daughter?

Appendix F: Example of initial line-by-line coding, with corresponding focused codes

Original ordering	Original transcript	Initial coding	Focused coding
1	OK, so.. if you could just sort of tell me the circumstances that have		
2	led to your diagnosis of postnatal depression, if I could just put it		
3	very broadly.		
4	**Crikey, erm.. er, I think they al.. always thought I was at risk,**	Feeling at risk; expecting to be depressed?	Feeling at risk; expecting to be depressed?
5	**erm having had it not diagnosed but I know that I did have it**	Not being diagnosed previously; lack of support/care?	
6	**with [son] four years ago** [Right] **Erm, and also erm during the**		
7	**pregnancy I had erm, quite a lot of stresses going on, er, I had**	Experiencing stress in pregnancy	
8	**erm two house moves within a year, actually the first one was**	Moving house; lack of stability?	
9	**just before I fell pregnant. I'd remarried, I'd got erm two**	Re-marrying; new relationship	
10	**stepchildren and so I was blending a family, my husband**	Blending a family; compromising?	
11	**changed job, er so everything [wow] you know, it was, it was**	Husband changing jobs	
12	**pretty full on. And then moving here I didn't know anybody and**	Moving somewhere unfamiliar; leaving support	
13	**when I moved here it was si.. I was six months pregnant and I**		
14	**was already really quite uncomfortable; I was quite large, and**	Feeling physically uncomfortable with pregnancy	
15	**erm I just didn't get out, I didn't meet anybody, I didn't know**	Isolating self	
16	**anybody really here, so I was quite isolated and not with any**		
17	**real feeling of it changing any time soon [Mmm] and I think**	Resigning self to isolation	
18	**because of last time I think I was quite fearful, although quite**	Feeling fearful; expecting difficulties	
19	**positive about wanting to be different this time and.. and it, the**	Hoping that things will be different	
20	**circumstances being different, erm with a new marriage and all**	Looking at the positives of current situation	
21	**that, erm just wanted very keen to get back to that kind of**	Wanting to feel more positively	
22	**position emotionally. Erm, and so I did erm, I did er, I tried a**	Protecting self against depression	Protecting self against depression
23	**few things, but I..I..I j.. I got the placenta encapsulated coz**		
24	**that's supposed to help with mood, and that first week after**		

25	**the baby was born, I was on cloud nine the whole time, and I**	Feeling happy about the baby	
26	**don't remember that at all last time, erm, and then the baby**	Comparing with previous experience	
27	**blues came in and I thought "OK, yeah, that's OK, I know what**	Accepting low mood as normal experience	
28	**this is", you know, but it just never really quite cleared, and**	Monitoring her mood?	
29	**then it just got worse and worse, erm.. That's pretty much it in**	Feeling the mood worsen	
30	**a nutshell is it? Is there anything else I haven't sort of said?**	Questioning memory of events	
31	**[pause] Yeah, those are the kind of circumstances.**		
32	OK, so sort of feeling that, initially it was kind of, sort of feeling low,		
33	feeling the baby blues and feeling "That's OK, that's.. normal"		
34	[Mmm] but then realising that actually that it wasn't going away		
35	[Mmm] and so what, what led to you.. prompting you to to actually		
36	go and get help?		
37	**[Sigh] Erm.. well first of all I mentioned it, I mentioned it at the**	Raising concerns	
38	**6-8 week check up; [Mmmhmm] mine was actually nine weeks**	Service delaying the check up	
39	**coz that's when they could fit me in, and erm no I mentioned it**	Misremembering details	
40	**before then, sorry, I mentioned before then coz we had to go**		
41	**with a..a..a..an XXXX with [baby] and erm she said "No, we'll**	Doctor delaying process;	Doctor delaying process;
42	**have, we'll wait until 9 weeks" and see if it was just the baby**	Doctor wanting confirmation	
43	**blues and I just remember thinking then, I just thought "I can't**	Increasing desperation; feeling unable to cope	
44	**stand this for another few weeks [Mmm] erm [pause] and it**		
45	**was just.. just the feelings were just so, so awful, I mean**		
46	**luckily I've bonded brilliantly with [baby] and she's.. what I**	Bonding with baby	
47	**would class as an easy baby really, [Mmm] she's very content,**	Describing baby in positive way	
48	**so luckily I, you know, in that sense I've bo.. you know I, it's..**	Feeling lucky	
49	**it's not affected my relationship with her luckily, but..**	Looking at impact on relationship with baby	
50	**everything else is such a trial, and erm very frightened at times**	Struggling with other areas of life	
51	**that it's going to affect my marriage, again, erm, because**	Fearing effect on marriage; remembering past marriage	Fearing effect on marriage; remembering past marriage
52	**finding it very difficult to connect with him er when I'm**	Disconnecting from husband when particularly low	

53	**particularly bad. Erm, really struggling when the stepchildren**	Struggling with presence of stepchildren	
54	**come, finding that all really really hard, erm and I just I'd said**		
55	**beforehand, "If, if..if it gets like that, if I get that bad, please**	Pre-empting things getting bad	
56	**force me to do something so probably at the time I won't know**	Putting preventative measures together; having insight	
57	**[Mmm] how bad it is", but I did, I do know how bad it is, I..I..I**	Being aware of how bad she is feeling	
58	**was very aware that I was really in a pit of despair at times and**	Despairing	
59	**just wanted to run away, erm.. yeah.**	Wanting to run away	
60	So much more about the emotional, sort of impact on you rather		
61	than kind of the relationship [Yeah] with..with [baby]? And you, you		
62	mentioned with [Son], you feel you had it undiagnosed but there		
63	was, it seems.. it sounded like you're saying there was some kind of		
64	similarity in, in the experience? Or you felt it was retrospectively		
65	that it was postnatal depression with [son], or..?		
66	**Erm.. [sigh] It's tricky with [son] because it we.. it went on for**	Feeling unsure about experience with son	
67	**such a long time, and the circumstances surrounding that was**	Struggling with physical illness	
68	**that I'd had M.E. for quite a long time [Mmm] erm, so I hadn't**		
69	**had sort of successful time for a while with a career, and there**	Illness impacting on career	
70	**were, so the odds were kind of stacked against me feeling like**	Feeling helpless/powerless	
71	**I had an identity, even though it was changing, that I had my**	Experiencing a lack of identity. Change of identity	Experiencing a lack of identity. Change of identity
72	**own identity in the first place, and I felt very claustrophobic in**	Feeling trapped	
73	**a very small cottage with not enough light, er so that.. it.. it**		
74	**was quite different last time [Mmm] and he was a very different**	Comparing experiences	
75	**baby last, you know that was.. that was a very different**	Differentiating experiences	
76	**experience plus it was my first, so I [Mmm] just felt like I was**	Expectations of first-time motherhood	
77	**really floundering about, and while I don't feel a lot of that this**	Floundering about, not knowing what to do	
78	**time, the feelings of.. I w..it's it's a feeling of it, that the, the..**		
79	**er.. it's incessant, being a mum is incessant isn't it? And then**	Feeling pressure? Obligation? Trapped?	
80	**it's erm you never have time off. It's not so much the practical**	Not having time to yourself	Not having time to yourself

81	**side of it, you..you..you're you're always on call it's that**		
82	**emotionally and mentally you never get a moment off [Mmm]**	Dedicating self emotionally and mentally	
83	**er.. and I love it and hate it at the same time [Mmm] and I'm..**	Loving and hating at same time. Ambivalence	
84	**I'm breastfeeding, so, erm and I will not step back from that. I**	Determined to breastfeed	
85	**set myself up such high expectations that anything else would**	Setting self high expectations	
86	**probably just make the depression worse, but it does mean**	Setting self up for depression? Thinking bias	
87	**that nobody can really sort of say to me "Look, just go out.**	Not allowing time for self	
88	**Just go.. go and do something", you know I..I know I can't do**		
89	**that, and I don't really want to either, I don't desperately want**	Not wanting time for self. Self-sacrifice. Not wanting to	Not wanting time for self. Self-sacrifice. Not wanting to
90	**an evening out or whatever but.. possibly just having some**	be seen wanting?	be seen wanting?
91	**time where I can get my head clear [Mmm] and do something**	Needing head space and time for self. Entertaining	
92	**for myself, er.. is he..**	possibility for need?	
93	And maybe just have the option		
94	**Yeah, just, just knowing I can**	Identifying a need for choice	
95	Even if you don't take it, [Mmm] just knowing that that option's there		
96	for you [Mmm]		
97	**I feel better today than I have done since, ironically, as.. er..**	Feeling more positive. Ironically because of the	
98	**since she came, and this weekend erm well there's a lot of**	interview?	
99	**things really. We've decided that we're going to try, once she's**		
100	**gone down for the evening to go out once a week or once a**	Deciding to try and make time as a couple	Deciding to try and make time as a couple
101	**fortnight just me and [husband] and just go down to the pub**	Diminishing time she is asking for. 'just'	
102	**down the end of the road and we just get to spend an hour**		
103	**just time out, erm and by the end.. by the end of it on Friday I**	Change in how things felt. Perceiving things differently	
104	**felt, I just felt something had shifted, possibly because it was**		
105	**a..an.. we had a weekend without the stepchildren coming as**	Struggle with stepchildren being there. Resentment?	
106	**well [Mmm] that kind of always helps a bit, and then Su..**		
107	**Saturday, coz I.. I like singing and I haven't done anything with**	Sacrificing hobby when pregnant	
108	**music for quite a long time, erm, coz I couldn't when I was**		

109	**pregnant and erm I did a scratch Messiah and I took her with**	Combining hobby with childcare	
110	**me, and I thought that I'd have to call [husband] to come and**	Pre-empting difficulty with baby	
111	**collect her lunchtime you know, when she'd had enough, and**		
112	**she stayed with me the whole day, she just.. she just fed when**	Giving control and responsibility to baby as to how day	
113	**she wanted to, slept when she wanted to and then listened and**	went. Being thankful to baby?	
114	**cooed the whole time, and just gave me freedom [Mmm] and**		
115	**ga.. I did something where I could actually focus in little**	Focusing on something she enjoys	Focusing on something she enjoys
116	**pockets on something other than my life at the moment and**	Distraction away from emotions/depression	
117	**how I feel at the moment, coz that's kind of depressing in**		
118	**itself. And, erm, and then we went to the beach yesterday and**	Diversion	
119	**it was just, it was just really lovely, really nice weekend, and I**	Feeling clearer	
120	**just feel.. clearer; I just feel like I've just done something**	Taking responsibility for change	
121	**different [Mmm]**		
122	And also the singing sounded like quite an important part of you		
123	**Massively, big part of me**		
124	You said you couldn't do that when you were pregnant; was that		
125	because..	Justifying not engaging with hobby	
126	**Because most of what I do is erm, is on stage [Oh, OK], so that**	Not joining another group since moving. Isolating self?	
127	**kind of counted that out, erm and since the move I don't.. I**		
128	**haven't joined anything else here, um.. so yeah so it was sort**		
129	**of practical reasons more than anything really. But I do, you**	Mixed feelings about missing hobby	
130	**know, I sort of miss it and I don't miss it, erm, but it was a**	Validating experience of re-engaging.	Validating experience of re-engaging.
131	**really good thing to do [Mmm], it was a really good thing.**		
132	**Mmm.**		
133	So now, it's all.. a..at this point in time sort of feeling much more		
134	positive, kind of, time for you.	Reconnecting with self	Reconnecting with self
135	**Yeah, I feel like I've sort of reconnected with myself a bit**	Beginnings of change in experience	
136	**somewhere, erm.. I'm starting.. I feel like I, I can I can access**	Thinking more clearly	

137	**my thoughts whereas before I just couldn't [Mmm] erm, and I**	Feeling more like self. Enjoying reconnection	
138	**just I sort of feel a bit more like me, which is quite nice.**		
139	Mmm. [Pause] So thinking back to your experiences when you had		
140	[son] [Mmm] and now sort of having [baby] [Mmm] and..I'm just.. I'm		
141	quite interested about sort of first time round, I mean obviously the		
142	circumstances that were going on for you were very different, quite		
143	different [Yeah] as well, but, you know sort of having had your		
144	experience sort of with [baby] and having got help [Yeah] via the		
145	GP initially	Clarifying information	
146	**No, ac.. no**		
147	You said at your six week check; who was that with?	Describing referral process	
148	**Yeah, that was with the doctor, erm.. I think I'd already, by nine**	Self-referred, frustrated at waiting time. Sense of	
149	**weeks I'd already self-referred myself, coz I didn't want to wait**	urgency	
150	**any longer**		
151	To? What did you refer yourself to? Coz it's different in every area	Informing about process and organisations available	
152	**Erm, yeah. I hadn't heard of this when.. where I was before, but**	locally.	
153	**the NHS have got something called 'Health in Mind' [Right] I**		
154	**don't know if you've heard of that, and then and I think they're**		
155	**connected to MIND, so MIND are.. that's who I'm seeing**		
156	**tomorrow having.. I'm having six weeks of 1:1 and then 'Health**		
157	**in Mind' do erm.. in conjunction with the children's centres**		
158	**they do erm, cognitive behavioural therapy type courses and**		
159	**you can do either group courses or 1:1 or there's a whole**		
160	**range of stuff they do specifically, some of it specifically for**		
161	**PND, and some of it [Mmm] isn't [OK] Erm.. But she, she I think**	Concurring with health professional about needing 1:1	
162	**quite rightly assessed me when I went to 'Health in Mind' and**	therapy first	
163	**said 'I think you need to have 1:1s first because you just**		
164	**[Mmm].. you can't clear your mind enough to kind of get any**		

165	**benefit anywhere else yet.**		
166	Yeah, so who.. you said you spoke to somebody prior to your six..		
167	oh no, you had your six week check at nine weeks [Mmm] but you		
168	spoke to someone prior...	Relaying what GP said about waiting for help	
169	**I did speak to the doctor and she said 'No, let's leave it'**		
170	'Let's leave it'?		
171	**Yeah**		
172	And then you felt that actually that even a few more weeks of this		
173	[Yeah] is just going to be too much for me, so you self.. found this		
174	'Health in Mind' and you self-referred yourself [laugh]		
175	**Yeah, yeah**		
176	Yeah, OK, and they assessed you.	Informing outcome of assessment	
177	**Yes. They assessed me and said 'Yes you do need the help'**	Concerned about being prescribed medication	Concerned about being prescribed medication
178	**and erm I think I was concerned that I.. when I went back to**		
179	**the doctors what she would do is put me on medication,**	Expressing concerns about breastfeeding and	
180	**because when I did mention it before, erm, she... I said 'You**	medication	
181	**know I've got you know I've got concerns because.. because**	Doctor validating concerns by researching it	
182	**of the breast milk' etc etc and she said, well she looked in the**		
183	**book and she was actually really good coz she was.. she was**		
184	**looking at the different types and erm said, you know, it's a**	Selecting least risky antidepressant	
185	**question of what, which one erm, what's the word I'm looking**		
186	**for? Erm.. oh what's going to be the less risky [Mmm] you**	Not wanting medication for self	
187	**know with everything. But I just didn't want.. I don't want to go**	Negotiating views about medication. Justifying?	
188	**on medication for myself, I just don't really feel like I want to**	Placating? Moderating?	
189	**do that, and before, and I've not got anything against it, but I**	Wanting to try talking. Do it by herself?	
190	**just don't wanna do it. And I wanted to kind of see, I..I felt like**	Getting it out	
191	**if I could just talk [Mmm] and get it out, coz it's just all stuck in**		
192	**me the whole [Mmm] time or whenever I talk to anybody here**	Not feeling able to talk to family, needing someone	Not feeling able to talk to family, needing someone

193	**it's so emotive because I'm talking about feelings to do with**	objective? Avoiding?	objective? Avoiding?
194	**family and stepchildren and umm and it's you know, it's ugly.**	Protecting husband? Wanting to try talking therapy first	
195	**[Mmm] It's ugly, and it's really hard for [husband] to hear**		
196	**[Mmm]. So I wanna try that first.**		
197	Yeah, so, sort of the name 'postnatal depression', when did that		
198	first kind of come into sort of the equation as it were? When along		
199	the process did you start to think, or did somebody else say,		
200	'Actually, this is..what it is'	Relaying GP's opinion that it probably was PND	
201	**Erm.. the doctor had originally said she thought it probably**		
202	**was**		
203	That was your GP?	GP choosing to leave it to be sure	
204	**Yeah [Right]. But, on the off chance it wasn't would leave it**		
205	**[OK], until, um.. and then when I went and had the assessment,**	Concurrence from other health professionals	
206	**yeah they agreed that yeah that's what it was as well; that was**		
207	**at 'Health in Mind'.**		
208	Was that assessed just from what you said or was there like a form		
209	that you filled out, or..?	Informing about the process of assessment; combining	
210	**There was about three forms that I filled out, although I.. I don't**	actuarial with clinical interview.	
211	**know if any of those were particularly.. though one of them**	Unclear about the forms given; making sense of forms	
212	**was related to postnatal depression [OK], the other two were**	for self.	
213	**general depression ones or anxiety or whatever [OK] to assess**		
214	**how bad it was, or where you were going with it, erm and the**		
215	**rest of it was, yeah, an hour of talk [Mmm] sort of therapy**		
216	**really to see what's going on.**		
217	Yeah. You said it sort of measures the severity; did you get a kind		
218	of feedback as to how.. how bad it was, or..?	Sussing out what forms are asking for	
219	**Not really. You kind of tell though, coz when you're looking at**		
220	**these.. answering the questions you can tell what they're**	Negotiating severity; not suicidal meaning the perceived	Negotiating severity; not suicidal meaning the perceived

221	**looking for. I mean they.. the worst case of cou.. of course is**	severity diminishes	severity diminishes
222	**looking at whether you're going to be suicidal or anything**		
223	**[Mmm] like that, and honestly no, you know [Mmm] I..I'm not**	Re-defining severity in terms of harm to self and baby	
224	**and I don't want to harm my baby and any of that. So I guess,**	Diminishing sense of severity 'officially'? but still	
225	**in that sense, er it's not that bad, but erm**	retaining some sense of struggle. Negotiating?	
226	It's bad enough		
227	**It's bad enough yeah. [Mmm] It's really really not nice [Mmm]**		
228	**at all.**		
229	I just wonder how this experience kind of with.. with [baby] but also		
230	getting.. how.. how old is [baby] now?	Remembering baby's age	
231	**I can't remember. [Laughs] She, well she's three months.**		
232	Three months, OK [Yeah]. So still obviously very, very recent.		
233	[Yeah] I was just wondering how this experience has kind of,		
234	whether you are thinking back to your time with [son] and sort of		
235	thinking, you know, 'This is what that was' or, erm you know about		
236	having help then, or.. I wonder whether it's, or you sort of remember		
237	back and think..	Comparing experiences of having children	
238	**Yeah, the.. the.. I mean the re.. the real similarities are, erm..**	Struggle to verbalise/express the feelings	
239	**how do I.. how do I express it? Erm.. some of it kind of**	Dismissing? or acknowledging as sleep deprivation	
240	**is..is..is.. could be sleep deprivation [Mmm], but it... I.. is**	Feeling trapped and angry	Feeling trapped and angry
241	**feeling.. it's feeling trapped. It's feeling er..erm.. feeling angry**	Giving power to baby.	
242	**with the.. with the baby when they don't want to do what you**	Desperation and frustration	
243	**need them to do you know when you desperately desperately**		
244	**want to take some time out [Mmm] and they just won't go**	Assuming/taking on guilt	
245	**down. And feelings of guilt no matter what you do.. with the..**		
246	**with the baby, and erm.. with.. with [son] I felt that I felt just.. I**	Seeing own despair in baby	
247	**felt like my despair was being reflected back at me because he**		
248	**wasn't a particularly giving baby; he didn't smile very much**	Not feeling bonded with baby	

249	**and I don't know that I really felt particularly bonded with him**	Lack of confidence in ability (to mother?)	Lack of confidence in ability (to mother?)
250	**[Mmm] for a long time. Erm.. I didn't feel confident, I didn't feel**		
251	**able, I didn't feel like I was able to do anything, and I've got**		
252	**over that with [baby].**		
253	What feels different this time? [Pause] Or what has allowed you to		
254	feel differently?	Relating experiences to relationships with husbands	Relating experiences to relationships with husbands
255	**I think on the one hand it's.. it's.. it's that.. my husband now,**	Maintaining power with new husband	
256	**my new husband, doesn't er.. try and take everything away.**		
257	**My..my ex-husband er, his way of helping was to do everything**	Disempowered by ex-husband	
258	**himself because he didn't think I could cope, erm.. and that**		
259	**just completely disempowered me, so I just completely**	Believing she was useless	
260	**believed that I was complet.. you know as useless I believed I**		
261	**was [Mmm] erm.. [husband] doesn't do that, but then I kind of**	Husband doesn't understand the stress	
262	**feel that he doesn't understand how stressful it is [Mmm],**	Recognising the difficulty of helping vs not helping	
263	**because he's not helping, so i.. you know they can't win no**		
264	**matter what they do really.**		
265	It's kind of that balance between [Yeah, I mean..] the support		
266	[Yeah] but not taking over	Comparing husbands' approaches to support	
267	**Yeah and I think [husband]'s got it much more right**		
268	**than..than..than my ex-husband had, but er.. coz he's still, you**	Husband being involved.	
269	**know, he's.. he's still fairly hands on; I mean he's completely**		
270	**hands on at the weekends and erm.. I think it's not really.. it's**	Dismissing the practical side as the main issue	
271	**not really practical.. the practical side of it that I feel that.. I**	Feeling lonely. Isolated?	
272	**just find.. I find being a mu.. being a mum is.. er.. is just the**	Not feeling understood, even by other mums.	Not feeling understood, even by other mums.
273	**loneliest.. I find it so lonely, because nobody around you, not**		
274	**even other mums know.. er knows exactly how you feel [Mmm]**		
275	**erm.. I mean other mums are the closest you're gonna get**	Pressured by presence of stepchildren	
276	**obviously. But now, this time of course, I've.. I..I..I've made it**		

277	**even more hard because I've got the stepchildren in the**		
278	**equation as well, and.. it's quite messy.**		
279	How old are the stepchildren?		
280	**Seven and twelve. And they're here every week, but they're**		
281	**here.. they're like one long weekend and then a couple of days.**		
282	Mmm. Coz you've mentioned a few times.. I think they're an		
283	important part of the story for you.	Working to absolute limit	
284	**Yeah, I think they are. I think they are because.. ah for lots of**		
285	**reasons, but in conjunction with [baby], I.. I feel like I am**		
286	**working to my absolute limit [Mmm] and then, suddenly I get**		
287	**two other children as well as obviously [son] as well. Two**		
288	**other children coming in, erm and then they're just that**	Not feeling her home is her own	
289	**they're.. [sigh] it's just very difficult.. because my house**		
290	**doesn't feel like my own any more when they come in.**		
291	And is that something that feels important for you; that sense of		
292	space, and you're.. having your own? Is that what you mean?	Not being considered Or understood?	Not being considered Or understood?
293	**[Sigh] Sort of that. It's.. I think it's in the se.. in terms of.. in**		
294	**terms of how I feel with [baby] it's.. it's that.. not a thought is**		
295	**being.. is being given by anybody to what my life is like the**	Defending needs of baby. And self?	
296	**rest of the time. It's like I don't.. it doesn't matter.. doesn't**		
297	**matter whether you want.. want it to be quiet now; doesn't**		
298	**matter whether it's her bedtime now; it doesn't matter.. doesn't**		
299	**matter whether you're working flat out to get a routine going;**		
300	**we're going to be noisy now, we're not even going to say hello**	Being ignored	
301	**when we come into your house now, and um.. I just feel bit**	Feeling trampled on	
302	**trampled on. And the.. the thing with.. I..I..I feel with.. with..**	Appreciating smiles from baby	
303	**with a baby is that, and I'm lucky with [baby] coz she smiles at**	Frustrated at lack of value or feeling valued	
304	**me, but you don't get anything back; you don't.. you don't get**		

305	**any gratitude, no matter how hard you're working around the**		
306	**clock, I don't think you feel va.. I don't.. I don't personally feel**		
307	**valued and erm.. and then I've got on top of that two children**		
308	**that come in, and I haven't got a bad relationship with them**		
309	**[Mmm], it's not bad, but.. it's a fu.. it's a strange relationship.**		
310	Mmm. And when you say about not feeling valued, do you mean by		
311	[baby] or do you mean wider?	Assumption of being dismissed by others	
312	**I er, I mean wider. I feel.. I feel like.. I feel like everyone just**	Not understood Feeling judged?	Not understood Feeling judged?
313	**kind of looks at you as if to say 'Well you've had this baby, you**		
314	**just need to get on with it. You.. you.. you.. you sort of know..**		
315	**know what you need to do; why are you now struggling with**		
316	**that? Why.. why is it emotionally difficult for you just to do**	Recognising a potential cognitive bias	
317	**what you need to do?' And they're probably not thinking that**		
318	**at all [laughs] but..**		
319	But that's your sense of how..		
320	**That is how I feel, yeah.**		
321	And is there part of you that feels that for yourself?	Responding to idea that she herself believes that she	
322	**Oh yeah, probably.**	shouldn't be struggling	
323	You should be able to just get on with it, and.. [Yeah] You know it		
324	almost sounds like you're being called ungrateful in some way; it's		
325	kind of 'Well you have this baby, so.. you chose it, so.. [Yeah] get		
326	on with it.'	Assuming other mums' experience matches hers.	
327	**Yeah, yeah. Yeah, and also, and I think this is probably every.. I**	Justifying or validating?	
328	**don't know.. I..I imagine every mum to feel like this, maybe not,**	Asserting that her and husband are compatible?	
329	**but the fact that no matter how compatible you are with your**	Resenting separate life?	Resenting separate life?
330	**husband before.. before you have a baby as soon as you have**	Negotiating views on the pressures on husband	
331	**the baby, they're going out to work and they have this separate**		
332	**life and they come back and yet, you know, they.. they may be..**	Acknowledging the difference (but downplaying?)	

333	**they may have sleep deprivation same as you, and erm.. you're**		
334	**just slightly talking a different language.**		
335	Mmm. Coz even though [baby]'s not the first child for either of you,		
336	it's the first child for you [Mmm] as a couple [Mmmhmm, yeah]; in		
337	some way she is [Yeah] the first [Yeah, yes] in a way [Yeah]. It's		
338	kind of negotiating for both of you.	Not being acknoweldged or understood	
339	**It is.. But I always sort of feel that no one.. mm.. not so much**		
340	**no one cares, but.. even just how difficult it is just to make**		
341	**dinner [Mmm], you know you've finally got the baby down and**	Relentless demands. Putting self under pressure?	
342	**you run around and instead of, you know, having a break,**		
343	**you're running around getting dinner ready and laundry on la-**	Hating domestic tasks	
344	**la, and I hate doing all that crap; I'm just not very domesticated**		
345	**[laughs] I think, erm..and then it's just.. it kind of gets.. gets**		
346	**eaten and.. and it's just.. I.. you know, I want someone to**	Feeling unappreciated	Feeling unappreciated
347	**realise how difficult it is for me..**		
348	Mmm. So there's two things; it's kind of the having to keep going,		
349	so [baby]'s having a sleep but you have to kind of keep going to		
350	make use of that time to kind of get all the other things kind of		
351	ticked off the list, but also they're things that you don't particularly		
352	enjoy doing [Yeah] and they're things that are kind of, not undone,		
353	but.. dinner's eaten and then that's it, it's kind of [Yeah], there's no		
354	kind of lasting impact [No, no] of those jobs.	Lack of achievement	
355	**Yeah, yeah. I don't get a sense of [laughs] achievement with**		
356	**that really [Mmm]. [Pause, sigh]**		
357	So I know it's all.. I mean it's all obviously happened over quite a		
358	short period of time, this time round, but is there any sense of any		
359	change in sort of seeing professionals and having those		
360	assessments and being told that actually 'Yes, you know it is		

361	postnatal depression and you do need the help, you.. and you will		
362	get the help'; do you feel any.. what was the impact of.. of that for		
363	you? If any?	Reluctance to pinpoint impact of getting help	
364	**Well, yeah it's difficult to say this time round because, erm.. I**		
365	**haven't.. I haven't really got the help this time yet [Mmm] erm..**		
366	So you've been told it's coming.. [Yeah] but it hasn't realised yet	Relief at having help in place	
367	**But I feel better ha..having tomorrow's date in the diary, coz I..**	Anger/frustration at the wait?	Anger/frustration at the wait?
368	**the.. it was, how many weeks? Eight weeks waiting for help?**		
369	**[Mmm] It's a flipping long time when you're feeling lousy, erm..**		
370	Mmm, coz even when you said three weeks or whatever it was,		
371	just.. it's too long..	Needing to chase up about help	
372	**Yeah, definitely, and I phoned.. I phoned up just to see, you**	Feeling forgotten	Feeling forgotten, left, abandoned?
373	**know, if.. if I've been forgotten coz you just don't know and I..**	Justifying need to chase up	
374	**and it's not that you think 'Come on, chop chop' and I.. I know**	Rationalising that there's a wait	
375	**there's a waiting list; I understand [Mmm] that concept, but**	Defending needs of the children. Anger?	
376	**[Mmm] I just kind of felt you know, that there are children**	Feeling guilty at impact on the children	
377	**involved here, and I.. it's not just.. it's not just [baby] in this**		
378	**equation; I've got, er my four year old and I just get so mad at**		
379	**him all the time [laugh] [Mmm] you know, so intolerant.. and**		
380	**it's ju.. you know, just.. it just feels I'm so angry so much of the**		
381	**time, that as soon as you.. as soon as they realise that there..**	Negotiating her level of need against that of (unknown)	
382	**there is.. there are children involved, surely they.. that must**	others	
383	**seem quite urgent, but I can't.. you know, I have no idea who**		
384	**else is on the waiting list, but [Mmm].. still, so, yeah so I'm on..**		
385	**I've got that and.. I feel better for that.**		
386	So feeling better for having sort of a date in the diary [Mmm] at		
387	which the help will start? [Yeah] So, not really feeling much impact		
388	of having the diagnosis and of kind of being placed on that waiting		

389	list, was it kind of on hold until that date's in your diary and actually		
390	it's starting, or..?	Knowing she had PND. Relief that someone else	Knowing she had PND. Relief that someone else
391	**[Sigh] I just knew I had it, [Mmm] so I don't know that, I think**	recognised it	recognised it
392	**the relief was somebody's recognised it.**		
393	Mmm. 'It's not just me that knows, somebody else [Yeah] does too.	Feeling uncertain	
394	**Yeah, because I, erm, I'm never quite sure whether if you say it**	Needing validation?	
395	**to your family or whatever, whether it just doesn't sound like**		
396	**you're saying 'Tut, Actually, this is a bit hard, I must have**		
397	**postnatal depression' or I'm just asking for more help or**		
398	**whatever [Mmm] I mean I've got a lot of support, I ju.. I.. I**	Rationalising, recognising support	
399	**can't.. I can't complain at.. you know, I'm lucky, but, um.. if I'm**	Needing reason for help	
400	**going.. if I'm going to be asking for that help, it's easier if I can**	Needing recognition	Needing recognition/validation?
401	**say it's been recognised that I have postnatal depression**		
402	**rather than just 'I'm just really finding this hard work'.**		
403	Mmm. So having that sort of objective opinion from outside [Yeah],		
404	sort of sense of validation to actually say [Mmm] that actually this is		
405	what it is [Yeah] and that sort of recognition	Having objective opinion making a difference (to..?)	
406	**Yes, does make a difference, mmm.**		
407	Mmm, so does that.. is part of what you're saying is that around		
408	kind of asking for the help or you know does it kind of give you..		
409	does it give you permission I guess in a way to, to ask for things, or		
410	I.. I don't know if that's part of what you're saying? Coz you've kind		
411	of got this support of this..diagnosis.	Having diagnosis making her feel she has permission to	
412	**Yeah, it does. Yeah it does feel.. make me feel like that. It's**	ask for help	
413	**slightly less frightening as well, knowing that that's what it is**	Diagnosis making it less frightening, making help	Diagnosis making it less frightening, making help
414	**and perhaps I can get help with it [Mmm].**	possible	possible
415	Because if there's a name for it, [Mmm] there's a.. not a fix, but..	Wanting people to understand	
416	**Well people.. people will recognise what I.. what it is that I'm**		

417	**saying, and [Mmm] erm..**		
418	So it's a language you can use?	Not coping	
419	**Yeah, yeah. And it's not just that I just can't cope, I mean that's**	Fearing that it is something in her	
420	**the fear is that actually it is just me and maybe I'm just not cut**	Doubting her ability (to mother?)	Doubting her ability (to mother?)
421	**out for it.**		
422	OK, so it sort of takes it outside of yourself? [Mmm, mmm] It's not		
423	a.. I don't know. It's not something about you as a person, as a		
424	mother; it's something that's kind of slightly outside of you.	Understanding and explaining why things are harder	
425	**Yeah, there's a.. there's a..a..an.. an extra reason why this.. this**	than she feels they should be	
426	**is more hard than it.. it needs to be [Mmm]. Mmm..**		
427	So how do you think your family view, and you can sort of go		
428	(laugh) through kind of thinking how your parents, husband [Mmm]		
429	view your postnatal depression or your, your experience [sigh];		
430	what's your sense?	Struggling to look objectively at how family view things	
431	**Ah.. I don't really know coz it's difficult for me to look at it**		
432	**objectively.**		
433	I suppose your sense, how does it feel to you that they.. they, you		
434	know..	PND validating effort and help mum is having to give	PND validating effort and help mum is having to give
435	**I think with my parents, my mum particularly, even with.. even**	Justifying?	
436	**with her it kind of validates that the extra effort that she's**		
437	**having to put in [Mmm] um.. for a while it was kind of, I was**		
438	**being made, almost, willi.. you know, whether she meant to or**	Feeling guilty for wanting/needing help	
439	**not, to feel guilty for wanting more help, for wanting her to**	Pressure of deadline to recover by	
440	**come over, erm.. there was like this feeling of there's a**		
441	**deadline here, erm.. constant talking about you know, wanting**	Recognising needs of parents	
442	**their life back and I get all that, I..I..I know, I know all that. I**	Reluctant to ask for help	
443	**don't want to ask for the help [Mmm], erm.. and what was**		
444	**happening was that she was getting.. she'd come.. she'd come**	Interpreting look as being 'jacked off' (angry?	

445	**in.. and she's got a way of looking just jacked off before you've**	Frustrated?)	
446	**even said anything and it's like 'I haven't slept and I've got a**	Assuming guilt/blame?	
447	**headache, and..' the implication and.. she'll say it, that she's**		
448	**been kept awake coz she's worrying about me and.. she's**	Mother helping for a long time	
449	**done this for a long time, coz I've.. I've had well, the marriage**	Listing problems	
450	**breakdown and I've had M.E. and I.. I just feel like I'm just a bit**	Feeling a burden	Feeling a burden
451	**of a burden really. Um.. and it kind of came to blows one day**		
452	**when she came and did that.. coz when she's talking to other**	Comparing her mother's treatment of her and others	
453	**people she hasn't got that face on.. I sound like I'm being**	Feeling she's being bitchy. Doubting herself?	
454	**really bitchy.**		
455	It's how it feels for you.	Challenging her mother	
456	**This is how it, yeah, and um.. I said to her 'Look, you know I**	Putting her side across, explaining herself	
457	**am.. I haven't slept for days and days, and on top of that I've**	Comparing her struggles with her mother's	
458	**got an..an..and I..I don't.. I.. I wasn't gonna list why it feels**		
459	**worse for me, I've got no idea if it feels worse for me, but I kind**	Giving mother permission to say 'No' to helping	
460	**of thought why I said to her 'Well, look, you.. if you're not able**		
461	**to come and help, if you're not feeling well enough or**	Blaming mother for not feeling able to have a rest	Blaming mother for not feeling able to have a rest
462	**whatever, then just say "No"; don't..please don't come and**	Assuming responsibility for mother's struggles?	
463	**make me feel like I can't go and have that rest when I get her**		
464	**down and [son]'s at nursery, because you should be having it,**	Struggling with guilt	
465	**or because... I can't deal with that guilt on top of everything**	Martyring self? Feeling defeated? Avoidant	
466	**else, [Mmm] I'd, you know I'd rather just.. just deal with it on**	Resenting mother's view/understanding of her?	Resenting mother's view/understanding of her?
467	**my own'.. yeah ah yeah apparently I didn't understand her and**	Doubting self? Acknowledging selfish elements?	
468	**I was being really selfish and yeah, maybe I.. maybe I was, you**		
469	**know I erm.. she's.. the last few days she said that I'm quite**		
470	**self-obsessed at the moment and that I think hands up, with**	Feeling trapped/helpless? Stuck in crappy emotional	
471	**the.. I can't get outside of how crappy my emotional world is a**	world. Struggling to connect to others	
472	**lot of the time, and I.. I find it very difficult to connect to other**	Acceptence of perhaps coming across as self-obsessed.	

473	**people, so erm.. I had.. I..I accept that's probably how it comes**	Not wanting to be seen as self-obsessed	
474	**across. I don't want it to, and I [Mmm], you know, I do.. I do**	Making it known she cares about others (for me?)	
475	**care, I do talk a lot to them about how they're feeling and**	Justifying self	
476	**what's going on in their lives, I.. I think. But um.. at that**		
477	**moment in time I obviously didn't feel like it. But I.. it wasn't so**	Unable to cope. Shutting down?	Unable to cope. Shutting down?
478	**much that I.. didn't care it was that actually at that moment in**		
479	**time I could not cope with anything else. I just couldn't, and**		
480	**erm.. so in that sense, going back round to the question, I**	Taking action by self-referring	
481	**think when.. when she realised that actually not only was I**		
482	**prepared to go and do something about it by self-referring but**	Validating her sense of struggle	Validating her sense of struggle
483	**that they'd reflected back and said 'Yeah, you're right, that is**		
484	**what it is, you do need help actually; you.. you need a bit more**	Underestimating her need for help	
485	**help than you think you need', and um.. she'll still say things**	Being made to feel guilty?	
486	**like 'Oh, we were going to.. we were going to do this that.. this**		
487	**week but we haven't been able to book that because we**	Others underestimating time needed to recover	
488	**thought originally this.. you wouldn't need us by now' and**	Parents finding it difficult	
489	**[Mmm] 'we thought, you know that it'd all be over by now' and**	Wishing mum didn't express her struggle	
490	**[Mmm] um.. so I still think they find it quite difficult, and I can**		
491	**understand that. I just wish she wouldn't say it (laughs, tears)**	Feeling mum wants her to feel guilty	Feeling mum wants her to feel guilty
492	**[Mmm] coz I think she's want.. she wants me to not only be**		
493	**aware but also to feel quite bad about it sometimes [Right]. My**	Husband finding it difficult	
494	**husband, again difficult for different reasons. He has erm.. his**	Previous experience of someone having PND	
495	**first wife, erm suffered with very bad postnatal depression by**		
496	**all accounts (sigh) erm.. she was on very very strong**		
497	**antidepressants, and he would find her, he'd come home from**		
498	**work and he's find her, um in the corner on the floor in the**		
499	**kitchen just sobbing, while the children were in a different**		
500	**room on their own, and.. he.. this is not really relevant but he..**		

501	**he doesn't feel that mine is any easier, you know, [Mmm] when**	Comparing different PND experiences	
502	**he listens to me talking about it; he doesn't think that I've got..**	Fighting it differently	
503	**got it better, but I think he thinks that I.. I fight it differently**		
504	**[Right] erm.. I don't feel like that. Mine.. when it's really bad I**	Not feeling she does fight it	
505	**don't feel like I am..**		
506	What you don't feel like you are fighting it?	Feeling beholden to feelings? Lack of control?	
507	**Well no, I don't think you can fight it, you know you either feel**	Ambivalence about wanting to know what he means	
508	**lousy or you don't, and.. I don't know, I don't.. I'd be interested**		
509	**to know what he.. what he meant by that; one day I might**		
510	**(laughs) ask him; I'm not sure I want to know the answer, but**	Talking about things that are bothering her	
511	**erm.. I do talk about things, you know, and things that are**		
512	**bothering me I talk about them, erm.. the problem is that I think**	Husband not knowing how best to help	
513	**now just like then he didn't know and doesn't know quite how**	Wanting to take it out on someone	
514	**best to help, and I want, I..I think I want somebody to, oh god,**		
515	**be able to take all the blows that I can give I think, which is,**		
516	**you know, not realistic probably, erm.. but be able to think**	Needing someone to think and understand outside of	Needing someone to think and understand outside of
517	**outside the box and..**	what is being said/done.	what is being said/done.
518	The other person to be able to think outside..		
519	**Yeah, for them to think outside the box and see what's going**	Need to be understood	
520	**on; see what I'm really saying, because erm I'm normally**		
521	**aware that there are, there's a whole mess of crap that's going**	Someone to listen to what's hurting	
522	**on and all I can say is one bit of it, which kind of is the bit**		
523	**that's making sense, but if someone could just listen to what's**		
524	**ke.. being said and then sort of hear what's hurting [Mmm],**	Needing a recognition of what she needs	Needing a recognition of what she needs
525	**then perhaps they could say 'Look, let's just do this. Let me**		
526	**just do this for you. Let.. let me do this so that you can do that'**		
527	**or.. and often I.. and often he just doesn't know.. he doesn't**		
528	**say anything, because he's so frightened he's going to say the**	Husband frightened of saying the wrong thing so saying	

529	**wrong thing [Yeah] because it.. I'm just.. sort of combustible.**	nothing	
530	**But that makes it worse coz then I just don't really feel like I'm**		
531	**being listened to at all.**	Not feeling listened to	Not feeling listened to
532	He kind of steps back a bit and.. [Yeah] you're feeling then that..		
533	[Yeah] he's stepping away rather than perhaps stepping [Yeah]		
534	back [Yeah]. And there's something you said about being listened		
535	to, so hearing what you're saying, but also maybe what you're not		
536	saying, and what's kind of underlying the things that you're saying;		
537	what's underneath it, [Yeah, which for me..] which is seeing that		
538	pain.		
539	**Yeah, and I've said to him, I've sa.. I.. I've used that word as**	Explaining pain to husband	
540	**well, I've said 'There's so much pain here, I just.. I.. it's not that**		
541	**I'm suicidal, it's that there are times when I just feel like, and**		
542	**it's not even courage, but it..i..i.. I wish I had the wherewithal to**		
543	**want to end it coz I just can't cope with this pain any more**	Wanting a way out of the pain	
544	**(Pause, crying). And it feels like what's under a lot of the stuff**		
545	**that's underlying it is sort of screaming out at me, but I can't, I**	Unable to express the level of pain coherently	Unable to express the level of pain coherently
546	**can't express it, so what comes out is quite hurtful I think to**	Not coping with pain	
547	**the person that's listening, but it's the only way I can get it out.**	Expressing pain in hurtful way as the only way	
548	Mmm.. because it's not coming out in a processed, intelligible way,		
549	it's just coming out as pain, and..		
550	**Yeah, yeah. [Mmm] And I so.. and I.. and I want someone to be**		
551	**able to (sniff) hear, hear what.. what's going on and.. erm.. I**	Needing someone to hear and understand	
552	**don't know. I think it is, I don't feel I want so.. I want someone**		
553	**to validate what's going on so that I feel like I'm not so alone**	Needing validation Feeling alone (isolated?)	Needing validation Feeling alone (isolated?)
554	**with these feelings (sniff). Ah, it's difficult, it's difficult to get**		
555	**them out so that people can hear them. (Pause) I'm talking**		
556	**rubbish (laughs).**	Belittling self and what she's saying	

557	Does it feel like rubbish?		
558	**Yeah, it does, it feels like I'm.. it feels like I'm talking in riddles.**	Talking in riddles	
559	And is that how you feel when you're trying to communicate to		
560	people how you're feeling? That you're talking rubbish, that it's		
561	coming out in riddles, there's no way they can understand you coz		
562	it's just all coming out as [unintelligible]?		
563	**Sometimes, although what I.. what I tend to do is I tend, I think**	Channeling pain into a peripheral issue	
564	**to (sigh) whatever.. whatever it might be bugging me at that**		
565	**moment in time, it's.. it's a kind of peripheral thing possibly**		
566	**and again, you know so..something like the stepchildren,**		
567	**which is difficult [Mmm], but I think a lot of my venom goes**		
568	**into that, so when I'm talking about it, it feel.. it go.. it all comes**		
569	**out in that, and I'm aware as I'm doing it, I'm aware that.. I**		
570	**don't know whether it's that..it..it's.. is it how I feel? It's not**	Confusion about how she feels	
571	**quite how I.. it's, oh I don't know. (Pause) I know, it's just**		
572	**whenever I say I feel like I'm being misunderstood and I think**	Feeling misunderstood	
573	**it's because I'm really not able to say what I want to say, or,**	Not able to say what she wants to say	
574	**[Mmm] because I can't either put it into words, it's..it's not**	Inability to put feelings into words	Inability to put feelings into words
575	**possible, or that I can only kind of pick on one thing at any one**	Picking on one thing at a time	
576	**time and it in no way therefore reflects that everything gets**		
577	**caught up in it [Mmm], everything feels wrong, everything feels**		
578	**so very black. (Pause)**		
579	Is there any sort of, chink of light in any area? Anything that doesn't		
580	feel quite so.. quite so black?		
581	**Yeah, ironically [baby], which is not what I expected [Mmm].**	Baby making her feel happy	
582	**But she makes me feel really happy. Because contrary to how I**	Contrasting with previous child's lack of response	
583	**felt with [son] whereas as I say I.. you know, you feel you get**		
584	**nothing back and.. she erm, she.. she will smile when she sees**	Responsiveness and affection of baby	Responsiveness and affection of baby

585	**me; she always, she.. she does she cuddles, she's.. she's just**		
586	**full of love, she's just.. she's lovely.**		
587	You say 'ironically'; I mean how do you sort of make sense of..		
588	she's kind of your lightness, but also in a way the darkness as well.		
589	**Mmm, well yes I.. I wouldn't feel like.. I wouldn't feel as dark if I**	Having baby causing darkness	
590	**didn't have her [Mmm] because I would.. my life would be very**		
591	**different. Erm, you know I.. before I've actually gone into her**		
592	**room, for, you know when the.. when the.. the feeds during the**		
593	**night and just think 'Oh my God, I can't do this' and as soon as**	Not feeling able to do night feeds	
594	**I go in there I think 'Ah, that's.. that's fine I'm OK with this, this**	Being with baby and feeling it's OK	Being with baby and feeling it's OK
595	**is just lovely.' For a bit, and then I want to go back to bed**		
596	**again.**		
597	And do you make sense of it, or does it just kind of sit as that kind		
598	of.. both/and kind of..		
599	**Mmm.. I think it, yeah, it's just, they just..**		
600	Sit alongside..?		
601	**Yeah. Yeah they do really. I think other.. everything else seems**	Other areas of her life seeming to suffer more as a	Other areas of her life seeming to suffer more as a
602	**to suffer more, as a result of that and the confusing..**	result of her ease with her baby	result of her ease with her baby
603	When you say everything else..? Can you..?		
604	**Well my relationships and my.. my really limited world at the**	Resenting and struggling with areas of her life	
605	**moment. I think I re.. resent and struggle with nearly**		
606	**everything else apart from.. apart from her, until she gets**		
607	**difficult and then I struggle with her as well. (Long silence)**	Struggling with baby when baby gets difficult	
608	There's that sense of things being a struggle, and everything, kind of, in your life feels like a struggle [Mmm] in all kinds of areas..		
609	**Yeah, and that I can't.. I can't do anything to kind of.. change**		
610	**that, you know I would like.. I'd like to.. I want to go and start**	Powerless to change things or improve things	
611	**retraining at some point soon, and suddenly I think 'Oh, I can't,**		

612	**I can't do that, because I'm still going to be.. she's still going**	Planning for the future	
613	**to be feeding, come next year, come October, and.. I don't**	Putting plans on hold in favour of baby's needs	Putting plans on hold in favour of baby's needs
614	**know, I just.. I don't know whether I'm just not cut out for.. for**		
615	**the role, and yet I also think I am, you know, I.. On.. in some**	Questioning whether she's cut out for 'the role' whilst	
616	**ways I'm quite a good mum, but I just think I some.. I often**	feeling she is	
617	**hate doing it.**	Recognising her ability as mother at times	
618	Mmm.. Was she a planned pregnancy?	Hating doing it (being mum or being good mum?)	
619	**Mmm. Doesn't sound like it, does it? (Laughs)**		
620	I just.. I just realised I hadn't actually asked that [Yeah] and that's		
621	quite an important.. part of the history.		
622	**We'd had a miscarriage.. I had a miscarriage before her [Mmm]**		
623	**so there was quite a lot of, I don't know, quite a lot of**	Taking responsibility for previous miscarriage	Taking responsibility for previous miscarriage
624	**emotional baggage going on..**	Emotional baggage carrying over into pregnancy	
625	At what stage did you miscarry?		
626	**Quite early on; eight weeks? And then, when I was pregnant**		
627	**with her, we had a kind of scare because they picked up on**		
628	**some kind of abnorm.. abnormality in her heart [Mmm] so we**	Health scare during pregnancy	Health scare during pregnancy
629	**were going backwards and forwards to a hospital in [City] to**		
630	**have scans done, it was just horrific. And I need to get that**	Travelling backwards and forwards to hospital for scans	
631	**checked out at some point, but I haven't heard back from**		
632	**anybody [Mmm] to get that checked, and that's.. that's kind of**		
633	**hanging over my head because I didn't.. I just.. would like to**		
634	**forget that chapter.**	Health scare still hanging over her head as not fully	
635	It sounds quite frightening.	checked out	
636	**Yeah, it was.**		
637	Probably frightening enough having, well certainly one miscarriage;		
638	I don't know if you've had others..?		
639	**No, just that one. Mmm..**		

640	So having sort of that anxiety as well, but then to be told that		
641	physically there's a complication, which.. [Yeah] you don't know		
642	what the effect of that will be..		
643	**I.. they..they think.. they thought that it had kind of righted**		
644	**itself [Mmm] and that the.. the check-up now should be just a**		
645	**peace of mind, and I'm not sure whether I'm just suspicious of**		
646	**that, whether it's for their peace of mind as well; it was.. they**	Feeling suspicious of hospital's motives of wanting	Feeling suspicious of hospital's motives of wanting
647	**said it was kind of for ours, but I think they just want to double**	further check-up	further check-up
648	**check that there wasn't anything.. abnormal going on.**		
649	Mmm, but for you it's still very much something that's very much		
650	hanging over [Yeah] for you.		
651	**Mmm.. yeah.**		
652	How long have you been married? This time round?		
653	**Erm.. I can't think. Erm, just over a year? It was March last**		
654	**year.**		
655	So it's quite sort of a new, a recent, well marriage if not relationship.		
656	**Yeah, and quite a new relationship as well; we only met the**		
657	**year before, so we've only been together just over two years. I**		
658	**don't think it was difficult second time round.**		
659	She was a planned pregnancy so I, you know, I wonder what she		
660	means to the relationship; it's kind of.. what place, having.. having		
661	that baby, what that meant for you and [husband]?		
662	**We really wanted, really wanted one that was going to be ours**		
663	**[Mmm] that we didn't.. wouldn't.. we wouldn't have to give up**	Wanting a baby that belonged in the relationship, that	Wanting a baby that belonged in the relationship, that
664	**every.. every week [Mmm] that.. would be, yeah, something**	wasn't shared?	wasn't shared?
665	**that was going to resemble us and signify what our.. our**		
666	**marriage means and [Baby crying in background] erm.. and it**	Baby resembling her and husband and signifying what	
667	**is, it's every.. it's.. she's everything we wanted, in that sense,**	the marriage means	

668	**and because she's such a joy as well it just feels that we were**		
669	**absolutely right [Mmm] to do that, and.. and I'd always wanted**	Feeling right in choosing to have baby	Feeling right in choosing to have baby
670	**two. I hadn't really anticipated it would be with two (laughs)**		
671	**different fathers but, erm.. it's been nice for me to have.. to**		
672	**have what I'd always wanted, and have a little girl as well.**		
673	Do you have any siblings yourself?	Having what she's always wanted	
674	**I've got an older brother. So the boy and then the younger girl**		
675	**[Mmm] is always what I had.. I'd sort of envisaged, so, you**	Re-creating her own childhood family	
676	**know, it's lovely, and that.. it.. it's nice. [Baby crying in**		
677	**background] I think I'm going to be wanted [Yeah]**		
678	INTERVIEW SUSPENDED WHILE ANNIE FEEDS BABY		
679	**I was just saying, with it erm.. having been told that I was at**		
680	**risk, erm and then realising that I was sliding really quickly**	Pre-empting PND	
681	**down there, erm.. I wanted somebody to say.. to..to..to realise**	Realising the slide towards PND	
682	**what I was saying sooner, and.. and give me some support or**	Wanting someone to realise and understand what she	Wanting someone to realise and understand what she
683	**give me some help sooner, and I spoke to the health visitor**	was saying	was saying
684	**and I got nothing back there, and yet [Mmm] they had put in**	Wanting help and support sooner	
685	**my.. in the red book on.. on my notes 'At risk' you know, erm**	Seeking help Not receiving help	
686	**when I was in.. when I was living in erm [Town] which is where**	Professionals defining her 'at risk'	
687	**I was when I became pregnant I was then going through [Area]**	Moving to a different location	
688	**and a different, so it's a different.. different [Mmm] hospital,**		
689	**and there I was assigned to somebody who was, who would**		
690	**have been erm.. a.. a contact, a midwife, but somebody who**	Being assigned someone as a regular contact	
691	**would have kept in contact throughout the pregnancy and**		
692	**afterwards, and then I come to.. and then I loo.. I lost that when**		
693	**I moved to [Town] and I was told 'No, it wou.. it's the health**	Losing that contact when moved location	
694	**visitor's team, that's who you'd be in touch with [Mmm] but**		
695	**they don't do anything, so um.. I guess they would eventually**	Trying to determine who's responsible for her care	

696	**have said 'Ah, OK I think you need to be referred on' but I don't**	Frustration at lack of action?	
697	**know how long that would have taken before somebody would**	Not trusting how long professionals would take	
698	**have said.. and.. they don't know how bad I am [Mmm].**	Not feeling understood, professionals not knowing how	Not feeling understood, professionals not knowing how
699	**Nobody, no.. the health visitor didn't say to me categorically**	bad it is for her	bad it is for her
700	**'Are you about to kill yourself or your baby' but..but I..I.. I think**		
701	**I.. I think I am fairly bad, but I'm just, you know, I'm not suicidal**	Judging need based on risk factors	
702	And as you said that's only part of the story [Yeah], whether you're		
703	suicidal or whether you're going to harm your baby..		
704	**Yeah, it's just, yeah..**		
705	You can still be feeling awful [Absolutely] and really struggling with		
706	that, having those feelings..		
707	**And that's where I was, that's what I and.. I.. I knew I was there**		
708	**[Mmm] but erm.. and then the same thing with the GP; I..I sort**	Feeling awful and struggling with feelings	
709	**of went in feeling a bit apologetic coz I.. I was fairly sure that**		
710	**she would say erm.. 'I don't want to put you on medication yet'**	Feeling apologetic for seeking help, taking time? With	
711	**or whatever, but I.. I still kind of hoped that someone.. that she**	GP	
712	**see.. see [Mmm, mmm] that the fact I'd even brought it to her,**	Hoping that someone would see (the suffering?)	
713	**or I was..I..I did talk a little bit about how I was feeling would be**	Wanting GP to understand significance of seeking help	Wanting GP to understand significance of seeking help
714	**enough for her to say 'OK, I'm going to take that seriously'**		
715	How was that for you, to actually volunteer that and to actually say	Wanting someone to take it seriously. Recognition?	
716	that.. that you were struggling?		
717	**(Sigh). I thought.. it's a weird one because on the li.. on their**		
718	**list is..is that question 'And how's your mood?' [Mmm] but I**	Questions asked but not hearing (or wanting) the	Questions asked but not hearing (or wanting) the
719	**felt they didn't really want to hear the answer [Right] They.. I..I..**	answer	answer
720	**I feel like.. they have got tick boxes, and erm they..they have**		
721	**been told that postnatal depression is a big problem and.. and**	Feeling reduced?	
722	**whatnot, but the caring's just not there; that's how I personally**	Hidden agenda (ticking boxes, being seen to act on	
723	**felt at least, [Mmm] and erm.. when I spoke to the doc.. to the**	'problem')	

724	**GP about it originally, I was outside the usual.. it was quite a**	Caring not there	
725	**long time after baby blues is supposed to have finished; four,**		
726	**five weeks, something like that, erm.. even if she could have**		
727	**said that.. 'You need to speak to somebody even if it's one,**	Wanting to be heard, recognised at outside the 'norm'	Wanting to be heard, recognised at outside the 'norm'
728	**two sessions, just to see how we're going with this', I would**		
729	**have felt like somebody had heard me.**		
730	So what, if the GP had said..		
731	**Yeah.. I understand money is an issue and all of that blah**		
732	**blah.. but just to be sent home and left [Mmm] again to feel as I**	Rationalising re lack of resources available	
733	**was feeling [Mmm] was.. was fairly awful actually, erm.. and to**	Being left to deal with feelings (on own)	Being left to deal with feelings (on own)
734	**be told I had to wait another few weeks to see if I was really**		
735	**bad..**	Being told to wait. Dismissed? Needing to reach a	
736	So even waiting a few weeks for the help, but actually waiting a few	threshold?	
737	weeks to see whether you.. [Yeah] warranted it		
738	**Yes, absolutely.**		
739	Mmm.. So what do you feel there needs to be.. for women wi.. with		
740	who have.. you know, struggling..		
741	**I think there needs to be.. erm.. a self-referral sort of immediate**		
742	**drop-in type place [Mmmhmm] or some kind of service, now it**	Needing help and support immediately	Needing help and support immediately
743	**could be the children centres that do that, erm.. as I say here**		
744	**they're doing this postnatal depression group, but you have to**		
745	**be referred either through your doctor or through MIND; that**		
746	**all takes time, there's a waiting list coz there's not very many**	Referral process delaying getting the help	
747	**of them, erm.. it..it's the same situation you're going to get**	Having to wait due to a lack of resources	
748	**anywhere, erm.. but if you are.. if you're feeling that bad with**		
749	**postnatal depression, you don't want to wait a few weeks or a**	Not wanting/unable to wait for support	
750	**few months (laughs) to get.. you just can't do that [Mmm], it's**		
751	**just.. it's too hard, erm.. and there's quite a lot at stake with..**	Struggling with feelings whilst waiting	

752	**with the baby and with other children, so.. the fact that there..**		
753	**they recognise it as being a problem is a.. I feel like it's a first**	Feeling pressure not just for self but for children	
754	**step towards doing what they need to do to help ladies,**	Recognising PND as a problem. Hoping that leads to	Recognising PND as a problem. Hoping that leads to
755	**mothers..**	more help being available	more help being available
756	Do you mean recognise it as a problem more widely or for you		
757	specifically?		
758	**No, widely [Mmm] Coz they.. coz they pay.. I feel like they pay**		
759	**lip service to the fact they realise it is a significant problem**	Professionals paying lip service to PND being a	
760	**[Mmm] but there's.. but there's nowhere to go with it unless**	significant problem	
761	**you're prepared to take the medication. And I.. you know that**	Lack of options with regard to help available	Lack of options with regard to help available
762	**works, that works for a lot of people and then maybe if you're**		
763	**not breastfeeding, you know, there's no real reason for not. I'd**	Rationalising about use of medication	
764	**probably still argue that actually having someb.. people to**		
765	**listen to and get support [Mmm] erm.. because there may well**	Justifying need for someone to talk to and listen	
766	**be reasons why, for me, OK, for me I recognise that there are**		
767	**stresses and there are reasons, baggage within myself that**	Recognising stressors within self which may contribute	Recognising stressors within self which may contribute
768	**have perhaps led me to..to..to..to this, which is what they said**		
769	**that in the first place; that's why I was at risk [Mmm] erm, so**	Needing space to offload stresses	
770	**having somebody that I could talk to about all of that so that I**		
771	**didn't just feel like, all of that was weighing me down would've**		
772	**perhaps been useful.**		
773	Yeah, so having some kind of drop-in that was instant that you		
774	could just access [Mmm] straight away [Yeah, yeah] would have		
775	been really helpful for you.		
776	**Yeah, definitely. I felt for weeks if I could just talk to somebody**		
777	**who's objective, who's not going to get hurt, who could just**	Needing objective ear. Needing someone who doesn't	Needing objective ear. Needing someone who doesn't
778	**take my pain [Mmm] who could just listen to it [Mmm] er..**	need protecting or worrying about.	need protecting or worrying about.
779	**yeah, that would probably've been quite helpful for me.**		

780	And did you.. I mean, you.. you ment.. how long did you wait before		
781	you even actually approached anybody about how you were		
782	feeling?		
783	**I don't remember really. Probably about six weeks.**	Waiting before approaching for help initially	
784	And were you struggling for the whole of those six weeks, or did it		
785	particularly hit after..?		
786	**I er probably struggled for five of them [Five, yeah] mmm.**	Struggling for time before asking for help	
787	So that in itself, before you've even approached help, that's already		
788	a long time to..		
789	**Yeah, it does seem a long time**	Struggling for a long time	Struggling for a long time
790	..struggle, and when you're struggling it feels even longer.		
791	**Yeah, yeah. Yeah, especially as it's day and night (laughs) as**		
792	**well, [Yeah] you don't get much.. much time off [Mmm] (talks**	Relentlessness of struggles	
793	**to baby).**		
794	INTERVIEW ENDED. DEBRIEF FOLLOWS.		

Appendix G: List of focused codes for all participants

ANNIE	BELINDA	CHARLOTTE	DAISY	EMMA	FIONA	GEORGINA	HANNAH
Feeling at risk; expecting to be depressed?	Aware of risk of developing PND	Confusion as to why feeling down and upset when	Experiencing health problems during pregnancy	Identifying factors Not bonding with baby to begin	Being put on a 'watch list' for PND due to previous	Depression impacting on enjoyment of pregnancy	Not expecting to get pregnant second time, so soon
Protecting self against depression	Preparing for relapse. Planning	supposed to be happiest time of life	Feeling she had no control over things	Crying over baby doing 'something silly'	depression	Assuming that everyone else felt wonderful in	Experiencing traumatic birth previously
Doctor delaying process;	Identifying trigger for depression	Feeling partner and baby would be better off without	Went into a rebound of elation	Not interested in baby after birth Detached	Getting self into stupor about everything to do with	pregnancy, feeling alone in negative feelings	Not getting over first birth before pregnant again
Fearing effect on marriage; remembering past marriage	Being told to prepare self for the worst	her	Able to breastfeed straight away	Not expecting to not feel any love or attachment	being mum	Needing it to be really bad, not coping before seeking	Not wanting to admit defeat or ask for help
Experiencing a lack of identity. Change of identity	Delaying own bonding	Recognising need to speak to someone	Not having the sleep you're used to	Having baby as relentless hard work	Feeling mood get lower and lower	help?	Needing someone (knowledgable) to say she needed
Not having time to yourself	Doubting own sense of reality	Feeling relief at it not being her going mad	Baby breastfeeding well, but detrimentally to mum?	Not feeling love towards baby, finding that difficult	Worrying about impact on baby	Thinking her feelings aren't how they 'should' be	help
Not wanting time for self. Self-sacrifice. Not wanting to	Paying for a private room, needing space/privacy, not	Being able to talk to partner about it	Not feeling as able to cope with routine trying to	Feeling inadequate	Speaking to her mum about how she was feeling	Having a critical inner voice of herself	Taking comfort in it being described as being broken,
be seen wanting?	wanting to be around 'healthy babies'	Chose not to take antidepressants	establish (pressure?)	Not feeling baby loved her like she loved dad	Going to see GP, explaining what was happening	Needing convincing by HV to attend support group	like physical break, that needs fixing
Deciding to try and make time as a couple	Grieving for the loss of a healthy baby/birth experience	Counsellor linking PND to the birth	(Needing to cope/be in control?) Not asking for help	Pressure to breastfeed	Being adamant she wasn't going to develop PND	Needing other people that felt the same	Husband not understanding she needed him to help
Focusing on something she enjoys	she wanted?	Uncertainty about what would have happened without	Approached HV with a concern and broke down	Not feeling so guilty about giving her an occasional	Confidence decreasing as time went on	Worrying about other mothers now that support group	with kids more
Validating experience of re-engaging.	Feeling helpless? Unable to do anything for him	support	Prior understanding of depression symptoms	bottle or having a break Giving self permission?	Not wanting to be labelled as having depression again	is gone	Not wanting to take meds, associating meds with
Reconnecting with self	Circumstances affecting bonding, losing bonding	Dismissing feelings as being miserable or hormonal	Being organised as coping mechanism	Professionals focusing on the positives of BF	Not thinking the two depressions are related,	Doctor directing her to stop BF and start meds	failure
Concerned about being prescribed medication	experiences	Not feeling others would understand,	Group providing long term support	Not being given information on bottle feeding	separating them	Feeling she was failing in everything other than BF	Upset at fact daughter was picking up on, and sad

Not feeling able to talk to family, needing someone	Unable to act to prevent PND practically	Contrasting feelings with it supposed to be happiest	Identifying triggers through talking in the group	Expressing worries and fears about BF	Starting to feel better and cope better with	Needing some support, either chemical or emotional	because of, her always crying
objective? Avoiding?	Feeling helpless/powerless?	time Feeling she shouldn't be a mum for thinking	Having space to relax within the group	Being caught in cylce of needing rest but unable to	motherhood a month after starting meds	Feeling a freak for not enjoying pregnancy	Choosing to do whatever it takes to get better for her
Negotiating severity; not suicidal meaning the perceived	Crying constantly	things like that	Not recognising depression in self until obvious signs	rest whilst BF	Initially feeling gutted at how she felt	Wanting to do right thing/make sacrifice for good of	kids
severity diminishes	Not caring Shutting self away, retreating	Wanting to go back to work but feeling guilty about	Relationship triggers for depression	Identifying medication as starting point for increase in	Finding transition from career to home quite difficult	baby	Put on counselling list but long waiting list
Feeling trapped and angry	Approaching health visitor/help. Acknowledging struggle	wanting to	Link of being depressed with pregnancy and not	confidence in self	Feeling more at peace with being at home now baby	Not asking for help due to fear that baby will be taken	Doctor explaining away her concerns about meds
Lack of confidence in ability (to mother?)	Shame at the state of house. Isolating self further	Thinking she should want to stay at home with baby	sleeping	Baby responding to mum	more interactive and settled	away if she was seen as not coping	Influenced and aware of stigma around depression
Relating experiences to relationships with husbands	Being questioned/graded with re PND	Questioning whether baby not sleeping was due to her	Putting baby's needs first	Reaching a point that she identified as not normal and	Feeling things become mundane and repetitive	Feeling ashamed of previous pregnancy as unplanned	and tablets
Not feeling understood, even by other mums.	Urgency from professional at needing treatment	going back to work	Lack of bonding not case for her	needing help	Enjoying time off more now	Looking forward to being pregnant second time,	Not wanting people to know she had PND and having
Not being considered Or understood?	Hiding how bad she felt from husband. Protecting?	Difficulty accepting her life had changed in having a	Pushing self aside all the time	Reluctant to talk to professionals due to feeling	Extending maternity leave to have some time to enjoy	feeling excited? but still not enjoying it	treatment
Not understood Feeling judged?	Setting deadline for feeling better and taking life	baby	Relating to other people's experiences	inadequate and not having experience she's meant to	it	Doctors telling her she was depressed; her not	Talking about it and finding lots of other people
Resenting separate life?	Wanting baby to stop breathing, wanting decision to be	Realising her life doesn't come first anymore	Husband's life going back to normal straight away	have	Getting out and about more now	accepting it	suffering with depression
Feeling unappreciated	taken for her	Resenting things that partner still able to do	Lack of communication in relationship as a trigger	Making contact with professionals	Expecting to deliver from 27 weeks, having to give up	Attributing mood and feelings to circumstances	Feeling she wasn't doing what she should be
Anger/frustration at the wait?	Wanting to give up role as a mother	Pregnancy as surprise as was told she couldn't	Label of PND helping husband come to terms with	Talking to HV and friends about how she was feeling-	work and rest	Feelin PND is more severe in terms of suicidal	Acknowledging she'd built up expectations in her head
Feeling forgotten, left, abandoned?	Refusing to take antidepressants	conceive naturally	who she'd become and what was going on at home	justifying not needing counselling?	Having regular scans during pregnancy to monitor	ideation	Feeling pressure to BF even though she was
Knowing she had PND. Relief that someone	Fear of side effects	Adjusting to a lot of changes in short space	Husband not believing until someone else has	Needing time to help feelings around the	Worried about going full term rather than being	Wanting to have a future but not seeing a	struggling

else		of time	said it	birth		way of	
recognised it	Failure of taking medication Taking medication meaning	Taking time to accept change to life	or needing to establish it for himself	Getting reassurance that she didn't do anything wrong	pregnant	getting there	Feeling a failure as she was not able to BF child
Needing recognition/validation?	she's succumbed to PND	Not wanting to say how she felt	Trying to cope, expected to cope	Finding debrief useful to talk through the sequence of	Managing to enjoy time off more once past critical	Being overwhelmed by sense of failure	properly
Diagnosis making it less frightening, making help	Having clearer idea of the problem and how to act on it,	Normalising it allowing her to move on	Unable to confide in husband generally	events at birth	stage	Assuming noone would notice her if she was gone	Terrified of having same pressures and not being able
possible	giving hope for the future	Glad to have seen someone when she did rather than	Talking about PND subsequent to being diagnosed	Needing to know that it wasn't her fault	Thinking birth would be the end of the stress	Husband not supportive during pregnancy	to BF again
Doubting her ability (to mother?)	Appreciating and standing up for HVs	leaving it	Feeling unable to ask for support	Needing confirmation that how she was feeling wasn't	Trying to BF but struggling due to reflux	HV persisting in maintaining contact and reviewing	Placing high expectations on herself
PND validating effort and help mum is having to give	Not wanting to admit to friends/family what was going on	Wanting a quick fix	Diagnosis of PND highlighting the issue of	her fault	Trying everything to make BF work, determined to BF	how she was feeling	Feeling (unrealistic) pressure to be superwoman
Feeling a burden	Not wanting to be a burden. Protecting husband	Being scared of the idea of weaning off of the	communication in relationship	Feeling better having spoken to the GP	Feeling a lack of support from professionals, feeling	Denying how she was feeling to the doctor, dismissing	Feeling incompetent
Blaming mother for not feeling able to have a rest	Feeling relief at having a name or label for it	medication	Struggling/feeling lack of communication in	Worried about taking medication	pushed into continuing BF	HV pushing her to get some help	Being aware of some of the difficulties but not how
Resenting mother's view/understanding of her?	Validation that it wasn't her going out of her mind	Choosing to wait for counselling	relationship	Feeling in conflict as to why she needs meds	Needing someone to say it's OK to stop BF and bottle	PND as heavier depression than felt before	hard it will be
Unable to cope. Shutting down?	Feeling trapped? In a big hole with no known escape	Scared of being addicted to antidepressants or	Getting low making her realise other things that were	Feeling a stigma of needing help	feed	Deciding that BF was more important than taking	Not put across the extent of the impact of having a
Validating her sense of struggle	Finding alternative ways of coping	needing them for life	missing	Having to have med suitable for BF	Being housebound by having to express so much	meds (choosing baby over self?)	baby
Feeling mum wants her to feel guilty	Choosing not to pursue further support due to struggles	Not wanting to go as far as taking tablets	Taking every possible bit of help offered on back of	Husband feeling relief that she'd done something	Feeling she was finally going to get some help	Enjoying baby	Feeling pressure from others and feeling inadequate
Needing someone to think and understand outside of	to get out of house	Only able to breastfeed for a week due to infection	diagnosis	about how she was feeling	Resigning self to fact she needed help	Being told later that she should have been referred for	Feeling more relaxed about routines with second child
what is being said/done.	Appreciating (practical) help she did get	Prioritising baby getting goodness of breastmilk	Adopting husband's coping mechanism of avoiding	Diagnosis making it OK to say something's not right	Husband busy at work so not around a lot during first	talking therapy	Separating being broken and being a failure
Needing a recognition	Linking practical help	Feeling like a mum but	talking about things	Not feeling she could	few weeks	Feeling people need to	Recognising need to

of what she needs	with helping mental health	unable to do the things a mum		just drop her PND into		go through PND to understand	acknowledge problem
Not feeling listened to	Professionals worried about delays caused to baby's	should be able to do in the beginning	Not having conversation to resolve the issue	conversation	Feeling more able to open up to mum than husband	it	Recognising a need for PND to be talked about more
Unable to express the level of pain coherently	development due to mum's physical constraints	Feeling things shouldn't be happening and wanting to	Having diagnosis giving an acceptability to how she	Not feeling fully supported by friends?	Mum normalising some of the areas of struggle	Finding friends through support group, needing shared	widely
Needing validation Feeling alone (isolated?)	Professionals dismissing physical problems as PND	be at home	was feeling	Feeling disregarded in favour of the baby?	Questioning how things would have been without	experience to open up fully	Hiding feelings for up to a year (waiting for someone
Inability to put feelings into words	Not accepting medical judgement, trusting own	Feeling she should be looking after baby, not partner	People not realising how low she was	She gets the little 1% left, after the baby, from others	mum's support	Fearing people would judge and label her	to notice?)
Responsiveness and affection of baby	experience	Acknowledging she would have struggled more	Putting a berrier up, pretending she's fine	Justifying why people focused on outcome for baby	Mum relieved at diagnosis, as possible end to	Feeling of no control over feelings, being carried along	Linking not coping with being a bad mother, or at least
Being with baby and feeling it's OK	Gaining second, specialist opinion	without help from partner	Diagnosis leading husband to talk to family and telling	Not getting the reaction from friends that she	struggle?	by the PND	perceived as such
Other areas of her life seeming to suffer more as a	Getting physical diagnosis and help needed	Contrasting the expectation that having a newborn as	them about the diagnosis	expected/hoped regarding fears of stillbirth	Reframing? meds as an extra boost when things were	Relief that she wasn't going mad	Avoiding becoming her mother by hiding her not
result of her ease with her baby	Needing to prove condition not in her head	a wonderful thing with their experience as a nightmare	Not getting support from other people	Convincing herself that baby had died during birth	really bad	Feeling lonely and scared being depressed with a	coping
Putting plans on hold in favour of baby's needs	Suffering more and struggling longer	Remembering partner saying they wouldn't have any	Not thinking she's going to change husband Resigning	Identifying thinking baby was dead as reason for	GP trying meds and then can review counselling if	baby	Hiding difficulties in attempt to protect children
Taking responsibility for previous miscarriage	Not feeling she is taken seriously	more children, partner not wanting to go thorugh	self?	detachment	needed	Assuming you're not meant to feel depressed	Realising the effect on her children
Health scare during pregnancy	Making sense of panic	experience again	Wanting to talk about something but other person	Not feeling she needed to tell family, so didn't	Wanting something to lift her mood to be better able to	Being influenced by other people, TV, society	Bringing up subject of PND and finding out that lots of
Feeling suspicious of hospital's motives of wanting	Therapist making allowances for her physical issues	Linking depression with lack of bonding in the	doesn't	Having a good relationship with husband's family	cope (meds not counselling)	Judging self for feeling depressed, especially as baby	people have suffered with it
further check-up	Feeling remote from own family and in-laws	beginning	Husband limiting the amount of conversation he draws	Having some commonality with sister-in-law; able to	Not wanting to be mum or have responsibility	was 'easy'	Initiating conversations with peers about her PND
Wanting a baby that belonged in the relationship, that	Not considered CBT postnatally	Baby bonding with other people in a different way to	from it	talk to her about some things	Husband happy to have diagnosis and some light at	Unable to make sense of depression	which opened up admissions from other mums who

wasn't shared?	Having to pay for therapy	with mum	Mum and dad living abroad; needing someone	Keen to assert she didn't want baby dead?	end of tunnel	Friends and family not understanding why she was	suffered
Feeling right in choosing to have baby	Not wanting to start from scratch with therapy	Sometimes feeling a slight rejection from baby	physically there to listen	Wanting things to be different but not wanting either	Feeling able to sit with husband and talk about it	depressed	Sharing experiences of struggling
Wanting someone to realise and understand what she	Wanting counselling but balancing against subsequent	Questioning if she's a bad mum	Not wanting to think of self as mum who couldn't cope	her or baby to not be around	Recognising lack of , and need for, support from	Not telling parents previously she was depressed as	Being able to normalise the bad days and appreciate
was saying	pain. Choosing physical health over mental health?	Attributing a lot of what she felt to being a new mum	and felt so distraught and anxious	Not expecting to not feel anything	husband in first few months	she was able to hide it	the good things more
Not feeling understood, professionals not knowing how	Husband relieved at diagnosis	Placing importance on what other people think	Needing to put things in perspective, needing	Professionals distinguishing between baby blues and	Comparing PND and previous depression; feeling	Mum not understanding what she had to be	Being subject to the fear and stigma around
bad it is for her	Denying to husband about PND	Not thinking going back to work would affect her as	someone else to do that for her	PND	lower with PND and less able to cope day-to-day	depressed about	discussing depression
Wanting GP to understand significance of seeking help	Not wanting to worry husband further, Protecting and	much as it did	Trying to find a way to move forward	Midwife saying it's probably baby blues but to see GP	Feeling pressure? of having a baby relying on you	Hiding her depression while she could, telling people	Wanting support and understanding from people
Questions asked but not hearing (or wanting) the	looking after him	Being a mum as weakening her	Attributing lack of memories to inability to relax and	or HV if it continues	Depression as individual thing; PND more about her	when she couldn't hide it any longer	Not being given the time with a professional to explore
answer	Dependent on husband	Feeling/wanting to believe (and me to believe)? she's	enjoy things as they were happening	Focusing energy on getting baby to sleep better	and baby	Associating depression with being mad	feelings?
Wanting to be heard, recognised at outside the 'norm'	Wanting to keep things to herself to save him from it	totally over it	Feeling frustration of being competent in other things	Not sleeping properly herself, worrying about things	Worrying about PND impacting on baby long term	People fear talking about depression as they don't	Needing time to adapt to being a mother before
Being left to deal with feelings (on own)	Reaching limit and unable to hide feelings/struggle	Linking depression with the shock of finding out she	but not that period of time	Trying to make a decision about caring for baby	Not telling people about having PND, only mum and	know how to cope or connect with it	knowing whether anything is wrong
Needing help and support immediately	anymore	was pregnant	Relief of feeling she wasn't going mad	Tormenting self or punishing self with what she was	husband	Once diagnosed and treated, feeling more able to	Finding it hard and scary to instigate getting help
Recognising PND as a problem. Hoping that leads to	Forewarning friend about PND before visit	Expecting depression to be madness or sitting at	Relief at being able to talk to somebody	doing	Initially feeling closer to mum than husband	open up conversation with friends about how they were	Appreciating the help that was available
more help being available	Friend pre-empting her PND	home crying all the time or unable to get out of bed	Not ashamed of diagnosis now	Not recognising own needs as important as baby's	Feeling her PND is a private thing for her	feeling	Not expecting to get depressed over a baby, as it's
Lack of options with regard to help available	Questioning whether she would have had	Relief at it being something that can be	Not wanting to tell people she had PND	Everything focused on baby's welfare	Worrying she'd be seen as a failure at surviving	Pressured to BF	supposed to be a wonderful experience

	PND if not for	worked on and					
Recognising stressors within self which may contribute	the disability issue	talked about	Feeling that she was meant to be happy/enjoying it	Unable to see that she also needed to be happy	motherhood by friends	Struggling to accept not being the kind of mother she	Telling self at start that she was well enough, just
Needing objective ear. Needing someone who doesn't	Struggling with pain	Gaining reassurance about not feeling guilty about	Normalising it? (everyone experiences it to some extent)	Experiencing pressure to feed her in certain way	Feeling it was a failure when it wasn't fine	felt she should be	emotional
need protecting or worrying about.	Managing her pain.	wanting to go back to work	Feeling relief at letting guard down	Comparing BF experiences with others	Not wanting people to judge her on her mood	Taking time to accept she couldn't be perfect	Having own concerns about having PND validated
Struggling for a long time	Linking feelings with having baby	Being able to explain to partner what it was	Relief that people able to relaise how low she was	Not thinking about PND as something that might	Not wanting people to think she's a bad mum	Needing to know other people feel similarly	Needing someone else to acknowledge it for her
	Comparing and contrasting depression, antenatal	Sense of relief at it being PND	feeling	happen to her	Wanting to deal with it in private, with family	Fearing that people would judge her as a mother for	Husband still not understanding her need for a break
	depression and PND	Shock of being someone with PND	Hiding how feeling until got to a point she couldn't	Not having any personal experience of it (PND)	Feeling a lone soldier having a baby in her friendship	being depressed	Viewing husband's work as his respite
	PND as experienced completely differently	Friends not guessing anything was wrong (Hiding it to	In hindsight acknowledging that (a lot of?) people feel	Expecting to be pleased to have baby	group	Feeling alone in how she was feeling	Needing to get out and about as distraction for her
	PND presenting as worse than other depression	not be different?)	like that	Experience initially making her reluctant to have more	Diagnosis giving husband more of an understanding	Fearing being judged and labelled as a bad mother	and children
	Linking pregnancy with thoughts	Unable to predict who is going to get it, no particular	Not expecting self to feel the way she did	children	Feeling more confident to speak to husband once	Peers not understanding her depression	Recognising need for 'me' time
	Being possessed by PND	sort	Baby as wanted by her and husband	Focusing on bad stuff when depressed	mood lifted	Feeling people think she chooses to be depressed	Needing more information on PND antenatally
	Feeling trapped in PND	Sorting things out without people knowing	Feeling sad/anxious at how she felt	Doing things differently next time, change birth	Husband's understanding helped by it being labelled	Needing more help and support during pregnancy and	Needing something to remove the stigma of talking
	Feeling swallowed up by PND	Concern about judgements or lack of understanding	Feeling lonely (isolating self?)	Would be easier on herself over feeding next time	something	postnatally	about it
	No definitive turning point	from other mums	Unable to admit feelings as not how you 'should' be	Being aware of PND a second time	Husband needing to rationalise why she feels as she	Needing professionals to communicate with each	Needing to know other people were having similar
	Taking on new projects Reengaging	Opening discussion with friends?	Hating self for feeling the way she did	Wanting more professional contact to prevent PND	does	other about antenatal care	experiences
	Having a purpose	Needing a reason for	Experiencing a constant	Not realising what she	Reacting against a	Feeling outrage (and	Talking about it

		getting the thoughts	cycle of emotions/thoughts	could call them for Not made	black and white view of why she	concern) at support stopping and	lessening the sense of shame
	Having something she could do (not able to mother?)	Telling friends eventually, when feeling strong enough	Not liking self and her inability to cope	clear what the service was for	was feeling low	impact on other mothers	Needing PND to be more widely talked about
	Anger at husband taking baby away from her, husband	Identifying the point at which it tipped into needing	Judging self for thinking suicidally and the impact on	Speaking to them numerous times once given	Feeling her explanation of how she was feeling wasn't	Needing someone to push her into getting help	Needing more awareness of help available
	taking over her role	help	others	permission	enough for husband to understand	Recognising it's OK and necessary to talk	
	Sacrificing herself physically to maintain certain tasks	Having the extra thought of planning something that	Feeling people should see an elated human being	Published information assuming all babies are the	Trying, and not managing, to pinpoint a reason or	Placing importance on not feeling alone	
	Not wanting to miss out on experience, despite pain	tipped her into recognising a problem and seeking	flourishing on motherhood	same Advice not working for her	trigger for depression	Feeling she wasn't trusted as a mother because she	
	Questioning point of having child if giving tasks over to	help	Adapting what you say according to what you feel they	Relaying the pressures in the early days postnatally	Not wanting to manage all the practical things like	admitted her depression	
	other people	Partner's (her own?) assumptions about depression	want to hear	Having to deal with baby and recover from surgery	sterilising bottles	Taking message that it's better to not admit how she	
	Feeling useless and a failure	being more obvious, doing worse things	Putting a limit on what you say to protect others	Wanting time to recover and help with feeding	Brought to her knees, physically	was feeling	
	Finding ways of managing childcare and physical health	Appearing like a normal mum carrying on with things	Feeling angry at parents for not being around	Being expected to just carry on after Caesarean	Winter weather and short days impacting on mood	Recognising that help sooner may have stopped it	
	Coping with the depression, finding mechanisms to cope	Partner confused about when thoughts were occurring	Opening up feelings at the lack of capsule family	surgery	Not knowing if she would still have got PND anyway	getting as bad as it did	
	Balancing own needs and feelings with husband's	as things seemed the same from the outside	Balancing own feelings of anger against protecting	Questioning need for counselling	without those factors		
	Mum knowing ins and outs of PND, sharing with mum	Feeling strong enough to explain to mum she's getting	family's feelings and being reasonable to their needs	Not wanting to disect life in detail through counselling	Comparing her and husband's viewpoints on		
	Future operation to remedy physical issues	help and explaining her needs	Needing a person to be physically available to support	Wanting more support with general issues with baby	understanding PND		
	Not wanting to be the person always complaining	People not saying anything to make her doubt self as	Worrying about possible effect on baby	Wanting someone 'expert'? trained to give advice	Reassured by knowing others are suffering, and some		
	Pragmatising the	a mum- coming from	PND highlighting	Acknowledging the	worse than her		

	experience, dismissing? Should be	her	network; what was there and missing	problem as most important thing			
	over it by now	Not wanting to be labelled as a bad mum for her	Increasing difference between who she was and who	Wanting some sort of monitoring/review to pick up	Feeling that there isn't really the support there		
	Feeling not normal to still be feeling it three years later	feelings	she thought was normal	issue sooner	Not feeling supported by professionals, feeling left on		
	Being robbed of having a happy birth	Having a name (PND) justifying her explaining it to	Preconceiving idea of what kind of mother she thought	Questioning whether she would have answered	her own, abandoned?		
	Needing to tell them how she feels. Validation? (Also in	people	she would be	questionnaire honestly; not wanting to acknowledge	Having a lot of support at the very beginning but then		
	doing interview)	Postnatal label not making much difference	Unable to offer what she thought she would offer	the problem	nothing after about 8 weeks		
	Feeling issue unresolved	Not thinking it was depression	Comparing self to other mums that seemed relaxed	Putting on a brave face for everyone else	Would put less pressure on self to be great mum		
	Not knowing how to deal with it and get past it	Feeling a need to talk to someone who might be able	Judging self against the relaxed person she wanted to	Recognising low moments not always being as low	Recognising seeking help sooner would mean she		
	Wanting closure? Undecided Ambivalence Feeling	to help	be naturally		would have been coping sooner		
	ready?	Wanting the relief of knowing it's not her going mad	Not allowing self to relax		Finding it harder to go to doctor and talk to someone		
	PND felt as taboo topic	Being able to search for information	Overanalysing what was happening and why		you have no relationship with		
	PND as failing	Being referred for counselling meaning it was	Viewing experience as point of learning		Wanting to be asked how she is feeling, not just baby		
	Feeling like a failure Not what you're meant to be	something recognised	Feeling happy in the possibility that she might get		Wanting a consistent relationship with a professional,		
	Talking openly about it allows other people to talk about	Needing more information about when PND can occur	PND again, having gone through process before		needing that relationship in order to open up		
	their own experiences	Needing more information about the symptoms. Being	Concern about impact on relationship		Expecting PND to come earlier		

	Being able to say I had it and I got through it (rather than	able to recognise it	Getting coping mechanisms		Being scared to talk about PND for fear of failing or		
	talking in the present tense of struggling with it)	Wanting women to know (and feel able?) to ring up	Bringing yourself back to normality		being judged on her ability to cope or raise a baby		
	Easier to talk about in past tense, slightly removed? Or	HV	Wanting to help other women having babies by		Having a prior expectation making her more		
	having the label and the terminology for discussion?	Wanting more information/preparation for the	recognising their struggle and offering help/support		determined that she wasn't going to have PND		
	PND needs more education antenatally	possibility	PCT stopping funding for the group		Being told low mood was normal and how she should		
	Needing to be prepared for it		Realising more people than thought aren't coping		be feeling as a new mum; needing someone to point		
	Needing to talk to others Feeling you're the only one in		Looking after baby as massive responsibility		out when it's not normal		
	the world with PND		Need for people to access the right services and		Thinking her low mood was delayed baby blues		
	Reducing it down to 'just' PND		getting attention		Feeling confused as to whether her feelings were		
	Linking other factors		Other mums having to wait for help post-diag due to		normal or not		
	Unable to access help available due to disability		lack of resources		Wanting 1:1 private time with HVs to be offered more		
	Needs not being recognised?		Needing early support which may prevent things		to new mums		
	Loss of breastmilk contributing to PND		escalating to PND				
	Breastfeeding as one thing a mother can do		Not knowing what support/resources are available or				
	Wanting more education		how to access them				
	Knowing how common		Funding constraining				

	it is meaning women might not		the level of support that was				
	feel that they can't talk about it		available				
	Needing space to talk about PND		Appreciating a service to enable her to talk freely				
	Dominant dialogue of motherhood being wonderful		Learning tools to cope better and prioritise				
	Getting the taboo away from it		Wanting whatever help was offered				
			Expecting to be able to solve own problems				
			PND expected as difficulties in coping being mum and				
			building relationship/bond with baby				
			PND understood as disassociation with motherhood				
			and the child				
			Questioning whether it was PND or depression				
			Trying to identify a trigger				
			Timing of the depression means it is categorised as				
			PND				
			Letting go of the postnatal label in time; reattributing it				
			to other problems and issues				
			Identifying how she deals with stress at other times				
			Wanting to question the questions on EPDS				
			compared to other depression measures				

			Beating self up for being (depressed?)				
			Motherhood as huge, sudden responsibility				
			Needing to blame someone for not doing it the way				
			you or society thinks is best				
			Feeling better once start offloading				
			Wanting to be a person that is able				
			Wanting to feel informed, capable and organised				
			Taking being organised to extreme as only thing felt				
			within control				
			Talking in the group alleviating the tension				
			Needing to know where the support is and how to get				
			it				
			Not disclosing feelings due to shame and feeling they				
			shouldn't be feeling it				
			HVs as having heavy worklaod and not having the time				
			to give adequate support to mothers				
			Learning from the experience				
			Appreciating work of HVs				
			Pointless to tell a mother that feeling low is normal				
			and not to be afraid of asking for help				

			PND as happening to anybody				
			HV as signposting for help or giving guidance				
			Needing someone to normalise feelings and anxieties				
			Wanting the ideal of a happy life				
			Ignoring the less nice side of motherhood				
			Needing to know beforehand of PND as a possibility,				
			before you get caught up in it				
			Everyone having access to different kinds of support				
			Only getting help by making the approach to a				
			professional				
			Differentiating between the anxieties of PND and how				
			you cope with them				
			Needing support perhaps after event rather than				
			straight away				

Appendix H: List of emerging categories

Life stresses?
Change/adapting to change?
Relational issues/support
Isolation?
Diminishing/negotiating own needs/Sacrifice
Validation (vs lack of)? Normalisation?
Talking/Silence/Being heard/being hidden
Understanding of PND/Depression (Link w negotiating label cat)
Taking action? Responsibility? (proactive vs assuming blame)
Pregnancy/childbirth
Expecting difficulties/being prepared?
Trying to be positive?
Positives
Protecting self (against depression?)
Questioning own sense of things?
Choices?
Making sense of experience?
Experience of being mother?
Resigning self to depression vs control?
Experience of 'depression'?
Monitoring own mindset?
Adequacy of professional support
Worries about wider impact?
Identity/sense of self?
Expectations vs experience (of motherhood)/Pressures
Expectations of others? Assumptions?
Experience as evolving
Negotiating label (perception?) for experience
Opening up possibilities/highlighting other issues
Impact on potential future?
Looking outward

Appendix I: Example of an expanded emerging category

Talking/Silence/Being heard/being hidden
Getting it out
Not feeling able to talk to family, needing someone
objective? Avoiding?
Struggle to verbalise/express the feelings
Knowing she had PND. Relief that someone else
recognised it
Needing recognition
Wanting people to understand
Talking about things that are bothering her
Needing someone to think and understand outside of
what is being said/done.
Need to be understood
Someone to listen to what's hurting
Needing a recognition of what she needs
Not feeling listened to
Unable to express the level of pain coherently
Needing someone to hear and understand
Talking in riddles
Not able to say what she wants to say
Inability to put feelings into words
Picking on one thing at a time
Wanting someone to realise and understand what she
was saying
Wanting to be heard, recognised at outside the 'norm'
Justifying need for someone to talk to and listen
Affirming not a cry for help
Hiding how she felt from others
Hiding how bad she felt from husband. Protecting?
Affirming she never wanted to hurt baby
Shock/surprise at seeing MH nurse
Not wanting to admit to friends/family what was going on
Hiding how she was feeling from husband
Talking openly after the event
Professionals using PND as explanation for physical problems
Dismissing physical problems as PND
Professionals attributing physical problems to depression
Being dismissed
Husband asking whether she had PND
Denying to husband about PND
Wanting to keep things to herself to save him from it
Forewarning friend about PND before visit
Asking friend not to tell anyone

Mum knowing ins and outs of PND, sharing with mum
Able to talk to mum
Needing to tell them how she feels. Validation? (Also in
doing interview)
Not wanting to cry
PND felt as taboo topic
Not wanting to talk about it
Not wanting to admit it. Feeling unable to admit it
Being kept hush-hush
Not openly admitted or acknowledged
Good to say you had it, for other people to hear
Talking openly about it allows other people to talk about
their own experiences
Being able to say I had it and I got through it (rather than
talking in the present tense of struggling with it)
Easier to talk about in past tense, slightly removed? Or
having the label and the terminology for discussion?
PND needs more education antenatally
Merely brushed on in classes
Not going into the ins and outs of it
Not covering where to go for support
Needing to talk to others Feeling you're the only one in
the world with PND
Preparing others for it, protecting them from your
feelings?
Reducing it down to 'just' PND
Needing an increased awareness for breastfeeding and
PND
Needing to know how common it is
Knowing how common it is meaning women might not
feel that they can't talk about it
Needing space to talk about PND
Getting the taboo away from it
Being able to talk to partner about it
Not wanting to say how she felt
Anticipating people to tell her to face it as she's a
mum, or that she's beig stupid
Talking about it, realising she wasn't going mad
Understanding it's common for women to think how she
did
Normalising it allowing her to move on
Staff being cheery about baby
Feeling/wanting to believe (and me to believe)? she's
totally over it
Relief at it being something that can be worked on and
talked about

Being able to explain to partner what it was
Being able to explain
Not speaking to everyone about it
Able to talk to mum
Valuing not being judged
Actually able to talk to people
Friends not guessing anything was wrong (Hiding it to not be different?)
Acknwledging that friends could have been going through it as well
Sorting things out without people knowing
Friends knowing afterwards that she had PND
Friends not knowing/guessing she had PND at time
Friends questioning how she knew. Opening discussion?
Not feeling strong enough to talk about it and the feelings
Not feeling strong enough at the time to talk
Needing to sort own head out before explaining feelings
Not telling friends about counselling at the time
Telling friends eventually, when feeling strong enough
Friends relating their experiences
Imagining friends having thoughts and bad day but carrying on as normal after
Appearing like a normal mum carrying on with things
Partner confused about when thoughts were occurring as things seemed the same from the outside
Partner not understanding where it came from
Feeling strong enough to explain to mum she's getting help and explaining her needs
Feeling the relief of being able to talk to family about it
Mum never would have known
The signs not being there
Able to talk about it, knowing what it was
Questioning people's judgements about her being mad or telling her to get over it.
Not talking about feelings
Not wanting to be labelled as a bad mum for her feelings
Having a name (PND) justifying her explaining it to people
Feeling a need to talk to someone who might be able to help
PND needing more recognition

Needing more information about when PND can occur
Needing more information about the symptoms. Being
able to recognise it
Needing to have eyes open as to what could actually
happen and what it can lead to
Wanting women to know (and feel able?) to ring up
HV
Needing more awareness from the very beginning
(during pregnancy)
Not wanting to admit feelings in front of family
People being ashamed to admit it
Other mum feeling she wasn't managing, suggesting
speaking to HV
Needing a stiff upper lip
(Needing to cope/be in control?) Not asking for help
People having different reasons but mutual anxieties
Relating to other people's experiences
Label of PND helping husband come to terms with
who she'd become and what was going on at home
Husband not believing until someone else has said it
or needing to establish it for himself
Finding it harder to communicate how low she was
feeling
Talking about PND subsequent to being diagnosed
Diagnosis of PND highlighting the issue of
communication in relationship
Comparing other people's experiences
Adopting husband's coping mechanism of avoiding
talking about things
Not having conversation to resolve the issue
Not discussing practical ways of helping situation
People not realising how low she was
Hiding some behaviour from people
Not being a person to ask for help
Putting a barrier up, pretending she's fine
Diagnosis leading husband to talk to family and telling
them about the diagnosis
Not wanting everyone to be aware?
Wanting to talk about something but other person
doesn't
(Husband) Recognising other people's (professional) involvement
Being told by HVs meaning husband then tells family
Mum feeling she can talk too much
Chatting openly as a family growing up
Internalises how she's feeling, more than others
Relief at being able to talk to somebody

Getting increasingly anxious and not talking
Having opportunity to let guard down
Not wanting to tell people she had PND
Looking at it in hindsight, talking to different
generations of people
Feeling relief at letting guard down
Relief that people able to relaise how low she was
feeling
Hiding how feeling until got to a point she couldn't
Unable to admit feelings as not how you 'should' be
Not knowing what other people go through in their
heads
Adapting what you say according to what you feel they
want to hear
Holding back on what you want to say
Being able to say what you really needed to in group
Putting a limit on what you say to protect others
Doing good to talk about things within the group
Acknowledging that you don't know what goes on for
other people
Realising more people than thought aren't coping
Not being able to communicate the anxiety leads to
feelings building up
Not knowing how many other people have asked for
help
Talking in the group alleviating the tension
Not disclosing feelings due to shame and feeling they
shouldn't be feeling it
Pointless to tell a mother that feeling low is normal
and not to be afraid of asking for help
Needing someone on hand to talk to, that knows?
PND not spoken about a lot
Ignoring the less nice side of motherhood
Not wanting to talk emotionally with neighbour-
emotionally and the fact she was a neighbour
Not made aware of PND or what to do about it during
pregnancy
Needing to know beforehand of PND as a possibility,
before you get caught up in it
Feeling that nobody would have picked up on her
struggle without her disclosing
Expressing worries and fears about BF
Reluctant to talk to professionals due to feeling
inadequate and not having experience she's meant to
have

Chatting woth HV about how she was feeling and things to do woth baby
Talking to HV and friends about how she was feeling- justifying not needing counselling?
Finding debrief useful to talk through the sequence of events at birth
Feeling relief at speaking to someone
Feeling relef at offloading and knowing what's wrong
Meds making it more apparant that she needs help?
Feeling a stigma of needing help
Not talking to people before diagnosis
After diagnosis, telling people she was on medication
Diagnosis making it OK to say something's not right
Finding it difficult to tell parents and in-laws
Not feeling she could just drop her PND into conversation
Making a point of telling friends (but not family?)
Sending email round to friends about what had happened and thinkning she was going to be stillborn
Making a big step in telling friends about stillbirth concerns
Not vocalising fears to family
Having a close relationship with family (or not wanting to say it isn't close?) but don't talk about emotions with them
Not feeling she needed to tell family, so didn't
Bursting into tears and saying birth wasn't good
Reading misinformed or biased material
Comparing BF experiences with others
Not knowing anyone that had PND
Relying on books and internet for information
Information not giving back up if suggested method doesn't work
Published information assuming all babies are the same Advice not working for her
Having plenty of people to talk to (but making full use of it?)
Questioning whether she would have answered questionnaire honestly; not wanting to acknowledge the problem
Aware of potential worry about social services taking baby away
Putting on a brave face for everyone else
Speaking to her mum about how she was feeling
Admitting to her mum how she was struggling
Crying with the GP

Knowing what was happening but denying it
Feeling able to sit with husband and talk about it
Speaking to husband post-diag about feeling better and
managing things differently in event of another baby
Not telling people about having PND, only mum and
husband
Opening up to husband more recently
Not wanting to let husband in, only wanting to talk to
one person
Not wanting/avoiding everyone knowing how she was
feeling and discussing her behind her back
Feeling her PND is a private thing for her
Avoiding discussing with another mum about feeling
low
Trying to stay upbeat and positive, or have excuse for
having a bad day/feeling low
Not wanting people to judge her on her mood
Not wanting people to pity her baby for having
depressed mum
Not wanting to be a point of discussion
Not wanting people to think she's a bad mum
Not wanting pity
Wanting to deal with it in private, with family
Not telling close friends about her PND
Dismissing questions about how she is by saying
she's fine, or tired
Feeling more confident to speak to husband once
mood lifted
More open with telling him about low days or really
low days, now there's more variation
Not wanting to keep telling him how low she was
feeling
Feeling her explanation of how she was feeling wasn't
enoughfor husband to understand
Going onto blogs and reading others' experiences
Reassured by knowing others are suffering, and some
worse than her
Querying what would have helped her to open up
Being scared to talk about PND for fear of failing or
being judged on her ability to cope or raise a baby
Assuming people wouldn't understand why she was
depressed
Not wanting others to see that she was depressed
Not asking for help, not wanting to be seen, or admit?
she was a 'freak'
Not asking for help due to fear that baby will be taken

away if she was seen as not coping
Learning to hide depression historically
Denying how she was feeling to the doctor, dismissing
HV pushing her to get some help
Not admitting it to people
Finding friends through support group, needing shared
experience to open up fully
Assuming everyone else saw her situation as perfect
Not telling parents previously she was depressed as
she was able to hide it
Hiding her depression while she could, telling people
when she couldn't hide it any longer
Feeling it was obvious to others she was depressed
Having diagnosis making people question what she
had to be depressed about, challenging it.
People fear talking about depression as they don't
know how to cope or connect with it
Not wanting to tell other friends having babies she
was depressed
Once diagnosed and treated, feeling more able to
open up conversatio with friends about how they were
feeling
Needing to know there is help available
Needing to admit how you're feeling to normalise it but
being scared to admit being abnormal
Assuming everyone else had it perfect
Trying to have conversations with peers about her
depression
Needing a change in attitude about talking about
feelings
Recognising it's OK and necessary to talk
Feeling she wasn't trusted as a mother because she
admitted her depression
Taking message that it's better to not admit how she
was feeling
Not wanting to admit defeat or ask for help
Pushing feelings to the side
Sister-in-law seeing her burst into tears and
challenging it
Being able to phone midwife
Not able to make husband understand she's asking
for help
Asking for help in roundabout way that gets missed
Not wanting people to know she had PND and having
treatment
Telling only select people at the start

Talking about it and finding lots of other people
suffering with depression
Not minding talking about it now, being open with
people
Issues building as they are not resolved and other
things add to it
Recognising need to acknowledge problem
Recognising a need for PND to be talked about more
widely
Hiding feelings for up to a year (waiting for someone
to notice?)
Not wanting people to say she couldn't cope
Hiding difficulties in attempt to protect children
Recognising that she wasn't hiding it from her children
as she thought
Realising the effect on her children
Facing fears of telling people she has a problem
Wishing now she'd sought help sooner
Bringing up subject of PND and finding out that lots of
people have suffered with it
Realising that PND is quite normal in terms of how
many people have suffered
Initiating conversations with peers about her PND
which opened up admissions from other mums who
suffered
Sharing experiences of struggling
Wanting people to talk about depression more
Wanting depression to be talked about
Finding it hard and scary to instigate getting help
Not wanting to admit she had a problem
PND not mentioned much
Avoiding talking to the doctor in case he thinks she's
stupid
Relief at knowing it's OK to ask for help
Needing normalisation of the experience? in order to
feel able to ask for help
Needing more information on PND antenatally
Needing information presented more actively than just
a leaflet you can ignore
Needing something to remove the stigma of talking
about it
Needing to know other people were having similar
experiences
Talking about it lessening the sense of shame
Needing PND to be more widely talked about
Needing more awareness of help available

Talking about it more leading to becoming aware of
more people having similar experience

Appendix J

Further quotes supporting the themes in the analysis

Comments supporting birth as a trumatic event:

> ...when he was born they told me he'd been born with Down's syndrome, and he hadn't.. and they didn't realise their mistake for about 48 hours, so I went through the trauma of being told...
> ...I feel absolutely robbed from having a happy birth.. it was one of the worst days of my life and it shouldn't have been; it should have been the happiest
>
> - Belinda

> ...and they [the counsellor] stemmed it all back to the birth coz I had an horrendous labour and birth...
>
> - Charlotte

> I had a traumatic delivery, erm and an emergency C-section ...erm.. I wasn't expecting to have, you know, a good delivery or whatever but it was quite hard..... And it.. her heart rate was dipping, I thought she was.. I can remember when they took me down for the C-section I thought she was going to be born dead...
>
> - Emma

Comments supporting birth as a positive experience:

> well, and then when it actually.. when he actually came, erm, I think I went into a bit of a rebound situation because you're elated aren't you? Well, I mean some people aren't but I.. well we were, you know, I had this feeling of happiness he was there. He took from 1 o'clock in the morning, contractions started til 9 o'clock the next night to come out... and he was perf.. you know perfectly.. it worked perfectly well.
>
> - Daisy

Comments indicating expectations of motherhood:

> ...them first couple of weeks wasn't this fairytale, happy, you know, beginning that we should have had...
>
> - Charlotte

> ..you think people should see this completely elated human being that, you know, is flourishing on motherhood...
>
> - Daisy

Comments supporting the idea of motherhood being relentless:

> But I always sort of feel that no one.. mm.. not so much no one cares, but.. even just how difficult it is just to make dinner, you know you've finally got the baby down and you run around and instead of, you know, having a break, you're running around getting dinner ready and laundry on la- la, and I hate doing all that crap; I'm just not very domesticated I think... and it's just.. I.. you know, I want someone to realise how difficult it is for me..
>
> - Annie

...nothing ever tells you how hard motherhood's going to be. Yes they tell you, you know, you're not going to get a lot of sleep and you'll get a pooey nappy but they don't tell you actually it's crap. It's really har.. it's brilliant, in all it's a whole, it's amazing and euphoric feeling, actually it's not all roses, it's goddamn hard and you've got to work really hard, because suddenly, and I think it's a pressure that you then have to look after something, and you've got a baby and it's.. it's not about you anymore or you as a couple, you're whole life is about this.. this being that's come in, erm and suddenly it's a whole new responsibility...

- Hannah

Comments surrounding expectations of a 'good' mother:

I mean my partner was brilliant; he would get on, you know, feeding her, changing her bum, anything like that, even in the night and stuff, but then that, I thought 'I should be up doing it not you. By the time I got out of bed, he'd changed her bum and was down here giving her her bottle, or.. you know, by the time I even got out of bed, which can't be helped, but it does make you think 'Oh', you know 'I should be the one getting up doing it all, not trying to get myself out of bloody bed'
... I was glad that he did get on and do it coz it needed.. you know, she needed to be cared for and so him doing it, I was glad that he was happy to get up, coz obviously if he wasn't I would have probably st.. well, I would have struggled even more erm, but no, it was just guilt on myself...

- Charlotte

...I just remember crying because, and I remember getting angry with my husband once coz he fed [baby] and bathed him, and I remember saying to him 'You're taking my baby away from me; stop taking my baby away from me. I want to do it' ... the PA was taking [baby] to nursery and picking him up and I stopped it in the end. I still had a PA but I got her to do different jobs because I was.. I couldn't bear to watch someone else take my son to s.. to nursery and pick him up again, and it killed me to do it ... but I was like 'I'm taking him no matter how much it hurts me'..

- Belinda

Comments around a pressure to breastfeed:

...because she was so early, erm, my milk didn't come in properly and erm then when she was born she was too early and didn't have.. wasn't able to latch on properly erm, and so we were having to try and syringe feed her and I was trying to express and you know I'd spend ages, you know, half an hour, an hour trying to express and get you know a few ml out and it was just awful and I was really struggling, and I carried on for 3 months but there is.. everyone's always on about you must breastfeeding your child, it's the best thing for your child and my husband was like 'You've got to give her breast milk, you've got to do this', we were having to top up on the formula because I couldn't produce enough, but there was such a.. and at 3 months I just said to him 'I just can't do it anymore, I've done 3 months' and that's, I had to kind of draw a line after that, you know, and that, I think that started the whole, you know 'You're a failure, you've not been able to breastfeeding your child properly'...

- Hannah

I wanted to breastfeed. I breastfed for 6 weeks but basically he just couldn't breastfeed because of the reflux. Every time I put him in position he'd scream and sort of feeding was hugely traumatic, even with the bottles...
...I mean I ended up in breast clinics and everything trying to get him to breastfeed coz I was so determined that I wanted to erm, and there was.. I felt there was a real lack of support from midwives and health visitors, especially the health visitors, and I felt all they wanted to do was push you into continuing to breastfeed, erm, when actually I don't think that was the right thing for me to do. I think if I'd stopped breastfeeding earlier when I really was getting into a panic about it, at that 4 week/5 week mark, erm, it.. I might not have got myself so completely overwrought with anxiety about it.

- Fiona

I was struggling with the breastfeeding but felt like I had to continue...
...Well, I didn't actually have any physical problems doing it, erm, but it was.. I didn't.. I wasn't sold on the idea, I mean obviously I knew it was the best thing for the baby and that and I thought I'd just give it a try in the hospital and it was.. it went fine so I thought I'd just carry on and then it was just relentlessly hard work, but I, sort of took to heart the message of, you know 'Oh, formula's evil, you couldn't give your baby a bottle' and I sort of felt that, coz I didn't love her I could do the right thing by feeding her the right way as such, erm.. you know at least I could do something right...

- Emma

...the doctor basically said 'You need to go back on antidepressants and you can't breastfeeding anymore' so that was hard because that was the only thing that I felt I was successful in doing. I was failing in everything else, in my head I was, so yeah, stopping breastfeeding was hard because it was like 'Look what I can do, it's the one thing that, you know, I can do to make my baby better'.

- Georgina

.. it seemed that if you'd sort of made the decision from the out to go one way or the other then if you decided, you know feeding your baby formula right from the start then that was fine, they [health professionals] just left you to it, but if you sort of expressed any kind of interest in breastfeeding it was (sigh) tunnel vision, this is what you're doing, erm.. I just don't think they're very realistic about how hard it is or can be, and I know people who've had, you know, found it fine, but I've spoken to a lot of people who had, you know, similar sort of experience as me, felt very.. a lot of pressure to do it...

- Emma

Comments showing the demands of breastfeeding:

..he couldn't breastfeed, I was expressing every feed and feeding him a bottled expressed milk so I was basically feeding/expressing all day so that's really another reason I ended up being in so much because I couldn't go out; you can't express out and about...

- Fiona

...whereas I was breastfeeding, expressing and I was just constantly felt I was.. yeah I was just constantly milking somewhere...

- Georgina

Comments questioning their previous sense of themselves:

I didn't think it would affect me as much as it did, coz I've always been quite a strong person, you know, I'm the one normally that all my friends come to when they're feeling down in the dumps; very rarely ever is it me, and so I think that.. you know when you can't get your head around that thinking 'Oh, being a mother's.. (laughing) weakened me sort of thing'

- Charlotte

...I've always generally been a supportive role to most of my friends; to think that I couldn't actually offer what I thought I was going to offer, or be able to achieve and just cope with was.. was.. was er an unknown comparative really coz I didn't know til I got there, and that's how it appeared I was.. I was doing coping, or achieving motherhood and it wasn't where I thought it was going to be.

- Daisy

I think I wanted to feel like I was a success at being a mother because I probably coz I was a success at work and I wanted to be able to say, you know, I can do both...

- Fiona

Comments indicating a lack of space for the mother:

..she [a friend] came out with a comment which a lot of people have said which I did agree with to a certain extent but to another extent not was all that matters at the end of the day is that the baby's healthy. I'm like well, you know, what about me? you know, it's been quite a.. tough old time for me, and just coz the baby's healthy, doesn't mean that.. I'm OK.

- Emma

I'm breastfeeding, so, erm and I will not step back from that. I set myself up such high expectations that anything else would probably just make the depression worse, but it does mean that nobody can really sort of say to me "Look, just go out. Just go.. go and do something", you know I..I know I can't do that, and I don't really want to either, I don't desperately want an evening out or whatever but.. possibly just having some time where I can get my head clear and do something for myself...

- Annie

...you know, just, even an hour a week, I want to be me, I don't want to be mother, I don't want to be wife, I just want to be Hannah...
To think you lose touch with it and you forget who you are, which then leads to problems further down the line, and just.. yeah.. It's really important to make 'you' time and everyone says, you know, it's important to make family time but actually it's really important to make 'you' time coz if you're not happy, your kids aren't happy and your partner's not happy...

- Hannah

Comments regarding the timing of professional input:

I think having more contact time with health visitors or midwives or anyone like that...post, after the birth, coz, I know my health visitor.. I think she came round once or twice after she was.. straight after she was born, I'd discharged from the midwife's care when she was ten days old, the health visitor came round once or twice after that and then again at.. She didn't come round, I had to go to them for six week check or eight week check or something like that, erm. I think maybe more contact time with health visitors you know, several weeks after the birth might be useful just as a standard...

- Emma

..it's quite early on coz you're still sort of finding your feet at that stage I think.
..I think that maybe they should do like a 3 month check or something to see if women are coping alright at that stage...

- Fiona

...like the 10 day check of midwives, I don't.. whether there should be one 3 months later I don't know, you know, 10 days.. you're still in the throes of 'I've just had a new baby and I've not slept for 8 days and I don't know who I am but I'm fine' but actually it's two months down the line when you think 'OK, well we're getting a routine together but actually I don't think I'm quite fine now'...

- Hannah

Comments around accessing of professional support:

..there needs to be more health visitors for a start, because.. there are so many different people having babies, different ages, different social status, support networks; do they access the right services? Are they getting the attention they need? And literally if you don't have enough of the resources as in health visitors, then people who even have got a diagnosis of PND, having spoke to mothers over the past couple of years, some of them wait so long, or only get a minimal input of support, and they haven't got other networks...

I just think literally there weren't e.. there weren't enough health visitors pick up on problems ... they didn't have time to pick up on somebody who might actually be presenting.. you know, obvious signs of anxiety because there just wasn't the time for them to do that...

- Daisy

...in an ideal world we'd all go off to some kind of nursing home or something for a month. I know one of my friends is from Korea and she says that, you know that happens in Korea according to, you know, what you can afford to pay or whatever, new mothers go off to nursing homes for 3 or 4 weeks to recover from surgery, and you know, or the birth and they're helped with feeding and they don't have to worry about coping and cleaning or anything like that, they're just looked after. Seems to be a bit easier. I don't know, I mean, you know, all of that would be very expensive .

- Emma

Comments around women feeling alone and inadequate in how they were feeling:

> ...and there were other mothers that appeared to be that person who erm, just took it with a pinch of salt and er.. you know, earth mothers I suppose, do you know what I mean? Or.. not necessarily earth mothers, but people that just took it as it rolled, you know, and even now I think to myself I wish I could be just one of those people that takes it as it rolls...
> ..I judged myself against the relaxed person, the person that I wanted just to be a natural occurrence, you know to.. to.. to do that...
>
> - Daisy

> Erm.. I think the word 'failure' comes to mind I think, I think women feel a failure, erm, it's not how you're meant to be; you're meant to be really happy that you've got a baby, erm.. and it's still quite hush-hush.
>
> To talk to other mothers that had it, because I felt like I was the only person in the world that had postnatal depression.
>
> - Belinda

> I felt I was the only one, that everybody else was fine and perfect, I was the only one that didn't feel that way.
>
> - Georgina

Comments around the fear of being judged:

> ..I feel like everyone just kind of looks at you as if to say 'Well you've had this baby, you just need to get on with it. You.. you.. you.. you sort of know.. know what you need to do; why are you now struggling with that? Why.. why is it emotionally difficult for you just to do what you need to do?' And they're probably not thinking that...
>
> - Annie

> ... I'd never go and discuss with another mother that I was feeling low, or, I think I was always trying to be quite upbeat and positive, or if I'm having a bad day I'll be like 'Oh, fine, he hasn't slept today' or something like that, I'd never really relate it back to me and how I'm feeling, I always kind of have an excuse as to why I'm feeling low because 'Oh, I've been up all night'...
>
> - Fiona

> Erm.. if.. you feel completely alien to be fair; you feel like you are a bit.. more than just a bit, you're abnormal and er (starts to cry), lonely coz you just think to yourself 'I can't possibly say how I'm really feeling coz it's just not how I should be feeling'
>
> - Daisy

> I think it needs to.. to me it still feels like it's really taboo and you don't want to talk about it, you don't want to admit it; I don't think women feel comfortable admitting it. ...I think the word 'failure' comes to mind I think, I think women feel a failure, erm, it's not how you're meant to be; you're meant to be really happy that you've got a baby, erm.. and it's still quite hush-hush.
>
> - Belinda

Comments from women describing reaching their tipping point:

> ...I just thought to myself they'd be better off..(starts crying) I'm gonna get upset already.. they'd be better off without me, which I didn't.. know how without me if you get what I mean; not, whether just to leave or what to do, erm.. and then you know a couple of minutes later I was sort of sorting myself out and thought 'For god's sake woman,' you know, 'you need to speak to someone' so, erm.. rung the health visitor who saw me straight away that afternoon...
>
> - Charlotte

> Er, it was actually that moment when she wee'd on the towel and I sobbed for, you know, ages, um and er.. I can remember sitting there whilst I was crying thinking 'This isn't.. this isn't normal, to be (laughs) crying about this sort of thing'...
> ... I just made an appointment to see the GP the following day and had a.. a good chat with him and erm.. filled in a questionnaire...
>
> - Emma

> ...like even friends, you know, they didn't know that I'd been depressed because it was just.. I was able to hide it and.. after [baby] it just got so so bad that I just, you know, couldn't hide it, it was kind of, I felt it was obvious to everyone else around me that I was depressed...
>
> - Georgina

Comments around accessing professional help:

> ...but the onus was on me to call them if I had any problems and I don't think I.. I didn't realise I could just call them about, you know sleeping issues or feeding issues or anything like that, erm, I remember the midwife coming round and very nicely sort of saying, you know 'Why didn't you call us sooner?' and I was just like 'Well I just didn't know (laughs) didn't know I could'
>
> - Emma

> ...it was only literally by putting my hand out to a professional that erm I was able to get the help that I got.
>
> - Daisy

> ...the only way really in which you can go and speak to a health visitor is a weigh-in centre and I didn't really want to open my heart out in weigh-in centre so I felt like they kind of preach about all this support once you've had the baby but really there isn't any and the GP was great, but actually I would have liked to have spoken to somebody who was more of a specialist in babies and new mothers who might have been able to help me more than a GP because ultimately with a GP you are like, in, out...
>
> - Fiona

> ...I ended up ringing my health visitor and just crying down the phone to her and um.. I just said to her 'I can't, um, you know I think I've got postnatal depression because I can't stop crying' erm.. and she was really good, I.. I had two health visitors I think, and they used to come round for extra visits during the week just to chat to me ...

... I know a lot of people moan about health visitors, that they're a bit interfering, but I have to say, I've had a few health visitors, and I don't know where I'd be without them. It was a real lifeline, to ring someone up and say 'Help me, I'm going mad' and for them to put something in place ...

- Belinda

...the health visitor managed to, erm.. at that time, which was really good erm, there was erm a postnatal support group, and it took her a while to get me to kind of agree to go to it coz I felt 'No', you know it just felt like I had a big neon sign above my head going 'I'm depressed' erm and it was run by health visitors themselves and there was just like a group of us erm, and that really really really helped.

- Georgina

...I phoned the doctor and spoke to the health visitors and they were super and [health visitor] was fantastic and normally she's booked up 2 or 3 weeks in advance and she said 'I've had a cancellation at lunchtime. I'll be there with you at 12:30' ...

- Hannah

Comments around relief at the diagnosis:

At the time.. er, there was an element.. a big element of relief to feel that actually I wasn't going mad (laughs)

- Daisy

Erm, it was actually quite a relief even to just to have spoken to someone about it erm, who, you know, and to confirm that it wasn't, as such my fault that I was feeling the way I was coz it wasn't that I was, you know, a bad person or a bad mother or whatever, it was, I think it looked like a chemical imbalance.. I don't know precisely but it's not, it's.. there was something actually wrong, rather than me just being a (laughs) terrible person so..

- Emma

Er.. it.. I think, coz I'd left it a couple of months, in a way it was quite nice to know that I wasn't going mad, I suppose, yeah I wasn't going mad coz I think I thought I was going mad, that there was like an end for it and I wasn't the only one that was feeling like that.

- Georgina

Relief again. Relief that.. that it had a name or a label, you know, that it wasn't just me going out of my mind, that it was.. there was something actually happening to me...

- Belinda

I just knew I had it, so I don't know that, I think the relief was somebody's recognised it.

- Annie

...I didn't really want to admit it which is why it was so long, but it's actually such a relief, me knowing that I wasn't going crazy, and actually it's OK to ask for help, erm.. I don't know it was just a sense of

relief when [sister-in-law] said you.. somebody.. I don't know whether it's her acknowledging for me because I didn't really want to acknowledge it myself ...

- Hannah

Comments around the opening of a dialogue:

...I'd start to talk about it a bit and then finding out that actually there are so many people that suffer with depression of all sorts but especially PND and that actually you're not on your own, erm, and there are people who, you know, need help who haven't got help and it's just.. It's erm.. yeah so no I don't mind talking about it now at all and I'm quite open with people and quite happy to explain and talk about my experience but yeah, at the time it was such a hard thing, my biggest thing was feeling like a failure if I wasn't doing what I should be doing, or coping...

- Hannah

I do think I was more confident to speak to him once my mood had lifted erm and I was much more open about it with him now if I have a really bad day or a really low day I tell him, whereas I never used to do that, coz to me, at that stage every day was a bad day and I was like 'I don't want to tell him again I'm feeling low, erm, he hears it every day'. Erm, so definitely I think I'm more open with him since my mood has lifted and I've.. I'm feeling better in myself, but yeah, probably I think his understanding of how I was behaving or how I was acting, was helped by it being labelled by something I guess.

- Fiona

.. it was like justified, now that I've got a name for it, it was justified that I was allowed to say to people 'This is what I've got'...
... my friends didn't know I was doing the counselling erm, but I did tell them eventually, when I felt strong enough to...

- Charlotte

...the lack of communication that we had at that time was a trigger as well I think, coz I couldn't tell him an awful lot, or make him understand, erm, and I think to a point, maybe a label of PND helped him to come to terms with.. this person that I.. I'd become, or what was going on at home.

- Daisy

Comments around taking medication:

I just thought 'It's like you're giving me, you know, heroin or something, just to lift me up a bit, but it could take a couple of years for you to come out and then I think 'Well what the hell am I going to be like after that couple of years; am I going to go straight back..

- Charlotte

I guessed at my breaking point I then didn't feel like a failure, erm, but it was a really hard step to make but it was one, she was very good at explaining you know it wasn't like in the old days ... I think that helps coz there was quite a stigma attached to depression and tablets and everything like that and I think that was one of my biggest fears as well

so for a long time I didn't want anybody to know that I had PND and I was taking tablets

- Hannah

Comments around the resources available for support:

why I stayed with the group for as long as I did really and it was an amazing resource that halfway through.. the.. the er PCT was going to stop funding for it and you just think it's so sad coz there wasn't really much else, erm, and the.. the health visitor that actually run it, approached children's centres, who were willing to have them as a venue, and willing to employ her for one day a week to do it; she wasn't even going to be paid as a health visitor to do it; she was being paid by another budget to do it, which is quite sad. So hence why it still continues.

- Daisy

so, you know, that kind of help was great and that help isn't there anymore, you know, because of funding and I just feel that without having anybody to talk to there are so many mothers that could, you know, end up in a worse place than I was...
...and with the CBT I was the second last group to do it, bearing in mind it was in a church, volunteers, old women to look after your children, it was an hour a week, the health visitors were all volunteers but no, there wasn't the funding or anything, we can't use that resource anymore and I just said 'There could be a lot of mothers there now who are struggling and not getting...' I even wrote to XXXX about it, I was so outraged when I heard they were stopping because I honestly believe that if I didn't have that help there I probably would have topped myself, because I just didn't.. I thought I was completely and utterly crazy and do-lally..

- Georgina

I think there needs to be.. erm.. a self-referral sort of immediate drop-in type place or some kind of service, now it could be the children centres that do that, erm.. as I say here they're doing this postnatal depression group, but you have to be referred either through your doctor or through MIND; that all takes time, there's a waiting list coz there's not very many of them, erm.. it..it's the same situation you're going to get anywhere, erm.. but if you are.. if you're feeling that bad with postnatal depression, you don't want to wait a few weeks or a few months (laughs) to get.. you just can't do that, it's just.. it's too hard, erm.. and there's quite a lot at stake with.. with the baby and with other children...

- Annie

Comments on the lack of health visitors:

I think access to HVs, a.. as a 1:1 with a HV should definitely be offered more. It isn't really offered enough I don't think, erm, other than that I don't think there's anything else to add, but I think you should be able to have some private time with HVs if you want it, or if that's available I don't know about it so they're not doing a very good job of talking to new mums about it.

- Fiona

Comments indicating more rationalising of things:

And I suppose in hindsight I was breastfeeding, he wasn't taking a bottle; it was fine for him to go out for a bike ride in the evening, and he would get his.. his life back to normal, erm, but I think in those times as I was getting that little bit lower, little bit lower, those hours seemed longer, and they were the times I felt at my lowest...
...but off the back of that whole process, and looking at [baby] and the beautiful boy that he'd become, and how settled I was being, you know, now being a mother, was like, I've learned from everything now, I'm not.. you know, and if I do, I'm gonna get help...
..I think the things that I find make me emotional will always make me emotional and sometimes life events bring up all sorts of things don't they?

- Daisy

It's OK to ask for help, it's OK to talk. Don't be afraid, there's nothing to be afraid of and if you don't get the help you're not going to get better. It doesn't matter how much you think you can deal with it yourself, if you're not coping you need help and support either medically, professionally or from your family and friends. But yeah, the main thing is it's OK to not feel normal and to speak to your doctor I suppose.

- Georgina

...the day you've got all these plans you've failed coz you haven't done anything you're supposed to do, erm, but actually you look at it, you've not failed because at the end of the day, your baby's still safe and healthy and happy and you've made it through the day and you go on to the next one then. The dust can wait...
... still have days when 'God' you know 'I'm absolutely rubbish' and everything else, but actually when you look at it, I've got 2 amazing children, erm and they're amazing because we've made them that way.

- Hannah

Comments around needing more information on PND:

Yeah, I think it needs more education.. I think it needs to be covered a lot more in antenatal classes erm.. because we really.. I.. I did NCT classes and we just brushed on it, you know they just said 'You'll cry three or four days later when your milk comes in and that's the baby blues; if you're crying any longer than that, that's postnatal depression.' We didn't really go into the ins and outs of it, we didn't go into, well OK if you have got it, where do you go? Who do you call? Where are the support groups, how do you find them? None of that was.. I don't remember receiving any of that advice..

- Belinda

...you've maybe get more in your packs or something, you get.. all that literature and bumph beforehand, and I think there was a little bit in your birth-5 year pregnancy book which says this about PND but it's one of those things you just kind of flick through, coz you think it's not going to happen to you, but maybe, erm, I don't know if they do an ante.. coz with the antenatal classes... maybe in one of those sessions there could be a bit about PND or something, just, I think rather than just literature, because you look at it and you think 'Yeah, not going to happen to me' and you put it to the back of the pile so you don't read it. Maybe some discussion somewhere along the line at one of your midwife checks, or postnatal appointments or something, erm, just

going through a bit, even if it's a 10 minute chat saying 'Look, you might be absolutely fine but actually 4 months down the line you might be feeling like a complete and utter failure. It's normal, but tell us so we can help you. You know, tell us. A year down the line you're going to think that..', Or.. something that takes the stigma away from 'you're a failure and we don't talk about it' things like that.

- Hannah

...I think if other women knew it was really common and there were other people near them or.. that had it as well, they wouldn't feel so, like 'Well I'd better not talk about this', coz you know, you can...
...I'm about to start a breastfeeding counselling course; that's kind (laugh) of my next thing to do is keep my mind occupied, but I'd like to do that and to provide a service to go round to mother's homes and help them breastfeed if they need it..

- Belinda

..just for women to keep their.. to have their eyes open as to what could actually happen, and you know, just what it can lead to.

- Charlotte

Appendix K

Edinburgh Postnatal Depression Score Calculator

Many health visitors use the Edinburgh Postnatal Depression Score (EPDS) as a screening method for depression in the post natal period, see related article on Postnatal Depression.[1]

- This is a self-report questionnaire which is both easy to complete and acceptable to the mother.
- Evidence from a number of research studies has confirmed the tool to be both reliable and sensitive in detecting depression and it has been validated for use in the community.[1,2,3]
- New mothers usually complete it 6-8 weeks post partum.
- A score of 11-12/30 has a sensitivity of 76.7% and specificity of 92.5% for depression.
- It should be confirmed by interview and mental state examination.

To use calculator, click on appropriate answer and score appears in box when all questions completed.

Edinburgh Postnatal Depression Score (EPDS)

Ask patient how they have been feeling OVER THE LAST 7 DAYS, not just today.

1. I have been able to laugh and see the funny side of things

0 points - As much as I always could
1 point - Not quite so much now
2 points - Definitely not so much now
3 points - Not at all

2. I have looked forward with enjoyment to things

0 points - As much as I ever did
1 point - Rather less than I used to
2 points - Definitely less than I used to
3 points - Hardly at all

3. I have blamed myself unnecessarily when things went wrong

3 points - Yes, most of the time
2 points - Yes, some of the time
1 point - Not very often
0 points - No, never

4. I have been anxious or worried for no good reason

0 points - No, not at all
1 point - Hardly ever
2 points - Yes, sometimes
3 points - Yes, very often

5. I have felt scared or panicky for no very good reason

- 3 points - Yes, quite a lot
- 2 points - Yes, sometimes
- 1 point - No, not much
- 0 points - No, not at all

6. Things have been getting on top of me

- 3 points - Yes, most of the time I haven't been able to cope at all
- 2 points - Yes, sometimes I haven't been coping as well as usual
- 1 point - No, most of the time I've coped quite well
- 0 points - No, I've been coping as well as ever

7. I have been so unhappy, I have had difficulty sleeping

- 3 points - Yes, most of the time
- 2 points - Yes, sometimes
- 1 point - Not very often
- 0 points - No, not at all

8. I have felt sad and miserable

- 3 points - Yes, most of the time
- 2 points - Yes, sometimes
- 1 point - Not very often
- 0 points - No, not at all

9. I have been so unhappy that I have been crying

- 3 points - Yes, most of the time
- 2 points - Yes, quite often
- 1 point - Only occasionally
- 0 points - No, never

10. The thought of harming myself has occurred to me

- 3 points - Yes, quite often
- 2 point - Sometimes
- 1 point - Hardly ever
- 0 points - Never

Edinburgh Postnatal Depression

Score = /30

Scores of 10 or less are considered normal. Scores of 13 or more suggest significant depression.

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1 Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. British Journal of Psychiatry 150:782-786.

2 Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199