

# **MATERNAL UNDERSTANDINGS OF POSTNATAL DEPRESSION**

A thesis submitted to the University of Manchester for the degree of

Doctor in Clinical Psychology

in the Faculty of Medical and Human Sciences

**2011**

**SONIA PATEL**

**SCHOOL OF PSYCHOLOGICAL SCIENCES**

## List of Contents

	<b>Page</b>
List of tables	6
List of figures	6
List of Appendices	7
Abstract	8
Declaration	10
Copyright Statement and Ownership of Intellectual property	11
Acknowledgements	13

---

## **Paper 1: Literature Review**

### **A Metasynthesis of Qualitative Studies Exploring Postnatal Depression in Immigrant Mothers**

Abstract	15
Introduction	16
Methods	22
Results	26
Discussion	44
Conclusions	49
References	51

---

## **Paper 2: Empirical Paper**

### **An exploration of illness beliefs in mothers with postnatal depression**

Abstract	71
Introduction	72
Methods	76
Results	80
Discussion	95
Conclusions	102
References	104

---

## **Paper 3: Critical Appraisal**

### **My Personal Journey through a Grounded Theory Methodology in Exploring Illness Beliefs in Mothers with Postnatal Depression**

Introduction	116
Conclusions	134
References	135

---

### **List of tables**

Table 1:	An Overview of the Inclusion and Exclusion Criteria Applied	63
Table 2:	Characteristics of the Included Studies	64
Table 3:	Individual Study Concepts as Related to the Overarching Themes	68
Table 4:	Participant Characteristics	113

---

### **List of figures**

Figure 1:	Diagrammatic Illustration of Overarching Themes and Relationships	69
Figure 2:	Representation of Categories and their Relationships	114
Figure 3:	Charmaz's (2006) Grounded Theory Model	122

---

## **List of Appendices**

Appendix 1:	Summary of Qualitative Health Research Journal Manuscript Guidelines	137
Appendix 2:	List of Key Words used for Literature Search	142
Appendix 3:	Results of Search Strategy and Identification of Studies Included in Review	144
Appendix 4:	The Study's Quality Assessment Criteria	146
Appendix 5:	Quality Rating Scoring of Included Studies	148
Appendix 6:	Noblit & Hare's (1988) Seven-step Approach	151
Appendix 7:	Key Themes and Concepts from Studies Included in the Metasynthesis	153
Appendix 8:	British Journal of Clinical Psychology Authorship Guidelines	158
Appendix 9:	National Research Ethics Service Approval letter	163
Appendix 10:	National Research Ethics Service Approval letter following substantial amendment	167
Appendix 11:	R&D Approval letter 1	170
Appendix 12:	R&D Approval letter 2	173
Appendix 13:	Participant Information Sheet	176
Appendix 14:	Consent Form	180
Appendix 15:	Demographic and Social Information Questionnaire	182
Appendix 16:	Edinburgh Postnatal Depression Scale	186
Appendix 17:	Interview Schedule	189
Appendix 18:	Anonymised Coded Transcript	192

---

**Word count: 29 990**

## **Abstract**

Paper one is a systematic literature review of qualitative studies examining postnatal depression in immigrant mothers using a metasynthesis approach. This review involved three phases: a systematic literature search of qualitative studies reporting on postnatal depression among immigrant mothers, critical appraisal of the studies from the literature search, and the metasynthesis of these studies. Fifteen studies met the inclusion, exclusion and quality criteria. The synthesis of the studies demonstrated that immigrant mothers are subjected to two overarching factors of migration and cultural influences that interact and give rise to psychosocial understandings of postnatal depression, healthcare barriers and views of potential remedies lying within the psychosocial domain. Mothers use self-help coping strategies in line with this. Social support appears to play an integral and mediating role for these immigrant mothers removed from their sociocultural context.

A grounded theory approach was taken in the second paper to explore illness beliefs in mothers with postnatal depression. Eleven participants were interviewed using a semi-structured interview schedule and data was analysed in line with a grounded theory methodology. A theory of illness beliefs in PND was developed encompassing six core categories: 'unmet expectations', 'identifying stressors in their life context', 'conflict over label', 'antidepressants: the lesser of two evils', 'loss of time' and 'uncertain futures.' It was concluded that participants made multiple appraisals of their PND in light of their initial difficulties, following service



involvement, their improvements, their consequences and the future. Participants' narratives were conflicting and uncertain with internal struggles evident as mothers were torn between their desire to be good mothers and their perceptions that PND meant that they were not good enough mothers.

The final paper is a critical appraisal that outlines my journey through a grounded theory approach exploring illness beliefs in postnatal depression. This appraisal first discusses why a qualitative methodology was chosen and more specifically a grounded theory approach. The difficulties attached to using grounded theory are then considered. Finally in keeping with the need for transparency within the methodology, there is a reflective account of the challenges encountered, the knowledge and skills gained throughout the process and how this has been important for my learning and progression towards becoming a qualified Clinical Psychologist.

## **Declaration**

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

## **Copyright Statement and Ownership of Intellectual property**

The author of this thesis (including any appendices and/or schedules to this thesis) owns certain copyright or related rights in it (the “Copyright”) and s/he has given The University of Manchester certain rights to use such Copyright, including for administrative purposes.

Copies of this thesis, either in full or in extracts and whether in hard or electronic copy, may be made only in accordance with the Copyright, Designs and Patents Act 1988 (as amended) and regulations issued under it or, where appropriate, in accordance with licensing agreements which the University has from time to time. This page must form part of any such copies made.

The ownership of certain Copyright, patents, designs, trademarks and other intellectual property (the “Intellectual Property”) and any reproductions of copyright works in the thesis, for example graphs and tables (“Reproductions”), which may be described in this thesis, may not be owned by the author and may be owned by third parties. Such Intellectual Property and Reproductions cannot and must not be made available for use without the prior written permission of the owner(s) of the relevant Intellectual Property and/or Reproductions.

Further information on the conditions under which disclosure, publication and commercialisation of this thesis, the Copyright and any Intellectual Property and/or Reproductions described in it may take place is available in the University IP Policy (see <http://www.campus.manchester.ac.uk/medialibrary/policies/intellectual-property.pdf>), in any relevant Thesis restriction declarations deposited in the University Library, The University Library’s regulations (see

<http://www.manchester.ac.uk/library/aboutus/regulations>) and in The University's policy on presentation of Theses

## **Acknowledgements**

I would like to thank Dr Anja Wittkowski and Dr John Fox for their invaluable advice, support and guidance while supervising my research. I am indebted to Dr Wieck and the staff at the Mother and Baby Unit and Trafford Perinatal Support Team who supported the recruitment. I am especially grateful to the women who gave up their time to take part in the study and shared their difficult and emotional experiences.

A special thank-you to my family and friends for their support and encouragement over the last few years.

## **Literature Review**

# **A Metasynthesis of Qualitative Studies Exploring Postnatal Depression in Immigrant Mothers**

Prepared in accordance with requirements for submission to the  
*Qualitative Health Research Journal*  
(Appendix 1)

Word count: 9304

## **Abstract**

Postnatal depression affects women from all cultures and countries. The postnatal period is thought to be a vulnerable time for all mothers. Immigrant women may be at particular risk as they attempt to adhere to childbirth rituals and practices in western societies which may exacerbate stress, whilst navigating through the multiple stressors they face from migration in the transition to motherhood. I used Noblit & Hare's metasynthesis approach to synthesise qualitative studies exploring postnatal depression in immigrant mothers living in western countries. From searching several databases I identified fifteen studies that met the inclusion, exclusion and quality criteria. The synthesis of the studies demonstrated that immigrant mothers are subjected to two overarching factors of migration and cultural influences that interact and give rise to psychosocial understandings of postnatal depression, healthcare barriers and views of potential remedies lying within the psychosocial domain. Mothers used self-help coping strategies in line with this.

**Keywords:** immigrants, metasynthesis, mothers, postnatal depression

## **Introduction**

Postnatal depression (PND), also known as postpartum depression (PPD), is a term used to describe the clinical depression phenomena experienced by mothers following childbirth. Both terms will be used interchangeably throughout the paper.

PND encompasses childbirth mood disorders from the baby blues to serious psychiatric illness (Department of Health, 1998) and affects 10-20% of mothers after childbirth (e.g., Hopkins, Marcus & Campbell, 1984). The potential devastating effects of PND on the mother, her marital relationship, and her children make it an important condition to diagnose, treat and prevent (Robinson & Stewart, 2001). Research has identified multiple risk factors for PND, in a synthesis of two meta-analyses conducted by Beck (2001) and O'Hara & Swain (1996), Robertson and colleagues (2004) identified the following predictors: (1) strong to moderate risk factors of depression or anxiety during pregnancy, past history of depression, recent stressful life events, lack of social support; (2) moderate risk factors of high levels of childcare stress, poor marital relationship, neuroticism, low self-esteem, difficult infant temperament and; (3) small risk factors of obstetric and pregnancy complications and low socio-economic status (SES).

There has been an expansion of research in this area over the last 40 years given the serious consequences of PND. Earlier studies have predominantly used quantitative methods but more recently there has been a surge of research focusing on qualitative designs in an attempt to capture the experiences of mothers with PND.

Qualitative studies have demonstrated several key themes common to mothers' experiences of PND. Beck (1992) conducted one of the first phenomenological studies exploring the lived experiences of women with PPD in the United States. Eleven themes emerged from this data: loneliness, obsessive thinking, insecurities, anxiety attacks, loss of



control, guilt, diminished concentration, fear that life would never be normal again, loss of interest in hobbies or goals, lack of all positive emotions, and contemplation of death. Beck (1993) went on to develop a substantive grounded theory of PPD named 'teetering on the edge,' based on women in the United States. She suggested that women with PPD attempted to cope with loss of control through a four-stage process of encountering terror, dying of self, struggling to survive and regaining control. In her metasynthesis of eighteen such qualitative studies published between 1990 and 2000, Beck (2002) identified four overarching themes to conceptualise PPD: incongruity between expectations and reality of motherhood, spiralling downwards, pervasive loss and making gains. Loss emerged as a pervasive component with multiple forms of loss apparent. Three of the studies included in this metasynthesis looked at the experience of Hmong mothers in the United States and Jordanian and Middle Eastern mothers in Australia. Although Beck included these studies, she did not offer an explicit analysis of the socioeconomic factors or cultural context that played a part. Generally, these qualitative studies have predominantly been conducted in western countries, with samples tending to consist of White middle-class mothers.

Over the last decade transcultural qualitative research has increased substantially with research in India (Rodrigues, Patel, Jaswal & De Souza, 2003), China (Chan, Levy, Chung & Lee, 2002; Chan & Levy, 2004), Taiwan (Chen, Wang, Chung, Tseng & Chou, 2006) and Ethiopia (Hanlon, Whitley, Wondimagegn, Alem & Prince, 2009) to name a few. Studies have demonstrated that PPD is a cross-cultural and universal concept (Halbreich & Karkun 2006) that affects mothers from all countries and cultures equally (O'Hara & Swain, 1996). Beck (2007) extended her "teetering on the edge" theory of PPD through the inclusion of recent cross-cultural studies and identified mothers from various countries and cultures progressed through the same four stages to regain control of their lives. She concluded that her existing theory of PPD could be modified to capture cross-cultural experiences of PPD.

One significant area, however, that is missing in Beck's study is an account of the role of cultural factors that will inevitably have played a part.

Traditional rituals, practices and beliefs that accompany the transition to motherhood are common to many non-western cultures. Many cultures prescribe to a traditional month's rest for the mother post-birth where mothers are relieved of their duties to recuperate (e.g. Taiwanese, Chinese, Bangladeshi, Mexican and many South American countries).

There may also be other rituals or practices, such as special diets, avoidance of both bathing and exposure to the wind, purification ceremonies and the receipt of gifts (Stern & Kruckman, 1983). These various traditional rituals are seen as "rites of passage" to motherhood, providing guidance and social support in facilitating adaptation to the new maternal role (Cox, 1996), and undoubtedly play a significant role in maternal experiences following childbirth. It has been suggested that these rituals may be protective for mothers against depression. According to Seel (1986), these rituals are critical in making mothers feel valued in their new roles by culture and supported by a social network; and without rituals or incomplete rituals mothers are stripped of protective layers which may be related to an increase in PND. The protectiveness of such rituals has been questioned and findings have been inconsistent. However, recent reviews (Bina, 2008; Klainin & Arthur, 2009) have found that cultural values and practices may be protective in some circumstances, whereas in others they intensify PND suggesting that rituals do not provide significant psychological benefits for new mothers. Cultural values and practices appear to have a possible detrimental effect on mothers not living in their home countries (Fung & Dennis, 2010). This phenomenon needs to be understood given the high levels of migration and the increasing multicultural western world.

Migration is a stressful experience, requiring the adaptation of one's thinking, behaviour, lifestyle, and social values to a new host country. This process is known as acculturation and may be complex as immigrants make sense of their new social environment and culture and decide how or whether they are going to integrate themselves into their new country (Berry, 1997). Their reason for migration will undoubtedly affect this process: people moving to a new country voluntarily may be more inclined to integrate themselves, whereas the same may not be true for refugees or asylum seekers. Acculturation has been identified as a possible source of stress that may leave immigrants vulnerable to numerous physical and psychological problems such as depression, anxiety, sleeping difficulties, isolation, headaches, and sickness (Dale, 2003). In a recent review, Fung and Dennis (2010) propose that immigrants are subjected to unique and multiple layers of challenges that might compromise their mental health. Indeed research has indicated higher prevalence rates of mental health problems in immigrants; with many immigrant women experiencing depression, suicide, and psychosis (Li & Browne 2000). According to Vissandjee and colleagues (2004):

*"Immigrant women may experience increased vulnerability related to settlement, isolation, and meeting the basic needs of the family with limited knowledge of resources in the host country. Such vulnerability potentially exposes them to differing structural, interpersonal, cultural and economic threats to their health and well-being."* (p. 3)

This suggests that immigrant women who become mothers may be especially at risk of experiencing PND. Barclay and Kent (1998) state:

*“The transition from ‘woman’ to ‘mother’ is a major one and it can be hugely stressful when combined with the transition from ‘local’ to ‘immigrant.’” (p. 6)*

Recent reviews have identified prevalence rates and risk factors for PND in immigrant mothers; with rates of PND about five times more likely in immigrant mothers (Dennis, Janssen & Singer, 2004; Collins, Zimmerman & Howard, 2011) This observation has been strengthened by studies conducted in Australia (Astbury, Brown, Lumley & Small, 1994) and Israel (Fisch, Tadmor, Dankner & Diamant, 1997). A number of significant risk factors for women becoming mothers in foreign countries have been highlighted including reduced familiar models of mothers or family members, language barriers (Rubin, 1984), distance from family, loss of established social support networks, difficulties developing new social networks that contribute to feelings of isolation (Wiklund, Aden, Hogberg, Wikman & Dahlgren, 2000; Tummala-Narra, 2004), physical health, length of residence, reason for immigration (Small, Lumley & Yelland, 2003), English as a first language (Onozawa, Kumar, Adams, Dor'e & Glover, 2003), multiple roles (Dennis et al., 2004), cultural factors (Collins et al., 2011) and pre-migration stress (Zelkowitz, Saucier & Wang, 2008). In addition to these risk factors, there may be a host of stressors including language and cultural barriers, legal status concerns, unemployment, socioeconomic disadvantage, homelessness or lack of stable housing, poor access to services such as education, healthcare, and social services, family separation, difficulties adapting to host cultures, and experiences of marginalisation, discrimination or harassment (Zelkowitz et al., 2008).

These studies and reviews provide insight into a host of risk factors and high prevalence rates, indicating the multitude of challenges that immigrant mothers face in the already vulnerable postnatal period. One significant area, however, that has been given little attention is the subjective experiences of these immigrant mothers with PND and how they

view their experiences. This area is vitally important to examine given the findings that ethnic minorities under-use formal systems of mental health services (Cheung & Snowden, 1990), including specific PND services (Rodrigues et al, 2003).

The existing literature shows that immigrant women's healthcare behaviour is influenced by several factors including their cultural knowledge and values, their SES, social support networks, gender roles and expectations (O'Mahony & Donnelly 2007). These factors need further exploration and understanding if services are to provide services that immigrant mothers are able to engage with.

### **Aim of Study**

Western countries are home to ever increasing numbers of immigrant women from diverse cultures and countries, and these cultures ascribe to different beliefs and traditions about childbirth and mental health. It is crucial to understand these given the myriad of risk factors immigrant mothers may be subjected to and the high prevalence rates of PND among this group. Due to the recent growth in qualitative literature exploring PND in immigrant mothers, there is a need to integrate and synthesise the emerging themes from this research for both clinical practice and theory development. To date, no systematic review focusing specifically on qualitative investigations of PND in immigrant mothers has been conducted. I set out to appraise and assimilate qualitative findings of PND in immigrant mothers and enlarge the interpretative possibilities and construct a larger narrative (Sandelowski, Docherty, & Emden 1997). This area is important to investigate due to the changing demographics of western countries and the reduced rates of accessing mental health services in this group of women. I hypothesise that this synthesis will provide an enriched understanding of PND in immigrant mothers living in western societies that will have important clinical implications.

## **Methods**

This review involves three phases: (1) a systematic literature search of qualitative studies reporting on PND among immigrant mothers, (2) the critical appraisal of the identified studies from the literature review, and (3) the metasynthesis of these studies.

### **Systematic Literature Search**

#### ***Search Strategy***

I identified published articles investigating PND using qualitative methodologies through searches of Web of Science, CINAHL, MEDLINE, PsycINFO, PubMed and EMBASE databases in English between January 1990 and January 2011. I chose these years because little research prior to the 1990s either focused on qualitative methods or immigrants. I combined search terms similar to those used by Beck's (2002) metasynthesis (i.e., *postnatal depression, qualitative, phenomenology and grounded theory*) in order to identify qualitative studies looking at PND (see Appendix 2 for a full list of search terms used). The combined search strategy yielded 620 studies. I also included studies of ethnic minority mothers with PND because these mothers had essentially migrated. I sought additional articles through manually searching the reference lists of the identified articles and recent published review articles of PND.

#### ***Inclusion and Exclusion Criteria***

In line with standard systematic review methodology, I applied inclusion and exclusion criteria to the studies from the literature search (Table 1).

**Table 1 here**

### ***Results of Search Strategy***

Following on from applying the criteria, 15 studies exploring PND in immigrant mothers remained (see Appendix 3 for flow diagram). The studies and their key characteristics are presented chronologically in Table 2.

### **Critical Appraisal**

I appraised the quality of the studies from the literature search by combining the Critical Appraisal Skills Programme (CASP; 2002), with guidelines suggested by Walsh and Downe (2005). CASP consists of 10 items that allow the classification of studies into categories referring to their methodological structure. I applied the quality criteria (Appendix 4) to the 15 studies identified and classified the studies into category 'A' or category 'B' (shown in Table 2). Category 'A' studies have a low risk of bias, meeting 9 to 10 items; whereas category 'B' studies meet 5 to 9 items and present a low to moderate risk of bias (see Appendix 5 for each study's quality criteria rating score). An independent researcher checked the studies against the criteria. There were no significant disagreements between the independent researcher and my own quality rating scores of the 15 studies.

**Table 2 here**

### ***Characteristics and Quality of the Included Studies***

The 15 studies elicited data from 296 mothers and were carried out with women from diverse countries and cultures who had migrated to the United States, Australia, Canada and United Kingdom.

By applying the criteria, I observed that the studies varied significantly in their methodological rigour and posed a range of methodological weaknesses, with 10 studies

classified as having a low to moderate risk of bias. All studies used mothers as the primary informants. Two studies (Stewart & Jambunathan, 1996; Parvin et al., 2004), however, did not set out to recruit mothers with PND but noted that several mothers within their samples met PND criteria. Although mothers in the studies were either categorised as immigrants or ethnic minorities, differing definitions of 'immigrant' women were used in these studies. Immigrants referred to refugees, asylum seekers, as well as first- and second-generation immigrants. Consequently, length of time since immigration varied greatly, with some mothers living in their host countries for up to 19 years. These different sub-groups of immigrants were likely to have different experiences and needs.

Another weakness pertains to the participant samples; several studies did not state how participants were selected and differed greatly in their descriptions of samples. The sample sizes varied significantly between the papers from six participants to 52 participants. Two studies (Edge et al., 2004; Abrams & Curran, 2009) used identical samples of mothers but applied different analyses and reported those at different times and in different journals (Edge, 2008; Abrams & Curran, 2011). Therefore, the mothers in these studies were only included once.

Although studies clearly described data collection and justification, collection of data was a mixture of focus groups, semi-structured interviews, in-depth interviews and over-the-phone interviews. Although all these methods allow mothers to reflect on and report their experiences, they may differ in terms of the types of data they gather. For example, semi-structured interviews usually have a framework of themes or questions to be explored, whereas in-depth interviews are less structured and may only cover one or two themes but in more detail (Britten, 1995). Additionally, the use of telephone interviews in two studies (Taniguchi & Baruffi, 2007; Ahmed et al., 2008) may have provided mothers freedom in



disclosing information that would not be shared in a one-to-one situation. Length of the interviews differed greatly from 20 to 120 minutes. Some of the studies used interpreters to capture information; although the use of interpreters may create a potential loss of information in translation, mothers may feel more able to disclose additional information with interpreters present (Templeton et al., 2003). Overall, the studies demonstrated weaknesses in reporting reflexivity and explicitly stating which qualitative methodologies were employed. I included all papers in the review, however, because studies with weaker methodologies can still be of value in the synthesis process (Noblit & Hare, 1988). In addition, I included these studies because they met a minimum level of quality and would therefore not affect the credibility, transferability, dependability or confirmability of the findings (Walsh & Downe, 2006).

### **Metasynthesis**

There are several approaches for synthesising qualitative research. I chose Noblit and Hare's (1988) metasynthesis approach as an appropriate method for several reasons. It is one of the most developed methods as well as one of the most frequently used approaches to synthesise qualitative research findings (Bondas & Hall, 2007). All types of qualitative research can be synthesised using this approach, whilst allowing for the possible preservation of the interpretative properties of primary data. The approach is structured and specifies explicit guidelines for conducting a synthesis (see Appendix 6 for steps) and has been utilised successfully in several qualitative reviews (e.g., Beck, 2002).

I began by reading and re-reading the 15 papers several times. I then identified and extracted the themes and concepts from each individual study and put these into tables, so that they became the raw data for the synthesis. I compared the tables of themes and concepts from each study and identified how they were related to one another. I

performed the synthesis through three techniques: (1) Reciprocal translation, where I examined the key concepts across each study and attempted to translate the concepts into each other. A table detailing the key themes from each of the 15 studies enabled the reciprocal translations for the metasynthesis. (b) Refutational synthesis, where I identified and attempted to explain the contradictions between concepts. (c) Finally, 'lines of argument' synthesis where I built a general interpretation of the findings. I formulated overarching themes of the concepts from the original studies to present a new interpretation of the findings (Sandelowski & Barroso, 2006) in diagrammatic (Figure 1) and written form. I have summarised the key concepts and their relations to the overarching themes in Table 3 (see Appendix 7 for full table of key themes and concepts for each individual study).

**Table 3 here**

## **Results**

I found significant overlap of the concepts across all the studies regardless of the quality rating applied to them; as such I treated the concepts equally in their translations. The synthesis of the studies demonstrated that immigrant mothers are subjected to two overarching themes: migration factors and cultural influences. The cultural influences include three sub-themes of upholding gender roles, adherence to childbirth rituals and practices, and cultural beliefs and values. These cultural influences can be seen to create tension for mothers living in the western world. The migration factors appear to make mothers vulnerable to PND and comprise the following sub-themes: feeling alone, relationship conflict and real life worries. Mothers have to navigate through the interaction of these conflicting themes; and as they experience more of these factors or more conflict between these factors, there is an exacerbation of PND symptoms. Taken together, the

migration factors and cultural influences give rise to a psychosocial understanding of PND, viewing potential remedies lying within the psychosocial domain and healthcare barriers. As a result of these consequences, mothers can be seen to opt for self-help coping strategies.

**Figure 1 here**

### **Overarching Theme 1: Migration Factors**

Mothers in the studies described numerous stressors due to migration that were grouped into three sub-themes.

#### ***Migration Factors Sub-theme 1: Feeling Alone***

This sub-theme describes the immense loneliness and isolation mothers felt following the birth of their child. Mothers had migrated far away from their families, friends, neighbours and communities into a new, foreign country where they had no established social network. Some mothers had no support and no one who could offer respite or who they could confide in; and they missed having their loved ones around.

*“I miss the company of my family, friends, and relatives...I feel so alone.”* (Study 2)

*“I have no other friends to talk to.”* (Study 3)

Husbands were the only family member available to most women and mothers felt dependent on them to provide support. Mothers felt extremely alone and isolated with a real lack of social support or felt a significant change to their social support networks. They naturally viewed these as precipitants to their feelings of helplessness and in nine studies mothers attributed their loneliness and isolation to their PND.

*“I think [what causes depression after childbirth] is loneliness. Just feeling lonely, because you feel empty.” (Study 11)*

Mothers in five studies also perceived their reduced social support to blame in not being able to adhere to childbirth rituals.

*“I have no other friends or family to talk to. I feel exhausted and depressed. In my country, after childbirth, we rest for 40 days. Somebody comes to help us with the baby, with the other children, and with the housework. Here, I have to do everything myself.” (Study 3)*

Mothers in three studies experienced their lack of social support as a real life worry; with low income mothers experiencing partners’ absence or lack of involvement (Abrams & Curran, 2011) and mothers in another study (Morrow et al., 2008) described having a frightening lack of security or safety without their family.

*“Putting things together, I think the reason I became fearful is that I was concerned with the prospect that, if something happened to me, my baby would be all by herself, all alone. No one was nearby to assist. I had no one to turn to. I think I had no security, no sense of safety. If my parents and siblings had been here, I could call them up in times of emergency.” (Study 12)*

One significant exception was the study by Stewart and Jambunathan (1996), involving Hmong mothers who described high levels of spousal and relative support. However, not all the mothers experienced PND as the recruitment in this study allowed for the inclusion of

mothers without PND. Additionally, following the application of quality criteria, I classified this study as having a moderate risk of bias and gave less weight to this finding.

### ***Migration Factors Sub-theme 2: Relationship Conflict***

This sub-theme relates to family conflict experienced by mothers from migration, particularly with their husbands, their in-laws and sometimes with their own families.

Among mothers described feeling angry with their partners and families (Schaper et al., 2003).

*“I get mad because they make me feel like I am not able to do anything.” (Study 5)*

Mothers described wanting more emotional support from their husbands due to their reduced social network.

*“I wanted my husband to be like my friend, that I could share everything with him and that he would with me. And that we could spend at least some time together. I didn’t have big expectations, but even the smaller ones did not get fulfilled. He doesn’t recognize that he has a wife and he should take care of her or that his wife is having a baby. These things upset me a lot also. It was because of this that I became very depressed. I was wanting my husband to take care of me. I felt very alone. Sometimes I became so depressed that I thought I would do something to myself.” (Study 12)*

Husbands were not able to provide the emotional support desired by their wives for several reasons: working long hours and not being physically available, lacking PND knowledge or not feeling that emotional support was part of their role as a husband. This is

similar to the experiences discussed by the Bangladeshi mothers (Parvin et al., 2004) in whose culture husbands are not expected to help with child issues because it is seen as 'unmanly' and may result in negative views from the wider community (Parvin et al., 2004). Taniguchi and Baruffi (2007) noted that mothers often experienced conflict with their partners over their lack of understanding of the difficulties they were experiencing following the birth of their child. As described in the quote above, mothers viewed their PND in part as a result of these relationship difficulties (Schaper et al., 2003; Morrow et al., 2008).

*"Yes, I felt the pressure that I almost wanted to die, I felt the pressure mainly when I had to deal with my in-laws. I think my emotions would be calmer if they are not here." (Study 12)*

This is highlighted by mothers' perceptions that their family conflicts coincided with their PND. In particular, mothers reported that conflict with in-laws increased in the absence of their own family (Morrow et al., 2008).

*"My parents in-law were here with me, but since they were not my biological parents, I would not request them to do too much for me. I would need to accept whatever they offered me. I would not express my unhappiness."(Study 12)*

In general, women viewed their mother in-laws as unsupportive and unfair at a time when they needed support. This can be attributed to the traditional relationships and roles established between women and their mother-in-laws; where the daughter-in-law's role is to serve their mother-in-laws, and the mother-in-law is seen as an authority figure with a role to solely nurture her son (Morrow et al., 2008).

### ***Migration Factors Sub-theme 3: Real Life Worries***

This sub-theme was a theme taken from Abrams and Curran's study (2009) as I felt it appropriately incorporated all the other stressors that mothers portrayed as a result of migration. Mothers in three studies described a multitude of complications from migrating that impacted on their everyday life. These included language difficulties and barriers, living in a foreign country with an unfamiliar culture alongside complications from social and material contexts, such as financial difficulties, material deprivation and poverty, a lack of stable housing or dangerous housing, deskilling, unemployment or underemployment (Templeton et al., 2003; Morrow et al., 2008; Abrams & Curran, 2009). These were genuine worries for mothers that could impact on their ability to provide safety and security for themselves and their children.

“...they tell me not to stress when I have rent due and electricity, DWP (Department of Water and Power) and a car note and insurance and a baby behind me and you're telling me not to stress?” (Study 13)

As mentioned and illustrated earlier, mothers viewed their lack of social support and isolation as viewed as a real life worry.

### **Overarching Theme 2: Cultural Influences**

Despite living in a foreign country, away from their own culture, women in the studies maintained their cultural beliefs and values and tried to abide by the various cultural prescriptions and proscriptions attached to childbirth. Cultural influences were seen to create tension for mothers living in the western world; women in a few studies described conflicts between living in western society and their cultural influences. For example, Jordanian mothers expressed conflict between cultural practices and healthcare advice,

feeling pressured to follow advice from healthcare professionals but wanting to follow their traditions (Nahas & Amasheh, 1999). Bangladeshi mothers, expecting to be cared, for felt confused at being sent home from hospital so soon after giving birth (Parvin et al., 2004).

*“You need rest at that time and they just send you home”.* (Study 8)

Mothers across the reviewed studies described cultural influences that I categorised into the following three sub-themes.

### ***Cultural Influences Sub-theme 1: Upholding Gender Roles***

This sub-theme relates to the traditional female gender roles held in cultures, where the woman has multiple and uneven responsibilities of household work, nurturing the children, attending to family social relations and employment outside the home (Anderson & Reimer-Kirkham, 1998; Spitzer 2004). Four studies discussed traditional gender roles; these mothers tended to be from the Asian and African subcontinents. Generally, mothers felt under high expectations to cope with their new gendered role and the responsibilities of this role without objection. Mothers felt unsupported in their transition to this role without the support from their family. They described feeling overwhelmed in their attempts to fulfil their new role and were fearful of failure as this would result in them being viewed negatively by their family.

*“I have to cope with everything. I have to show them [family] that I am coping very well and that I am happy. If I say one bad thing about my life now, they will say I’m not good enough for my husband...”* (Study 3)



Mothers' overwhelming feelings, fear of failure, not feeling strong enough or in control of their new roles were perceived to be the trajectory that led to helplessness or depressed feelings for mothers (Nahas & Amasheh, 1999; Parvin et al., 2004). Mothers attributed their PND in part to the pressures of trying to fulfil this role.

*"You bring the baby home. You need to eat, the family need to eat, have to clean the house, have to wash the children, take them to school, take them to Arabic reading (classes). You have to do all this work in one day, how can you get rest? Is there time?" (Study 8)*

Morrow and colleagues (2008) noted that mothers themselves had high self-expectations of maternal role attainment; they did not ask for help and they masked their difficulties in order to maintain their role. Inevitably this placed further pressure on themselves; mothers described feeling stressed, which turned into sadness, anxiety and guilt. Mothers may feel obliged to conceal their distressing feelings for fears of causing family conflict or fears of alienation or isolation from their family. Mothers demonstrated this concealment was at the expense of personal sacrifices. Community expectations also served to exacerbate maternal ideals and compound mothers' feelings of helplessness (Morrow et al., 2008).

*"And there was this one lady and she would just... She asked me how I was doing, and I told her how it was so hard because I don't get enough sleep. And then she said, "Oh, well, all of us did it, and I don't know what difficulty you're finding, and you just have to organize yourself." And she almost implied that I wasn't good enough, or that I wasn't strong enough, and, you know, it was hard...She was trying to imply that I should pull up my socks and stop complaining and whining, and she made me feel that what I was saying was not legit." (Study 12)*

### ***Cultural Influences Sub-theme 2: Adherence to Childbirth Rituals and Practices***

Mothers in five studies discussed the cultural rituals and practices associated with childbirth. They wanted to adhere to the proscriptions of these rituals for fear of bad health or future health problems if they did not. However, living in western cultures made it difficult or more stressful for mothers to comply with them (Nahas & Amasheh; Nahas et al., 1999).

*“We have to rest for 40 days. At home people look after us (family, friends, paid helpers). They cook, clean, go to the market, help with other children, and lots of other work around the house.” (Study 3)*

Mothers felt that their lack of social support was responsible for their difficulties adhering to these rituals (Parvin et al., 2004). In contrast, the Hmong mothers felt less vulnerable to PND due to complying with their cultural practices (Stewart & Jambunathan, 1996). As previously mentioned this study did not set out to recruit mothers who were experiencing PND; the mothers in this study also reported high levels of support.

### ***Cultural Influences Sub-theme 3: Cultural Beliefs and Values***

This final sub-theme includes various beliefs, values, myths and stereotypes attached to culture that mothers held and were common to nine of the studies reviewed. These were most often in relation to mothers' views of PND, perceptions of healthcare and the management of their difficulties.

Cultural beliefs held about PND were negative and stigmatising, based on myths and stereotypes. For example, African American and Black Caribbean mothers held beliefs of

PND as a moral failure and an internal weakness which were counter to the views of themselves as strong Black women (Amankwaa, 2003).

*“But so two things, in African-American culture, the idea of being able to handle your own problems and black women being strong and able to, you know, what you need to do, and no time to talk about being depressed” (Study 4)*

African American women did not perceive PND as a valid illness and believed in myths that PND only happened to white women (Edge, 2008).

*“I mean, I’ve never met a Black person who’s said they’ve got it [PND].” (Study 10)*

As a result of holding such myths and perceiving a stigma attached to PND, mothers were unable to recognise depression in themselves, or saw PND as extremely damaging that they minimised, normalised and masked their difficulties to protect their self-concepts of being strong.

Mothers in other studies reported cultural values that impacted on the way in which they managed their PND. For example, some cultures prohibit open discussion of PND in line with PND being viewed negatively (Abrams et al., 2009). The Hmong culture has a highly developed code of privacy, with beliefs and cultural norms that bad things should not be discussed and that talking about it makes it worse (Schaper et al., 2003).

*“You grow up with a family, traditions, the customs that tell you you’re not to express so much. It’s hard to go to counsellors even if you believed they could help you.” (Study 5)*

Hmong mothers comply with these values and cope through silence and hope it disappears (Nahas & Amasheh, 1999). Similarly, Bangladeshi mothers indicated that discussing practical or emotional problems signifies a weakness and failure in their role (Parvin et al., 2003). Mothers also discussed cultural restrictions of limited outings and rarely being allowed to go out alone or unaccompanied (Templeton et al., 2003) and felt it was their duty to “carry on” with their roles without accessing help. These restrictions were certainly thought to affect whether mothers sought help for their PND.

Each culture has its own belief system about health and illness, which underpin health-related behaviours (Helman, 2007). Other cultural values and beliefs identified pertained to perceptions of healthcare as being unacceptable. Latina mothers described a family ethic of rejecting mental health services, needing the husband’s approval to seek help and potential shame for accessing help (Abrams et al., 2009).

*“I don’t know I think sometimes we are ashamed, for the majority of us we are ashamed to talk about a certain family problem with someone that you don’t know.” (Study 14)*

African Americans rejected professional or mental healthcare, viewing it as a bad investment that is frowned upon by culture (Abrams et al., 2009). Within the Hmong culture medications are viewed as inappropriate, because suffering is inevitable and illness results from the soul or spirit (Schaper et al., 2003). Medication also holds a stigma for the Hmong mothers and her family; with fears of being labelled as “crazy”. Antidepressants and western medicine were viewed negatively by families and cultures in several studies with preferences for natural remedies (Schaper et al., 2003; Morrow et al., 2008; Abrams et al., 2009).

*“I just...medicine and me, Western medicine and me, you know my whole life I tried to tolerate pain and do without it, because I really do believe in natural healing - ayurvedic or homeopathic, so I’m not really into this strong Western medicine, even such things like antibiotics or headache pills. I never in my life did take them.”*

(Study 12)

These cultural sub-themes demonstrate that culture comprises an important context to consider with cultural expectations, rituals, beliefs, values and norms for emotional responses and behaviour all affecting mothers’ experiences of PND and their help-seeking.

### **Consequences of Migration Factors and Cultural Influences**

The migration factors and cultural influences can be seen to interact and conflict with one another, influencing mothers’ understandings of PND, their view of potential remedies and creating healthcare barriers.

#### ***Consequence 1: Psychosocial Understanding of PND***

It was evident that none of the mothers in the studies reviewed reported holding a biomedical model of PND; and instead favoured a psychosocial aetiology for their PND.

*“I didn’t think like that...that I had a problem. I didn’t think that this thing was a disease. I thought I was anxious because it was hot in India and because I was in an enclosed house with no light. This is what I thought was causing my anxiety. I didn’t think it was a disease, but here [in Canada] the doctors are saying it is a disease.”*

(Study 12)

Mothers in the majority of the studies outlined social, situational, contextual or cultural attributes for their PND. Social factors included isolation, lack of social support, loneliness, family conflict and no respite (e.g. Nahas et al., 1999; Schaper et al., 2003; Morrow et al., 2008).

*“This time I was very sad after the birth. Nobody helped me. I had to help myself for everything. When I gave birth to my first child, my mother was there to help me. This time I was all by myself.” (Study 12)*

Situational and contextual factors mothers cited comprised of being in an unfamiliar and new culture (e.g., Ahmed et al., 2008), poor education, insufficient incomes, financial pressure, worries or poverty, demands from low economic status and managing bureaucracy, services and systems (Abrams & Curran, 2009; 2011).

*“I guess it depends on the level of depression you have 'cause with me, my depression is, I think, totally different. That's me from not working, from not havin' a car, not havin'—you know, money just to go out and have a good time, go out to eat, shop...You know, and I'm poor.”(Study 13)*

As expected mothers from low income backgrounds tended to cite more of these situational and contextual causes and described an accumulation of stressors including feeling alone, feeling out of shape, and mounting mental, physical and external stressors. For these mothers their explanatory frameworks of PND explicitly alluded to their worries about supporting themselves and their children.

Mothers also described the impact of cultural factors and felt overwhelmed in response to their role and their multiple responsibilities of caring for their children. This indicates that mothers attributed their PND to both migration factors and cultural factors.

### ***Consequence 2: Healthcare Barriers***

This sub-theme illustrates the number of barriers to help-seeking that were identified in the studies; mothers described that they were up against several struggles in accessing help. The first barrier related to a reported lack of knowledge regarding available services and support:

*“I don’t know what support is out there” (Study 6)*

Black Caribbean mothers illustrated this lack of knowledge through their fears of healthcare and mental health services which were linked to worries about being labelled (Edge et al., 2004).

*“I’m very much aware that black people are more likely to be labelled as having psychiatric problems...They’re not recognised with postnatal depression, but yet they recognise other [more serious] forms of psychiatric problems quite readily...Therefore I don’t want people labelling me...you know what I mean?  
(Study7)*

Bangladeshi mothers viewed their G.P., health visitor and midwife as physical healthcare and therefore only discussed physical health problems with them (Parvin et al., 2004).

*“Well you won’t tell [the G.P.] your innermost problems. You might say, ‘I couldn’t sleep at night, because of pain, because of this and this.” (Study 8)*

Tied into this lack of knowledge about mental health services and support was the second barrier identified: little or no understanding of PND (Nahas et al., 1999; Edge, 2008).

*“I don’t know what PND is...I don’t know what PND is supposed to be, how you’re supposed to feel, look or whatever, I don’t know. I have no idea” (Study 7)*

In addition to fears around healthcare and mental health services, mothers described hesitation and fear around mental health terms and PND. This was linked to views of a stigma attached to PND and fears of being perceived as a bad mother or the possibility of having their child removed (Ahmed et al., 2008).

*My biggest concern is that people will think I’m crazy or that I’m not normal and then they’re going to come to the conclusion that I’m not able to take care of my child and then they’re going to take my child from me. That’s the biggest reason why I didn’t go and seek help. (Study 11)*

The third barrier relates to language difficulties and mothers perceived that not speaking English prevented access to services and support. This perception is consistent with literature (Dennis & Leinic, 2006).

*“Sometimes when you have a baby, a woman comes from the hospital. Bengali girls don’t come with the midwife, we don’t understand what they say, we just sit there staring at their faces.” (Study 8)*



Instrumental barriers were the final barriers recognised and included financial strains, childcare issues and transportation costs (Edge, 2008; Abrams et al., 2009).

It is important to note that in a few studies, some mothers overcame the barriers and accessed healthcare services. This, however, appeared to not be through choice and mothers turned to healthcare due to the limited effectiveness of non-medical input (Edge et al., 2004), as a result of having suicidal or infanticide thoughts (Amankwaa, 2003) and due to symptoms persisting (Ahmed et al., 2008). It is still important to consider that when mothers' difficulties became long-standing and more severe, they were able to access help. It may be that these mothers felt that they had no other choice and this superseded their fears and perceptions of barriers. When mothers turned to professionals, however, they had mixed experiences, mothers generally found healthcare helpful but felt that their GPs were too busy and had limited time for them (Ahmed et al., 2008; Morrow et al., 2008). This may have served to reinforce views of healthcare as uncaring or inappropriate.

*“Well to be frank I don’t think the doctors here have time to really help you with these problems. When I went for my check-ups, the doctor spent literally three minutes with me and that’s it. They are so busy with other cases; you don’t feel like you can discuss these problems with them.” (Study 11)*

### ***Consequence 3: View of Potential Remedies and Coping Strategies***

In line with mothers' predominant psychosocial attributions for their PND, their views of medication as unhelpful and their cultural beliefs of not discussing depression; mothers felt that recovery lay within the psychosocial domain. This sub-theme illustrates the multiple and variety of self-care resources that mothers employed as alternatives to medical input. The coping strategies that mothers used were grouped as either 'internal' or 'external'

resources. Internal resources included various self-help coping strategies, such as asserting positive identities, maintaining self-concept, personal agency and mastery (Edge et al., 2004). In Abrams and Currans's study (2011) mothers used various techniques including prioritising their child and their child's needs, and self-sacrifice, creating a self-image as engaged mothers who invest time in their children and finding mothering pleasurable; dealing with conflicting views of self through comparing self to others, relational approaches and externalising their PND.

*"So whatever is going on with me is getting pushed out of the way for the two kids that I have. I will go to bat for my children."* (Study 15)

*"For me it's more taking care of kids and making sure that, you know, that they have my love, my attention, my belief that they want from me and everything."*  
(Study 15)

Other internal strategies included "keeping themselves happy" (Parvin et al., 2004), silence or avoiding discussions about difficulties (Schaper et al., 2003; Parvin et al., 2004). In addition, some mothers used various emotional, cognitive, behavioural strategies as well as educating themselves about PND (Abrams et al., 2009). Religious coping could be seen as either an internal or external resource. Many of the mothers felt that religious coping or affiliation helped in their recovery in providing strength, comfort and healing (Parvin et al., 2004; Taniguchi & Baruffi, 2007; Abrams et al., 2009).

*"Some of the Christian sisters, they've had depression symptoms and the church has taken it all away. So when you start to experience the symptoms of depression, to the people who have suffered from depression, you need to start hearing Christian*

*music and pray to God. . . . So that is what has helped me so I don't pay attention when I get those symptoms. I tell myself that this will not happen to me and it will pass. I lift my self-esteem myself."* (Study 14)

External resources included family, friends, god and community support. Social support was seen by several mothers to be a potential remedy in accordance with their views that their loneliness and isolation caused their PND. Some mothers wanted social support from their own mothers and husbands, other mothers viewed support outside the family via community support groups or more practical support (Nahas et al., 1999) as possible solutions (Ahmed et al., 2008; Abrams et al., 2009). Mothers reported finding solace from others in their own cultural groups using community centres (Nahas et al., 1999; Ahmed et al., 2008; Abrams et al., 2009).

*"Being in the centre felt good because I can take my mind off my worries and my loneliness because I do not have any family support who I can talk to."* (Study 3)

*"I think that the thing the I looked most for [in a community service or support centre] was something that allowed me to meet people, just get out of the house and meet others, like new mothers, people that I could speak to...people who are in the same position as myself, who are learning to be a new mom, dealing with the stressors of that, that's good."* (Study 11)

The African American mothers, despite not being religious, used community-based and religious coping and support from black-led churches and faith communities (Edge et al., 2004).

*“...the support brought me through it, believe me – the support pulled me through it! There’s no doubt about it! I was reading my bible and I do follow, like, the Rastafarian faith.” (Study 10)*

Regardless of the type of support sought, it was clear that mothers attempted to overcome their extreme loneliness using various types of social contact. Overall, it was evident that immigrant mothers were extremely resourceful and proactive in the coping strategies they employed.

## **Discussion**

The purpose of this review was to synthesise qualitative studies exploring PND in immigrant mothers living in western countries. I chose to focus on qualitative studies in order to gain better insight into the inner worlds of these mothers and to enrich the findings from these existing qualitative studies. The synthesis of these 15 studies demonstrated that immigrant mothers are subjected to two overarching factors of migration and cultural influences that interact and conflict with one another creating healthcare barriers, mothers’ understandings of their PND and impacting on their views of potential solutions. It was evident that cultural influences and migration factors influenced one another and did not exist in isolation.

Social support appeared to play an integral and mediating role for immigrant mothers; with mothers perceiving that their lack of social support caused several difficulties. Firstly, mothers in many of the studies saw their lack of social support, loneliness and isolation as causal for their PND and in line with this sought out social support via several avenues to counteract and help remedy their symptoms; and saw benefits from accessing this support. Secondly, mothers also blamed their lack of social support for their difficulties in adhering

to childbirth rituals and fulfilling their gender roles. Finally, a lack of social support was seen by some as a real life worry because it played a role in their relationship difficulties. Social support is a recognised determinant of psychological and physical health (Thornton, Kieffer, Salabarria-Pena, Odoms-Young, Willis, Kim, & Salinas, 2006; Dennis & Hodnett, 2008).

There is a strong relationship between social support and PND in non-immigrant mothers and it has been identified as a major risk factor for PND in all mothers (O'Hara & Swain, 1996). According to Surkan, Peterson, Hughes and Gottlieb (2006), it is important to consider social networks as possible mediators to PND given that social support and networks are significantly related to PND. However, the loss of social support in immigrant mothers may be greater or methods of increasing social support may be more difficult to implement due to their immigrant status. Stuchberry, Matthey and Barnett (1998) suggest that the type of social support and its significance may vary according to the mother's cultural background and that culture may generate expectations of support or even contribute to a mother's high expectations and her consequential feelings of failure. They concluded that cultural factors can be seen to intervene between social supports and PPD.

The synthesis unexpectedly revealed many similarities between immigrant mothers and non-immigrant mothers in numerous areas. Immigrant mothers' difficulties or experiences, however, appear to be compounded by migration factors. Immigrant mothers' psychosocial frameworks of their difficulties indicate that they attribute their PND to similar causes as non-immigrant mothers. Non-immigrant mothers tend to assign various psychosocial factors as causes for their PND; for example, changed relationships (Chew-Graham, Sharp, Chamberlain, Folkes & Turner, 2009), work ethic (Hanley & Long, 2006) and problematic relationships with partners and mothers (Bultjens, & Liamputtong, 2007). Many cultures do not endorse beliefs as PND being a 'medical' condition that needs medical intervention (Holopainen, 2002; Rodrigues et al., 2003; Thome, 2003; Ugarriza, 2004). This lack of

recognition may result in immigrant mothers dismissing or denying their distress and symptoms (Chan et al., 2002; Rodrigues et al., 2003). Again, non-immigrant mothers frequently report this but this is thought to be more common amongst mothers from non-western countries where there is less emphasis on medicine.

Immigrant mothers' views of healthcare and medication are comparable to those from mothers in the western world who share perceptions about antidepressants being stigmatising (Turner, Sharp, Folkes & Chew-Graham, 2008). Healthcare services, particularly mental health services, hold a stigma within cultures and mothers avoided accessing services not only due to conflict with personal beliefs and values, but also due to fear of being alienated by others and bringing shame to the family. This is consistent with studies that have demonstrated that shame, stigma, and the fear of being labelled mentally ill are significant deterrents to seeking or accessing help (Chan et al., 2002; Ugarriza, 2004). This perceived stigma is not unique to non-immigrant mothers but these mothers may be more fearful of being alienated and isolated in a foreign country by the only few people known to them.

Existing research indicates that similar to immigrant mothers, non-migrant mothers and mothers from diverse cultures are not proactive in their health-seeking behaviours (Chan et al., 2002; Chan & Levy, 2004; Dennis & Leinic, 2006; McCarthy & McMahon, 2008). This may be more pronounced in immigrant mothers in unfamiliar and unknown healthcare systems. Likewise, mothers' fears of having their baby removed are not exclusive to immigrant mothers but these concerns might be heightened in immigrant women due to them not understanding the healthcare and social services systems of their new home country. Reasons for migration may play an additional role here; if women have fled their

home countries because of rape and violence endorsed by authorities, they are likely to be reluctant to trust any other government services.

It is interesting to note that the healthcare barriers reported by mothers in the reviewed studies reflect those barriers perceived by healthcare workers. Teng and colleagues (2007) examined healthcare barriers for recent immigrants with PND from a healthcare provider's perspective and divided the types of barriers into 'practical barriers' and 'cultural barriers'. Additionally, O'Connor and colleagues (2002) found that healthcare providers viewed cultural values as the barrier that was most complicated and difficult to address, and identified two related categories within this concept: internal and external conflicts. Internal conflicts related to difficulties reconciling needs with their own beliefs or values and external conflicts existed when the mother's needs conflict with others' desires and expectations, or her perception of these desires and expectations. Mothers in the studies reviewed described both types of conflicts, internal ones in relation to meeting their own maternal ideals and external conflicts of trying to meet family expectations. This observation suggests that healthcare workers have rich insight into mothers' barriers and need to be using appropriate strategies to overcome the known barriers.

### **Limitations of a Metasynthesis Approach**

I will discuss some of the limitations attached to a metasynthesis approach because there has been much debate around synthesising qualitative research (Sandelowski, Docherty & Emden, 1997) and the majority of the steps in the metasynthesis process. Contention exists regarding whether or not it is appropriate to review and integrate qualitative studies that originate from different traditions. It has been argued that there is a need for studies to have similar methodologies for successful synthesis to happen and to avoid difficulties in theory development because of epistemological differences. Additionally, Sandelowski and

colleagues (1997) propose that summarising qualitative studies destroys the original findings. In contrast, Walsh and Downe (2005) suggest that it may be helpful to view metasynthesis as a process that opens up spaces for new insights and understandings to emerge. Indeed, this has been indicated from the various successful metasynthesis studies (e.g. Beck, 2002) derived from studies with different methodologies. The most essential part is that the methodology developed to synthesise qualitative research is appropriate to the research being integrated. I chose Noblit and Hare's (1988) approach because it sanctions the synthesis of all types of qualitative research whilst allowing for the possible preservation of the interpretative properties of primary data. This enabled the synthesis of studies which used diverse methods of grounded theory, thematic analysis and content analysis. Metasynthesis focuses on the researcher's interpretations in both developing understandings from several qualitative studies and achieving theoretical development beyond that achieved in any individual study. The themes derived in this review are therefore a product of my own interpretations and thus introduce a level of subjectivity and possibly bias. However, Noblit and Hare's (1988) approach acknowledges that resulting findings are partial and positional on the part of the researcher. I attempted to provide clarity and transparency through the including the tables of extracted themes and concepts.

One of the most contentious stages of the metasynthesis approach is the use of quality criteria to appraise qualitative studies. The use of such criteria can be seen to introduce bias as the researcher has to decide how well the individual studies meet the criteria. Despite this, I felt it was important to apply some type of quality rating criteria to weight the studies included in the review. I tried to ensure external validity of the studies included through the use of an independent researcher to rate the studies against the criteria. Regardless of the tensions surrounding metasynthesis approaches, there appears to be a



consensus that it is worth doing and that the findings can add to the general sum of knowledge (Downe, 2008).

### **Clinical Implications**

There is no easy or straightforward solution in providing effective care to immigrant mothers. These mothers experience conflict between receiving healthcare services, particularly mental health services with their cultural values and beliefs. Perhaps what services need to think about is the provision of services that fit in with maternal perceptions of solutions. For example, social support via community centres which will overcome their feelings of isolation and provide social networks for these immigrant women who feel terribly lonely. Services could combine this with practical help to overcome instrumental barriers including arranging transportation, childcare or someone to accompany the immigrant mother to the location.

Healthcare professionals need to be culturally competent and understand the conflicts that may be pertinent to these mothers as a result of their cultural values. This will help to understand these mothers better, engage them easier and help in facilitate breaking down the conflicts.

### **Conclusions**

Immigrant mothers living in western countries are subject to multifaceted and multifactorial stressors following the birth of their child, possibly making them more susceptible to developing PND and influencing their subsequent healthcare behaviour. These stressors are related to migration or being an immigrant in a western society as well as cultural influences, which are harder to comply with as an immigrant living in a different

country, removed from their sociocultural context. Social support appears to play an integral and mediating role for these immigrant mothers living in western countries.

## **References**

Abrams, L. S., & Curran, L. (2009). And you're telling me not to stress? A grounded theory study of postpartum depression symptoms among low-income mothers. *Psychology of Women Quarterly, 33*, 351–362.

Abrams, L. S., Dornig, K., & Curran, L. (2009). Barriers to service use among low-income ethnic minority mothers in the United States. *Qualitative Health Research, 19* (4), 535-551.

Abrams, L. S., & Curran, L. (2011). Maternal identity construction among low-income mothers with symptoms of postpartum depression. *Qualitative Health Research, 21* (3), 373-385.

Ahmed, A., Stewart, D. E., Teng, L., Wahoush, O., & Gagnon, A. J. (2008). Experiences of immigrant new mothers with symptoms of depression. *Archives of Women's Mental Health, 11*, 295–303.

Amankwaa, L. C. (2003). Postpartum depression, culture, and African–American women. *Journal of Cultural Diversity, 10*, 23–29.

Anderson, J. M., & Reimer-Kirkham, S. (1998). Constructing nation: the gendering and racializing of the Canadian health care system. In V. Strong-Boag, S. Grace, A. Eisenberg, & J. Anderson (Eds.), *Painting the Maple: Essays on Race, Gender and the Construction of Canada* (pp. 242–261). Vancouver, BC: UBC Press.

Astbury, J., Brown S., Lumley, J., & Small, R. (1994) Birth events, birth experiences and social differences in postnatal depression. *Australian Journal of Public Health, 18*, 176–84.

- Barclay, L., & Kent, D. (1998). Recent immigration and the misery of motherhood: a discussion of pertinent issues. *Midwifery, 14*, 4–9.
- Beck, C. T. (1992). The lived experience of postpartum depression: A phenomenological study. *Nursing Research, 41*, 166-170.
- Beck, C. T. (1993). Teetering on the edge: A substantive theory of postpartum depression. *Nursing Research, 42*, 42-48.
- Beck, C. T. (2001). Predictors of postpartum depression: an update. *Nursing Research, 50*, 275–285.
- Beck, C. T. (2002). Postpartum depression: A metasynthesis. *Qualitative Health Research, 12* (4), 453-472.
- Beck, C. T. (2007). Exemplar: Teetering on the edge: a continually emerging theory of postpartum depression. In P. L. Munhall (Eds.), *Nursing research: A qualitative perspective* (pp. 273–292). Sudbury, MA: Jones and Bartlett.
- Berry, J. W. (1997). Immigration, acculturation, and adaptation. *Applied Psychology: An International Review, 46*, 5–34.
- Bina, R. (2008). The Impact of Cultural Factors upon Postpartum Depression: A Literature Review. *Health Care for Women International, 29* (6), 568–592.

Bondas, T., & Hall, E. (2007). A decade of metasynthesis research in health sciences: A meta-method study. *International Journal of Qualitative Studies on Health and Well-being*, 2, 101–113.

Britten, N. (1995). Qualitative interviews in medical research. *BMJ*, 311, 251-253.

Buultjens, M., & Liamputtong, P. (2007). When life starts to take the life out of you: women's experiences of depression following childbirth. *Midwifery*, 23, 77-91.

Critical Appraisal Skills Programme (CASP; 2002). *Making sense of evidence*. London, UK: Oxford.

Chan, S. W. C., Levy, V., Chung, T. K. H., & Lee, D. (2002). A qualitative study of the experiences of a group of Hong Kong Chinese women diagnosed with postnatal depression. *Journal of Advanced Nursing*, 39, 571–579.

Chan, S., & Levy, V. (2004). Postnatal depression: a qualitative study of the experiences of a group of Hong Kong Chinese women. *Journal of Clinical Nursing*, 13, 120–123.

Chen, C. H., Wang, S. Y., Chung, U. L., Tseng, Y. F., & Chou, F. H. (2006). Being reborn: the recovery process of postpartum depression in Taiwanese women. *Journal of Advanced Nursing*, 54 (4), 450–456.

Cheung, F. K., & Snowden, K. R. (1990). Community mental health and ethnic minority populations. *Community Mental Health Journal*, 26, 277–291.

Chew-Graham, C. A., Sharp, D., Chamberlain, E., Folkes, L., & Turner, K. M. (2009).

Disclosure of symptoms of postnatal depression, the perspectives of health professionals and women: a qualitative study. *BMC Family Practice*, *10*, 1-9.

Colaizzi, P. (1978). Psychological research as the phenomenologist views it. In R. Valle & M. King (Ed.), *Existential Phenomenological Alternative for Psychology* (pp. 48-71). New York: Oxford University Press.

Collins, C. H., Zimmerman, C., & Howard, L. M. (2011). Refugee, asylum seeker, immigrant women and postnatal depression: rates and risk factors. *Archives of Womens Mental Health*, *14*, 3–11.

Cox, J. L. (1996). Perinatal mental disorder: A cultural approach. *International Review of Psychiatry*, *18* (1), 9–26.

Dale, T. (2003). Considering an expat assignment? *Velocity*, *5*, 32–35.

Dennis, C-L. E., Janssen, P., & Singer, J. (2004). Identifying women at risk for postpartum depression in the immediate postpartum period. *Acta Psychiatrica Scandinavica*, *110*, 338–346.

Dennis, C-L. E., & Leinic, C. L. (2006). Postpartum depression help-seeking barriers and maternal treatment preference: A Qualitative Systematic Review. *Birth*, *33*, 323–331.

Dennis, C-L. E., & Hodnett, E. (2008). Psychosocial and psychological interventions for preventing postpartum depression. *Cochrane Database Systematic Reviews*, 2007, Issue 4.

Department of Health [DH] (1998), *Modernising Health and Social Services: National Priorities Guidance*. London: Department of Health.

Downe, S. (2008). Metasynthesis: A guide to knitting smoke. *Evidence Based Midwifery*, 6, 4–8.

Edge, D., Baker, D., & Rogers, A. (2004). Perinatal depression among black Caribbean women. *Health & Social Care Community*, 12 (5), 430-438.

Edge, D. (2008). 'We don't see Black women here': an exploration of the absence of Black Caribbean women from clinical and epidemiological data on perinatal depression in the UK. *Midwifery*, 24, 379–389.

Fisch, R. Z., Tadmor, O. P., Dankner, R., & Diamant, Y. Z. (1997). Postnatal depression: a prospective study of its prevalence, incidence and psychosocial determinants in an Israeli sample. *Journal of Obstetric and Gynaecological Research*, 23, 547–54.

Fung, K., & Dennis, C. L. (2010). Postpartum depression among immigrant women. *Current Opinion in Psychiatry*, 23, 342–348.

Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory*. New York: Aldine.

Glaser, B. G. (1978). *Theoretical sensitivity: advances in the methodology of grounded theory*. Sociology Press, Mill Valley, CA.

Halbreich, U., & Karkun, S. (2006). Cross-cultural and social diversity of prevalence of postpartum depression and depressive symptoms. *Journal of Affective Disorders, 91*, 97–111.

Hanley, J., & Long, B. (2006). A study of Welsh mothers' experiences of postnatal depression. *Midwifery, 22*, 147-157.

Hanlon, C., Whitley, R., Wondimagegn, D., Alem, A., & Prince, M. (2009). Postnatal mental distress in relation to the sociocultural practices of childbirth: an exploratory qualitative study from Ethiopia. *Social Sciences Medicine, 69* (8), 1211-1219.

Helman, C. (2007). *Culture, health and illness* (5th Ed.). London: Hodder Arnold.

Holopainen, D. (2002). The experience of seeking help for postnatal depression. *Australian Journal of Advanced Nursing, 19*, 39–44.

Hopkins, J., Marcus, M., & Campbell, S. B. (1984). Postpartum depression: A critical review. *Psychological Bulletin, 95* (3), 498-515.

Klainin, P., & Arthur, D. G. (2009). Postpartum depression in Asian cultures: a literature review. *International Journal of Nursing Studies, 46* (10), 1355-1373.

Knafl, K., & Webster, D. (1988). Managing and analyzing qualitative data: A description of tasks, techniques and materials. *Western Journal of Nursing Research, 10*, 195-218.



Leininger, M. (1991). *Culture care diversity and universality: A theory of nursing*. New York: National League for Nursing Press.

Li, H. Z., & Browne, A. J. (2000). Defining mental illness and accessing mental health services: perspectives of Asian Canadians. *Canadian Journal of Community Mental Health* 19, 143–159.

McCarthy, M., & McMahon, C. (2008). Acceptance and Experience of Treatment for Postnatal Depression in a Community Mental Health Setting. *Health Care for Women International*, 29, 618 – 637.

Morrow, M., Smith, J. E., Lai, Y., & Jaswal, S. (2008). Shifting landscapes: immigrant women and postpartum depression. *Healthcare for Women International*, 29, 593–617.

Nahas, V., & Amasheh, N. (1999). Culture care meanings and experiences of postpartum depression among Jordanian Australian women: a transcultural study. *Journal of Transcultural Nursing*, 10, 37–45.

Nahas, V., Hillege, S., & Amasheh, N. (1999). Postpartum Depression: The lived experiences of Middle Eastern migrant women in Australia. *Journal of Nurse-Midwifery*, 44, 65-74.

Noblit, G. W., & Hare, R. D. (1988). *Meta-ethnography: Synthesizing Qualitative Studies*. Newbury Park, CA: Sage Publications.

Norwood, S. (2000). *Research and Strategies for Advanced Practice Nurse*. Upper Saddle River, NJ: Prentice Hall Health.

O'Connor, K. M., De Dreu, C. K. W., Schroth, H., Bruce, B., Lituchy, T. R., & Bazerman, M. H. (2002). What we want to do versus what we think we should do: An empirical investigation of intrapersonal conflict. *Journal of Behavioural Decision Making* 15, 403–418.

O'Hara, M. W., & Swain, A. M. (1996). Rates and risk of postpartum depression: A meta-analysis. *International Review of Psychiatry*, 8, 37–54.

O'Mahony, J. M., & Donnelly T. T. (2007). The influence of culture on immigrant women's mental health care experiences from the perspectives of health care providers. *Issues in Mental Health Nursing*, 28, 453–471.

Onozawa, K., Kumar, R. C., Adams, D., Dor'e, C., & Glover, V. (2003). High EPDS scores in women from ethnic minorities living in London. *Archives of Women's Mental Health*, 6 (2), 51–55.

Parvin, A., Jones, C. E., & Hull, S. A. (2004). Experiences and understandings of social and emotional distress in the postnatal period among Bangladeshi women living in Tower Hamlets. *Family Practitioner*, 21 (3), 254-260.

Robertson, E., Grace, S., Wallington, T., & Stewart, D. E. (2004). Antenatal risk factors for postpartum depression: a synthesis of recent literature. *General Hospital Psychiatry* 26, 289–295.

Robinson, G. E. & Stewart, D. E. (2001). Postpartum disorders. In N. L. Stotland & D. E. Stewart (Eds.) *Psychological aspects of women's health care* (pp. 117-139). Washington, DC: American Psychiatric Press, Inc.

Rodrigues, M., Patel, V., Jaswal, S., & de Souza, N. (2003). Listening to mothers: qualitative studies on motherhood and depression from Goa, India. *Social Science Medicine*, 57 (10), 1797-1806.

Rubin, R. (1984). *Maternal Identity and Maternal Experience*. New York: Springer.

Sandelowski, M., & Barroso, J. (2006). *Handbook for synthesizing qualitative research*. New York, NY: Springer.

Sandelowski, M., Docherty, S., & Emden, C. (1997). Focus on qualitative methods. Qualitative metasynthesis: issues and techniques. *Research in Nursing & Health*, 20, 365-371.

Schaper, A., Murphy, P., & Truscott, V. (2003). Postpartum distress among Hmong women living in La Crosse, Wisconsin. *Gunderson Lutheran Medical Journal*, 2 (1), 20-24.

Seel, R. M. (1986). Birth Rite. *Health Visitor*, 69, 135-138.

Small, R., Lumley, J., & Yelland, J. (2003). Cross-cultural experiences of maternal depression: associations and contributing factors for Vietnamese, Turkish and Filipino immigrant women in Victoria, Australia. *Ethnicity & Health*, 8, 189–206.

Speigelberg, H. (1975). *Doing phenomenology*. The Hague: Martinus Nijhoff.

Speigelberg, H. (1976). *The phenomenological movement*. Volume 2. The Hague: Martinus Nijhoff.

Spitzer, D. (2004). In visible bodies: minority women, nurses, time and the new economy of care. *Medical Anthropology Quarterly*, 18, 490–508.

Stern, G., & Kruckman, L. (1983). Multidisciplinary perspectives on postpartum depression: an anthropological critique. *Social Science & Medicine*, 17, 1027– 1041.

Stewart, S., & Jambunathan, J. (1996). Hmong women and postpartum depression. *Health Care for Women International*, 17, 319-330.

Stuchberry, M., Matthey, S., & Barnett, B. (1998). Postnatal depression and social supports in Vietnamese Arabic and Anglo-Celtic mothers. *Social Psychiatry Psychiatric Epidemiology*, 33, 483–490.

Surkan, P. J., Peterson, K. E., Hughes, M. D., & Gottlieb, B. R. (2006). The role of social networks and support in postpartum women's depression. *Maternal and Child Health Journal*, 10 (4), 375-383.

Taniguchi, H., & Baruffi, G. (2007). Childbirth overseas: The experience of Japanese women in Hawaii. *Nursing and Health Sciences*, 9, 90-95.

Templeton, L., Velleman, R., Persaud, A., & Milner, P. (2003). The experiences of postnatal depression in women from black and minority ethnic communities in Wiltshire, UK. *Ethnicity & Health*, 8 (3), 207–221.

Teng, L., Robertson Blackmore, E., & Stewart, D. (2007). Healthcare worker's perceptions of barriers to care by immigrant women with postpartum depression: an exploratory qualitative study. *Archives of Women's Mental Health, 10*, 93–101.

Thome, M. (2003). Severe postpartum depression in Icelandic mothers with difficult infants. A follow-up study on their healthcare. *Scandinavian Journal Caring Sciences, 17*, 104–112.

Thornton, P. L., Kieffer, E. C., Salabarría-Pena, Y., Odoms-Young, A., Willis, S. K., Kim, H., & Salinas, M. A. (2006). Weight, diet, and physical activity-related beliefs and practices among pregnant and postpartum Latino women: The role of social support. *Maternal and Child Health Journal, 10*, 95-104.

Tummala-Narra, P. (2004). Mothering in a foreign land. *American Journal of Psychoanalysis, 64*, 167–182.

Turner, K. M., Sharp, D., Folkes, L., & Chew-Graham, C. (2008). Women's views and experiences of antidepressants as a treatment for postnatal depression: a qualitative study. *Family Practice 2008, 25*, 450–455.

Ugarriza, D. N. (2004). Group therapy and its barriers for women suffering from postpartum depression. *Archives of Psychiatric Nursing, 18*, 39–48.

Vissandjee, B., Desmeules, M., Cao, Z., Abdool, S., & Kazanjian, A. (2004). Integrating Ethnicity and Migration as Determinants of Canadian Women's Health. *Women's Health, 4*, (1), 32-42.

Walsh, D., & Downe, S. (2005). Metasynthesis method for qualitative research: A literature review. *Journal of Advanced Nursing, 50*, 204–211.

Walsh, D., & Downe, S. (2006). Appraising the quality of qualitative research. *Midwifery 22* (2), 108–119.

Wiklund, H., Aden, S. A., Hogberg, U., Wikman, M., & Dahlgren, L. (2000). Somalis giving birth in Sweden: a challenge to culture and gender specific values and behaviours. *Midwifery, 16*, 105–115.

Zelkowitz, P., Saucier, J. F., & Wang, T., (2008). Stability and change in depressive symptoms from pregnancy to two months postpartum in childbearing immigrant women. *Archives of Women's Mental Health, 11*, 1–11.

**Table 1: An Overview of the Inclusion and Exclusion Criteria Applied**

Parameters	Inclusion Criteria	Exclusion criteria
<b>Sample/ Population</b>	Immigrant or ethnic minority mothers living in western countries	Non-ethnic minority or non-migrant mothers/ living in non-western countries
	Studies focusing on mothers with PND.	Studies which are not focusing on mothers with PND.
	Mothers are the primary informants	Mothers are not the primary informants
<b>Language</b>	Studies written in English	Studies not written in English
<b>Time frame</b>	Studies published from 1990	Studies published prior to 1990
<b>Study type</b>	Qualitative methods (e.g. interviews, focus groups)	Studies which do not include qualitative methods of data collection and analysis
	Primary research	Book reviews, opinion pieces, unpublished theses, literature reviews, non-peer reviewed journals

**Table 2: Characteristics of the Included Studies**

Study	Authors and Title	Principal experiences explored	Sample characteristics	Data Collection	Methodology	Analysis	Quality category
1	Stewart & Jambunathan (1996): Hmong women and postpartum depression	To explore PPD in Hmong women living in the U.S. and the influence of cultural practices on PPD	52 Hmong mothers living in North eastern Wisconsin, USA Mean age 27.3 years	In depth interviews (based on the modified Childbirth Questionnaire )	Ethnographic qualitative methods	Sensitization method used by Knafel & Webster (1988)	B
2	Nahas & Amasheh (1999): Culture care meanings and experiences of postpartum depression among Jordanian Australian women: A transcultural study	To discover, describe and explain personal experiences, perceptions and care meanings of Jordanian Australian women	22 Jordanian mothers living in Sydney, Australia diagnosed with PPD	Observations, one-to-one interviews and participatory activities	Ethnonursing research method	Leininger's (1991) analysis	B
3	Nahas, Hillege & Amasheh (1999): Postpartum depression: The lived experiences of middle Eastern migrant women living in Australia	To explore the lived experiences of PPD among Middle Eastern women living in Australia	45 Middle Eastern mothers (18 Lebanese, 14 Egyptian, 13 Palestinian) living in Sydney, Australia diagnosed with PPD. Mean age: 28.6 years	In-depth, unstructured interviews lasting between 45 and 70 minutes	Speigelberg's (1975, 1976) Phenomenological method	Colaizzi's (1978) phenomenological method	A
4	Amankwaa (2003): Postpartum depression among African American Women	To describe the nature of PPD among African American women from their view point	12 African Americans living in USA. Age range 22-40 years	Two one-hour interviews	Qualitative approach (not specified)	Constant comparative method (Glaser & Strauss, 1967)	A
5	Schaper, Murphy & Truscott (2003): Postpartum Distress Among Hmong Women living in La Crosse, Wisconsin	To develop a culturally sensitive understanding of the negative experiences of Hmong women in the postpartum period	16 Hmong mothers living in Wisconsin, USA Age range 16-49 years	Individual interviews and focus groups	Exploratory study (not specified)	Narrative analysis protocol	B



Study	Authors and Title	Principal experiences explored	Sample characteristics	Data Collection	Methodology	Analysis	Quality Category
6	Templeton, Velleman, Persaud & Milner (2003): The experiences of postnatal depression in women from black and minority ethnic communities in Wiltshire, UK	To describe the experiences of women suffering PND in BME communities in Wiltshire, UK	6 BME mothers living in Wiltshire, UK (Bangladeshi, Indian, other Asian, 2 Portuguese and one mixed race)	Semi structured interviews with 6 mothers and focus groups with 12 mothers.	Not stated	Descriptive thematic analysis	B
7	Edge, Baker & Rogers (2004): Perinatal depression among black Caribbean women	To explore Black Caribbean women's beliefs about perinatal depression and their attitudes to help-seeking	12 Black Caribbean mothers living in the Northwest of England Age range 20-40 years	Interviews based on a topic guide lasting between 45 and 120 minutes.	Not stated	Thematic analysis	B
8	Parvin, Jones & Hull (2004): Experiences and understandings of social and emotional distress in the postnatal period among Bangladeshi women living in Tower Hamlets	To explore 1 <sup>st</sup> generation Bangladeshi women's understandings and experiences of postnatal distress and to describe coping strategies during postnatal period	25 Bangladeshi mothers living in London, UK  Mean age 34.3 years	3 Focus groups lasting up to 90 minutes	Not stated	Thematic content analysis	B
9	Edge (2008): 'We don't see Black women here': an exploration of the absence of Black Caribbean women from clinical and epidemiological data on perinatal depression in the UK	To explore (1) Black Caribbean women's beliefs about PND and the inter-relationship between their beliefs and attitudes to help-seeking for symptoms of PND (2) The impact of women's experiences of engaging with healthcare professionals on their help-seeking practices.	12 Black Caribbean mothers living in the Northwest of England. Age range 20-40 years	In-depth interviews lasting between 45 and 120 minutes	Not stated	Glaser's constant comparative approach (Glaser, 1978)	B

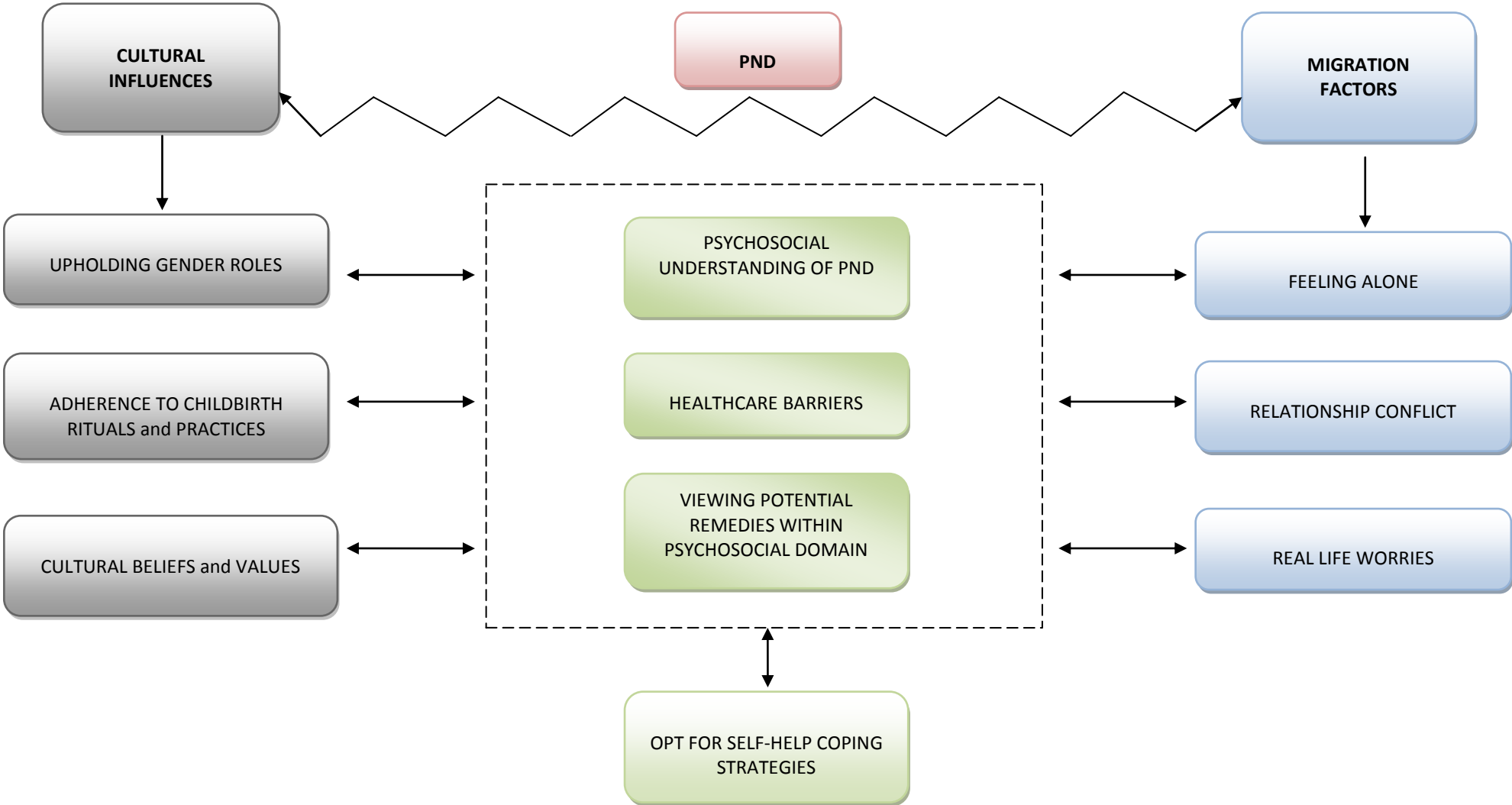
Study	Authors and Title	Principal experiences explored	Sample characteristics	Data Collection	Methodology	Analysis	Quality Category
10	Taniguchi & Baruffi (2007): Childbirth overseas: The experience of Japanese women in Hawaii.	To investigate which kinds of stress women experience during childbirth in a foreign country and to explore whether childbirth in a foreign country influences women's mental health.	45 Japanese mothers who had given birth in Hawaii, USA  Primiparas mean age 31.0 years; multiparas mean age: 36.3 years	Semi structured telephone interviews Lasting between 20 and 60 minutes.	Not stated	Generic inductive analysis process (Norwood, 2000).	<b>B</b>
11	Ahmed, Stewart, Teng, Wahoush & Gagnon (2008): Experiences of immigrant new mothers with symptoms of depression	To better understand the experience of depressed mood in new immigrants	10 immigrant mothers (Chinese, Indian, Pakistani, Egyptian, Haitian, South American) living in Canada Age ranged from early 20s to early 40s	Semi structured telephone interviews	Not stated	Constant comparative approach (Glaser & Strauss, 1967)	<b>B</b>
12	Morrow, Smith, Lai & Jaswal (2008): Shifting Landscapes: Immigrant women and postpartum depression	To examine: (1) women's experiences of PND; (2) variables associated with psychosocial stress identified by the women as contributing to their experience (3) role of women's family and community in the postpartum period; (4) kinds of support sought in this period	18 Various immigrants (7 Mandarin-speaking, 8 Cantonese-speaking and 3 Punjabi-speaking) living in Canada  Age range: 27-49 years	Semi-structured, open ended interviews	Ethnographic narrative approach	Constant comparative analysis	<b>B</b>
13	Abrams, & Curran (2009): "And you're telling me not to stress": A grounded theory study of postpartum depression symptoms among low-income mothers	To explore low-income mothers' experiences and explanatory frameworks for their PPD symptoms	19 Low-Income mothers in USA (10 African Americans, 5 Latinas, 2 Caribbean, 1 African, 1 multiracial) Mean age: 27 years	Open-ended qualitative interviews lasting between 45 and 120 minutes.	Grounded theory	Constant comparative analysis	<b>A</b>

Study	Authors and Title	Principal experiences explored	Sample characteristics	Data Collection	Methodology	Analysis	Quality Category
14	Abrams, Dornig & Curran (2009): Barriers to service use postpartum depression symptoms among low-income ethnic minority mothers in the US	To investigate perceived barriers to mental health service use for PPD among low-income ethnic-minority mothers in an urban US setting	14 Low income ethnic minority mothers in USA (2 Latinas, 5 Mexicans, 1 El Salvadorian, 4 African American 1 Liberian, 1 Belizean) Mean age: 27 years	5 focus groups (lasting between 50 and 100 minutes) and in-depth interviews (lasting between 45 and 120 minutes)	Grounded theory	Constant comparison analysis and use of data matrices	A
15	Abrams & Curran (2011): Maternal identity negotiations among low-income women with symptoms of postpartum depression	To explore maternal identity negotiations among low-income ethnic-minority mothers with PPD	19 Low income mothers in USA 10 African Americans, 5 Latinas, 2 Caribbean, 1 African, 1 multiracial Mean age: 27 years	In-depth interviews lasting between 45 and 120 minutes.	Constructivist grounded theory	Constant comparative analysis	A

**Table 3: Individual Study Concepts as Related to the Overarching Themes**

Study	Cultural Influences			Migration Factors			Consequences			
	Upholding Gender Roles	Adherence to Childbirth Rituals & Practices	Cultural Beliefs & Values	Feeling Alone	Relationship Difficulties	Real Life Worries	Psychosocial View of PND	Viewing Remedies within Psychosocial Domain	Healthcare Barriers	Self-help Coping Strategies
1				Yes			Yes			
2	Yes	Yes		Yes	Yes		Yes			
3	Yes	Yes		Yes			Yes		Yes	Yes
4			Yes	Yes			Yes		Yes	Yes
5		Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes
6			Yes	Yes		Yes		Yes	Yes	
7			Yes				Yes	Yes	Yes	Yes
8	Yes	Yes	Yes	Yes			Yes	Yes	Yes	Yes
9				Yes	Yes		Yes	Yes		Yes
10			Yes						Yes	Yes
11				Yes			Yes	Yes	Yes	Yes
12	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
13				Yes		Yes	Yes			
14			Yes					Yes	Yes	Yes
15			Yes				Yes			Yes

Figure 1: Diagrammatic Illustration of the Overarching Themes and their Relationships



## **Main Paper**

# **An Exploration of Illness Beliefs in Mothers with Postnatal Depression**

Prepared in accordance with requirements for submission to the  
*British Journal of Clinical Psychology*  
(Appendix 8)

Word count: 8440

## **Abstract**

**Objectives:** Postnatal depression (PND) affects around 10% of mothers following childbirth.

Whilst PND is considered to be no different to major depressive disorder, it may have significant impacts on the family as well as detrimental effects on the developing child. The most important difference between PND and major depression is that mothers have a newborn baby, and this might affect their experience and perception of their illness. Illness beliefs have been extensively examined using models from physical health; however, recent studies have identified that physical health models may not be an appropriate framework to explore mental health problems and require adapting. Therefore this study employed qualitative methodology in order to explore illness beliefs in mothers with PND and develop an understanding of what illness beliefs they do hold.

**Design:** Semi-structured interviews were conducted with eleven participants who were depressed following the birth of their child.

**Method:** Interview transcripts were analysed using grounded theory methodology.

**Results:** A theory of illness beliefs in PND was developed encompassing six core categories: 'unmet expectations', 'identifying stressors in their life context', 'conflict over label', 'antidepressants: the lesser of two evils', 'loss of time' and 'uncertain futures.'

**Conclusion:** Participants made multiple appraisals of their PND in light of their initial difficulties, their improvements and consequences, the future and following service involvement. Participants' narratives were conflicting and uncertain with internal struggles evident as mothers were torn between their desire to be good mothers and their perceptions that PND meant that they were not good enough mothers.

## **Introduction**

Postnatal depression (PND) encompasses childbirth mood disorders from the baby blues to serious psychiatric illness (Department of Health, 1998), affecting 10-20% of mothers after childbirth (e.g., Hopkins, Marcus & Campbell, 1984). Studies indicate that mood disturbances following childbirth are not significantly different from affective illnesses that affect women at other times in their lives (Cox, Murray & Chapman, 1993; Kumar & Robson, 1984). Whilst PND can be seen as no different to major depressive disorder, PND can have a significant impact not only on the family but also detrimental effects on the child, including cognitive and emotional difficulties (Murray, Stanley, Hooper, King & Fiori-Cowley, 1996; Hay, Pawlby, Sharp, Asten, Mills & Kumar, 2001). Mothers who are depressed provide less play and poorer quality of play or stimulation for their child, engage in intrusive or hostile play, are less responsive and slower to respond to their child, hold negative views of themselves as parents with reduced self-efficacy, show increased negative expressions and fewer expressions of positive emotion (Cohn, Campbell, Matias & Hopkins, 1990). The literature also suggests that children may be at risk for later psychopathology (Hay et al., 2001; Halligan, Murray, Martins & Cooper, 2006).

PND is most commonly treated with the same approaches used to treat depression (NICE, 2007). Historically, it has been difficult to identify or treat PND and this may be linked to several factors: some mothers may dismiss it as the 'baby blues', others may not realise exactly what is wrong, some may worry about other's perceptions or may feel ashamed to admit that they are not enjoying motherhood, especially at a time that is supposed to be joyous (Beck, 1993). Additionally, some women may worry that their baby will be removed from their care by social services (Edwards & Timmons, 2005).



The medical model has been the dominant theoretical perspective of PND for many years; where PND is considered as an illness and a medical condition. This perspective implies an individual pathology, where the deficiencies are rooted in the mother and the social or environmental conditions of the mother's life are excluded (Mauthner, 1998). Feminist theory disputes this model and proposes that terms, such as "illness", hide the social nature of women's problems (Nicolson, 1986; Oakley, 1981).

Over the last forty years there has been a vast amount of research into PND and qualitative designs have frequently been used to attempt to capture the voices of mothers. In a metasynthesis of eighteen qualitative studies published between 1990 and 2000, Beck (2002) identified four over-arching themes to develop a concept of PND: (1) incongruity between expectations and reality of motherhood, (2) spiralling downward, (3) pervasive loss and (4) making gains. Although existing studies like Beck's have provided valuable insight into maternal experiences of PND, no research has directly examined mothers' beliefs about their PND. Understanding patient beliefs about their condition can be a useful way of predicting behaviour and outcomes.

Leventhal's self regulatory model (SRM; Leventhal, Nerenz, & Steele, 1984) has been extensively used to examine health beliefs. This model postulates that illness cognitions have five key dimensions: identity, cause, timeline, consequences and cure/control. According to this model, patients create illness models once symptoms are experienced and these determine coping. The SRM has been employed successfully to understand patient behaviour in various chronic medical conditions including Addison's disease (Heijmans, 1999), chronic fatigue syndrome (Moss-Morris, Petrie, & Weinman, 1996), psoriasis (Fortune, Richards, Main & Griffin, 2000), multiple sclerosis (Vaughan, Morrison & Miller, 2003) and rheumatoid arthritis (Treharne, Lyones, Booth & Kitas, 2005).

Physical health models have more recently been used to explore illness beliefs in individuals with mental health problems, focusing on how patients' view of their mental health difficulties may relate to psychological and treatment outcomes. Illness perceptions have been explored using standardised measures (e.g., Illness Perception Questionnaire, IPQ; Weinman, Petrie, Moss-Morris, & Horne, 1996) within anorexia nervosa (Holliday, Wall, Treasure & Weinman, 2005), psychotic or personality disorders (Broadbent, Kydd, Sanders & Vanderpyl, 2008), and depression (Brown, Dunbar-Jacob, Palenchar, Kelleher, Bruehlman, Sereika & Thase, 2001; Fortune, Barrowclough & Lobban, 2004). The IPQ has also been modified for patients with psychosis/schizophrenia (Watson, Garety, Weinman, Dunn, Bebbington, Fowler, Freeman & Kuipers, 2006; Lobban, Barrowclough & Jones, 2004) and their carers (Barrowclough, Lobban, Hatton, & Quinn, 2001). These studies indicate the applicability of illness perceptions across a wide range of common mental health difficulties. For example, Fortune and colleagues (2004) suggested that people have models of depression that were similar in content and structure to the models of physical ill health.

Although there has been some utility applying health models to mental health difficulties, studies have also highlighted difficulties; in schizophrenia only a limited number of the SRM variables had any relation to their outcome variables (Barrowclough et al., 2001). It is therefore important to consider that patients with physical health problems may not have the same underlying beliefs as those with mental health difficulties. Lobban and colleagues (2003) propose that there is a clear need to focus more on each individual's appraisal of their experiences and examine their own definitions of their problems, experiences and management strategies. It is important to develop more sophisticated ways to investigate these with qualitative methodologies being a valuable tool. So far there have been few qualitative studies addressing this area, but from those that have been done, there is a suggestion that patients with mental health difficulties do form cognitive representations

of their condition (Pollack & Aponte, 2001; Kinderman, Setzu, Lobban & Salmon, 2006). However, these qualitative studies support the notion that applying health models to mental health is not straightforward. In anorexia nervosa it was noted that patients did not have static beliefs about their illness and patients' accounts transcended the dimensions offered by the SRM (Higbed & Fox, 2010). In schizophrenia, Kinderman and colleagues (2006) found beliefs about mental health were not stable and patients might have no desire to hold coherent beliefs or endorse an illness model; in fact, patients understood their mental health difficulties differently to the suggested health models. Researchers have recommended that significant modifications to these health models are needed to make them applicable to mental health problems and to capture a full understanding and the complexity of perceptions (Kinderman et al., 2006; Higbed & Fox, 2010). Further studies using qualitative methodologies need to be undertaken to add strength to these findings.

Within the medical model, PND is perceived as an "illness" but women may not view their experiences in this way. To date, no studies have directly examined whether women view their PND as an illness. Exploring how mothers view their PND is crucial as it may lead to opportunities to better support them and tailor psychiatric and psychological interventions more appropriately. This seems vital given the serious and disabling nature to both the mother and baby. This study set out to explore illness beliefs in mothers with PND in order to develop a theoretical understanding of these illness beliefs. It was designed to focus on their ideas, thoughts and beliefs about their experiences.

## **Method**

This study employed Charmaz's (2006) Grounded Theory methodology which involves developing a theoretical understanding using a 'constant comparison' method, whereby concept and theory generation become progressively more abstract at each level of comparison (Charmaz, 2006). Data are collected and analysed simultaneously as this is a key element of the methodology, thus analysis of initial data explicitly shapes the direction of further sampling and refines the interviewing process.

Reflexivity and transparency are key throughout the process as 'theory *depends* on the researcher's view; it does not and cannot stand outside it' (p. 130, Charmaz, 2006). Reflexivity involves examining one's previous knowledge, values, effects and role as a researcher on the research process, in relation to the methodological approach, data collection and interpretation (Elliot, Fischer & Rennie., 1999).

The researcher is a 27-year-old, unmarried British Indian woman without any children. While she had no personal experience of PND, she had worked therapeutically with two individuals with PND which she found very challenging and reflected on the impact having a baby had on the clients' motivations for therapy. She also had previous experience using the IPQ within a haematology service. The researcher was aware that this experience could impact upon the research, but felt that this facilitated elements of the data analysis.

Ethical approval was obtained from the University of Manchester's research governance department, the National Research and Ethics Service (NRES, Appendices 9 & 10) and relevant NHS Trusts' research and development committees (R & D, Appendices 11 & 12).

The inclusion criteria included: (1) women who were diagnosed with depression post-birth, (2) women whose depression started in pregnancy and remained depressed post-birth, (3) women with babies up to 24 months old and, (4) women who scored over 10 on the Edinburgh Postnatal Depression Scale (EPDS; Cox, Holden & Sagovsky, 1987). The EPDS is a ten-item, self-rated questionnaire extensively used for the identification and screening of PND. A cut-off score of 12 is suggestive of major depressive disorder; however, a lower threshold of 10 has been recommended for community screening to ensure identification of all potential PND cases (Cox et al., 1993). Mothers were excluded if they were current substance abusers and if their babies had developmental delays.

### **Recruitment**

Participants were recruited primarily via two perinatal services in the Northwest of England. The researcher met with teams to discuss the research and to find out about the context of the services. Five mothers were recruited from a Perinatal Support Team, comprising a team of health visitors offering CBT. Three patients were recruited through a Mother and Baby Unit (MBU) which offers inpatient care for more severe perinatal difficulties. Three mothers were recruited through non-health services.

Participants received information about the study (Appendix 11) prior to giving consent. Once consented (Appendix 12), questionnaires pertaining to demographic and social information and the EPDS were completed (Appendices 13 & 14).

In line with grounded theory methodology, semi-structured interviews were carried out and audio-recorded. The interview schedule consisted of several open-ended questions with a number of prompts (Appendix 15). The researcher developed the schedule with the IPQ components in mind, including the use of illness labels; feelings about the future; and

sense of causes. The researcher was mindful of using general questions to allow identification of beliefs, thoughts and ideas about individual experiences. In accordance with grounded theory principles, the interview schedule was reviewed alongside emerging data during supervision. Although the interview schedule was not formally changed, further prompts were added regarding the process of acceptance and to gauge differences between current and previous episodes for mothers with recurrent depression.

Data collection took part over a 7-month period. Interviews were scheduled at a convenient time and place chosen by the participants (i.e., their homes, G.P.'s surgeries, etc.). Interviews varied in length from 45 to 83 minutes. Brief memos of personal reflections and theoretical insights were made immediately after each interview to ensure early insights were captured.

The analysis followed Charmaz's (2006) methodology as a dynamic process of continuously comparing data with data and data with codes. This began with the researcher transcribing the audio-recordings verbatim. Simultaneous memos of personal reflections and coding ideas were made throughout the transcribing process as the researcher re-heard participants' narratives. Open-coding of each transcript followed as the initial level of analysis; this involved going through each line and capturing the meaning in fewer words (see Appendix 16 for an anonymised coded transcript). Data collection and analysis were conducted concurrently, allowing the analysis of initial data to explicitly shape the direction of further data collection, future sampling and the refining of the interviewing process, which is known as theoretical sampling (Glaser & Strauss, 1967). Memos captured within a reflective journal were crucial to the analysis process and included the researcher's personal ideas that developed from the narrative and thoughts regarding the analysis such as coding ideas and links to existing theories. Once open coding was complete, the

researcher compared, grouped and lifted these codes into core categories to capture what was happening in the data (through focused and axial coding). Advanced memo-writing aided the clarification of the ideas generated. Core categories were then given conceptual definitions and built into conceptual models and theories by linking them to each other and the existing literature (Charmaz, 2003; Henwood & Pidgeon, 2003).

The researcher went onto producing a visual representation (figure 2) of the analysis through identifying and teasing out relationships between the core categories. This was achieved through an iterative process whereby the researcher tested out connections and processes by going back and forth between interview transcripts and the developed categories. Supervision played a crucial part in this ensuring the model fitted participants' narratives.

Throughout the analysis process, attempts were made to ensure that the emerging ideas and categories were clearly grounded in the data. Dey (1999) discussed that it is rare, if not impossible, for grounded theory studies to ever reach theoretical saturation. Therefore, this study worked towards the concept of theoretical sufficiency to guide recruitment and analysis. This means that the analysis represents the data collected but there is possible scope for further analysis.

The researcher used qualitative guidelines and recommendations (Elliot et al., 1999) to ensure and enhance methodological rigour and quality control. This comprised addressing subjectivity through reflexivity, situating the research and sample; using a reflective journal, memos and supervision; and presenting the results explicitly in a way that could be understood through the illustration of direct quotes. Finally, in order to ensure reliability, credibility checks were used. Two independent qualitative researchers checked through a

coded transcript to verify agreement on codes. A high level of agreement between the main researcher and the additional researchers of 90% was achieved providing external validity of the researcher's analysis. There was some discussion on the discrepancies but this did not result in any changes to the analysis or emerging theory.

## **Results**

A purposive sample of eleven participants took part in the study. They had a mean age of 29.4 years and the mean age of their babies was 8.9 months. Mothers scored between 12 and 23 on the EPDS, indicating they were all experiencing depressive symptoms at the time of the interview. All participants were of British White ethnicity and lived in Northwest England. Two participants were currently inpatients on a MBU; and another had recently been discharged. Five participants were primiparas and six were multiparas. Five participants had no previous diagnosed mental health difficulties; three participants experienced a previous single episode of anxiety or depression diagnosed by their G.P.; and three participants described long-standing histories of anxiety and depression. One participant was diagnosed with depression during pregnancy. The diversity within the sample allowed for different theoretical perspectives to be captured.

### **Table 1 here**

A theory of six core categories was developed from the data, including: (i) unmet expectations; (ii) identifying stressors in life context; (iii) conflict with label; (iv) antidepressants: the lesser of two evils; (v) loss of time; and (vi) uncertain futures. A visual representation of categories and their relationships is provided in Figure 2.



Participants' accounts were driven by perceptions that PND was threatening to their self-concepts as mothers and having PND meant they were not good enough mothers. This threat was central to the beliefs participants held about their PND and was compounded by stigma, labelling and the use of antidepressants. This was evident in mothers' narratives of a struggle as they tried to develop their identity as a mother and establish causes.

Participants made multiple appraisals over their initial difficulties, the causes, labelling, treatment, consequences of having PND and the future. These appraisals tended to reinforce the threatening nature of PND and mothers responded with behaviours and thoughts that allowed them to strive towards being a good mother.

**Figure 2 here**

### **Core category 1: Unmet expectations**

This first category relates to incongruence mothers experienced post-birth between their idealised expectations and their early motherhood experiences. Mothers managed this incongruence through defences to maintain their ideals.

Participants' early experiences of motherhood were dominated by difficult emotions of low mood, anxiety and anger and poor physical health from obstetric complications which did not match up to their expectations.

*"I had an expectation, I guess it's a bit too Disneyland isn't it sometimes?"*

(Participant 10 )

The incongruence created awareness in participants that things were not right and this recognition depended on whether they had previously been depressed or not. Mothers

with no previous depression genuinely did not understand what was happening when their mood deteriorated; whereas mothers with past depression had more awareness of their experiences.

All participants however, appraised these first experiences as threatening to their self-concepts as good mothers. Mothers attempted to counteract this threat through a process where they initially denied or minimised these early difficulties. This enabled mothers to strive to meet personal, societal and culturally constructed expectations and ideals of motherhood and protect their self-concept as good mothers. Mothers were able to achieve minimisation of their difficulties through externalising and attributing them to a variety of reasons including *'a passing phase', 'the baby blues', 'the first coming home', 'hormones', 'lack of sleep' and 'exhaustion'.*

*"I thought it was a phase that would pass...I assumed I'd get better."* (Participant 1)

Additionally, mothers used externalising language to further protect their self-concepts as mothers, separating themselves from their experiences and they frequently referred to their difficulties as *'it'*.

### ***Descent into PND***

Despite attempts to deny difficulties, participants described a descent into PND using a range of terms: *'nervous wreck', 'hysterical', 'loss of control', 'unable to cope.'* Mothers may have experienced guilt from not meeting their ideals, which reduced their self-esteem and self-efficacy as a mother and creating guilt, possibly leading mothers into a vicious cycle.

Difficulties escalated to a crisis point where they no longer felt able to ignore what was happening. Various expressions were used to illustrate the catastrophic nature: *'flipped'*, *'breaking point'*, *'spiralled out of control'*. It was at this point that participants began to attempt to make sense of what was happening.

### **Core category 2: Identifying stressors in their life context**

This category relates to the causes mothers held responsible for their PND. Participants had evidently searched for their own causes and explanations, developing personal narratives of their difficulties. Participants held multiple and uncertain causes of their PND.

Participants described biomedical factors which helped clarify the physical evidence but these did not fit with their world view. They used explanations or discourses available to them and identified other stressors that were in the context of their own lives. These included psychosocial factors, their histories of depression and their previous experiences. Participants did not describe tension between holding a predominant psychosocial model with some biomedical explanations.

A psychosocial aetiology appeared to be the dominant framework held by participants as they searched for tangible and understandable stressors in their lives. Holding these psychosocial causes allowed mothers to externalise their PND and possibly disentangle the dilemma of stigma in their desire to meet their ideals of being a good mother. Mothers cited various psychosocial factors as causal including traumas, difficulties adjusting to the parenting role, personal factors and other psychosocial stressors. Participants identified their deterioration in mood as a result of a combination of multiple stressors in their lives.

*“...that's one more stress on top of every other stress you've been put under and sort of, one of them must have been the straw that broke the camel's back. But which one? There are just so many straws.”* (Participant 7)

Childhood abuse, traumatic pregnancies and births were referred to by many participants as underlying their PND; one mother assumed birth trauma was the sole cause and experienced flashbacks and nightmares:

*“I assume it stems from my horrific delivery.”* (Participant 2)

Difficult births were common to many participants' accounts; however other mothers described these played less of a causal role and saw these births as creating a negative start to motherhood that did not promote bonding.

Difficulties in distinguishing between symptoms of depression and the physical adjustment to motherhood were universal to participants' narratives, whether they were primiparas or multiparas. These difficulties created complications and further confusion for mothers as they tried to develop an understanding of their PND. One mother described trying to differentiate between physical and mental health:

*“I found it difficult to distinguish between what was just complete exhaustion and maybe what was the depression really and I still think that they are still linked.”*

(Participant 3)

Other psychosocial factors mothers felt were involved included lack of social support, weight gain, changes to lifestyle, relationship problems, financial concerns, stresses of moving house and work-related worries.

It is important to note, that although mothers had come up with this range of explanations, their descriptions held expressions of uncertainty (e.g. *'I assume', 'I don't know', 'I think'*). This uncertainty was thought to stem from coming up with their own accounts. Participant 1 initially attributed her PND to several reasons, however later on in the interview, she described having no understanding.

Several participants related their PND to more personal characteristics of sensitive, emotional or miserable personalities and low self-esteem.

*"I don't know, I think perhaps that has something to do with it, the fact that I've always been a bit of a misery guts."* (Participant 11)

These mothers saw their intrinsic qualities as causal and placed some blame within themselves, which may have reinforced that they were not good enough mothers. All three of the participants with past depression held more personal models of biography, history and vulnerability, citing being susceptible to PND.

*"It was a worry that I'd get PND cos I thought I might be a bit more susceptible to it..."* (Participant 5)

Participants who held these more personal causes did not externalise or distinguish between themselves and their PND, viewing PND as part of their pre-morbid personality and perceiving vulnerability within themselves. This was at odds with their use of

psychosocial models to externalise their PND, emphasising their uncertainty over possible causes.

Biomedical factors including genetics, hormones and brain factors were indicated by some participants as additional causes that were not as prominent as the prevalent psychosocial frameworks. These causes appeared to be held as a result of experiences and their symptoms. For example, some mothers perceived their hormones playing a part from their previous hormonal experiences. Several participants used physical symptoms and evidence of exhaustion, confusion and memory difficulties and located some pathology in the brain. One mother believed that her brain had stopped working.

*“I could not actually get away from this, I need to deal with it and really my brain was failing...and that frightened me.” (Participant 3)*

Only one participant who was a current inpatient endorsed a pure medical model. This mother described a long-standing history of difficulties and antidepressant use; she was worried about her medications being reduced and could not see the potential help of seeing a clinical psychologist. However, she was severely depressed and appeared to have very little insight into her difficulties. In contrast, other inpatients struggled to see the role of chemicals despite being surrounded by a sea of medical terminology.

*“I think it’s harder to grasp, I don’t know because it’s all to do with feelings and emotions and it’s hard to sort of try and understand that it’s a chemical that’s causing that.” (Participant 11)*

These others inpatients were able to recite the medical model as a deficiency in their brains' ability to produce serotonin and likened it to a diabetic's deficiency in producing insulin, but they sought out other reasons in the context of their lives. This search for other explanations may serve to externalise mothers' PND from themselves.

### ***Service Involvement: Disclosure and being 'Medicalised'***

When participants hit crisis point, they sought help and disclosed their difficulties to their most accessible healthcare professional, usually their health visitor or G.P., where their difficulties were essentially "medicalised".

### **Core category 3: Conflict over label**

This category relates to how the label of PND was clearly at odds with how mothers wanted to be viewed and this was more dominant for those mothers who were depressed for the first time. Although the label provided a sense of relief, it was superseded by the stigma and the threat to their self-concept as mothers and mothers used defences to protect their self-concept.

Participants held conflicting and contradicting views of the label of PND; with the labelling process itself creating both relief and fear for mothers: relief related to no longer feeling alone or that they were going mad and could now understand their experiences. The label normalised their experiences and provided access to healthcare and input.

*"It means it's treatable."* (Participant 7)

It was hypothesised that relief was experienced as mothers were now able to get help to go on fulfil their ideals of mothering. Participants, however, also openly acknowledged and

expressed fears due to the stigma associated with the label. There was a sense that the stigma attached to mental health problems was heightened for these mothers. Being labelled with PND was 'scary' as it reinforced the threatening nature to their self-concepts as mothers. Participants believed that this label would lead to multiple negative views from others as 'weak', 'not normal', 'unpredictable', 'not functioning', 'not in control', and 'not able to care for or love their child'.

*"I should just accept it and I just don't know I am worried about what other people think about me..." (Participant 1)*

This perceived stigma made it difficult for mothers to accept PND. Participants who had never experienced previous depression demonstrated this by describing a process in which they continued to use defences and deny were suffering from PND despite receiving a label.

*"...but I was adamant that I was fine and that it was just a lack of sleep and this that and the other and I would not let her (Health visitor) refer me to anybody because I was fine, I was just blocking it out..." (Participant 3)*

In order to maintain and protect their self-concepts as good mothers and avoid stigma, participants also concealed their difficulties from others through withdrawing, avoiding or lying to others or refusing to use words like 'depression' or 'antidepressants'. Participants were fearful of the stigma and avoided disclosure to friends; disclosure meant having to accept their PND themselves and this would reinforce that they were not good enough mothers



*"I just can't bring myself to say it. Fear of ridicule I suppose...and I don't want people to feel that I can't look after my children because I can...and I love them..."*

(Participant 2)

This mother, like others who were depressed for the first time, still had difficulties in accepting their PND at the time of interview despite receiving specialist interventions, antidepressants and volunteering to take part in the research.

*"I accepted that I wasn't unwell and I needed help, I don't know whether I've accepted that it was depression."* (Participant 1)

This suggests the extent of the pervasiveness of the stigma attached to the label and mothers illustrated this through their use of various defences. The defences enabled them to facilitate their rejection of PND and its threat to their self-concept. Mothers with previous depression did not use these defences indicating they accepted and admitted their PND easier and were willing to engage in treatment quicker. It was hypothesised that these mothers may hold existing and stable models of depression and are able to integrate these into the construction of their PND experiences without as much conflict as those mothers who had never experienced depression before.

#### **Core category 4: Antidepressants: "the lesser of two evils"**

This category describes the battle mothers expressed over antidepressants. Conflict held over the label was thought to create and interact with conflict over the use of antidepressants. Although mothers perceived a stigma attached to antidepressants, their responsibilities and practicalities took precedence over the stigma.

Nine participants were on antidepressants and ten received some form of non-medical input; however, mothers' discussions about treatment were dominated by the use of antidepressants. Mothers who were depressed for the first time, had little knowledge about antidepressants and were fearful of them; they described a stigma attached to taking medications, viewing them as a weakness that would lead to negative views from others. This was thought to reinforce the threat of not being good enough mothers.

*"People will think she needs to be on meds to be a normal mother..."* (Participant 2)

Participants also described taking antidepressants heightened stigma and they were no longer able to use their defences of concealment.

*"...if you're not taking the drugs you can kind of pretend you haven't got it but when you are taking drugs, you can't hide behind anything, you have a mental illness that you are taking drugs for and therefore, you've got that stigma."*

(Participant 7)

Mothers described oscillating between their fears of antidepressants and the stigma with needing a solution. Participants had reached a crisis point, mustered the courage to seek help and felt unable to wait to see a counsellor. Participants described a problem-solving process at this point where they had to get on with being a mother.

*"I still have to take my kids to school and I still have to do my food shopping and pay my bills...I have to pull through."* (Participant 1)

Antidepressants were therefore viewed as a viable option, and a sense of pragmatism was apparent in participants' narratives that surmounted some of the stigma.

*"I'd rather not, but it's the lesser of two evils I guess." (Participant 4)*

Although they adhered to antidepressants, participants who were depressed for the first time expressed significant struggles around their use. This was demonstrated through avoidance of the word 'antidepressants' and questioning their efficacy; mothers were reluctant to attribute improvements to medication and wanted to be the source of improvement. It was hypothesised that there appeared to be a cost associated with improvements, in that mothers would never know whether their ability to be a good mother was due to the efficacy of antidepressants or themselves.

*"...the medication seems to have helped. I would like to think it was me but it is probably not, it probably is the medication taking the edge off." (Participant 2)*

One mother who chose not to take antidepressants indicated this; she needed to be source for improvement and wanted to ensure she could attribute her improvements and good mothering to herself and not medications.

*"I'm not the sort of person who easily gives into things. If I can possibly do it without the drugs, then I must be a stronger person." (Participant 3)*

Mothers with previous depression did not express the same struggles, having had antidepressants previously, but described feelings of disappointment and sadness.

*“...before I had PND I was quite a happy person who could manage without antidepressants, so I’m annoyed at myself that I have to be back on them.”*

(Participant 5)

Non-medical interventions utilised included PND support groups, counselling, and individual or group-based CBT. Mothers still accessed this support despite reporting they had begun to feel better whilst waiting to access services. It was thought that mothers may have utilised this support to try and attribute some of their improvements to themselves in their desire to be a good mother, or because these interventions matched their belief models. Support received was dependant on what they were able to access; mothers expressed wishes for more accessible and non-medical input.

*“It shouldn’t all be about pills...”* (Participant 9)

They expressed disappointed and frustration at waiting lists and the limited nature of services, offering an insufficient number of sessions.

### **Core category 5: Loss of time**

The interview schedule allowed mothers to reflect on the consequences of having PND following on from their improvements. This category relates to mothers’ allusions of going through a grieving process; with a loss of time evident in all mothers’ accounts as they underwent a post-mortem of their PND. This perceived loss of time varied significantly between mothers’ descriptions ranging from ‘a blur’ to more substantial memory loss. As mothers reflected on this loss of time, they described immense guilt that undoubtedly reinforced their beliefs that they were not good enough mothers. This guilt related to the perceived negative impact on their babies, partners and families.

*"I feel like I've lost out on the first few months of her life cos it's like a blur, there just no memory of it kind of thing, and so like there's the guilt that comes with that. Like I only get 9 months off work to be with her so there's the guilt that I've missed out on her...and of wasting some of that time being ill or it being interrupted... but it's just something that I feel everyone's had to go through, not just me, if you know what I mean? Cos like my family have obviously been worried about me and my partner's been worried about me and he's had to look after me loads so it's more like the impact on the family and stuff like causing worry for them and stress..."*

(Participant 5)

It was hypothesised that this grief was particularly prominent due to society's expectations of motherhood being a time that is joyous and treasured. Participants hinted at continuing to strive towards being a good mother through attempting to regain normality, returning to work and resuming their previous lives.

### **Core category 6: Uncertain futures**

Feelings about the future formed part of the interview schedule to enable dialogues about recovery. This final category illustrates mothers' beliefs of the pervasive uncertainty attached to PND. Mothers openly articulated concerns about the future and its uncertainty; these were particularly pertaining to perceptions about PND being enduring and fears of future episodes. Some mothers felt that they would need to monitor their lives for future depression, perceiving PND as part of their lives now.

*"It has made me more vulnerable now... I'm going to have to keep my eye on for repeats I've buggered it up for the rest of my life"* (Participant 11)

Some participants illustrated this vulnerability by choosing not to have any future children.

*"I am having no more babies so there is no chance of that no way..."* (Participant 10)

Just as mothers wanted a future without depression, they wanted a future without antidepressants. Mothers highlighted their fears about antidepressant use with fears and conflict about dependency.

*"...I am quite happy to take it forever if it makes me feel like I can get up in the morning...but...I would like to think I could stop taking it and go back to my normal self but I don't know whether I would want to for fear of going back to that crazed fool..."* (Participant 2)

These worries undoubtedly reinforced that they were not good enough mothers. They described conflict around long-term use and efficacy. Mothers may have viewed that long-term use of antidepressants would mean never finding out if they could be good mothers without medication.

Participants' uncertainty and fears about the future were also apparent in their perceptions of timelines. They either felt unable to or did not want to put a time-line on their recovery.

*"...you can't really put a timescale on it, you just need to keep working towards it..."*  
(Participant 6)

*I'm taking one day at a time; I don't want to look into the future because that's too scary.*" (Participant 7)

As mothers viewed a loss of time as a consequence of their PND, there was a sense that their PND could create a potential loss of future. Mothers described that their PND could continue to have a hold on their lives as they took one day at a time.

Although uncertainty and fears dominated mothers' descriptions of the future, mothers expressed they were more hopeful and optimistic about the future than they previously had been, allowing them to strive to meet their ideals.

## **Discussion**

This is the first study to directly investigate illness beliefs in PND and develop a theoretical understanding of these beliefs using grounded theory. This qualitative methodology allowed participants to explore and explain their experiences. The overall sense from participants' narratives was a complex, conflicting and uncertain process where they made multiple appraisals of PND. Internal struggles were evident as mothers strived to be good mothers but perceived that PND meant that they were not good enough mothers. Mothers who were depressed for the first time underwent a more conflicted and uncertain appraisal process.

The participants' expectations of motherhood and the reality of their experiences were highly incongruent and this challenged mothers. Mothers strove to meet their ideals of being a good mother through using defences of denying, concealing and externalising. This incongruence is prevalent in the existing literature; Beck (2002) identified incongruence in

her metasynthesis as a significant perspective where conflicting expectations and experiences of motherhood led mothers down a path to becoming overwhelmed, perceiving themselves as failures as mothers, and bearing a suffocating burden of guilt.

As other research has shown mothers with PND frequently use conceptual frameworks of their experiences that neglect conventional illness or medical models and tend to favour more psychosocial causes (Chew-Graham, Sharp, Chamberlain, Folkes & Turner, 2009; Buultjens, & Liamputtong, 2007). Although participants depicted biomedical factors as contributory, they searched for other factors and stressors within the context of their own lives and developed a predominantly psychosocial aetiology. This observation supports findings of a study of illness perceptions in perinatal depression using the IPQ; where participants were less likely to endorse beliefs that their depressed mood was due to medical illness or causes (O'Mahen, Flynn, Chermack & Marcus, 2009). Being provided with a medical or biological model by healthcare professionals and services did not impact on participants' appraisals of their PND as not being caused entirely by biomedical factors. Everingham and colleagues (2006) suggest there are several possible sociocultural frames that organise mothers' understandings of their PND and different frames will be more relevant depending on their own biographies, experiences and backgrounds. Mothers in this study had clearly used their own experiences and histories of depression to construct their causes. Mothers identified causes to understand their illness in line with physical health models, but their aetiologies were multiple, uncertain and complex. Mothers both externalised their PND to protect their self-concept but also perceived it as part of their personality. This reinforces previous findings that psychiatric patients struggle to conceptualise their ill health (Kinderman et al., 2006). This also demonstrates that mothers did not necessarily distinguish between themselves and their illness, as proposed by physical health theorists (Helman, 1994).



As shown in other studies, the women in this study accepted help from a healthcare professional at the point where they felt they had no choice (McCarthy & McMahon, 2008). It was surprising that even mothers who had experienced past depressive episodes allowed themselves to descent to a crisis point before seeking help. Mothers' desires to meet their ideals, their fears of failure, of losing their child and potential social services involvement certainly impacted on this.

Although the label of PND created relief and normalised mothers' experiences, this was overshadowed by the stigma associated with PND. Many studies have concluded that mental health labels actually increase stigma (Haywood & Bright, 1997; Prince & Prince, 2002). The label of PND caused immense tension for those mothers who had never previously suffered from depression, who viewed the perceived stigma extremely threatening that they concealed their PND from others. These findings echo those of another study exploring stigma in postnatal illnesses (Edwards & Timmons, 2005), where women felt a stigma towards themselves and feared being seen as a bad mother. Mothers' use of various defences like concealment and denial highlight the complexity of the beliefs that mothers held.

From the existing literature it is clear that a patient's views about their illness are clinically relevant for their management of the condition, their recovery and capacity to cope (Diefenbach & Leventhal, 1996), their compliance with treatment and their behaviour (Horne, 2006; Weinman & Petrie, 1997). Participants in this study advocated health behaviour that was dictated more by practical consequences than by theory, medical knowledge or illness beliefs. There was a clear absence of biological causes despite mothers taking prescribed antidepressants. However, mothers did seek out non-medical input in

line with their predominant psychosocial models. Mothers' use of antidepressants was guided by pragmatism and this seemed to lead to concerns over their efficacy and long-term use. Antidepressants posed most difficulties for those without a history of depression, with mothers viewing them as reinforcing their feelings of not being good enough. This mirrors Halopainen's (2002) findings of mothers' ambivalence about antidepressants; they felt that they needed them to function but they reinforced personal beliefs of being weak and unable to manage on their own. Mothers' reluctance to take antidepressants due to concerns about dependency, side-effects, and the stigma attached has been identified in other studies (Turner, Sharp, Folkes & Chew-Graham, 2008). Turner and colleagues (2008), however, found that women's views towards antidepressants could become more positive, while mothers in the current study continued to worry about dependency and future use.

Mothers were able to identify consequences of their PND in line with physical health models, and described grief related to a loss of time as they reflected on the consequences of their PND. Mothers attempted to mediate this loss through striving to meet their ideals and attain their old lives. Multiple losses have been acknowledged as part of the normal adjustment to motherhood (Nicolson, 1999; Buultjens & Liamputtong, 2006) and in relation to PND; where PND is likened to a normal grief reaction and part of a normal postnatal profile (Hall, 2006). This includes loss of self or former identity (Chen, Wang, Chung, Tseng & Chou, 2006), loss of relationships (Beck, 2002) and loss of control (Beck, 1992). Loss of time, however, is less often recognised, with Beck's study (1993) being one of the only studies indicating this particular type of loss; where mothers mourned lost time as they regained control of their lives. Loss may require future assessment as it is a key element of PND and the normal transition to motherhood. Services should consider identifying the grief, loss and guilt that mothers experience and normalise it as a natural process.

Uncertainty dominated participants' views of their futures. Although mothers had subjectively improved, they continued to have doubts around their prognosis and long-term use of antidepressants as well as future episodes of depression. Fears of future episodes were common to all mothers and mothers in previous studies (Beck, 1993) regardless of whether they had a history of depression or not. These concerns are essentially realistic ones with research indicating that mothers with PND are more likely to experience future episodes of depression (Cooper & Murray, 1995).

In line with earlier studies (Kinderman et al., 2006; Higbed & Fox, 2010), these findings illustrate that physical health models (e.g. Leventhal's self-regulatory model, SRM) have limited applicability for examining illness beliefs in mental health and need some modification. Although mothers in this study identified consequences and causes in line with the physical health models; their content was uncertain, conflicting and complex. Furthermore, mothers made multiple appraisals which were driven by a perceived stigma attached to PND and their desire to meet their ideals. This shows that the illness beliefs in PND exceed the five dimensions offered by the SRM; and that physical health models would not necessarily allow for a full explanation of the stigma and the multifaceted representations of PND described by mothers. As Lobban and colleagues (2003) note, models (such as the SRM) are unable to substitute individual formulations that are more informative and offer complexity of these beliefs.

According to Beck (2002), PND can be likened to a chameleon and takes on different appearances depending on which mother is experiencing it. The mothers in this study described very distinct experiences, narratives and understandings of their PND. Despite this diversity, a theoretical understanding of PND was developed. It is hoped that these

insights would inform and influence how healthcare services approach interventions for women experiencing PND.

### **Limitations**

There are a number of potential limitations that need to be considered. The first one pertains to the use of the EPDS to screen for PND; it has been criticised for not accurately detecting PND. Mothers were recruited from different sources and differed in how they had been diagnosed and by whom. Therefore, it was important to have an overall PND screen to ensure all mothers were experiencing a sufficient degree of depressive distress. The EPDS indeed indicated all mothers presented with probable depression.

The generalisability of the findings needs to be discussed as there were several features of the sample that may create difficulties in generalising the findings to the wider population. These include the small sample size, the restricted geographical area participants were recruited from and the characteristics of the participant sample being of higher education and socio-economic status and all receiving treatment. The various services involvement and interventions will inevitably have influenced and shaped the beliefs mothers held about PND. The researcher aimed to overcome these generalisability difficulties through capturing the diverse views of participants.

It is worth mentioning the pragmatic difficulties of recruiting participants for research from this population and the challenges these posed. The researcher found it extremely difficult to identify participants and multiple recruitment avenues were pursued unsuccessfully. As a result of these recruitment struggles and time constraints, theoretical saturation and sampling, in line with grounded theory approaches was difficult to adhere to.

The change of criteria to include mothers with previous depression was an issue of contention; as these mothers are likely to hold different beliefs about their PND from those who had never been depressed before. However, the existing literature indicates a previous history of depression is a moderate to strong predictor of subsequent PND (Beck, 2001). This suggests that many mothers with PND will have experienced previous depression; therefore it was important to include these mothers when exploring illness beliefs in PND. The addition of this subgroup can be seen as adding strength to the study in allowing for the comparison of different theoretical perspectives and representing a typical clinical sample. The researcher ensured she was mindful of these subgroups when drawing interpretations. A convenience sample was also sought, via non-health services including PND website forums and support groups to facilitate recruitment. This sample was chosen because it proved difficult to recruit from healthcare professionals working in under-resourced services. The researcher acknowledged that the convenience sample may introduce a sample selection bias that could impact upon the external validity of the findings.

There are several avenues that could be pursued for further research. Exploring illness beliefs in mothers who have not received any treatment or service involvement is one possibility, as all mothers in the study were involved with healthcare services and this was thought to have an impact on their beliefs. The inclusion of a more culturally-diverse group of women may lead to further development of the categories from this study. Future research could also attempt to collect data over an extended time period and revisit participants and their beliefs as this study was limited to data drawn from one interview.

## **Clinical Implications**

These findings have particular implications for healthcare services in providing PND care. Healthcare professionals should consider the negative impact of the provision of labels and medications for mothers and try to normalise this as much as possible. The stigma attached to PND has been well documented in other studies (McCarthy & McMahon, 2008); and breaking down romanticised views of motherhood appears to be necessary to reduce stigma. The issue of stigma attached to mental health is challenging, especially for mothers who face established expectations of motherhood as joyous. Healthcare professionals can also attempt to overcome this difficulty through normalising difficult early experiences and losses. Ideally, this could be done by health visitors during their routine post-birth visits. In addition, more time needs to be allocated to PND during antenatal classes. These classes aim to prepare new mothers for late pregnancy, birth, and early parenthood and this should include information on PND given its high prevalence rates. It is hoped that this would help new mothers understand their experiences and increase their awareness of their symptoms so they can access help quicker. This may also help to reduce the stigma attached to PND. Healthcare professionals also need to be aware that when participants first agree to antidepressant medications they do so without firmly believing in a medical model. They should consider reviewing their use after initial improvements or offering regular follow-up to discuss mothers' concerns about medications and their long-term effects. Finally, healthcare professionals need to try and improve accessibility to non-pharmacological treatments when mothers do seek help for the PND.

## **Conclusions**

This study highlights the complex nature of illness beliefs in PND and the value of gaining an understanding of these beliefs. Participants' narratives were full of internal struggles illustrating the tension between their desire to be good mothers and their perceptions that

PND meant that they were not good enough mothers. Mothers who were depressed for the first time underwent a more conflicted and uncertain appraisal process than those with previous depressive episodes.

## References

Barrowclough, C., Lobban, F., Hatton, C., & Quinn, J. (2001). An investigation of models of illness in carers of schizophrenia patients using the Illness Perception Questionnaire. *British Journal of Clinical Psychology, 40*, 371-85.

Beck, C. T. (1992). The lived experience of postpartum depression: A phenomenological study. *Nursing Research, 41*, 166-170.

Beck, C. T. (1993). Teetering on the edge: A substantive theory of postpartum depression. *Nursing Research, 42*, 42-48.

Beck, C. T. (2001). Predictors of postpartum depression: an update. *Nursing Research, 50*, 275-285.

Beck, C. T. (2002). Postpartum depression: A metasynthesis. *Qualitative Health Research, 12* (4), 453-472.

Broadbent, E., Kydd, R., Sanders, D., & Vanderpyl, J. (2008). Unmet needs and treatment seeking in high users of mental health services: The role of illness perceptions. *Australian and New Zealand Journal of Psychiatry, 42*, 147–153.

Brown, C., Dunbar-Jacob, J., Palenchar, D. R., Kelleher, K. J., Bruehlman, R. D., Sereika, S. & Thase, M. E. (2001). Primary care patients' personal illness models for depression: A preliminary investigation. *Family Practice, 18*, 314–320.



- Buultjens, M., & Liamputtong, P. (2007). When life starts to take the life out of you: women's experiences of depression following childbirth. *Midwifery, 23*, 77-91
- Charmaz, K. (2003). Grounded Theory. In J.A. Smith (Eds.), *Qualitative Psychology: A Practical Guide to Research Methods*. London: Sage.
- Charmaz, K. (2006). *Constructing Grounded Theory*. London: Sage.
- Chen, C. H., Wang, S. Y., Chung, U. L., Tseng, Y. F. & Chou, F. H. (2006). Being reborn: The recovery process of postpartum depression in Taiwanese women. *Journal of Advanced Nursing, 54* (4), 450–456.
- Chew-Graham, C. A., Sharp, D., Chamberlain, E., Folkes, L., & Turner, K. M. (2009). Disclosure of symptoms of postnatal depression, the perspectives of health professionals and women: a qualitative study. *BMC Family Practice 2009, 10*, 7-15.
- Cohn, J., Campbell, S., Matias, R., & Hopkins, J. (1990). Face to face interactions of postpartum depressed and non-depressed mother-infant pairs at 2 months. *Developmental Psychology, 26*, 15-23.
- Cooper, P. J., & Murray, L. (1995). Course and recurrence of postnatal depression. Evidence for the specificity of the diagnostic concept. *British Journal of Psychiatry, 166*, 191-195.
- Corbin, J., & Strauss, A., (2008). *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*. 3<sup>rd</sup> ed. Thousand Oaks, CA: Sage.

Cox, J. L., Murray, D., & Chapman, G. (1993). A controlled study of the onset, duration and prevalence of postnatal depression. *British Journal of Psychiatry*, *163*, 27-33.

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

Department of Health [DH] (1998). *Modernising Health and Social Services: National Priorities Guidance*. London: Department of Health.

Dey, I. (1999). *Grounding grounded theory*. San Diego, CA: Academic Press.

Diefenbach, M. A., & Leventhal, H. (1996). The common sense model of illness representation. *Journal of Social Distress and the Homeless*, *5*, 11–38.

Edwards, E., & Timmons, S. (2005). A qualitative study of stigma among women suffering postnatal illness. *Journal of Mental Health*, *14*(5), 471-481.

Elliot, R., Fischer, C.T., & Rennie, D.L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, *38*, 215-229.

Everingham, C. R., Header, G., & Connor, L. (2006). Couples' experiences of postnatal depression: A framing analysis of cultural identity, gender and communication. *Social Science & Medicine*, *62*, 1745-1756.

Fortune, D. G., Richards, H. L., Main, C. J., & Griffiths, C. E. M. (2000). Pathological worrying, illness perceptions and disease severity in patients with psoriasis. *British Journal of Health Psychology, 5*, 71-82.

Fortune, G., Barrowclough, C., & Lobban, F. (2004). Illness representations in depression. *British Journal of Clinical Psychology, 43*, 347-364.

Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory*. New York: Aldine.

Hall, P. (2006). Mothers experiences of postnatal depression: an interpretative phenomenological analysis. *Community Practitioner, 79*, 256-260.

Halligan, S., Murray, L., Martins, C. & Cooper, P. (2006). Maternal depression and psychiatric outcomes in adolescent offspring: a 13-year longitudinal study. *Journal of Affective Disorders, 97*, 145–154.

Hay, D., Pawlby, S., Sharp, D., Asten, P., Mills, A., & Kumar, R. (2001). Intellectual problems shown by 11-year old children whose mothers had postnatal depression. *Journal of Child Psychology and Psychiatry and Allied Disciplines, 42*, 871-889.

Haywood, P., & Bright, J. A. (1997). Stigma and mental illness: A review and critique. *Journal of Mental Health, 6*, 345 – 354

Heijmans, M. (1999). The role of patients' illness representations in coping and functioning with Addison's disease. *British Journal of Health Psychology, 4*, 137-49.

Helman, C. G. (1994). *Culture, health and illness*. 3rd ed. Oxford: Butterworth Heinemann.

Henwood, K., & Pidgeon, N. (2003). Grounded theory in psychological research. In M. Paul, J. E. Rhodes, & L. Yardley (Eds.), *Qualitative Research in Psychology: Expanding Perspectives in Methodology and Design*. Washington DC: American Psychological Association.

Higbed, L., & Fox, J. F. (2010). Illness perceptions in anorexia nervosa: A qualitative investigation. *British Journal of Clinical Psychology, 49*, 307-325

Holliday, J., Wall, E., Treasure, J., & Weinman J. (2005). Perceptions of illness in individuals with anorexia nervosa: A comparison with lay men and women. *International Journal of Eating Disorders, 37*, 50–56.

Holopainen, D. (2002). The experience of seeking help for postnatal depression. *Australian Journal of Advanced Nursing, 19*, 39-44.

Hopkins, J., Marcus, M., & Campbell, S. B. (1984). Postpartum depression a critical review. *Psychological Bulletin, 821* (2), 498-515.

Horne, R. (2006). Beliefs and adherence to treatment: The challenge for research and clinical practice. In P. W. Halligan, & M. Aylward (Eds.), *The power of belief*. Oxford: Oxford University Press.

Karasz, A. (2005). Cultural differences in conceptual models of depression. *Social Science and Medicine, 60*, 1625–1635.

Kinderman, P., Setzu, E., Lobban, F., & Salmon, P. (2006). Illness beliefs in schizophrenia. *Social Science and Medicine*, *63*, 1900–1911.

Kumar, R., & Robson, K. M. (1984). A prospective study of emotional disorders in childbearing women. *British Journal of Psychiatry*, *144*, 35-47.

Leventhal, H., Nerenz, D. R., & Steele, D. F. (1984). Illness representations and coping with health threats. In A. Baum & J. Singer (Eds.), *A Handbook of Psychology and Health*. Hillsdale, NJ: Erlbaum.

Lobban, F., Barrowclough, C., & Jones, S. H. (2003). A review of models of illness in mental health. *Clinical Psychology Review*, *23*, 171-196.

Lobban, F., Barrowclough, C., & Jones, S. H. (2005). Assessing cognitive representations of mental health problems. I. The illness perception questionnaire for schizophrenia. *British Journal of Clinical Psychology*, *44*, 147-62.

Mauthner, N. S. (1998). It's a woman's cry for help: A relational perspective on postnatal depression. *Feminism & Psychology*, *8*, 325-355.

McCarthy, M. & McMahan, C. (2008). Acceptance and Experience of Treatment for Postnatal Depression in a Community Mental Health Setting. *Health Care for Women International*, *29*, 618 – 637.

Moss-Morris, R, Petrie, K. J., & Weinman, J. (1996). Functioning in chronic fatigue syndrome: Do illness perceptions play a regulatory role? *British Journal of Health Psychology* 1, 15-25.

Murray, L., Stanley, C., Hooper, R., King, F., Fiori-Cowley, A. (1996). The role of infant factors in postnatal depression and mother-infant interactions. *Developmental Medicine and Child Neurology*, 38, 109-119.

National Institute for Clinical Excellence [NICE] (2007). Antenatal and postnatal mental health: full guideline. National Institute for Clinical Excellence, England.

Nicolson, P. (1986). Developing a feminist approach to depression following childbirth. In S. Wilkinson (Ed.), *Feminist social psychology: Developing theory and practice*. Milton Keynes and Philadelphia, PA: Open University Press.

Nicolson, P. (1999). Loss, happiness and postpartum depression: The ultimate paradox. *Canadian Psychology*, 40, 162–178.

O'Mahen, H. A., Flynn, H. A., Chermack, S., & Marcus, S. (2009). Illness perceptions associated with perinatal depression treatment use. *Archives of Women's Mental Health*, 12: 447–450.

Oakley, A. (1981). Prologue: reflections on women and household labour. In D. B. Fenstermaker D (Eds.), *Women and Household Labour*. Beverley Hills, California: Sage Publications.

Oakley, A. (1986). *From here to maternity: Becoming a mother*. Hammondsworth: Penguin.

Petrie, K. J., Cameron, L., Ellis, C. J., Buick, D., & Weinman, J. (2002). Changing illness perceptions after myocardial infarction: an early intervention randomized controlled trial. *Psychosomatic Medicine, 64*, 580–6.

Petrie, K. J., Broadbent, E., & Kydd, R. (2008). Illness perceptions in mental health: Issues and potential applications. *Journal of Mental Health, 17*, 559-564.

Pollack, L. E., & Aponte, M. (2001). Patients' perceptions of their bipolar illness in a public hospital setting. *Psychiatric Quarterly, 72*, 167–179.

Prince, P. N., & Prince, C. R. (2002). Perceived stigma and community integration among clients of assertive community treatment. *Psychiatric Rehabilitation Journal, 25*, 323 – 331.

Treharne, G. J., Lyons, A. C., Booth, D. A., & Kitas, G. D. (2005). Predicting fatigue in rheumatoid arthritis: the impact of psychosocial resources 1 year earlier. *Annual Rheumatoid Disorder, 64* (3), 582.

Turner, K. M., Sharp, D., Folkes, L. & Chew-Graham, C. (2008). Women's views and experiences of antidepressants as a treatment for postnatal depression: a qualitative study. *Family Practice, 25*, 450-455.

Vaughan, R., Morrison, L., & Miller, E. (2003). The illness representations of multiple sclerosis and their relation to outcome. *British Journal of Health Psychology, 8*, 287-301.

Watson, P. W. B., Garety, P. A., Weinman, J., Dunn, G., Bebbington, P. E., Fowler, D., Freeman, D., & Kuipers, E. (2006). Emotional dysfunction in schizophrenia spectrum psychosis: the role of illness perceptions. *Psychological Medicine, 36*, 761-770.

Weinman, J., Petrie, K., Moss-Morris, R., & Horne, R. (1996). The illness perception questionnaire: A new method for assessing the cognitive representation of illness. *Psychology and Health, 11*, 431-445.

Weinman, J. & Petrie, K. J. (1997). Illness perceptions: A new paradigm for psychosomatics? *Journal of Psychosomatic Research, 42*, 113–116.



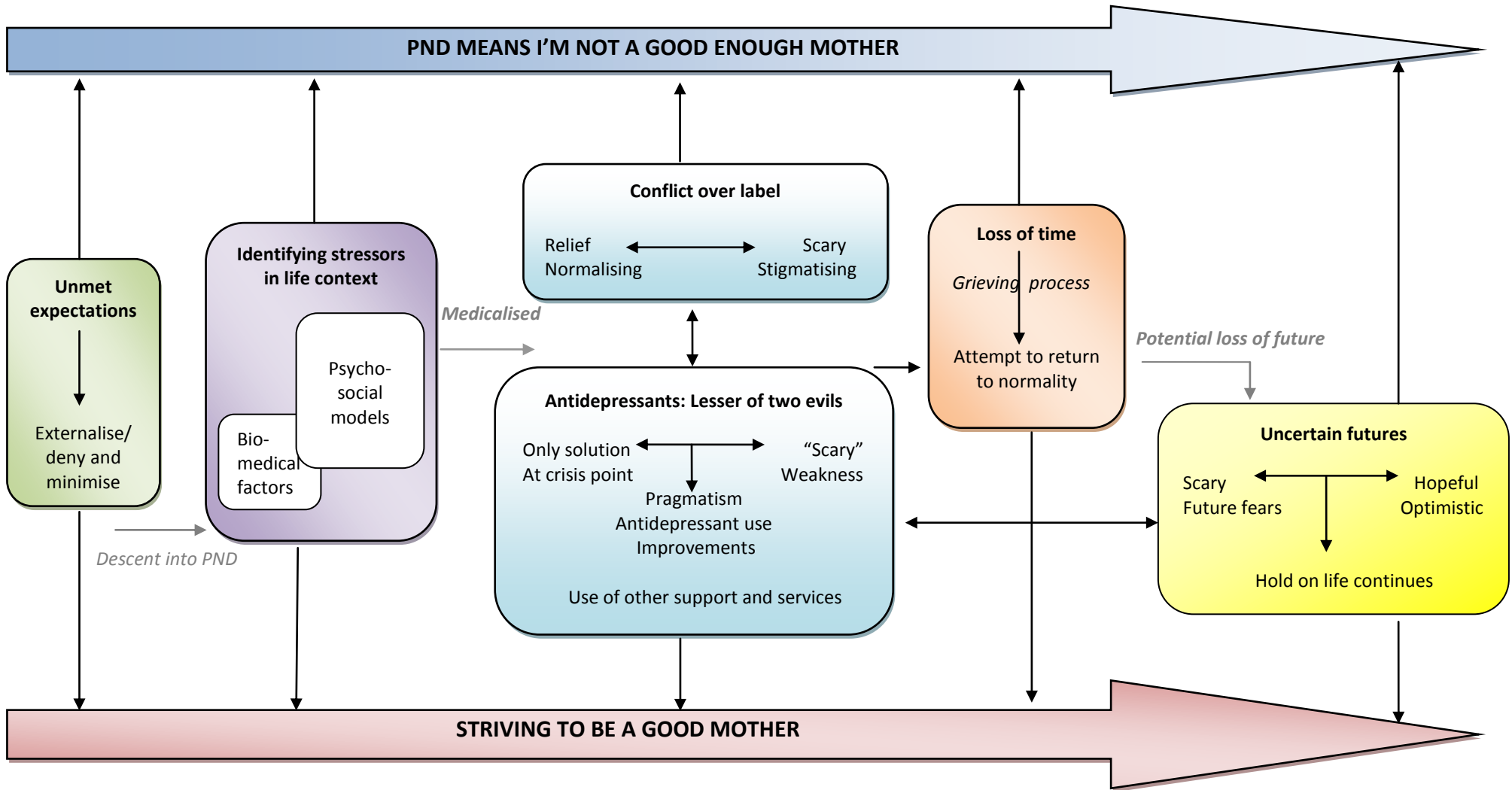
**Table 4: Participant Characteristics**

Participant No	Age	EPDS score	Age of baby (months)	Gender of baby	Mode of delivery	Parity	Previous mental health difficulties	Current Interventions
1	22	14	11	Male	C-section	2	None	ADs & CBT
2	32	13	10	Male	Natural	2	None	ADs & CBT
3	32	14	12	Male	Natural	2	None	CBT
4	35	12	5	Male	C-section	1	Single episode	ADs & CBT
5	27	12	9	Female	Forceps	1	History of anxiety & depression	ADs, counselling, group-based CBT team
6	35	23	4	Male	Natural	4	History of anxiety & depression	Inpatient treatment: ADs
7	34	14	4	Male	C-section	1	History of anxiety & depression	Inpatient treatment: ADs & CBT
8	27	17	6	Female	C-section	2	None	ADs & CBT
9	26	17	6	Female	Natural	2	None	ADs, counselling, group support
10	24	12	22	Male	Forceps	1	Single episode	Group & specialist mental health support
11	33	18	2	Female	Natural	1	Single episode	Inpatient treatment: ADs & CBT

ADs: Antidepressant Medication

CBT: Cognitive Behavioural Therapy

Figure 2: Representation of Categories and their Relationships



## **Critical Review**

# **My Personal Journey Through a Grounded Theory Methodology in Exploring Illness Beliefs in Mothers with Postnatal Depression**

Word count: 5233

## **Introduction**

This critical review outlines my journey through a grounded theory methodology in exploring illness beliefs in postnatal depression (PND). This review first discusses why a qualitative method was chosen and more specifically a grounded theory approach. This review will then go on to identify some of the difficulties attached to using grounded theory. As grounded theory involves the researcher in the data analysis and there is a need for the researcher to ensure transparency, the final part of this approach will be devoted to a reflective account of using grounded theory and the challenges and difficulties I encountered. I will reflect on the knowledge and skills I have gained throughout the process and how this has been important for my learning and progression towards becoming a qualified Clinical Psychologist.

### **My interest in this research area**

My previous clinical experiences guided my interests into this area of research. As an assistant psychologist, I worked in a physical health setting and had experience of using the Illness Perception Questionnaire (IPQ; Weinman, Petrie, Moss-Morris, & Horne, 1996) with patients suffering from sickle cell disease and thalassaemia. Using this measure with these patients was valuable in gaining an understanding of patients' beliefs about their illness. I was curious about how physical health models and measures may be applicable to mental health difficulties. As a trainee clinical psychologist, I had experience of working with individuals with depression and more specifically I worked with a client with depression following the birth of her child, who had experienced recurrent episodes of depression throughout her life. Whilst undertaking the latter stages of the research, I was working with a young, first-time mother who described symptoms of PND. I found working with both of these clients extremely challenging and reflected on the impact that having a baby had on the clients' motivations. I was keen to enhance my understandings of PND, perceiving it as

a serious illness that may have detrimental impacts on the wider system around the mother. I think it is also important to note that I wanted to use qualitative methods and chose a research study that would allow me to pursue such methods. I felt that this approach would extend my existing research background and produce more interesting findings.

### **Rationale for using qualitative methodologies**

Qualitative methodologies produce rich, detailed descriptions and interpretations of investigated phenomena in contrast to quantitative approaches. Qualitative designs are often chosen as the most appropriate approach in relation to the research question being asked (Corbin & Strauss, 2008). It can be argued that quantitative methods could be used to develop an understanding of illness beliefs in PND with efficacy using established measures, such as the IPQ. However, participants' beliefs about their PND are likely to be complex and this complexity is unlikely to be captured using measures or questionnaires. In using measures, participants are restricted to making a decision to select an option that best fits their response rather than being a true reflection of them. Additionally, measures do not allow detail about responses to be described. Therefore, the use of quantitative measures to examine such phenomena can be seen as restrictive and limiting and may lead to some reduction of valuable and detailed information.

Both illness beliefs and PND are multifaceted phenomena and require an understanding from the participants' perspective. Illness beliefs explore how patients understand their experiences and what representations they have made in their internal worlds. This includes participants' senses of causes, their own and others' labelling, their perceived consequences, their view on recovery and their beliefs about the future. PND is undoubtedly a devastating experience for mothers and mothers' beliefs are unlikely to be

straightforward; as demonstrated in the main paper, mothers' held uncertain, conflicting and complex beliefs. Furthermore, understanding PND involves finding out about meanings, inter-subjectivity, values, beliefs and personal knowledge. Qualitative approaches consider all of these, enabling researchers to delve in to meanings as well as experiences, patterns, relationships and values. Qualitative methods have been developed to explore the inner experiences of participants and to determine how meanings are formed through and in culture (Corbin & Strauss, 2008). These methods can therefore provide valuable insight, because the researcher is able to identify contextual and setting factors and their relationship to the phenomenon of interest as well as dynamic processes. Qualitative approaches allow for individual formulations to be constructed, these provide a far more complex and useful guide to the individual's understanding of their illness and the meaning it has for them (Lobban, Barrowclough & Jones, 2003). In summary, mothers' illness beliefs in PND are multifaceted and in order to gain a comprehensive understanding of these beliefs requires a qualitative approach.

Qualitative methods use a range of different approaches to collect data including focus groups, direct observations and different types of interviews; and can be seen of additional value in their data collection. For example, the use of a semi-structured interview provides a context in which there are ideas to be explored but allows the responses of participants to be followed. Therefore, participants can share their narratives whilst feeling listened to. Interviews assessing illness beliefs have been found to be therapeutic because they allow participants to tell their story, consider new issues and clarify aspects of their illness (Pollack & Aponte, 2001). Although PND is a highly sensitive topic that some mothers may find difficult to speak about, providing them a space within an interview was beneficial for many participants. Sharing their narratives appeared to help participants validate the reality of their difficult experiences and make sense of the events that had happened prior

to the birth to the months following the birth of their baby. Participants described finding it useful to discuss and reflect back on their experiences and were able to identify how much they had recovered.

I felt that choosing a measure to assess illness beliefs would not only have been very restrictive and limiting for patients but also for myself as the researcher to attain a thorough understanding of illness beliefs in PND. From using open-ended questions, I was able to probe into areas and develop greater knowledge about experiences and how beliefs had developed. In addition, I felt using qualitative measures was a more sincere way of asking mothers to share their experiences. Within both of my papers, it was clear that mothers wanted to be understood and listened to. I reflected on the narratives and data obtained as well as the theoretical model that was developed. I found it difficult to perceive how I would have obtained such valuable information from a non-qualitative approach. In summary, I believe there is a strong rationale for using a qualitative approach to explore this area of research.

### **Rationale for a grounded theory approach**

Qualitative research encompasses numerous different methods, the majority of which have been developed from the phenomenological and social interactionist perspectives.

Examples include phenomenology, ethnography, interpretative phenomenological analysis (IPA) and grounded theory. These methods have several similar features including flexibility, a primary focus on the experience of the individual, similar methods of data collection, a consideration of the impact of the researcher on the research and some of steps of analysis are comparable. However, there are clear differences between them, related to their aims and objectives, their theoretical underpinnings and the later data analysis which can extend beyond looking for themes.

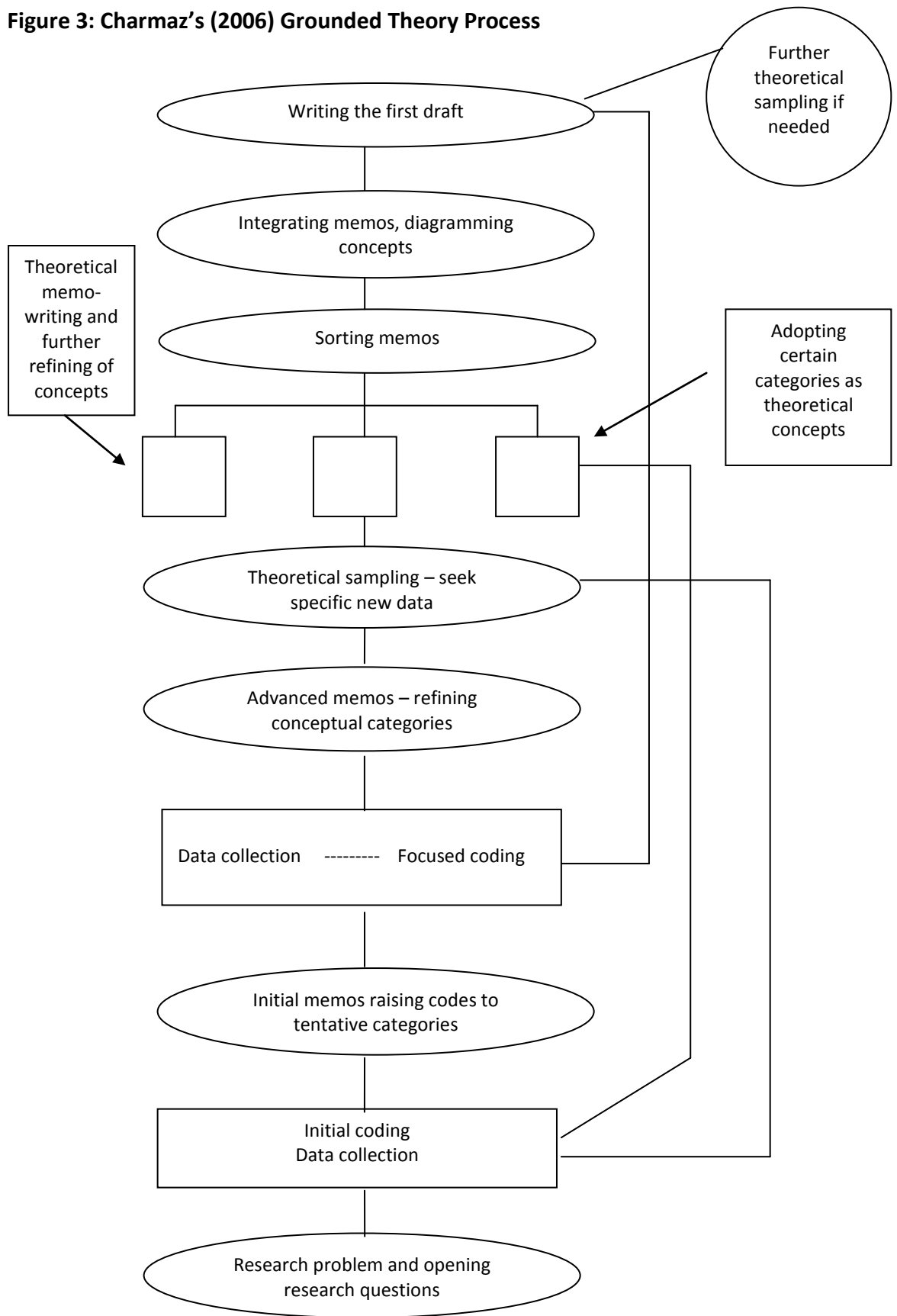
Recently there has been a trend for IPA studies within qualitative research, making it a popular choice. IPA focuses on making sense of the meanings that people attach to their experiences; usually using a small sample with the aim of producing an interpretative account that has richness and depth (Smith, Flowers, & Larkin, 2009). Therefore, IPA is used to give insight into how people feel about their experiences, and given this definition IPA can be seen as an appropriate methodology to explore illness beliefs in PND. Many studies have used qualitative methodologies, including IPA, to explore and examine PND, and these studies have found there are similar key themes reported by mothers with PND (Beck, 2002). Grounded theory not only gives insight into experiences and offers an interpretative account but extends existing findings through developing a theoretical understanding of phenomena. This approach does not just simply describe themes but integrates these themes into to the existing knowledge base. Grounded theory was chosen as a preferred approach for the study for this reason, as well as numerous others. Firstly, this approach provides guidelines and a framework for data analysis. It consists of *“systematic, yet flexible guidelines for collecting and analyzing qualitative data to construct theories ‘grounded’ in the data themselves”* (Charmaz, 2006; illustrated in Figure 3). I saw this as particularly appealing due to having very little knowledge about qualitative methods. It has been used successfully to investigate PND (Beck, 1993; Abrams & Curran, 2009) as well as many other areas. Grounded theory allows processes to be captured which are likely to be particularly pertinent to PND. Data collection and data analysis occur simultaneously in grounded theory, which allows the researcher to identify areas which may have initially been missed or overlooked; and subsequent data collection can help clarify the emerging insights, codes and theory. Within this approach, theory emerges from the data with an explicit goal to develop a theory that is grounded in participants’ accounts. This shifts the research findings beyond the rich and in-depth accounts of a few numbers of participants, to form a theoretical model that can be tested



out and developed in future research. Therefore, grounded theory not only overcomes difficulties of generalisability attached to qualitative methods but it also links to the wider literature clearly. Finally grounded theory places considerable value on the contextual setting which was important in choosing this method. Feminist theorists view motherhood in a wider socio-political and cultural context and suggest that because childbirth occurs in many simultaneous contexts (including medical, social, and economic), the mother's reactions to it are shaped by all of them (Mauthner, 1998). PND was more than a biological or medical issue for these mothers, and their PND clearly existed within both a social and psychological context, which strongly and negatively impacts on mothers' beliefs about their PND. Grounded theory demonstrates the importance of these psychosocial factors for women experiencing PND. There was a clear rationale for using a grounded theory approach to explore illness beliefs in PND.

Furthermore, a constructivist grounded theory approach was employed (Charmaz, 2006). A constructivist approach relates to understanding data as constructions of experience; and it was used in this study to examine how mothers understand and construct their beliefs about PND in relation to their lived experiences. In addition, it has been suggested that constructivist approaches are particularly appropriate for investigating depression because the experience of depression is subjective and involves the individual's constructions of their world and their relationships in that world (Bennett, Boon, Romans & Grootendorst, 2007).

**Figure 3: Charmaz's (2006) Grounded Theory Process**



## **Difficulties of a grounded theory approach**

Despite the numerous advantages of working in such an approach, there are some difficulties attached to this method that need to be considered.

### **1. The place of the literature review**

The place of the literature review in grounded theory has long been disputed and misunderstood (Charmaz, 2006). There is a common belief that existing theory should be avoided until analysis has ended to avoid preconceiving ideas impacting on the work. This has been identified as a misinterpretation and is highly unlikely to be the case because researchers will often bring existing knowledge and experience to a new research study. Glaser (1978) discusses the importance of existing theory as sensitising the researcher to the conceptual significance of emerging concepts and categories. This indicates that an understanding of related theory and empirical work may enhance theoretical sensitivity. I did not have the luxury of postponing a literature review to later on in the research process. Instead I tried to ensure I was mindful of the impact of conducting a literature review might have on my analysis. For example, I tried to ensure that I was not imposing existing ideas onto my emerging themes and tried to be transparent about what ideas I had attained following on from the literature review using reflexive practices.

I believe that I gained additional value from doing my literature review concurrently with my research study that was not focused on solely gaining knowledge. For example, as part of the metasynthesis, I utilised quality criteria for appraising studies included in the review and this was particularly helpful in ensuring that my own study had methodological rigour to meet such quality criteria. I wanted to create a study that had high levels of quality and transparency to overcome some of the negative perceptions of qualitative research.

## **2. Coding**

The risk of placing excessive emphasis on identifying codes and not offering an explanation of how codes relate to each other has been identified extensively in the literature (Glaser, 1992; Stern, 1994). My own reflections of coding mirrored this risk, I had initial doubts about what a code was, what a code should be and I had many concerns that I was not open coding correctly and that there could be a better way of coding data. I tried to be mindful of Glaser's (2001) recommendation that if a researcher is uncertain about the process, that he or she should just analyse the data in front of them and write what they see. I also tried to maintain the purpose of open-coding as simply a way to reduce the data down to fewer words and kept in mind that the subsequent stages of coding held more importance. I found axial coding quite satisfying in bringing codes together and describing their relationships; I felt that this provided coherence to the multitude of open codes I had gathered.

## **3. The constant comparison approach**

One of the key features of grounded theory is the constant comparison approach, whereby data are compared with data, data with category, category with category and category with concept. Problems are thought to arise from this method if researchers do not ensure that it is ongoing throughout the process. I found this to be a liberating way of conducting research allowing me to be flexible whilst keeping me grounded in the data.

## **4. Theoretical sampling**

Theoretical sampling refers to collecting further data (or samples) based on emerging concepts to develop categories and sampling. This is a central component of the grounded theory process that I found difficult to adhere to. As a result of difficulties in recruitment, I was not able to seek out particular participants to illuminate and define early findings. I

was, however, able to test out my emerging categories on my future participants and comply with this sampling approach to some degree. On reflection of the participants interviewed, I felt that I was able to use this diverse group and their variety of experiences to attain different theoretical perspectives.

### **My reflections on my personal journey of grounded theory**

I felt that it was important to include an account of my personal reflections of some of the stages of the grounded theory approach used, especially the difficulties I came across. The majority of the difficulties I encountered in this methodology were attached to my inexperience and restricted knowledge of using these approaches that made the process very daunting.

### ***Ensuring reflexivity***

Reflexivity is central to qualitative methods because the researcher becomes the main analysis tool within the process and as Charmaz states, the 'theory *depends* on the researcher's view; it does not and cannot stand outside it' (p. 130, 2006). Given the highly interpretative nature of the analysis and the inevitable influence on the analysis, reflexivity is essential throughout to protect against the researcher potentially biasing the interpretations. The use of reflexive practice and strategies were a very novel way of working and conducting research. I had never thought about situating my own stance prior to conducting research. I became especially aware of how my previous experiences and knowledge may influence the research and interpretations made. As the main researcher I spent significant time reflecting on my own position in the research but this served to heighten my anxieties. I questioned my own beliefs and assumptions, how similar or different I was to the participants, how I would be viewed as a female of a similar age without any children. I wondered whether participants would view my lack of experiences

of motherhood as being less able to understand the challenges they faced as mothers. I felt that I had the ability to empathise without being a mother but was unsure whether participants would feel the same. I also queried whether being from a different cultural background could impact on whether mothers felt I would be able to understand their difficulties.

I examined my previous clinical experiences pre-training and during training and the impact that this may have on the research. Although I recognised that my earlier clinical experiences would inevitably impact on the research, I felt that this would only be in a positive way in providing knowledge and facilitating the analysis. I tried to be mindful of this throughout the research process by examining the interpretations I made and constantly exploring possible alternatives.

Reflexivity, however, was beneficial in creating a high standard of quality; it allowed me to take a step back and look at the research process as a whole. I developed a way of working where I would constantly ask myself questions and try to put myself in the shoes of participants. For example, in developing the participant information sheet, I questioned whether I would take part in the research if I was suffering from PND, and how ethical and respectful the research was of participants. In developing the interview schedule I wondered whether the questions would provide me with the means to say everything if I were telling my narrative on PND. I also developed a more self-critical approach to the research; some of this was borne out of my constant attempts to ensure I was following the grounded theory framework.

### ***The reflective journal***

The reflective journal is used to enhance reflexivity throughout the research process. I initially found it very difficult to use this journal, feeling unsure of what to write in it. I avoided journal entries at the beginning of the research process, simply making practical notes following on from supervision. As soon as I started my participant interviews, however, I found that I needed a space to reflect on these interviews. Furthermore, I saw that the journal had the potential to serve many purposes. Firstly, it provided a chronological record of research events and the development of my thinking within the research process. I would make entries after recruitment meetings, supervision, interviews and following on from transcribing and coding interviews. I used it practically as a resource to document emerging ideas and theoretical insights via memos that needed additional thought. I found it most beneficial as a space to reflect on my own emotions during the research process. These included my frustrations, especially those pertaining to recruitment difficulties, finding it somewhat cathartic. I also discussed my desires in wanting to offer further assistance to mothers after hearing their struggles and emotional stories. I perceived the journal as a valuable resource that encompassed my entire research journey.

### ***Memo-writing***

Memos are seen as the 'discovery phase' (p. 85, Charmaz, 2006) of grounded theory and encourage early data analysis and the formation of codes. I found it challenging to use memos at first, finding them to be somewhat mysterious. Memo-writing is supposed to free the researcher to explore ideas about codes and categories. However, I became very caught up in what they should include and struggled writing them freely. Memos can be seen as making hypotheses in that they capture ideas around the researcher's thoughts, early insights and theoretical understandings. In my clinical practice I frequently develop

hypotheses; however, these are very rarely written down formally. Once I recognised this and stopped pressuring myself to write them, I found memo-writing was vital and facilitated my analysis. Similar to the use of the reflective journal, I found that the memos also served many functions in capturing my personal reflections, my early theoretical insights, my coding ideas, my ideas on which codes were most significant to be raised to categories, my ideas of linking codes to existing theory and my interpretations. They also served a use in supervision as a way of presenting my ideas, my rationale and the conclusions I had drawn. I found myself constantly returning to these memos when I found myself getting caught up in participants' narratives and discovered that they allowed me to take a step away from the raw data, whilst keeping grounded in the data and my initial insights. The advanced memos were particularly helpful during the latter stages of the analysis in raising codes and helping to refine concepts and categories through comparing participants' narratives.

### ***The interview schedule***

In my first interview, I did not use the interview schedule appropriately and I followed the schedule rigidly rather than pursuing the participant's responses and the theoretical glances offered. My supervisor was able to listen to my first interview and give constructive feedback on this, allowing me to change my practice early on. In my next interviews, I was very mindful of attempting to dig deeper, probe more and think more theoretically. I was surprised by my initial use of the interview schedule as in my usual clinical practice I am normally very flexible addressing the issues that patients choose to talk about and taking their lead rather than keeping to a fixed interview. I reflected on my rigidity being in part due to my anxieties around using a completely new methodology that I was trying to conform with.



Additionally, I was very aware of ensuring that interviews were “research interviews” and not clinical interviews. I attempted to maintain their purpose to obtain knowledge of the phenomena investigated. I found myself having to actively abstain from asking questions that were not relevant for the research aims and not offer reassurance and clinical advice, whilst maintaining an engaging and compassionate interview style. Not being able to offer reassurance and advice posed a particular difficulty for myself especially when it was requested. I often felt torn between my role as a trainee clinical psychologist and a researcher and found myself providing encouragement once the interview had ended. When listening back to the interviews, I was able to identify that I did sometimes ask questions that were not directly relevant for the research question and slip into a clinical role.

### ***Uncertainty***

I know from my own experiences that I find it challenging to tolerate much uncertainty. I found myself in a constant battle with not having the certainty that is obtained from quantitative methods. I struggled with the ambiguity and uncertainty of the approach at times, finding myself wanting to draw conclusions early on.

### ***Time-consuming and demanding nature of approach***

On reflection, many of the challenges I faced with my thesis may have been evaded had I recognised the demanding nature of qualitative work earlier on in the research process. At the outset I relied on the expertise of my supervisors; finding it difficult to grasp some of the methods by only reading about them. I know from my own experience that I learn most from doing and assumed that I would develop understanding and knowledge as I progressed through the tangible methods. If I were able to re-do the whole research process, I would definitely spend more time at the beginning developing my understanding

of grounded theory. This would have provided a stronger foundation in the methodology earlier on which would have inevitably been valuable and reduced many of the anxieties I held around the approach. I highly under-estimated how time-consuming this approach would actually be despite my supervisors' warnings. Transcribing audio-recordings and open coding were demanding and I often felt discouraged because this was only the beginning of the analysis. I often felt disheartened having to go back to transcripts once coding had ended but recognised that this was part of the iterative process.

I also found it demanding to be the sole person who had the most knowledge about my data and felt very responsible for ensuring that my analysis and interpretations were a true reflection of participants' accounts. Although my attempts to be thorough can be seen as an advantage, I often got overwhelmed in trying to capture everything and needed supervision to allow myself to view my data through another set of eyes. The analysis process often felt like a test of self-confidence, in that I had to be confident in my own interpretations and understanding of the data. This was extremely overwhelming initially but as I became increasingly immersed in my data and the narratives, I became more secure in my analysis and interpretations. I struggled with making a decision of when to finish data analysis and stop drawing conclusions. I felt that this process could essentially go on for many more months with new insights possible.

### ***The latter stages***

The latter stages of the grounded theory process including theoretical sorting; diagramming and integrating came easier to me as my confidence in my coding and interpretations increased. Having visual images of diagrams was rewarding in providing concrete images of my ideas after months of transcripts, codes and post-it notes. As I moved into this stage, I felt that my interpretations were falling into place and I was able to

offer visual representations of categories and identify their connections and relationships. Although I found this stage more straightforward, I often tried to include everything holding on to mothers' powerful narratives.

The identification of the 'core categories' can be seen as the goal of grounded theory; this is the theory that conceptually defines the most significant process. Throughout the analysis this was seen as my ultimate goal that almost seemed un-attainable early on. I found it challenging to leave the identification of these categories until very late on.

### ***Recruitment***

One of my biggest challenges that I had not anticipated was pertaining to recruitment. I made assumptions that once ethical approval was granted I would be able to recruit instantly and with ease. These expectations were highly unrealistic with recruitment through other healthcare professionals extremely difficult. Health professionals in community-based perinatal services were working in contexts that were remarkably stretched, under-resourced and were going through significant reconfigurations during the time my study was conducted. This was extremely discouraging and disappointing, despite this, I gained insight into the context of these services and the difficulties they faced in trying to provide perinatal services. It was evident that professionals in this area were often frustrated in trying to provide high quality services with little resources and changes to the contexts they worked in. These frustrations were echoed in participants' accounts of the need for more accessible services that did not focus on pharmacological interventions. I found it highly uncomfortable and difficult to rely on other staff to help with recruitment. I did not feel that I had their cooperation with recruitment despite their interests in the research. I sought multiple recruitment avenues, most of which were unsuccessful and often felt like I was somehow doing something wrong and missing

potential recruitment avenues. This led me to change the inclusion criteria and seek out a convenience sample via non-health services where I would essentially have more control over recruitment and overcome the ethical issues of having to recruit participants through other healthcare professionals. In light of difficulties in identifying mothers with PND who had never experienced previous depression, the inclusion criteria were also extended to include mothers who had experienced depression in the past. I was initially very reluctant to do this and some of this reluctance was generated through having to make a substantial amendment to the ethics committee and the impact that this could have on my research progress. Some of it, however, was a result of my early interviews being carried out with mothers with no previous depression. I felt that mothers who had experienced depressive episodes in the past would undoubtedly view their PND differently to these mothers I had interviewed early on and was concerned what this would mean for my results. Difficulties in recruiting inevitably impacted upon the whole research approach and this was particularly pertaining to theoretical sampling. If I were to change one aspect of the research, I would definitely try to establish stronger ties to services to recruit from and attempt to incorporate myself into their services to facilitate recruitment. This may have been achieved through attending the health visitors' clinic check-ups with mothers in which they may have been screened for PND.

From reflecting on the difficulties I encountered, I was able to identify that these were entangled within my inexperience of the approach and the anxieties of these new ways of working. The non-linear approach of grounded theory was invaluable in enabling me to be a more effective grounded theory researcher.

### **What I have learnt from the grounded theory process**

On reflection of the entire research process, I felt that I learnt the most from the grounded theory approach. Although my previous research experience is somewhat restricted, I found that using qualitative methodology has challenged my limited research background. I found it to be a way of collecting data that allowed remarkable richness of information to be sought and captured that is very often missed. This has given me an appreciation of qualitative methods that has superseded the challenges and time-consuming nature I often found myself in. I would like to further my qualitative research background in my future life as a qualified clinical psychologist following on from my appreciation of such methods.

In addition, I have obtained knowledge of qualitative research and found that this methodology suited me as a researcher despite having numerous struggles with some of the stages early on. I also gained expertise in PND and illness perceptions which I have already found useful in my clinical work. During the latter stages of the research, I started working therapeutically with a young mother who expressed many of the same initial difficulties the participants described. I was mindful of how participants had made sense of their initial difficulties and the impact of stigma and societal expectations when working with her. As a clinical psychologist I have found the research invaluable in shaping my clinical work, in particular it has reinforced the importance of exploring patients' understandings and beliefs about their illnesses (whether physical or mental health problems) without making assumptions especially about their health-related behaviour. I also learnt not to undervalue the impact of stigma felt by patients in receiving a mental health diagnosis. A pervasive part of mothers' perceptions of their illness was driven by the stigma these mothers felt was attached to PND.

I have also learnt a great deal about myself from the process, including the way in which I work and practice and what has influenced my thinking.

## **Conclusions**

The research journey has been a long road that has often felt challenging, torturous and never-ending. Having this space to reflect on the research process has been invaluable in helping me to re-identify the value of conducting qualitative research, why it was initially chosen, what I have learnt and what I will take away from the research.

## **References**

- Abrams, L. S., & Curran, L. (2009). And you're telling me not to stress? A grounded theory study of postpartum depression symptoms among low-income mothers. *Psychology of Women Quarterly, 33*, 351–362.
- Beck, C. T. (1993). Teetering on the edge: A substantive theory of postpartum depression. *Nursing Research, 42*, 42-48.
- Beck, C. T. (2002). Postpartum depression: A metasynthesis. *Qualitative Health Research, 12* (4), 453-472.
- Bennett, H. A., Boon, H. S., Romans, S. E., & Grootendorst, P. (2007). Becoming the best mom that I can: women's experiences of managing depression during pregnancy – a qualitative study. *BMC Women's Health, 7*, 13-26.
- Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London: Sage Publications.
- Corbin, J., & Strauss, A. (2008). *Basics of qualitative research* (3rd Ed.). Los Angeles, CA: Sage.
- Glaser, B.G. (1978). *Theoretical Sensitivity: Advances in the Methodology of Grounded Theory*. Mill Valley, CA: Sociology Press.
- Glaser, B. G. (1992). *Basics of Grounded Theory Analysis: Emergence vs. Forcing*. Mill Valley, CA: Sociology Press.

Glaser, B. G. (2001). *The Grounded Theory Perspective: Conceptualisation Contrasted with Description*. Mill Valley, CA: Sociology Press.

Lobban, F., Barrowclough, C., & Jones, S. H. (2003). A review of models of illness in mental health. *Clinical Psychology Review, 23*, 171-196.

Mauthner, N. S. (1998). It's a woman's cry for help: A relational perspective on postnatal depression. *Feminism & Psychology, 8*, 325-355.

Pollack, L. E., & Aponte, M. (2001). Patients' perceptions of their bipolar illness in a public hospital setting. *Psychiatric Quarterly, 72*, 167-179.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research*. London: Sage.

Stern, P.N. (1994). Eroding Grounded Theory. In J. Morse (Eds.), *Critical Issues in Qualitative Research Methods* (pp. 212-223) Thousand Oaks, CA: Sage.

Weinman, J., Petrie, K., Moss-Morris, R., & Horne, R. (1996). The illness perception questionnaire: A new method for assessing the cognitive representation of illness. *Psychology and Health, 11*, 431-445.



**Appendix 1:**  
**Summary of Qualitative Health Research Journal Manuscript**  
**Guidelines**

## **A Summary of Qualitative Health Research Journal Manuscript Guidelines**

Qualitative Health Research (QHR) is an international, interdisciplinary, refereed journal for the enhancement of health care and furthering the development and understanding of qualitative research methods in health care settings. We welcome manuscripts in the following areas: the description and analysis of the illness experience, health and health-seeking behaviors, the experiences of caregivers, the sociocultural organization of health care, health care policy, and related topics. We also consider critical reviews; articles addressing qualitative methods; and commentaries on conceptual, theoretical, methodological, and ethical issues pertaining to qualitative inquiry.

### **General Information**

#### **Important Considerations**

- *Qualitative Health Research* is a peer-reviewed journal. Only complete, finished manuscripts should be submitted for consideration.
- We do not publish stand-alone abstracts, *quantitative* studies, manuscript outlines, pilot studies, manuscripts-in-progress, letters of inquiry, or literature reviews. Research articles *must be pertinent to health*.
- Write both the abstract and the text of your manuscript in *first-person, active voice*.
- For best results, review this entire document prior to preparing and submitting your manuscript.
- Proper manuscript preparation will speed the peer-review process for your manuscript, and will facilitate a smoother production process if it should be selected for publication.

- Improper manuscript preparation could result in burdensome revisions, lengthy delays in the review and production processes, and the possible rejection of your manuscript.

### **General Style**

Authors considering submission to *QHR* should first be familiar with the journal, the types of articles we publish, and our readership. Read several recent articles published in the journal prior to submitting your work, and consider whether your manuscript is a good —fit for the journal.

In general, *QHR* adheres to the requirements of Sage Publications, Inc., and the guidelines contained in the ***Publication Manual of the American Psychological Association*** [—*APA* ], **6th edition** (ISBN 10:1-4338-0561-8, soft cover; ISBN 10:1-4338-0559-6, hardcover; 10:1-4338-0562, spiral bound), with regard to manuscript preparation and formatting.

Elsewhere in these Guidelines this book is referred to as the *APA Publication Manual*, or just *APA*. Additional help may be found online at <http://www.apa.org/>, or search the Internet for —*APA* format. Many universities and private organizations have Web sites devoted to *APA* style. However, when guidelines found on those sites, or in the *APA Publication Manual*, conflict with *QHR* Guidelines, *you must follow the QHR Guidelines*.

### **Abstract and Keywords**

The abstract should be placed on page 1 of the main manuscript document. It should be a single paragraph, no more than 150 words in length, and briefly describe your article. Place your keywords below the abstract, on the same page.

Double space the entire abstract page (including the keywords). Briefly state the purpose of your research, the main findings, and your primary conclusions.

### **Main Manuscript**

*There is no predetermined word or page limit.* Provided they are —tight and concise, *without unnecessary repetition* and/or irrelevant data, manuscripts should be as long as they need to be.

The editor might require a reduction in length if the manuscript contains material that does not add anything useful to the topic being discussed. Limits might be imposed on the number/size/length of tables, figures, reference lists, and appendices.

The main text of the manuscript begins on page 2 of the document, immediately after the abstract page. Write your article in the first-person, active voice.

The main text of the manuscript should be broken into appropriate sections by the use of section headings. Sections should flow in a logical sequence, and include, at a minimum, *Methods, Results, and Discussion*; other headings and subheadings may be used at the author's discretion. The author may choose to use different names for the three main sections, but the basic content should be that which would appropriately fall under the headings of *Methods, Results, and Discussion*.

There are very specific requirements for the preparation of in-text citations; refer to the *APA Publication Manual*, 6th edition, for details. Every in-text citation should have a corresponding reference in the reference list—*no exceptions*.

During the review process, author citations should include only the word *Author* and the year: (*Author, 2008*). If and when the manuscript is accepted for publication, the missing information can be restored.

Double space the entire manuscript document, *except for text contained in figures*.

Use only U.S.-English spelling (except in the references, as appropriate, and for direct quotations from published written sources). Use U.S.-English translations of non-English quotations or excerpts.

Attend to copyright regulations and permission requirements (*required*). Submit, at the time of manuscript submission, written permission for the use of any names, photographs, or copyrighted tables, figures, and/or text; written permission must come from the person(s) depicted in the photographs, or in the case of copyrighted work, from the copyright holder (which is not necessarily the author or the journal in which it is published; see page 6).

**Appendix 2:**  
**List of Key Words used for Systematic Literature Search**

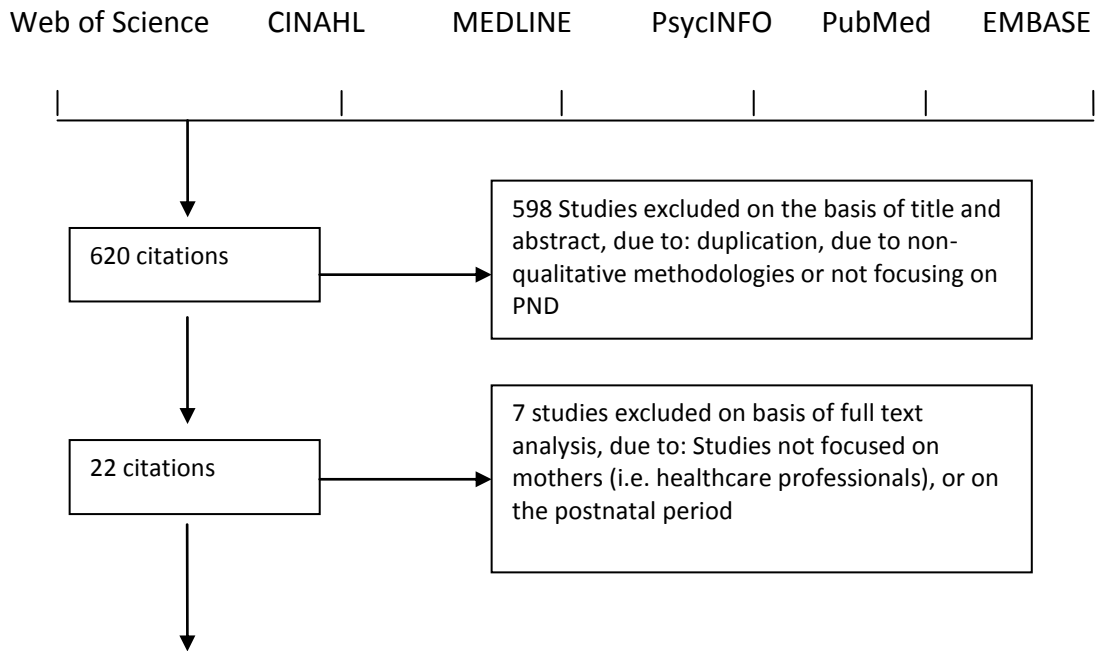
### Key Words used for Systematic Literature Search

Words related to PND	Words used to identify qualitative literature	Words used to identify sample
Postnatal depression	Qualitative	Mother
Postnatal	Phenomenology	Mothering
Postpartum depression	Ethnography	Immigrant
Postpartum	Narrative	Migrant
Depression	Discourse	Refugee
Perinatal	Thematic	Asylum seeker
Childbirth	Interpretative phenomenology	Ethnic minority
	Grounded theory	
	Grounded	
	Interview	
	Focus group	
	Social constructions	
	Exploration	
	Observational	
	Discourse	
	Constant comparative	

**Appendix 3:**  
**Results of Search Strategy and Identification of Studies Included in**  
**Review**



**Flow Chart to Illustrate Results of Search Strategy and Identification of Studies Included in Review**



15 studies, 296 mothers, which met the inclusion/ exclusion criteria

**Appendix 4:**  
**The Study's Quality Assessment Criteria**

**The Study's Quality Assessment Criteria**  
(based on Walsh and Downe, 2005 and CASP, 2002)

1. A focus on mothers with PND, i.e. mothers are the primary informants for the research
2. The mothers are either immigrants or part of an ethnic minority group in the western country they are living in.
3. Clearly stated aims and objectives: the report explicitly and clearly states the aims, the purpose and the relevance of the study.
4. A research design that is appropriate to address the goals and aim of the research. There is discussion and explanation for the focus of the study and the methods used
5. A clear description of sample and why the recruitment strategy was appropriate for the aims of the research. This should include how the participants were selected and an explanation of whether there was any disparity between the planned and actual sample.
6. A clear data collection methodology and justification for this method. This includes methods to collect data and methods of data analysis. It should also include any modifications to the study, such as topic guide being adapted. The form of data should also be clear as well as discussion on data saturation.
7. Clarity on reflexivity. There is discussion of the relationship between the researcher and participants including the researcher examining their own role, potential bias and influence on stages of the research process and the effects of the research on themselves.
8. Evidence that ethical issues have been taken into account; including how ethical standards were sought and maintained, with evidence of fairness with all participants, such as issues around informed consent, confidentiality and how dilemmas were met.
9. Evidence of attempts made to establish the reliability and validity of data analysis. Data analysis that is sufficiently rigorous; analysis should be explicit with an in-depth description of the analysis process. The inclusion of sufficient original data to mediate between data and interpretation; the report should present data in the form of, data tables, direct quotations from interviews or focus groups, or from observations, to enable the reader to see that the results and conclusions were grounded in the data. The study should also include some discussion of the evolution of the coding systems and conceptual frameworks.
10. Clear statement of findings; the findings and research process should be explicit to allow others to follow their decisions. The findings should be discussed in relation to the original research questions. The findings should also be discussed in terms of its contributions to existing knowledge and understanding; its implications and further recommendations of future. The findings should also be explained in their generalisability to other populations.

**Appendix 5:  
Quality Rating Scoring of Included Studies**

### Quality Rating Scoring of Included Studies

Quality rating items	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
<b>1. Mothers with PND are the primary informants for the study</b>	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
<b>2. Mothers are immigrants or part of an ethnic minority group</b>	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
<b>3. Clear and explicit aims objectives, purpose and the relevance of the study.</b>	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
<b>4. A research design that is appropriate to address the goals and aim of the research.</b>	1	1	1	1	1	0.5	0.5	1	0.5	0.5	1	1	1	1	1
<b>5. A clear description of sample and why the recruitment strategy was appropriate for the aims of the research. Including selection of participants and an explanation of whether there was any disparity between the planned and actual sample</b>	1	0.5	1	1	1	0.5	1	0.5	1	0.5	1	1	1	1	1
<b>6. A clear data collection methodology and justification. This includes methods to collect data and methods of data analysis. It should also include any modifications to the study, such as topic guide being adapted. The form of data should also be clear as well as discussion on data saturation.</b>	1	1	1	1	1	1	0.5	1	1	0	1	1	1	1	1
<b>7. Clarity on reflexivity; including discussion of the relationship between the researcher and participants. The researcher examining their own role, potential bias and influence on stages of the research process.</b>	0	0	1	0	0	0	0	0	0	0	0	0	1	0	0
<b>8. Evidence ethical issues have been taken into account: how ethical standards were sought and maintained, evidence of fairness with all participants, informed consent and confidentiality.</b>	0	0	1	1	0	1	0.5	0.5	1	0.5	0.5	0	1	1	1

<b>9. Evidence of attempts made to establish the reliability and validity of data analysis. Data analysis that is sufficiently rigorous. The analysis should be explicit with an in-depth description of the analysis process. The inclusion of sufficient original data to mediate between data and interpretation; the report should present sufficient data in the form of, for example, data tables, direct quotations from interviews or focus groups, or data from observations, to enable the reader to see that the results and conclusions were grounded in the data. The study should also include some discussion of the evolution of the coding systems and conceptual frameworks.</b>	0	1	1	1	1	0	0	0.5	0	0	1	1	1	1	1
<b>10 A clear statement of findings; the findings and research process should be explicit to allow others to follow their decisions. The findings should be discussed in relation to the original research questions. The findings should also be discussed in terms of its contributions to existing knowledge and understanding; its implications and further recommendations of future. The findings should also be explained in their generalisability to other populations.</b>	0.5	1	1	1	1	1	1	1	1	1	1	1	1	1	1
<b>Total score</b>	6.5	7.5	10	9	8	7	6.5	7.5	7.5	5.5	8.5	8	10	9	9
<b>Category A or B</b>	B	B	A	A	B	B	B	B	B	B	B	B	A	A	A

The studies are classified into category 'A' or 'B'.

Category 'A' studies have a low risk of bias and they meet 9 or more of the 10 items proposed.

Category 'B' studies meet 5 to 9 of the 10 items proposed and have a low to moderate risk of bias.

**Appendix 6:**  
**Noblit and Hare's (1988) Seven-step Metasynthesis Approach**

## **Noblit and Hare's (1988) Seven-step Metasynthesis Approach**

(1) *Choosing a phenomenon of study.*

(2) *Deciding which qualitative studies are relevant.*

(3) *Reading the studies carefully.*

(4) *Determining the relationships between the studies.* Compare the tables of themes and concepts from each study to identify their relationships. The synthesis is achieved through three techniques:

a) Reciprocal translation examines the key concepts across each study and attempts to translate the concepts into each other. The ability of the concept of one study to capture the concepts of others is based on the attributes of themes, and the concept (considered to be 'most adequate') is chosen.

b) Refutational synthesis involves identifying contradictions between the concepts and studies which are investigated and explained.

c) 'Lines of argument' synthesis involves building a general interpretation of the findings which are grounded in the findings of the separate studies.

(5) *Translating the studies into one another.* A table detailing the key themes from each study can be created to enable reciprocal translations for the metasynthesis.

(6) *Synthesising translations.* Once studies are translated into each other, overarching themes of the concepts from the primary studies can be formulated, presenting a new interpretation of these findings (Sandelowski & Barroso, 2006).

(7) *Expressing the synthesis.* The synthesis is communicated in diagrammatic (Figure 1) and written form.



**Appendix 7:**  
**Key Themes and Concepts from Studies Included in the Metasynthesis**

## Key Themes and Concepts from Studies Included in the Metasynthesis

Study: Authors and Title	Key concepts and themes
<b>Stewart &amp; Jambunathan (1996) Hmong women and postpartum depression</b>	<ul style="list-style-type: none"> <li>• <b>Psychosocial understanding of PND:</b> unfamiliar culture and language, lack of support systems, insufficient income, poor education</li> <li>• <b>Feeling alone:</b> lack of support systems</li> <li>• Support systems and cultural practices protective, less vulnerable to PND</li> </ul>
<b>Nahas &amp; Amasheh (1999) Culture care meanings and experiences of postpartum depression among Jordanian Australian women: A transcultural study</b>	<ul style="list-style-type: none"> <li>• <b>Upholding gender roles:</b> high expectations to devote life to husband and child, role expectations, pressures to cope and not complain, viewed as a bad mother if role not met</li> <li>• <b>Relationship conflict:</b> impact on relationship with husband, less time with husband</li> <li>• <b>Psychosocial understanding of PND:</b> Fear of failure, not feeling strong enough, responsible or in control of new role, exhaustion from new role, loss of own life. Helplessness (from gender roles and lack of family), loneliness, isolation and lack of social support. Feelings of failure, leading to guilt and depression and poor self image</li> <li>• <b>Feeling alone:</b> loneliness, isolation and lack of social support</li> <li>• <b>Adherence to childbirth rituals and practices:</b> disrupted, feeling robbed of recuperation period. Childbirth rituals more stressful or difficult to adhere to. Conflict between wanting to following practices and pressure and advice from healthcare professionals</li> </ul>
<b>Nahas et al. (1999) Postpartum depression: The lived experiences of middle Eastern migrant women living in Australia</b>	<ul style="list-style-type: none"> <li>• <b>Adherence to rituals and practices:</b> more stressful away from home country or not possible to adhere to. Conflict: between traditional customs and health problems leads to PND intensifying</li> <li>• <b>Upholding gender roles:</b> high expectations, pressures to cope, not complain; fear of failure, not feeling strong enough, or in control</li> <li>• <b>Psychosocial understanding of PND:</b> overwhelming to fulfil role, loneliness leads to helplessness, feeling depressed and exhausted</li> <li>• <b>Feeling alone:</b> lack of social support, isolation and loneliness</li> <li>• <b>Healthcare barriers:</b> lack of PND knowledge and support services; hesitation and fear around PND</li> <li>• <b>Coping strategies:</b> community centres, finding solace from others in own cultural group; diversional activities</li> </ul>
<b>Amankwaa (2003) Postpartum depression among African American Women</b>	<ul style="list-style-type: none"> <li>• <b>Traditional beliefs and values:</b> (1) ideal views of a strong Black woman, avoid discussing (2) negative myths, stereotypes and stigma attached to depression; misconceptions of depression and suicide as an internal weakness</li> <li>• <b>Coping strategies:</b> (1) internal resources such as religious coping, maintaining view as strong female, hiding it due to fears of stigma (2) external support: family, friends, and god (3) getting professional and medical help with harm thoughts</li> <li>• <b>Psychosocial view of PND:</b> caring for children, feeling alone, out of shape, financial worries, mental, physical &amp; external stressors</li> <li>• <b>Feeling alone:</b> feeling alone, lack of support</li> <li>• <b>Healthcare barriers:</b> view of self as strong Black woman, avoid discussing difficulties, acceptance of myths; lack of PND knowledge “only happens to white women”</li> </ul>

Study: Authors and Title	Key themes and concepts
<p><b>Schaper, Murphy &amp; Truscott (2003)</b>  <b>Postpartum Distress Among Hmong Women Living in La Crosse, Wisconsin</b></p>	<ul style="list-style-type: none"> <li>• <b>Adherence to childbirth rituals &amp; practices:</b> restrictions a sources of stress that leads to helplessness, difficulties adhering</li> <li>• <b>Feeling alone:</b> lack of support</li> <li>• <b>Relationship conflict:</b> family ignored and normalized distress symptoms, husbands not limited in their activities</li> <li>• <b>Cultural beliefs &amp; values:</b> (1) communication style contributes to feelings of isolation (2) sickness due to soul/ spirit (3) medications inappropriate. Conflict (1) between extended family model and culture; (2) between traditional, modern and western beliefs</li> <li>• <b>Psychosocial understanding of PND:</b> distress from conflict, isolation and relationship difficulties</li> <li>• <b>Healthcare barriers:</b> bad things not discussed; stigma attached to medications; lack of PND knowledge with no word for depression</li> <li>• <b>View of potential remedies:</b> spiritual approach needed</li> <li>• <b>Coping strategies:</b> silence and hope it goes away</li> </ul>
<p><b>Templeton, Velleman, Persaud &amp; Milner (2003)</b>  <b>The experiences of postnatal depression in women from black and minority ethnic communities in Wiltshire</b></p>	<ul style="list-style-type: none"> <li>• <b>Real life worries:</b> family problems, violence, bereavement, financial difficulties, unemployment, accommodation, harassment</li> <li>• <b>Feeling alone:</b> isolation</li> <li>• <b>Cultural beliefs &amp; values:</b> (1) depression not discussed (2) restrictions: rarely go out unaccompanied, their duty to carry on</li> <li>• <b>Healthcare barriers:</b> unaware of support available, language barriers, refusing help, lack of PND knowledge, unable to identify PND, hoping it would go away; others had an understanding of PND but disbelief or no recognition of PND in selves</li> <li>• <b>View of potential remedies:</b> wanting practical help with housework</li> </ul>
<p><b>Edge, Baker &amp; Rogers (2004)</b>  <b>Perinatal depression among black Caribbean women</b></p>	<ul style="list-style-type: none"> <li>• <b>Psychosocial understanding of PND:</b> accumulation of stressors during pregnancy and early motherhood</li> <li>• <b>Cultural beliefs &amp; values:</b> self concept as a strong, Black woman; depression leads to negative outcome</li> <li>• <b>View of potential remedies:</b> maintaining self concept, and personal agency, autonomy and mastery</li> <li>• <b>Coping strategies:</b> lies within community-based and religious coping and support through spiritual, emotional and practical support from black-led churches and faith communities. Personal and spiritual resources limited effectiveness for some who turned to GPs</li> <li>• <b>Healthcare barriers:</b> fears of healthcare and mental health services; lack of PND knowledge</li> </ul>
<p><b>Parvin, Jones &amp; Hull (2004)</b>  <b>Experiences and understandings of social and emotional distress in the postnatal period among Bangladeshi women living in Tower Hamlets</b></p>	<ul style="list-style-type: none"> <li>• <b>Psychosocial understanding of PND:</b> product of social stress, practical problems of no time to rest and lack of social support</li> <li>• <b>Feeling alone:</b> family in Bangladesh, husbands working, not part of their role to help</li> <li>• <b>Upholding gender roles:</b> overwhelmed by fulfilling roles once home leads to helplessness and depressed feelings.</li> <li>• <b>Healthcare barriers:</b> (1) Language barriers (2) Poor understanding of healthcare services: view GP, health visitor and midwife as physical healthcare, present with physical symptoms from emotional distress (3) Lack of PND knowledge: not seen as an illness</li> <li>• <b>Coping strategies:</b> “keeping self happy”, religious coping and avoiding discussing emotional or practical difficulties</li> <li>• <b>Cultural beliefs &amp; values:</b> discussing indicates a weakness or failure in role; home matters not discussed</li> <li>• <b>Adherence to childbirth rituals &amp; practices:</b> difficulties adhering to them when not in home country</li> </ul>

Study: Authors and Title	Key themes and concepts
<p><b>Taniguchi &amp; Baruffi (2007)</b>  <b>Childbirth overseas: The experience of Japanese women in Hawaii.</b></p>	<ul style="list-style-type: none"> <li>• <b>Psychosocial understanding of PND:</b> poor marital adjustment, distance from family, early discharge, language barrier, different culture</li> <li>• <b>Feeling alone:</b> loneliness and isolation</li> <li>• <b>Coping strategies:</b> religious coping</li> <li>• <b>View of potential remedies:</b> wanting mother's help, and partner's support and love</li> <li>• <b>Relationship conflict:</b> partner's lack of understanding leads to further loneliness</li> </ul>
<p><b>Edge (2008)</b>  <b>'We don't see Black women here': an exploration of the absence of Black Caribbean women from clinical and epidemiological data on perinatal depression in UK</b></p>	<ul style="list-style-type: none"> <li>• <b>Cultural beliefs &amp; values:</b> (1) Reluctance to discuss mental illness (2) beliefs as a strong Black woman (3) minimise and normalise distress; (4) depression seen as a moral weakness and personal failure and stigma attached to failing and weakness</li> <li>• <b>Healthcare barriers:</b> (1) healthcare not viewed as culturally sensitive or appropriate, preference for counselling from someone with same ethnic and cultural background, fears around confidentiality (2) instrumental barriers to healthcare: long waiting lists and childcare facilities (3) Lack of PND knowledge: unable to identify depression in themselves</li> <li>• <b>Experience of healthcare:</b> PND either normalised and self management encouraged or reinforced social model</li> <li>• <b>Coping strategies:</b> personal agency, mastery, religious coping. Help-seeking with self-harm thoughts</li> </ul>
<p><b>Ahmed, Stewart, Teng, Wahoush &amp; Gagnon (2008)</b>  <b>Experiences of immigrant new mothers with symptoms of depression</b></p>	<ul style="list-style-type: none"> <li>• <b>Healthcare barriers:</b> Language difficulties; stigma, fear of being an unfit mother or losing child; lack of knowledge of services</li> <li>• <b>Experience of healthcare:</b> seeking help with persisting symptoms; mixed experiences; generally helpful; limited time with doctors</li> <li>• <b>Psychosocial understanding of PND:</b> overwhelmed by baby; financial pressures, physical changes; new unfamiliar country</li> <li>• <b>Feeling alone:</b> social isolation</li> <li>• <b>View of potential remedies:</b> social and practical support; community support groups; returning to previous occupation</li> </ul>
<p><b>Morrow, Smith, Lai &amp; Jaswal (2008)</b>  <b>Shifting Landscapes: Immigrant women and postpartum depression</b></p>	<ul style="list-style-type: none"> <li>• <b>Psychosocial view of PND:</b> social, situational and contextual factors, emphasis on interpersonal relationships and family conflict.</li> <li>• <b>Feeling alone:</b> reduced social network, isolation, no sense of security or safety and reduced or no support</li> <li>• <b>Relationship conflict:</b> lack of emotional support from husbands and conflict with in-laws</li> <li>• <b>Real life worries:</b> job deskilling, lack of stable housing and financial difficulties</li> <li>• <b>Adherence to childbirth rituals &amp; practices:</b> disrupted, beliefs of bad health with non adherence and experience of stress</li> <li>• <b>Upholding gender roles:</b> (1) pressure to adhere to role (2) High self-expectations of role, masking difficulties to maintain role and not ask for help, community expectations exacerbate maternal ideals</li> <li>• <b>Cultural beliefs &amp; values</b> (1) negative view of western medication (3) preference for natural remedies</li> <li>• <b>View of potential remedies:</b> problem solving within family; natural remedies</li> <li>• <b>Coping strategies:</b> social support from husbands, family, sometimes friends or community-based resources</li> <li>• <b>Healthcare barriers:</b> professionals not seen as appropriate, avoid doctors due to not wanting medications: family view of ADs as negative and encouraged not to take them or modify dosage; doctors viewed as too busy, use culture specific analogies &amp; metaphors</li> </ul>

Study: Authors and Title	Key themes and concepts
<p><b>Abrams, &amp; Curran (2009)</b>  <b>“And you’re telling me not to stress”: A grounded theory study of postpartum depression symptoms among low-income mothers</b></p>	<ul style="list-style-type: none"> <li>• <b>Psychosocial view of PND:</b> juggling, balancing and managing multiple responsibilities, feeling overwhelmed by responsibilities, situational factors from material and social circumstance of poverty, demands of low economic status, managing bureaucracy, service and systems, lack of social support and need for respite</li> <li>• <b>Real life worries:</b> child’s health problems and situational factors of financial difficulties, poverty, material deprivation and dangerous living situations.</li> <li>• <b>Feeling alone:</b> loneliness, emotional isolation and absent fathers</li> </ul>
<p><b>Abrams, Dornig &amp; Curran (2009)</b>  <b>Barriers to service use postpartum depression symptoms among low-income ethnic minority mothers in the US</b></p>	<ul style="list-style-type: none"> <li>• <b>Cultural values/ beliefs:</b> (1) African Americans beliefs that good mothers don’t get depressed, self concept as strong and self reliant with views that depression means you’re crazy. Mental healthcare: seen as bad investment and frowned upon (2) Latinas and family ethic rejecting of mental health services: cultural norms prohibit open discussion, potential shame for accessing help and needing husband’s approval to seek help</li> <li>• <b>Healthcare barriers:</b> (1) rejecting professional help, viewed as uncaring, given a pill, bad investment and medications not appropriate (2) Instrumental barriers accessing support: financial strains, lack of knowledge of services, childcare and transportation costs</li> <li>• <b>View of potential remedies:</b> talking it out or use of support groups</li> <li>• <b>Coping strategies:</b> self care and using self help practices: various emotional, cognitive, behavioural strategies as well as educating self about PPD, and religious coping provides strength, comfort and healing</li> </ul>
<p><b>Abrams &amp; Curran (2011)</b>  <b>Maternal identity negotiations among low-income women with symptoms of postpartum depression</b></p>	<ul style="list-style-type: none"> <li>• <b>Cultural beliefs &amp; values:</b> PPD threatens idealised mothering/ ideal expectations, depression means you’re a bad mother or incompetent mother</li> <li>• <b>Psychosocial understanding of PND:</b> poverty and distressing economic conditions exacerbate symptoms, paternal absence or lack of involvement</li> <li>• <b>Coping strategies:</b> (1) internal resources: asserting positive identities, prioritising child, child’s needs, and self sacrifice, (2) creating image of self as engaged mothers who invest time in child and finding mothering pleasurable (3) dealing with conflicting views of self through comparing self to others, relational approaches and externalising their PND</li> </ul>

**Appendix 8:**  
**British Journal of Clinical Psychology- Guidelines for Authorship**

## British Journal of Clinical Psychology- Guidelines for Authorship

The British Journal of Clinical Psychology publishes original contributions to scientific knowledge in clinical psychology. This includes descriptive comparisons, as well as studies of the assessment, aetiology and treatment of people with a wide range of psychological problems in all age groups and settings. The level of analysis of studies ranges from biological influences on individual behaviour through to studies of psychological interventions and treatments on individuals, dyads, families and groups, to investigations of the relationships between explicitly social and psychological levels of analysis.

The following types of paper are invited:

- Papers reporting original empirical investigations
- Theoretical papers, provided that these are sufficiently related to the empirical data
- Review articles which need not be exhaustive but which should give an interpretation of the state of the research in a given field and, where appropriate, identify its clinical implications
- Brief reports and comments

### 1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

### 2. Length

Papers should normally be no more than 5000 words (excluding abstract, reference list, tables and figures), although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

### 3. Submission and reviewing

All manuscripts must be submitted via <http://www.editorialmanager.com/bjcp/>. The Journal operates a policy of anonymous peer review.

### 4. Manuscript requirements

- Contributions must be typed in double spacing with wide margins. All sheets must be numbered.
- Manuscripts should be preceded by a title page which includes a full list of authors and their affiliations, as well as the corresponding author's contact details. A template can be downloaded from [here](#).

- Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.
- Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi.
- For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, Results, Conclusions. Review articles should use these headings: Purpose, Methods, Results, Conclusions.
- For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full.
- SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.
- In normal circumstances, effect size should be incorporated.
- Authors are requested to avoid the use of sexist language.
- Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright. For guidelines on editorial style, please consult the APA Publication Manual published by the American Psychological Association.

##### 5. Brief reports and comments

These allow publication of research studies and theoretical, critical or review comments with an essential contribution to make. They should be limited to 2000 words, including references. The abstract should not exceed 120 words and should be structured under these headings: Objective, Method, Results, Conclusions. There should be no more than one table or figure, which should only be included if it conveys information more efficiently than the text. Title, author name and address are not included in the word limit.

##### 6. Supporting Information

BJC is happy to accept articles with supporting information supplied for online only publication. This may include appendices, supplementary figures, sound files, videoclips etc. These will be posted on Wiley Online Library with the article. The print version will have a note indicating that extra material is available online. Please indicate clearly on submission which material is for online only publication. Please note



that extra online only material is published as supplied by the author in the same file format and is not copyedited or typeset. Further information about this service can be found at <http://authorservices.wiley.com/bauthor/suppmat.asp>

#### 7. Copyright

Authors will be required to assign copyright to The British Psychological Society. Copyright assignment is a condition of publication and papers will not be passed to the publisher for production unless copyright has been assigned. To assist authors an appropriate copyright assignment form will be supplied by the editorial office and is also available on the journal's website at [http://www.blackwellpublishing.com/pdf/CTA\\_BPS.pdf](http://www.blackwellpublishing.com/pdf/CTA_BPS.pdf). Government employees in both the US and the UK need to complete the Author Warranty sections, although copyright in such cases does not need to be assigned.

#### 8. Colour illustrations

Colour illustrations can be accepted for publication online. These would be reproduced in greyscale in the print version. If authors would like these figures to be reproduced in colour in print at their expense they should request this by completing a Colour Work Agreement form upon acceptance of the paper. A copy of the Colour Work Agreement form can be downloaded [here](#).

#### 9. Pre-submission English-language editing

Authors for whom English is a second language may choose to have their manuscript professionally edited before submission to improve the English. A list of independent suppliers of editing services can be found at [http://authorservices.wiley.com/bauthor/english\\_language.asp](http://authorservices.wiley.com/bauthor/english_language.asp). All services are paid for and arranged by the author, and use of one of these services does not guarantee acceptance or preference for publication.

#### 10. Author Services

Author Services enables authors to track their article – once it has been accepted – through the production process to publication online and in print. Authors can check the status of their articles online and choose to receive automated e-mails at key stages of production. The author will receive an e-mail with a unique link that enables them to register and have their article automatically added to the system. Please ensure that a complete e-mail address is provided when submitting the manuscript. Visit <http://authorservices.wiley.com/bauthor/> for more details on online production tracking and for a wealth of resources including FAQs and tips on article preparation, submission and more.

#### 11. The Later Stages

The corresponding author will receive an email alert containing a link to a web site. A working e-mail address must therefore be provided for the corresponding author. The proof can be downloaded as a PDF (portable document format) file from this site. Acrobat Reader will be required in order to read this file. This software can be downloaded (free of charge) from the following web site: <http://www.adobe.com/products/acrobat/readstep2.html>.

This will enable the file to be opened, read on screen and annotated direct in the PDF. Corrections can also be supplied by hard copy if preferred. Further instructions will be sent with the proof. Hard copy proofs will be posted if no e-mail address is available. Excessive changes made by the author in the proofs, excluding typesetting errors, will be charged separately.

## 12. Early View

British Journal of Clinical Psychology is covered by the Early View service on Wiley Online Library. Early View articles are complete full-text articles published online in advance of their publication in a printed issue. Articles are therefore available as soon as they are ready, rather than having to wait for the next scheduled print issue. Early View articles are complete and final. They have been fully reviewed, revised and edited for publication, and the authors' final corrections have been incorporated. Because they are in final form, no changes can be made after online publication. The nature of Early View articles means that they do not yet have volume, issue or page numbers, so they cannot be cited in the traditional way. They are cited using their Digital Object Identifier (DOI) with no volume and issue or pagination information. E.g., Jones, A.B. (2010). Human rights Issues. *Human Rights Journal*. Advance online publication. doi:10.1111/j.1467-9299.2010.00300.x

**Appendix 9:**  
**National Research Ethics Service Approval Letter**



21 July 2010

Miss Sonia Patel  
Trainee Clinical Psychologist  
University of Manchester  
Division of Clinical Psychology  
Second Floor, Zochonis Building  
Brunswick Street  
Manchester  
M13 9PL

Dear Miss Patel

**Study Title:** An exploration of illness beliefs in mothers with depression after childbirth  
**REC reference number:** 10/H1013/33

Thank you for your letter of 07 July 2010, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Vice-Chair.

**Confirmation of ethical opinion**

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

**Ethical review of research sites**

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

**Conditions of the favourable opinion**

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research

This Research Ethics Committee is an advisory committee to North West Strategic Health Authority

governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

*Where the only involvement of the NHS organisation is as a Participant Identification Centre (PIC), management permission for research is not required but the R&D office should be notified of the study and agree to the organisation's involvement. Guidance on procedures for PICs is available in IRAS. Further advice should be sought from the R&D office where necessary.*

*Sponsors are not required to notify the Committee of approvals from host organisations.*

**It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).**

### Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Investigator CV		10 May 2010
Protocol	3	03 December 2009
CV Wittkowski		11 May 2010
REC application	2.5	10 May 2010
Covering Letter		11 May 2010
Covering Letter		07 July 2010
Letter from Sponsor		07 May 2010
Interview Schedules/Topic Guides	1	07 February 2010
Questionnaire: Edinburgh PD Scale		
GP/Consultant Information Sheets	2	02 July 2010
Response to Request for Further Information		07 July 2010
Participant Information Sheet	2	02 July 2010
Participant Consent Form	2	02 July 2010
Health and Safety Lone Working Policy	2	01 September 2007

### Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

### After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email [referencegroup@nres.npsa.nhs.uk](mailto:referencegroup@nres.npsa.nhs.uk).

**10/H1013/33**

**Please quote this number on all correspondence**

Yours sincerely



**Mr Francis Chan  
Chair**

Email: [stephen.tebbutt@northwest.nhs.uk](mailto:stephen.tebbutt@northwest.nhs.uk)

Enclosures: "After ethical review – guidance for researchers"

Copy to: Mr Mohammed Zubair, University of Manchester

**Appendix 10:  
National Research Ethics Service Approval Letter following Substantial  
Amendment**



## National Research Ethics Service

16 December 2010

**Private & Confidential**  
Miss S Patel, Trainee Clinical Psychologist  
Division of Clinical Psychology  
University of Manchester  
Second Floor, Zochonis Building  
Brunswick Street  
Manchester  
M13 9PL

Dear Miss Patel

**Study title:** An exploration of illness beliefs in mothers with depression after childbirth  
**REC reference:** 10/H1013/33  
**Amendment number:** Substantial amendment 1  
**Amendment date:** 06 December 2010  
**Summary:**

To extend recruitment:

- to include mothers with babies up to 2 years (changed from up to 12 months)
- to include mothers with previous episodes of depression or recurrent depression
- to add a new NHS site
- to recruit from non-health services

The above amendment was reviewed by the Sub-Committee in correspondence.

### Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

### However:

The amendment form says under 'summary of changes' that you propose to extend the exclusion criteria..... Please confirm that this should read 'to extend the inclusion criteria'.

The proposed information to be placed on the Internet is considered to include terms which are not explained and are non- lay friendly such as PND, illness dimensions, illness coherence and emotional representations. It is considered that these could deter recruitment. If you wish to amend the wording, please submit a revised version.



It was felt that the proposed change to include any form of depression rather than limiting it to post-natal depression could affect the validity of your conclusions, and you will no doubt discuss this with your educational supervisor.

### Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Participant Information Sheet	4	07 December 2010
Protocol	2	07 December 2010
Notice of Substantial Amendment	Substantial amendment 1	06 December 2010

### Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

### R&D approval

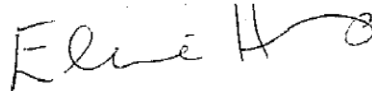
All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

### Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

10/H1013/33:	Please quote this number on all correspondence
--------------	--

Yours sincerely



**Ms Elaine Hutchings**  
Committee Co-ordinator

E-mail: [elaine.hutchings@northwest.nhs.uk](mailto:elaine.hutchings@northwest.nhs.uk)

Enclosure: List of names and professions of members who took part in the review

Copy to: Dr N Thakker, R&D  
University of Manchester

**Appendix 11:  
R & D Approval Letter 1**



**NHS Salford+D Director:  
R&D Lead:**

Professor Bill Ollier  
Rachel Georgiou

**Enquiries:**

Email: [Salford\\_Regroup-RD@manchester.ac.uk](mailto:Salford_Regroup-RD@manchester.ac.uk)  
Tele: 0161 205 8343  
Fax: 0161 205 4205

**Salford+D web address:  
ReGroup web address:**

<http://www.nhssalfordrd.org.uk/>  
<http://www.gmregroup.nhs.uk/index.html>

9<sup>th</sup> February 2011

Miss Sonia Patel  
Trainee Clinical Psychologist  
Division of Clinical Psychology  
2nd Floor Zochonis Building  
Brunswick St  
Uni of Manchester  
M13 9PL

Dear Sonia

**Study Title: An exploration of illness beliefs in mothers with depression after childbirth**  
**REC Reference: 10/H1013/33**  
**R&D Reference: 2011/005**

Thank you for forwarding all the required documentation for your study as above. I am pleased to inform you that your study has been registered with NHS Salford+D and has gained NHS R&D approval from the following NHS Trusts:

- 

All clinical research must comply with the Health and Safety at Work Act, [www.hse.gov.uk](http://www.hse.gov.uk) and the Data Protection Act. <http://www.hmsc.gov.uk/acts>

It is a legal requirement for Principal Investigators involved in Clinical Trials to have completed accredited ICH GCP training within the last 2 years. Please ensure that you provide the R&D Department with evidence of this (certificate for completing the course). A list of GCP training courses can be obtained from the R&D Office.

All researchers who do not hold a substantive contract with the Trust must hold an honorary research contract before commencing any study activities related to this approval. The 'Research Passport Application Form'. This can be obtained from web addresses: <http://www.gmregroup.nhs.uk/researchers/passports.html> and <http://www.hope-academic.org.uk/academic/salfordrd/Research%20Passports.html>. This form should be completed and returned, with a summary C.V and recent (within 6 months) CRB to the address shown above.

It is a condition of both NRES and NHS R&D approval that participant recruitment data should be forwarded on a regular basis. Therefore, progress reports must be submitted annually to the main REC and copied to the R&D office until the end of the study. <http://www.nres.npsa.nhs.uk/applicants/review/after/progress.htm#annual>.

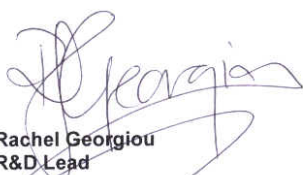
Where clinical trials of investigational medicinal products are sponsored by Salford Royal NHS Foundation Trust or Salford Primary Care Trust, it is a condition of Trust approval that Chief Investigators submit quarterly progress reports (to include Annual Safety Reports at the appropriate time) to R&D. For clinical trials of investigational medicinal products hosted within Salford Royal NHS Foundation Trust and Salford

Primary Care Trust, the local PI will be expected to submit bi-annual progress reports to R&D. It is also a condition of approval that delegated duties (as agreed within clinical trial agreements and trial delegation logs) are fulfilled by only those delegated to undertake a specific duty. This will be monitored by the Sponsor's Representative during routine monitoring of the trial. Persistent non-compliance with these requirements may result in removal of Sponsorship or Trust R&D Approval.

Any amendments to the study should also be notified and approval sought by Ethics Committee and R&D Department. ***Where Salford Royal NHS Foundation Trust or Salford Primary Care Trust is acting as Sponsor then amendments or changes MUST be discussed with the Sponsor prior to REC submission.*** On completion of the study you are required to submit a 'Declaration of End of Study' form to the main REC, which should also be copied and forwarded to the R&D office at the address shown above.

Any serious adverse events or governance issues related to the research must be notified to the R&D office.

Yours sincerely,



**Rachel Georgiou**  
R&D Lead

**Appendix 12:  
R & D Approval Letter 2**

**Standardised Process for  
Electronic Approval of Research**

30<sup>th</sup> July 2010

Sonia Patel  
Division of Clinical Psychology,  
2nd Floor,  
Zochonis Building,  
Brunswick Street,  
University of Manchester,  
M13 9PL

Research & Development Office  
Manchester Mental Health & Social Care Trust  
Room N.3.FC027  
3rd Floor  
Rawnsley Building  
Manchester Royal Infirmary  
Hathersage Road  
Manchester  
M13 9WL  
t 0161 276 3311

**Information for ID Badge if required:**

Research Project Ref No: 0959  
Expiry Date: 01/09/2011

You must take this letter with you.

Dear Sonia,

**Re: Research Governance Decision Letter**

**Project Reference: 0959**

**Unique SPEAR Identifier: 0959**

**Project Title :** *An exploration of illness beliefs in mothers with depression after childbirth.*

Further to your request for research governance approval, we are pleased to inform you that this Trust has approved the study. Please note when contacting the R&D office about your study you must always provide the project reference numbers provided above.

Trust R&D approval covers all locations within the Trust, however, you should ensure you have liaised with and obtained the agreement of individual service/ward managers before commencing your research.

Please take the time to read the attached 'Information for Researchers – Conditions of Research Governance Approval' leaflet, which give the conditions that apply when research governance approval has been granted. Please contact the R&D Office should you require any further information. You may need this letter as proof of your approval.

It is your responsibility to contact us a week prior to the expiry date we have recorded for this project to let us know if you wish to extend it, as we will need to send a new approval letter. You will also need to let us know immediately if for

any reason the project finishes earlier and provide us with a summary and copy of the Ethics 'end of study' report

May I wish you every success with your research.

Yours sincerely



Dr. Richard Hopkins  
**Research & Development Director**

cc : Dr. Anja Wittowski,   
Mohammed Zubair – University of Manchester

Enc: Approval Conditions Leaflet  
Induction & ID Badge Information  
TrustTECH Leaflet

**Appendix 13:  
Participant Information Sheet**



## Participant Information Sheet

Thank you for reading this.

This sheet tells you all about the research that I am doing at the University of Manchester. Before you decide if you would be interested in participating in this study it is important for you to understand why the study is being done and what it will involve.

### 1. Title of the research project

An exploration of illness beliefs in mothers with depression following childbirth

### 2. What the research is about?

Around 1 in 10 women experience postnatal depression (PND) after they have had a baby. It usually occurs in the first few months and is characterised by low mood, low self esteem, anxiety, disturbed sleep and appetite, fatigue, irritability, poor concentration, lack of energy and motivation. Mothers who experience PND may experience guilt, inadequacy or rejection for having negative thoughts. However, these negative thoughts are very common after birth and have also been found in mothers who do not have PND. A questionnaire called the Illness Perception Questionnaire (IPQ-R) has been created to measure people's feelings and beliefs about having a physical illness but it has also been modified to be applicable to a mental health context. This study will help us to develop a theoretical understanding of the illness beliefs (beliefs and feelings that women have about their PND) in women with PND and what particular illness dimensions (dimensions of the illness include consequences, identity, timeline, control/cure, cause, illness coherence and emotional representations) are important to these women. This knowledge may ultimately to refine current treatments for women experiencing PND.

### 3. Invitation

We are trying to explore women's illness beliefs about their depression following the birth of their baby and would like to invite you to take part in this study.

### 4. Why have I been chosen?

I am inviting anyone who has experienced depression following the birth of their baby within the **last 24 months** to take part in the research.

### 5. Do I have to take part?

No, taking part is voluntary. If you decide that you would like to take part in the research or if you change your mind and decide that you would rather not be part of the study, you can withdraw at any time and this will not affect the treatment that you or your baby receive. I will give you a consent form for you to sign when we meet. You can keep a copy of this form.

### 6. What do I have to do?

If you choose to meet with me, the meeting will last around an hour and a half. I can meet with you at your home, or at a location more convenient for you, such as a local GP Clinic or

Children's Centre. I will initially go through one brief questionnaire and ask you more questions that will provide me with some information about yourself. I would then interview you asking about your specific experiences. This interview will be audio recorded to help me remember your answers.

**7. Are there possible disadvantages and risks of taking part?**

Usually there are no risks associated with studies of this kind. Your treatment will not be affected in any way, whether you agree to meet with me or not.

The interview may include topics that you may find upsetting or distressing. If you did become upset during the study, you would be offered the following options: to carry on, to have a break, to postpone or to terminate the interview. You may also be offered the possibility to be signposted to appropriate services/ professionals such as your GP or health visitor for advice or to discuss any concerns raised by your involvement in the study.

Usually, whatever you talk about stays confidential. I will be letting your GP know that you have agreed to take part in the research but I will not be telling them about what you have said. However, I would need to tell someone else if I was concerned about any risk of harm to yourself or to someone else but I would talk to you about this first.

**8. Are there any benefits to taking part in this research?**

You may benefit from speaking to someone about your feelings and experiences, especially if you do not have anyone else to speak to about these. The research may help to refine current treatments.

**9. Expenses and Payments**

Unfortunately travel expenses will not be reimbursed. However, I can meet with you at the most convenient location including your home, your local hospital or at a local GP Clinic or Day Centre.

**10. What will happen to the information I give to you at our meeting?**

I will analyse your responses. Any information you provide will be stored in a locked cupboard, including the audio recordings. Any forms that you fill in will be anonymised and the forms will have a number on instead of your name. I will be the only person that knows what your number is. All personal information I have gained from the study will be destroyed in 5 years time. The research that I write up will be published but your name will not be given. I will be able to give you a summary of all the findings if you wish; this may be in the form of a summary sheet or one-to-one.

**11. What if there is a problem?**

**Complaints**

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. If they are unable to resolve your concern or you wish to make a complaint regarding the study, please contact a University Research Practice and Governance Co-ordinator on 0161 2757583 or 0161 2758093 or by email to [research-governance@manchester.ac.uk](mailto:research-governance@manchester.ac.uk).

## **Harm**

In the event that something does go wrong and you are harmed during the research you may have grounds for a legal action for compensation against The University of Manchester and Manchester Mental Health And Social Care Trust but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you.

The University of Manchester has cover for no fault compensation for bodily injury, mental injury or death where the injury resulted from a trial or procedure you received as part of the trial. This would be subject to policy terms and conditions. Any payment would be without legal commitment. (Please ask if you wish more information on this). The University would not be bound to pay this compensation where the injury resulted from a drug or procedure outside the trial protocol or the protocol was not followed

## **12. Who is organising and funding the research?**

The research has been organised and funded by the University of Manchester. If you would like any more information on the research, please do not hesitate to phone me on 0161 306 0400. If I am not available you can leave a message and I will ring you back. I can also be contacted at **sonia.patel@postgrad.manchester.ac.uk**

Thank you for considering taking part in the research.

Sonia Patel (Trainee Clinical Psychologist)  
University of Manchester  
Division of Clinical Psychology  
2<sup>nd</sup> Floor, Zochonis Building  
Brunswick Street  
Manchester, M13 9PL

Anja Wittkowski (Clinical Psychologist)  
University of Manchester  
Division of Clinical Psychology  
2<sup>nd</sup> Floor, Zochonis Building  
Brunswick Street  
Manchester, M13 9PL

**Appendix 14:  
Consent Form**

**Consent form**

**Title of Project:** An exploration of illness beliefs in mothers with depression following childbirth  
**Researcher:** Sonia Patel

Please delete and initial as necessary

1. Have you read the Participant Information Sheet dated 07/12/10 (Version 4) for the above study?	<b>YES/NO</b> Initials:.....
2. Have you received enough information about the study? Have you had the opportunity to consider the information, ask questions and have these questions answered satisfactorily?	<b>YES/NO</b> Initials:.....
3. Do you consent to be audio taped as detailed in the Participant Information Sheet for the purpose of analysing responses accurately?	<b>YES/NO</b> Initials:.....
4. Do you understand that you do not need to take part in the study and if you do enter you are free to withdraw:- * at any time * without having to give a reason for withdrawing * and without detriment to you?	<b>YES/NO</b> Initials:.....
5. Do you understand that relevant sections of your medical notes and data collected during the study may be looked at by individuals from the University of Manchester, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research? Do you give permission for these individuals to have access to your records?	<b>YES/NO</b> Initials:.....
6. Do you consent to your medical records being accessed by the researcher (Sonia Patel)?	<b>YES/NO</b> Initials:.....
7. Do you understand that your G.P will be informed that you will be taking part in this research?	<b>YES/NO</b> Initials:.....
8. Do you understand that as part of standard practice, that in the event of disclosure of risk or harm, confidentiality will be breached in the best interests of those involved?	<b>YES/NO</b> Initials:.....
9. Do you agree to take part in this study?	<b>YES/NO</b> Initials:.....

**Name of participant:** ..... **Signed:** ..... **Date:** .....

**Name of researcher:** ..... **Signed:** ..... **Date:** .....

**Appendix 15:**  
**Demographic and Social Information Questionnaire**

## Demographic and Social Information Questionnaire

### Part 1 – Demographic Information

Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Age: \_\_\_\_\_

Maternal age: \_\_\_\_\_

Age of child: \_\_\_\_\_

Gender of child: M F

Mode of delivery: \_\_\_\_\_

Parity: \_\_\_\_\_

Marital status: SINGLE MARRIED DIVORCED SEPARATED OTHER

Who do you live with? PARTNER PARENTS ALONE CHILDREN  
PARTNER AND CHILDREN OTHER

#### Ethnicity: with which ethnic group do you identify?

##### WHITE

A BRITISH  
B IRISH  
C ANY OTHER

##### BLACK OR BLACK BRITISH

M CARIBBEAN  
N AFRICAN  
P ANY OTHER

##### MIXED

D WHITE & BLACK CARIBBEAN  
E WHITE & BLACK AFRICAN

##### OTHER ETHNIC GROUPS

R CHINESE  
S ANY OTHER ETHNIC

##### GROUP

F WHITE & ASIAN  
G ANY OTHER

##### ASIAN OR ASIAN BRITISH

H INDIAN  
J PAKISTANI  
K BANGLADESHI  
L ANY OTHER

#### Highest level of educational attainment:

GCSE (or equivalent) \_\_\_\_\_ A-Level (or equivalent) \_\_\_\_\_ Degree \_\_\_\_\_

Masters \_\_\_\_\_ PhD (or equivalent) \_\_\_\_\_

**Part 2 – Social and Personal information**

**How would you rate your financial situation at present?**

1.....2.....3.....4.....5.....6.....7.....8.....9.....10

Unsatisfactory

Satisfactory

**How expected was your pregnancy?**

1.....2.....3.....4.....5.....6.....7.....8.....9.....10

Planned

Complete surprise

**How did you feel when you found out you were pregnant?**

1.....2.....3.....4.....5.....6.....7.....8.....9.....10

Unhappy

Very happy

**How many pregnancies have you experienced prior to this current one? \_\_\_\_\_**

**How many children do you have? \_\_\_\_\_**

**How old are your other children? \_\_\_\_\_**

**Have you experienced any emotional or psychological difficulties in the past?**

Yes (please specify)

No

Anxiety

Depression

Other \_\_\_\_\_

**If so, what help did you receive?**

None

Medication

Talking therapy Admission to hospital

Other (please specify) \_\_\_\_\_

**How was your health during your pregnancy?**

---

---



**I have good friends who support me**

Always            Most of the time            Some of the time            Rarely            Never

**My family is always there for me**

Always            Most of the time            Some of the time            Rarely            Never

**My husband/ partner helps me a lot**

Always            Most of the time            Some of the time            Rarely            Never

**There is a lot of conflict with my husband/ partner**

Always            Most of the time            Some of the time            Rarely            Never

**I feel controlled by my husband/ partner**

Always            Most of the time            Some of the time            Rarely            Never

**I feel loved by my husband/ partner**

Always            Most of the time            Some of the time            Rarely            Never

**Appendix 16:**  
**The Edinburgh Postnatal Depression Scale (EPDS)**

## The Edinburgh Postnatal Depression Scale (EPDS)

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.

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed:

*I have felt happy:*

- a. Yes, all the time
- b. Yes, most of the time
- c. No, not very often
- d. No, not at all

*This would mean "I have felt happy most of the time during the past week.*

**In the past 7 days:**

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

- a. As much as I always could
- b. Not quite so much now
- c. Definitely not so much now
- d. Not at all

**2. I have looked forward with enjoyment to things -**

- a. As much as I ever did
- b. Rather less than I used to
- c. Definitely less than I used to
- d. Hardly at all

**3. I have blamed myself unnecessarily when things went wrong -**

- a. Yes, most of the time
- b. Yes, some of the time
- c. Not very often
- d. No, never

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

- a. No, not at all
- b. Hardly ever
- c. Yes, sometimes
- d. Yes, very often

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

- a. Yes, quite a lot
- b. Yes, sometimes
- c. No, not much
- d. No, not at all

**6. Things have been getting on top of me -**

- a. Yes, most of the time I haven't been able to cope at all
- b. Yes, sometimes I haven't been coping as well as usual
- c. No, most of the time I have coped quite well
- d. No, I have been coping as well as ever

**7. I have been so unhappy that I have had difficulty sleeping -**

- a. Yes, most of the time
- b. Yes, some of the time
- c. Not very often
- d. No, not at all

**8. I have felt sad or miserable -**

- a. Yes, most of the time
- b. Yes, some of the time
- c. Not very often
- d. No, not at all

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

- a. Yes, most of the time
- b. Yes, quite often
- c. Only occasionally
- d. No, never

**10. The thought of harming myself has occurred to me -**

- a. Yes, quite often
- b. Sometimes
- c. Hardly ever
- d. Never

**Appendix 17:  
Interview Schedule**

## Interview Schedule

### **How has it been for you since the birth of your child?**

Probes:

- Is this what you expected?
- What did you expect?

### **How would you describe how you have been feeling since the birth of your child?**

Probes:

- E.g. Towards your baby/ family
- Is this what you expected?
- What did you expect?
- Do you understand what this means/ what is happening?
- Have you felt this way before? When? What happened?

### **Has anyone given you a label?**

Probes:

- Feelings about labels: agree/disagree?
- How would you describe it?
- Would you describe yourself as unwell?
- Positive aspects?
- Negative aspects?

### **What's your sense about the causes of how you've been feeling?**

### **What other factors do you think have led to how you have been feeling after the birth?**

### **How do you think things will be for you in the future?**

Probes:

- Short-term
- Long-term
- Optimistic or pessimistic views
- Hopes and worries

**What was your view of PND before experiencing it?**

**Are there any positive (negative) aspects of PND?**

**Have you had any support (practical/ emotional) following the birth of your child?**

Probes:

- Is this what you expected?
- Who did you turn to?
- Was there anybody? (family, friends, staff, services)
- If you have had support, what was helpful/ not so helpful?

**Is there anything else I should know, understand better?**

**Appendix 18:**  
**Anonymised coded transcript**



**Anonymised coded transcript**

<b>TRANSCRIPT: 2</b>	<b>CODE</b>
<p><b>How has it been for you since the birth of Jake?</b></p> <p>Very busy. It was very hard actually at first. I have a, my eldest child she was quite a full on child. Umm, and she was poorly, she had severe gastroenteritis a few days before I was due to have Jake and we ended up in hospital with her and then the night she came home from hospital, when she was still poorly my waters went. So I was in hospital with, having Jake. Natural delivery, his delivery was quite good compared to my eldest. I was in hospital for a couple of days so I had my mum and my husband look after Nyla and I came home and then we had to pack up the house and move house three days later. So it was quite, it was quite stressful at first, new baby, we had a sick Nyla, we had a new house so it was really a lot going on. A lot, a lot going on.</p> <p><b>Do you think things might have been different if you didn't have all that going on?</b></p> <p>Possibly, I think because it was necessary at the time, we were meant to move a few months before hand but it fell through so we had to, it was, you know we had to go regardless so it probably would have made things a bit easier. I think mine and my husband's relationship became quite strained as well because of the stress under everything. So I think it was an accumulation of things. But I don't know whether she mentioned it when I explained to the Doctor about how I was feeling and everything it stems from my eldest. Apparently and what happened was I realised when Jake was born how different I felt. Between the two children. That is how it started and....</p> <p><b>So can I just check, how was it different, what did you notice that was so different between the two?</b></p>	<p>Busy since birth Difficult at first</p> <p>Other child's ill health</p> <p>Natural birth Easier birth than first Extended hospitalisation Family support</p> <p>Moving house</p> <p>Multiple stressors</p> <p>Role of stressors</p> <p>Stressors unavoidable Easier without stressors Strained relationship</p> <p>Accumulation of stressors</p> <p>Seeking help Difficulties longstanding Due to first child Realisation with current child Different feelings with children</p>

<p>Well when I was having Nyla she was, the delivery, the labour was horrific and she was stuck, and she was the wrong way, and they didn't know, and I had an epidural. She was not coming out, she got under distress, ended up with a hundred and million one people in the room and an emergency ventouse delivery. And afterwards I was quite battered and bruised really. But I was just shocked when she was placed on me I just felt shocked and I didn't feel, I was expecting that rush of love that everybody tells you that you get and I didn't get it. I didn't get it. I felt...It was awful to say but I felt disappointed at the time and it was really bizarre why you would feel this way but I was just so tired and so, and then we came home and we just went through the motions really of having a new baby but I didn't actually feel that really rush of love until a good few months down the line with her. But with Jake when I had Jake it was like an instant thing, so that's when, when I had Jake I felt guilty, I started to feel really guilty about why didn't I feel like that towards my little girl and that's when I started to sort of really not feel myself. And started to question a lot of feelings and I was starting to struggle. We were going through a bit of a terrible twos as well. And I started to, it was horrible feelings of resentment and guilt and I started to have anxiety attacks and panic attacks, feeling like I couldn't cope. Couldn't be on my own, so I locked myself in the rooms a couple of times and sort of thing, I thought I just couldn't go on like this and that is when I went to the Doctor. Well it was after, I told my husband how I was feeling but instead of sort of coming together about it we went the other way and became very protective of Nyla. BUT we have really sort of, we have picked up now. About three, how old was Jake, we went away when Jake was about four months, five months old and that's when I came clean to John and it was a few months after that, that I sort of went to the Doctor, so it has been about three or four months now.</p>	<p>Horrific labour Complicated labour</p> <p>Pain relief Baby distressed Emergency delivery</p> <p>Physical impact of labour</p> <p>Shock after labour Ideal expectations No rush of love Expectations not met Disappointment Tiredness Return home Going through motions Rush of love delayed</p> <p>Instant with second child</p> <p>Guilty feelings</p> <p>Not feeling right Questioning feelings Struggling Difficulties with first child Resentment, guilt Anxiety, panic Not coping Unable to be alone Locked self away Unable to carry on</p> <p>Sought help Disclosure to husband Partner not supportive</p> <p>Improved relationship</p> <p>Disclosure to husband</p> <p>Sought help</p>
<p><b>How would you describe that you have been feeling towards</b></p>	

<p><b>Jake himself, since the birth?</b></p> <p>I adore him. Towards, you know I do, I adore both my children I do. At first in the first few months, it was like I was just looking after them. Wasn't, I was just doing things for them. Sometimes like they weren't my own. Sort of thing.</p> <p><b>Is that what you expected to experience?</b></p> <p>No, no. I expected to be you know the best mum in the world and I would have the best two kids in the world but you know no one tells you how difficult it is going to be and how much strain it puts on your relationship as well and you know the practicalities of having two children, working, running a household, it is, it does take its toll I think. And I think after having Nyla, I was having nightmares about the birth and stuff for about six months afterwards. But I just put it down to that was normal really and didn't really think it was anything else out of the ordinary. So I didn't know I was feeling different until I had Jake. And that was the sort of pinnacle point where that happened.</p> <p><b>And what was different about the way you were feeling, would you be able to describe what that felt like for you?</b></p> <p>It is like, with Jake I didn't have to try and I could just let him be him whereas with Nyla it was really bizarre it is really bizarre like if she didn't look a certain way, if I wasn't happy with her I would be upset and it would upset me all day. It was really bizarre sort of irrational things would really upset me for the rest of the day. I used to look at her and think you know you don't look like this and you don't look like this and I didn't accept her for what she was, whereas with Jake, he is just Jake sort of thing. I have accepted him for what he really is.</p> <p><b>Did you understand what was happening when you first had those feelings...?</b></p>	<p>Adores children</p> <p>No emotions initially Simply caring for children Children didn't feel like hers</p> <p>Ideal expectations Idealistic mothering</p> <p>Difficulties not anticipated Strained relationship</p> <p>Difficulties of two children Multiple responsibilities Trauma symptoms post-birth</p> <p>Minimised difficulties, normalised difficulties Realisation with second child</p> <p>Easier with second child More accepting of second child Unusual feelings Not accepting of first child</p> <p>Irrational Wanting daughter to look different</p> <p>Accepted second child</p>
---	---

<p>I had an incline but you just get on with it really. Because you haven't got really a choice because you have got another baby that needs your undivided attention so you kind of have just got to get on with it, and it is hard to sort of come out and say I am not coping to people you know and finding it difficult and I don't know if I am feeling normal because you want to be normal and you want to be the best mum that you can be.</p>	<p>Inclination initially Having to continue  Baby needs attention  Difficult to say not coping  Wanting to be normal Wanting to meet ideals</p>
<p><b>Yeah of course. Did anyone ever say PND to you?</b> No. No one.</p>	<p>PND not said initially</p>
<p><b>So when did that label first come about?</b> When we were on holiday and me and my husband had a bit of a heart to heart. He said he thinks it is PND because I was taking, I didn't mean to but he perceived it as I was taking a lot of stuff out on Nyla. I was shouting at her a lot and we were going through a stage with Nyla at the time but I just couldn't cope with her, I just could not, sometimes I felt awful. I felt like she wasn't mine and it was awful and it was, and then having the other one there, having Jake there and you know the contrast of feelings was just I couldn't cope with it. I just couldn't understand why you could feel one way and then feel another.</p>	<p>Disclosure to husband Husband labelled PND  Husband's perceptions Shouting at baby Not coping with baby  Feeling awful No attachment/ bond Not feeling like mother Massive contrast in feelings Unable to cope Not understanding feelings</p>
<p><b>So when John said to you that he thought it was PND did you agree with it?</b> Yeah I kind of did and he said well, I said what should we do about it, should I go to the Doctors or...? And he said well now you know what you need to understand is just realise what you are doing and how you address situations with the kids and don't put yourself under too much pressure, but it was difficult because you are under pressure regardless. It is your responsibility to look after the kids and everything else so, and then after that, that's when John became very protective of Nyla so it made the situation worse because rather than encouraging me and Nyla to have the</p>	<p>Some agreement with label Wanting advice  Feeling pressured  Feeling responsible  Husband protective over child Situation worsened</p>

<p>time together on our own which I wanted, he sort of stepped in all the time. So the situation got worse. I felt like he thought I couldn't cope but then he would be opposite with Jake like he wouldn't have much to do with Jake and then, so I would feel like he couldn't trust me sort of thing, it is the only way I can put it into words really. So at one point I got very upset and I said he wasn't being supportive, he just ignored what I told him. Yeah so and that was a few months after I told him originally when Jake was about, I told him when Jake was around five months and a few months later, about a couple of months later I ended up at the Doctors in tears because I couldn't cope with, because by that time then I had started having really bad anxiety attacks, feeling like I couldn't be in the house on my own and scared basically of not being able to look after them and I just felt like a nervous wreck really.</p>	<p>Husband not supportive Situation worsened Perceptions from husband  Not feeling trusted Upset Husband not supportive Ignored by husband  Crisis point, Descent Unable to cope Escalation of difficulties Anxiety worsened  Scared alone, unable to care, nervous wreck</p>
<p><b>So at that point how would you have described it?</b></p> <p>I couldn't sleep, I wasn't eating very much, just very tearful all the time, it felt like every little thing was just going wrong all the time, I just couldn't see the positive on anything I just felt like everything was just you know out to get me really. You just feel so irrational. Really not able to control your feelings, not able to, it is awful absolutely awful.</p>	<p>Unable to sleep, not eating Tearful Catastrophic, unable to see positives  Paranoid, irrational No control over feelings</p>
<p><b>And at that point did you think you were unwell?</b></p> <p>Yeah. Yeah and that is when I went to the G.P. and was distraught and just said I can't for the sake of my family I need to get to the bottom of this because I can't cope and I just couldn't cope anymore with how I was feeling and that's when, she was lovely and she was very understanding. She put me on some medication which seems to have helped. I would like to think it was me but it is probably not, it probably is the medication taking the edge off. Feeling so up and down all the time and the anxiety has dropped right off. Yeah. I have the odd occasion but it is not often, it is not</p>	<p>Felt unwell, distraught Sought help Wanting help Unable to cope  Doctor supportive Antidepressants given Questioning efficacy Wants efficacy to be her Medication taking edge off Anxiety reduced  Odd anxiety attack</p>

<p>like three times, four times a day which it was and I am happy to be at home on my own with the children doing things. I don't feel like I need to be up out the door around other people all the time. A bit more sort of happy in our own skin sort of thing.</p>	<p>Happy to be alone Happier feelings Improved feelings</p>
<p><b>And did the GP actually say PND to you as well?</b></p> <p>Yeah she did and she referred me to the postnatal team who she said would come and have a chat and stuff and be there as long as I feel like I need to have the support. And she visited a couple of times but she said that, we have not made another appointment yet she thinks that at the moment what we were doing we're fine so she will ring in a few weeks.</p>	<p>GP gave label Referral to specialist services Specialist service input</p>
<p><b>How do you feel about that label of PND?</b></p> <p>It is difficult you know and I am really an open minded person and you know I am a nurse myself so it is not you know, I look after people who aren't well all the time and I am really close to my group of friends that we met. With both children I have had very good friends, we have all had babies at the same time and we have all offered support to each other and if anyone could <b>come clean</b> and say what is happening I would of thought I could do to them but I have not been able to and its, I feel like, umm, bad but I don't know it is where we were, I don't understand why I can't just say to them I've been told I have got PND and I am on medication for it and if any of you feel the same you know I am here to talk but I just can't bring myself to say it. Fear of ridicule I suppose.</p>	<p>Difficulties with label Open minded person Nurse by profession Cares for ill patients Close to friends Supportive friends Unable to disclose PND Hidden PND from friends Feels bad for hiding Unaware of reason for hiding Unable to disclose PND Unable to say on meds Fear of ridicule, stigma</p>
<p><b>You think maybe that...</b></p> <p>Yeah I don't think they will the type of people they are I don't think they will I think it is me, I think it is more me. I think it is more about...I don't want to feel like that so....</p>	<p>Friends don't judge Places blame in self Not wanting feelings</p>
<p><b>You don't want to feel low?</b></p> <p>I don't want to have PND but I suppose really if I did tell other</p>	<p>Not wanting PND Disclosure helps</p>

<p>people that it would be more of a common occurrence and people wouldn't feel like they shouldn't tell everybody...I think people are very cagey about if you are suffering with mental health issues, they don't know how to talk to you, and they don't know how to react to it, so it is better to avoid it. I think to be honest from what I have seen I think every mother suffers with it to a degree, not necessarily for a couple of years like I have had it but for a couple of months at least. And from what I have seen from the groups of ladies that I see they have all got, from what I can see sometimes how I have been in the past</p>	<p>Stigma with MH Others not understanding Others unsure how to react Better to avoid PND affects all mothers  PND common</p>
<p><b>So it sounds like you accept the label of PND but it is difficult to say that to people. Is that right?</b> Yeah, yeah...</p>	<p>Accepts label Unable to say PND</p>
<p><b>Have you been able to tell anyone apart from your partner about it...?</b> My mum knows and my best friend. And that is it really.</p>	<p>PND still hidden</p>
<p><b>We've talked a little bit about the negative aspects of having a label of PND; do you think there are any positive aspects of having the label?</b> Well it gives you the access to the help that you need. I mean you don't realise what is out there until you sort of, it is going to your GP and sitting down and talking to them, not a lot of people have the courage to do that. And not a lot of people feel like they've got a relationship with the GP. I mean I haven't personally because I don't go to the Doctors, I don't always need to but it's telling that stranger that something that might have took you a year or two to tell your partner and it is very hard, it is difficult to do that. But the support is out there it's just you don't know about it.</p>	<p>Label accesses help Unaware of support prior to seeking help  Difficult to go to GP  Difficult disclosing to stranger  Support available</p>
<p><b>So getting that label kind of gives you access to that support?</b> Yeah and I think when you have had a child like the Health Visitors</p>	

<p>they come and see you and they come and visit and everything and they do the postnatal score but they are not very, I don't know, it is not really, it is just a piece of paperwork I think, because they do it, I mean what age do they do it. They do the postnatal score not long after having the baby. You see I personally think that's too early. When you have had your child you might have the beginnings of it, but you have had your child. You will have a couple of weeks of everybody being round at your house and seeing the baby and you will have your partner at home and then you will have a couple of weeks on your own, so you have not actually got to grips with your new baby or your new feelings for a couple of months, a few months really. And I think, and it's, and the routine of having a child doesn't actually kick in properly for a few months and that is when it starts to effect how you feel and your life. I had those feelings from the get go but I didn't really address it because I just thought it was because I was so traumatised by the birth, that I felt so distant and I assumed you know after a few months I would probably be better and it was. I just think with your Health Visitors when they actually come and see you, they come see you, see your baby, you fill in a questionnaire and then off they go. And you are very much left to your own devices apart from if you go to clinic to get your baby weighed and then it is has your baby put on weight, no, well don't you think you should feed them sort of thing. So I don't know. You've probably seen mothers more than what I do so you will know at what stage they start at.</p>	<p>PND screening like paperwork</p> <p>Screening too early</p> <p>Reality of baby comes later</p> <p>Takes time to get used to</p> <p>Routine with baby comes later</p> <p>Difficult feelings from outset, avoided addressing feelings</p> <p>Traumatised initially</p> <p>Feeling distant</p> <p>Assumed it was a phase</p> <p>Minimised difficulties</p> <p>Feeling alone, feeling unsupported by health visitors</p> <p>Negative view of health visitors</p>
<p><b>So it sounds like you feel like there are some positives to getting that label in terms of accessing help and support. What about the negative aspects of the label apart from being able to share it? Is there anything else?</b></p> <p>Our relationship really. As soon as I sort of came out that I was suffering with problems we had real issues because as I said before it was like the trust had gone and like I wasn't worthy to</p>	<p>Negative impact on relationship, conflict with partner</p> <p>No trust in relationship</p> <p>Didn't feel worthy to care</p>



<p>look after them, I wasn't capable. I was doing it all the time but like when he was home he was doing it better sort of thing and he was very protective of them, of our eldest one mainly because Jake was still quite tiny. See my husband is not very good at discussing about emotional things anyway so that was quite difficult for him on his part as well. So I have had to sort of discuss it with other people like my mum and friend and stuff and he has got a lot better at it, at sort of discussing about the situation but I think that was the main thing. And my mum actually said something a bit strange. A few weeks ago I was meant to be going, well I was visiting her mum and dad with the children and my mum said just don't tell my mum anything about anything going on, and I said what do you mean, and she said just don't mention anything, and I said well I don't understand what you mean, and she said well I don't want to give my mum any ammunition, I want her to just hear wonderful things from you and your children. And I felt quite upset at the time because it is my choice if I want to tell anybody. And it made me feel like she was embarrassed so you know and I had confided in her and felt like her real feelings sort of snuck out a little bit, like she was embarrassed of it, didn't want people to know.</p>	<p>Didn't feel capable to care</p> <p>Husband protective Husband not emotionally supportive Difficult for husband</p> <p>Sought others to discuss</p> <p>Husband better at discussing now</p> <p>Mum wanting to hide PND</p> <p>Mum wanting her to portray ideals Upset at mum's request Felt mum was embarrassed</p> <p>Confided in mum Mum not wanting others to know</p>
<p><b>And is that how you think other people might see it as well?</b></p> <p>I don't think...I think it is hard to say because it is not really talked about and if you do talk about it, it is sort of oh right. No one knows what to say to you. I only know of one other person who has had PND for a few years and that is someone I work with and she told me about it before I had children and I think, I'm trying to remember my reaction. I think my reaction was pretty neutral. I felt quite sorry for her at the time but I had very little understanding of it at the time but she sort of explained to me how she felt distant towards her son and afraid to be alone with him. Sort of thing.</p>	<p>PND not discussed</p> <p>Others unsure what to say</p> <p>Neutral reaction to colleague's PND Little knowledge of PND previously</p> <p>Colleague's explanation</p>

<p><b>Earlier you said that you've not mentioned your PND to your friends because of fear of ridicule, can you tell me a little bit more about that?</b></p> <p>I don't know. I think at the moment now if I did say anything to them they would probably be absolutely fine and they wouldn't be, I think it's me, it's not them, it's me.</p>	<p>Unsure</p> <p>Placing blame on self</p>
<p><b>And what is it about you that...?</b></p> <p>I think it is just accepting it really.</p>	<p>Difficulties accepting PND</p>
<p><b>Accepting that you have...?</b></p> <p>Yeah. And I don't want people to feel that I can't look after my children. Because I can. And I love them and that's it because people when they say, because that is what, when I told my mum about it she said well I thought you loved Nyla, I said "I do love her mum I love her to death but I have had some feelings over the past few years that I have not been able to sort of understand and I have not been able to understand them until I had Jake because the difference of those two children has helped me understand that there is a difference". Because that's, that was it "I thought you adored Nyla, I do adore Nyla, I don't not adore her."</p>	<p>Fears of negative views/ as a bad mother</p> <p>Can care for children, loves children</p> <p>Mum questioning her love for daughter</p> <p>Explanation to mum</p> <p>Didn't understand feelings initially</p> <p>Adores daughter</p>
<p><b>So it sounds like you worry that other people might think that you don't love your children or you can't look after them because you've got that label of depression, when that is not the case at all.</b></p> <p>Yeah. My mum has given me the idea that I don't love them and my husband has made me feel like I can't look after them. From the two people that I've told and you would think from those two people you wouldn't get that response and if that is from my mum and my partner what would I get from general friends and family? So that's, it's probably not helped. Having those sort of, they have not meant it in a malicious way obviously but you know you can't expect them to know the ins and outs of PND because they don't. I</p>	<p>Negative views from loved ones</p> <p>Worries about others' negative views</p> <p>Not expecting others to understand</p>

<p>mean I reached, the day that I thought I just cannot, I came home and I was in the car and I was hysterical in the car. The two children were asleep and I just couldn't stop shaking and I couldn't breathe and I thought I can't go in the house with these two kids. I had had a "bit of a morning with Nyla", it is nothing major it was we were potty training so she'd had a few accidents and she was being a two year old where you know they are very, know their own mind but I just felt I was doing everything wrong and I had the most awful child in the world, badly behaved child and you know I couldn't take her out in public because she was so badly behaved, but she wasn't badly behaved now looking back she was just a two year old. But I remember I was texting John saying you need to come home, you need to come home, I can't be on my own I need you there. Anyway he didn't get back to me for hours and hours and hours because he was busy at work and I just felt sort of very alienated on my own at the time.</p>	<p>Crisis point, hysterical Physiological symptoms of anxiety</p> <p>Difficult morning prior to crisis point</p> <p>Catastrophising</p> <p>Wanting husband</p> <p>Fears of being alone</p> <p>Isolated/ alienated</p>
<p><b>What's your sense about the cause of how you have been feeling?</b></p> <p>The cause. I <b>assume</b> it stems from my horrific delivery. That's what I think. I don't know whether because we were trying for a year to get pregnant. I was getting quite.... It was quite, I was getting quite stressed out that I wasn't getting pregnant and I was desperate, desperate to have this baby, absolutely desperate, I couldn't think about anything else, my life revolved around trying to get pregnant it was awful. I was an absolute maniac and then I got pregnant and everything was absolutely wonderful. The pregnancy was fine, we were organised, we were settled, we were married and then I went into have her and I just felt like a rug had been ripped from under me it was awful. Like I had this horrific birth, I had this baby that bless her she looked absolutely traumatised, she looked horrific because she was just so traumatised from the birth and I was just, I couldn't walk, I couldn't move. They put me in a side room on my own and I</p>	<p>Birth trauma causal Uncertainty over cause Trying to conceive</p> <p>Stressed at not conceiving Desperate for baby</p> <p>Life centred on conceiving</p> <p>Wonderful once pregnant Good pregnancy Feeling settled</p> <p>Massive impact from birth Traumatic/ horrific birth</p> <p>Baby traumatised Poor physical health Unable to move Alone in hospital</p>

<p>couldn't get out of bed and no one came near to help me. I'd not eaten for two and a half days and in the morning they sort of the midwives knocked on my door and said your breakfast is ready, go and get it, and at the time I said oh no I'm going to have to eat because this child needs feeding, I was going to breast feed her and I couldn't get out of bed so I literally crawled nearly along the corridor, along the wall to get to some weetabix, and I had to leave the baby because they didn't tell me that I could wheel the baby out, no one said anything and only a student midwife came and saw me and I just said I need to go home I just wanted to go home, that is all I could think about was just get me home. It was, I felt very very ill at the time, very faint, very ill and I felt like I had been run over by a bus but I felt like, I didn't know what had gone on with the birth I didn't know and I feel like if someone had come and sat down with me and explained this is what went wrong and this is what happened I would have, I felt like I left the hospital without any answers. And I felt like, and then for months I was just having flash backs and nightmares all the time. I mean loads of people have traumatic births and stuff and I do think if someone, if one of the midwives actually came down and sat and said you know because you have been given drugs so you are not actually with it a lot of the time, you just haven't got a clue what is going on you are in absolutely agony, you can't control your body and you don't know what, if there is something serious that was wrong and you didn't know and no one took the time out to come and see, sit with you and say this is what happened. I mean when you have had an operation the Consultant will come and sit down with you. You have had this thing, you have had this done and this is your care afterwards. No one does that they just pack you off home with the baby. With no answers of you know, those three days that happened, and it felt like you were in a dream, that is how it felt. I just felt very sort of deflated really, exhausted deflated. And I <b>assume</b> from that point forward from there it made me feel quite distant towards Nyla. But I don't know.</p>	<p>Unsupported in hospital</p> <p>Difficult experience in hospital</p> <p>Having to leave baby</p> <p>Wanting to go home</p> <p>Feeling ill, faint</p> <p>Birth unknown No explanation of birth</p> <p>No answers to birth Wanting answers/ explanations</p> <p>Trauma symptoms Traumatic births common Explanation may have helped</p> <p>In agony during birth Unable to control body</p> <p>No explanations</p> <p>Explanations given post-operations</p> <p>Sent home post-birth No explanations post-birth</p> <p>Loss of days Birth not reality Deflated post-birth Exhausted post-birth Birth caused distant feelings to baby</p>
---	--

<p><b>Do you think there are any other factors that led you to how you were feeling?</b></p> <p>I don't know really it is hard to pin point it really. She wasn't a great sleeper either. I had more or less two years of broken, of no sleep, she wouldn't sleep. I think that is a big thing... and being back at work.</p> <p><b>How do you think things might be for you in the future?</b></p> <p>Hopefully more settled. I am quite positive. I don't think I am going to have any more kids. If it happened, it is highly unlikely because I went and had the coil fitted. But if we ever did decide to have any more it will be when the two children are in school, like in four, five years but it is unlikely that we will have any more, and you know we are happy to have the two healthy kids that we have got now. I think, I am looking forward to the future with them, I am. Whereas a few months back I thought I was going to, I thought, I actually contemplated I thought I could just walk out and leave because I just thought they would be better off without me. Whereas now they wouldn't, they need me. But it's, to feel like you are not good enough is awful really.</p> <p><b>So you said that you hope for things to be more settled so what does that mean for you?</b></p> <p>Settled probably, you see when you are on maternity leave you are not really living the reality. I am at home all the time so it is me going back to work, my husband at work, my children in a childcare and the routines. I am working towards just having a regular future as a family sort of...</p> <p><b>And is that what regular would be?</b></p> <p>To me yeah.</p> <p><b>Any worries or concerns about the future?</b></p>	<p>Baby poor sleeper Broken sleep Sleep big factor Return to work</p> <p>Wanting to be more settled Optimistic for future No more children On contraception</p> <p>Future babies unlikely</p> <p>Happy with two kids</p> <p>Looking forward to future</p> <p>Previously wanted to leave</p> <p>Felt unneeded Feels needed now Not feeling good enough</p> <p>Maternity leave not reality Home all the time now Returning to work Children in child care</p> <p>Wanting regularity</p>
--	---

<p>There are some financial worries but I think that would alleviate once I am back at work. I mean our relationship does need some work between me and my partner. We just don't to spend much time together you know and it is difficult to get a babysitter for two children, so I think we need to sort of focus on us a little bit as well because you forget, you just become mum and dad and you forget who you are kind of thing, you forget you liked to listen to the radio in the morning, you forget you used to like doing simple things for yourself because nothing is for yourself anymore. Everything is for somebody else, every single moment of your day, every single moment of your week is for somebody else. So it's, you know before you have children, you have days off. You don't have days off when you have children and it's you know it's that. I think it is important to try and get some time to ourselves even for each other, or individually just to remember to do things. What you used to be like before you were a mum and a dad because you forget. I mean I have forgotten what it is like to do things on your own, to just to pop to the shops on your own, or something without a car seat. You see I tend to do all the practical stuff with the children, all their classes, all their activities and stuff. I would like us to start doing stuff more together, so it is not just me. Doing everything with them but then I would like to have some time to myself and to give my husband some time to himself as well. Because I think you know it is important really.</p>	<p>Financial worries Relationship difficulties Time with partner needed Little time together</p> <p>Childcare difficult</p> <p>Change in roles</p> <p>Previous life forgotten</p> <p>Responsibilities change</p> <p>No days off now Change in lifestyle</p> <p>Needing time to self</p> <p>Forgotten previous life</p> <p>Practical parenting role</p> <p>Wants to do more as family</p> <p>Wants time to self Husband needs time to self Important to have time to self</p>
<p><b>How about in terms of the depression, how do you think that will be in the future?</b></p>	
<p>I am worried that I will be on this medication forever. Well I am not worried I am quite happy to take it forever if it makes me feel like I can get up in the morning, and I adore my children and can't wait for the day ahead. Whereas before I was, I didn't know how I was going to cope through the year. If it is me, it is me but if it is the medication, then it is the medication that is fine.</p>	<p>Fears about long term use Ambivalence over meds Happy for long term use Meds helping Unable to cope previously Difficulties attributing improvements</p>

<p><b>It sounds like you are a bit unsure about the efficacy of the medication?</b></p> <p>Yeah. I would like to think I could probably stop taking it and go back to my normal self but I don't know whether I would want to stop for fear of going back to being that crazed fool that I thought I was.</p>	<p>Unsure over efficacy</p> <p>Fears of loss of control</p>
<p><b>So it does sound like it has been helping?</b></p> <p>Yeah it does. But I mean I had to find one that I could take while I was breastfeeding so it wasn't just pick anything off the shelf kind of thing when I went to the GP.</p>	<p>Medications helping</p> <p>Difficulties choosing medication</p>
<p><b>Before you mentioned something about not accepting having PND in terms of telling other people. Can you tell me a bit more about that?</b></p> <p>I think, I don't like to feel like I am not in control of my own feelings and my own life and having a mental health illness makes you feel like you haven't got control or you know you are extremely unpredictable and people think you are unpredictable and you can't function normally and that is how I feel, I feel that people will think 'oh well she is on meds to be a normal mother sort of thing'. And it's not, it's not like that, I just think I don't know. It just helps to take the edge off feeling that loss of control.</p> <p>The feeling of just feeling like you were absolutely going mad is awful and that is how you feel, you just feel like you are going mad and you can't think straight, you can't function really, it is a very bizarre feeling. You know because I know I am a level-headed person relatively level headed and I know my own mind so when you feel like your mind is running away with you and you can't control yourself, you can't control your feelings, you can't control your outbursts, it's scary really.</p>	<p>Dislikes not being in control</p> <p>Stigma/ negative connotations with MH</p> <p>MH indicates no control, unpredictable, can't function</p> <p>Meds mean not a good mother</p> <p>Fears of others' negative views of mothering</p> <p>Meds help with loss of control</p> <p>Felt like she was going mad</p> <p>Difficulties thinking</p> <p>Difficulties functioning</p> <p>Usually level headed</p> <p>No control over mind</p> <p>No control over self</p> <p>No control over feelings</p> <p>No control over outbursts</p> <p>Scary to lose control</p>
<p><b>Where there any other consequences of feeling like that?</b></p> <p>Well there is the general things like the not sleeping, not eating,</p>	<p>Not sleeping, not eating</p> <p>Poor self care</p>

<p>not wanting to take good care of yourself. Well I did, but you know just a bit sort of 'why bother'. I just didn't have the energy. I didn't have the enthusiasm that I should have when you have got two children that need so much attention and encouragement. I just couldn't be bothered. I just sat in the morning; to try and get us dressed was the biggest effort. I had to shout everything to do anything and I lost the ability to, I don't know, take a step back and review the situation. Whereas I was just jumping in with feet first you know and trying to get things done the quickest way possible but it all going a mess and then feeling like I am an absolute waste of time mother and can't do anything. It was very irrational at the time.</p>	<p>No motivation No energy</p> <p>Children needing attention</p> <p>Effortful to dress Constant shouting</p> <p>Loss of perspective</p> <p>Feeling like a bad mother Feeling unable to do anything, irrational</p>
<p><b>And what was your view of PND before experiencing it?</b></p> <p>I didn't have one to be honest because I didn't really have much knowledge much, I mean it wasn't something I would ever sort of look down on anyone for because I wanted, because it is not in my nature but I think I am very, I don't like, it is quite a, I don't like to feel disliked by people. So I wouldn't think, I would hate to think that people are thinking bad of me behind my back sort of thing when I have not <b>done anything wrong</b>. But then at the end of the day if their opinion is going to be negative then they are probably not worth having as friends. Except for my negative opinion of my mum and my partner, I can't really get rid of them can I?</p>	<p>No previous view of PND Little knowledge of PND Doesn't judge others</p> <p>Not wanting to be disliked</p> <p>Assuming others' negative opinions Not feeling at fault/ externalising?</p> <p>Unable to change others' views</p>
<p><b>And finally then is there anything else that I should understand better or know more about.</b></p> <p>No I don't think, I think I have covered most things.</p>	