Postnatal Depression: A Relational Perspective

by

Natasha S. Mauthner

Emmanuel College

A dissertation submitted to the University of Cambridge for the Degree of Doctor of Philosophy

July 1994

Preface

I declare that this dissertation is the result of my own work and includes nothing which is the outcome of work done in collaboration. No part of the dissertation has been submitted for any degree or diploma or qualification at any other University. The length of this dissertation does not exceed 80 000 words.

The names of all research participants, their children, and all those individuals mentioned by them, have been changed for reasons of confidentiality.

Natasha Mauthner

Summary

Current research conceptualizes postnatal depression as individual pathology or as a socio-political problem. By adopting a relational perspective, this thesis bridges the theoretical divides between individualistic and social explanatory frameworks, and between psychology and sociology. The self is seen to be essentially relational, and postnatal depression understood in terms of interrelationships between an active self, others and society.

In-depth interviews were conducted with 40 mothers of young children living in Britain, recruited through community sources. Mothers defined their own psychological state following childbirth: 17 found motherhood unproblematic; five had difficult experiences which they distinguished from 'postnatal depression'; 18 experienced, what they defined as, 'postnatal depression', after the birth of their first, second or third child. These 18 mothers are the central focus of the study. The data were analysed using Brown and Gilligan's (1992) 'voice-centred relational method'. Key methodological and theoretical concerns include: listening to mothers on their own terms; considering the interpretations and meanings mothers attribute to their experiences; theorizing similarities, and differences, amongst mothers; exploring changes within individual mothers over time.

Postnatal depression was characterized by, and resulted from, a psychological process of relational disconnection, in which mothers felt alienated from themselves and others. During the depression, they believed their moral worth and social acceptability depended on complying with cultural expectations of motherhood. The 12 first-time mothers felt under pressure to conform to normative definitions of the 'good', selfless mother. All 18 mothers felt under pressure to conform to a cultural ethic of individuality and self-sufficiency. In order to protect their own integrity, and preserve their relationships, mothers actively withdrew their needs and feelings from relationships with their children, partners, relatives, friends, other mothers with young children, and health professionals. This social withdrawal was distinct to, and occurred irrespective of, physical isolation and unsupportive relationships. Although the mothers conformed, they also questioned cultural norms which construct the needs of self and other as separate, competing forces. During the depression, their resistance was a silent one.

The move out of depression was accompanied by shifts in the mothers' moral beliefs about themselves, others and society. They felt it morally acceptable to attend to their own needs and those of others. Relationships with other mothers were critical to these moral re-evaluations. They enabled them to openly question normative constructions of motherhood, providing them with the possibility of a voiced resistance.

Policy implications of this research are considered in terms of prevention and intervention programmes for depressed mothers.

In memory of my mother.

Acknowledgments

For the time they spent sharing their experiences with me, and for allowing me to tell their stories, I am deeply grateful to the mothers who took part in this research. The study would not have been possible without them. I also thank the Association for Postnatal Illness, Cry-sis and the National Childbirth Trust for assisting me in finding these mothers.

I thank Martin Richards, my supervisor, for his encouragement and support. I am particularly grateful for his assistance in my transfer from the Department of Experimental Psychology to the Social and Political Sciences Faculty during the early stage of my research, and for providing me with the opportunity to work in the friendly environment of the Centre for Family Research.

It is a pleasure to thank Carol Gilligan for her wisdom, inspiration and enthusiasm. She gave generously of her time during the last 18 months of the study; from her, I have learnt a great deal about the psychology of women, and about how to listen.

Financial support was provided by the Medical Research Council, and Emmanuel College, Cambridge.

For advice or discussion on various parts of this study I thank Andrea Doucet, Jo Green, Jane Ireland, Katerina Logothetis, Melanie Mauthner, Ginny Morrow, Shirley Prendergast, Frances Price, Deborah Thom and members of the Women's Workshop on Qualitative Family and Household Research. For invaluable intellectual and editorial comments on final drafts of the thesis I give special thanks to David Burslem, Jane Ireland, Martin Mauthner, Melanie Mauthner, Ginny Morrow and Martin Richards.

I also thank Jill Brown and Sally Roberts for practical advice and assistance, and for their warm and welcoming presence in the Centre for Family Research.

Many friends helped and encouraged me in various ways during the period of this research; thanks to Jane who has been a most generous friend and colleague, and has provided me with a steady stream of beautiful poetry; Katerina for the idyllic days we spent in Aylestone Road, and for all those Greek goodies; Julia for her support, and for being at the end of the phone, particularly during the writing-up phase; Ginny has provided valuable advice and insights into my work, as a sociologist and as a mother; Myra and I have shared

the joys and pains of doing a PhD, and I am grateful to her for her support throughout this time; Adam has offered much support and advice; I thank Lynda and Peter for sharing Michael's birth with me, and for putting little Michael my way to distract me; thanks to the Burslems for being a wonderful second family to me, and for use of their attic; I thank Derek for providing a listening ear, words of comfort and a much-needed ZB treatment at times of stress - he, Andrea and Vanessa, and more recently, Hannah and Lilly, have been my family in Cambridge.

For their care and concern, I thank my own family, and especially my father and sister. My father has supported me in many ways over the years. I am particularly grateful for his meticulous editing of several chapters of the thesis. My sister has helped foster many of my ideas. Her love, encouragement and enthusiastic interest have sustained me over the years.

My final thanks go to two dear friends. Andrea has been a very special friend in so many ways. Her generosity has been unbounded. Thanks to her, carrying out this research has been both possible and enjoyable. Lastly, I thank Dave for his love, support and patience, and for always being there.

Table of Contents

Introduction

This thesis addresses the questions of how and why some mothers become depressed following childbirth. I explored these issues through a retrospective, qualitative study of the lives of 40 mothers of young children living in Britain. Eighteen of these said they had experienced, what they termed, postnatal depression, following the birth of their first, second or third child. Seventeen had found motherhood relatively unproblematic, and five had had periods of low mood which they distinguished from postnatal depression. The core of this thesis focuses on the 18 postnatally depressed mothers, while the remaining 22 mothers are considered in less detail.[1]

A central assumption guiding my research is that, in order to learn about postnatal depression, we must listen to depressed mothers' personal accounts, and attempt to understand the ways in which they construct and experience their world. This assumption goes against two long-standing traditions in psychology; first, the exclusion of female experience from research, or its representation as deviant and deficient in relation to a male norm (Gilligan, 1982); second, the devaluation of the perspectives of psychologically troubled individuals because these have been seen as a 'distorted' view of reality, reflecting a 'disturbed' mind (Goffman, 1987).[2] One of the aims of this thesis is to bring the perspectives of depressed mothers into the academic arena.

Through attending closely to the mothers' accounts, I have come to argue that the boundaries between internal and external realities, and between 'objective' and subjective truths, cannot be delineated. My primary concern in this study is with the subjective reality of the individual mother, and with what *feels real to her* - that is, with how she perceives, interprets, constructs and experiences her world. This, I believe, is the key to understanding her depression.[3] I also argue that any analysis of the mothers' experiences

---

1 The label 'postnatal depression' has been criticized because it suggests a medicalization and pathologization of women's distress. Other terms such as "depression following childbirth" (Nicolson, 1986: 135), "unhappiness after childbirth" (Romito, 1989: 1433), and "unhappiness" (Oakley, 1986a: 149) have been put forward. While acknowledging that the use of psychiatric labels can be problematic, I will be using the term 'postnatal depression' because the mothers in my study used it in describing their experiences. Furthermore, as I discuss in Chapters One and Two, there are reasons to believe that 'postnatal depression', and what might be described as 'unhappiness', constitute different experiences and feelings, characterized by different underlying psychological processes. Finally, the term 'postnatal depression' suggests both a temporal and causal association between childbirth and depression. I use the term to refer to the temporal association only, as the possible causal link between childbirth and depression is an unresolved issue (Cox, 1989).

2 The antipsychiatrists (e.g. Laing, 1965; Laing and Esterson, 1986; Goffman, 1987) represent an exception to this tradition. For example, Laing argues for the need to understand the subjective experience, thoughts and feelings of individuals with psychological problems.

3 Unless otherwise specified, I use the terms 'depression' and 'postnatal depression' interchangeably.

must be embedded within cultural and interpersonal contexts. In a given society, there is a body of shared norms, values and expectations about how mothers and children 'ought' to behave (Phoenix *et al.*, 1991), and individuals surrounding mothers might come to hold some of these beliefs and attitudes. Critical to understanding mothers' lives are how they construct and experience themselves, other people, and the society in which they live.

The interrelationships between the self, others and society are conceptualized in a dynamic way, in which each of these elements mutually affects, and interacts with, the others. At the heart of this dynamic interplay lies the self, which I conceptualize in an active way. The mother is understood to take an active role in the construction of her own life, given certain immediate and wider structural constraints. Consequently, different mothers will construct and experience their worlds in different ways. A given mother will also construct and experience her world in ways that will evolve over time. The notions of difference and change are therefore central to this thesis. I take the view that recognizing and conceptualizing differences between mothers, as well as the changes that occur within an individual mother, are critical methodological and theoretical tasks. In this sense, my thesis adopts a developmental perspective, in which individuals are understood to grow and change over time, both emotionally, and in their thinking about themselves, others and society. Inherent within this perspective is the notion that psychological crises are particularly fruitful occasions for such change and growth (see Gilligan, 1982).

To recapitulate, the central themes running throughout this thesis are the following: the inseparability of external and internal realities; the importance of mothers' subjective constructions and experiences of their worlds to understanding their depression; the embedding of mothers' experiences within interpersonal and cultural contexts; a dynamic conceptualization of the interrelationships between self, others and society, at the heart of which lies an active self; and the notions of difference and change. These themes converge within my theoretical framework, that of a relational perspective (Gilligan, 1982; Jack, 1991; Miller, 1986a).[4]

In taking this approach, my work joins a growing body of research that has been carried out by relational psychologists working in the United States, both at the Harvard Graduate School of Education (e.g. Carol Gilligan) and at the Stone Center, Wellesley College (e.g. Jean Baker Miller). Within this perspective, the self is understood to be

---

[4] These themes overlap with postmodernist ideas. For example, within postmodernism, thought and meaning are viewed as constructed through language, and are therefore seen as relational. Postmodernism also stresses that there are no objective scientific 'truths', but that all knowledges are 'discursive constructs'. Differences between individuals, and the ways in which individuals change over time, are also central to postmodernism (see Jackson, 1992). A consideration of postmodernist thought lies beyond the scope of this thesis.

essentially relational - that is, 'in relationship' to itself, others and the surrounding world. Relationships are seen as primary to psychological health and development. The goal of development is 'relationships' rather than individual self-development. Women's thinking, feelings, judgements and actions revolve around a primary concern about relationships, and their desire to form and maintain relationships with others.

I was introduced to this relational work by Carol Gilligan when she came to Cambridge as Pitt Professor in the autumn of 1992. Upon taking up her position, she set up a small graduate research group with the aim of introducing us to a recently-developed method of analysing detailed interview material.[5] I was eager to join this group as, in my initial reading about the method, I realized that the principles underlying it resonated with a number of my own theoretical and methodological concerns (see Chapter Two). Furthermore, the formation of this group coincided with the completion of the last of my interviews, and with the beginning of the period over which I was to analyse the interview transcripts. Over the course of the following 18 months, I, and three other graduate students, learnt how to use this valuable method of qualitative data-analysis.

My work within this group evolved from the initial learning of the method to a broader theoretical understanding of the psychological development and health of women. The work I carried out within the context of the group - analysing the interview transcripts, learning from Carol Gilligan's insights into psychology, and learning from other members of the group - in parallel to my own reading of the work of relational psychologists, enabled me both to understand my data, and consolidate my theoretical position on this material. The point I want to make clear at the outset is that the theoretical perspective I adopt in this thesis has arisen from close attention to a polyphony of voices, and to three in particular: the voices of my research participants, the voices of the theoretical literature, and my own voice and thinking.[6] In maintaining the differences between these three voices throughout the research process, my aim has been to ensure that I analyse the mothers' accounts 'on their own terms'. By this, I mean that I was concerned first, not to confuse the mothers' perspectives with my own, and second, not to submerge the mothers' perspectives within existing theoretical categories. Indeed, this thesis documents how

---

5 I discuss this 'voice-centred relational method' (Brown and Gilligan, 1992) in Chapter Two.

6 The concepts of 'voice' and 'silence' are central to this thesis, both methodologically and theoretically. 'Voice' is taken as an indicator of the self (Gilligan, 1993; Jack, 1991). As Gilligan (1993: xvi) notes, "... people ask me what I mean by 'voice'. By voice I mean voice ... To have a voice is to be human. To have something to say is to be a person". Furthermore, the themes of 'voice' and 'silence' are key analytical concepts in understanding women's accounts of their lives for they tend to recur in female narratives (Gilligan, 1988c). As the following chapters illustrate, the mothers in my study spoke about difficulties in 'voicing' their experiences, hearing 'voices' in their heads, and 'silencing' their 'voices'.

attending to the perspectives of the depressed mothers can break down, and take us beyond, existing theoretical frameworks.

I now briefly present the essence of my argument, thus providing the reader with a guide to the following chapters. Based on the accounts given by the 40 mothers in my study, I argue that women's experiences of motherhood must be understood in terms of a *range* of *different* emotional responses. In particular, I suggest that what I, and the mothers themselves, term postnatal depression, can be distinguished from, both relatively unproblematic experiences of motherhood, and feelings of low mood. Eighteen mothers in my study defined their experiences as postnatal depression. A further five women had experienced difficulties and low mood, but distinguished their feelings from what they understood as postnatal depression. The remaining 17 mothers had found motherhood enjoyable and had encountered few problems. By drawing on the mothers' accounts, I argue that, unlike the experience of low mood, postnatal depression was characterized by isolation and social withdrawal - the 18 depressed mothers had felt unable and unwilling to voice their needs and ambivalent feelings to partners, relatives, friends, other mothers with young children and health professionals.

I suggest that the mothers were led to this position of silence and withdrawal through the ways in which they had resolved a conflict they encountered between their expectations, and their experiences, of themselves and their children. The first-time mothers had held idealized expectations of motherhood and babyhood, derived from normative constructions of mothers and children. Both first-time and subsequent mothers had perceived themselves as self-sufficient individuals who should be able to 'cope', single-handedly, with their practical and emotional needs. These expectations reflected a cultural "ethic of individuality and self-sufficiency" (Jordan, 1992: 5), which devalues help-seeking behaviour.

The mothers' depression had been rooted in this conflict between their idealized constructions, and their experiences, of themselves and their children. They described this conflict as a moral dilemma: they could either be true to themselves and their experiences; or abandon their own perspectives and attempt to bring these into line with their idealized constructions. The adoption of one or other of these positions had implications for their relationships. By 'staying' with their experiences, and resisting normative prescriptions, they had feared coming into conflict with partners, relatives, friends and society. By complying to what they perceived as social expectations, and expectations held by people around them, the mothers had come into conflict with themselves and their own feelings.

What characterized the depressed mothers' experiences, and what marked their thinking at the time of the depression, was the way in which they had resolved this dilemma. They had felt under pressure, from themselves, society, and others to deny their own needs and feelings, in order to be accepted by others and so preserve their relationships and their sense of moral worth. It seems that, at the time of the depression, the mothers had been aware that this abandonment of themselves was linked to their depression. However, they had felt it was 'better' to avoid conflict, despite the damaging effect such avoidance had on them, for they had feared that in revealing their feelings to others, they might be rejected and morally condemned for being 'bad' mothers.

The key to understanding this denial of their experiences lies in the ways in which the mothers constructed themselves and others, and defined relationships and morality. During the depression, the mothers had felt their own moral worth as individuals and as mothers depended on their conforming to cultural notions of 'the good mother' and 'the good woman'. They had experienced having, and expressing, needs and ambivalent feelings as selfish and morally wrong. At this time in their lives, they had felt that removing themselves, their needs and their feelings from their relationships was the morally 'right' action to take, and a move which would secure their relationships to others.

The paradox of this situation, however, is that by withdrawing from their relationships, for the sake of preserving them, the mothers had come to feel a profound sense of isolation, because these became relationships in which they could not express the true nature of their feelings. These relationships could not contain their needs and vulnerability, and so the potential of relationships to enhance growth and well-being was lost. I argue that this relational disconnection, both from themselves and others, constituted the essence of their depression. I use the term relational disconnection to refer to the mothers' feelings of alienation from themselves and others, feelings which had been engendered by their active social withdrawal.

The mothers' journey out of depression was associated with their becoming involved in 'authentic' relationships, in which they felt they could voice the true nature of their thoughts and feelings. As they came out of the depression, their understandings of themselves, others and normative constructions of motherhood changed. They came to accept themselves for whom they were. They came to realize that it was possible within a relationship for their own needs to coexist alongside those of others. Moreover, they no longer saw it as morally wrong to have, and express, their own feelings. They came to see the interdependence of their own needs and those of others, including their children.

In essence, I argue that the depression was a state in which the mothers had been unable and unwilling to express, or experience, their feelings and needs. They had found it difficult to accept themselves for whom they were, in part because of their moral evaluations of themselves, in part because of the ways in which they had constructed and experienced their relationships with others, and in part because of how they had interpreted cultural definitions of motherhood.

The thesis is organized in the following way. In Chapter One, I discuss existing research on postnatal depression. I highlight how, to date, postnatal depression has been conceptualized either as an individual, pathological condition, or as a socio-political problem. I argue that what has not been addressed, either theoretically or empirically, is the *relationship* between individual mothers and society. I suggest that, by adopting a relational perspective, postnatal depression can be understood in terms of the complex interrelationships between the self, others and society.

In Chapter Two, I describe how the nature of my theoretical concerns led me to adopt a qualitative methodology, in which listening to women's voices, and understanding their experiences, 'on their own terms', were of primary importance. I also note that I adopted a phenomenological perspective which would allow me to conceptualize both the differences, and similarities, between the mothers. I also outline the methods I used to find the sample, collect the data, and analyse the mothers' accounts.

In Chapter Three, I show that the mothers' depression was characterized by relational disconnection. I point out that this experience differs from the isolation discussed in previous research on the role of interpersonal relationships in postnatal depression. These studies have considered relationships in a *one-sided* way and in terms of the support that women fail to *receive* from their relationships. They suggest that depressed mothers lack adequate support due to physical isolation or unsupportive relationships. In contrast, I point out that relationships are not unidirectional but bidirectional, and that the mothers were not suffering passively from a lack of support, but were actively involved in removing themselves from their relationships. In this chapter, I outline the psychological processes through which the mothers withdrew from their relationships.

In Chapter Four, I discuss how the 12 first-time depressed mothers in my study had removed themselves from their relationships with their children. I describe how these mothers had experienced a conflict between their idealized constructions of mothers, children, and relationships between them, and their own experiences of themselves as 'real' mothers in a 'real' relationship to a 'real' child. In resolving this conflict, they had

abandoned their own experiences of motherhood and attempted to be 'good', selfless mothers by withdrawing their needs and feelings from their relationships with their children. Here, I also explore how this move had been facilitated by the interpersonal and cultural contexts in which the mothers had been living.

In Chapter Five, I examine all 18 depressed mothers in my study and describe the processes through which they had withdrawn from their relationships with significant others (apart from the children), such as partners, their own mothers and their mothers-in-law. I show that the mothers had withdrawn because they had believed their moral worth as mothers and individuals had depended on denying their needs and vulnerability to others. In voicing their feelings, they had feared rejection and moral condemnation. For some, these beliefs and fears had been reinforced by their difficult relationships with partners, mothers or mothers-in-law. These mothers had felt that these individuals had either failed to offer help, or, when they had asked for support, it had been denied to them. In order to preserve their own integrity, and their relationships, the mothers had silenced their voices. I discuss how this relational disconnection from others, and therefore themselves, had lead to their depression.

Chapter Six considers the mothers' move out of depression. I examine the forms of support, and kinds of relationships, that had been key to this journey, and note that it was associated with dialogue, and with the mothers voicing their needs and feelings. I also explore the psychological processes through which the mothers had emerged from the depression, and describe their changed understandings of themselves, and their relationships, and their changed orientations towards social norms and expectations of motherhood.

Chapter Seven draws out a number of general conclusions from my study. I also explore the policy implications of my research. Finally, I outline potentially fruitful areas for future research into postnatal depression.

Chapter One

Theoretical Perspectives on Postnatal Depression

Chapter One

Theoretical Perspectives on Postnatal Depression

Introduction

Postnatal depression has been studied within a wide range of disciplines, including physiology, obstetrics, psychiatry, psychology,[8] psychoanalysis, sociology, social psychology and anthropology.[9] Some of this research has been carried out by health professionals, including general practitioners (e.g. Playfair and Gowers, 1981), midwives (e.g. Ball, 1987) and social workers (e.g. Gruen, 1990). In addition, literature on postnatal depression has been produced *for* health professionals (e.g. Ball, 1987; Cox, 1986; Kendall-Tackett, 1993). A 'popular' literature exists which describes the author's and/or other women's personal experiences of postnatal depression (e.g. Comport, 1987; Dalton, 1989a; Dix, 1986; Marshall, 1993; Price, 1988; Sapstead, 1990; Swyer, 1979; Welburn, 1980). Other publications have been issued by lay organizations, such as the Association for Postnatal Illness,[10] the Meet-a-Mum-Association[11] and the National Childbirth Trust.[12] These are voluntary sector organizations which provide support and advice for parents. Finally, media coverage has brought postnatal depression to the attention of the public, as magazines and newspapers periodically feature articles on this subject.[13]

---

8 Developmental psychologists have investigated the effects of postnatal depression, and the mother's psychiatric state in general, on the mother-child relationship (e.g. Murray and Stein, 1991) and on the child's emotional, cognitive, behavioural and social development (e.g. Cogill *et al.*, 1986; Whiffen and Gotlib, 1989; Wrate *et al.*, 1985). In this thesis, I am primarily concerned with the question of the aetiology of postnatal depression, and so this research will not be considered. See Murray (1988), Melhuish *et al.* (1988) and Margison (1982) for reviews of this research.

9 Our knowledge of the prevalence of postnatal depression in other cultures comes mainly from ethnographic studies of childbirth, which have tended to focus on birthing practices rather than on psychological distress following childbirth *per se*. Within these anthropological studies, no formal assessments of postnatal depression are made, but anecdotal information is provided regarding its prevalence. A review of this literature indicates little evidence of postnatal depression in India (Upreti, 1979; cited in Stern and Kruckman, 1983), China (Pillsbury, 1978), Jamaica (Kitzinger, 1982), Mexico (Stern and Schensul, 1977; cited in Stern and Kruckman, 1983), Kenya (Harkness, 1988) or Nigeria (Kelly, 1967). Cox (1983, 1988b) and Aderibigbe *et al.* (1993) have carried out specific studies of postnatal depression in Uganda and Nigeria, respectively. They found prevalences of depression of 10% and 14%, respectively. These results must be treated with caution, however, as research has highlighted the methodological and theoretical problems in the cross-cultural study of emotions generally (e.g. Leff, 1977), and depressive disorders specifically (e.g. Singer, 1975).

10 E.g. *'The Baby Blues and Postnatal Depression'.*

11 E.g. *'Behind the Painted Smile: An Insight into Postnatal Depression'; 'Lifting the Veil of Silence: On Emotional Problems after Childbirth'.*

12 E.g. *'Mothers Talking about Postnatal Depression'.*

13 E.g. *The Daily Mail*, 22 March 1994; *The Guardian*, 9 October 1990, 26 November 1991, 4 December 1991, 31 January 1992, 7 February 1992; *The Independent*, 2 March 1993. The media has also shown interest recently in so-called postnatal depression in fathers (e.g. *The Guardian*, 29 May 1992; *The Independent*, 20 March 1994).

Much of the research on postnatal depression has been influenced by developments within the wider and related fields of both depression and motherhood. These large bodies of literature - on postnatal depression, depression, and motherhood - are too vast to cover within the scope of this chapter. Here, I will consider in detail the studies of postnatal depression that have examined the questions of why and how women come to be depressed following childbirth. The remaining research, including work on the prevention and treatment of postnatal depression, as well as analyses of depression[14] and motherhood,[15] will be reviewed selectively in this and subsequent chapters.

This chapter therefore considers aetiological explanations of postnatal depression. These can be divided into two distinct groups, according to the way in which the relationship between depression, the individual, and the social context is conceptualized. The first perspective takes the individual as the unit of analysis, and understands postnatal depression primarily as the result of individual deficiencies or circumstances. This approach, which predominates in this field of research, both historically (Day, 1985) and currently (O'Hara and Zekoski, 1988), is described as a 'medical-psychiatric' approach (Busfield, 1986), in which a 'medical model' (Jordanova, 1981) is adopted. It includes biochemical, psychodynamic, psychological and social explanations of postnatal depression. The second perspective is one in which the socio-political context of motherhood constitutes the unit of analysis. This approach has developed over the last 20 years, largely as a critique of the individualistic, medical perspective, and is advocated principally by feminist sociologists and social psychologists (e.g. Nicolson, 1988; Oakley, 1980; Romito, 1990b). Feminists have criticized the ways in which women's distress is medicalized[16] and pathologized, and have highlighted the problematic structural and ideological conditions in which women have children in Western societies.

The chapter is structured in four parts. In the first, I define postnatal depression, and distinguish it from the postnatal blues and from puerperal psychosis. I then consider individualistic explanations of postnatal depression. In the third section, I consider feminist, socio-political theories. I examine the strengths and weaknesses of the latter, and point out that, although this perspective has made significant contributions to our understanding of postnatal depression, it is limited in several ways. In particular, in criticizing the individualistic approach, feminists social scientists have tended to over-

---

14 For reviews of research on depression in general, see Coyne (1985a), and Gilbert (1984). Also see the recent *British Journal of Psychiatry Special Issue on 'Depression'* (Volume 164, March 1994).

15 See Phoenix *et al.* (1991) for a recent collection of articles exploring women's lives as mothers, and the diverse contexts, meanings and experiences of mothering.

16 The term 'medicalization' was coined by Zola (1972) and refers to the increasing medical control of health and illness (Abercrombie *et al.*, 1988).

emphasize the socio-political context at the expense of the individual. In this section I suggest how we might move beyond these conceptualizations, by drawing upon the work of relational psychologists, and recent feminist sociological research on women's experiences of various aspects of household and family life. In the fourth section, I conclude the chapter with an outline of the central theoretical concerns of my own study.

I. Puerperal psychological difficulties: distinctions and definitions

Psychiatric complications following childbirth have been recognized and studied since the time of Hippocrates (Hamilton, 1962). Cox (1986) claims that reliable clinical observations were only made in the 19th century, in particular, by two French psychiatrists, Esquirol (1845) and Marcé (1858). Since that time, distinctions have been made between different types and degrees of psychological difficulties associated with childbearing. First, a distinction is made between psychological distress occurring during pregnancy and in the postpartum period, with some suggesting that the two are linked (e.g. Bridge *et al.*, 1985; Dennerstein *et al.*, 1989; Dimitrovsky *et al.*, 1987; Green, 1990; Green and Murray, in press; Hayworth *et al.*, 1980; Nott *et al.*, 1976; Playfair and Gowers, 1981; Watson *et al.*, 1984; Zajicek and Wolkind, 1978). Others, however, argue that the evidence for such a link is inconclusive (e.g. Kumar, 1982; Kumar and Robson, 1978, 1984; O'Hara, 1985).[17] Second, a distinction is drawn between three 'disorders' occurring in the postpartum period: postnatal blues, puerperal psychosis and postnatal depression (Brockington and Cox-Roper, 1988; Inwood, 1985). These categories are medical constructs (Green *et al.*, 1988), and it is argued that there are empirical grounds for this classification, based on variation in severity and length of impairment (O'Hara and Zekoski, 1988). However, there is still some debate within the medical literature as to whether these should be considered as distinct disease entities or as belonging to a continuum (O'Hara and Zekoski, 1988). I now consider these three types of distress in turn, with a more detailed consideration of postnatal depression, as this is the subject of my study.

1. Postnatal blues

The postnatal blues, also known as the baby blues, the maternity blues and the three-day blues (Stein, 1982), are estimated to affect up to 80% of women during the first

---

17 Psychological problems occurring during pregnancy will not be considered in this thesis, as the focus of my study was specifically women's experiences of *postnatal* depression. For reviews of the literature on the psychology of pregnancy, see Breen (1975). For a discussion of psychological problems in pregnancy, see Kumar (1982), and see Fisher (1993) for a more recent and extensive review of this literature.

three to ten days following childbirth (Hopkins *et al.*, 1984; York, 1990). These mood changes are transient, regarded as 'normal', and usually resolve spontaneously without treatment (Stein, 1982). They are characterized by a lability of mood, heightened sensitivity, tearfulness (often without associated sadness), poor concentration, anxiety and irritability (Kennerley and Gath, 1986; Stein, 1982).

It is popularly believed that the postnatal blues are due to the hormonal or biochemical changes that occur in the mother's body in the period immediately following the birth. There appears to be some evidence to support these claims, but direct conclusive evidence has yet to be found. Existing studies have demonstrated links between low mood in the first postpartum days and biochemical changes in the body, such as a drop in progesterone levels (Nott *et al.*, 1976), a reduced plasma total tryptophan level (Gard *et al.*, 1986; Handley *et al.*, 1977; Stein *et al.*, 1976), decreased levels of circulating beta-endorphins (Smith *et al.*, 1990), and fluctuations of urinary adenosine monophosphate (Ballinger *et al.*, 1979). Premenstrual tension has been taken as evidence of a hormonal aetiology (Condon and Watson, 1987; Nott *et al.*, 1976; Yalom *et al.*, 1968). In a review of the research, Kennerley and Gath (1986) point out that the evidence is still inconclusive, in particular because of inconsistencies in the methodologies that have been used to examine the condition. Furthermore, some researchers argue that hormonal and psychosocial factors contribute independently to the observed mood changes in the immediate postpartum period (e.g. Smith *et al.*, 1990).

Despite mixed evidence as to the precise aetiology of the blues, they are a phenomenon widely recognized and accepted both by mothers and health professionals, largely because they tend to occur when women are still in hospital, and therefore still 'seen' by health professionals (McIntosh, 1986; Oakley, 1980).

2. Puerperal psychosis

While the blues are regarded as a common and normal occurrence, puerperal psychosis is a very rare condition estimated to affect only one to two per thousand mothers in Britain (Brockington and Cox-Roper, 1988; Kendell, 1985). The condition is an acute psychosis which develops within the first month postpartum, can lead to suicide and infanticide, and usually results in hospitalization (Pitt, 1968). There is continuing debate in the literature about the precise phenomenology of this condition, but recent reviews appear to agree that these psychoses are characterized by affective symptoms as well as thought disorder, delusions, hallucinations and confusion (Hamilton, 1982; Kendell, 1985). There

is also some debate as to whether puerperal psychoses are distinct from non-postpartum psychoses (O'Hara, 1987).

Puerperal psychoses are regarded as affective psychoses of the manic-depressive type, which happen to be precipitated by childbirth (Kendell, 1985; Kendell *et al.*, 1987). It is believed that childbirth causes the psychoses, as the incidence of psychotic illness rises dramatically within the first three months of delivery (Kendell *et al.*, 1976, 1987; Nott, 1982). Increased risk of postpartum psychosis has been associated with having a first as opposed to subsequent child; having a personal or family history of affective psychosis; single marital status; perinatal death; and a caesarian delivery (Kendell, 1985; Kendell *et al.*, 1987, 1981b). Kendell (1985) concludes his review of the research by suggesting that constitutional predisposition plays a major role in puerperal psychoses, a predisposition with might be similar, or identical, to the genetically transmitted predisposition to affective psychoses.[18]

3. Postpartum depression[19]

Postpartum depression has been studied within the last 20 years only as, until then, most of the research carried out on psychological distress following childbirth was restricted to women who had been hospitalized or required in-patient treatment, and were therefore most probably descriptions of severe cases only, and of puerperal psychosis (Kendell, 1985). The large number of moderate cases were cared for in the home and were never recorded (Cox, 1988a). Indeed, it is argued that postnatal depression is still under-recognized today, partly because women tend to minimize their reports of distress for fear of being labelled 'a bad mother' (Gruen, 1990; McCord, 1984; Price, 1988), but also because health professionals might fail to recognize it (Cox, 1986; Cox *et al.*, 1982; Gruen, 1990; Kumar, 1982). The figure of one in ten mothers experiencing postnatal depression represents only those mothers who are identified as such, and is therefore probably an underestimate of the number of women who experience depression following childbirth (Jebali, 1993).

Whilst the blues and the psychoses have been relatively clearly delineated, postnatal depression has been the subject of much discussion and some would argue confusion (Nicolson, 1988; Romito, 1990a, 1990b). However, there is consensus on two points;

---

18 For a more extensive review of the literature on puerperal psychosis, see Brockington *et al.* (1982). See Hamilton (1982) for a discussion of the historical developments of this research. For a review of psychoanalytic understandings of postpartum psychosis, see Breen (1975). For a personal account of puerperal psychosis, see Atkinson and Atkinson (1983).

19 The terms 'postnatal depression' and 'postpartum depression' are used interchangeably in the literature, and in this chapter.

first, that the timing of the onset of postnatal depression is ill-defined (O'Hara and Zekoski, 1988), although recently Cox *et al.* (1993) noted a threefold increase in the rate of onset of depression within the first five weeks postpartum; and, second, that postnatal depression "lies between the extreme of severe puerperal depression ... and the trivial weepiness of the blues" (Pitt, 1968: 1325).

However, there are two particular issues that still cause debate. The first concerns whether postnatal depression constitutes a separate and unique condition occurring only in the period following childbirth, or whether it should be considered as diagnostically similar to depression occurring at other times (Kumar, 1982; Nott, 1987). The second issue concerns the variety of definitions and diagnostic criteria that have been used to identify 'cases' of postnatal depression (Arizmendi and Affonso, 1984; Kendell, 1985; O'Hara and Zekoski, 1988). The different ways in which postnatal depression has been measured, and variations in the sizes and compositions of the samples, has resulted in a range of estimates of prevalence, which varies from 2.9% (Tod, 1964) to 25% (Jacobsen *et al.*, 1965), with most studies finding that approximately 10-12% of mothers experience it (Cox, 1983; Pitt, 1968).

Pitt (1968) was amongst the first to study postnatal depression. His criteria for the presence of depression following childbirth, still used by some researchers (e.g. Breen, 1975; Romito, 1990b), were that: women should describe depressive symptoms; these symptoms should have developed since delivery; they should be unusual in their experience and to some extent disabling; and they should have persisted for more than two weeks. The commonly cited symptoms include: anxiety, insomnia, tearfulness, labile mood, feelings of inadequacy and inability to cope, suicidal thoughts and a fear of harming the baby, guilt, self-deprecation, irritability, loss of libido, and fatigue (Hopkins *et al.*, 1984; Kendell, 1988; Nott, 1987; Pitt, 1968). Most episodes of postnatal depression resolve in less than six months (Cooper *et al.*, 1988; Watson *et al.*, 1984), although researchers have found that the condition can last up to four years (Kumar and Robson, 1984). This raises the question of how similar postnatal depression is to depression in mothers of preschool children (e.g. Brown and Harris, 1978; Moss and Plewis, 1977; Richman, 1974), which tends to be seen as a different academic field (Oakley, 1980; Romito, 1989).

The demographic distribution of postnatal depression amongst mothers is unclear. A number of studies have found that postnatal depression is more common among young women (Feggetter *et al.*, 1981; Hayworth *et al.*, 1980; Paykel *et al.*, 1980), while others find that it is more common among older mothers (Gordon and Gordon, 1960; Kumar and Robson, 1984), and that it is associated with delaying motherhood to the fourth decade

(Dennerstein *et al.*, 1989). Other studies find no association with age (Pitt, 1968; Playfair and Gowers, 1981). In terms of parity, several studies have found it to be more common among first-time mothers (Paffenberger and McCabe, 1966; Gordon and Gordon, 1959; Gordon *et al.*, 1965; Pitt, 1968), while others show that it is more common after the birth of a subsequent child (Kaij *et al.*, 1967; Tod, 1964). Still further studies find no evidence of an association between postnatal depression and parity (Green, 1990; Hayworth *et al.*, 1980; Paykel *et al.*, 1980; Watson *et al.*, 1984). Several researchers find the incidence of postnatal depression is not linked to socio-economic status (Hayworth *et al.*, 1980; Paykel *et al.*, 1980; Pitt, 1968; Watson *et al.*, 1984), while others have identified a link with the mother's lower socio-economic background (Feggetter *et al.*, 1981). Some researchers find that marital status is not associated with postnatal depression (Hayworth *et al.*, 1980; Playfair and Gowers, 1981), while others show that it is linked to being single or separated (Braverman and Roux, 1978; Feggetter *et al.*, 1981). No links have been found between the mother's ethnic origin and prevalence of postnatal depression (Hayworth *et al.*, 1980; Watson and Evans, 1986).

Having considered the distinctions between different types of psychological distress associated with childbearing, I now examine the research which attempts to uncover the aetiology of postnatal depression specifically. I begin by considering studies which have conceptualized postnatal depression as an individual pathology, and then move on to feminist theories which highlight its socio-political origins.

II. Medical-psychiatric, individualistic analyses of postnatal depression

The four groups of studies which adopt an individualistic framework of explanation are either biochemical, psychodynamic, psychological, or 'social factors' studies.

1. Biochemical explanations

Proponents of hormonal explanations argue that dramatic hormonal changes, for example, in progesterone levels, take place during childbirth and lactation, and that these might bring on depression in mothers (Dalton, 1971, 1989a, 1989b). Other researchers propose that the biological mechanisms which underlie all depressions are involved in postnatal depression. The finding that antidepressant drugs appear to alleviate symptoms has stimulated investigations into the possible role of monoamines in depression (Sandler, 1978).[20] Other investigators argue that the links between a history of premenstrual mood

---

20 Monoamines are a group of neurochemicals (noradrenaline, dopamine and 5-hydroxytryptamine) in the central nervous system (Gilbert, 1984).

change and postnatal depression constitute evidence in support of a biological aetiology (Dalton, 1971; Pitt, 1968). It has also been suggested that fluctuations in mood in the puerperium[21] may be linked with changes in plasma concentrations of the steroid cortisol (Handley *et al.,* 1980). Others argue that thyroid depletion is a factor which creates a physiological crisis and disruption in the emotional well-being of the new mother (Clayton, 1986). Despite the large number of studies that have explored possible biochemical influences on postnatal depression, no evidence for any direct or indirect links has emerged to date (Gelder, 1978; Hopkins *et al.*, 1984; Kendell, 1985; O'Hara *et al.*, 1991; O'Hara and Zekoski, 1988).[22]

Despite the lack of solid evidence for any biochemical aetiology, there is a "widespread but unproven assumption" (Kendell, 1985: 7-9) within the medical profession, the media, the general public, and mothers themselves that postnatal depression has a hormonal basis (Elliott *et al.*, 1988; Kendall-Tackett, 1993; Oakley, 1980). Newspaper articles, for example, tend to emphasize the hormonal nature of postnatal depression.[23]

Katharina Dalton, author of the popular book *Depression after Childbirth* (1989a), is perhaps the best known and most active proponent of hormonal theories of postnatal depression (and also of Premenstrual Syndrome: see Dalton, 1964). Although Dalton's position may be regarded as extreme, and many psychiatrists would disagree with her ideas, her book was the most widely read publication on the subject of postnatal depression by the women I interviewed. For this reason, it is important to give some indication of the tone of this book, and of the ideas put forward. Dalton (1989a: 27) states that postnatal depression "is an illness due to a biochemical abnormality in the brain, which controls the workings of the body, and also a biochemical abnormality in the blood which perfuses all the tissues of the body". According to Dalton (1989a: 20), the signs that suggest that a mother might be suffering from this 'illness' are the following:

> A home visit reveals the patient as quite different from the carefully made-up, well-coiffeured lady who attended the antenatal clinic. She's now dishevelled with no make-up, and no recent signs of a shampoo and set.

---

21 The 'puerperium' refers to the first six weeks postpartum during which the anatomic and physiologic changes brought about by pregnancy resolve (Glanze *et al.*, 1990).

22 For a more thorough and extensive review of the research on the possible biochemical aetiology of postnatal depression, see George and Sandler (1988).

23 See, for example, the case reported in 1993 of a mother who drowned her 7-week-old baby, and was said to have postnatal depression. *The Guardian* highlights the hormonal nature of the mother's depression and points out that she was being seen by Katharina Dalton, the Harley Street specialist in hormone replacement therapy, and was taking progesterone. It emerged that the night before the morning of her daughter's death, the mother "missed her progesterone injection" (*The Guardian*, 23 February 1993: 4).

> The home is a bit of a muddle with the baby's clothes on the floor, a pile of nappies waiting to be washed, and several cups on the draining board.

Dalton (1989a: 40) argues that the irritability seen in postnatal depression is of biochemical origin, and she writes that:

> The irritability is reflected on the husband, for too often he is at the wrong end of his wife's bad temper. He finds she has changed from the elated, vivacious person she was during pregnancy into the ever-moaning bitch of today. Can you blame him if he stops in for a quick pick-me-up on his journey home before he faces another irrational flow of verbal abuse or physical danger?

At the end of the book, Dalton (1989a: 154) concludes that "babies should bring happiness but if they do not something is wrong. This book is an attempt to help when things do go wrong".

Although the hormonal basis of postnatal depression has not been established conclusively, these are the explanations with which my sample of depressed mothers was most familiar with, and came into most contact with. Moral statements such as "babies *should* bring happiness but if they do not something is *wrong*" (emphasis added) have important implications for how mothers morally evaluate their own feelings, and therefore potentially for their depression following childbirth (I take up this issue in Chapter Four).

There are four important points to conclude in relation to biochemical explanations of postnatal depression.

First, there is little empirical support for biochemical theories. In a review of the research on biochemical correlates of 'puerperal mental disorders', George and Sandler (1988: 104) conclude that "the results of endocrine research in puerperal mental illness are not encouraging. Despite a profound feeling that hormones 'have something to do with it' there are few positive data".

Second, the mechanisms by which biochemical changes affect the mother's mood are rarely explained. As noted by Kumar (1982: 111), "there is still no certainty that [findings of biochemical changes] can provide insights into mechanisms underlying *pathological* mood states". For example, despite the fact that all mothers experience these hormonal changes and adjustments, not all mothers experience depression. Nevertheless, hormonal explanations are widely held by the general public, and, in particular, by the depressed mothers I interviewed.

Third, at a theoretical level, these theories are problematic because they fail to look beyond individual physiology to the broader social context of motherhood. Evidence from other sources, however, suggests that there are reasons for questioning a *purely* physiological aetiology to postnatal depression, as suggested by Dalton (1971, 1989a, 1989b). In their personal accounts, mothers describe a wide range of psychological and social experiences which led them to become depressed (e.g. see Welburn, 1980) and which biochemical theories ignore. Furthermore, studies show that postnatal depressive reactions can be experienced not only by the biological mother, but also by fathers, grandmothers, and adoptive parents (Asch and Rubin, 1974; Atkinson and Rickel, 1984; Quadagno *et al.*, 1986). Finally, anthropological research suggests that postnatal depression might be a culture-bound phenomenon restricted to Western industrialized societies (Harkness, 1988; Jansson, 1987; Seel, 1986; Stern and Kruckman, 1983).[24] These studies indicate that, even if there are biochemical influences in postnatal depression, the distress mothers experience cannot be reduced purely to physiology, and psychosocial processes are clearly also implicated.

A final limitation of these studies is their failure to elicit the mothers' personal accounts of their depression as this is not part of their theoretical or methodological framework.

2. Psychodynamic accounts

Psychodynamic theories describe the postpartum period as one of psychological crisis during which the mother adjusts and adapts to her new role, by resolving intrapsychic and interpersonal conflicts (Blum, 1978; Kaplan and Blackman, 1969; Leifer, 1977; Pines, 1972). In cases of postnatal depression, psychological regression, which, it is argued, occurs in all women during pregnancy, may re-evoke earlier conflicts, particularly in cases where there are inadequate maternal role models or there is a rejection of maternal roles (Hopkins *et al.*, 1984). Postnatal depression, then, results from 'unresolved conflicts' about, and rejection of, the motherhood role (Karacan and Williams, 1970; Klatskin and Eron, 1970). According to this model, postnatal depression results from the mother's failure to adapt, or her inability to re-integrate, following delivery. It is postulated that conflicts around femininity, issues to do with dependence and independence, and relationships with the women's own mothers are unresolved and lead to depression

---

24 These authors suggest that the absence of postpartum 'rituals' in the West, such as those in non-Western societies, may contribute to the occurrence of postnatal depression. Postpartum 'rituals' in other cultures include: cultural recognition of a distinct postpartum period during which the mother's normal duties are interrupted; a confinement period; mandated rest; practical and emotional assistance mostly from other women; and social recognition of the mother's new status through rituals, gifts and a celebratory feast.

(Bibring *et al.*, 1961; Lomas, 1960). Thus, psychoanalytic theory sees the experience of dissatisfaction in motherhood as evidence of developmental problems and poor adjustment to feminine psychosexual identity.

Psychoanalytic theories of postnatal depression have been particularly valuable in pointing to the potential importance of a mother's relationship with her own mother. However, there are several limitations to these explanations.

Psychoanalytic formulations operate at the level of the individual mother, and her particular intrapsychic processes. Where external circumstances, or any social context, are taken into account, these tend not to be emphasized. The causes of postnatal depression are assumed to be internal to the individual mother, and few links are drawn between these inner processes and the wider social context in which the woman is carrying out her mothering role. Although psychoanalytic accounts highlight the importance of relationships, in particular, with the woman's own mother, they fail to explore how these relationships are influenced by social norms and gendered expectations of women and mothers.

Psychoanalytic theory also provides relatively little insight into women's *subjective* experiences of motherhood. As Boulton (1983: 8) points out, within psychodynamic accounts "a woman's experience as a mother ... becomes merely an empirical indicator of her underlying developmental conflicts and anxieties: it is these conflicts and anxieties that are the real subject matter of psychoanalysis".

One notable exception to these studies is Breen's research on women's first-time experiences of pregnancy, birth and motherhood (Birkstead-Breen, 1986; Breen, 1975). The relevance of this study to my own is that Breen considered the relationship of the individual to society, and discussed the links between mothers' perceptions of themselves and social representations of motherhood (see Chapter Four).

3. Personal history, personality, and psychological formulations

A third group of studies has investigated the psychiatric and psychological characteristics of the mother. Some researchers have observed that postnatal depression is associated with a personal history of psychiatric illness (Ballinger *et al.*, 1979; Feggetter *et al.* 1981; Gordon and Gordon, 1960; O'Hara *et al.*, 1983, 1991; Paykel *et al.*, 1980; Tod, 1964; Watson *et al.*, 1984; Wolkind and Zajicek, 1981) while others find no such evidence (Dalton, 1971; Kumar and Robson, 1984; Pitt, 1968). Several studies report links between

postpartum depression and a family history of psychiatric conditions (Ballinger *et al.*, 1979; Gordon *et al.*, 1959; Nilsson and Almgren, 1970). Studies have also shown that particular personality features predispose their carriers to depression (Boyce *et al.*, 1991a, 1991b). Other research has concentrated on whether postnatal depression is associated with the blues in the early days postpartum. Studies have noted that the occurrence of the blues is associated with an increased risk of later clinical depression (Cox *et al.*, 1982; Kendell *et al.*, 1981a; Paykel *et al.*, 1980; Pitt, 1968; Playfair and Gowers, 1981; Romito, 1990a; Stein, 1982). However, Gard *et al.* (1986) found that blues and later depression were only slightly related and were predicted by different factors. Other research points out that a history of previous postnatal depression is correlated with postnatal depression (Braverman and Roux, 1978; Playfair and Gowers, 1981). A recent study suggests that postnatal depression is associated with the 'Highs', or 'mild hypomania' - an elated mood in the first week postpartum (Glover *et al.*, 1994).

Further research has explored links between depression following childbirth and the woman's pregnancy. Studies report that women who are depressed and/or anxious during pregnancy may be more at risk of experiencing continuing depression postpartum (Dalton, 1971; Hayworth *et al.*, 1980; Kumar and Robson, 1978; Nott *et al.*, 1976; O'Hara *et al.*, 1984, 1991; Playfair and Gowers, 1981; Saks *et al.*, 1985; Tod, 1964; Whiffen, 1988), although others find no such links (Kumar and Robson, 1984; Pitt, 1968).Similarly, some studies note that postnatal depression is associated with an unplanned pregnancy (Braverman and Roux, 1978; Kumar and Robson, 1984; Nilsson *et al.*, 1967), while others find no such evidence (Dalton, 1971; Paykel *et al.*, 1980; Pitt, 1968). Complications in pregnancy appear not to be linked to postnatal depression (Dalton, 1971; Paykel *et al.*, 1980; Pitt 1968; Playfair and Gowers, 1981).

The few psychological studies focus on personality characteristics (Boyce *et al.*, 1991a, 1991b), attitudinal variables such as anxiety (Grossman *et al.*, 1980; Tod, 1964) and maternal attitudes towards children (Grossman *et al.*, 1980; Shereshefsky and Yarrow, 1973), deficiencies in self-control, attributional style, social skills in pregnancy (Cutrona, 1983; O'Hara *et al.*, 1982), and the effects of internal versus external locus of control (Dimitrovsky *et al.*, 1987).

All these studies focus on problems internal to the mother, and fail to explore psychiatric or psychological characteristics in conjunction with other aspects of these women's lives (e.g. see Boyce *et al.* (1991b) who study only one risk factor - personality - in postnatal depression).

4. The 'social factors' approach

The three approaches outlined above have focussed on the mother's deficiencies, whether hormonal, psychodynamic, or psychological. 'Social factors' approaches to postnatal depression set out to examine the immediate social environment in which the difficulties experienced by depressed mothers are embedded, and make some attempt to redress the emphasis placed on the individual.

The role of social factors in postnatal depression was first examined by the Gordons in the late 1950s (Gordon and Gordon, 1959, 1960; Gordon *et al.*, 1965). They identified a positive association between postnatal depression and the amount of 'social strain' reported by the women, such as the presence of cultural differences between husband and wife, physical complications in pregnancy, the mother's lack of experience with babies, and no help being available to her (Gordon and Gordon, 1959).

The Gordons' social approach was largely neglected until the 1980s, when a wave of studies examined the effects of 'life events' and social support on depression following childbirth.[25] The theoretical framework adopted by these studies is Brown and Harris' (1978) 'vulnerability model' in which depression is recognized as an understandable response to adverse social conditions. Brown and Harris argue that in the face of a life event or long-term on-going difficulties - termed 'provoking agents' - the women most at risk of depression are those exposed to a number of social 'vulnerability factors', such as lack of a supportive and confiding relationship, lack of paid employment outside the home, presence of three or more children under the age of 14, and loss of mother before the age of 11.[26] Other studies have explored whether childbirth itself might be considered a life event, with its own intrinsic psychological stress, in the same way that job losses or bereavements are classified as life events that predispose to depression (see Cox *et al.*, 1989). However, there is no clear consensus amongst researchers as to whether the experience of pregnancy and childbirth *per se* should be considered as a life event, as some authors suggest (e.g. Cox *et al.*, 1993; Kumar and Robson, 1984), or whether it simply constitutes an 'additional stress in tenuous situations', as Paykel *et al.* (1980) argue. However, it has been established that postnatal depression is associated with the occurrence of other stressful life events, such as death in the family, illness, moving house, or childcare-related

---

25 Holmes and Rahe (1967) defined 'life events' as events that are stressful to the extent that their 'advent is indicative of, or requires, a significant change in the on-going life patterns of the individual'. Examples of such life events are: divorce, marriage, death, birth, moving house, loss of job.

26 Brown and Harris (1978) carried out a community study of depression in women in Camberwell, London; their study was not on postnatal depression specifically.

stresses (Cutrona, 1982; Kumar and Robson, 1984; Murray, 1989; O'Hara, 1986; O'Hara *et al.*, 1983, 1984, 1991; Paykel *et al.*, 1980; Small *et al.*, forthcoming).[27]

Researchers have also investigated 'social support' - that is, the quality of mother's relationships, with her confidants in particular. The most consistent finding has been the link between a poor marital relationship and postnatal depression (Boyce *et al.*, 1991a; Cox *et al.*, 1982; Hopkins *et al.*, 1984; Kumar and Robson, 1984; O'Hara, 1986; Paykel *et al.*, 1980; Small *et al.*, forthcoming; Stemp *et al.*, 1986; Whiffen, 1988). Postnatal depression has also been linked with a poor parental relationship (Boyce *et al.*, 1991a; Kumar and Robson, 1984; Uddenberg, 1974) and inadequate social support in general (Cutrona, 1982, 1984; Gordon *et al.*, 1965; O'Hara, 1986; O'Hara *et al.*, 1983; Small *et al.*, forthcoming; Stemp *et al.*, 1986).[28]

Investigations of social factors have also asked whether postnatal depression is associated with obstetric complications or difficulties. Several researchers argue that there is a link (Day, 1982; Fisher, 1993; Green, 1990; Green *et al.*, 1988; Oakley, 1980), while others find no such evidence (Elliott *et al.*, 1984; O'Hara, 1986; Paykel *et al.*, 1980; Pitt, 1968). In a recent study, Murray and Cartwright (1993) found that obstetric complications were associated with postnatal depression only in (primiparous) mothers who had a previous history of depression.

The literature on the various social correlates of postnatal depression is characterized by contradictory findings. In part, these are the result of differences in methodology: for example, different samples of women are used, women are recruited antenatally and/or postnatally, different criteria are used to assess postnatal depression; the time of assessment varies; and some use questionnaires and others use interviews. Green (1990) has pointed out that these studies fail to consider a sufficient range of variables and their additive effects, and fail to use multivariate statistics in their analyses. However, these studies have been useful in highlighting that postnatal depression is, at least in part, related to social and psychological phenomena. In particular, they have pointed to the central role of interpersonal relationships, and focussed attention on the marital relationship. However, four limitations must be highlighted.

First, the main aim of these studies is to establish whether correlations exist between incidence of postnatal depression and a number of variables. Studies of correlation

---

27 See Cox (1988b) for a discussion of methodological problems in the 'childbirth as a life event' research.

28 Studies on the links between postnatal depression and the marital relationship, the parental relationship, social support, and social networks will be considered in greater detail in Chapter Three.

matrices are limited by the inherent subjectivity introduced by choosing which particular variables to investigate - e.g. the marital relationship versus other variables - and what particular aspects of these variables to explore - e.g. the lack of practical and emotional support from the partner, versus other aspects of the relationship. Therefore, if these studies indicate that there are associations between postnatal depression and a number of factors, the question of whether these are causal links, or whether postnatal depression and a particular factor both share other common causal factors, is unclear. Computational resources often limit the number of variables that can be chosen for analysis, and so doing constrain conclusions that might be drawn about the *processes* involved in postnatal depression. These studies are valuable because they can identify and describe what particular factors are important; however, because of their limitations, they need to be complemented by qualitative research.

Second, these studies have placed little emphasis on personal accounts of postnatal depression. In some cases, only 'objective' evaluations are made. For example, the measurement used by Paykel *et al.* (1980: 340) to asses the impact of 'life events' "rated, on a five-point scale, the degree of negative impact the event would be expected to have on someone when its full nature and particular circumstances were taken into account, but *completely ignoring the patient's subjective report of reaction*" (emphasis added). Indeed, women's subjective accounts of their feelings are generally regarded as problematic in psychiatric research, because it is assumed that the depression gives women a 'distorted' and negative view of reality. Where subjective accounts are used, they are considered a limitation of these studies, because "the use of subjective measures of perceived support ... are likely to be compounded with disorder" (Hopkins *et al.*, 1987: 237). Pitt (1978: 126) notes that "although, according to a personality test, the depressive [mothers] appeared significantly more introverted and anxiety prone, it may have been that their depression distorted their answers to the test".

In other words, the results are regarded as a potential artefact because the data are 'contaminated' by the mother's depression, and her negative perceptions. These researchers fail to point out that what they regard as "distorted ... answers" constitute the nature of depression. The work of cognitive theorists indicates that, while depressed, individuals hold a particular perception of the world (e.g. Abramson *et al.*, 1978; Beck, 1967; Teasdale, 1983). This perception, far from being a source of contamination, and something that can be distinguished from 'objective' reality, comprises the very essence of depression. In addition, research has shown that postnatally depressed mothers are *not* "universally negative in their recollections of their intrapartum experiences" (Green, 1990: 182; see also Small *et al.*, forthcoming).

Third, while these studies describe the social origins of women's depression, they are criticized for failing to recognize that many so-called vulnerability factors describe everyday aspects of women's lives as mothers (Oakley, 1980; Romito, 1990b). This research fails to point out that the depression mothers experience is rooted, not only in a social context, but also a political one. Although these studies explore the social roots of postnatal depression, they nonetheless remain at the level of the individual.

A final limitation of 'social factors' theories is their deterministic nature, and their suggestion that an individual's psychological state is determined by the environment in an uni-directional way.

5. Strengths and weaknesses of individualistic perspectives on postnatal depression

Studies that take the individual as the unit of analysis have improved our understanding of postnatal depression in important ways. Despite the lack of evidence, biochemical studies suggest that physiological changes might affect a woman's psychological experience. Psychodynamic theories have pointed out that a mother's relationship with her own mother might be problematic, and that the conflict between her own experience and the social role of mother might also be implicated in postnatal depression. Studies of social factors have identified the importance of relationships with partners and parents. However, the individualistic perspective is limited by its deterministic understanding of psychological distress, its failure to include women's subjective accounts of their experiences, and its emphasis on individual pathology. Finally, this approach has failed to conceptualize postnatal depression as a multi-dimensional problem, as opposed to one which is caused in a linear way by biochemical changes, intrapsychic processes, psychological or social factors. There is, however, increasing recognition that postnatal depression might be best understood from an interactive perspective (Breen, 1975; Cutrona, 1982; Fisher, 1993; Heitler, 1976; O'Hara and Zekoski, 1988; Paykel, 1991; Romito, 1989).

III. Feminist, socio-political analyses of postnatal depression

1. Introduction

Within the last 15 years the theories of postnatal depression outlined above have come under increasing attack (e.g. Calvert, 1985; Day, 1982, 1985; Jebali, 1993; Nicolson, 1986, 1988, 1989a, 1989b, 1990, 1991/92; Oakley, 1979, 1980; Romito, 1989,

1990a, 1990b; Ussher, 1989; Vines, 1993). Much of this criticism has been voiced by feminist researchers objecting to the medicalization and pathologization of women's distress following childbirth, the deterministic notion of the aetiology of illness inherent within the medical model, and the absence of women's accounts within medical-psychiatric research (Mauthner, 1993).

Feminist discontent with the medical model of postnatal depression is embedded within wider feminist critiques of both medicine and psychiatry (e.g. Penfold and Walker, 1983; Smith, 1975; Ussher, 1989), which themselves have their origins in the antipsychiatry movement of the 1960s (see Ussher, 1991). Although the precise arguments put forward by different so-called antipsychiatrists (e.g. Foucault, 1992; Goffman, 1987, 1990; Laing, 1965; Laing and Esterson, 1986; Scheff, 1966; Szasz, 1972) varied, and a number of them objected to being categorized under one label (Ingleby, 1981), they did share a common social perspective on mental illness, in which the latter is understood in its cultural and historical context. The antipsychiatrists also criticized psychiatric labels which they regarded as a form of social control (e.g. Scheff, 1966). In reconceptualizing women's psychological problems, feminists have been influenced by the arguments of the antipsychiatrists, but they have also modified them by placing gender at the centre of the analysis. However, just as the arguments of the antipsychiatrists are limited by their emphasis on the notion of 'social control', and a passive construction of the individual (Busfield, 1986; Ingleby, 1981), so too are feminist formulations of women's psychological problems (Jordanova, 1981).

Feminists researching postnatal depression have been concerned with its ontology and aetiology. One of the central research aims within their work has been to elucidate whether postnatal depression constitutes a discrete disease entity as implied by the medical model. Romito (1989: 1433) notes that "the fundamental question is whether or not an entity we label postpartum depression actually exists". Similarly, Nicolson (1988: 46) points out that her central research aim was "to question the existence of 'postnatal depression' as an objective reality". Feminist researchers have argued that because most women experience depression following childbirth, depression is a 'normal' response to motherhood and therefore cannot be considered as an illness. They maintain that postnatal depression is a social construction rather than a medical condition. The label postnatal depression should not be used because it obscures the social nature of women's problems, and may be used as a way to control 'deviant' women.

Feminists also object to the medical model of postnatal depression because it implies pathology rooted in individual deficiencies - whether biochemical, psychodynamic,

psychological or social. They argue that if most women experience depression it cannot be regarded as pathological, and that it must be a socio-political rather than an individual problem. They suggest that women's depression is linked to mothers' inferior status within society, and to the structural and ideological contexts in which women have children.

In this section, I consider the work of the three feminist social scientists Ann Oakley, Patrizia Romito and Paula Nicolson. These researchers are alone in having set out to conduct in-depth, qualitative studies of postnatal depression, and so I will analyse their work in some detail. Furthermore, I focus on these particular studies because they provided the starting point, and therefore also the point of reference, for my research. There are two main differences between these studies and medical-psychiatric research. First, the former include a qualitative dimension, although two of them (Oakley, 1980; Romito, 1990b) were also quantitative and correlational. Unlike the studies described above, they set out to collect women's personal accounts of their experiences of childbirth and motherhood. Second, these studies acknowledge the political nature of the social context of motherhood by documenting the structural and ideological constraints under which women bear and rear their children within Western societies.

I begin by giving detailed, separate accounts of these three studies, and then move on to critique them together, further below.

2. Ann Oakley - a sociological study

Oakley has carried out extensive sociological research on women's lives as housewives and mothers, childbirth practices and experiences, and various aspects of women's physical and psychological health (e.g. Oakley, 1974, 1986b, 1992, 1993). Her research on postnatal depression is based on a study of women's reactions to childbirth carried out in the mid 1970s and it is this particular study that I shall focus on here (Oakley, 1979, 1980).

Oakley was among the first to question the medical-psychiatric approach to postnatal depression. In doing so, she moved away from individualistic analyses, to consider "the institution of motherhood and its medical control", and in particular, "the contribution of medical maternity care to women's feelings about becoming a mother" (1980: 1). Her study was a longitudinal one of 55 middle-class women who were having a baby for the first time. She interviewed these women during pregnancy and the postpartum period, the last contact being at five months after the birth.

Oakley's sample was therefore heterogeneous in terms of the women's emotional and psychological responses to becoming a mother. Indeed, she pointed out that, based on what the women said in the interviews, four distinct mental health outcomes could be distinguished: postnatal 'blues'; anxiety; depressed mood; and depression. She argues that these are "four 'postnatal depression' categories", four "different meanings of the term 'postnatal depression'" (1980: 114) which "were branded 'postnatal depression' - either by the women themselves, by their husbands, relatives or friends or by the medical staff involved" (1980: 115). Of particular interest is the distinction that Oakley draws between 'depressed mood' and 'depression', a distinction which has been given little attention, either in the literature on postnatal depression, or in the literature on depression more generally (as also noted by Brown and Harris, 1978). Oakley notes that there are clear differences between these two conditions and, in particular, that the mothers who were "depressed" felt considerably more "disabled" by their condition than those who experienced "depressed mood" (1980: 117). Despite drawing this important distinction, in her analysis of the data, Oakley then merges the two groups, thus failing to follow through these differences in her theoretical analysis of depression. I discuss this further below.

By taking 'postnatal depression' to mean the blues, anxiety, depressed mood and clinical depression, Oakley found that only two of the 55 women in her sample "experienced no negative mental health outcome" (1980: 278). By using the term 'postnatal depression' to designate *the whole range* of 'negative' feelings that the women experienced following childbirth, Oakley argues that "it is *normal* to experience difficulties" (1980: 278; emphasis added), and that postnatal depression is a 'normal' response to having a baby. In a more recently published collection of essays, Oakley reiterates this point and notes that "it is hard to avoid the fact that there is something really depressing about motherhood" (1993: 85). Oakley concludes that the question we should ask is not "Why do some mothers get depressed or 'adjust' badly" to motherhood, but rather "Why do some mothers 'adjust' 'well' and avoid any kind of postpartum depression" (1980: 120). Oakley therefore conceptualizes depression as the norm, and 'happiness' as problematic.

Oakley puts forward a life-event model of postnatal depression similar to Brown and Harris' (1978) model I described above. She posits that "given a birth marked by high or medium levels of technology," four "vulnerability factors are able to discriminate between victims and victors" of childbirth. These "vulnerability factors" are: "not being employed, having a segregated marital role relationship, housing problems and little or no previous contact with babies" (Oakley, 1980: 279).[29]

---

29 Oakley found that "depression" was associated with medium to high use of technology in childbirth. However, neither Elliott *et al.* (1984) nor Green (1990; Green *et al.*, 1988) confirm this finding.

By criticizing traditional explanations of postnatal depression, which blame women's deficient physiology, or intrapsychic processes, Oakley (1980: 113) argues that what is needed is "a new way of understanding women's reactions to childbirth" which "stresses variables of *human* responses that are unconnected with traditional reductionist models of femininity". She suggests that women's responses to the "life event" of childbirth should be understood as human responses, and not as gender-specific ones:[30]

> Women are 'first and foremost' human beings, and they do not cease to have this status because they have babies ... The question of how relevant gender is in any situation is hypothetical and not a matter for *a priori* assumption. (1980: 258)

By viewing the life event of childbirth from its human rather than female characteristics, Oakley (1980: 179-180) "dispute[s] the assumption that childbirth must represent *gain* whereas other life events ... are thought necessarily to occasion *loss*" (emphasis added).[31] She maintains that motherhood is characterized by loss, and that "the primary loss of women in becoming a mother is a loss of identity" (1980: 244). What also emerges from Oakley's account is that her conceptualization of identity is that of a "separate", "autonomous" and "individuated" self:

> Motherhood erodes the sense of *personal* identity - the feeling of being a separate person in an equal community of other persons. Once a woman has a baby she will never entirely be a person in her own right again - that is, she will never achieve a personal identity on the same terms and in the same way as before she had a baby. (1980: 244)

More recently, Oakley (1993: 89) has reiterated that women's "basic problem" is that "of an insufficiently individuated sense of self".

According to Oakley, the main reason for loss of identity following childbirth is loss of paid employment. Oakley suggests that the 'solution' for women is therefore to return to paid employment. In her model of postnatal depression, "not being employed"

They point out that it is the mother's *perception* of the intervention and its appropriateness, rather than obstetric intervention *per se*, that is the critical factor. Since her 1980 publication, Oakley has refined her argument, noting that "the most likely impact on maternal mood of obstetric technology is restricted to the period immediately following birth, for hospitalized mothers", and that obstetric technology *per se* is not linked to depression either at six weeks or one year postpartum (Oakley and Rajan, 1990: 49). Oakley and Rajan (1990) also found that *the mother's feelings* of control in labour were significantly associated with depression at six weeks postpartum.

30 In a later essay, Oakley (1981a: 100) reiterated this point, noting that "childbirth can, and should, be seen as a human life event, that is, as a major change in *people's* lives rather than as an archetypally feminine experience".

31 This is rather contradictory; as Callaway (1978: 163) notes, "giving birth" is "the most essentially female function of all".

increases vulnerability to depression, while "being employed" protects against depression. Women are also said to lose their sense of identity through the isolation they experience, and because their marital relationship is no longer an "equal" or "joint" (1980: 266) one, but becomes "segregated" (1980: 279). Oakley therefore argues that maternal difficulties are best understood within a bereavement framework in which "depression as an outcome of first birth can be restated as grief work for the mother's lost identity" (1980: 255).

In order to understand why the "hopelessness that is occasioned by loss is so often generalized into frank depressed mood or full-blown clinical depression", Oakley claims it is because the experience of loss is mediated through "a specifically female psychology" (1980: 262).[32] By applying Jean Baker Miller's (1986a) analysis of women's subordinate position, and Seligman's 'learned helplessness' model of depression, Oakley puts forward the following reconceptualization of postnatal depression:[33]

> (1) women experience response-outcome independence (failure to control events by their own actions) throughout their lives as members of a subordinate group; (2) they are therefore more likely to approach childbirth with a weak sense of their own efficacy to control its progress and resolution; (3) the element of uncontrollability in childbirth itself (e.g. as regards the onset of labour, the number of contractions needed to dilate the cervix, and so forth) acts to confirm the mother's role as *helpless victim* ... (4) what doctors do in the name of medical control re-inforces the responses of learnt feminine helplessness to trauma; (5) and medical control therefore, through its capacity to re-inforce feminine helplessness, intensifies the likelihood of postpartum emotional disturbance. (1980: 271; emphasis added)

In Oakley's model of postnatal depression, the social context is emphasized and the social changes she proposes reflect this position. She argues for three types of changes: first, that childbirth should be less interventionist and more female-controlled; second, she advocates changes in the ways in which children are reared, including more state participation in childcare, more integration of children in mainstream social concerns and activities, and less isolation of families; third, she suggests changes within the wider context, including more realistic childbirth and parenthood preparation, woman-controlled

---

32 There is some confusion here as this position contradicts her earlier argument that women's responses to childbirth must be looked at as human, not female, reactions.

33 In Seligman's (1975) experiments, two groups of dogs were exposed to electric shocks. The first group were able to escape the shock, while the second group could not. The first group learnt that it could avoid the shock by moving away. The second group, however, learnt that its actions were independent of the shock. When faced with electric shock again, although they *could* escape, the dogs failed to make attempts at moving away, because they had learnt 'response-outcome independence'. Seligman argued that these dogs were showing 'learned helplessness', a condition which he suggested had parallels with depression in humans.

reproductive care,[34] the reduction of poverty and class-based inequalities, and restructuring the labour market.

3. Patrizia Romito - a sociological study

Romito's (1988, 1989, 1990a, 1990b) study of postnatal depression focussed on the effects of the structural organization of motherhood on the mother's emotional well-being. The aim of her research was to describe "the ordinary experience of mothers, emphasizing those aspects which may be more relevant for an understanding either of the mother's well-being or of her distress and unhappiness" (1990a: 20). Romito places her study within the research on the transition to parenthood. By drawing on these studies, she argues that there is evidence that various social circumstances (such as aspects of childbirth, breastfeeding, housework and childcare, and husbands' behaviour) may have a negative effect on mothers.

Romito was interested in women who were becoming mothers for the first-time. Her sample consisted of 44 predominantly middle-class French women living in France. Her study was a longitudinal one. The women were contacted four times, over pregnancy and the postpartum period, the last contact being when the child was between eight and 12 months old.

Romito (1990b) distinguishes between four "psychological states" (1990b: 115). Two subjective evaluations were made by the individual mother (the 'baby blues' and 'feelings of sadness and discouragement') as well as two objective measures of depression (a conservative and a wider measure). The latter were assessed using Pitt's (1968) criteria.[35] Romito (1990b) states that the measures of 'feelings of sadness and discouragement', and of 'depression', correspond to Oakley's (1980) two categories of 'depressed mood' and 'depression'.

Romito (1989) argues that psychological difficulties are part of the 'normal' experience of motherhood, on the basis that 57% of the mothers had cried, and had moments of sadness and worry within five weeks of the birth, and 52.5% had had these within four months. As a result, depression should not be considered an exceptional pathological response, but a reaction to the socio-political circumstances of mothers.

---

34 For a detailed discussion on this point, see Oakley (1976), where she examines the historical changes in the medical and social organization of childbirth, and, in particular, the increasing involvement of the male obstetrician.

35 Romito established two criteria of depression, based on Pitt's (1968) questionnaire: one that corresponded to his psychiatric definition and another, wider definition which took into account feelings of sadness and discouragement, but which did not fit into the psychiatric definition of depression.

Furthermore, because Romito (1990b) found that the same social conditions (lack of sleep, a crying baby, breastfeeding problems, isolation, the amount of housework, problems with their partners) were linked both with 'depression' and 'feelings of sadness and discouragement', she claims that there is a continuum rather than a dichotomy between the minor difficulties of most mothers and the more severe problems that a few of them experience and that clinicians define as pathological.

Romito argues that different degrees of feelings of depression have a common aetiological basis. Therefore, because such feelings are the norm, she postulates that 'postnatal depression' does not exist outside the research process; "the phenomenon labelled 'postpartum depression', rather than being an actual entity, is not only defined by, but actually constructed by the instruments used to measure it" (Romito, 1989: 1433).

Romito (1990b) also adopts Seligman's 'learned helplessness' model of depression as her theoretical framework. At the centre of her model of postnatal depression is the mother's perception of the independence between her own actions and the outcome of these actions. She maintains that women are socially conditioned to be helpless, both at work and in relationships with male partners, and hence lack control over their lives. This learned helplessness is compounded when women discover the discrepancy between their expectations, and the reality, of motherhood. Romito identifies the 'reality' of motherhood as the social conditions of motherhood which include: the medicalization of childbirth; the institution of the family; the 'unequal' division of household labour; caring for husbands as well as children; isolation; a lack of space; and a gendered labour market. The greater the discrepancy between expectations and reality, the greater the sense of loss of control, and the higher the risk of depression. The degree to which women have control over their experiences is therefore seen to determine their risk of depression, and depression is understood as resulting from a lack of control.[36]

Romito (1989) also describes the route to change as lying within the structural organization of motherhood within Western society. With regard to breastfeeding, for example, she notes that "most of the difficulties mothers experience in breastfeeding are linked to the social organization of motherhood, and could be avoided, provided that changes are made in the way society defines the role of the mother" (Romito, 1988: 89). She states that we cannot expect individual women to change their own circumstances because changes can create conflict and threaten the well-being of partners and relatives. Instead, Romito (1990b) advocates changes in the social conditions of motherhood, as well

---

36 Here, Romito joins other researchers who have emphasized the notion of control, in particular in childbirth (e.g. Elliott *et al.*, 1984; Entwisle and Doering, 1981; Green *et al.*, 1988; Oakley, 1980).

as wider socio-political reforms including fewer gender differences in education; a review of working hours for both parents; and developing strategies which enable mothers to remain in the labour market under favourable working conditions.

4. Paula Nicolson - a social psychological study

Nicolson (1986, 1988, 1989a, 1989b, 1990, 1991/1992) approaches postnatal depression from a social psychological background, and outlines some of the limitations of sociological approaches. She states that a limitation of what she terms the "social science position" (1988: 14), which includes both 'social factors' and sociological approaches, is that it fails to consider the subjective interpretations of the individual, and the meanings attributed by the women to their own experiences. In failing to explore subjective factors, these models portray mothers as victims of their immediate or wider socio-political environments. Nicolson also made the important point that the 'social science position' cannot account for differences between individual women, and why, given a common socio-political context, different women have varying experiences of motherhood.

Nicolson therefore addressed the question of why some women experience depression in the period following childbirth, while others do not. She was also concerned with identifying common elements to the experience of childbirth and early mothering, which would enable her to construct the "normal" "profile" (1990: 693) of this experience. Nicolson also asks whether postnatal depression exists as an objective reality.

Her study was a longitudinal one in which mothers were contacted initially during pregnancy, and a further three times following the birth, the last contact being at six months postpartum. I discuss three points in relation to Nicolson's sample and methodology. First, her participants were predominantly middle-class. She notes that "the potential commitment of up to 10 hours of the respondent's time suggests the sample needs to comprise volunteers with verbal and intellectual competence, and commitment" (1988: 105).

Second, in her sample, "all but one of the women had had a previous experience of depression" (1990: 689). The sample was therefore an unusual and unrepresentative one, because the majority of women who experience postnatal depression have not been previously diagnosed with a psychiatric disorder (Hopkins *et al.*, 1984).

Third, there was an unusually high attrition rate in Nicolson's sample, an important consideration in research on psychological problems. Initially, 24 women were contacted, and this number reduced to 23 at the second interview, 22 at the third interview and 13 by

the fourth interview. An additional four to six women were sent a questionnaire instead of being interviewed a fourth time.[37] In other words, about 25% of the women were not contacted a fourth time. It is likely that those who dropped out were the mothers who were clinically depressed, because social withdrawal is a classic symptom of depression (Jack, 1991; McCord, 1984).

Further grounds for questioning whether Nicolson's sample actually included women with clinical postnatal depression is that "most respondents ... stressed that they *did not* have postnatal depression. Not one woman said that she actually had it, even though *23 women reported some degree of negative/depressed feelings* during the postnatal interviews" (1989a: 128).[38]

Nicolson (1988: 45) notes that "it is not clear that individuals mean the same thing as each other when they talk about feeling 'depressed'". The women she spoke to used the word 'depressed' in various ways, and used different terms: "depressed/churned up/upset/feeling hopeless/pissed off/fed up/low/down/freaked out" (1989a: 127). Furthermore, Nicolson (1991/92: 84) notes that the women in her sample did not label their feelings as 'postnatal depression', but used "alternative terminology":

> I got through the so-called 'postnatal depression' time without being depressed - although I was upset a couple of times about specific things which I could say 'that's why I got upset.' But I didn't get 'postnatal depression'. (1991/92: 91)
>
> I'm not depressed - just pissed off. (1991/92: 91)

Nicolson argues that these women *did* feel depressed, but that "the tension between recognizing the pathologizing effect of being labelled as having 'postnatal depression' and *feeling* depressed" (1991/92: 90) lead the women to use "alternative terminology" in order to "gain personal distance from the 'postnatal depression as pathology' discourse" (1991/92: 84). Nicolson (1991/92: 92) suggests they distanced themselves from this discourse because it "regulates women's own accounting of their experience":

> Women's subjective accounts are *regulated* by and *subordinated* to the dominant, culturally valued discursive practices so that respondents in this

---

37 It is unclear whether four or six women were sent a questionnaire as, in one publication, Nicolson (1990: 691) writes that "a postal questionnaire was substituted for a fourth interview in six cases", and in another publication, she writes that "instead of the fourth interview, four women ... were sent a postal questionnaire" (1991/1992: 81).

38 There is a further point of confusion in Nicolson's research regarding the number of women who reported negative feelings. In one publication, Nicolson (1989a: 128) states that only one woman experienced no such feelings, and in another publication, she writes that "only *two* women did not feel negative at all" (1991/92: 89).

> study *were unable* to validate their own accounts as contradictions of the superordinate discourse (1991/92: 93; emphasis added).

Nicolson failed to follow through distinctions drawn by the mothers in her study between different types and experiences of 'depression'. Instead, she argues that women are regulated by 'a postnatal depression as pathology discourse'. This conclusion is contradicted by the mothers' statements - such as "I'm not depressed - just pissed off" and "although I was upset ... I didn't get 'postnatal depression'" - because these show that the women *were* validating their own experiences; they contrasted them with another and different experience which they labelled 'postnatal depression'. An alternative interpretation of these accounts would be that, based on their own experiences, the women said there was something different about 'postnatal depression' or 'clinical depression' on the one hand, and 'unhappiness', feeling 'upset' or 'pissed off' on the other. As all but one of these women had experienced clinical depression in the past, they knew from experience that what they were feeling after childbirth was different to what they had felt before.

Nicolson (1988) argues that postnatal depression is a component of the "'normal' experience of childbirth and early mothering" (1988: 375) because most women in her sample suffered 'some degree of depressed/negative feelings'. Therefore it "does not exist as an objective reality" (1988: 411), but is a cultural construct.

Nicolson's theoretical framework encompasses two central ideas: she conceptualizes motherhood in terms of loss, and depression in terms of bereavement. She notes that her evidence "suggests that childbirth and early motherhood fit more easily into a model of loss and bereavement than one of an accumulation of life events" (1990: 694). Nicolson maintained that first-time motherhood is characterized predominantly by loss, including "a loss of the former self" (1988: 69). Consequently, she asserts that the mother must grieve and come to terms with this loss, and that "depression" should be seen "as a healthy and normal grief reaction, which, given conducive support, will enable a successful transition to motherhood" (1990: 695).

The "universal/common experience" of motherhood (1988: 69) identified by Nicolson is the experience of "breastfeeding problems, lack of sleep, lack of closeness with her partner" (1988: 69), and "oppression" in that "women are *prevented* from mourning their loss of self" (1988: 69).[39] Nicolson sees women as "the passive object" (1992: 27),

---

39 This appears to be another point of confusion in Nicolson's research, as she seems to be arguing that depression is a "normal grief reaction" (1990: 695) to what is lost in motherhood, and yet she also suggests that women become depressed when they are "*prevented* from mourning their loss of self" (1988: 68).

victims of patriarchal society; she argues that the "internalization of passivity ... is central to understanding the psychology of women's health" (1992: 9).

Nicolson (1989a, 1989b) highlights the potential for changes by the individual, the level which has been left out by sociological accounts, as a means of improving women's lives. It emerges from her work that professional support, in particular the counselling psychologist, might be of help to depressed mothers.

5. Strengths and weaknesses of feminist theories of postnatal depression

(i) Introduction

Feminist social scientists have been concerned principally with countering the individualism inherent within the medical-psychiatric approach to postnatal depression. They have focussed on the socio-political context in which women in Western societies bear and rear their children. This work has made important contributions in several ways. It has challenged the extent to which childbirth has become increasingly medicalized. Oakley's (1976, 1979, 1980, 1990) extensive work in this area has been particularly influential. These researchers have also criticized current labour market structures, and the limited opportunities many mothers face in their return to paid employment following childbirth. This work has also highlighted the sometimes isolating nature of motherhood. Furthermore, feminist social scientists have pointed out the ways in which some women might experience motherhood as a loss of identity, in particular, through the loss of their occupational status. Finally, they have indicated that parenthood is often accompanied by a more stereotypical gender division of household labour, and that some mothers find this difficult, and perhaps depressing.

However, during my research, I became aware of discrepancies between the experiences of the women in my sample and the theoretical ideas of feminist social scientists. The dissonances centred around four particular issues. I came to question the idea that postnatal depression is a 'normal' response to childbirth and motherhood. I also found that notions of 'social control' and 'regulation' failed to capture the complex and variable ways in which mothers negotiate, and resist, the social contexts in which they live. Absent from these theories was the fact that the mother actively constructs her own psychological world from some common 'ideological raw material', and that as a result of this dynamic relationship between the individual and society, different mothers respond to their social contexts in different ways. A third concern was the implicit male, public-world

perspective that seemed to be taken when examining mothers' lives. Motherhood and depression are conceptualized primarily in terms of loss, and in particular a loss of identity, conceived as autonomy, independence, power and paid employment. A fourth and related issue was the apparent failure to listen to the mother's accounts from their own perspectives, and to analyse their experiences on their own terms. Based on the accounts given by the women in my own study, it seemed that feminist researchers had heard only one voice, only one side of what the mothers described about their experiences of depression. The accounts that I was hearing appeared not to have been represented within these theories.

These four limitations of feminist work arise from attempts to counter two assumptions which underlie medical-psychiatric explanations of postnatal depression. Medicine and psychiatry have tended to conceptualize women's bodies as unstable, weak and deficient, and attribute women's psychological problems to their female biology (Penfold and Walker, 1983; Showalter, 1987; Ussher, 1989). In the case of postnatal depression, women's hormones are most often regarded as the cause of the problem, as I discussed above. In response, feminist social scientists have adopted, either explicitly or implicitly, an 'egalitarian' framework in which women and men are regarded as 'humans' and gender differences are dismissed. In attempting to move away from the "equation of femininity with passivity, masochism and inferiority" (Breen, 1975: 14), the feminists have neglected gender differences altogether. The denial of differences is most explicitly put forward by Oakley (1980), who stresses that women's responses to childbirth and motherhood should be understood as 'human', rather than specifically female, responses.

There are several problems, however, with theories which conceptualize the individual in a gender-neutral and disembodied way (see Gilligan *et al.*, 1990a) and in which there is a "confusion of equality with sameness" (Breen, 1975: 14). Perhaps the greatest problem with these formulations is their equation of 'human' with 'male' (Gilligan, 1982; Gilligan *et al.*, 1990a). What emerges from Oakley's (1980) work, but also from that of Romito (1990b) and Nicolson (1988), is that a male, public-world perspective is adopted in examining and theorizing the lives of depressed mothers, just as it has predominated within much psychological and sociological research (Bell and Ribbens, 1994; Doucet, forthcoming; Edwards, 1990; Gilligan, 1982; Ribbens, in press; Stacey, 1981). Feminist researchers have examined depressed mothers' lives from a 'male' perspective, in which autonomy, power and paid employment are regarded as primary, and relational issues as secondary, to women's mental health. These models of postnatal depression could therefore be described as belonging to "egalitarian feminist psychology" (Squire, 1989: 4), that is, psychology operating within "liberal or equal opportunities

feminism" (Gill, 1991: 293). Within the liberal feminist tradition, "women and men are [seen as] equal, and given opportunity and access to power, women will thrive and succeed" (Ussher, 1991: 188).[40]

A second central feature of the medical model of explanation is its emphasis on psychopathology, and on the dichotomy between 'normal', happy, healthy mothers on the one hand, and 'abnormal', depressed, 'pathological' mothers on the other.[41] Postnatal depression is generally considered as an 'illness' (Brockington and Kumar, 1982) or a 'disorder' (Hopkins *et al.*, 1984), and the feminists have taken exception to this pathologization and dichotomization. Their response has been to shift the emphasis from the individual to the social, and argue that depression is a 'normal' response to the social context of motherhood. However, in attempting to remove the blame from the individual mother, and by placing it instead on society, feminist social scientists have lost sight of the individual as active agent, and of the differences that exist between mothers. They have failed to explain why many mothers do *not* experience postnatal depression, and why depressed mothers eventually *do* emerge from their depression. While traditional psychiatric accounts of differences are problematic because they conceptualize them in terms of pathology, feminist accounts are equally problematic because here differences disappear altogether.

To overcome the limitations of feminist work on postnatal depression, I have turned to psychological and sociological research that has taken place outside the field of postnatal depression. In particular, I have drawn upon the research of relational psychologists (e.g. Bernardez, 1988; Brown and Gilligan, 1992, 1993; Gilligan, 1982, 1990; Gilligan *et al.*, 1988, 1990b; Kaplan, 1984; Miller, 1984, 1986a, 1986b; Miller *et al.*, 1991; Stiver and Miller, 1988; Willard, 1988). I have also drawn upon a growing number of excellent sociological studies of women's experiences of various aspects of family life, including motherhood, which have emphasized the need to understand women's lives on their own terms (e.g. Bell and Ribbens, 1994; Boulton, 1983; Doucet, forthcoming; Graham, 1984;

---

40 "Woman-centred feminist psychologies" have emerged as "radical alternatives to both traditional and egalitarian feminist psychologies" (Squire, 1989: 4), and as a response to the constraints of the latter. These perspectives belong to "radical", "women-centred" or "cultural" feminism (Ussher, 1991: 190). Woman-centred psychology, like woman-centred feminism more generally, "takes the biological female subject as its object and seeks to redress the specifically female aspects of subjectivity, producing a celebration and idealization of femininity" (Gill, 1991: 294). Woman-centred psychology has been criticized for its essentialism, for its failure to challenge traditional discourses of gender and simply valuing femininity positively instead, for its tendency to ignore differences between women other than those of sexuality, and for its lack of political resistance (Squire, 1989; Ussher, 1991).

41 Within medical-psychiatric accounts, women's mental instability is seen as both normal, because it results from their deficient female biology, and as pathological, because of their deviation from socially-prescribed behavioural norms. Oakley (1981a) provides an excellent discussion of this contradiction as it applies to postnatal depression.

O'Donnell, 1985; Ribbens, 1990, in press). In the next section I use these research studies in order to discuss the limitations of the feminist work outlined above, and point out the ways in which I seek to build upon, and move beyond, current research.

(ii) Postnatal depression as a 'normal' response to motherhood

There is a fundamental confusion and contradiction within feminist accounts of postnatal depression, between, on the one hand, their argument that mothers are more or less at risk of depression; and, on the other hand, their contention that depression is a 'normal' and common response to motherhood. Oakley (1980), Romito (1990b) and Nicolson (1988) all maintain that their theories allow for different responses to motherhood. In Oakley's (1980) model, women are more or less vulnerable to depression depending on the number of vulnerability factors they experience. Romito (1990b) proposes that women are more or less at risk depending on the degree to which they experience a discrepancy between their expectations and the reality of motherhood, and that a continuum exists between different emotional responses to motherhood. Nicolson (1989b) also argues for a continuum of feelings. On the other hand, they assert that postnatal depression is a 'normal' response to motherhood, a view which reflects much of the wider sociological literature on women's experiences of motherhood, as Boulton (1983: 27) points out:

> Sociological theory ... suggests that the frustration and distress which women in Britain suffer as mothers are normal, expected responses to the social organization of the role. That is, it sees such distress as a social problem and locates its causes in the basic structure of society: in the way society views and values childcare, in the way society ensures that children are looked after, and therefore in the organization of society as a whole.

This apparent contradiction stems, in part, from the failure of these accounts to adequately conceptualize the differences that exist between mothers, and the range of feelings they experience and express. Two particular types of differences have been left untheorized: first, the fact that not all women experience motherhood as depressing, and many enjoy it; and, second, the fact that mothers express a range of negative feelings which cannot all be understood as clinical, postnatal depression.

Studies show that many women do find motherhood a satisfying and rewarding activity, from which they can derive "a sense of meaning and purpose" (Boulton, 1983: 103), and opportunities to take an active part in their local community (O'Donnell, 1985) and become involved in rich networks of other mothers (Bell and Ribbens, 1994). The fact that the feminist research portrays motherhood as depressing can partly be understood

within the context of the "rebellion against 'the feminine mystique'" (Breen, 1975: 14). This position is problematic, however, because it relies on, and has led to, the amplification of certain voices at the expense of others:

> Some readers may feel that the portrait of motherhood given here is too bleak, too depressing, an inaccurate rendering of the satisfactions many women derive from having and looking after a baby. I have tried to show the positive side, but of course it is to some extent true that the best news is bad news: happiness doesn't hit the headlines because it is boring. In some ways, too, the picture is *deliberately* black. What many of the women who were interviewed said was that they were misled into thinking childbirth is a piece of cake and motherhood a bed of roses. They felt they would have been better off with a clearer view of what lay in store for them. I have constructed the book around this conclusion, perhaps *amplifying* it somewhat, because only in that way are messages made impressive. But the insight itself is authentic - theirs, not mine, even if it does help to interpret the way I felt back in 1968 (Oakley, 1979: 6; emphasis added).

Arguing that depression is 'normal' also trivializes women's experiences of depression, in particular for those who feel that their feelings are 'abnormal' and out of the ordinary. This can have consequences in the ways in which depressed mothers are treated by health professionals. As Arizmendi and Affonso (1984) have pointed out, clinicians tend to overlook depression because its symptoms are seen as 'normal' concomitants of childbirth.

Furthermore, as Smith (1992: 117) has pointed out, in suggesting that depression in motherhood is 'normal', feminist writers "agree with mainstream psychologists that becoming a mother can be a negative experience for women". Smith notes the irony within this position given that these same authors criticize psychoanalysis, psychiatry, and medicine for equating femininity with pathology, and for arguing that pregnancy, childbirth and motherhood are inherently pathological events.

Feminist accounts have also neglected the range of *different* negative feelings that mothers can experience. As mentioned above, Oakley, Romito and Nicolson all recognize that the term 'depression' seems to be used by mothers to mean different experiences and feelings. However, in their analyses of their data, and in their theoretical conceptualizations of postnatal depression, these distinctions appear to be lost and untheorized. For example, Oakley merges 'depressed mood' and 'depression' into a single category - 'depression' - in her vulnerability model (see Oakley, 1980: 172; Table 7.1).

Other work, however, suggests that, experientially, negative feelings following childbirth do vary. For example, Birkstead-Breen (1986: 33) notes that:

> One needs to make a distinction between postnatal depression as a state in which depression is lasting and involves relentless feelings of guilt and self-admonition ... and the more fleeting feelings of depression so common after childbirth relating to the working through of the conflicts and anxieties.

Furthermore, the literature on depression in general, draws distinctions between 'depression' and 'unhappiness' (Rowe, 1983), 'depression' and 'sadness' (Stiver and Miller, 1988), 'clinical depression' and 'a disturbance of mood' or 'depressed mood' (Brown and Harris, 1978), and depression as a 'clinical syndrome' versus a 'mood state' (Coyne, 1985b). Freud (1925) referred to this distinction as that between 'melancholia' and 'mourning', where mourning was described as a 'normal grief' response, and melancholia as a more pathological reaction. This distinction is also made by depressed individuals themselves (e.g. see Nairne and Smith, 1984; Stiver and Miller, 1988). What remains unresolved, however, is the exact nature of the differences between these emotional states, and in particular, whether these differences are quantitative or qualitative ones (Brown and Harris, 1978; Coyne, 1985b). Coyne (1985b: 3) notes:

> Similarities between everyday depressed mood and the complaints of depressed patients have encouraged the view that clinical depression is simply an exaggeration of a normal depressed mood. However, patients sometimes indicate that their experience of depression is quite distinct from normal feelings of sadness, even in its extreme form.

This distinction between clinical depression and depressed mood is important because, as Stiver and Miller (1988) argue, these states, which differ at the experiential level, also differ in terms of their underlying psychological processes. They suggest that:

> ... phenomenologically, significant and qualitative differences exist between sadness and depression. It is a difference between a 'feeling state' and a state in which feelings are hidden; what is left is a 'nonfeeling state' but with 'clear dysphoric components'. (1988: 2)

In terms of the psychological processes underlying these two states, they posit that "when there is not an adequate relational context in which sadness can be experienced, expressed and validated, depressive reactions develop" (1988: 2). They also point out that they "do not see sadness and depression on the same continuum" (1988: 2) but rather as qualitatively different conditions.

I would suggest that Oakley (1980), Romito (1990b) and Nicolson (1988) have failed to theorize the experience of postnatal depression as clinical depression, because they have confused it with 'sadness'. The fact that Nicolson (1988) argues that depression is both a grief reaction *and* the result of a failure to grieve is an indication of this confusion. There are several reasons why these authors might have made this confusion. First, as I

noted above, there are reasons to doubt whether Nicolson's sample actually included any cases of clinical depression. Second, these researchers carried out longitudinal studies which means that only about 10% of the women in their samples would be likely to develop postnatal depression (Pitt, 1968). This represents a small number of clinically depressed mothers - two to three in Nicolson's (1988) sample, four to five in Romito's (1990b), and five to six in Oakley's (1980). Indeed, only three women in Oakley's sample were on 'drug treatment' for their depression,[42] whereas 14 of the 18 depressed mothers in my own study were on some kind of medication.[43] Third, within their analyses of the data, these authors appear to have merged the clinically depressed mothers with those who experienced depressed mood.

It seems to me that Oakley, Romito and Nicolson are pointing out that women are not necessarily happy when they have a baby, and that the expression of a range of emotions should be regarded as 'normal'. They suggest that we need to understand women's feelings, not in terms of a dichotomy between happy and depressed, but rather as a continuum of feelings. While I agree entirely with this position, I also accept Stiver and Miller's (1988) point that there is something qualitatively different between sadness and depression, and that clinical depression appears to be more than simply the end point of the continuum. Indeed, as I discuss in Chapter Two, the mothers in my study felt there was a qualitative difference between postnatal depression and other forms of low mood. While I agree that a range of feelings, including sadness, can be regarded as 'normal' following childbirth, my data indicate that the same cannot be said of clinical depression. In this sense, the feminist studies have not adequately addressed the issue of clinical postnatal depression, and contrasted it with 'sadness' or 'depressed mood'.

(iii) A deterministic relationship between the individual and society

The formulations of postnatal depression put forward by the feminist sociologists in particular stress the structural and ideological context of motherhood. As Boulton (1983: 17-18) notes:

> In accounting for any distress or dissatisfaction a woman may feel in caring for her children social perspectives focus on the structure of society and point to the obligations of the mother role and the social conditions which impinge upon its performance ... the main emphasis ... is on the way the role itself is institutionalized in society and therefore on the social conditions which make it generally rewarding or distressing.

---

42 This information is not given in either Nicolson's (1988) or Romito's (1990b) study.

43 Twelve of these mothers were on antidepressants, one on tranquillizers, and one was prescribed progesterone.

This emphasis on the socio-structural level of analysis can be seen, in part, as a reaction to the way in which the medical-psychiatric approach tends to blame the individual mother for her problems (Nicolson, 1988). However, in removing the blame from the individual, feminist researchers have also removed the mother's agency altogether. The level of the individual is bypassed, and relationships between individuals and their social contexts fail to be adequately theorized. As a result, feminist scholars have slipped into deterministic arguments about 'social control', in which mothers' feelings are seen to be determined by the institution of motherhood, medical control, and medical discourses. This deterministic and passive representation of women is perhaps most obvious within the learned helplessness models put forward by Oakley (1980) and Romito (1990b).[44] Here, women are portrayed as "helpless victim[s]" (Oakley, 1980: 271) of medical control and of the institution of motherhood more generally. Within these conceptualizations the possibility that women might engage with, and resist, the social context is denied, as Oakley (1980: 272) clearly states: "both medical control and [women's] subordinate group status militate against self-determination and encourage helplessness".

Nicolson has attempted to move beyond such conceptualizations, in which mothers are portrayed as passive victims, by taking into account the level of the individual, and by arguing that the social context must be considered in conjunction with the women's own subjective "interpretations of reality" (1986: 146). However, when it comes to the analysis and interpretation of the women's accounts, Nicolson also seems to slip into deterministic arguments in which the women are said to be "regulated by and subjected to" (1991/92: 93) medical discourses of postnatal depression. As I noted above, the mothers' views about the differences between feeling "depressed", and feeling "low" and "pissed off", are not taken as an indication that, at the experiential level, there is something different between these experiences, but rather as evidence that women are regulated by 'the postnatal depression as pathology discourse'. Nicolson (1991/92) seems to deny what the women themselves have to say about their own feelings, and, instead, portrays them as passive victims of a dominant discourse. Furthermore, there is an unsettling sense in which Nicolson's arguments sometimes hint at 'false consciousness':

> Women are *prevented* from mourning their loss of self. This partly by social mores (i.e. they are supposed to be happy) and partly because *on an unconscious level, they accept the dominant ideology*: that mothering and loss of personal autonomy is the 'natural' female experience. (1988: 69-70; latter emphasis added)

---

44 See Kaplan (1984) for a critique, from a relational perspective, of Seligman's 'Learned Helplessness' model of depression.

These deterministic arguments in which the mother's agency is lost have two implications. First, this type of argument does not allow or account for differences between women, and for the fact that women respond to their social context in different ways. Second, this argument does not allow for changes to occur *within* women over time, and for the fact that mothers *do* emerge from their depression, despite the fact that the socio-political context remains largely unchanged. Feminist researchers see socio-structural changes as the key to the amelioration of mothers' lives, because the root of postnatal depression is seen to lie within structural and ideological conditions. As Ussher (1991: 189) points out, within 'liberal feminist perspectives' "women's madness is seen to be related to our position within the structures and institutions in society, and thus institutional change is one of the major keys to enlightenment and freedom, and to the alleviation of madness".

However, the fact that women do come out of depression, in the absence of such changes, suggests women's changing constructions and understandings of the social context are involved in the move out of depression. A related problem is that, as a number of scholars have pointed out (e.g. Jordanova, 1981; Ussher, 1991), sociological accounts do not suggest solutions at the individual level. While they "may in theory alleviate future distress by affecting planning policy ... this is rather remote and abstract when compared with present-day pain" (Jordanova, 1981: 105). Nicolson, however, does consider the individual mother, and she suggests that the counselling psychologist might have an important role to play in helping depressed mothers. What is clearly needed are solutions which operate both at individual and societal levels.

(iv) 'Vantage points' from which mothers' stories are heard

> What is the point of view from which a psychologist observes the field that he or she is describing? Who is observing whom and from what vantage point? Who is speaking about who and in whose terms? (Gilligan *et al.*, 1990a: 90)

As I noted above, medical and psychiatric explanations of postnatal depression have tended to associate femininity with pathology. As in many areas of psychology, women's differences with men have been seen as deficiencies and have been devalued (Gilligan, 1982). In response, feminist social scientists have tended to adopt, either explicitly or implicitly, an 'egalitarian' framework in which women and men are regarded as 'humans', and in which 'human' has been equated with 'male'. Within feminist accounts, motherhood tends to be devalued and portrayed in negative terms. It is conceptualized predominantly in terms of loss, including loss of an independent and autonomous sense of identity, loss of paid employment, limited access to the public sphere, loss of 'power' in the home and loss

of social contacts. The sources of women's depression are therefore seen to lie within these losses. Feminist writers argue that if mothers had greater access to public-world activities and sources of identity, they would not get depressed.[45]

While these portrayals might represent *some* aspects of *some* mothers' lives, it now seems clear from recent research, in which women's experiences are analysed and understood on their own terms, that the lives of both depressed and non-depressed mothers are more complex than feminist accounts suggest. I now consider five assumptions which are central to feminist understandings of postnatal depression and which, in the light of recent work, need to be questioned and re-evaluated. These assumptions are: (a) that motherhood entails loss and therefore depression; (b) that motherhood means a loss of identity and therefore depression; (c) that motherhood leads to the loss of employment and therefore depression; (d) that motherhood is isolating and therefore depressing; and (e) that motherhood is accompanied by the lack of an 'equal' marital relationship, which further contributes to postnatal depression.

(a) Motherhood, loss and depression

Central to Oakley and Nicolson's theories is the equation of motherhood with loss. As well as the assumed "loss of identity", "loss of occupation" and "loss of friends", which I discuss below, women are said to experience a range of other losses including, for example, "a loss of power in the family" (Nicolson, 1990: 693). However, several writers have challenged this assumption.[46] Research shows that mothers can, and often do, have power within the domestic sphere, even if it is "informal, fragile and constrained power" (David *et al.*, 1993: 21; see also Ribbens, 1993). Furthermore, in her fascinating account of "the problematic but real dimension of power" in the housewife role, Martin (1984: 24) has pointed out that while housework can be experienced as a source of "real and often bitter oppression" (1984: 33), housework *also* entails "control of *time*, *territory* and *resources* in the home" (1984: 26), control which can increase with the arrival of children. To conceptualize the *changes* that women experience when they become mothers simply as *losses* is too simplistic an analysis which does not do justice to the complexity of individual women's lives, and to the ways in which these changes might be experienced in variable ways by different women, and in different ways over time. Nor does it account for the gains that a number of women do experience in motherhood. Finally, by equating

---

45 This point is particularly clear in the proposals for change put forward by Oakley (1980) and Romito (1990b), which focus almost exclusively on structural changes.

46 The feminist literature on motherhood is characterized by a deep tension between the view that motherhood constitutes the cornerstone of women's oppression, and a view in which motherhood is said to be a potentially empowering experience (see Segal, 1987; Tong, 1989).

motherhood with loss, motherhood is presented as the problem, depression is understood as the direct result of motherhood only, and other aspects of women's lives that might also be problematic are not examined.

The equation 'motherhood=loss=depression' appears particularly problematic in the light of evidence suggesting that equal numbers of mothers become depressed after a subsequent child as after a first-born (Green, 1990; Hayworth *et al.*, 1980; Paykel *et al.*, 1980; Watson *et al.*, 1984). Feminist formulations have failed to explain adequately why mothers of subsequent children are just as likely to experience depression as are first-time mothers. Their models rely too heavily on the notion of the *transition* to motherhood. Despite this, they nonetheless argue that their models are equally valid for first-time and subsequent experiences of motherhood. The elements of their models, however, refer mainly to the changes that take place in first-time motherhood.

A central element in Oakley's model is the notion that women lose their identity when they become mothers, in particular because they often leave the labour market. Oakley (1980: 255) points out that such a formulation does not discount the fact that mothers might become depressed after a subsequent child:

> Depression as an outcome of first birth can be restated as grief work for the mother's lost identity. This formulation does not necessarily suppose that first childbirth will provoke a depressive response in greater measure than subsequent ones. Although the extent of the change that is capable of interpretation as loss can be seen as greater in the case of first birth, it is possible that aspects of loss are intensified by the addition of other children to the family.

However, her model does not explain depression following the birth of a subsequent child. She conceptualizes depression in terms of loss of identity and "entry to the full adult feminine role; a status passage from non-mother to that of mother; retirement from the employment sphere; occupational career change" (1980: 182), changes which are more likely to apply to the birth of a first, rather than subsequent, child. In addition, one of the vulnerability factors in Oakley's model - little or no previous experience with babies - is obviously more likely to apply to first-time rather than multiparous mothers.

Similar criticisms can be made of Romito's theory that depression results from women's high, and unfulfilled, expectations of childbirth, breastfeeding and the division of household labour. It is difficult to argue that with a subsequent child, women still hold such unrealistic expectations, and experience this kind of disappointment when the child is born. By this time, the division of household labour is likely to have already changed, as this tends to happen with the first birth (Brannen and Moss, 1991; Croghan, 1991;

Entwisle and Doering, 1981; Moss *et al.*, 1987); and a mother is also more likely to know what to expect of childbirth, breastfeeding, and the reality of motherhood more generally (as I argue in Chapter Four).

Unlike Oakley and Romito's samples, Nicolson's sample did include six mothers of a second or third child. Nicolson (1988: 68-69) points out that her conceptualization of postnatal depression can apply to first-time and subsequent mothers:

> The status passage from non-mother to mother involves *disruption* and *loss* of the old sense of self, even though it is seen as a desired move in relation to identity. Further, the status passage from mother of one to mother of more than one child potentially *strengthens* the sense of identity as a mother, but consequently strengthens the loss of independence and control over a woman's own life. Each birth adds to the eighteen years or so of future mothering and confirms a loss of the former self.

However, the model itself features predominantly the changes that women experience when they first become mothers. Her theory stresses that depression results from the losses experienced in the "passage from non-mother to mother", and the losses she highlights characterize primarily first-time motherhood:

> ... changes in body image, loss of sexuality, loss of personal space, perceived loss of intellectual ability and memory, loss of power in the family, loss of occupation, occupational status or changed expectations of occupational role, loss of role in the public sphere, loss of friends, loss of contact with men, change from being a 'liberated' to a 'traditional' woman. (1990: 693)

Thus, the models put forward by feminist social scientists emphasize the changes that occur when women first become mothers, and explain why first-time mothers might become depressed, but fail to account for depression following a subsequent child.

(b) Motherhood, loss of identity and depression

The notion that becoming a mother is accompanied by a loss of identity, and that this is pivotal to mothers' depression, is central to the arguments put forward by Oakley and Nicolson. In describing what they understand by "identity" and "a sense of self", these authors stress "an autonomous self" (Nicolson, 1988: 70), and those aspects of the self that, it is argued, give the mother a sense of "independence" (Nicolson, 1988: 69), such as paid employment outside the home and the concomitant occupational status, their previous lifestyle in which they had no children, and their personal space which is now reduced. Oakley (1980: 266) notes that "in becoming a mother a woman loses the main basis for self-worth provided by male-led society: the social and financial rewards of employment".

Relationships are considered of secondary importance: "The identity change and impact on self-esteem is primary: the alterations in life-style and relational identities are secondary" (1980: 245).

However, while there is little doubt that becoming a mother can entail a loss of independence, autonomy and freedom for many women, motherhood involves far more than this. Similarly, while depression might be associated with these losses for some women, relational psychologists point out that it is women's interpersonal relationships, and their relationships to the culture in which they live, that appear to be central to understanding their depression (e.g. Bernardez, 1988; Jack, 1991; Kaplan, 1984; Stiver and Miller, 1988; Willard, 1988).

(c) Motherhood, lack of paid employment and depression

Feminist arguments suggest that the lack of paid employment is central to mothers' depression. The fact that they consider employment at all represents a significant advance on the medical, psychiatric and 'social factors' research on postnatal depression, which has consistently failed to include the mother's employment situation in any of its analyses.[47] The difficulty with the feminist arguments, however, is that the significance of paid employment to mothers, and to their depression, is conceptualized in only one way: employment is seen as necessarily desirable and healthy. Oakley writes that with motherhood, "the *automatic* confirmation of self in 'work' is lost through the *induced* primacy of the commitment of childrearing" (1980: 267; emphasis added). Furthermore, the "lack of paid employment" is a vulnerability factor within Oakley's model. These studies (e.g. Oakley, 1980; Romito, 1990a) assess whether mothers "miss work", but they do not ask whether mothers who are employed outside the home might prefer either to work fewer hours, or improve their pay and working conditions as part-time workers, or be full-time mothers.

However, the assumptions that paid employment is, (a) desirable, and (b) healthy, are problematic for several reasons. Research on motherhood and parenthood suggests that full-time or part-time employment are not *necessarily* viewed as desirable when compared to certain aspects of motherhood which are equally, or more highly, valued by women (e.g. Coote *et al.*, 1990; Doucet, forthcoming; Hock *et al.*, 1984; O'Donnell, 1985). Indeed, in cases where women are employed in low-paid, low-skilled and low-status

---

47 For example, in their extensive review articles of the research on postnatal depression, neither O'Hara and Zekoski (1988) nor Hopkins *et al.* (1984) include any studies on possible links between postnatal depression and the mother's employment situation.

work, motherhood can represent an attractive alternative (Westwood, 1984). Furthermore, while employment can and does protect some mothers against depression, 'working' mothers who attempt to be 'supermother' can also experience depression (e.g. Brown and Bifulco, 1990; Willard, 1988). Finally, the literature on employment and mental health shows that it is not employment *per se* that is beneficial to women's mental health but rather the degree of congruence between their desired and actual employment situation (Brannen and Moss, 1991; Hock and DeMeis, 1990; Willard, 1988).

(d) Motherhood, isolation and depression

One aspect of motherhood that has been emphasized is its isolating nature. Researchers have argued that motherhood restricts women's contacts and activities outside the home (e.g. Friedan, 1982; Gavron, 1983; Lopota, 1971; Oakley, 1974), and that such isolation leads mothers to become depressed (Nicolson, 1988; Oakley, 1980; Romito, 1990b).

There are several problems with this argument. The assumption that motherhood is *necessarily* an isolating activity, restricted to the nuclear family, has recently been challenged by Bell and Ribbens (1994). They point out that "social researchers are still inclined to present pictures of women's lives exclusively in terms of the connections and relationships between home/family on the one hand, and employment/paid work on the other" (1994: 228). They note that "mothers are frequently viewed as 'housewives', often portrayed as isolated within their own four walls, with paid employment as the only possible escape" (1994: 228), and that feminist research seems to assume that women are unable to build their own social networks. However, Bell and Ribbens document how mothers can, and often do, become involved in "complex maternal worlds" (1994: 227) and networks with other mothers.[48] They also point out that "the meaning of 'isolation' should ... be open to further scrutiny, both ideologically and experientially" (1994: 232), and that we need to distinguish between different types of isolation. Finally, we must also question the assumption that isolation is necessarily 'unhealthy' while community is necessarily 'healthy' (Bell and Ribbens, 1994; Oakley and Rajan, 1991). Studies show that depending on their nature and quality, social ties can be draining, as well as rewarding (Belle, 1982; Graham, 1984; Riley and Eckenrode, 1986).

---

48 The argument about isolated housewives and mothers might be a historically-specific one. This might be an accurate description of the lives of many mothers in the 1950s and 1960s (e.g. Friedan, 1982; Gavron, 1983), but less so of the mothers of today. The relatively recent progress in modern communication (e.g. telephone, transportation) has possibly facilitated increased contact between mothers and their extended family and friends.

(e) Motherhood, lack of an 'equal' marital relationship and depression

Feminist formulations of postnatal depression posit that with motherhood the marital relationship becomes more polarized along gender lines, and that this contributes to women's depression.

This position is problematic for several reasons. First, it is the researchers themselves who are imposing terms such as "equal" (Oakley, 1980: 266), "liberated" and "traditional" (Nicolson, 1990: 693) upon these women, rather than allowing the women themselves to voice their own definitions of "equality" or "equity". However, Doucet's (in press) research clearly shows that different men and women define such terms in variable ways, and therefore that the meaning of these terms must be elicited from the individuals themselves. Second, within feminist formulations there is an implicit assumption that what these authors term "equal" or "joint" relationships are necessarily what women want. Again, Doucet's (in press) research shows that the picture is more complex. Although some women and men define and desire "equality" as "sameness", others define and desire "equality" as different, but equivalent, contributions to household labour. Third, it is also assumed that "equality" as "sameness" or "joint[ness]" is necessarily beneficial to the mother's mental health, whereas a "segregated" relationship necessarily leads to depression.[49] As I discuss in the course of later chapters, my findings support neither the assumption that all mothers want "equality" as "sameness", nor the assumption that positive mental health depends on non-segregated marital roles.

In sum, feminist social scientists have observed, listened to, and described depressed mothers' experiences from one particular "vantage point" (Gilligan *et al.*, 1990a: 90). Positioning themselves within an 'egalitarian' perspective, they have interpreted women's accounts in relation to a male norm, and have highlighted only certain features of these women's lives, such as 'autonomy', 'independence' and paid employment. While these elements definitely constitute part of women's experiences of *motherhood*, they are *but a part* of a more *complex* picture. These aspects might be important for some women but negligible for others. Furthermore, according to the mothers in my study, issues such as autonomy, independence and paid employment, were not central to their *depression.* Consequently, in 'amplifying' certain voices, other voices have been diminished or left unheard within feminist research on postnatal depression.

---

49 Nicolson (1990: 693), however, does point out that "having a supportive partner or network does not necessarily prevent depression although negative support is a clear provoker".

IV. Moving beyond existing theories of postnatal depression: a relational perspective

Having reviewed the existing work on postnatal depression, and its limitations, I now discuss how I seek to build upon this research. The theoretical framework I adopt has emerged within the context of an on-going 'dialogue' between my reading of the academic literature, the accounts of the mothers in my study, and my own interpretations of these perspectives. While certain aspects of my theoretical stand-point were developed in a preliminary way before the data-collection phase of the project, the theoretical issues have largely been developed, and refined, on the basis of the empirical data, and of the new insights that my findings have brought to bear on existing research. The following five key theoretical points have emerged from this process, and inform my study.

1. A relational perspective

In this thesis, I draw upon the work of relational psychologists (e.g. Gilligan 1982; Jack, 1991; Miller, 1986a), and adopt a relational perspective on postnatal depression. Relational psychology differs from the majority of past and present theoretical traditions within psychology in its conceptualization of the self as fundamentally relational. Gilligan (1982) has pointed out that separation, individuation, autonomy and self-sufficiency have been seen as the hallmarks of adult health and maturity. A growing number of studies, however, has found that this view of psychological development is at odds with the experiences and perspectives of many adolescent girls and women (Belenky *et al.*, 1986; Brown and Gilligan, 1992; Gilligan, 1982; Gilligan and Rogers, 1993; Steiner-Adair, 1990). Listening to women's accounts has led to a "paradigm shift" in which "a psychology premised on a view of human life as lived ultimately in separation has given way to a psychology that rests on a view of human life as lived essentially in relationship" (Gilligan and Rogers, 1993: 125).[50]

Within this perspective, identity is defined in a context of intimacy, care and relationship (Gilligan, 1982). Miller (1986a: 83) notes that "women's sense of self becomes very much organized around being able to make, and then to maintain, affiliations and relationships". She and others have added that "self, other and the relationship are no longer clearly separated entities in this perspective but are seen as *mutually forming processes*" (Miller *et al.*, 1991: 5). Other aspects of the self such as creativity, autonomy, and assertion are seen to develop within this primary context in which relationships are

50 More recently, a relational understanding of men's psychological development has emerged (e.g. Bergman, 1991; Bergman and Surrey, 1992).

understood as the basic goal of development (Surrey, 1985). This alternative construction of women's identity and sense of self, as defined and known primarily in the experience of connection with others, has implications for our understanding of mental health, and in particular, depression in women. As Miller (1986a: 83) points out, depression "is related to one's sense of loss of connection with another". Within a relational perspective, women's psychological problems are seen to arise out of their inability to make or sustain authentic relationships to others - that is, relationships in which they feel that they can express views and feelings that might engender conflict (Jack, 1991).

It is important to point out that the notion of the self as intrinsically relational, and as developing within the context of on-going relationships, has been put forward by other scholars within other theoretical traditions (e.g. Shotter, 1984, 1993; Harré, 1970, 1983). Bowlby (1969, 1973, 1979, 1980), for example, argues that all children are biologically predisposed to form an attachment to their care-giver, and that it is only rarely, after repeated experiences of separation, that children become permanently emotionally detached and incapable of giving love. Bowlby (1980: 247) also points out that "in most forms of depressive disorder, including that of chronic mourning, the principal issue about which a person feels helpless is his ability to make and to maintain affectional relationships". Developmental psychologists, such as Stern (1977), Emde (1980) and Trevarthen (1977), have also documented the infant's sociability and relational capacity and disposition. The work of relational psychologists follows in this tradition, but is also unique in having considered the significance of gender. It highlights the political dimensions of the interpersonal and cultural contexts in which women live, and documents the role of gendered social norms and expectations in women's depression (Jack, 1991; Kaplan, 1984).

In taking a relational perspective on the self and on postnatal depression, I will be discussing the mothers' experiences in terms of three key relational dimensions: the mother's relationship to herself, to others, and to society. As I discussed above, existing research studies tend to focus either on the individual or on the social context. In this study, I examine postnatal depression in the context of the individual mother, her immediate social milieu and interpersonal experiences, and the collective experience and position of women as mothers in our society.

The relationship between the self, others and society is conceptualized here in a *dynamic* way in which the mothers' perceptions and experiences of themselves are related to their perceptions and experiences of the cultural context, both of which are also related to their perceptions and experiences of their interpersonal relationships. In others words, at

both theoretical and experiential levels, boundaries between the self, others and society cannot be delineated. For the purposes of discussing the mothers' experiences, however, I have partly separated these three levels. While doing so, I also attempt to retain the dynamic interplay between these three relational dimensions of the mothers' experiences.

In my thesis, I adopt a perspective in which relational issues are considered as primary, rather than secondary, to psychological development and health. In Chapter Three I document this claim by discussing the different ways in which the mothers described their sense of isolation. I argue that, common to all 18 depressed mothers, was a sense of relational disconnection in which they had felt unable and unwilling to voice their needs and feelings to partners, relatives, friends and other mothers with young children. I show that this sense of isolation occurred irrespective of whether the mother had felt physically isolated, and emotionally or practically unsupported.

I also examine the range of relationships in which the mothers were embedded. However, I give greater consideration to relationships described by the mothers as central to their experiences of motherhood and postnatal depression - relationships with their partners, own mothers, mothers-in-law, other mothers with young children, and health professionals.[51]

2. The active nature of the self

In this study, the mother is understood to take an *active* role in the construction of her own life, given certain immediate and wider structural constraints. The women are not conceived as passive victims of their immediate or wider socio-political circumstances. They are seen as actively interpreting this social context for themselves. For example, as I discuss in Chapter Four, while the mothers' beliefs and expectations about motherhood were informed by prevailing social constructions of motherhood, they were not *determined* by them.[52]

---

51 Where relevant, I will also briefly mention fathers, siblings, friends from before having a baby, work colleagues, and neighbours.

52 Conceptualizing the self as active creator in her own life is not a new approach, and has been adopted in several empirical studies of motherhood (and parenthood) in Finland (e.g. Gordon, 1990), Australia (e.g. Wearing, 1984), North America (e.g. Gerson, 1985; Kaplan, 1992; O'Donnell, 1985) and Britain (e.g. Boulton, 1983; Breen, 1975; Doucet, forthcoming; Graham, 1982; Ribbens, 1990). Furthermore, a number of theoretical traditions, such as social constructivism (e.g. Berger and Luckmann, 1984), symbolic interactionism (e.g. Blumer, 1969) and person-centred psychologies (e.g. Kelly, 1955, 1963) have conceptualized the individual as active creator in her or his own experiences and lives. It is argued that social behaviour is understood in terms of the interpretations and meanings individuals give to the world around them and in terms of the ways in which these interpretations shape their actions.

The active nature of the self is highlighted in four ways in the thesis: (a) I document how the mothers' depression was characterized by their active withdrawal of their needs, thoughts and feelings from their relationships with their children, partners, relatives, friends, other mothers with young children, and health professionals (this theme is fully introduced and discussed in Chapter Three but is the central theme of the thesis); (b) I discuss how the mothers actively interpreted social constructions of motherhood, and elaborated their own particular versions of what it meant to be a 'good' mother (Chapter Four); (c) I examine how the mothers actively interpreted their interpersonal relationships, and the words, silences and behaviour of others (this theme runs throughout the thesis); (d) I illustrate the ways in which the mothers were both actively complying with cultural norms and expectations of mothers and individuals, while at the same time resisting this conformity (see Chapters Four and Five).

3. Mothers' subjective constructions and experiences of their worlds

The mother's subjective interpretations of herself, the people around her, and society are seen as critical to understanding what she feels, thinks and experiences. This theme recurs throughout the thesis, and in Chapter Two I discuss how my choice of an appropriate methodology was informed by this theoretical position.

One aspect of the emphasis I place on the mothers' subjective interpretations and experiences concerns the question of whether postnatal depression constitutes an objective disease, examined by Romito (1990a) and Nicolson (1988). I want to stress that this is not a question I have addressed in my study, and consequently, I make no statements or judgments about any 'objective' ontological status of 'postnatal depression'. What is of interest to me is how the mothers themselves defined their experiences of motherhood, and whether they felt they had had postnatal depression. Eighteen of the mothers I spoke to defined their emotions as 'postnatal depression'. In attempting to understand the nature of their experiences, I am primarily concerned with the fact that their feelings of depression felt very real to them. These mothers described their experiences as abnormal, debilitating, and traumatic ones which had scarred them for life, and it is these accounts that I consider to be critical to understanding their feelings. Although I stress the importance of the mothers' subjective definitions and experiences, I deny neither the historical (e.g. Day, 1985; Showalter, 1987) nor the cultural (e.g. Kleinman, 1977; Stern and Kruckman, 1983) specificity of postnatal depression, and mental illness generally.

A methodological implication of this theoretical point is that objective assessments of various aspects of these women's lives were not central to my study. For example, in

the case of the mothers' relationships with their male partners, objective questions regarding the partners' actual degree of practical involvement in household and childcare tasks and responsibilities, or emotional support, were not a feature of my research. What was relevant, however, was how the women *felt* about what their partners did or did not do, however involved their partners actually were. This emphasis on the importance of the mothers' subjective constructions and experiences is a theme that runs throughout the thesis.

4. Theorizing differences amongst mothers

The emphasis on individual and subjective interpretation is crucial because it allows us to understand and conceptualize both differences amongst mothers, and changes within an individual mother over time. For example, each mother constructed her own unique version of what it meant to be a 'good' mother, and these constructions therefore varied across different mothers. The recognition and theorizing of differences amongst mothers is regarded as a central theoretical issue in my study.[53] Differences are not denied but rather embraced as they provide an opportunity for valuable theoretical insights and refinements to the argument. Indeed, a 'no-difference' stance is theoretically untenable and incoherent because it implies a separation of the self or 'psyche' from itself, others and society (see Gilligan *et al.*, 1990a). Nor does the denial of differences make sense empirically or psychologically. If we listen to women speak about their lives, it is clear that differences between themselves and others recur within their accounts and structure their experiences (e.g. see Chapter Four).

I consider three types of differences within my research.

In Chapter Two, I outline the differences between the depressed and non-depressed mothers in my sample. I discuss the differences between the 17 women who had found motherhood relatively unproblematic, the five mothers who had had periods of low mood, and the 18 women who defined their experiences as postnatal depression.

I also explore differences between the first-time and subsequent mothers' experiences of postnatal depression, and in particular how these differences were related to the different ways in which they constructed motherhood (see Chapters Four and Five).

---

53 Differences amongst women are increasingly being recognized and theorized within psychology and sociology, including differences in race (e.g. Bhavnani and Coulson, 1986; Collins, 1991; Edwards, 1990; Phoenix, 1990; Phoenix and Bhavnani, 1994), class (e.g. Boulton, 1983), sexuality (e.g. Kenney and Tash, 1992; Kitzinger *et al.*, 1992), age (Berryman, 1991; Phoenix, 1991a, 1991b), and reproductive status (Bell and Ribbens, 1994).

Finally, I examine differences amongst the first-time mothers' experiences of postnatal depression, and the variable ways in which they constructed the meaning of being a 'good' mother (see Chapter Four).

5. A developmental perspective: changes within individual mothers over time

A final theoretical issue that has guided my study is the notion of 'development'.[54] As I noted above, the mothers' experiences were mediated by the active and particular way in which they perceived and constructed the world around them. Consequently, as their perceptions and constructions evolved, their experiences changed over time and over the course of their depression. These changes in individual mothers highlight again how their beliefs and expectations were informed, but not determined, by prevailing social constructions of motherhood.

I examine this issue in detail in Chapter Six which considers the mothers' journey out of depression, and the changes in their constructions of themselves, others and society that accompanied this move. I have refrained from using the term 'recovery' in discussing the mothers' movement out of depression, for this term suggests that they returned to a previous state similar to how they had been before their depression. However, their accounts clearly indicated that this was not the case. They spoke about how they had 'learnt' from this experience. In particular, they spoke about how, through the depression, they had come to view themselves, others, and society, in a *different* way. They were now able to accept themselves, their children and others for whom they were. The position I adopt therefore ties in with Gilligan's characterization of a 'developmental perspective'. She points out that the notion "that crisis also creates character is the essence of a developmental approach" (Gilligan, 1982: 126).

---

54 The term 'development' can be problematic because it suggests moving towards a 'better' state. However, I use this notion because the mothers in my study described themselves in these terms.

Chapter Two

Methodology and Methods

Chapter Two

Methodology and Methods

This chapter is divided into two parts, according to the distinction drawn between 'methodology' and 'method' (Harding, 1987; Smith, 1987). "Method is about what we, as researchers, do, and methodology is about our reasons for doing it that way; one is a description of the nuts and bolts we use, the other the theory behind why some nuts and bolts are more appropriate to the task at hand than others" (Andrews, 1991: 42). I begin the chapter by outlining the key methodological concerns of my study. I then move on to give an account of how I carried out the research, and of the various difficulties that arose at different stages in this process.

I. Methodological issues

The choice of an appropriate methodology followed on directly from the theoretical issues outlined in the previous chapter. Indeed, the theoretical and methodological concerns in this study are inseparable, as they are within most research. A methodology was chosen which would allow for the mothers' accounts to be elicited and analysed in, and on, their own terms, and for the conceptualization of differences between mothers, and changes within individual mothers over time. The methodology I adopted encompassed the three following features: it was qualitative, it emphasized the importance of listening to women's voices and perspectives, and it was phenomenological.

1. A qualitative approach

Quantitative studies have dominated in the field of postnatal depression. As I discussed in the previous chapter, this type of research can offer only limited insight into the subjective meanings attributed by the mothers themselves to their experiences. The three-fold emphasis I placed within my own study was on: first, the ways in which the mothers themselves interpreted and made sense of their experiences; second, understanding these experiences as they related to a wide range of aspects of these women's lives; and third, on generating the theoretical concepts on the basis of the empirical data. This meant that a qualitative approach was most appropriate. A qualitative methodology provides an opportunity for the researcher to view the world through the eyes of the participant, and to understand the meaning and significance an individual gives to her actions (Jones, 1985). Furthermore, as many researchers have pointed out "a qualitative methodology seeks to

explore the depth and complexity of particular phenomena" (Andrews, 1991: 43; see also Brannen, 1992; Walker, 1985).

Given the vast number of quantitative studies on postnatal depression, I felt the most useful and important way of contributing to the field at this stage in our understanding of this experience would be to carry out a small-scale qualitative research project, based on in-depth interviews. Along with several other researchers (e.g. Andrews, 1991; Brannen, 1992; Henwood and Pidgeon, 1992; Oakley, 1992), I view qualitative and quantitative methodologies as complementary approaches, rather than bipolar opposites, which can, and have been, usefully combined (e.g. see Oakley's (1992) 'Social Support and Pregnancy Outcome Study').

The qualitative approach has been criticized on the grounds that the research findings generated are subjective rather than objective (see Andrews, 1991; Brannen, 1992; Hammersley, 1992; Oakley, 1981b). However, several scholars point out that the entire research enterprise is subjective and 'reflexive' from the outset, from the moment that a particular topic is chosen (Hammersley and Atkinson, 1983; Ribbens, 1990; Stanley and Wise, 1993). As I noted in the previous chapter, there is an inherent subjectivity within all research, including quantitative studies of postnatal depression, in that the researcher pre-defines which 'factors' will be explored. Authors have also commented that research on human behaviour is a fundamentally social activity, at the heart of which lies the relationship between researcher and researched (e.g. Edwards, 1993; Hammersley and Atkinson, 1983; Jones, 1985; Ribbens, 1990).[1] Rather than regard this relationship as a source of 'bias', they argue that this relationship constitutes an integral part of the research and of the data. As Andrews (1991: 51) notes: "It is through establishing rapport, or 'bias' as some may call it, that interviewers come to understand interviewees". Similarly, Brown and Gilligan (1992: 28) write that "rather than blurring perspective or clouding judgement with feelings, relationship is the way of knowing ... an avenue to knowledge".

2. Listening to women's voices on their own terms

As I have pointed out, one of the central methodological and theoretical aims of my study was to elicit depressed mothers' own accounts of their experiences of postnatal depression, and to understand these mothers' lives on their own terms. A critical

---

[1] There is an on-going debate about the woman-to-woman interview relationship, and whether having gender in common creates a non-hierarchical interview situation. This is a fascinating debate which I cannot go into here. See Edwards (1990, 1993) and Ribbens (1989) for two excellent critiques of earlier feminist arguments suggesting that the woman-to-woman interview is a 'special' non-hierarchical relationship (e.g. Oakley, 1981b; Finch, 1984).

assumption underpinning my research is that because the mothers' subjective perceptions and constructions are central to understanding their depression, we can learn about postnatal depression only by listening to what they say about their experiences.

Taking women's own words, perspectives and accounts at face value, and as the primary source of knowledge about their experiences, goes against a tradition in psychology in which the voices of women, and the voices of those experiencing psychological problems, have been dismissed and devalued (Jack, 1991; Miles, 1988; Ussher, 1991; Jordanova, 1981). Edwards (1990: 479) notes that:

> Women's round lives have been pushed into the square holes of male-defined theories, and where their experiences do not fit those experiences have been invalidated, devalued, or presented as deviant.

Women's personal accounts of their experiences of postnatal depression are rarely taken into account, let alone presented, in the academic literature.[2] Medical-psychiatric research either fails to elicit women's accounts altogether, or where it does consider them, it seems to do so almost by default. One gets the impression that if psychologists could find a way of accessing the mothers' experiences in an 'objective' way, by bypassing their subjective accounts altogether, this would be regarded as a 'better' and more 'scientific' research strategy and source of data. The fact that a mother's account is by definition a subjective one is regarded as a problem by many psychologists, and as a source of contamination to the 'objective' reality of the situation. Feminist research has stressed the need to consider mothers' personal accounts, but as I discussed in Chapter One, here, mothers' stories have been heard and theorized from an 'egalitarian' perspective only.

The importance of listening to women's accounts on and in their own terms, and of offering an "insider perspective" versus, or as well as, an "outsider perspective" (Ribbens, in press: 3)[3] has been pointed out by feminist scholars, both in sociology (e.g. Boulton, 1983; Doucet, forthcoming; Edwards, 1990; Edwards and Ribbens, 1991; Ireland, 1994; Phoenix, 1991a, 1991b; Ribbens, in press; Stacey, 1981; Stanley and Wise, 1993) and in psychology (e.g. Brown and Gilligan, 1992, 1993; Gilligan, 1982; Jack, 1991; Ussher, 1991; Wilkinson, 1986).[4] Ribbens (in press: 44) has noted that the challenge and

---

2 However, these voices are increasingly being represented within a growing number of popular books on postnatal depression, newspaper and magazine articles, and publications distributed by lay organizations seeking to support postnatally depressed mothers (see Chapter One).

3 Quotations and page numbers from Ribbens (in press) refer to a draft.

4 A consideration of the nature of feminist research is beyond the scope of this chapter. See the following texts for such discussions: Bowles and Klein (1983), Harding (1987), Reinharz (1992), Roberts (1981), Smith (1987), Stanley and Wise (1993) and Wilkinson (1986).

> ... 'catch 22' dilemma for feminism - of how to conceptualize women's lives in ways that both value women's perspectives within the private sphere yet also allow for critical insights from outside - is similar to that of the ethnographer who both seeks insider insight and outside analysis without importing outsider misinterpretations.

Understanding women's lives on their own terms means that at all stages of the research process - including, the data-collection phase, the analysis of the data, and the writing-up of the findings - the following differences must be maintained: differences between the different voices of the research participants; differences between these perspectives and our own views as researchers; and differences between the views of the research participants and existing theories.

Within the context of my research, in collecting the data, the emphasis was placed on listening to the mothers' own stories in the interview, rather than imposing a pre-defined agenda in the form of a structured interview schedule. As Sonya, one of the mothers in my study, rightly pointed out, I was looking for the mothers' "free form way[s] of speaking" about their lives:

> It comes out pretty unconsciously ... If I listened to this back, then I would think 'Did I say that?' ... It's a free form way of speaking, therefore you're getting quite a lot ... I mean, if you said to me, 'Did you feel this, a) or b), tick' ... that would be stilted. But there's so much ... I've experienced, and I can speak volumes on it.[5]

My main concern in the interview was to tap these "volumes" that the mothers felt they could speak about their experiences. Consequently, the issues explored in the interview reflected both those aspects of the mother's life that she felt were implicated in her experience of motherhood and/or depression, as well my own questions which I had brought along in the form an interview guide (see Appendix 4).

In terms of the data-analysis, the emphasis on the women's perspectives meant my ensuring that each mother's voice was maintained as a distinctive voice. Each mother's views were not to be confused with those of the other mothers in the study, nor to be submerged either to my own perspective, or to the theoretical ideas of existing research. As Brown and Gilligan (1992: 28) point out, in truly listening to and hearing what a woman says about her life, the task of the researcher is to "discover how she speaks about herself before we speak of her". Listening to women's voices has been a central theoretical and methodological theme in the work of relational psychologists, and Brown and Gilligan

---

5 For the sake of clarity, I have edited the quotations of the research participants. Three full stops - ... - indicate such editing.

(1992, 1993) have developed a 'voice-centred relational method' as a way of implementing this principle. This method is the one I used in analysing the interview material, and I discuss it below.

Finally, at the writing-up stage of the study, it is again important to highlight the voices of the women so as to give them a voice within the academic debates. It is also critical to retain the distinctions between the views of different women in the study, and the differences between their perspectives, those of the researcher and those of the theoretical field.

3. A phenomenological perspective

A final methodological consequence of the theoretical issues outlined in Chapter One is that I have taken a phenomenological approach, in which the distinction between subjective and objective realities is understood to be blurred, and to some extent meaningless. Within this perspective, reality is defined as what the individual knows her experience to be, and the meaning that she attributes to this experience (Patton, 1990; Berger and Luckmann, 1984). Here, the subjective and lived experience of the individual is of primary importance (e.g. see Bergum, 1989; Jack, 1991; Pirie, 1988).[6]

Medical and clinical studies of postnatal depression emphasize objective ratings of events and circumstances that occur in depressed mothers' lives, in accordance with their general emphasis on objectivity in the research process. However, at the heart of the theoretical perspective I adopt lies the notion that the mothers' own subjective evaluations of the significance of various events in their lives are critical to understanding their depression. A phenomenological mode of enquiry was therefore most appropriate.

In addition, such an approach is useful because, in focussing on subjective experience, it stresses the notion of difference, and the fact that the same event (e.g. a birth with a high degree of technology or the lack of support from a partner) might have variable meanings to different individuals occupying different circumstances and holding different expectations. The emphasis on difference, however, does not preclude generalizations being made across individuals. Indeed, finding similarities between individuals also constitutes the nature of a phenomenological approach, which rests on "the assumption that *there is an essence or essences to shared experiences*" (Patton, 1990: 70). The purpose of a

---

6 Phenomenology, as a philosophical tradition, was developed by the German philosopher Edmund H. Husserl. Alfred Schutz (1972) extended, and firmly established, phenomenology as a major philosophical and social science perspective.

phenomenological enquiry is to uncover the 'essence' of the particular experience in question, in this case, postnatal depression. It is assumed that individuals' experiences share similarities, even though there is also a particular set of experiences that is unique to each individual. The object of the analysis of the data is to identify these "basic elements of the experience that are common to members of a specific society" (Eichelberger, 1989: 6), while also recognizing differences in experiences.

II. Methods

In the following section I discuss how I found my sample, whom I included in it and why, how I gathered the information I was looking for, and how I interpreted and made sense of this data. I spent 20 months contacting and interviewing mothers, including an eight-month pilot stage from February to October 1991, and a 12-month main study stage from October 1991 to October 1992. I will discuss these two stages together as they were not clearly delineated phases of the research, but involved a continuously evolving process of gaining experience in how best to access the women I was looking for, deciding whom to talk to and learning how to interview them.

1. A retrospective design

The first question I faced in designing the study was whether to carry out a longitudinal study, in which the mothers would be interviewed over the course of pregnancy, childbirth and the postpartum period, or a retrospective approach in which the mothers would be interviewed several weeks, months or years following the birth. I adopted a retrospective design and this decision was informed by the following observations. First, given that one in ten mothers becomes depressed following childbirth, I would have had to interview approximately ten times the actual number of depressed mothers I wanted in my sample. This was too great a number of mothers for one person to interview. Second, during the pilot stage of the project and based on my discussions with health professionals, and with the 12 pilot women that I interviewed, I became aware that depressed mothers find it very difficult to talk about their depression and might be reluctant to talk to me while they were currently depressed, or at least during the worst part of the depression. I thought it more likely that mothers would agree to take part, either as they were emerging from, or some time after, the depression, when they might find it easier, emotionally, to talk about their experiences.

Retrospective studies are criticized for the validity of the data they produce, and for the inaccuracy of the past events that are being recalled (O'Hara and Zekoski, 1988).

However, research shows that mothers do accurately and clearly recall their postnatal depression several years later (Cox *et al.*, 1984). Furthermore, the purpose of this study was not to establish the objective events that had lead the mothers to become depressed. My overall interest was in how the mother perceived her own world, and what aspects of that world were most significant to her, and were therefore worth telling me about. As Andrews (1991) points out, people remember events in their lives because they carry particular significance for them, and the way in which they remember them reflects this significance. Each mother's account therefore reflected those elements in her life that she felt were most significant in understanding why motherhood had been a more or less positive experience.

Given my research questions and concerns, I believed a retrospective approach carried the following three advantages. First, this approach afforded some emotional protection to the depressed mothers. While they all found it upsetting to talk about their experiences, even in cases where their depression had occurred six years before the time of the interview, it is likely that they were considerably less distressed than they might have been had I talked to them during the depression, or during the worst part of the depression. A second advantage was that a retrospective approach allowed me to explore the ways in which the mothers changed over the course of their depression, and over the course of their journey out of depression. As I discuss in Chapter Six, charting these changes and processes provided me with the opportunity to test, albeit in a preliminary way, the ideas that I put forward regarding the onset of the depression. A third advantage of a retrospective design was that in gaining distance from their depression, and in having spent several weeks, months or years reflecting upon their own experiences and talking to other mothers who had also experienced postnatal depression, the mothers were able both to *describe*, and *analyse*, these experiences, and offer their own insights into why they, and other mothers they had known, had become depressed following childbirth.

As my study was retrospective, the mothers spoke about their lives at the time of the interview, at the time of the depression, and at the time they had moved out of the depression. The main body of the thesis - Chapters Three, Four and Five - focuses on the mothers' descriptions of their lives at the time of the depression. In Chapter Six, I discuss the mothers' lives over the course of their journey out of depression.

2. Accessing the mothers through community sources

When I first began the research, I sought a group of approximately 40 first-time mothers of a child up to two years old, all living with the fathers of their children, and who had had varying experiences of motherhood.[7]

The main question I faced regarding accessing the mothers involved my deciding whether to find them through community sources and organizations, and/or whether to go through health professionals and the health service. During the pilot stage of the research, I explored different avenues to finding mothers in general, and mothers who had experienced postnatal depression specifically. I sought advice from several health professionals, including a senior consultant obstetrician, a general practitioner, a number of health visitors, and a consultant community paediatrician. I also attended a series of antenatal classes and spoke to the mothers-to-be taking part, and to the midwife who was running them. Besides these sources, I spoke to mothers themselves, both informally, and more formally in the pilot interviews that I carried out with 12 women.[8] I also contacted the local National Childbirth Trust (NCT) and spoke to a committee member, and the local NCT 'postnatal illness supporter'.

Having spoken to these people, I decided that I would access my sample through the community rather than through the health service. I gathered from speaking to these individuals, and from the literature, that many mothers experiencing postnatal depression do not contact, or are not identified by, health professionals (e.g. Cox, 1986; Gruen, 1990; Jebali, 1993; McCord, 1984). Accessing women through this channel might therefore have meant that I would be talking to a certain type of mother, the type that sought professional help. I was also aware that some mothers might have a negative opinion of health professionals, or might be dissatisfied with the medical treatment they received during childbirth or in the postnatal period. For these reasons, I felt it was important not to associate myself with health professionals, or the health service in general.[9]

---

7 As I discuss below, however, I had to 'loosen' these criteria for several reasons.

8 The pilot mothers were contacted through a variety of sources, including snowballing from colleagues and friends who had children themselves, notices put up in local shops, and an article in a local paper. All twelve pilot interviews were with first-time mothers. Eleven of these had had positive experiences of motherhood, and one had experienced postnatal depression. Two of the 12 pilot women were interviewed longitudinally, both during pregnancy and after the birth. The remaining ten women were interviewed after the birth and were mothers of a child aged up to three years.

9 Other researchers have noted similar concerns about identifying themselves with particular institutions. Ribbens (1990: 67), for example, was reluctant to access her sample of mothers through schools because she did not want to be "identified with formal authority figures". Edwards (1990), who did associate herself with educational institutions in accessing a sample of mature women students, encountered a number of difficulties because of negative feelings held by potential participants about these institutions.

As I soon discovered, however, the disadvantages of accessing the mothers through community sources were that the depressed mothers were particularly difficult to find, because what characterizes depression is both a withdrawal from social contact (Jack, 1991; McCord, 1984), and mothers' outward presentation of themselves as happy and coping (Grossman *et al.*, 1980; Price, 1988). I therefore had to spend several months (18), and go through a wide variety of sources, in order to find the number of depressed mothers that I wanted to talk to.

The 40 women I interviewed for the main study - 18 of whom defined their experiences as postnatal depression - were contacted using a combination of the following sources and strategies.

(i) The National Childbirth Trust[10]

I began by contacting mothers through the National Childbirth Trust (NCT). I enclosed a letter inviting women to take part in my research in the Autumn 1991 local NCT Newsletter which was circulated to 350 women (see Appendix 1). At this stage, the selection criteria for inclusion in the study were that the woman should be "a first-time mother with a child aged between one and two years old, and living with the father of your child". Thirty seven women wrote back requesting a questionnaire. A questionnaire, accompanying letter and pre-paid envelope were sent (see Appendix 2). The questionnaire covered basic demographic details about the mothers and their partners, and the mothers' feelings about motherhood. It was designed as a way of ensuring that mothers covering a range of socio-economic backgrounds, ages, and experiences of motherhood would be represented within the interview sample. Of the 37 women who requested the questionnaire, two failed to return it, 16 returned it but were not 'selected' for interview, and 19 were interviewed. These 19 were selected to represent a range of mothers' ages, socio-economic backgrounds, employment status (i.e. in full-time employment, part-time employment, or full-time motherhood), and experiences of motherhood (five had experienced 'postnatal depression', four had felt 'low', and ten had found motherhood relatively unproblematic).

---

10 The National Childbirth Trust was set up in 1956 under the name of the Natural Childbirth Association. It was originally formed in order to promote Grantly Dick Read's teachings about childbirth and how to approach labour free from ignorance and fear (Kitzinger, 1990). Today, the NCT is a national organization, described by Garcia *et al.* (1990: 10) as "the largest British lay organization concerned with childbirth". It has charitable status and is partly funded by the Department of Health. For further details on the history of the NCT, as well as its current organization and aims, see Kitzinger (1990).

(ii) Cry-sis Support Group

The NCT proved to be fertile ground for responsive mothers willing to take part in the research. However, it was also a predominantly middle-class and 'happy' sample of mothers.[11] I therefore decided to contact mothers through Cry-sis which, as an organization which offers support to parents of crying babies, was more likely to attract women who might have found motherhood difficult.[12] Notices were circulated in the December 1991 and January 1992 Cry-sis Newsletters (see Appendix 3). Three women subsequently contacted me, and later returned questionnaires. One woman lived too far to visit. I interviewed the two others, one of whom had experienced postnatal depression.

Cry-sis was not a very fruitful source of interviewees, and I was still concerned that the respondents were mainly middle-class and 'happy' mothers. I felt this might be occurring for two reasons: first, because I was using a questionnaire, I might have been steering the sample towards women who could write and felt comfortable doing so, and therefore possibly towards women of a higher socio-economic status. Second, the letter accompanying the questionnaire stated that "I am interested in interviewing women about their experience of becoming a mother and the wide range of emotions that women feel during this time". There was no mention of postnatal depression (for reasons discussed below), and perhaps because of this the responses I received were mostly from women who had experienced motherhood as a positive and relatively unproblematic experience. I therefore decided to drop the questionnaire and letter, in favour of more direct methods of accessing the women, such as seeking out mothers where they were likely to congregate. To increase opportunities for talking to mothers who had experienced postnatal depression, I also decided to broaden the criteria for inclusion in the study to any mother who had experienced postnatal depression. To find these mothers I contacted the Association for Postnatal Illness, I attended a play-group on a council estate stating that I wanted to talk to women who had experienced postnatal depression, and I used snowball sampling starting from the depressed mothers that I contacted.[13] In order to find women of lower socio-economic status, I attended a health clinic on a council estate (and also the above-mentioned play-group), and also used snowball sampling.

---

11 Kitzinger (1990) notes that the NCT tends to be dominated by white, middle-class mothers.

12 Cry-sis, a registered charity, offers telephone support to parents and issues several newsletters a year.

13 In 'snowball' or 'network' sampling the researcher starts from an initial set of contacts and is then passed on by them to others, who in turn refer others and so on (Lee, 1993).

(iii) The Association for Postnatal Illness[14]

In March 1992, I contacted the Association for Postnatal Illness and they gave me the name of a mother who had only just emerged out of depression, and whom I interviewed.

(iv) A council estate play-group

In June 1992, I attended a play-group organized by a community house on a council estate. I individually approached the mothers and asked them whether they would be willing to take part in a study about women's experiences of motherhood and postnatal depression. Four women agreed to take part, three of whom had experienced postnatal depression.

(v) A council estate health clinic

In October 1992, I contacted a health clinic on a council estate and went along on the morning of their mother-and-baby clinic. I approached mothers in the waiting-room; five agreed to take part, all of whom had had relatively positive experiences of motherhood.

(vi) Snowball sampling

I used snowball sampling, from the mothers accessed through the above sources, as a way of contacting nine mothers, and in particular mothers who had experienced postnatal depression and who were proving difficult to find.[15] Snowballing from a mother I met at the play-group yielded one non-depressed mother. Snowballing initiated from two other sources yielded eight depressed mothers. Three of the women (two of whom had experienced postnatal depression) that I contacted through the NCT each put me in touch with mothers whom they knew had experienced postnatal depression, which amounted to four mothers. The woman whom I contacted through the Association for Postnatal Illness put me in touch with a depressed mother whom she was 'counselling' on the telephone.

---

14 The Association for Postnatal Illness is a registered charity, set up in 1979, with the aim of helping mothers who experience postnatal depression. The Association works in co-operation with other organizations such as the National Childbirth Trust, the Meet-a-Mum Association and the Federation of Women's Institutes.

15 I asked mothers if they knew of any mothers who had experienced postnatal depression. If they did, they then contacted these women to find out if they might be willing to take part in the study. If this second mother agreed, either she then contacted me or the original mother gave me the telephone number of the second mother. In no instance did I contact this second mother prior to her having been consulted and informed about the study by the first mother, and prior to her consenting to take part.

This latter mother then gave me the name of another mother who had set up a local postnatal depression self-help group. This mother then put me in touch with two further mothers who were attending the group.

(vii) Summary and discussion of the methods of access

In summary, the mothers in my study were contacted in the following ways:

Table 1: A summary of the sources of contact of the 22 non-depressed mothers

Sources of contact	Number of mothers
National Childbirth Trust	14
Cry-sis	1
Council estate play-group	1
Council estate health clinic	5
Snowball sampling	1
Total	**22**

Table 2: A summary of the sources of contact of the 18 depressed mothers

Sources of contact	Number of mothers
National Childbirth Trust	5
Cry-sis	1
Association for Postnatal Illness	1
Council estate play-group	3
Snowball sampling	8
Total	**18**

Initially, my intention had been to talk to first-time mothers of a child between one and two years old. However, given the difficulties I encountered in finding a sample of depressed mothers, I decided it was worthwhile using less stringent criteria for inclusion in the study. This has meant that my sample is a heterogeneous one in terms of both, the numbers and ages of the children, and the child after whose birth the mother became depressed - whether it was after a first, second or third baby (see Table 4 in Appendix 6). However, I do not view the heterogeneity of my sample as presenting a problem in my research. My study is a small-scale exploratory one. Whether my findings can be generalized, and therefore the representativeness of my sample, are not primary concerns.

Furthermore, regarding the parity of the mothers, my interest was in women's experiences of motherhood and postnatal depression in general, and not in first-time motherhood or the experience of postnatal depression after a first child, specifically.

Snowball sampling has been criticized as a method of accessing participants because it tends to generate samples which are homogeneous in their attributes, and which are unrepresentative of the wider population (Gerson, 1985; Lee, 1993). However, when such sampling is used in addition to other methods of access, when it is initiated from diverse sources (e.g. Dunne, 1992; Martin and Dean, 1993), and when the representative nature of the sample is not a primary concern, the drawbacks of snowball sampling are less significant. Furthermore, this method seems particularly useful where the sample involves a group of individuals who are difficult to find without going through official institutions and organizations, and/or who might constitute a socially and psychologically stigmatized community (Renzetti and Lee, 1993). As Lee (1993: 66) points out, "snowball sampling is ubiquitous in the study of deviant populations because it often represents the only way of gathering a sample". Contacting women who had experienced postnatal depression was a difficult task, and felt like entering an underground world largely invisible to those above-ground. Snowball sampling proved to be the most efficient and effective way of accessing this underground community, without going through the health service.

3. Research tools

(i) Introductions: What I told the mothers about the research

When I first started interviewing the mothers I was unsure what to say about the nature of the research project, and whether to disclose that it was about postnatal depression. In her discussion of studying sensitive subjects, Brannen (1988: 553) notes that one of the characteristics of such research is "the problem of whether and how to name the topic under investigation":

> ... sensitive researchers tread warily at the beginning of interviews and don't reveal all their hand at the outset ... [because] it is important not to prejudge the research problem by labelling it or defining its boundaries too closely; respondents may thereby define the problem in their own terms. This is especially important where the research topic is seen as problematic, either socially or psychologically, and is likely to prove stigmatizing to those who admit to having such difficulties.

Brannen's comments reflect my own experience and dilemma. Initially, I told women that I was studying women's *varying* experiences of motherhood. At this stage I was reluctant to mention postnatal depression for several reasons.

First, I wanted to interview women who had had positive and negative experiences of motherhood and I feared that by mentioning postnatal depression I might put off the women with positive experiences because they might feel the study did not strictly concern them.

Second, by suggesting that I was investigating a 'psychological problem' I feared I might be seen as a mental health professional and that women might be wary and suspicious, and perhaps feel a degree of stigma at contacting me.

Third, I was interested in how the mothers themselves named and defined their experiences, and so I did not want to set the agenda and define the terms of the discussion by providing any labels. Part of what I was seeking to explore in the interview were the different ways in which women themselves speak about, and name, their experiences of motherhood. I wanted to allow "the research topic to emerge gradually in its own terms" (Brannen, 1988: 553). I also wanted to ensure that I spoke to mothers who had had difficult experiences of motherhood but did not necessarily define these as postnatal depression.

However, after several months of not finding depressed mothers, I wondered whether my not explicitly saying that the research was also about postnatal depression might be contributing to these difficulties. As I discussed above, I then decided to opt for a more direct approach, in which I openly stated that I wanted to talk to mothers who had experienced postnatal depression.

(ii) The interviews

The pilot interviews started off as conversations in which I had a range of topics I wanted to cover, but in which my main interest was in hearing how the women spoke spontaneously about their experiences of motherhood and postnatal depression. Gradually, over a period of months, the interview guide was developed and refined.

The interview format combined unstructured (exploring particular 'themes' and 'topics' in the most appropriate way) and semi-structured (such as background details, and mapping social networks) elements. I began the interview with an open question: "Perhaps you would like to begin by telling me a bit about what motherhood has been like for you?". This enabled the mother to set her own agenda, and ensured that the issues that were of importance and concern to her emerged first. When the woman felt she had covered most

of what she wanted to say at this initial stage of the interview, I turned to other questions that she might not have mentioned or fully covered. The interview covered the following issues: (i) becoming, and being, pregnant; (ii) the experience of childbirth; (iii) coming home from the hospital and the first few days at home; (iv) the experience of distress, or postnatal depression; (v) the experience of being a mother; (vi) the mother's relationship with her partner; (vii) relationships with, and support from, family, friends, other mothers with young children, neighbours, and health professionals; (viii) the mother's employment situation; (ix) background details (see Appendix 4 for the full interview guide).

The mothers were interviewed once or twice (amongst the depressed women, ten were interviewed once, and eight had two interviews). The length of the combined interviews varied from one hour and 15 minutes to six hours. On average, the interview lasted three and a half hours. All the interviews took place in the respondents' homes and were tape-recorded and subsequently transcribed. I did not hesitate to answer any questions the women asked me. The most common question was whether I had children (I do not).

During the interview I offered the mother an information sheet (see Appendix 5) that I had compiled about postnatal depression, which included local and national organizations that they might find useful, and listed several books about postnatal depression. Most of the depressed mothers were keen to have a copy of the sheet. Before leaving, I asked them whether they would like to receive a summary of the main findings of the research. Finally, the interview with each mother was followed up with a thank-you letter.

4. A range of experiences of motherhood

The sample of 40 mothers I spoke to described a wide range of experiences of motherhood which could be broadly divided into three groups: those who said motherhood had been unproblematic, those who described it as difficult, and those who defined their experiences as postnatal depression.[16] It is important to emphasize that in making these groupings I am presenting a deceptively static picture, when in reality, the mothers' experiences and feelings were far more fluid and changing over time. Furthermore, there was also variation *within* each of these groups. Consequently, these groups simply reflect what the mothers said about their experiences *at the time that I interviewed them.* My intention in grouping the mothers in this way is to explain why I chose to focus on one

16 I made no formal psychiatric assessments of the mothers' mental health.

particular group in this study, the group of mothers who defined their experiences as postnatal depression.

(i) Group 1: relatively unproblematic experiences of motherhood

The first group of 17 mothers felt that motherhood had been a happy, and relatively unproblematic, experience.[17] These mothers, who varied widely in age and socio-economic status, described their experiences of motherhood in the following ways:

> When Gregory came along ... our whole life changed round to ... suit him. I loved it though, I've always wanted children, so it was great. My friend suffered postnatal depression and I can never understand why, because I was just so happy ... I think it's the best thing that's happened in our life. (Sasha, 22-year-old full-time mother of 11-month-old Gregory)

> I thoroughly enjoy motherhood. Whether I would be if I was doing it all day, probably not. Yes, it's great, I don't find *any* of the tasks irksome ... I did think, before, that I'd get very impatient at all this fiddling around putting clothes on ... and I'd resent the time, and that I'd think there were more important things to do, but I don't. I mean ... our life as a couple has changed, but only in ways we welcome because ... Liam (the child) is there, and that's really nice, and all the changes are nice changes. (Amanda, 31-year-old mother of Liam aged 18 months, in full-time employment as a tax consultant)

(ii) Group 2: difficult experiences of motherhood

A second group of five mothers described their having found motherhood a difficult experience.[18] They had felt "low", "depressed" and "stressed" during the first few months after the birth. These mothers had experienced a range of problems, including a traumatic birth, difficulties breastfeeding, a screaming baby, marital problems and the loss of time to themselves:

> I was very disappointed by the birth and the hospital, but I've never been disappointed by Zoë. More than anything I was sore, exhausted, angry with the hospital and felt my enjoyment of Zoë had been seriously marred. (Hannah, 24-year-old full-time mother of 14-month-old Zoë)

---

17 Fifteen of these were first-time mothers of a child under the age of three years. One woman had 20-month old twins, and another woman had three children, the oldest aged seven years. These mothers varied in age from 20 to 42 at the time of the birth of the first child. All except for one were living with the father of their child(ren). One woman was of Afro-Caribbean origin and the remainder were white, British mothers. Fifteen of these women were full-time mothers. One mother was employed part-time as a supply teacher, and another was employed full-time as a tax consultant.

18 These were all first-time mothers of a child under the age of two years. They varied in age from 22 to 35 years at the time of the birth of the child. Two were full-time mothers. One was employed full-time as a probation officer, and another worked part-time as a cleaner and as a dance teacher. One was on maternity leave, deciding whether to return to her job as a publisher on a full-time or part-time basis.

> The first few weeks after the birth were hell ... I always assumed breastfeeding would be easy and natural - not true. It was *always* painful ... This discomfort made me *dread* Laura feeding and I was often in tears. So this combination of pain and lack of sleep just increased my anxiety and tearfulness. (Vivien, 36-year-old mother of Laura, aged 13 months, in full-time employment as a probation officer)

This group of mothers was different from the first group in that, initially, they had had a difficult time with motherhood. However, this group was also markedly different from the third group of clinically depressed mothers. In response to my question about whether they felt they had experienced postnatal depression, the mothers in group 2 all explained that, based on their readings and/or based on mothers that they had known to have experienced postnatal depression, they felt they had not had postnatal depression. Anna, for example, explained that although she had found motherhood "difficult", she had not experienced postnatal depression. Based on her own previous experience of severe depression in late adolescence (unrelated to motherhood), Anna was able to articulate clearly what she felt the difference was between feeling "depressed" or "low", and feeling "depressed depressed" or clinically depressed:

> *So what's your understanding of what postnatal depression is?*
> I think perhaps having the same feelings that I was having, but really not being able to sort of come to terms with them, and to really let them get on top of you ... One of the things that I learnt from ... being depressed before, was that you have to have room for your feelings, and there are times when you don't feel happy or you feel angry or you feel sad, and that you shouldn't pretend that you don't feel those feelings. So when I felt low [after the birth], I didn't pretend that I didn't feel low. And I think ... my interpretation of being sort of depressed, in that respect, is feeling low and feeling really bad about feeling low. (Anna, 30-year-old full-time mother of one-year-old Rose)

As I discussed in the previous chapter, Stiver and Miller (1988) have characterized the difference between 'sadness' and clinical depression as that between a 'feeling state' and a 'non-feeling state', which ties in well with Anna's account. The 18 postnatally depressed mothers, described below in group 3, were similar to these five mothers insofar that they had felt the same sadness and difficult feelings. However, as I go on to document in this thesis, these two groups differed in that by denying their negative or ambivalent feelings to themselves and to others, the 18 postnatally depressed mothers had not confronted and experienced these feelings, and consequently had become clinically depressed. As Stiver and Miller (1988: 2) point out, "when there is not an adequate relational context in which sadness can be experienced, expressed and validated, depressive reactions develop".

(iii) Group 3: mothers who experienced postnatal depression

A group of 18 mothers described themselves as having experienced postnatal depression. The criteria for the presence of postnatal depression were the mothers' own assessments and definitions of their experiences.[19]

The mothers in this group differed from the other mothers in my study, and in particular from those in group 2, in several ways. In outlining these differences it is important to bear in mind that there was also variation within this group of 18 mothers, in particular in terms of the severity and duration of the depression. However, the mothers in this group shared the following characteristics, which distinguished them from the mothers described in group 2.

First, there were psychological differences between these two groups of women. These differences form the subject of the thesis, and so here I just want to cite Stiver and Miller (1988: 4), who capture the essence of these differences in the following way:

> Perhaps the major difference between sadness and depression is that the depressive experience is very isolating and nonrelational. It is exquisitely self-centred in that the person has withdrawn from others and has focussed on her personal defects, often around concerns about appearance and performance.

Second, just as the mothers in group 2 believed that what they had experienced was *not* postnatal depression, the mothers in this group felt sure that what they had experienced *was* postnatal depression, and labelled their experiences as such. They clearly explained that their feelings had been those of "depression", and were definitely different to the kinds of feelings described by the mothers in group 2:

> I think people can be very flippant about it ... as if it's like a Monday morning feeling ... People use the word depressed very casually, 'Oh I feel depressed today, nothing's going right' - well, that's just feeling low, that's not what depression is. (Celia)

> When I was depressed, I used to think, 'I wish I could feel fed up', because being fed up is nothing like being depressed. (Pam)

> There's ... a difference between feeling tired and run down, and feeling like you're doing this depression. (Sonya)

---

19 The mothers' assessments had also been informed by what they had been told by health professionals at the time of the depression.

> I'm sure you get people that get depressed ... just depressed from sheer exhaustion really, but it's knowing the difference between just being exhausted depressed, and going a bit further down the road. (Frances)

There was a consensus amongst these mothers that the "depression", "postnatal depression", and "postnatal illness" that they had experienced was markedly "different" to feeling "low", "down", "fed up", "tired", "run down", "exhausted" and "a Monday morning feeling".

A third difference between these mothers and those in group 2 was that these mothers all used the term postnatal depression, and explained how having this 'label' had provided some relief to them:

> I was relieved ... that somebody had pin-pointed that I'd actually got a problem, rather than that I was just being totally unreasonable. (Sandra)

> It usually takes a professional to say, 'Look, I think you're suffering from depression' and it's quite a relief when they say it.
> *Why was it a relief for you?*
> Well, I thought I was going mad. (Dawn)

The responses of depressed mothers in my study were therefore quite different to the account given by Nicolson (1991/1992) of the mothers in her sample, whom she described as distancing themselves from the 'postnatal depression as pathology discourse', and as emphasizing that they did not have postnatal depression.

These 18 mothers described their feelings as having been completely "abnormal", as "a bolt out of the blue" that had "struck" them down. Their behaviour and personality had changed so dramatically, they explained, that they had felt they were "going mad" and "crazy", "a bit loopy", "a bit screwy", "mental", "nutty", and that they had "flipped". Many mothers also described their fear that they might one day find themselves in the local mental hospital.

These mothers had experienced a range of debilitating and distressing physical and psychological symptoms, including panic attacks, phobias, migraines and headaches, a churning stomach, and chronic tiredness:[20]

> I could feel panic rising up in my stomach if [my daughter] wouldn't put her coat on to go out, if she cried a bit and ... if we had a little tussle ... it would be a big thing to me ... and panic ... I could feel it rising like bile in my stomach ... as soon as she did anything that was not what I expected. (Sonya)

---

20 Some of these symptoms were also possibly side-effects of the antidepressants.

> I was incredibly superstitious ... I mean, the number of 13, as far as I'm concerned, was absolutely horrendous ... If we had a dog in the kennel of that age, I wouldn't go near it ... If I touched anyone of that age, I'd come home, wash my clothes, have a bath. (Frances)

All the mothers in this group described their having had suicidal thoughts, which none of the other mothers I interviewed spoke about:

> When I was ... really depressed ... I was really quite suicidal ... and one day, I walked off down the road and Jim came running after me and said 'Where are you going?' and I said 'I'm going to the [motorway]' and I wanted to lie under this lorry, I wanted to just lie on the [motorway] and I just felt really calm about ... I said 'I just want to lie there and everything will be over'. And I'm sure I would have done it ... because there was just this feeling I had, I just wanted to get it all over with. (Pam)

Based on the experiences of the 40 mothers in my study, and in particular the differences expressed between groups 2 and 3, I believe that the studies carried out by Oakley (1980), Romito (1990b) and Nicolson (1988) included few clinically depressed mothers of the type described in group 3. I raised this issue in the previous chapter, and discussed how, both methodologically and theoretically, these researchers have confused the experiences of mothers in groups 2 and 3; in my view, the experiences of these two groups of mothers must be distinguished, at both methodological and theoretical levels. I would suggest that, there have been no qualitative, in-depth studies, to date, of mothers' experiences of postnatal depression specifically. I therefore decided that the most important group of mothers to focus on in my own research were those 18 mothers who described their having experienced postnatal depression. These mothers form the core of my study. It is these mothers' accounts that I consider in depth in the following chapters. In contrast, I carried out much less detailed analyses of the interview transcripts of the mothers in groups 1 and 2. My findings with regard to these two groups are based only on preliminary analyses, and so I discuss these mothers only very briefly in the remainder of the thesis. I want to emphasize that even the minor points I make about the mothers in groups 1 and 2 are tentative ones which will require further research.

5. Composition of the core sample

The core of this research is based on interviews carried out with 18 mothers who had experienced postnatal depression. I now describe the socio-demographic characteristics of these women.

At the time of the interview, the ages of the mothers ranged from 20 to 39, and the ages of the children after whose birth the mothers had become depressed ranged from 12 months to six years (see Table 2 in Appendix 6). The ages of the mothers at the birth of their first child ranged from 17 to 37. The ages of the mothers at the birth of the child after which they became depressed ranged from 18 to 37 (see Table 3 in Appendix 6).

In terms of parity, 12 mothers had become depressed after the birth of a first child, four after the birth of a second, and two after the birth of a third (see Table 4 in Appendix 6).[21] The six subsequent mothers had not experienced postnatal depression previously.

The mothers came from a range of educational backgrounds, as illustrated by Table 3 below:

Table 3: Educational background of the 18 depressed mothers[22]

Education	Number of mothers
CSE[23] level	3
O-Level	2
O-Level and a further course of training[24]	4
A-Level and a further course of training	6
University degree	2
Postgraduate training	1
Total number of mothers	**18**

As I noted in the previous chapter, existing qualitative studies on postnatal depression (e.g. Nicolson, 1988; Oakley, 1980; Romito, 1990b) have comprised predominantly middle-class mothers. For this reason, I wanted to interview a group of women from a range of educational and socio-economic backgrounds, in order to represent a spectrum of experiences of postnatal depression. However, I do not discuss my findings in terms of educational or class differences. When I analysed the interview material, there were no apparent such differences in terms of the underlying psychological processes involved in depression. Furthermore, I accept Ribbens' (1990, in press) point that research which

---

21 I use the term 'first-time mothers' to describe those who became depressed following the birth of a first child; and the term 'subsequent mothers' for those who became depressed after the birth of a second or third child.

22 See Table 5 in Appendix 6 for further details on individual mothers.

23 Certificate of Secondary Education.

24 E.g. secretarial, nursing, social work, journalism, nannying.

focuses on social-class differences can neglect variabilities within middle- or working-class categories, as well as data that show no social class patterns at all. Attention to class differences can therefore obscure other differences, and similarities, between mothers.

In terms of their employment status, at the time of the depression, 11 women were full-time mothers, three were in part-time employment and four in full-time employment (see Table 6 in Appendix 6 for further details. See Table 7 Appendix 6 for the mothers' employment status and occupations at the time of the interview).[25]

In terms of marital status, sixteen of the mothers were married and living with the father of their child(ren). One mother was cohabiting with her partner and father of her child. One mother, who had become depressed after the birth of her second child, was cohabiting with the father of her third child. Her first two children were fathered by two other partners.[26]

With respect to the depressed mothers' ethnicity, all were white. Fifteen were British, one Welsh, one Scottish, and one Canadian.

The length of the depression varied from six weeks to three and a half years. The depression had set in between the day that they had given birth and six months following the birth.

The time that had elapsed between the mother's depression and the interview varied. At the most, it was four years since the mother had emerged from the depression, and, at the least, it was where the mothers described their still being depressed, although feeling better than they had done in previous months. Of the 18 mothers, eight had fully emerged from the depression, four were currently emerging and were towards the end of this journey at the time of the interview, and six were still quite depressed.

6. Analysis of the data: a 'voice-centred relational method'

The empirical material on which the analysis is based comes mainly from the interview transcripts. However, what was said and done while the tape recorder was

---

25 Partners' occupations at the time of the interview were the following: sales manager; mechanical engineer; tyre-fitter; army corporal; cardiac perfusionist; charge nurse; management consultant; carpenter; unemployed; desktop publisher; two factory workers; laboratory technician; transportation engineer; tailor; company director; taxi service operator; and printer/machine manager.

26 In general discussions in the thesis, I use the term 'partner' to designate the men with whom the mothers were living. When I describe particular mothers, I use the terms 'partner' or 'husband' depending on whether they were married.

switched off was also considered. I have included the questionnaire material, and my thoughts about the interviewee, her child (if present), her home and any relevant exchanges that I had with participants by telephone or by letter in the course of gaining access to the mothers, and setting up the interviews. I am also focussing some attention on the form, as well as content, of the interviews - on how things were said, as well as what was said - as form is particularly important in research on sensitive topics (Brannen, 1988).

In analysing the interview material, I have used Brown and Gilligan's (1992, 1993) 'voice-centred relational method'.[27] I chose this method for three main reasons.

First, as I discussed in the introduction to the thesis, I was able to take part in a small graduate research group set up by Carol Gilligan in Cambridge with the purpose of learning how to use this method of analysis, directly from her. This method is designed to be used in the context of a group of other researchers at similar stages in the research process, and I was also attracted to the idea of working in such a supportive environment. It was therefore in the context of a group of five researchers, including Carol Gilligan, that ran over the course of 18 months, that I learnt how to use this method.

Second, this method was ideally suited to the theoretical issues I wished to address within the study, outlined in Chapter One. The method centres around the asking of the following four questions: (i) 'Who is speaking?'; (ii) 'In what body?'; (iii) 'Telling what story about relationships?'; (iv) 'In what societal and cultural frameworks?' In asking the first question, it therefore highlights the active role of the self and of the 'I' who is telling its story. The following three questions also highlight the relational nature of the self, in relationship to itself, others, and society.

At the heart of the method lies the notion that women's voices and accounts must be heard on their own terms. Rather than fit the data to the theory, the goal is for the theory to be grounded in the women's own voices. As Gilligan *et al.* (1990a: 96) write, this method provides "a way of listening ... that takes into account both our stance as researchers and the stance of the person speaking within the text". In this respect, the method has common features with other methods such as Glaser and Strauss' (1967) Grounded Theory, which also stresses that data must be used as the ground from which theoretical insights can develop, and empirical investigations proceed.

The method also emphasizes the relational and reflexive nature of research. Brown and Gilligan (1992) indicate that research is a practice of relationship. It is important to ask

---

27 This method has been evolving over at least the last six years (see Gilligan *et al.*, 1990a).

not only "who is speaking" but also "who is listening" (1992: 22). Voices change, depending on whether they are heard or not heard, responded to or not. The listener is seen to be brought into responsive relationship with the speaker. Indeed, Brown and Gilligan see relationships as the way to acquire knowledge and begin to understand the inner psychological world of another person. They write:

> This relational understanding of the research process shifts the nature of psychological work from a profession of truth to a practice of relationship in which truths can emerge or become clear. Instead of holding as an ideal a no-voice voice or an objective stance - a way of speaking or seeing that is disembodied, outside of relationship, in no particular time or place - we seek to ground our work empirically, in experience and in the realities of relationship and of difference, of time and place. (1992: 22-23)

A further reason for choosing this method was that it provided concrete steps to follow, that is the 'nuts and bolts' of how to do the analysis.

I now turn to the four questions outlined above, and describe how I used the method.

(i) 'Who is speaking?'

The first listening focuses on the story that is being told. Here, the plot and drama are uncovered. The researcher listens for "recurring words and images, central metaphors, emotional resonances, contradictions or inconsistencies in style, revisions and absences in the story" (Brown and Gilligan, 1992: 27). My analysis of the mothers' accounts has involved a critical examination of the words, images and expressions they used in speaking about their experiences.

In this first reading and listening, the researcher also places herself, with her own particular history and experiences, in this relationship with this person. Here, the reflexive nature of the research process is observed. "Writing out our responses to what we are hearing, we then consider how our thoughts and feelings may affect our understanding, our interpretation, and the way we write about that person" (Brown and Gilligan, 1992: 27).

(ii) 'In what body?'

In the second reading, the researcher listens for 'self' - for the voice of the active 'I', for the way in which the individual experiences and speaks about herself. The 'I' is literally traced in the interview transcript in order to uncover who this person is and how

she feels about herself. Brown and Gilligan (1992: 27-28) write that this listening is crucial as it brings the researcher into relationship with this person, and also because, as researchers, we discover how "she speaks of herself before we speak of her".

Through this second listening, the researcher attempts to know the interviewee *on her own terms* and respond to what she says both emotionally and intellectually. Through this reading, the researcher ensures that the respondents' perspectives are confused neither with her own, nor with those of existing theories:

> This second reading, designed to attune one's ear to the voice of the person speaking, is key to a shift in stance with respect to analyzing or interpreting the interview text, a shift marked by the change in language from *coding, which implies fitting a person into a pre-existing set of categories*, to reading, which implies *opening one's eyes and ears to the words of another,* taking in his or her story. The exercise of directing my attention to the way the person speaks about herself is designed to highlight or amplify the terms in which she sees and presents herself ... I listen to her voice and attend to her vision and thus *make some space between her way of speaking and seeing and my own.* (Gilligan *et al.*, 1990a: 103; emphasis added)

(iii) 'Telling what story about relationship - from whose perspective or from what vantage point?'

In the third reading, the researcher listens to how the respondent talks about the relationships in her life, in particular, her struggle for relationships in which she can freely voice her feelings and thoughts, and in which she feels that these will be heard.

(iv) 'In what societal and cultural frameworks?'

In the fourth reading, the researcher listens for relationships in which the interviewee feels that she cannot be true to herself, cannot express herself and how she really feels and thinks.[27a] This listening focuses on "the way in which institutionalised restraints and cultural norms and values become moral voices that silence voices, constrain the expression of feelings and thoughts, and consequently narrow relationships, carrying implicit or explicit threats of exclusion, violation, at the extreme violence" (Brown and Gilligan, 1992: 29). The appearance of moral terms and language - such as "should", "ought", "must", "right" and "wrong" - are taken as "signs of self-silencing or capitulation to debilitating norms and values" (Brown and Gilligan, 1992: 30).

Guided by these four questions, the researcher carries out at least four readings and listenings of the interviewee's story. Brown and Gilligan (1992) point out that four coloured pencils can be used to literally trace these four voices in the transcript, and the

---

27a It is not clear whether Brown and Gilligan (1992) use the notion of what a girl or woman 'really feels and thinks' in a theoretical sense, and/or to refer to how girls and women actually talk about themselves.

ways in which they interweave with one another throughout the text. Having traced these voices, the researcher moves on to what are termed 'Worksheets'. Gilligan *et al.* (1990a: 136) write that:

> Worksheets provide a place for the reader to document relevant pieces of text and to make observations and interpretive remarks. The Worksheets, then, are designed to highlight the critical move from the narrator's actual words to a reader's interpretations or summary of them ... They leave a trail of evidence for a reader's interpretation that can be followed by another reader.

In this sense the method can be said to be essentially empirical, as it illustrates the stepping stones of the evidence. Using this technique, I recorded the words of the interviewee in one column, and my own interpretations of her words alongside in a separate column. This Worksheet technique is particularly useful because it maintains the important distinction between the interviewee's words, and our own. It therefore ensures that the participant retains her own voice, and that her voice is not lost in and amongst the voices of other participants, or the researcher's voice.

Having carried out these readings, I summarized the plot, how the mother spoke about herself, what she felt were the positive and understanding relationships in her life, and which relationships seemed to cause her distress and difficulties.

Then, as a way of 'breaking down' the lengthy transcripts so as to make them more manageable, I 'cut up' the transcript material into the following eight overlapping themes: (i) self - how the mother describes or speaks about herself; (ii) postnatal depression; (iii) motherhood; (iv) relationships with partner, relatives, friends, other mothers with young children and neighbours; (v) support from health professionals; (vi) feelings about her employment status; (vii) emerging from the depression; (viii) background details. Because these themes were overlapping, several transcript extracts featured under more than one theme.

Having done this for all 18 mothers, I took each theme one by one. For example, with the motherhood theme, I went through each mother's 'motherhood' transcript extracts and listed points and issues she spoke about. Having compiled 18 such lists for the motherhood theme, I looked at these lists together, seeing what were the common themes and patterns, and what were the differences, across mothers. I then went back to the transcript extracts on motherhood, to look again at *how* the mother spoke about the particular issues and patterns that seemed to be significant. At this stage, I was again attending closely to the words the mothers used, and to the *ways* in which they spoke about

these particular issues. I carried out the same procedure with each theme, moving back and forth between, on the one hand, the mothers' actual words and accounts, and, on the other hand, my lists of common and different points and issues, until I began to put together a picture of how and why these mothers had become depressed.

7. Ethical considerations

Ethical considerations were particularly important in this study, in which highly personal and confidential information was being disclosed. I therefore attempted to contend with any potential ethical problems that might arise at all stages of the research.

Before embarking on the data-collection phase of the study, the project was approved by the Cambridge University Psychology Research Ethics Committee.

Before deciding to take part in the research, the women were told about the nature of the project. When they agreed to take part, and we met for the interview, I again told the mothers about myself, the research, and the interview (see 'Introductory comments to the interview guide' in Appendix 4), and they were invited to participate on the basis of their informed consent. During the interview, the research participants were potentially vulnerable to their own emotions. Indeed, many of the mothers found it upsetting to speak about their experiences of depression. In these circumstances, I switched off the tape recorder, asked the mother to take as much time as she needed or wanted, and paused in silence. I then offered to end the interview either for that day or for good, stressing that I would be happy to do either of these, and asked her what she was most comfortable with. In fact, we never had to end the interview, but simply carried on after a pause. Indeed, all 18 depressed mothers expressed how "useful" and "therapeutic" it had been to talk about their experiences, and "get it off my chest". They also pointed out that their reasons for taking part in the study were to share their experiences so that this knowledge might help other depressed mothers. Thus, at all stages of the participants' involvement in the research, they were given the opportunity of withdrawing from the study.

To ensure confidentiality and anonymity in both written and spoken public presentations of my research, I have changed the names of the mothers, their children and all other individuals mentioned by them.

A further ethical consideration concerns the ways in which I have written about these women's lives. In writing up this research, I have attempted to convey what the mothers themselves said about their experiences of their depression, and what they felt

were the important issues in terms of understanding their feelings. Gilligan suggest that "in writing up results, a researcher should imagine that she will be sitting beside her respondents as they read what is written about them" (Gilligan, 1985; cited in Andrews, 1991: 49). I feel that this is what I done, to the best of my ability. Whilst the aim of this thesis is to present a coherent understanding of why and how these mothers came to be depressed, I have also attempted to portray the complexity of these women's lives and accounts.

A final point is that, because I have experienced neither motherhood nor postnatal depression myself, I feel that I have not attempted to fit these mothers' words and views into any of my own pre-existing beliefs about these experiences. I feel that I have not 'used' the mothers to defend my own view-point. However, the final product is clearly as much a reflection of myself as a researcher, as it is of the mothers' narratives. As Ribbens (1990: 62) points out, the notion that the researcher is invisible is an illusory one, and "all research must be regarded as socially constructed, providing one particular account of the many that are possible about any particular social experience". I have had to make certain decisions about how to analyse the data, and what particular aspects of the mothers' lives to focus on. I have also had to edit the transcripts and present selected quotations. I have therefore had the job of interpreting what the mothers said, and selecting what I will say about their lives. This in mind, I nonetheless feel that this thesis tells *their* story, albeit in a different way and form to how they told it to me. I have heeded Gilligan's (1985) advice and trust that if the mothers were to read this account, they would find that it resonated with their experiences. Indeed, it seems to me that this would be a good test of the material presented here.[28]

Conclusion

In conclusion, I want to highlight those aspects of my methodology that serve to qualify the findings presented in my thesis. My sample is not representative of the wider population of either depressed or non-depressed mothers. The study is based on a small number of interviews. No attempts were made to select the sample in a random way. The mothers who took part in the study were self-selected, and just under a third were contacted through network sampling. The sample is biased towards women who were willing to talk about their lives to a stranger, and also women who were willing to disclose painful emotional experiences. These women might be very different to those who, either did not

---

28 In her study of mothers' experiences of childrearing, Ribbens (1990) went back to the women in her study with her own analysis of their lives and this consultation was a further source of data in her study. Unfortunately, time constraints meant that I was not able to do this in my own research.

come forward, or refused to take part in the study. Although the participants varied in age, educational background, and socio-economic status, the sample was nonetheless relatively homogeneous. Most mothers were living in a relatively affluent part of Britain. The sample is not representative of the many ethnic minority groups living in the country. Although my findings speak for the mothers who took part in my study, further research will be required to ascertain how far they might be extrapolated to the wider population.

The core of the thesis focuses on 18 of the 40 mothers that I interviewed - that is, on those who said they had experienced postnatal depression following the birth of their first, second or third child. The fact that I did not carry out detailed analyses of the two non-depressed groups of mothers, and systematically compare these with the depressed mothers, is a limitation to this study. This would also be a valuable question for future research.

Chapter Three

The Relational Disconnection of Postnatal Depression

Chapter Three

The Relational Disconnection of Postnatal Depression

> If I were to look back, and to have one word that described my period of depression, then I would come up with the word isolation ... I think that really sums it up. (Tina)

Introduction

In this thesis I argue that the depression experienced by the 18 mothers in my study was characterized by, and resulted from, a profound sense of isolation from other individuals in their lives, and alienation from themselves.[1] Before considering the evidence that emerged from my study to support this claim, I briefly review existing research on the role of interpersonal relationships in postnatal depression.

A growing literature has investigated the role of social relationships in the onset and maintenance of psychiatric problems in general (Cobb, 1976; Leavy, 1983; Mueller, 1980). Interpersonal relationships have been found to be critical to the prevention of ill health, protection from adversity and to the successful negotiation of life course crises and transitions (Gottlieb, 1981, 1988). Studies have shown that poor relationships feature strongly in women's experiences of depression across the life-cycle (Belle, 1982; Brown and Harris, 1978; Mueller, 1980), and especially in depression in mothers with young children (D'Arcy and Siddique, 1984; Moss and Plewis, 1977; Richman, 1974, 1976).

As I pointed out in Chapter One, the work of Brown and Harris (1978) is probably the most well-known research in this area, and a classic example of a study documenting the importance of confiding relationships. A number of later studies have consistently confirmed the role of a confiding relationship in protecting mothers against depression in the face of a life event (Brown and Prudo, 1981; Costello, 1982). Following in the tradition of the Brown and Harris study, a substantial number of correlational studies have investigated the role of interpersonal relationships in postnatal depression. The majority of these studies have focussed on the mother's relationship with her male partner, and have

---

1 In this and the following two chapters I will be considering the nature of the mothers' relationships at the time of the depression. However, it is important to emphasize that these relationships were not static. As the women described them, they had changed with the birth of a first, second or third child, and they had evolved over the course of motherhood and the depression. In Chapter Six, I discuss the particular changes that occurred in the mothers' relationships over the course of their journey out of depression.

identified a link between postnatal depression and a poor marital relationship.[2] These studies show that women experiencing postnatal depression report poor communication with their partner, a lack of practical help with childcare and housework, a lack of emotional support, an over-controlling partner who provides little care, and a general deterioration of the marital relationship after the birth of the child (Boyce *et al.*, 1991a; Braverman and Roux, 1978; Cox *et al.*, 1982; Feggetter *et al.*, 1981; Grossman *et al.*, 1980; Kumar and Robson, 1984; O'Hara, 1986; O'Hara *et al.*, 1983; Paykel *et al.*, 1980; Playfair and Gowers, 1981; Stemp *et al.*, 1986; Tod, 1964; Watson *et al.*, 1984).

Correlational studies have also shown that a poor relationship with the mother's parents, low maternal care from the mother and an over-protective father are linked to postnatal depression (Boyce *et al.*, 1991a; Kumar and Robson, 1984; Tod, 1964; Uddenberg, 1974).[3] Other studies have found that postnatal depression is also associated with the lack of close relatives living nearby (Gordon *et al.*, 1965), the lack of help from relatives (Gordon and Gordon, 1959), the lack of close confidants other than the partner (O'Hara *et al.*, 1983; Paykel *et al.*, 1980), and having few close friends available to offer help (Wandersman *et al.*, 1980).

Feminist social scientists have also addressed the issue of interpersonal relationships. In Chapter One, I noted that these researchers have characterized motherhood as intrinsically isolating, and stressed the physical isolation that depressed mothers experience (Nicolson, 1988; Oakley, 1980; Romito, 1990b). They have also identified links between postnatal depression and the quality of mothers' relationships. They too have focussed principally on the marital relationship, finding that depressed mothers have 'segregated' marital roles and unsupportive partners who offer little practical help with childcare and housework (Nicolson, 1988; Oakley, 1980; Romito, 1990b). They also point out that mothers often receive contradictory advice from health professionals, which often induces anxiety and depression (Nicolson, 1988; Romito, 1988, 1990b). Finally, they report that motherhood leads to a change in women's friendship patterns (Nicolson, 1988, 1989; Oakley, 1980).

In sum, existing research has considered depressed mothers' relationships in two main ways; first, it has examined the physical isolation that depressed mothers experience; second, it has documented depressed mothers' unsupportive relationships, and here it has primarily been concerned with the marital relationship.

---

2 With the exception of Blair *et al.* (1970) and Hopkins *et al.* (1987).

3 Paykel *et al.* (1980) find no link between postnatal depression and a poor parental relationship.

The argument I propose, based on the analysis of the 18 depressed mothers in my study, differs markedly from current conceptualizations in three ways.

First, existing research has focussed exclusively on physical isolation, and on the emotional isolation that mothers feel within unsupportive relationships. However, as I illustrate in this chapter, these two 'types' of isolation were insufficient to explain the depression and loneliness experienced by the mothers' in my study. While these two types of isolation contributed to their depression, all 18 mothers described a deeper and underlying process in which *they* had actively withdrawn *themselves* from their relationships.

Second, the studies discussed above conceptualize the mother in a passive way, and theorize relationships in a unidirectional way. The mother is depressed because she fails to *receive* something from the other, who is seen as the giver. However, my finding that the mothers were actively removing themselves from their relationships, highlights both the active nature of the self and the two-way nature of relationships.

Third, existing research considers relationships to be one 'factor' amongst many others that might explain postnatal depression. I propose that the isolation experienced by the depressed mothers in my study, characterized by their active social withdrawal, constituted the very nature and essence of their depression. I argue that, in order to understand why and how these mothers became depressed, it is necessary to examine the processes through which they were led to withdraw from their relationships.

I now move on to substantiate these three points, by discussing the material that emerged from my study. In the first part of the chapter, I address the question of physical isolation and show that, while several of the depressed mothers experienced such isolation, the latter could not fully account for their feelings of loneliness and depression. In the second section, I turn to the issue of unsupportive relationships. I argue that such relational difficulties were insufficient to explain the mothers' sense of disconnection. They also described removing themselves from their relationships. The third part of the chapter examines the nature of all 18 mothers' withdrawal from social contact. I outline the key psychological processes through which they withdrew into silence, and consequently became depressed. I conclude the chapter by joining my work to that of relational psychologists, who have similarly argued that psychological difficulties arise out of a failure to form or sustain authentic connections with significant others.

I. Postnatal depression and physical isolation

In this section I examine the extent to which the mothers in my study experienced a sense of physical isolation, and what role it played in their depression. One way of conceptualizing this physical isolation is by drawing on the notion of 'social networks', which refers to the web of interrelationships within which a particular individual is embedded (Mueller, 1980). A distinction is drawn within the literature between 'social networks' - that is, the quantity and types of social ties - and 'social support' - that is, the quality of these various ties (Cobb, 1976; Mueller, 1980). The size and composition of social networks partly determine the availability of, and access to, other individuals.

Physical isolation can occur for different reasons, and encompasses different types of isolation. For example, a mother can be *geographically* separated from her mother. If she works outside the home, she can be *socially* isolated from other 'non-working' mothers. She can be *physically* isolated from her partner who works long hours during the day, evenings and week-ends. These types of isolation are all physical, and I now consider the mothers' experiences of such isolation within their relationships with partners, their mothers and other mothers with young children.

1. Physical and geographical isolation from partners

All but one of the mothers in my study had been living with their partners at the time of the depression. However, one of these mothers, Fiona, had been geographically isolated from her partner during much of this time. Her husband was in the army, and in the three years since they had had their children, he had spent an average of eight to ten months a year away from home. A second mother, Caroline, had also felt isolated from her husband. For the first five months after the birth, he had been away at work during the day, and nursing his dying mother during evenings and week-ends. Both mothers felt the absence of their partners had contributed to their feelings of depression. For the remaining 15 mothers, whilst the majority of their partners worked long hours (up to 14 hours a day), they had been available when the mothers had been depressed.

2. Geographical isolation from their mothers

Nine women had lived elsewhere from their mothers at the time of their depression.[4] However, only three women described this as a problem. The remaining six

---

4 One mother, not included in this number, had lost her mother two years before the birth of the child after whose birth she became depressed.

had difficult relationships with their mothers anyway, and welcomed this geographical distance. This is a critical point, for it indicates that it is the mother's subjective feelings of isolation that are important, rather than an objective assessment of her degree of isolation.

Although three women said they had felt isolated from their mothers, their feelings of loneliness had involved more than this physical separation. Celia, for example, said she had missed her family, in particular, just after her husband had returned to work, following his paternity leave:

> Neither of us have got any family down here, and I think that was quite a big thing ... Robert had a week off. He was really good, he did all the cooking and everything and I just had to sit there and look after her ... But once he went back to work, I had no family nearby to come ... just for company ... It [was] very lonely.

Celia also noted, however, that her isolation had involved more than this physical distance, for she had felt unable and unwilling to talk to her parents anyway:

> I didn't say anything [to my parents], partly because I didn't want to upset them, partly because I feel they wouldn't understand, 'cos ... my mother had been a very natural mother ... So I was sort of protecting them. I didn't want them to have unnecessary worries that they couldn't really do anything about, and I wanted them to believe that I was coping. So it was more my decision to keep them at a distance rather than the fact that they didn't care.

Celia's isolation had involved not simply geographical separation, but an additional process, in which she herself had been reluctant to reveal her needs and feelings to her family.

3. Physical and social isolation from other mothers with young children

The most important type of isolation reported by the women was feeling isolated from other mothers with young children. Several researchers have commented on the value of having similar others to 'compare notes with' in pregnancy and in motherhood (e.g. Brannen and Moss, 1991; Cutrona, 1984; Grossman *et al.*, 1980; McCannell, 1988; O'Donnell, 1985; Urwin, 1985). In her study on the transition to motherhood, McCannell (1988: 99) comments on "the value of being part of a circle of other parenting adults, with whom concerns and anxieties regarding the new role can be shared".

It was particularly the 12 first-time mothers who described physical and social isolation from other mothers as an important issue. In this section, I consider the two main 'structural' reasons for this isolation. With the exception of Fiona, the mothers who

became depressed after a subsequent child were already involved in networks of other mothers. Despite this, they described their feeling isolated from these mothers, but, as I explain in Chapter Five, this isolation was not physical. It resulted from their own withdrawal from these networks.[5]

In becoming mothers, these women felt they had gone from a "past life" to a "new life". In entering this "different world", they had wanted and needed the company of other mothers with young children. Their needs from existing relationships had changed for two main reasons. First, they had wanted to see people during the day. Second, they had been looking for psychological and emotional affinity, and for relationships in which they could share their common experiences with other mothers who might be more responsive to them, and better able to share the joys, and understand the constraints, of motherhood. Both the 'working' and 'non-working' mothers had felt a need for friends who could understand their lives as mothers.[6]

These women described several difficulties in meeting other mothers with young children. They spoke about two main 'structural' obstacles: first, the lack of local places to meet with other mothers; and, second, the mothers who had returned to work following the birth had found their day-time employment had restricted their opportunities to take part in activities with other mothers, which took place mainly during working hours.

Several mothers spoke about the lack of a "community centre or place where you bump into people", a place where mothers could meet one another, or simply "push the pram to".[7] This absence meant the job of "making a new life" and new friends was that much harder, because meeting other mothers who lived locally became a difficult task. This problem was described by mothers who lived both in urban and rural settings.[8] Helen, who had lived in the centre of a town, explained how she felt:

---

5 Fiona moved away from where she had grown up shortly before the birth of her first child. Since that time, she had not become involved in a local network of other mothers. She explained that the attitude of the army wives living in the barracks was that they "just kept to themselves" and did not socialize with one another. During her depression, Fiona had not formed any friendships with other mothers of young children.

6 Five of the 12 first-time mothers had been employed outside the home at the time of the depression, either full-time (four) or part-time (one). See Table 6 in Appendix 6 for further details. The remaining seven women were full-time mothers at the time of the depression. Women's unpaid work inside the home, paid or unpaid involvement in the community, and paid work outside the home are all forms of 'work' (Pahl, 1984). For the purposes of this discussion, however, I will use the term 'work' to refer to 'women's paid employment outside the home'.

7 O'Connor (1992: 44) notes that "a concrete inhibitor of women's friendships within patriarchal society arises from the scarcity of public spaces where women can meet and mingle and form and maintain friendships".

8 At the time of the depression, amongst the 12 first-time mothers, five had been living in small villages, three in towns, and four on housing estates. (Amongst the six subsequent mothers, one had lived in a village, one in a town, and four on council estates).

> There's nothing really in this area for mothers, I found it very difficult to meet up locally ... I would have liked to have known ... other mothers around, and if there was sort of a central meeting place in this area, because ... I don't actually know this area very well, because until we had Ben, I worked, came home ... went away week-ends ... and it's actually very different then having a baby.

The first-time mothers had also wanted access to local settings which they could get to on foot, even though all except for two of these mothers[9] had had use of a car.[10]

As Helen pointed out above, the lack of places where mothers could meet one another at a local and informal level exacerbated a problem the first-time mothers already faced in making the transition from paid employment to motherhood. Having been away at work during the day before having a child, they had had limited opportunities to form relationships with people living in their neighbourhood. During their maternity leave, and during subsequent months for the women who had not resumed paid employment, the mothers had found themselves spending time at home and in their local community, during day-time hours.

A second reason for the mothers' difficulties in meeting other mothers had been their paid employment outside the home during their depression. Although the mothers who had returned to work following the birth mentioned the company they had derived from work colleagues, they also felt they had been missing out on networks of mothers who stayed at home.[11] Their day-time employment had limited opportunities to meet other mothers and they expressed sadness at having missed out on these networks.[12]

Some women had experienced the return to work as doubly isolating because they had felt they were losing social ties at work and in their local community. At work, some mothers had felt they could not share their new experience of parenthood with colleagues who were not parents themselves. Several mothers had felt alienated from colleagues who

---

9 Amongst the six mothers who became depressed after a subsequent child, four did not have use of a car.

10 Other studies, however, note that lack of access to transport, and a car in particular, contributes to mothers' sense of isolation (Boulton, 1983; Oakley and Rajan, 1991).

11 Brannen and Moss (1991) also found that women who had intended to return to work, and women who had resumed employment, knew significantly fewer parents than non-working mothers.

12 As Bell and Ribbens (1994) point out, it is often explicitly argued, or implicitly assumed, that returning to work is the solution to the isolation experienced by mothers who stay at home to care for their children. This issue is more complex, as mothers who do return to work might also experience a sense of isolation, albeit of a different nature. If contacts with other mothers are central to mothers' mental health, as my study suggests, this issue needs to be considered in research on the relationship between mothers' employment and their mental health.

disapproved of working mothers.[13] Others commented that work colleagues had lost interest in them once they had had a child. A number of the working mothers had felt isolated from local networks of other mothers because of the restrictions of working daytime hours, or because they thought other mothers had rejected them for being 'working mothers'.

Penny, for example, had returned to work four months after her son's birth, because she had felt inadequate as a mother and incapable of looking after him. Against her will, she had worked for a year, feeling extremely isolated during this time. She had felt unsupported at work - "Some of [my work friends] were nasty because I went back to work ... I don't know if I'd still call them my friends", she said. As a result of working, Penny had not become involved with the "mumsy crowd", as she called it, and felt she had "missed *so much"* during that year. When she eventually left work, she "really got into the mumsy crowd" and said, "now, I'm just one of them and it's great because I've got someone to talk to". Leaving her job and becoming integrated into a network of other mothers had marked the beginning of Penny's journey out of her year-long depression.

Other women had found their work environment and colleagues very supportive of their return to paid employment, and of the difficulties they sometimes faced as working mothers. Some of these women felt they had lacked support and understanding from full-time mothers who disapproved of them as 'working' mothers. Helen explained that she had lost, and missed, "the on-going network of friends and people that you meet up with regularly", after her return to paid employment. Helen thought this loss had been exacerbated by the disapproval expressed by non-working mothers:

> When you go back to work ... your whole social network is again completely different ... You then ... very quickly lose the contacts that you've made ... The people that I met through the NCT ... I was very friendly with, and really enjoyed their company, but I was made to feel really much of a second-class citizen when I went back to work ... A lot of them were very critical of me going back to work.

While describing the structural obstacles they had encountered in meeting other mothers, the women in my study also spoke about how they *had* come into contact with other mothers at some point during the first few weeks following the birth. Some had had a neighbour, friend, sister or other female relative who also had young children. Many first-

---

13 Women who must work for financial reasons are likely to get more backing than those who return to satisfy their own needs and interests (Brannen and Moss, 1991; Richardson, 1993). A mother who is seen as having to work can still be construed as selfless and self-sacrificing, because it can be assumed that she is not working out of choice but rather to support her family. On the other hand, women who express a desire to work are more likely to be seen as selfish (Lewis, 1991).

time mothers had met other women through hospital-based or local antenatal classes, and later developed these friendships. Women who had been to NCT-run antenatal classes attended NCT postnatal reunions, and several mothers had attended NCT-run or other postnatal support or mother-and-baby groups. Indeed, Louise said she had felt "bogged down with invitations" to "come for coffee". The mothers therefore described coming into contact with other mothers, at least in the initial weeks, and in some cases months, after the birth.

The isolation the first-time mothers felt from other mothers had resulted mostly from their own reluctance to disclose their feelings to these women, rather than from difficulties in meeting other mothers:

> The original NCT group have been quite important ... but they don't *know* [I'm depressed], so ... they're an important social network, but they're not supportive, 'cos they don't know. (Sonya)

> I've got good friends, don't get me wrong, but not any that really helped me at the time ... because I wasn't prepared to admit to it. (Frances)

As I discuss in the following chapter, during their initial contacts with other mothers, they had felt others had not shared their own difficult experiences and ambivalent feelings. They had felt 'different' and 'abnormal', compared to these women, and isolated within their experiences. This had led them to withdraw, either from further opportunities for meeting other mothers, or from disclosing the true nature of their feelings to these women.

4. Discussion

In concluding this consideration of the physical isolation the mothers had experienced, and its possible links with postnatal depression, I want to highlight three points.

First, although most of the mothers in my study had been surrounded by other people, nonetheless they had *felt* isolated and lonely. This illustrates how the objective characteristics of their social networks do not necessarily give an indication of the quality or meaning of their contacts, or of how isolated they *feel* (Belsky and Rovine, 1984; Perlman, 1988). Indeed, objective measures of the extent of mothers' social networks are not associated with degrees of psychological distress, while the subjective experience of social support is (Stemp *et al.*, 1986).

Second, while some mothers described having felt physically isolated, few tied the actual *physical*, *geographical* or *social* obstacles discussed above to their depression. They explained that, while this isolation might have increased their feelings of depression, their loneliness had resulted from their own withdrawal from their relationships.

Third, the difficulties the first-time mothers had experienced in meeting other mothers had been linked to the *depression*, rather than to the isolating nature of *motherhood* (as suggested within feminist research; see Chapter One). While some mothers find motherhood physically isolating, and encounter structural obstacles in forming friendships with other mothers, we cannot assume that motherhood is necessarily isolating and mothers therefore get depressed.

As I discussed in Chapter One, Bell and Ribbens (1994) have shown that mothers can and do build and maintain networks of other mothers. Studies also show that the transition to parenthood tends to be accompanied by increased contact with other parents or future parents (Belsky and Rovine, 1984; Brannen and Moss, 1991; Urwin, 1985), even if involvement in such networks takes some time to develop (Bell and Ribbens, 1994). Studies of non-depressed mothers therefore show that, on the whole, mothers do form relationships with one another.

The assumption that physical isolation leads to depression is equally problematic, for three reasons. First, many of the depressed mothers in my study had not been physically isolated although they had *felt* isolated. Second, as documented above, even where mothers had been physically isolated they explained that their feelings of depression had resulted primarily from their own reluctance to reach out to others. A third point, which is based on my less detailed analysis of the 22 non-depressed mothers who took part in my study, is that, even where mothers had been physically isolated, they were not necessarily depressed. They might have been isolated, they might have felt isolated, and they might have felt 'low'. However, I suggest that these feelings are distinct to clinical depression and to what the 18 core respondents had experienced. The major difference, I argue, is that the latter mothers experienced an additional process in which they had withdrawn from social contact. I argue that this process characterized their depression, and that it was absent from the 22 non-clinically depressed mothers.[14]

---

14 I stress that the analysis I carried out of the 22 non-clinically depressed mothers was less detailed than that of the 18 core respondents. While this more preliminary analysis supports the idea that mothers can feel physically isolated without necessarily being depressed, this issue requires further research.

In conclusion, while physical isolation had undoubtedly *contributed* to the mothers' depression, it was also insufficient to explain their feelings. An additional process in which these mothers had withdrawn from social contact accounted for their feelings of depression.

II. Postnatal depression and the quality of relationships

Existing research on the role of interpersonal relationships in postnatal depression has found that depressed mothers tend to have unsupportive relationships in which they receive poor practical and emotional support, from partners in particular, but also from their parents. My study corroborates these findings, but also indicates that poor relationships are, in themselves, insufficient to explain the emotional isolation and disconnection depressed mothers experience. Three observations drawn from my data support this claim.

First, several depressed mothers described their having had positive relationships with significant individuals in their lives, such as their partners and mothers. Of the 17 mothers whose relationships with their partners are considered, nine mothers said their partners had supported them throughout their period of depression.[15] Despite this, they had felt emotionally isolated from their partners because they had been unable or unwilling to reveal their needs and feelings to them. Their sense of disconnection within these relationships had involved more than a lack of practical or emotional support, as existing research suggests. Similarly, of the 17 women whose mothers were still alive, nine said their mothers *had* supported them, practically and emotionally, throughout the depression; or *would have* supported them, had they asked for help. The mothers explained that the limited support they had received from these relationships had been largely because they had not voiced their feelings and their needs to these individuals.

Second, even where the mothers had found their relationships to be unsupportive, these relationships had also been characterized by the mother's withdrawal. The mothers did not simply portray themselves as 'passive victims' of poor support. Rather, they described both a lack of support *and* a consequent active withdrawal from their relationships with individuals whom, they felt, had failed to respond to them and to their needs. Eight mothers explained how their difficult relationships with their partners had led them to stop expressing their feelings to them. Similarly, eight women said they had withdrawn from their problematic relationships with their mothers.

---

15 Sophie's partner left her while she was pregnant with the child after whose birth she became depressed, which is why only 17 women are considered here.

Third, while a mother might have had a difficult or poor relationship with her partner and/or mother, this might not necessarily have lead her to become depressed. This observation is more speculative, being based on my less detailed analysis of the 22 non-depressed mothers in my study. This preliminary analysis showed that some mothers had experienced considerable marital problems, and that while they might have felt low, they had not experienced clinical depression.

I now focus on the first two observations. I will not address the third point, on the issue of comparisons between depressed and non-depressed mothers, given that my study sought to document the experience of postnatal depression.

Poor or difficult relationships were an integral part of the depression experienced by most mothers in my study. However, I argue that an additional process accounted for their depression - namely, their own withdrawal from their relationships. The primary role of this process in depression is most clearly demonstrated by those mothers who had felt supported by significant others. By way of illustrating this process, I examine in detail the nine mothers who had felt supported by their partners during the depression. I document how their sense of relational disconnection resulted from their own silence within these relationships. I then turn briefly to the eight mothers who had felt unsupported by their partners, to show how, despite the differences in the quality of their relationships, common to both groups of women was a withdrawal from their partners.[16]

1. Positive relationships with male partners

Nine women in my study said their partners had supported them, practically and emotionally, in motherhood and throughout the depression. They had been satisfied with their partners' practical contributions to the household and childcare, whatever this contribution had been. Three, one in part-time, and two in full-time employment during the depression, said their partners' involvement in the home had been equivalent to their own:

> He does everything ... He'll do anything in the house ... He vacuums, he washes, he irons, he cooks ... He is just like a woman really ... He loves looking after [our son] ... he is *a proper* daddy ... he gets down on the floor and plays with him ... He loves being with Adam. (Penny)

16 These distinctions between positive and difficult relationships with partners are based on what *the mothers* said about their relationships. I reiterate that I am discussing the mothers' subjective perceptions and interpretations of their partners' behaviour and attitudes.

The remaining six women (one in part-time employment and five full-time mothers) said their partners had been less involved in the home, but that they had been happy with their contributions:

> I tend to do most of the housework, but it's not because Robert does not want to do it, it's just that, again, I feel that I'm at home, that's my job, he works hard enough outside. But, I mean, very often in the morning, if he doesn't have a shirt ironed ... Robert ... will just automatically go and iron it. He doesn't think, 'Ah, this is not my job' ... He's very supportive and ... if he's around, he will look after the children just as much as me. He's not 'Oh, I'm just the breadwinner' and off he goes and comes back and waits for his tea. (Celia)

These mothers had taken on the responsibility for carrying out and organizing housework and childcare[17], but had been satisfied with their situation.[18] There were several reasons for this: first, their partners had been in full-time employment and they had seen housework and childcare as their 'job';[19] second, they had not felt that their partners' limited involvement in the home reflected on their being "typical male[s]" who expected their shirts to be ironed, and their dinner on the table; third, they explained that their partners *would* have been more involved were it not for the fact that they themselves had, at times, discouraged their partners' involvement, either because of "different standards" for housework and childcare, and/or because they had preferred that their partners spend the time they did have at home either with them, or with the children, and not doing housework; (iv) and fourth, when they had asked for help they felt their partners had always responded in a positive way.[20]

In sum, these six women felt the limitations to their partners' involvement in the home had been, either to do with institutional or societal constraints, and in particular the current "work ethic", as Louise explained:

---

17 Numerous studies show that women continue to assume the major responsibility for both housework and childcare, even in dual-earner households (e.g. Brannen and Moss, 1991; Doucet, forthcoming; Lewis and O'Brien, 1987).

18 Authors have commented on the discrepancy between women's responses to a direct question about satisfaction with their partners' contributions, and what otherwise emerges throughout the course of the interview (e.g. Brannen and Moss, 1991; Mansfield and Collard, 1988). I accept this point, but also suggest that this appeared not to be the case for the mothers who described positive relationship with their partners. Unlike the women who described their relationships as difficult, and whose disappointment could be heard throughout the interview, these mothers did not describe their relationships in such a disappointed tone of voice.

19 Research shows, however, that mothers' taking on the responsibility for household labour, and partially or fully withdrawing from the labour market, can be financially hazardous for them (see Joshi and Davies, 1991).

20 Although these mothers expressed satisfaction with the gendered division of labour in their households, such a division is not necessarily unproblematic, either personally or politically (Doucet, in press). What is important in the context of this thesis, however, is that, during the depression, these particular mothers had not regarded this issue as problematic, and described feeling satisfied with this arrangement.

> It's not so much the work he's doing, it's the culture he works in where everybody has to be seen to be busting a gut for the company ... You're *expected* to fit in with the company ethos ... of 'do or die'.

or because the mothers themselves had taken on the responsibility and had discouraged their partners, as Vera explained:

> To be fair to [my husband] ... he never does it *right* enough for me ... I'm silly ... if he does [anything], I'll have to bite my tongue ... saying 'You didn't do that' or 'You didn't do that'. So ... if I ask him, he'll always do it, and he'll do it with good ... grace, he won't moan about it. But I do feel angry with myself ... I've done it, it's my own fault ... I've sort of said 'I'll do this, I'll do that', but then again I think, 'Well, he is at work' ... and I prefer the evening to be free for us just to talk or do other things.

Furthermore, four of the nine women with positive relationships noted that their partners' had failed to "see" or "notice" what housework and/or childcare needed to be done. Whilst their partners had sometimes lacked initiative, they never felt they had lacked good will. Their partners had always been "quite happy" to do anything they had asked for. These mothers found that, when asked for help, their partners had rarely failed to *respond* to their needs and requests. The fact that these mothers had felt their partners had taken initiative in the home, and had responded to their requests for practical help, seems to have contributed to their sense of emotional closeness to their partners, in a way that was absent from the mothers who had felt 'unsupported'.[21]

The 'supported' mothers also felt their partners had responded to them *emotionally*, by standing by them and by being there when they had needed them:

> My husband was brilliant, I don't know how he kept going, he didn't understand what was going on. But I remember once sitting in that chair and just feeling *awful* ... and all I wanted him to do was hold my hand, and he just sat in the chair next to me, and held my hand, and didn't even question it, and it was like brilliant ... 'cos the last thing I needed was a husband dumping on me as well saying, 'Oh why don't you pull yourself together'. (Rachel)

---

21 Mothers with both positive and difficult relationships said their partners' had failed to "see" or "notice" what needed to be done in terms of housework and/or childcare. However, this issue had been perceived and experienced differently by these two groups of women, highlighting how it is the mothers' subjective interpretations that are key to understanding their feelings. The mothers who described their relationships as positive generally had felt emotionally supported by their partners, and thought their partners had always been willing to give practical help when asked. They had not felt their partners' lack of initiative was a problem in the relationship, because their partners had otherwise shown their care and concern. In contrast, the mothers who described their relationships as difficult had experienced such lack of initiative as a major difficulty, and as central to their feelings of depression. They felt it had been symptomatic of their partners' general failure to understand their lives as mothers. This particular aspect of the relationship had come to symbolize their wider 'marital' problems, because they had felt emotionally unsupported in other ways.

Despite their positive, supportive, and understanding relationships, these mothers had come to feel emotionally isolated from their partners. They explained that the emotional distance had resulted from their own withdrawal from these relationships. Celia said that "a lot of the time, I wouldn't *let* him help"; she explained this further:

> He's very supportive, and we've always been good friends ... but on the whole, I don't think he ever realized my true feelings about it all, because I was so good at creating this impression of coping, and I didn't really express how I really felt ... It was only when I was asked to give a talk ... at a befriending scheme ... it was the first time I sat down, and wrote down, sort of chronologically, what had happened ... and when I'd done it, Robert said to me that he'd like to read it, and it made him cry, 'cos he said ... 'I never knew how you felt' and he said ... 'Why didn't you say this before'.

They had felt constrained within these relationships in two ways. First, they had felt emotionally constrained. They had feared that in voicing their needs and feelings, they might burden their partners, or be misunderstood, rejected or morally condemned by them. They had also felt that having experienced neither motherhood, nor depression, their partners' understanding of their feelings would be limited.[22] Based on their fears and "projections", they had refrained even from attempting to seek out their partners' understanding:

> [My husband] was good, really, and I could tell him, it's just that I think he'd never been depressed, he didn't understand depression ... I think a lot of men are probably like that, because they don't even have to suffer with PMTs[23] like we do ... so I knew it was hard for him. So I mean he probably wasn't as understanding as someone that has been depressed would be, but I think he did what he tried ... He just sort of stood by me and put up with me. (Petra)

Second, the mothers had felt morally bound. They had not voiced their needs and feelings to their partners because they had believed they "should" neither need help, nor have ambivalent feelings, nor voice these needs and feelings to their partners.

These emotional and moral dimensions to the mothers' silence and withdrawal within their relationships with partners, and others, are issues which I discuss in detail in Chapter Five. Here, I want to make the point that the depressed mothers' sense of isolation and disconnection was not necessarily a product of unsupportive relationships; rather, it had resulted from their withdrawal from these relationships.

---

22 According to all 18 mothers' accounts, none of their partners had experienced depression.

23 Premenstrual tension.

2. Difficult relationships with male partners

The eight mothers with difficult relationships with male partners felt the latter had failed to offer help. The mothers believed their partners had expected that they would take full responsibility for household and childcare activities. They also felt their partners had failed to respond to their requests for practical help, and to their attempts at voicing their ambivalent feelings. If their partners had responded, the mothers regarded their help as having been given on their partners' terms only. They had also felt their partners' had been critical rather than comforting. Feeling emotionally wounded, rejected and silenced, the mothers had then withdrawn from these relationships. Helen, who was still depressed at the time of the interview, explained:

> Simon (her partner) has never had Ben (their child) for a whole day on his own, never ... out of choice. In the early days, he said, 'We're paying so much for this nursery place ... he can go to nursery'. My own feeling is that I actually *want* to spend more time with Ben, so if I had a day off during the week ... I'd spend it with Ben ... I have suggested it but there becomes a point where it's not actually worth discussing it any longer, and it's something that I want Simon to have but Simon doesn't want to have it with Ben ... It amazes me ...this child that we both wanted and he actually doesn't want to spend any time [with him].

In addition to this emotional dimension to their silence and withdrawal, there had been a moral issue similar to that described by the mothers with positive relationships. Mothers with difficult relationships also spoke about having felt morally constrained in continuing to voice their needs and feelings. They had believed they "should" neither need help, nor have difficult feelings about motherhood, nor express their needs and feelings to their partners, and these moral beliefs had been reinforced within these difficult relationships.

Chapters Four and Five discuss the mothers' experiences of difficult relationships, with partners and others. I leave full documentation of the points made above to these chapters. What I emphasize here, is how, in response to what they experienced as rejection and condemnation, the mothers' had withdrawn from their relationships.

3. Conclusion

Irrespective of how supported the mothers had felt, they described having removed themselves from their relationships. The mothers had taken different routes to do so. Whether supported or not, there had been emotional and moral dimensions to their silence, but there were differences within these. The mothers with difficult relationships had felt

isolated from their partners because they had attempted to voice their needs and feelings, but had felt silenced and rejected. This had led them to withdraw from their partners. The mothers with positive relationships had felt disconnected from their partners because they had been unwilling and unable to voice their needs and feelings at all, for fear of burdening their partners, being misunderstood, rejected or morally condemned. I have discussed the mothers' relationships with their male partners to illustrate the different routes the mothers took to this silence and withdrawal. In the following two chapters, I describe analogous processes within the mothers' relationships with other individuals in their lives.

To summarize the discussion so far: my findings show that physical isolation, and unsupportive relationships, contributed to, but could not fully explain, the mothers' depression. An additional process, in which the mothers had actively withdrawn from their relationships, was common to all mothers in my study and accounted for their depression. Indeed, the mothers *themselves* explained that neither physical isolation nor unsupportive relationships had been at the *root* of their depression:

> My parents and my in-laws were ever so good, they'd come round, they didn't understand at all ... but they were just kind. None of them sort of said 'Snap out of it' ... My husband was being ever so good ... I was lucky I had the support of my husband ... Nobody told me to pull myself together, I was lucky like that, I was waiting for it all the time, but everyone around me was ever so kind ... I weren't in the type of situation where I've heard from others that ... they're either on their own, or sort of had really unsympathetic people around them. (Vera)

III. Postnatal depression and silencing the self

In her American study of women's experiences of depression, Jack (1991) documented a process similar to the social withdrawal I have discussed above. She termed it 'silencing the self', and in this and following chapters, I will adopt her useful description of this process.

I now focus on the psychological processes of this silencing of the self. By 'psychological', I mean that which pertains to the 'psyche', and here I draw on Gilligan *et al.*'s (1990a: 87) articulation of what it means to have a 'psyche':

> ... Psyche - currently known as "the self", the modern heir to the soul, the sense of an I, the sense of a center of feeling, of consciousness, of being in life, of appearing, of taking part, of standing in human condition, of living in connection with others by virtue of having a common sense, or perhaps sensibility, or perhaps a common spirit - a breath, a wind, what once might have been called the hands of a living god?

Gilligan *et al.* (1990a: 87) stress that the psyche must be embedded "in body, relationships, and culture", and that "the self" must be understood in relation to others and society. In the ensuing discussion, I momentarily and artificially separate the psyche from this relational context, in order to focus attention on the depressed mothers' inner (mental) worlds, and to outline the psychological structure of depression common to the 18 mothers in my study.

1. Conflicting expectations and experiences

All the mothers described having faced a conflict between their expectations, and experiences, of themselves - that is, between what they had wanted to be, and what they had felt they were. They spoke about two critical types of conflict.

The first was described only by the 12 first-time mothers. They had encountered a mismatch between their highly idealized constructions, and their experiences, of motherhood - that is, between their expectations of themselves as mothers, their children, and their relationships to their children, and their actual experiences. Other authors have described this conflict as one between the 'ideal self' and the 'self' (Breen, 1975), or between the 'role' of mother and the experienced 'self' as mother (Attanucci, 1988; Willard, 1988). I examine this conflict in Chapter Four.

The second type of discrepancy was described by all 18 mothers, and concerned their expectations, and experiences, of themselves as 'coping' individuals. They had perceived themselves as women who had always "coped", and should be able to "cope", with situations. They had defined 'coping' as meeting their own needs single-handedly, without calling upon the help of partners, relatives, friends, or health professionals. Following the birth of the child after which they became depressed, they had felt unable to 'cope' and be self-sufficient in this way, and this experience had clashed with their expectations of themselves. The nature of this conflict, and how the mothers had contended with it, are issues I address in Chapter Five.

In writing about her own experience of postnatal depression after the birth of her second child, Vivienne Welburn (1980: 154) gives a good illustration of the differences between, and similarities within, the conflicts that first-time and subsequent mothers can experience:

> Whilst I don't see this internal idealized picture of the perfect mother as part of my own depression, I do believe the effect of false expectations can be devastating. I certainly expected myself to be able to cope with two children as easily as I had with one. In fact I expected more of myself as an 'experienced' mother than I had as an inexperienced one.

2. The two voices and divided self of depression

The mothers had experienced the conflict between their ideal, and actual, self as the hearing of two voices.[24] One voice had embodied their expectations, and the other their experiences, of themselves. Jack (1991: 95) has also documented the "inner dialogue" of depression in women, and Gilligan (1990: 509) has observed this "doubling of voice" in adolescent girls.

Jack (1991) gives a valuable analysis of these two voices. She points out that one voice, what she terms the voice of the "I" and of the "authentic self", is the voice that "speaks from experience, that knows from experience. The bases for its values and beliefs are empirical; they come from personal experience and observation" (1991: 94). This 'voice of experience' is countered, however, by an internalized moral voice, what Jack (1991: 94) has called the "Over-Eye". This voice, notes Jack (1991: 94),

> ... speaks with a moralistic, "objective", judgmental tone that relentlessly condemns the authentic self ... It says "one should, you can't, you ought, I should". It speaks to the self, and like the classical psychoanalytic concept of the superego, it has the feeling of something *over* the "I", which carries the power to judge it. Or like the object-relations notion of the false self, it conforms to outer imperatives and perceived expectations in order to gain approval and protect the true self.

Jack (1991: 94) also points out that:

> The Over-Eye carries a decidedly patriarchal flavour, both in its collective viewpoint about what is "good" and "right" for a woman and in its willingness to condemn her feelings when they depart from expected "shoulds".

This moral voice - which is expressed by the use of moral language such as "should", "ought", "must", "right", "wrong" and "bad" - carries the voice of social conventions, of what is expected of women and mothers (Gilligan, 1982).[25]

The internalized moral voice described by the mothers in my study had been informed by normative representations of women and mothers, and reflected the way in which individual mothers had constructed for themselves these cultural prescriptions. An

---

24 I use the term 'voice' in a literal way. The mothers described literally hearing two voices in their heads, as Marcia's vivid description in Chapter Five, page 149, illustrates.

25 The moral and condemnatory dimension to depression was noted by Freud (1925: 157), when he wrote: "In the clinical picture of melancholia, dissatisfaction with the self on moral grounds is far the most outstanding feature".

example of this moral voice comes from Sonya, who spoke about its domineering presence during her depression. She explained that, "in the illness, you're constantly thinking 'I shouldn't be here, I should be somewhere else'". She illustrated the moral and condemning nature of this voice in the following way:

> I'd be almost looking in the corners of the room, and thinking, 'God, it's dirty down there, I feel really depressed because there's a piece of fluff down there' ... I used to think, 'The kitchen floor is dirty, therefore I'm a terrible person, which goes to prove that ... I'm even worse than I thought I was', you know, you're *crucifying* yourself all the time ... When you're in the illness, everything is the end of the world - it's black and white, good and bad. 'You were bad, you didn't do the cooking right, you didn't socialize enough, you didn't make enough witty, sparkling conversation' ... As soon as someone's gone, you're saying to yourself, 'You're bad, you're bad, you didn't do this, you didn't do that', but why, why do you do this?

The mothers described having heard two voices, and two people, within their heads, carrying on a conversation. Sonya said the voices would "carry on ... in my mind", saying, "'If you'd been more relaxed, this wouldn't have happened. If you'd taken each day as it came, and didn't worry if Suzie made a mess, it wouldn't have happened ... Because you're an obsessional personality, this happened'". Sonya had felt "weighed down by all these stupid thoughts going through my mind". Similarly, Celia had found that "the hardest thing is because it's inside your head, and even when you close your eyes, it doesn't go away ... you can't escape it". Vera characterized the depression as having "such bad thoughts in my head" all the time.

The mothers also reported an inner conflict between two parts of the self, which was illustrated in the language they used. Marcia described the depression as "this constant battle going on in my head". Sonya defined it as "all this mental strife and fighting with yourself". Petra provided a striking account of this internal struggle:

> I often describe it as if you've been got by the devil ... dragging you down, and he was winning, and you'd be fighting it. 'Cos I used to try and put up a fight, and I used to try and make [my]self feel better, and yet he would always win, and he'd be taking over your whole body, and it's like you were being sort of *possessed* somehow, and this whole thing was taking you over and you were fighting like mad.

During the depression, the 'voice of experience' had capitulated to the moral voice. The mothers explained that they had felt unable and unwilling to "authorise" - "to lend authority to or take seriously" (Brown and Gilligan, 1993: 13) - their own experiences. They had constructed, and experienced, their relationships, and the culture in which they were living, in such a way that they had felt under pressure to withhold their true needs and feelings.

Indeed, the word "pressure" recurred within their accounts: "I felt under pressure", "I felt added pressure", "I'd put so many pressures on myself", they said. Psychologically, this pressure was experienced as one part of the self - represented by the moral voice - taking action against and suppressing the other part of the self - represented by the voice of experience. The presence, within the mothers' narratives, of the linguistic construction: "I (verb) myself", signalled this psychological process. The mothers spoke in the following ways: "I punish myself", "I did it to myself", "I forced myself ", "I wouldn't let myself", "I was pushing my[self]", "I was ... battling against myself", "I made myself". These expressions tell of the women's attempts to fit themselves into a mould provided by someone or something else. They also illustrate the *active* nature of this process in which one part of the self was 'pushing', 'forcing', and 'making' another, resisting, part of the self conform.

3. Silencing the self

Rather than validate and claim their own experiences and perspectives, the depressed mothers had buried this part of the self. They had silenced this 'authentic voice', and denied their own needs, both within themselves and in their relationships with others, including their children, partners, relatives, friends, other mothers with young children, and health professionals. It is important to point out that the internal silence within themselves, had gone hand in hand with their public silence. From a relational perspective, the self is known and experienced in relationship to others. By not voicing their thoughts and feelings, the mothers had come not to know and experience these thoughts and feelings (see Brown and Gilligan, 1992).

The language the mothers used to portray their feelings of depression told of how they had buried part of themselves. They spoke about feeling "lifeless", as if they had "died inside". The most striking way in which they conveyed this burial of part of themselves was in the common metaphor they drew upon when illustrating how it had *felt* to be depressed. It had felt like being enclosed in a dark and confining space, they said, such as "a tunnel", "a pit", "a cage", "a box", "a hole" or "a prison". They characterized the depression as a "dark hole", "a great big hole". It felt like "going deeper into the pit", they said. The women often used the word "black" to describe their feelings, suggestive of how dark this underground world felt to them. The depression had been a "black period" in their

lives, "total blackness", "straight feeling black", they explained.[26] Sophie gave one of the most graphic descriptions of how it feels to be depressed:

> *So what was it like when you were feeling depressed - I mean, how did you feel?*
> Despair really, you think you're just in this little tunnel and you can't find your way out. It is absolutely *horrible*, it really is ... I wanted my friends round me, but when they were around me, I didn't want them around ... You feel *so alone*, but then again I was making myself alone, if you know what I mean? I didn't want to mix with people and yet, at the same time, because I didn't want to mix with them, so they sort of kept away from me ... They weren't nasty or anything, but they sort of thought 'Oh well, leave her alone for a minute, she'll be alright'. I thought 'Oh they're rejecting me', so whatever they did wasn't right in my eyes, and I'm not normally like that, I'm normally a happy-go-lucky person, get on with most people.

Central to all 18 mothers' accounts of their depression was this inability and unwillingness to speak to others about the true nature of their experiences.[27] First-time and subsequent mothers alike said they had "bottled up" their feelings - "you just want to cocoon yourself away from the world", "lock yourself away" and "hide" how you feel, they said. They had voiced neither their thoughts, nor their feelings, nor their practical or emotional needs to people around them:

> I'm not a depressive personality ... I just feel that when I'm affected by this illness, I want to just hide away, and then when I hide away, it's even harder to say: 'Here I am folks, I've just not been in touch for a while'. (Sonya)

> Trouble is, you want to hide it ... you want to keep it to the back of your mind really. I think you don't want to actually admit to *anybody* how you're feeling ... There's something inside you not actually wanting to admit that you feel like it. (Frances)

The silencing of the self had been characterized by their attempts to suppress the voice of the "I" within themselves, which had left them feeling alienated from themselves and their own needs:

> I was always very remote from myself. I could see this person ... I could see myself not being able to deal with it ... I was constantly telling myself to pull my socks up, and stop being so bloody silly, but it didn't actually work. I couldn't pull my socks up and I couldn't make myself. (Marcia)

---

26 Relational psychologists have noted that women depict their experience of relational disconnection in such terms (e.g. Stiver and Miller, 1988; Surrey, 1987). Surrey (1987: 6), for example, writes that "When an important relational context cannot enlarge to allow for mutual experience and the movement of dialogue, women feel disempowered. If the connection feels severed there can be a sense of deadness, blackness, and even terror; some have described this experience as a 'black hole' ".

27 As is clear from the interview material presented in this and following chapters, the mothers described feeling *both* unable *and* unwilling to voice their needs and feelings to others. As Dawn said: "I just *couldn't*, just didn't *want* to tell anyone" (emphasis added).

The mothers also described a division between their internal and external worlds, and here they spoke about withholding how they had felt "inside", from the "outside" world:

> I can act if you like, I can appear okay to the outside, even though ... I feel terrible inside ... If I had been out with a group of friends and I'd been able to convince them that I was alright ... it took such a toll on me, I'd come home and collapse, because I was acting a role out *so much.* (Sonya)

> It's like when you're in a dream, and you can see everything happening, and you can see yourself in it playing a part, and yet you're looking down on it, you're not really there, you're not really in control of it all. (Celia)

Other authors have also noted that depressed individuals hide and silence the 'true self' (Miller, 1987), the 'real me' (Nairne and Smith, 1984), the 'inner' self (Laing, 1965) and the 'authentic self' (Jack, 1991).

At the time of the interview, the mothers were aware that their silence and withdrawal had been the root of their depression. Frances recognized that "half the problem" had been not talking about her feelings, and she explained that, had she done so, she would have "got over it a lot better":

> This is what's so funny about postnatal[28] ... you don't want to show it ... and I think that's half the problem ... I didn't want to broadcast it, perhaps if I'd broadcast it, perhaps I'd have got over it a lot better ... So I think that it would be a good idea if people were made more aware of the fact that if they felt that they were even just feeling a little odd ... in their feelings ... that the best thing to do is to talk about it straight away ... and not to worry about it ... I'm sure that if people were only aware of the situation, to talk about how they feel, and not to feel stupid ... whatever their fears or anxieties were, I'm sure that there'd be a lot less problems in the end.

Many mothers also said the key "turning point" which had brought about their journey out of depression had been opening themselves up to another person, and sharing the feelings they had kept buried.[29] Penny explained:

> I never told anybody any of this, and then I told my friend ... We had a real heart to heart, and it was when I told my friend that that's when I started feeling better, when we had a heart to heart.

There are a number of further points to highlight at this stage. First, as discussed above, the mothers' silence and withdrawal had occurred within a range of relationships,

---

28 Throughout her interview, Frances referred to postnatal depression as 'postnatal'.

29 The links between speaking their thoughts and feelings, and the mothers' movement out of depression are further discussed in Chapter Six.

including those with partners, relatives, friends, other mothers, as well as in their encounters with health professionals. As I discuss in Chapter Four, the mothers had also removed themselves from their relationships with their children, by prioritizing the latter's needs at the expense of their own. The nature of the mothers' relationships varied depending on the degree of emotional closeness, and so the precise reasons for withdrawing from these relationships had also varied across different relationships.

Second, it is unclear whether the mothers had felt they could speak to no-one, or only certain individuals. They all said they had believed there was "nobody" to talk to, and "everybody" had abandoned them. However, as I documented above, depression is a condition in which the individual *feels* totally isolated and abandoned, even though she herself might also point out that this is not necessarily the case. Furthermore, the retrospective nature of my study made it difficult to ascertain the extent of their silence and withdrawal during the depression, and this question will require clarification in future research.

Third, my study shows that all 18 depressed mothers had felt unable and unwilling to voice their needs and feelings within at least one of what they described as 'close' and important relationships (e.g. partners, mothers, mothers-in-law, other relatives described as close, or close friends).[30]

Finally, it is likely that the nature of the mothers' withdrawal from social contact had changed over time, and over the course of the depression. In the early part of the depression, they might have spoken to several people, 'checking out' their thoughts and feelings with others, and then gradually withdrawn further and further. Given the retrospective design of my study, again this question could not be addressed directly. Two findings, however, support the idea of the mothers' social withdrawal being a gradual process. First, as I discuss in the following chapter, the first-time mothers had initially revealed their ambivalent feelings to other mothers with young children. Feeling that their experiences were not shared by other mothers, they had gradually withdrawn from further contact with these women. This withdrawal appears to have been followed by a generalized sense of isolation, which the mothers associated with the onset of their depression. Second, in Chapter Six, I discuss how, as the mothers emerged from the depression, they

30 It is possible that all 18 mothers also felt unable and unwilling to speak to other mothers of young children, specifically. This question was not directly asked of the women because it emerged out of my analysis of the data. However, 16 of the 18 mothers explicitly said they had felt reluctant to talk to other mothers. The two other women did not state this explicitly, but nor did they say that they *had* spoken to other mothers. It would be interesting to explore this issue in future research.

seemed to have gradually spoken to more and more individuals. This would also support the idea that social withdrawal was a gradual process.

4. The paralysis of depression

The mothers described the psychological experience of two parts of the self in constant conflict as two opposing forces that had paralysed them.[31] They had felt too "numb" to move out of the pit in which they had found themselves, because the depression "takes your will away". They had felt "paralysed", "imprisoned" and "stuck" within this dark space:

> When you're in the worst part of this thing, you're almost paralysed ... it's like in one of the books I read recently, it says, when you have a baby, it's like a bank of sand has been deposited outside your front door ... and the ones that have settled down with their babies then burrow out through this sand ... I thought that described very well the postnatal depression; it was like ... there were sand banks on each door, and even though I knew I could open them and walk out, I didn't. (Sonya)

> When you're depressed, it's one thing you can't do, and that's the trouble, you can't keep in contact with people ... You want people to ring you, and you want people to come to you, to show they care, but there's no way that you can go to them. (Petra)

This paralysis had underpinned their reluctance to seek help from others, and voice their feelings. Although a part of them had wanted to reach out to others, another part had felt unable and unwilling to make this move.

5. Depression and fear

The theme of 'fear' also recurred within the mothers' accounts. They had feared that in voicing their needs and feelings, they might harm others or themselves:

> It feels like being in a box really, too frightened to open the lid. Everything I did I thought, 'Should I do that, should I not do that', indecisive, *fear, total fear* the whole time of what's going to go wrong today. It's a very, very odd feeling of being frightened continuously ... frightened to do anything. (Frances)

As I discuss in Chapters Four and Five, the mothers had feared that in expressing their own needs and feelings, they would burden their partners, mothers, relatives and

---

31 Paralysis and the inhibition of action is a characteristic sign of depression (Beck, 1967; Jordan, 1992; Kaplan, 1984; Seligman, 1975).

friends, or damage their children. They had also feared that in admitting their feelings, they might be rejected and condemned for being 'bad' mothers.

6. The vicious circle of depression

The mothers' silence and withdrawal had resulted in a vicious circle. The kinds of relationships they had wanted and needed were ones in which they *could* speak, in the knowledge that their voices would be heard, and they would be accepted for whom they were. They had been aware that relationships in which vulnerability can be shared offer the potential for emotional closeness and psychological health. They had also feared, however, that in revealing their vulnerability they might not be listened to, and they might be rejected or morally condemned. The double potential of relationships both to harm and foster growth has been described by Gilligan (1988a: v):

> The vulnerability or openness of people to one another enables people to wound one another and also creates a powerful channel for help. Such openness, thus, is both a mark of human frailty and a source of human strength.

The mothers' fear had paralysed them, and they had therefore not created the very relational context which they had known was key to their movement out of depression. Consequently, although some had been aware of their "supportive" and understanding relationships, they said they had not *felt* supported because they had not revealed their feelings:

> I didn't have any support ... none at all, because ... I didn't tell anybody ... If somebody had known, I would have got support and I wouldn't have felt so poorly. But ... because nobody knew, I mean they were supporting me as friends, as family, supportive of me in who I am, but not supportive because they knew I had postnatal depression. (Celia)

A relationship could only *feel* supportive - and be a 'real' relationship - if both parties were able or prepared to reveal the 'true' nature of their thoughts and feelings, they said. An emotionally enhancing relationship was one in which there could be "a heart to heart", as Penny said - that is, where heart meets heart.

7. The hopelessness of depression

As the mothers had withdrawn further and further from their relationships, they had felt increasingly hopeless about being able to speak to others in an open and honest way. Gilligan (1990: 511) has written that "what is unvoiced, because it is out of relationship,

tends to get out of perspective and to dominate psychic life", and this 'psychological truth' is key to understanding the experiences of these depressed mothers. Silence and withdrawal had characterized their depression. As their thoughts and feelings had remained unvoiced, they had come to feel that these feelings were more and more "terrible", and more and more unspeakable. They had withdrawn further and further, as their sense of hopelessness at being able to have genuine or open relationships had increased. Their use of words such as "everybody" and "nobody" tell of this sense of despair:

> I thought ... 'God I haven't got anybody, I'm having to cope with this all on my own' ... At the time, there was really nobody, d'you see what I mean? They were just friends that came round, they weren't necessarily anybody I could talk to ... nobody that was close ... that knew about anything. (Tina)

> I felt let down by *everybody* ... Nobody listens to you, that's the trouble, nobody wants to know, you can't really sort of sit and tell people what it's like or what's happened or how you're feeling, 'cos you know they're not listening or they talk about themselves. (Petra)

The mothers had *felt* abandoned by "everybody", with "nobody" to talk to, even though, at the time, they had also *known* they were surrounded by relatives, partners and friends, many of whom had been supportive and understanding individuals.[32]

8. Depression: a particular way of perceiving the world

The point made above indicates how, during the depression, the mothers had constructed and experienced their cultural context and interpersonal relationships in specific ways. As Gilligan (1988b: xxiii) has pointed out:

> The self, when conceived as a narrator of moral conflict or as a protagonist in a moral drama, also chooses, consciously or unconsciously, where to stand, what signs to look for, and what voices to listen to in thinking about what is happening (what is the problem) and what to do.

Indeed, the mothers explained that part of their depression had been that they were perceiving their world in a particular way, that was often out of perspective to the reality of the situation. Marcia, who became depressed after her second child, said: "everything was a hundred times life size ... that's the best way I can describe it". Sonya explained that, "your brain decides to bring on ... 'the world is against you' type of feelings", and that, although "that reality is only mine ... you can't convince me that it is". Sophie similarly pointed out that, during the depression, "whatever [my friends] did wasn't right in my

---

32 Futility and hopelessness characterize the experience of depression in general (Jack, 1991; Miller, 1987; Nairne and Smith, 1984; Rowe, 1983).

eyes, and I'm not normally like that". Sandra said: "I was just working on my own perception of what I should do and what I should be". She also explained how aware she had been that this perception was a "personal" one that, she knew, was not necessarily shared by others:

> [My daughter] throws tantrums ... I think, 'That's your own personal perception', if you ask, it'll be 'Oh well, she's two and a half, of course she's gonna sit in the middle of the room and scream and hit me, that's what two and a half year olds do'. And you think 'Well my two and a half year old shouldn't do that. If I was a good mum, they wouldn't'.

Sonya similarly explained that even though part of her had known that her friends would not reject her if she revealed her feelings to them, another part believed they would, and this had been why she had felt "imprisoned in my own prison":

> When we went to the [NCT] one year birthday party, all the babies were one ... Angela, whose garden it was, stood up and said ... 'We've all made it, we've all got through somehow and ... none of us has had any PND[33]' ... and I thought 'God, I wonder what they would think if they knew'. They would probably be very supportive, I mean they're not going to say to me 'Never come to one of our coffee mornings ever again', are they?

Thus, during the depression, the mothers had constructed and perceived their relationships to themselves, to others and to the culture through a particular lens. This way of seeing the world had accounted for much of their depression. Indeed, their move out of depression was linked to a shift in these perceptions of themselves, others and society (see Chapter Six).

IV. Concluding discussion

While existing research has recognized the importance of interpersonal relationships in postnatal depression, there are major differences between this work and the findings presented in this chapter.

Based on the 18 depressed mothers' accounts, I argue that the relational disconnection documented above constituted the essence of their depression, and not one factor amongst many others that is correlated with depression, as current research proposes. As I discuss in greater detail in Chapter Five, I suggest that the mothers' depression had resulted from their feeling disconnected from themselves and others.

---

33 Postnatal depression.

I have also shown that this sense of relational disconnection was distinct from, and characterized by more than, either physical isolation, or unsupportive relationships; it was primarily a product of the depressed mothers' withdrawal from their relationships. The mothers had withdrawn, either in response to what they had experienced as rejection and moral condemnation by others; or, in order to avoid possible rejection and condemnation.

The conceptualization I put forward differs from existing research, because it highlights the active nature of the self and the two-way nature of relationships. Existing explanations of the role of interpersonal relationships in postnatal depression assume a unidirectional model of relationships. The 'social factors' studies reviewed above, emphasize the *lack* of practical and emotional support, as does feminist research. Nicolson (1989: 129) notes "a remarkable *lack of support* from health visitors, relatives and partners". Similarly, Romito (1989: 1441) states that "although the experience of early motherhood is certainly influenced by many factors, the help a woman *receives* following childbirth seems the most important of all" (emphasis added).

Relational psychology posits an active construction of the self, and a bidirectional conceptualization of relationships. This aspect of their work has been particularly valuable, and relevant, to my study. These theorists point out that, although psychoanalytic literature (e.g. Freud, 1925; Kohut, 1971), and what I have have termed 'social factors' studies (e.g. Belle, 1982; Brown and Harris, 1978), maintain that interpersonal factors play a key role in depression, their emphasis remains unidirectional (Jordan, 1992; Kaplan, 1984). It is "the loss of something that would be given to the individual" (Kaplan, 1984: 7), and "the need to *receive* support" (Jordan, 1992: 5), which are most often cited in this literature.

In contrast, a relational perspective emphasizes not so much "the one-way loss from the so-called giver to the so-called receiver", but rather "a two-way mutual process" (Kaplan, 1984: 7). Depression occurs because women feel they lose the *opportunity to participate* in an authentic relationship, rather than simply because they lose something that would be *provided* by the other person (Kaplan, 1984). Jack (1991: 16) points out that "according to the relational point of view, depression arises from the inability to make or sustain supportive, authentic connection with a loved person". 'Authentic', mutual' or 'real' relationships are defined as relationships in which both parties can be true to themselves and express the full range of their thoughts and feelings without fear of hurting the other person. *Both* parties speak honestly and openly about their experiences, and if a situation of conflict arises, they 'stay with each other', and with their feelings, rather than walk away from the conflict and from the other (Gilligan *et al.*, 1988; Surrey, 1985; Jordan, 1992). Conversely, "inauthentic" relationships are ones in which individuals are

"adopting roles and coming from distanced and protected places" (Jordan, 1992: 4). When individuals feel they cannot connect to others in such an authentic way, they withdraw from their relationships, and can become depressed:

> In a major depression, a veil of numbness settles over the self to form an invisible shroud that separates one from others. Ashamed of the authentic self and condemning its past actions and future prospects, depressed women withdraw from social contact. (Jack, 1991: 128)

In this chapter, I have similarly demonstrated that, passive constructions of the individual and, one-way conceptualizations of relationships, fail to capture the underlying essence of the depressed mothers' experiences - namely, their own active withdrawal from their relationships. In moving beyond current theories, I therefore join a number of relational psychologists who have argued that many of the psychological problems experienced by young girls', women and mothers arise out of the experience of what Brown and Gilligan (1993: 11) have termed "a relational impasse or crisis of connection" - that is, a failure to connect to another person in an 'authentic' way (Attanucci, 1988; Brown and Gilligan, 1992, 1993; Jack, 1991; Jordan, 1992; Kaplan, 1984; Steiner-Adair, 1990; Stiver and Miller, 1988; Willard, 1988).

Furthermore, the findings presented in this chapter shed light on an issue which is often raised in research on the role of interpersonal relationships in mental health which is that of causality (e.g. Cox, 1988b; Kumar and Robson, 1984; Mueller, 1980; O'Hara, 1986; Watson *et al.*,1984). These studies ask the question: do the quality of the individual's relationships, and her social network characteristics, *precede* psychological problems, suggesting that social support and networks are involved in the *onset* of the depression; or, are social support and network characteristics a *result* of psychological difficulties. My study shows that relationships and feelings of psychological well-being cannot be separated in such a way, and must be understood in terms of on-going interactions, rather than in terms of causal links. The depressed mothers were perceiving and constructing their worlds, including their relationships, in particular ways, which they knew were not necessarily representative of external reality. Based on these beliefs, they had withdrawn from their relationships, irrespective of their quantity or quality. This suggests a complex relationship between relationships and depression. The problem with asking such a question about causality is that it presupposes that the quality of relationships is an objective fact, which can be objectively assessed, and delineated from the depression. However, I have demonstrated that the mothers' depression reflects their subjective experiences, not the objective quality, of these relationships.

In this chapter, I have focussed on the common and underlying psychological process of postnatal depression - that is, the mothers' social withdrawal and consequent sense of relational disconnection from themselves and others. Here, I have distinguished it from the experience of physical isolation, and unsupportive relationships. The following two chapters explore why and how the mothers in my study had withdrawn from their relationships during their depression.

In Chapter Four, I focus on the 12 first-time mothers in my study. Unlike the subsequent mothers, these women had held idealized and unrealistic expectations of motherhood *per se*, which had conflicted with their own experiences of mothering their particular child. I discuss how these mothers had resolved this conflict by removing themselves from their relationships with their children. Their attempts to conform to normative constructions of the 'good' and selfless mother had led them to prioritize their children's needs at the expense of their own. As they had excluded their own feelings from their relationships with their children, they had come to feel disconnected from themselves, their children, and others, and became depressed. In this chapter, I also examine how both the cultural context, and the mothers' relationships with partners, mothers, mothers-in-law, other mothers of young children and health professionals had facilitated this move.

In Chapter Five, I describe a set of processes common to all 18 mothers in my sample. I discuss how these mothers' perceptions of themselves as self-reliant women had clashed with their difficulties in coping single-handedly, following the birth of the child after which they had become depressed. I point out how, in resolving this conflict, the mothers had withdrawn their needs and feelings from their relationships with significant others (apart from the children), such as partners, their own mothers and their mothers-in-law. They had silenced their voices either because they had called upon others for support and had felt rejected and condemned; and/or in order to avoid possible rejection and condemnation. I also discuss how the cultural context had contributed to the mothers' withdrawal from social contact. In this chapter, I examine in greater detail the ways in which disconnection from the self and others leads to depression.

Chapter Four

The First-Time Mothers' Constructions and Experiences of Themselves and Their Children

Chapter Four

The First-Time Mothers' Constructions and Experiences of Themselves and Their Children

> I think the trouble was, in one way ... what took over was I put so much into [my daughter] and had so little for myself, and it became an obsession ... Once I could look after her, only I could do things. I wouldn't let anybody else. (Celia)

Introduction

In the previous chapter, I argued that the experience of postnatal depression was characterized by the mothers' silence and withdrawal from their relationships. In this and the following chapter, I explore how these processes were embedded within the context of the society in which the mothers were living, and the particular relationships in which they were involved.

Before doing so, it is critical to point out that there were important differences between mothers who had become depressed following the birth of a first child, and those who had become depressed after a second or third baby. While all the mothers described withholding their thoughts and feelings from significant others (e.g. partners and mothers), other mothers with young children and health professionals, only the first-time mothers described removing their needs and feelings from their relationships with their children. Only they had felt under pressure to live up to normative and idealized representations of 'the' mother-child relationship, in which the mother must remove her self in order to care for her child in a self*less* way.

Indeed, it is in the transition to motherhood that a woman first becomes fully aware of, and sensitive to, the "interpretive schemes of the culture" (Gilligan, 1988b: xxiii), and to social norms and expectations of mothers. These come to impinge on her thinking, perception and judgement in a more direct way, defining within the context of a given society what is 'the right way' for a mother to feel, think and behave. As Jack (1991: 187) points out, with the birth of a first child, "a woman encounters the commands of the authorities telling her what she must do to be a perfect mother in their eyes".

By the time the subsequent mothers had had their second or third baby, their mothering of this child had been informed not by cultural ideals, but by their own experiences of having mothered a previous child. They knew from their own and other

mothers' experiences that there was no such thing as 'the perfect mother' or 'the perfect child', and that all mothers are different, as are all children. It is important to emphasize these differences between first-time and subsequent mothers for they highlight the fact that the *transition* to motherhood is not necessarily problematic for women, as the six subsequent mothers in my study had found. The fact that these mothers had not experienced depression as a result of *becoming* a mother suggests that postnatal depression involves more than simply the ideological and structural changes, or personal losses, that can accompany first-time motherhood, changes and losses which many researchers have stressed as central to postnatal depression (see Chapter One).

Chapter Five explores the common features of the first-time and subsequent mothers' experiences of depression. In this chapter, I focus on a set of issues that were expressed predominantly by the first-time mothers, and I have indicated the few instances where the subsequent mothers also spoke upon these issues. I examine the first-time mothers' constructions and experiences of themselves as mothers, of their children, and of their relationships to their children. I show how the conflict between their constructions and experiences had led them to remove their feelings and needs from these relationships, in an attempt to be 'good', selfless mothers. I also illustrate how the mothers' withdrawal had been facilitated by cultural constructions of motherhood, and by the mothers' relationships and encounters with other individuals.

I have structured this chapter in four parts. First, I briefly outline ideas about the social construction of motherhood. By drawing on analyses of the childcare advice literature, and of popular media images of mothers and babies, I discuss current normative representations of motherhood. I indicate that, while there is still a tendency to portray mothers, children and relationships between them in monolithic and prescriptive ways, 'alternative' scripts are now more widely available for mothers to 'draw upon'.

The second part of the chapter documents how the first-time mothers in my study constructed their own individual versions of what it means to be a 'good' mother, highlighting how their interpretations had been *informed*, but not *determined*, by cultural representations of motherhood. The individual nature of these interpretations meant that there were differences *amongst* the first-time mothers' constructions. However, these constructions shared three common characteristics: they were all idealized, moral and monolithic ones.

In the third section, I explore the conflict the mothers encountered between their highly idealized and monolithic expectations of motherhood, and their own experiences of

mothering their particular child. I discuss how the mothers' resolution of this conflict had involved their removing themselves from their relationships with their children. I examine how this process led the mothers to feel alienated from themselves and others, and how this was linked to their feelings of depression. I also explore how the mothers' exclusion of their own needs in caring for their children had been facilitated by their interpersonal relationships, and by the cultural context. In particular, I discuss how the notion that mothers who fall short of normative definitions of 'good' mothering damage their children, or have them taken away and put into care, acted as a powerful sanction against the expression of negative or ambivalent feelings by mothers.

I conclude with a discussion of my findings, and point out where these move beyond current conceptualizations of postnatal depression.

I. Conflicting social constructions of motherhood and mothering

Before examining the mothers' accounts, it is important to highlight the cultural framework within which these women experienced motherhood and their depression. In considering the 'institution' of motherhood (Rich, 1986), I am more concerned with its ideological, than its structural, dimensions. Structural constraints on women's lives as mothers are extremely important, and their role in postnatal depression has been well documented (e.g. Oakley, 1980; Romito, 1990a). However, the ideological context, and the ways in which mothers interpret, negotiate and/or resist ideologies, have received less sustained attention in research on postnatal depression, and for these reasons, I shall restrict myself to a detailed consideration of this context.

Social constructions of motherhood are both historically (Urwin, 1985) and culturally (Kitzinger, 1978) specific. Within our society, dominant definitions of motherhood specify who are the 'right' people to have children, with regard to marital status (Busfield, 1974; Macintyre, 1976) and age (Berryman, 1991; Busfield, 1974; Phoenix, 1991a, 1991b); what are the 'right' or ideal circumstances in which to have and rear children - that is, within the context of a heterosexual nuclear family in which the father is employed outside the home and the mother looks after the children (Phoenix and Woollett, 1991b; Marshall, 1991); and what is 'the right way' to mother a child (Marshall, 1991; Oakley, 1986c; Willard, 1988).

It is these latter "ideologies"[1] (Phoenix and Woollett, 1991a: 5; see also Brannen and Moss, 1991; Wearing, 1984) or "cultural scripts"[2] (Willard, 1988: 225) of motherhood that are of interest here. Women are exposed to these varying definitions of 'the ideal mother' through the media (Holland, 1992), the childcare advice literature (Hardyment, 1983; Marshall, 1991; Urwin, 1985), the attitudes and practices of health professionals (Macintyre, 1976; Mayall and Foster, 1989; Phoenix and Woollett, 1991b; Oakley, 1981a; Urwin, 1985), antenatal classes (Combes and Schonveld, 1992), 'voluntary sector' associations for parents and parents-to-be such as the National Childbirth Trust, and family, friends, neighbours and work colleagues (Lewis, 1991). Over the last two decades, views about what it means to be a 'good' mother have become increasingly varied, and at times contradictory (Hardyment, 1983; Marshall, 1991; Richardson, 1993; Willard, 1988). While there has been a rise in 'professionalism' in the area of childcare and development, in which motherhood has been increasingly claimed as an area of expertise by, often male medical, 'experts' (Antonis, 1981; Marshall, 1991; Phoenix and Woollett, 1991a), there has been a concomitant emphasis on the notion that each 'mother knows best' what is 'right' for her child.

Mothers today are faced with diverse and conflicting advice in which strong normative prescriptions about 'the right way' to be a 'good' mother still prevail, while a flexible approach to childcare has increasingly been advocated (Marshall, 1991). 'Flexible', 'realistic', 'sympathetic' and 'sensitive' approaches to parenting are now put forward within much of the childcare advice literature, and the "manuals state that flexibility in approach is perfectly satisfactory" (Marshall, 1991: 72; see also Richardson, 1993). "The Flexibility account", notes Marshall (1991: 73), "states that women can mother in many varied and satisfactory ways and that there is not *one* right way within the context of a loving and caring relationship".

Nonetheless, the childcare manuals also appear to "clearly ... lay down prescriptions for how mothers should behave towards their babies" (Marshall, 1991: 72), suggesting that there are "certain 'rules' that a good mother should follow" (Marshall, 1991: 73; see also Hardyment, 1983; Richardson, 1993). There is "an implied 'right way of doing things' known only to the experts" (Antonis, 1981: 70), which sets certain moral standards to be followed (Bradley, 1989; Urwin, 1985). As Phoenix and Woollett (1991a: 2) point out, within these texts, "the phrases 'the mother' and 'the child' reflect the

---

1 Phoenix and Woollett (1991a: 5) define these "ideologies" as helping to "construct what motherhood is considered to be and hence circumscribe the range of practices that mothers seek to employ with their children".

2 Willard (1988: 225) defines "cultural scripts" for motherhood as the "messages from the culture about the "right way" to be a mother".

tendency to view motherhood and childhood as homogeneously universal categories", and therefore in monolithic terms. Mothers are thus encouraged to turn to the expert and to their advice as their model of good practice (Holland, 1992; Marshall, 1991; Oakley, 1981a; Woollett and Phoenix, 1991b).

I now consider eight specific themes within cultural constructions of mothers and babies, the themes which the first-time mothers in my study most often drew upon.

1. The child's 'normal' development lies in the mother's hands

Phoenix and Woollett (1991b: 14) note that within "normative social constructions of 'good/normal' mothers ... it is mothers who are seen to have the responsibility of ensuring that their children 'turn out right'". It is the mother who is regarded as responsible for her child's behaviour and 'normal' psychological development (Marshall, 1991; Richardson, 1993). A mother guarantees that her child is a 'well-adjusted' individual by being present with her child 24 hours each day and by providing 'stimulating' and 'attentive' company, and a safe and secure emotional environment (Marshall, 1991; Urwin, 1985).

If her child's development is not 'normal', the blame falls on the mother (Bradley, 1989; Marshall, 1991). As Urwin (1985) points out, it is assumed that bad parenting results in amoral, undisciplined, maladjusted delinquents, which in turn lead to social ills which can then be blamed on the individual mother.

2. Motherhood as 'ultimate fulfilment'

A second theme which can be detected in both the childcare advice literature (Marshall, 1991; Richardson, 1993) and in popular media images (Holland, 1992), is that motherhood should be a naturally rewarding and fulfilling experience (see also Bradley, 1991). As Marshall (1991: 68) notes:

> One of the key accounts emerging from study of the manuals is the description and evaluation of motherhood as satisfying and important. The experience of childbirth, having a newborn baby and the process of childcare are all described in exalted terms ... The end result is ultimate fulfilment for women which can be gained in no other way.

tendency to view motherhood and childhood as homogeneously universal categories", and therefore in monolithic terms. Mothers are thus encouraged to turn to the expert and to their advice as their model of good practice (Holland, 1992; Marshall, 1991; Oakley, 1981a; Woollett and Phoenix, 1991b).

I now consider eight specific themes within cultural constructions of mothers and babies, the themes which the first-time mothers in my study most often drew upon.

1. The child's 'normal' development lies in the mother's hands

Phoenix and Woollett (1991b: 14) note that within "normative social constructions of 'good/normal' mothers ... it is mothers who are seen to have the responsibility of ensuring that their children 'turn out right'". It is the mother who is regarded as responsible for her child's behaviour and 'normal' psychological development (Marshall, 1991; Richardson, 1993). A mother guarantees that her child is a 'well-adjusted' individual by being present with her child 24 hours each day and by providing 'stimulating' and 'attentive' company, and a safe and secure emotional environment (Marshall, 1991; Urwin, 1985).

If her child's development is not 'normal', the blame falls on the mother (Bradley, 1989; Marshall, 1991). As Urwin (1985) points out, it is assumed that bad parenting results in amoral, undisciplined, maladjusted delinquents, which in turn lead to social ills which can then be blamed on the individual mother.

2. Motherhood as 'ultimate fulfilment'

A second theme which can be detected in both the childcare advice literature (Marshall, 1991; Richardson, 1993) and in popular media images (Holland, 1992), is that motherhood should be a naturally rewarding and fulfilling experience (see also Bradley, 1991). As Marshall (1991: 68) notes:

> One of the key accounts emerging from study of the manuals is the description and evaluation of motherhood as satisfying and important. The experience of childbirth, having a newborn baby and the process of childcare are all described in exalted terms ... The end result is ultimate fulfilment for women which can be gained in no other way.

3. How to give birth

Cultural representations of birth appear to be mixed, with birth being presented both as a "painful, dangerous and often disastrous" experience (Beech, 1992: 153), and as a harmonious event in which its "turbulence ... is rarely glimpsed in the iconography of babyhood" (Holland, 1992: 27).

Several messages prevail about 'the right way' to give birth. On the one hand, Beech (1992: 154) notes that the media "will invariably question and dismiss critical views of users but appear to accept unquestioningly the medical point of view". On the other hand, pressure groups working in maternity care have achieved enormous success and popularity. Changes have been brought about by individuals, such as Sheila Kitzinger (1972, 1979), Ann Oakley (1979) and Wendy Savage (1986), and by groups such as the Association for Improvements of Maternity Services (AIMS) and the National Childbirth Trust (NCT).[3] Women's health groups and pressure groups have contributed towards informing and empowering women in their relationships with the providers of maternity services. In doing so, they have "helped to change women's expectations and understandings of pregnancy and labour" (Kitzinger, 1990: 112), by emphasizing notions of choice and control in childbirth, and by challenging the wisdom of many medical treatments (Durward and Evans, 1990; Kitzinger, 1990).

4. Is 'breast best'?

According to the advice given by professionals (Antonis, 1981; Oakley, 1993), and childcare manuals (Marshall, 1991; Richardson, 1993), and according to popular imagery of babyhood (Holland, 1992), the message that 'breast is best' appears to be loud and clear, while "the bottle enters ... very much as second best" (Holland, 1992: 32).

5. Mother love and mothering as 'instinctive'

The 'maternal instinct' is socially constructed as the 'natural' and 'instinctive' love that a mother feels, or should feel, for her child (Badinter, 1981; Marshall, 1991).[4] It is characterized as 'natural' and 'taken for granted' that mothers feel love for their children, not necessarily at once, but in time (Marshall, 1991).[5]

---

3 See Durward and Evans (1990) for a discussion of voluntary sector 'pressure groups' working towards improving services for parents-to-be, new parents, and new-born babies.

4 The term 'maternal instinct' is also taken to mean that a mother knows instinctively how to care for her child, and that women have a 'natural' and 'instinctive' desire to have children (Richardson, 1993).

5 See Badinter (1981) on the history of the practice and ideology of the 'maternal instinct' and 'maternal love' in the context of French society.

The mother is also assumed to 'instinctively' know how to care for her child (Holland, 1992; Richardson, 1993). The 'natural' mother knows 'instinctively' what her child needs and wants, and how to satisfy her/his needs.

6. Employment: the 'selfless mother' and the 'supermother'

Advice about whether, and how, mothers should combine employment with motherhood is mixed. There is an implicit assumption that mothers should stay home to look after their children, and an explicit message that it is possible for a woman to 'do it all', by working full-time and caring for her child(ren) as full-time mothers do.[6]

At the heart of assumptions about 'good mothering' is the notion that the 'ideal' mother looks after her children when they are young and does not work outside the home (Lewis, 1991; Richardson, 1993; Urwin, 1985; Wearing, 1984). This assumption is reinforced by political policies and structural conditions such as the poor provision of adequate and affordable childcare facilities.[7] As a result, mothers of young children employed outside the home tend to follow a "female pattern of work" (Lewis, 1991: 204) involving periods of part-time work (often in low-paid jobs for which women are over-qualified), or breaks in employment for childcare.[8]

Although the notion of 'maternal deprivation' put forward by Bowlby (1952, 1965) in the 1950s has now been widely criticized and disclaimed (e.g. Rutter, 1981; Sluckin *et al.*, 1983), with growing evidence showing that a mother's employment is not necessarily detrimental to her child's emotional and psychological welfare (Hoffman, 1974), the belief that a mother might damage her young child by working outside the home still prevails, and underpins much of what is taken for granted about childrearing (Lewis, 1991; Marshall, 1991; Oakley, 1981a).[9] In cases where mothers do work, they are still held mainly

---

6 See Lewis (1991) for a discussion of current social constructions of motherhood and employment.

7 There has been a steady decline in State nurseries' provision since the war (Riley, 1983). Richardson (1993: 8) notes that, in 1988, day nursery places were available for only two per cent of children under five in England and Wales. Oakley (1993: 147) points out that compared to our European neighbours, "the UK does badly, providing publicly-funded child care for only 2% of children under 3, compared with 44% in Denmark, 25% in France, 5% in Italy and 4% in Portugal".

8 Several studies question the notion that mothers of young children *necessarily* want to work outside the home when their children are young, or *necessarily* full-time rather than part-time work (e.g. Coote *et al.*, 1990; Doucet, forthcoming; O'Donnell, 1985). Nevertheless, the fact remains that a 'female pattern of work' can disadvantage women in a number of ways. For example, career or employment breaks often incur important financial losses to mothers (see Joshi, 1987). Part-time employment is often low-status and low-paid, without promotion or training opportunities, or the benefits of sick leave, paid holidays or a pension scheme (Brannen and Moss, 1991).

9 See Tizard (1991) for a discussion of the criticisms and implications of Bowlby's writings on 'maternal deprivation'.

responsible for the child's well-being.[10] This can encourage in women, and other members of society, a tendency to blame mothers for many of the problems and difficulties which befall their children and families (Lewis, 1991).

Over recent years, an alternative image has emerged - that of "superwoman" (Willard, 1988: 229) or "supermother" (Lewis, 1991: 197). 'Supermother' is the mother who can 'do it all' by excelling in her career, whilst at the same time doing all the things that 'good mothers' are expected to do in the home (Lewis, 1991; Wearing, 1984; Willard, 1988). This image is clearly equally oppressive as "it implies that women can comply with the cultural prescriptions of a good mother and a good worker, without modifying the demands of either" (Lewis, 1991: 197; see also Arber *et al.*, 1985; Willard, 1988).

7. 'Deviant' and 'unnatural' mothers

Inherent within constructions of 'normal', 'natural', 'good' mothering are notions of 'abnormal', 'unnatural' and 'bad' mothering. Where mothers fall short of the prescriptions described above they are seen as deviant mothers. In particular, mothers who experience strong negative feelings such as depression, are depicted as 'unnatural' mothers who cannot cope with motherhood (Graham, 1982; Marshall, 1991; Phoenix and Woollett, 1991b).

Authors have pointed out that the unhappy or depressed mother, as well as being constructed in this deviant way, is largely absent from public portrayals, which still present motherhood through a rose-tinted lens (Bradley, 1989). In her analysis of popular media images, Holland (1992: 27) notes that "any hint that baby and mother are not always in harmony are kept well under control".

However, it does seem that the difficulties, and depression, that mothers can experience are being increasingly recognized, and given some, even if at times only minor, consideration. As I pointed out in Chapter One, postnatal depression has received media coverage over recent years in both newspapers and magazines. There are a number - at least eight according to my own search - of popular books that deal specifically with the issue of a difficult experience of motherhood, and with depression in its various forms (see Chapter One). Richardson (1993: 50), for example, notes that

> During the 1970s and 1980s ... increasingly childcare books acknowledge the work and the worry, as well as the pleasures and satisfactions, that

---

10 In Britain, one in five women with dependent children now works full-time, and twice the number work part-time (Richardson, 1993).

> having a child can bring. Women are told that if they do sometimes experience strong negative feelings towards their children they should not feel guilty, or that they are failing as mothers. Motherhood is not always fun, and women should not expect automatically to love their children.

Marshall (1991) also finds that most of the childcare manuals mention the possibility that mothers might feel depressed. A distinction is drawn between the 'blues' and 'real depression', where 'the blues' is said to be 'normal', "natural and experienced by most mothers" (Marshall, 1991: 71; see also Oakley, 1981a). "'The 'blues' are thus incorporated into the construction of 'natural' motherhood" (Marshall, 1991: 71). In contrast, "'real', long-lasting depression ... is described as an illness necessitating consultation with a doctor" (1991: 71). Marshall notes that "this sets up a different kind of mother, the abnormal mother" (1991: 71) and the "'unnatural mother'", and that such "'real' depression" is therefore "beyond the scope of the manuals" (1991: 70).

Thus, the way in which the 'depressed' mother is depicted, constructed and discussed is also contradictory. While mothers are expected to have and express only positive feelings about motherhood and for their children, they are also told that it is normal to feel tired, irritable and depressed. Oakley (1981a: 87) comments on this "ambiguous" treatment of postnatal depression within the advice literature noting that "while the books don't say that normal mothers are depressed, they do say that depression both before and after childbirth is normal".

II. The first-time mothers' constructions of themselves and their children

The above discussion shows that cultural representations and constructions of 'good' mothering *are* becoming increasingly varied. Implicitly, prescriptive rules about how to be 'a good mother' still prevail, but at an explicit level, flexible approaches to mothering and parenting are being provided. It is interesting to observe that the first-time mothers in my study said that, during the depression, their thinking about themselves and their children, had been of a highly *prescriptive* rather than *flexible* nature. This is how Vera described it:

> I always felt I was doing things *wrong*. Like the midwife told me 'Give him a dummy ... he likes to suck', but I thought 'Oh, but you *shouldn't* be doing this'. I was so *strict* with what I thought was *right* and if I did give in, I'd feel ... 'Oh, you've *failed*'. (emphasis added)

Vera's words illustrate how the first-time mothers' conceptions of motherhood and mothering had been characterized by idealized, moral and monolithic constructions of mothers, children, and relationships between them. I now consider these three common

elements to the first-time mothers' interpretations of motherhood, as well as the differences that existed amongst these.

1. Idealized constructions

The first-time mothers' constructions of motherhood and babyhood were highly idealized ones. They said the main sources of these beliefs, or what, in retrospect, they called "unrealistic" expectations and "misconceptions", had been "the media", "magazines", the "telly", "textbooks" about pregnancy and childcare, and antenatal classes. They had imagined motherhood to be "this peaceful, charming little experience that you see pictured", in which "you just sit in a chair and smile at this little cradle". They had anticipated their children would be "these cute little babies with lots of downy fur and ... blond things with great big blue eyes". The words, "serene", "glorious", "rosy", "lovey-dovey", "calm" and "idyllic" recurred within their narratives, mirroring the "overwhelming impression of harmony" (Holland, 1992: 27), and the "idealization of infancy" (Bradley, 1989: 9; see also Bradley, 1991), inherent within popular constructions of mothers and babies. The mothers also frequently used the word "perfect". They said they had expected perfection of themselves - "I was trying to be this perfect mother"; "I thought to myself I'm going to be this perfect mother"; "I was still trying to keep a perfect house as well as look after him" - and of their children - "when she started walking and talking she was going a bit beyond my control, and if we went out, I couldn't put her in the corner, and she'd look perfect and smile prettily".

Dawn's expectations of herself as a mother spoke for many of the first-time mothers in my study:

> I always pictured myself in floral dresses in the summer, pushing prams with these idyllic little blond-haired children. It never worked out that way ... I'd got such a naive outlook on children ... I just had pictures of cute little babies, that was my plans of when you become a mother, like you see them on the telly, slim, pretty [laughs].

They had believed that this serene and calm picture of motherhood would be assured by their babies sleeping most of the time, and simply waking up to feed:

> I think I'd been fooled a little by this ... myth that's perpetrated by magazines and things, that ... you feed the baby, you pop it in its cradle, you sit and smile at it, it goes to sleep, you do your housework, it wakes in four hours time, you feed it again, you pop it back ... and ... with Seamus, he didn't sleep during the day at all. (Louise)

These mothers had imagined motherhood would be effortless because it was supposed to come "naturally" and "instinctively". As Celia said: "I think as a woman, you feel, 'Oh, it's the most natural thing in the world, I should be able to just [take to it] like a duck to water'".

Within the first-time mothers' idealized expectations, the interests of mother and child had been constructed as identical. These constructions had not allowed for the range of feelings and needs they later experienced within their relationships with their children, because they had understood mothering in the conventional terms of selflessness and self-sacrifice. Having emerged from the depression, the mothers now realized that these idealized expectations had been part of their depression, as Louise explained:[11]

> When Seamus was little ... [I took] on the brunt of things. I realize, looking back, I tried to do far too much and my standards were much too high. I should have just let them go, but I didn't always do that, I was a bit particular about things.

2. Moral constructions

These women had also constructed motherhood and mothering in moral terms. During the depression, they had had a heightened sensitivity to the moral dimension of cultural representations of motherhood. They had been highly attuned to issues of 'right' and 'wrong', and 'good' and 'bad'. As Sonya said: "when you're in the illness everything is ... black and white, good and bad". The moral nature of the mothers' thinking was apparent in their striking use of moral language. They constantly spoke about what they had believed they "should" and "should not" do, "must" do, "ought" to do. They repeatedly referred to what a "good" mother is "supposed" to do and feel, and what is the "right" way to be a mother. They had believed there to be only 'one right way' to be a mother - namely, the idealized and selfless version of motherhood described above. They had felt they "should" breastfeed, love their children with "undying devotion", know how to care for their children in an "instinctive way", and have a spotless house. They had assumed their children should neither cry, nor have tantrums.

---

11 At the time of the interview, the mothers provided explanations for their depression. Given the retrospective nature of my study, it is unclear at what point they first began to formulate these accounts. It seems that during their depression, they had been aware of, but unable to validate, the reasons for their distress (see Chapters Three, Four and Five). Their emergence from the depression seems to have come about in part through a crystallization and confirmation of these explanations (see Chapter Six).

3. Monolithic constructions

The mothers had interpreted the meaning of being a 'good' mother or a 'good' child in monolithic, rigid and narrow ways. Different aspects of motherhood had particular salience for particular mothers. For some, natural childbirth had been regarded as 'the right way' to give birth. Others had seen breastfeeding as 'the right way' to feed their child. What the mothers had not entertained during their depression, was the possibility of there being several *different*, but equally acceptable, ways to give birth, feed their children, love their children, and so on. When their experiences had conflicted with their expectations, they had not constructed their experience as simply *different,* but as "wrong", "abnormal", and a moral failure on their part.

They had constructed monolithic ideals of how they should behave as mothers, but also of how their children should behave. Each mother had elaborated her own version of 'the right way' for a child to behave, in which the child had been stripped of her or his individuality, and in which no room had been made for the differences between their own children, and 'the child' of the textbooks, or other known children. The mothers interpreted their child's failure to conform to their expectations as their own failure, and as a reflection of their inadequacy as a mother. Sandra explained: "You think ... my two and a half year old shouldn't do that, if I was a good mum, they wouldn't".

While cultural scripts for 'good' mothering are not straightforwardly rigid and monolithic, the first-time mothers in my study had constructed them in these ways. They had picked up, not so much on the notion that there are as many different ways to be a mother or child as there are mothers and children, but rather on the idea that there is only one 'right' way to be a mother or child.

4. Individualized constructions

So far, I have highlighted the common elements of the first-time mothers' constructions of motherhood. I have shown how these interpretations had reflected conventional representations of the 'good', selfless mother who responds to her child's demands by taking her own feelings and needs out of the relationship with her child.

Within this common over-arching construction, there were also differences *amongst* the first-time mothers' interpretations of the meaning of being a 'good' mother. Each mother had elaborated *her own particular version* of 'good' mothering, in which different aspects of motherhood carried different meanings for particular mothers. For example, the

birth had been an important issue for Dawn. She had believed the "right" way to give birth was with minimal intervention. The fact that she had to have an epidural left her with a sense of failure. Louise, on the other hand, had also given birth with the help of medical intervention, but had not experienced this as a failure on her part. Different mothers believed they had failed in different areas of motherhood. Thus, the *subjective meaning* of particular aspects of motherhood to individual mothers was important. The mothers did not feel they had failed in *every* instance in which their experiences had conflicted with their expectations, but only in those aspects of motherhood that had been particularly significant to them individually.

III. The first-time mothers' experiences of themselves and their children

"In reality", the first-time mothers had found that their own experiences had not matched up to their idealized and "unrealistic" expectations of motherhood. In the next section, I examine the mothers' experiences of this discrepancy between how they had *actually* felt, and how they had believed they *ought* to feel. I illustrate how the mothers had resolved this conflict by abandoning themselves, and denying their own feelings, in order to comply to cultural representations of the 'good', selfless mother. I show how, in attempting to be "the best", "perfect", and "good" mother, they had removed themselves from their relationships with their children, and become alienated from themselves and their own needs, and consequently depressed.

All the first-time mothers had experienced this conflict between their expectations and experiences of motherhood, and between their own needs and those of their children. They had also all resolved the conflict by excluding their own feelings, but different mothers had done so in different areas of motherhood. Some had denied their own needs in order to feed their child in 'the right way'; others had done so in attempting to be full-time mothers; others had done so in order to be 'supermother'; and so on. It is important to emphasize these differences amongst the first-time mothers, for they highlight the ways in which the mothers had actively interpreted social constructions of motherhood in their own ways.

1. The mothers' removal of themselves from their relationships with their children

Psychologically, the mothers had experienced the clash between their expectations, and the reality, of motherhood, as an inner division in which two voices were constantly battling against each other. As I noted in the previous chapter, one voice was an

internalized moral voice, while the second spoke to the mothers on the basis of their own experiences of motherhood. This latter voice had constantly interjected and countered the moral voice, telling them that 'the right way' to be a mother might not necessarily be right *for them.*

Sandra's account of her difficulties in combining paid work with motherhood provides a good illustration of these two voices. Four months after Alice's birth, Sandra returned to her full-time job as a district nurse, against her wishes and for financial reasons. Despite returning to work, Sandra had still felt she "should" be like the "mums [who] stayed at home", who "cooked and ironed and looked after the home". She had therefore attempted to fulfil the demands of being a full-time mother, while being in full-time employment. This "double burden" came to be one of the most problematic aspects of her experience of motherhood:

> I've found that the hardest, having to assume, *as well* as working, that I should do everything else that mums at home do, you know, I should bake and clean and whatever.

Faced with this heavy burden, Sandra had wanted to give up work. However, her husband, Bob, had been against her leaving work, stressing their financial needs. She had felt under pressure from Bob because he had assumed that she "should" be able to work *and* "do everything else that mums at home do", without any help.

Part of Sandra also felt that she should be able to "achieve everything". Another part, however, realized that "to a degree, it's impossible practically to do that", "you can't, it's just impossible", "I'd set myself these goals which were impossible". Sandra explained that, based on her own experience, she "couldn't work out how you were supposed to deal with the baby and do everything else as well, which you can't":

> It tends to be mothers who are at home that seem to go everywhere with the kids, go swimming, go to ballet classes, do this, do that ... and that's what I feel I should be doing, I should be sewing and baking and cooking and going swimming with her and I mean ... that's cloud cuckoo land, I'm not very good at sewing anyway, I don't particularly like baking.

During the depression, two voices had articulated two opposing positions, and two parts of Sandra had assessed her situation from two different view-points. One voice had been grounded in the reality of her life as a full-time employed mother. The other had voiced her expectations of herself, which were informed by cultural notions of 'supermother' who can 'do it all', and reinforced by her husband's views. In the face of this conflict, however, Sandra had not listened to her 'voice of experience' telling her of the

impossible nature of combining caring for a child, a home and working full-time. Instead, she had followed the internalized moral voice - she *should* be able to achieve everything, she thought to herself. Despite the stress she was experiencing, Sandra denied her own needs and feelings. Against her wishes, she continued to work full-time, and just "went on doing" everything - "I just made myself" carry on, she said, because "I was just working on my own perception of what I should do, and what I should be". Sandra consequently removed herself from her relationship with her child by considering her child's needs (and her husband's wishes) at the expense of her own. As she did so, she also became increasingly alienated from herself and her own needs. Sandra associated this move with her depression. She explained how she had become depressed when she had disregarded her own feelings, and forced herself to carry on with what felt like an "impossible" situation:

> I think I'd almost got into the way of thinking, 'Well yes, I ought to be better, I ought to try harder' ... which is what happened when I got depressed with Alice. I felt so guilty ... I felt I should have done better and it was all my fault.

While Sandra described her attempts to be 'supermother', despite *not wanting* to work, Sonya, spoke about her wish to be a selfless mother who stayed at home, despite having *wanted* to work. Sonya had ambivalent feelings about combining employment with motherhood. She had not returned to work since her daughter's birth 18 months before the time of the interview. While part of her had wanted to return to work, another part had stressed that 'the good mother' stays at home and cares for her child:

> It's more my natural personality to have part work, part Suzie, but I kept thinking 'No, if I'm going to do this mother thing properly, I'm going to be at home, I'm going to watch Neighbours, I'm going to make jam and I'm going to go to the local play-groups'. What I did was almost ... sweep the business woman under the carpet, and say 'Ah, but I'm this now', but by denying the skills there, right, I was harming myself.

In resolving the conflict between her own desire for part-time work and what she believed was in Suzie's best interest, Sonya had 'denied' her own needs in order to be the attentive mother who is always there for her child. In caring for her daughter, Sonya had put Suzie before herself, despite her awareness that in removing her own needs she was also 'harming' herself:

> I think I damage myself by trying to shut that off ... I was intent on 'This is my big sacrifice, this is me changing my life style for the good of Suzie' and pushing my own needs completely down to the bottom of the bag ... because I thought ... 'I will be the best mother of all time' ... like people do, and then they start putting pressure on themselves because of unrealistic expectations.

During her depression, Sonya had constructed the conflict between her own needs and those of her child in an either/or fashion. As she perceived it, she could either be "the best mother of all time", and stay home to care for Suzie; or, she could return to work and Suzie might suffer as a result. In making this decision, Sonya had been informed not by her own experience, but by her beliefs and fears about how others might judge her:

> I didn't want to appear to be rushing back to work, because that would sort of make it look as if I *was* trying just to return to normal ... 'Okay, I had this baby, it was a wonderful experience, now I'm going back to work and getting on with the real life'.

In attempting to be the self-sacrificing mother she believed she should be, Sonya had become depressed because she had not taken her own needs into account and, as she said: "I wasn't being true to myself":[12]

> I was thinking that ... once I have a baby, then I'm no longer the business woman, I'm ... the person who should always be there with the hugs and does the ironing and I was almost pushing the rest of me out of the way ... I wanted to revel being at home and doing the housework ... but I wasn't being true to myself.

In order to further highlight the differences *amongst* the first-time mothers' experiences of motherhood, I now consider Vera's account. Two aspects of motherhood had been particularly problematic for her: feeding and loving her son Felix. She had subscribed to the view that breastfeeding was 'the right way' to feed her child. Her experience of breastfeeding, however, was a painful and difficult one. She had faced a clash between her desire to give up breastfeeding, and her belief that breastfeeding was "the thing you're meant to do". In resolving this conflict, Vera had neglected her own feelings, and "forced" herself to carry on breastfeeding:

> [The doctor] said 'Stop breast feeding', and I *wanted* to stop breastfeeding, but I wouldn't let myself, 'cos I thought 'Well *that's the thing you're meant to do* ... you're not to bottlefeed' ... I *wanted* to be told by somebody it was okay to do it, I wouldn't let myself do it myself.

The doctor had advised Vera to stop breastfeeding, because "You're only torturing yourself", he said. Despite this, Vera had felt reluctant to counter the pressure she was exerting on herself to breastfeed Felix. In the absence of overt external pressure from health

---

12 In her American study of mothers of young children, Willard (1988) also found that mothers who made the decision about combining paid work with motherhood in terms of cultural scripts of, either the 'good selfless mother', or the 'selfish supermother', got depressed. Conversely, the mothers who did not get depressed were those who defined caring for their child in neither the selfish nor the selfless mode, but rather based on their own experience and understanding of what it meant for them to care for their child.

professionals, her husband, her family, or friends, she nonetheless "wouldn't let [her]self" stop breastfeeding because of her conviction that 'a good mother' breastfeeds her child.

Vera described similar moral and monolithic beliefs about what she had regarded as 'the right way' to love Felix. She was one of the few mothers in my study who had experienced negative feelings towards their children:[13]

> I didn't care for him - I cared for him, but I didn't love him, I didn't feel any sort of mother love or anything. He was the biggest mistake of my life as far as I was concerned.[14]

Vera had found that she did not love Felix in the culturally-prescribed way - she had not 'instinctively' and immediately fallen in love with him. Rather than accept her own feelings, she had forced herself into playing the "part" of the all-loving mother, who has only positive feelings for her child. She had taken her own emotions out of this relationship, and as she had done so, had become increasingly alienated from herself, and depressed:

> I just expected to fall in love with him totally, straight away, which I didn't ... I hate myself for that, I felt ever so wicked ... I felt really tortured about that ... that I didn't love him. I know it's not that unusual ... with people who even haven't got depression, but I felt evil for not feeling the way I thought I would ... I cuddled him, 'cos I felt I ought to, not because I particularly wanted to ... I was going through all the motions ... but my heart wasn't it, and I always was aware of it, and it just felt like an act, I felt like a fraud.

These psychological processes of idealization, conformity to dominant cultural prescriptions of motherhood, removal of, and alienation from, their own needs and feelings applied to the mothers' experiences of themselves, but also their children. They had interpreted their child's failure to conform to their image of the "perfect" child as their own failure, and as an indication that they were 'bad' mothers. Sonya explained how her depression had started when Suzie was six months old, the moment when "suddenly, [I] thought to myself, 'Why is she not that sweet little baby any more in my mind'":

---

13 Five of the 18 mothers in my study had experienced negative feelings towards their children at some point during the depression, and had felt regret at having them. Of these five mothers, only two had become depressed after the birth of an unplanned and unwanted child (see Table 8 in Appendix 6). In one case, the woman's mother-in-law had looked after the child for the first three months following the birth. None of these five mothers (nor any of the other 13 in my study) had seriously physically harmed their children. At the time of the interview, only one of the 18 women still expressed regrets at having her child, and still felt her life would be easier without him. Fiona said: "There's times when I'd part with him, I'd give him away to *anybody*, 'cos he's the one that really gets to you ... he is just a *complete* and *utter* nuisance".

14 Vera's son *was* a planned child.

> I expected her to be like a robot ... I'd dress her, she'd put her arms up, and I mean, that's not reality, if she wants to run around a bit before she puts her nappy back on, then that's normal. But to me, I was thinking 'She shouldn't be doing this, she should have her nappy on now' ... It was like an obsession about 'She will always look clean, she will always eat her dinner without a spot going on her', you know, it was almost that sort of 'I'm imposing standards on her that are much, much too high', and I was trying to fulfil them and making myself feel ill.

Sonya's "thinking" seemed to have dominated her feelings. Her thoughts about how Suzie "ought" to behave had prevented her from accepting Suzie for whom she was. She had carried on telling herself that Suzie "should" behave in a certain way, and that Suzie's failure to do so was her own failure.

It can be seen from this review of the data that what marked these mothers' thinking during the depression, was its monolithic and moral nature. They had constructed a single right way to be 'a good mother' or 'a good child'. When their experiences had deviated from these constructions, they had not interpreted their experiences as *different* and equally acceptable. Rather, they had seen these as 'the wrong way' to be a mother, and as an indication that they were "bad" mothers who had "failed" at motherhood. This deep sense of failure was apparent in Celia's account of the inner conflict she experienced between what she wanted to be - an "earth mother" - and what she felt that she was - not an earth mother and someone who might have liked to have gone back to work:

> I really felt that one of the reasons I felt so down was because I had to admit to myself that I was not an earth mother, and no matter how much I wanted to be the sort of parent that stayed at home, perhaps I had to accept the fact that I would be happier going to work ... I think it was a sort of conflict really, I wanted to feel 'Oh this is great' ... and feel very content at home, but I couldn't.

In failing to be an earth mother Celia felt she had failed to meet her own expectations of herself as a mother, and that *she* had therefore failed as a mother:

> My feeling deep down was that I was failing as a mother if I couldn't cope with being at home. I think it was a fear of failure, really, that I couldn't devote a certain amount of time to being at home.[15]

---

15 Whether at work, or at home, it seems that Celia would have experienced split feelings and a sense of failure. Had she gone back to work - which she considered at one point because she was offered what was for her "an ideal job", with ideal hours - she would have felt divided because she would not have been the 'good' full-time mother that she wanted to be. She might therefore have felt she had failed. As it was, she had stayed home, but had still felt a sense of failure because she had not been able to be *fully* content, because part of her had wanted to work. Celia's predicament shows how complex the relationship is between a mother's depression and her employment situation, a complexity which has failed to be captured within the research on postnatal depression and employment (see Chapter One).

As I noted above, the precise area of motherhood in which the first-time mothers had denied their own experiences was of minor significance. However, all linked their depression to the moment at which they had excluded themselves, and their own needs and feelings, in order to fulfil their expectations of the 'good', selfless mother. As Rachel put it, they were "trying to fit [their] experience into what an expert says". They had gone to great lengths to bring their experiences into line with their culturally-derived constructions in order to preserve their sense of moral worth and ensure social acceptability.

2. The interpersonal context

The mothers' constructions and feelings were not taking place within a vacuum, but rather within a relational context - both interpersonal and cultural - which lay at the heart of their experiences of motherhood and depression. In the face of the moral conflict described above, this relational context made it more or less difficult for them to validate their own voices, and include their own needs in caring for their children. In the following two sections, I discuss how the mothers' interpretations of their interpersonal relationships, and of their cultural context, had led them to prioritize their children's needs at the expense of their own.

(i) Feeling 'abnormal' compared to other mothers with young children

The first-time mothers' encounters with other mothers with young children were particularly important to their experiences of motherhood and depression. Their observations of other mothers had provided a yardstick against which they had assessed their own, and their children's, behaviour. They were therefore pivotal to the moral evaluations they had cast upon their own, and their children's, performances, and to whether they had judged these 'right' or 'wrong', 'good' or 'bad', 'normal' or 'abnormal'.

As I pointed out in Chapter Three, all the first-time mothers had come into contact with other mothers at some point after the birth of their child. In these initial contacts, the women described how they had 'checked out' their feelings with these women, and enquired about their experiences of the birth, feeding the baby, loving the child, the child's behaviour, and so on. They had felt none of these other mothers had echoed their own difficult feelings, and they had therefore come to feel isolated within their experiences:

> I remember going to [a postnatal group] ... and I ... thought ... 'You shouldn't be here'. I just felt everyone else seemed so happy and so really pleased with their labours, and I remember saying to one girl 'How did you find it?' ... and she [said] ... 'I found it really much easier than I thought', and I burst into tears on the spot. So I didn't go there again. (Vera)

> This girl I knew ... I said 'Oh, do you feel like that, do you?' and she'd say 'Oh no no no' and I said 'Oh-oh, pull yourself together dummy ... you're alright', and then I'd get home and think 'She doesn't feel like that, perhaps it isn't normal' ... I couldn't understand it because ... that was the one thing that really got to me through it all, that I couldn't find anyone who felt like I did, and I felt like I was going through it on my own ... I couldn't find anyone who said 'Oh yes, I felt like that, don't worry, you'll get better' ... and that was really worrying me like anything. I was just thinking 'Nobody else feels like this, why do I ... why me?', it was awful. I felt really isolated and lonely through it. (Pam)

Feeling that none of these other mothers shared their own experiences, each mother described how she had come to feel that she was "an alien", "a freak", "a weirdo", and "the only one" to think and feel the way she did:

> I felt like a freak, like I was the only one in the world who couldn't cope with their baby, and ... the only one who felt so miserable about it all. (Louise)

> I wish somebody had put me in touch with somebody in a similar position a lot earlier, 'cos I felt very isolated for a long time. I had all these people coming to see me but I was a sort of ... an alien, I'd reacted so terribly against this little child. (Sandra)

Not only did they come to feel their experiences were *different* to those of other mothers, but that they were the *wrong* way to be a mother, a sign that they were "bad" and "abnormal" mothers. They described how they had constructed themselves and others in dichotomous and oppositional ways, in terms of better or worse, 'good' or 'bad', right or wrong, rather than in ways which could embrace difference and diversity.

Their feelings of 'difference' and 'abnormality' compared to other mothers had led them to withdraw from these relationships. In the face of difference, they had found it "easier to keep quiet", rather than risk voicing their own experiences. In some cases, they continued going to mother-and-baby gatherings. Rather than express their thoughts and feelings, however, they had "acted out a part". They had pretended to be like, what they perceived as, the other happy mothers. They had consequently become involved in 'fraudulent' (Brown and Gilligan, 1992) and 'inauthentic' (Jordan, 1992) relationships, in which they had withheld how they really felt, in order to be accepted by others:[15a]

> It's almost like being a ... pretender ... I'm putting across what I think people want to see rather than what I am myself hence ... I was getting into that spiral 'I must put on a good face, I must always be marvellously dressed, Suzie must always behave well'. (Sonya)

15a Debates about the nature of the self, and whether there is an 'authentic' or 'inauthentic' self, are beyond the scope of this thesis. When I use these terms, I am drawing on notions and language that the mothers in my study were using.

In other cases, they had withdrawn from other mothers altogether and from any further opportunities at meeting these women, because inauthentic relationships felt "just as bad" as no relationships at all:

> The best sort of support would be ... with other mothers with children ... that would be the ideal thing to do ... But, on the other hand, it's really awful being with other women that look as if they're coping ... that's just as bad as being with nobody. (Rachel)

As the mothers had stopped talking to other mothers, and revealing what they really thought and felt, few opportunities had arisen in which these very thoughts and feelings might be *contradicted* by the words of other mothers. As they had withdrawn into silence, their knowledge of the experiences of other mothers came to be based on their *observations* and *perceptions* of these women. It is interesting to note that, as they described their move into silence, they used *visual* metaphors to speak about how they had constructed other mothers. They spoke about 'seeing', 'looking' and 'impressions', as they came under the illusion that all other mothers were coping and happy:

> I can remember thinking, 'Oh, look at them, they're so happy' ... You see all these people looking so happy, it just makes you feel worse, you just think, 'Oh they're so happy with their family and I'm not'. (Pam)

As they had withdrawn from other mothers, the gap between their own experiences and those of these women had seemed wider and wider. They came to believe that "*all*" other mothers were "happy" and "coping", while they were "the *only* one[s]" to be having a difficult time. Their sense of isolation was profound. During the depression, they had felt it was one of them against the rest of the world.

The mothers' illusions and isolation had been *maintained* by the fact that they were *watching* and *looking* and *seeing* other mothers, but not *talking* to them. Although they knew that sharing their experiences with another mother would probably have broken the isolation, they had also felt unable or unwilling to do so, for fear of rejection and moral condemnation. Through their continued isolation from other mothers, the internalized moral and blaming voice had come to sound louder. Sandra explained this position very clearly:

> I think you almost feel it should come instinctively, therefore you should know how to go through each stage, but you don't if you've never done it before ... One battle ground was [Alice's] feeding because ... I just couldn't understand why this child wouldn't eat - I was doing all the right things ... But if I'd known there was other people out there, it took me quite a few weeks to realize I wasn't the only one going through this problem and ... I didn't want to ask for help because I thought it was something I was doing ... But the more it went on, the more of a problem it became, because it just became a problem to me.

To conclude, the first-time mothers' encounters with other mothers had confirmed their perceptions of themselves as 'abnormal' and 'bad' mothers. Based on these initial encounters, they had withdrawn from their relationships with other mothers, and become increasingly attuned to the 'moral' voices of the 'experts' and the childcare manuals. In the previous chapter, I noted that the moment at which the depression set in seems to have coincided with the mothers' withdrawal from their relationships. It therefore seems reasonable to suggest that the first-time mothers' depression might have set in when they stopped talking to other mothers, or no longer disclosed their true thoughts and feelings to these women.[16]

(ii) Partners, relatives, friends and health professionals as added moral voices

Several first-time mothers said that, during the depression, the words or 'advice' given to them by their partners, mothers, mothers-in-law, and health professionals had come to sound like added moral voices. These had further increased the volume of their own internalized moral voice, and reinforced their moral constructions of themselves and their children.

Here, I discuss this issue through Sandra's account, for she provided a particularly striking example of the ways in which the mothers' perceptions of their interpersonal relationships could facilitate the denial of their own needs in caring for their children.

Sandra had felt virtually every person she had spoken to (except her mother-in-law) had implied her depression was of her own making, and that she was a 'bad' mother. Since her daughter's birth, Sandra had been struggling to "come to terms" with the fact that she loved her daughter Alice "in my own way", which was different to the "undying devotion" of cultural representations of motherhood. Although part of her had believed that 'her own way' of loving Alice was acceptable, she had struggled to validate this belief, because her husband, Bob, had been critical of her. His disapproval had further reinforced her internalized moral voice telling her she should have loved Alice in the culturally-prescribed way:

> My husband said 'I was shocked when you first had her ... I could see that you hadn't bonded straight away and that upset me ... I assumed that came naturally' ... He can't understand why there isn't undying devotion and

16 The role of women's friendships with other mothers in postnatal depression is discussed further in Chapter Six.

> love for Alice. I think he finds that quite hard to take on board, that I haven't got that inner, and I have, but in my own way ... I'm trying to do a number of different things in the evening and I think he just can ... come in and play with her, and he can't understand why I'm not sitting there and playing ... And I think it's me as well, I *need* to do other things as well, I can't just play with her, that's me, and I've got to come to terms with that.

Sandra said Bob's attitude in general had made it difficult for her to legitimate her feelings because she felt he had blamed her for what he saw as *her* problem. She spoke about having been "brainwashed" by Bob, because he had attempted to erase her own understanding of her difficult feelings:

> At one point I had been brainwashed ... into thinking it was all me ... My husband ... thought the problem was mine ... he just kept saying, 'When you snap out of it, we can get back to a normal life'.

Sandra had found her mother's help equally unsupportive. Sandra had interpreted it as yet another moral voice telling her what she 'should' and 'should not' do. She felt her mother had also blamed her for her problems, and this had further eroded her confidence in her own ability. Her mother's constant criticism had "exacerbate[d]" Sandra's existing problems, because she had constantly said "'You're not to do that ... you're not to react like that". Whether it was breastfeeding, washing the kitchen floors, or feeding routines, Sandra experienced her mother's words as judgemental and critical:

> Mum used to keep ... saying: 'You're not [breastfeeding] properly, you *can't* be doing it properly, this baby shouldn't be feeding this much, why don't you go on the bottle?'
>
> My mum said: 'I've washed your kitchen floors'. I said, 'Ooh great', and she said, 'Well, you do do it every day, don't you?'
>
> Mum said ... 'All of you were in a routine, you were six, ten, two, and six, and every baby should be like that. You're not coping 'cos ... you should get Alice into a routine. They *must* be in bed by six' ... She always said 'If only she was ... six, ten, two, and six, your life would be [easier]'.

Sandra, along with several other mothers, had not drawn upon their own mothers' experience as a source of knowledge; they had felt their mothers were "interfering", "invading" and "criticizing" them.

Sandra had even felt her health visitor had criticized her, and reinforced her own sense that she had failed as a mother:

> [I] feel very guilty, very isolated, very ashamed and ... that's almost put on you as well 'cos the health visitor ... said 'Will you have another one?' and I said 'Well, I wouldn't mind, but not without ... knowing I've got some

people here that will help' ... and she said 'Yes, I suppose you feel you've failed'!

Despite Sandra's struggle against this tide of voices, eventually, as she said, "I hadn't got any fight in me". Unable to 'hold onto' her own experience and voice, she had become depressed:

> I suppose I was ill then really, and I hadn't got any fight in me. I just did what everybody said, well tried to do what everybody said, 'cos I thought 'Well I'm not trying hard enough, so I'm not feeding properly, 'cos *I* am not doing it properly', and I tried and tried.

Many mothers described similar experiences to Sandra's. For example, when Sonya first began to experience negative feelings she had attempted to voice these to the people around her. She had approached her mother-in-law and told her on the phone one day: "You've gotta come here now, I just can't handle this, you've gotta come now". She had told her sister-in-law: "I've taken these tablets". She had said to her close friend: "I feel terrible". She had told her husband: "I feel ill". She had informed her health visitor that "This is happening to me, and I don't know what to do about it". She had told the doctor: "I ... feel bad". But Sonya had felt that the way these people had responded to her denied her feelings and silenced her voice. Her mother-in-law had said: "pull yourself together". Her sister-in-law had told her to "chuck the tablets" that the doctor had prescribed for her. Her close friend had said: "You need to go back to work". Her husband had said: "I don't want to hear all this". The health visitor had said: "I'll get you to the doctor". Finally, the doctor had told her to "keep on the tablets". Sonya had come up against powerful messages telling her she could not and should not feel the way that she was feeling.

3. The cultural context

I now consider two aspects of the cultural context in which the mothers were living which seem to have similarly facilitated the mothers' exclusion of their own needs and feelings in caring for their children. These were: first, the notion that a mother who fails to conform to cultural constructs of the 'good' mother is liable to damage her child; and, second, that such a mother is unfit to look after her children and that they should therefore be taken away and put into care.

(i) Fear of damaging their children

A particularly powerful source of pressure to conform to both the socially and individually-constructed prescriptive 'rules' about how to be a 'good' mother had been the

mothers' fears that in deviating from these norms they might have been damaging their children. As I noted in the first section of this chapter, it is the mother who is largely held accountable for her child's psychological, emotional, physical and intellectual health and development. The first-time mothers in my study described the acute sense of responsibility they had felt toward their children.

Sandra, for example, explained how in failing to be what she constructed as the 'good' and 'right' way to be a mother - because she "didn't bond that well in the beginning" with her daughter Alice, she "wasn't there" for Alice because of her full-time employment, and she had been depressed - Sandra had feared that her daughter might later blame and reject her for being "an awful mother":

> I just hope that ... when she's 18, she won't come and say 'You were an awful mother when I was one and two' ... which she'd have every right to say ... I'm expecting her, when she's 18, to throw it back in my face, but perhaps she won't.

Vera too said she had had "bad thoughts in my head" because she felt she might be damaging her child by being depressed:

> I had such bad thoughts in my head, that's the only way I can really describe it, bad thoughts about myself in my head, that I just thought ... 'I'm gonna be like this forever, I'm never gonna be right again, I'm gonna damage him by being like this'.

Indeed, even though Vera had largely come out of the depression at the time of the interview she explained how she was still plagued by feelings of guilt. She spoke about her anxiety because her then two-year-old son was still not "speaking sentences". She feared that her son's late language development had been caused by, what she perceived as, her inadequate mothering. "I've always blamed myself", she said, "I think, 'Oh, I haven't done this right ... maybe when he was a baby, I didn't do this right or that'". The culpability that society places at the mother's doorstep, and the blame that 'the mother' receives for any faults and failings in her child, weighed heavily on the first-time mothers, and operated as a powerful source of internalized pressure to conform to cultural constructions of 'the good mother'.

In some cases, the mothers' fear of damaging their children had been so extreme that they had thought the child might die should they look after it. Penny described how she had literally removed herself from her relationship with her son, by returning to work full-time, against her wishes. She did so in order to leave her child in someone's else's care, and thus remove him from, what she constructed as, her own potentially fatal influence:

> I thought he was gonna die, and I thought if he died, I definitely can't cope. But if he was with someone else, they could look after him better than I could, because I don't know what to look for, d'you know what I mean? ... 'Someone else more experienced knows what they're doing and I'm not experienced.[17] Oh yeah, I can bath a baby, I can change a baby, I can feed a baby, but they need more than that', where really they don't. They just need someone to feed them and change them, they don't need someone to watch them 24 hours a day, which I was doing.

In some cases, the mothers' fear had reached such proportions that it had literally paralysed them. They had felt unable to take care of their babies while their partners were at work, and they described waiting for them to return to care for the children:

> I was terrified, I was really frightened, and I sort of worried about everything I did ... until I was really at the stage where I was waiting for my husband to come home from work to feed him, to change his nappy. I wouldn't do anything, 'cos I just thought I couldn't do it. (Petra)

> I can remember when my husband worked till midnight on one of his late nights, he went from half past one ... and ... he got back at half past 12, and he stepped out that door, and I'd sat there holding [my son] till half past 12. I hadn't had a drink or anything to eat. I daren't put him down 'cos I thought 'If I put him down, he's gonna die' ... It was all just too much for me, no sleep, the thought of someone giving him the flu, and him dying on me or him chocking or him having a cot death or being stolen. (Penny)

These moving accounts speak of the depth of the mothers' fears of damaging their child, of the power that cultural constructions do hold for some mothers, and of the lengths that the mothers went to remove themselves from their relationships with their children, in the paradoxical belief that in doing so, they would actually be protecting their children.

(ii) Fear of having their children taken away

Most first-time mothers had also feared that a public admission of their true thoughts and feelings might lead to their children being taken away and put into care:[18]

---

17 In fact, Penny was one of the most experienced mothers in my study. She had virtually brought up her younger sister, who was born when Penny was 13 years old. Five of Penny's six siblings had had children before her, and so, as she said, "all the way through my life I've had babies" around. Penny had had so much experience that her expectations of herself were that much higher: "I thought I knew it all about babies ... I expected to know it all when I had Adam". This illustrates how "previous experience with babies" cannot be straightforwardly assumed to be a 'protective factor' against postnatal depression, as Oakley (1980) has suggested.

18 Antonis (1981: 67) has also noted that "the admission of ... difficulties may serve as an indicator for social workers, health visitors and doctors that the woman is a 'problem case' and suitable material for the 'risk register'".

> I was afraid more than anything of actually saying to someone, 'I think I'm over-reacting to situations', 'cos I was worried the children would be taken into care, that was my main concern. (Dawn)

As Dawn and others pointed out, this fear and silence had been particularly directed at health professionals, and especially health visitors. As a health visitor herself, Helen understood why mothers come to hold this fear:

> I think a lot of people are very concerned that by saying that they're depressed, and how low they feel, they're going to have their baby taken away from them. I think that's very common, especially the group of people who I work with, who are very low down the social class scale, and as far as they're concerned, health visitors are welfare ... and we take babies away.

The mothers felt, again, an inner split with regard to this issue. Part of them believed "mothers who can't cope have their children taken away from them", while another part thought "they [don't] do that ... they just give you more help and support". As Penny explained, however, during the depression "you think the worst" - her fear of losing her son had taken over, and so she had not voiced her feelings:

> You hear these things about ... 'Mothers who can't cope have their children taken away from them', so you don't go out and say to health visitors ... 'I can't cope with my child' in case they ... say, 'Right, we'll take him away, and when you can cope, we'll bring him back' ... I was frightened of letting anyone know ... that I was depressed in case they come and took him away from me and say ... 'You're not capable of looking after him in your state of mind', which depresses you even more ... I don't think they do that, I think they just give you more help and support, but ... you think the worst.

The first-time mothers feared that in speaking, their voices would be misheard and their words misconstrued. They feared that these would be taken as an indication that they were incapable of caring for their children and that they would be taken away and put into care. This fear was a powerful one, which struck to the core of their emotional and moral being. In speaking out, the mothers felt they would have run the risk of losing their children. They also feared the strong moral condemnation that such a loss symbolized to them, and the moral judgment of being pronounced a 'bad mother', who was damaging, and therefore unfit to care for, her child.[19]

---

19 Only one of the subsequent mothers, Monica, expressed the fear of losing her child. It is interesting to note that she was the youngest mother in the sample - 17 when she had her first child and 18 when she had her second, after whose birth she became depressed. Possibly her young age, and relative lack of experience compared to the other subsequent mothers, accounted for her fear.

IV. Concluding discussion

The findings presented in this chapter corroborate previous research, but also go beyond it in two ways. First, the data presented in this chapter shed light on the contradictory results of correlational studies on the links between postnatal depression and various aspects of motherhood (e.g. the birth experience, method of feeding, the child's temperament). Second, my findings further the debate, highlighted by feminist research, concerning the discrepancy between women's expectations and experiences of motherhood.

Correlational studies have explored the relationship between postnatal depression and various aspects of motherhood. The areas that have been focused on include: the birth experience (Elliott *et al.*, 1984; Green *et al.*, 1988; Murray and Cartwright, 1993; Oakley, 1980; Paykel *et al.*, 1980; Romito, 1990b); breastfeeding (Alder and Bancroft, 1988; Alder and Cox, 1983; Dalton, 1971; Kumar and Robson, 1978; Paykel *et al.*, 1980; Pitt, 1968; Romito, 1990b; Susman and Katz, 1988); the child's temperament (Cutrona and Troutman, 1986; Hopkins *et al.*, 1987; Feggetter *et al.*, 1981; Romito, 1990b; Small *et al.*, forthcoming; Whiffen and Gotlib, 1989); and the mothers' employment status (Hock and DeMeis, 1990; Oakley, 1980; Romito, 1990b). These studies have yielded conflicting results; some find positive correlations while others do not.[20] These contradictory findings reflect, in my view, two major limitations of these studies, highlighted by the data presented in this chapter.

First, although a number of the studies cited above do use the mothers' own subjective assessments of their experiences (e.g. Cutrona and Troutman, 1986; Green *et al.*, 1988; Hopkins *et al.*, 1987), there is still a tendency to either use, or stress the importance of using, objective ratings (see Chapter One). However, this chapter demonstrates how one of the central processes involved in depression was the mother's subjective construction and interpretation of her own experience. These findings therefore emphasize the importance of investigating postnatal depression from the mother's perspective. Failure to do so possibly accounts for the contradictory findings of the above-mentioned studies.

---

20 For example, some researchers find no link between method of feeding and postnatal depression (e.g. Kumar and Robson, 1978; Paykel *et al.*, 1980; Pitt, 1968), while others find that breastfeeders are more likely to experience depression (e.g. Alder and Bancroft, 1988; Alder and Cox, 1983; Dalton, 1971). Romito's (1990b) findings are more sophisticated and in part confirm the results of my own study - she found that the women most likely to be depressed four months after the birth were those who had failed at breastfeeding *despite having wanted to do so*. Another significant finding was that not one of the women who had planned to bottlefeed before giving birth became depressed, which supports my argument in this chapter.

Second, this and the previous chapter illustrate a common psychological process that underpinned the women's experiences of various aspects of their lives as mothers. It was not the specific areas of motherhood *per se* that were important (e.g. the birth, breastfeeding or bottlefeeding, the mother's employment status, the child's behaviour); rather, the particular way in which the depressed mothers interpreted and evaluated their difficulties and performances as mothers. Correlational studies exploring *separate* correlational links between postnatal depression and these different aspects of motherhood fail to identify the complexity of the phenomena at hand, and therefore the psychological processes which underpinned the women's experiences of each of these different aspects of motherhood. I would therefore argue that no hard and fast rules can be drawn about links between depression and 'factors' such as a medicalized birth, breastfeeding, the lack of employment, or little or lack of previous experience with babies, because different aspects of motherhood carry varying significance for different mothers.

The second issue my findings shed light on concerns the contradiction between women's idealized, and often unrealistic, expectations of motherhood, and their actual experiences of being mothers. This conflict has repeatedly been noted in writings on motherhood (e.g. Antonis, 1981; Oakley, 1981a, 1993; Prendergast and Prout, 1980; Rich, 1986), and postnatal depression (Jebali, 1993; Gruen, 1990; Nicolson, 1988; Oakley, 1980; Romito, 1990b). In explaining the processes whereby this conflict can lead to depression, the latter studies emphasize women's lack of control, their 'helplessness', and the structural conditions which are held responsible for rendering women helpless in Western society (see Chapter One).

My own research, however, indicates that the mothers were playing an active part in this process. As the mothers were the first to point out, their own perceptions and constructions of society's definition of the role of mother played a large part in their depression. The central weakness of feminist theories is their failure to conceptualize the mother as an active agent involved in an on-going process of interpretation and re-interpretation of herself, others and social norms and expectations of motherhood. Explanations which rely on notions of 'helplessness' theorize the mother as passively absorbing, and conforming to, ideologies of motherhood. However, the data from this chapter starkly illustrate that this is not the case. First, by drawing on a shared body of cultural beliefs about motherhood, each mother had actively constructed her own particular version of what it meant to be 'a good mother'. Hence, these constructions had varied across different mothers in the sample. Second, while the mothers described complying with these constructions, they also spoke about a *resistance* to such conformity, and about

an inner "conflict", "struggle" and "battle" with that part of them that had attempted to conform.

In order to further understand the accounts given by the mothers in my study, I have drawn on Breen's (1975) study of first-time mothers.[21] Her work stands out as an exception to the feminist research cited above, because she has captured the active way in which mothers both interpret the social role of mother, and then attempt to modify themselves to conform to this role. She also found that the women in her sample who had found motherhood difficult, experienced moral conflicts of the type described in this chapter:

> The most striking feature amongst the women who experienced most difficulties, was the split between a very idealized picture of what they felt a mother should be like ... and the way in which they saw themselves, after the birth of the baby. Although this same picture was at times present in well-adjusted[22] women during pregnancy, they generally modified their picture of the good mother after the birth of the baby to a more realistic one with which they were no longer at odds ... It is as if [the ill-adjusted mothers] had a stricter idea of what they should or should not be like and that what they should be like was more unattainable that the other women ... they seemed ... to be stuck with the negative experience, as opposed to the well-adjusted women who were more flexible and able to maintain an openness to other experiences. (1975: 192)

Breen's study is of particular interest, not only because it supports my findings, but because it sheds light on a question that could not be addressed within this thesis - namely, that of how depressed mothers' experiences compare to those of non-depressed mothers. As noted above, Breen shows that there are indeed differences between the ways in which depressed and non-depressed mothers construct and interpret the mothering role, and in how they resolve the conflict between their expectations and their experiences of motherhood. Furthermore, she also found differences between the two groups of 'depressed' women I differentiated in Chapters One and Two - namely, mothers with postnatal depression and those with low mood. She noted that although both groups experienced similar problems and conflicts, postnatal depression was related to "a woman's struggle with her feelings about good and bad mothering" (Birkstead-Breen, 1986: 33). She writes:

> Women who suffer from postnatal depression ... get stuck in the experience of bad mothering, in the need to separate rigidly between good and bad, and the need to attack themselves for being an inadequate mother. (Birkstead-Breen, 1986: 33)

---

21 Breen's (1975) research was not on postnatal depression specifically.

22 These were the mothers in her study who found motherhood relatively unproblematic.

Breen's findings lend support to the notion that the processes described by the mothers in my study were indeed a result of their depression, and would not have been identified within non-depressed mothers or those who had had periods of low mood.[23]

However, one question which emerged as important in my own study, and which was not addressed by Breen is that of 'resistance', and the ways in which the mothers in my study described *both* conforming to, *and* resisting, cultural constructions of 'the good mother'. In order to conceptualize this resistance I have turned to the work of relational psychologists who have written about the ways in which young girls and women resist cultural definitions of femininity.

Analogous processes to those I have documented above - in which the mothers resolved the conflict between their expectations and experiences of motherhood by removing their own needs and feelings from their relationships - have been described by relational psychologists in mothers of young children (Attanucci, 1988; Willard, 1988), women at other stages of the life-cycle (Jack, 1991), and adolescent girls (Brown and Gilligan, 1992, 1993; Gilligan, 1990; Gilligan *et al.*, 1988, 1990b; Steiner-Adair, 1990).

These authors have pointed out that this moral conflict centres around a central dilemma which concerns the problem of disconnection (see Gilligan, 1988a). Attanucci (1988) notes that within cultural definitions of motherhood, the relationship between mother and child is lost because the interests of mother and child are either fused - the 'good' mother responds to her child's needs and demands in a selfless way - or they are seen as separate and opposed - the 'bad' mother takes into consideration her own needs and is thereby perceived as selfish. This is the cultural framework in which girls, women and mothers tend to live, for the moral equation of care with self-sacrifice is inherent within conventions of feminine goodness (Gilligan, 1982). In resolving this conflict between their own experiences of themselves and the expectations of society, girls and women are often faced with making decisions about their relationships to themselves, others and society. When they find that their own experiences do not conform to their interpretations of cultural prescriptions, they are faced with the following question: is it better to be 'selfish', stay with their own needs, and turn away from others; or be 'selfless', and abandon themselves in order to stay in relationship with others (Gilligan *et al.*, 1988).

---

23 My less detailed analysis of the 22 non-depressed mothers supports this idea. Such a comparison between depressed and non-depressed mothers' constructions of the role of mother, and resolutions of the conflict between their constructions and experiences, is an interesting question that deserves further investigation.

The mothers in my study had faced a similar question, and in resolving it, had abandoned themselves in caring for their children. They had attempted to bring their experiences into line with their own moral constructions of the 'good' mother, constructions which were informed by normative definitions. The critical point to note, however, is that as they had done so, they had not lost sight of their own feelings and experiences. Throughout the depression, they had been aware of their own needs, but had buried these underground. While the mothers had apparently conformed to cultural scripts of motherhood, they had done so in a *self-conscious* way - that is, they had also been actively *resisting* these normative prescriptions.

The work of relational psychologists sheds light on the character of this resistance. In their research on adolescent girls, Brown, Gilligan and Rogers have distinguished three types of resistance (Brown and Gilligan, 1992, 1993; Gilligan, 1990; Gilligan, *et al.*, 1988; Rogers, 1993). They argue that before reaching adolescence, young girls show signs of what they term a "healthy resistance" (Brown and Gilligan, 1992: 167), or what Rogers (1993: 265) calls "ordinary courage": "to speak one's mind by telling all one's heart". Here, girls freely and truthfully speak their minds, and fully reveal their inner world of feelings. As they reach adolescence, these authors note that this 'healthy resistance' tends to develop, either into a "political resistance" where girls "disagree openly with others, to feel and speak a full range of emotions" (Brown and Gilligan, 1993: 17), or it comes under pressure to be silenced and taken underground where it becomes a "psychological resistance", which also damages the self:

> We found that girls' struggle to hold on to their voices and to stay in genuine relationships with themselves and others in the face or pressure to not know and not speak leads some girls to risk the open trouble and disruption of political resistance and others to move their strong feelings and thoughts underground. Once there, unspoken and out of relationship, girls' underground knowledge threatens to become buried, to become a psychological resistance - a reluctance to know and a fear that such knowledge, if spoken, will endanger relationships and threaten survival. (Brown and Gilligan, 1993: 14)

These authors suggest that, at this time in their lives, when girls become aware of cultural norms and values of femininity, they find it difficult to both be true to themselves, while *at the same time* stay in touch with others, and with the world around them (Brown and Gilligan, 1992, 1993; Gilligan, 1990; Gilligan, *et al.*, 1988). As they reach adolescence, girls begin to resist a cultural and "prevailing ethos of detachment and disconnection" (Gilligan, 1988b: xxx). They resist the separation of self and other which is inherent within conventional definitions of feminine goodness, and within the equation of care with self-sacrifice.

This analysis of young girls' resistance has parallels with the processes I have described in this chapter, and can shed light on the experiences of the depressed mothers. It seems that while the mothers had conformed to normative definitions, they had also resisted idealized constructions of the mother-child relationship in which the interests of mother and child are fused, rather than seen as connected and different. The mothers had therefore resisted the separation and disconnection between mother and child inherent within these cultural representations, in which the 'good' mother must take her self out of this relationship, "in the name of love" (Gilligan, 1990: 522). However, at this particular moment in their lives, they had felt unable and unwilling to openly voice this resistance for fear of damaging their children, and for fear of coming into conflict with, and being morally condemned by, others and society. They had felt under pressure from themselves, others and society, to take this resistance underground, where it had become a 'psychological resistance' - that is, their depression.

In sum, the data from this chapter show that the depressed mothers had not been helpless and passive victims of a hostile socio-political context, as feminist research has suggested (see Chapter One). Rather, they had actively struggled with, and resisted, cultural definitions of motherhood. During their depression, however, their resistance had been a silent one, and their outward behaviour suggested conformity on their part. In this chapter, I have discussed this resistance primarily in the context of the mothers' relationships with their children. In Chapter Five, I explore this theme within the context of the mothers' relationships with other individuals in their lives, such as their partners and mothers. I describe how the mothers had resisted the separation inherent within the cultural "ethic of individuality and self-sufficiency" (Jordan, 1992: 5), in which individuals are expected to cope with their own needs single-handedly. The following chapter examines how, during their depression, the mothers had withdrawn from their relationships with significant others, in an attempt to fulfil their own, others', and society's expectations that they should be coping, self-sufficient individuals.

This analysis of young girls' resistance has parallels with the processes I have described in this chapter, and can shed light on the experiences of the depressed mothers. It seems that while the mothers had conformed to normative definitions, they had also resisted idealized constructions of the mother-child relationship in which the interests of mother and child are fused, rather than seen as connected and different. The mothers had therefore resisted the separation and disconnection between mother and child inherent within these cultural representations, in which the 'good' mother must take her self out of this relationship, "in the name of love" (Gilligan, 1990: 522). However, at this particular moment in their lives, they had felt unable and unwilling to openly voice this resistance for fear of damaging their children, and for fear of coming into conflict with, and being morally condemned by, others and society. They had felt under pressure from themselves, others and society, to take this resistance underground, where it had become a 'psychological resistance' - that is, their depression.

In sum, the data from this chapter show that the depressed mothers had not been helpless and passive victims of a hostile socio-political context, as feminist research has suggested (see Chapter One). Rather, they had actively struggled with, and resisted, cultural definitions of motherhood. During their depression, however, their resistance had been a silent one, and their outward behaviour suggested conformity on their part. In this chapter, I have discussed this resistance primarily in the context of the mothers' relationships with their children. In Chapter Five, I explore this theme within the context of the mothers' relationships with other individuals in their lives, such as their partners and mothers. I describe how the mothers had resisted the separation inherent within the cultural "ethic of individuality and self-sufficiency" (Jordan, 1992: 5), in which individuals are expected to cope with their own needs single-handedly. The following chapter examines how, during their depression, the mothers had withdrawn from their relationships with significant others, in an attempt to fulfil their own, others', and society's expectations that they should be coping, self-sufficient individuals.

Chapter Five

Postnatal Depression and Silencing the Self

Chapter Five

Postnatal Depression and Silencing the Self

> I have this theory about postnatal depression, and my theory is that it's a woman's cry for help ... well it was my cry for help. I'm a very coping, very capable person and to actually admit that I can't cope, or even to know what not being able to cope is like, I wouldn't know. So I think ... that's how depression set in, and it was like 'Look, I can't cope but I can't tell anybody' type of thing. (Tina)

> You try and keep yourself inside, 'cos you're afraid that if you let any of your real self out then you'll just collapse ... either in tears, or however. So you try and keep this tough exterior and having to get on with things. (Celia)

Introduction

In the previous chapter, I discussed how the first-time mothers in my study had felt under pressure to exclude their own needs in caring for their children, in their attempts to conform to cultural definitions of motherhood, which equate care and moral goodness with selflessness and self-sacrifice. I also noted that, by the time the subsequent mothers had had their second or third child, they had known what 'real' mothers and 'real' children were like. They had no longer constructed these in idealized terms, but in ways which had reflected their own experiences of motherhood. Consequently, they had not encountered the conflict described by the first-time mothers, between idealized expectations, and the reality, of motherhood.

In this chapter, I describe a set of processes common to all 18 mothers in my sample. Although only the first-time mothers had removed themselves from their relationships with their children, all 18 mothers had withdrawn from their relationships with other individuals in their lives. The critical point to underline here is that all the mothers had felt disconnected from others and themselves, and this underlying experience characterized their depression. The precise routes they each took to this point of disconnection varied amongst the mothers; the idealization of motherhood had featured in the first-time mothers' experiences of depression, while all the mothers had expected they would be able to 'cope', both practically and emotionally, with their new baby.

All the mothers in my study had perceived themselves as self-sufficient individuals who had always 'coped' with situations single-handedly. "We've always been a very ... strong ... capable, coping family", said Tina. Similarly, Celia explained: "I tend to be the

sort of person that goes and helps other people, but I'm not very good at accepting help". Following the birth of the child after which they had become depressed, they had experienced a conflict between these perceptions of themselves, and their difficulties in 'coping' on their own. They had found that, contrary to their expectations, they had needed practical help in caring for their children. They had also felt "vulnerable" and "sensitive", and the need to be emotionally supported and cared for.

The mothers experienced this clash as a moral dilemma because they had seen themselves as individuals who, not only *had* always coped, but *should* be able to cope, without help. As I have described in previous chapters, this conflict was experienced by the mothers as a double voice and divided self. Marcia's rendering of these voices was particularly striking:

> There was these little voices at the back of my head saying, 'Of course you can do it', and it was like schizophrenia ... It was like, on the one hand, there was me sort of - 'I can't cope with this, I can't deal with it, how am I going to manage for a whole day, what time's he (her husband) going to come home' - ... and, on the other hand, there was me saying to myself - 'For heavens sake, it's only two children, some people have four ... you've got everything that you need to deal with them, it isn't a big problem, you can handle them, you've handled much worse than this in your life ... two bloody kids, really, it's not a big deal' - and so there was this constant battle going on in my head the whole time. That's what I remember most distinctly about that particular period of time.

All the mothers had resolved this clash, by attempting to deny their needs for support, both to themselves and others. They had felt reluctant to make demands on their partners, relatives, or friends. Instead they had thought it "better [to] just soldier on". The use of the word 'soldier' is telling in that it suggests a strong, shielded, stoical individual who must keep in line with others. Indeed, the mothers had felt under pressure to keep themselves 'in check', which they expressed through a range of expressions: "I had to keep going", "I had to keep being there", "don't let go", "keep on top of everything", "I just tried to do too much", "I done too much too quick", "having to get on with things", "I wouldn't let myself give in", "trying to keep up with things not giving in at all", "I sort of kept going", "I must keep up", "I wouldn't let things go". These expressions show how the mothers had denied their needs and "kept going", rather than "give in", by accepting and expressing these needs to others. The mothers therefore described how their resolution of the conflict between their expectations, and experiences, of 'coping' had led them to abandon themselves. They had persisted in their attempts to cope, single-handedly and in silence.

This chapter seeks to understand why the mothers had felt under pressure to silence their voices within their relationships with significant others (other than their children). I also examine *how* this withdrawal had led to their depression. I highlight three processes through which the mothers were led to social withdrawal. I have already touched upon these processes in Chapters Three and Four; indeed, the processes I document in this chapter have parallels with those described in Chapter Four in my discussion of the first-time mothers' withdrawal from their relationships with their children. In this chapter, however, I am concerned specifically with the mothers' relationships with individuals in their lives, other than their children.

The three processes I discuss are the following. First, I examine why the mothers had felt reluctant to even attempt to confide their feelings in others. They had believed that doing so would be a moral failure on their part. They had felt they did not have the 'right' to burden others with their difficulties. They had also feared others would interpret their requests for help as an indication that they were not 'coping' with motherhood. They had feared that in speaking out, they would be misunderstood, rejected or morally condemned for being 'bad' mothers. I discuss these processes in the first part of the chapter.

Second, for some mothers, these beliefs and fears had been reinforced by their difficult relationships with partners, mothers or mothers-in-law. The mothers who had felt unsupported by these individuals had found it difficult to voice their needs and feelings, either because the latter had failed to offer any help or comfort; or, because the mothers had felt rejected and silenced by these individuals, when they had attempted to disclose their experiences. These difficult relationships had led them to withdraw from these individuals. I address these issues in the second part of the chapter .

Third, the cultural context had contributed to the mothers' silence and withdrawal. The expression of negative or ambivalent feelings by mothers tends to be regarded as unacceptable within our society. Furthermore, a cultural 'ethic of individuality and self-sufficiency' (Jordan, 1992), in which help-seeking behaviour is discouraged, had reinforced the mothers' moral beliefs that they 'should' be able to 'cope' without resorting to others. In the third part of the chapter, I discuss this cultural context, by drawing both on my data and on the work of other researchers.

In the final section, I document how the mothers' social withdrawal had led to their sense of alienation from others and themselves, which they associated with their depression.

I. Silencing the self: the mothers' constructions of themselves and their relationships

In this section I examine how the mothers had refrained from voicing their needs and feelings to others, because of the meaning they had attributed to such a move. They had believed that having, and expressing, needs and feelings was a moral failure on their part; and they had feared that they would burden others, and be misunderstood, rejected and morally condemned by others.

1. Voicing their needs as a moral failure on their part

In Chapter Four, I discussed how the first-time mothers had interpreted their own experiences of motherhood as a failure, because they had not matched up to their expectations. All the mothers expressed a similar sense of failure at having needs and ambivalent feelings, and expressing these to others. They believed that they "shouldn't be depressed" and that they didn't "have the right to feel depressed". They had heard a voice inside their heads telling them they had everything they needed to be happy: "a husband", a "lovely baby", "a nice house". They had seen no reasons for their depression, and this had made it particularly difficult for them to accept their feelings. They had felt both responsible for, and guilty about, their experiences:

> When you're in a fortunate position ... you kind of think, 'Well I shouldn't be feeling depressed, I've got a husband with a good job, I've got a car, I've got a nice house, we don't have to worry about the bills ... we have holidays, we've got family, we're healthy'. *Everything* is on your side, but you still feel depressed, and that makes you feel even more guilty about it. (Louise)

The mothers had also felt they did not have the right to *express* their needs and feelings to others. Vera, for example, had experienced the question of whether or not to seek help from her parents as a *moral* issue:

> Every time [my husband worked shifts] ... I'd go and stay with my parents, and I felt like 'This isn't right, I should not be doing this, I shouldn't be needing this help'.

In thinking about this dilemma - whether to ask for help, whether to bring her needs into her relationships - Vera had felt under pressure to withdraw, because to admit her needs and vulnerability to others would be shameful and embarrassing, a sign of weakness and failure:

> I was ashamed, 'cos I'd always coped with everything before with no trouble ... I'd always got on with things, I'd never needed any help from anybody, I'm quite a private person ... I was embarrassed by it ... 'cos I've always been ... quite self-sufficient and not needed any sort of help.

Louise had also experienced a conflict between wanting and needing the help of others, and yet thinking that she should neither need, nor request, such assistance. In thinking about this dilemma, she had been guided by how she believed others might judge her, rather than by her own feelings:

> I could have just done with somebody, just to have [my son] for half an hour, *here and there*, just so I could make a phone call, write a letter, do a little but important job, peel the potatoes for the tea ... My neighbour ... actually ... offered to have him, but again, I think there was this thing about 'I must be seen to be coping, I can't possibly be seen to be running round next door ... every time I want somebody to hold him'.

This outsider's perspective, experienced psychologically as an internalized moral voice, had "bound" her and kept her from bringing her needs and feelings into her relationships:

> I expect if I'd clamoured a bit more, and made a bit more of a fuss ... my health visitor perhaps would have come a bit more often. But again, I was bound by this fact that I was 32 years old, intelligent, articulate, I *should* be able to *handle* it ... I *shouldn't* have to be calling on these people all the time. I was *desperately* trying not to I suppose.

Like Vera, Louise had constructed the dilemma of whether to voice her needs as a moral issue. Louise had believed that a silent, stoical and coping response - that is, a withdrawal from her relationships - was morally correct. Consequently, when, on one occasion, Louise had exposed her vulnerability, she had experienced a deep sense of failure:[1]

> There's one Friday morning when I just ran round in desperation with him. He was just screaming, couldn't shut him up, and I was in a *terrible* state ... I did actually go round [to my neighbour] and just said 'Look, I'm really upset, would you just come round and have a cup of tea with me, I feel very lonely and isolated here', and she did ... And she took the baby off me ... and about two minutes later, he was fast asleep, and I just couldn't do a thing with him ... So then you don't know whether to feel pleased or to feel even more of a failure that someone else has succeeded where you couldn't [laughs].

---

1 Graham (1982: 113-114) similarly notes that "the very definition of the mother's role militates against action, individual or collective" because "successful coping hinges around the quiet acceptance of your lot: to speak out, to criticize, to protest, to set up alternatives, lies outside the repertoire of the coper. To be vociferous in a campaign to change your situation is tantamount to a public admission of your failure as a woman-who-copes".

Louise had found that "just having other people around" - like her neighbour - "was quite supportive". She also said her "parental home [was] quite a little cocoon", a place where "even at my great age ... I feel very safe". Despite her need and wish to be with these comforting people, Louise had felt under pressure to deny her desire for company. She had feared what others might think - "I didn't want to be seen to my husband, 'I'm going home to mother', sort of thing" - and that they might judge her a 'bad' mother who could not "cope" with motherhood.

Critical to all the mothers' accounts was their deep sense of failure at feeling unable to be "independent", "strong", "capable" and "self-sufficient" mothers who "coped" with their needs single-handedly:

> I felt like I was a bad mother, and I couldn't cope with it all... I felt I couldn't tell anybody, even though I was sort of glad that they knew what was the matter. I couldn't tell anybody because I felt like I'd let everyone down. I wanted to do really well and for everyone to think 'Isn't she doing well and isn't she wonderful and isn't the baby wonderful' ... I still feel that I'm a failure 'cos I couldn't do it ... I sort of gave into this, if you like, it got hold of me, and I was weak. (Petra)

> I'm my own worse enemy in a way because ... I'm quite independent ... and ... I just like to think and show people that I can cope, and perhaps I couldn't at the time ... But I didn't want to show it to anyone ... I thought ... 'I've gone through two other children', and I wasn't going to let myself down by admitting the fact that perhaps I couldn't cope. (Frances)

> You feel it's a crime to feel depressed - 'I'm not going to talk about it, keep it to myself'. I didn't want anybody to know I was depressed; it means you can't handle looking after your child. (Fiona)

It is important to appreciate the full weight of what these mothers were saying. They felt that to have a relationship in which they could disclose their needs and feelings, that is, to have precisely what so many research studies have now shown protects women against depression (see Chapter Three), was morally wrong and emotionally treacherous.

2. Voicing their needs and fear of burdening others

Kaplan (1984: 6) has noted that "the fear of harming others even as one is reaching out" appears repeatedly in therapy with depressed women. The mothers in my study expressed similar concerns. They said they had been reluctant to disclose their experiences because they had feared "burdening" their partners, relatives and friends:

> I didn't really want to talk to my *family* because ... seeing me poorly upset them ... I knew it was worrying my parents if I talked about it at great

length ... so I didn't ... I don't want to worry [my mum] ... I don't like her to think I'm not coping with things. (Louise)

I could talk to [my husband] about it but it come to a point where I thought I couldn't, 'cos it's just not fair on him, he doesn't want this, he's working, we've got money troubles, it's just not fair on him ... I didn't really want to burden him with it all, 'cos I felt he'd had enough of it already. He never said that, but I felt ... 'He can only take [so much]'. (Vera)

Vera's account illustrates again the moral nature of the mothers' thinking about themselves and others. She had felt it would not be "fair" for her to, as she saw it, "burden" her husband. During her depression, Vera had seen no way of voicing her emotions without feeling she might be harming her husband.

The mothers had feared that bringing their own needs and feelings into their relationships might "hurt" or "worry" others. They had believed, and had feared others might judge, such actions to be selfish and morally wrong. During their depression, they had constructed themselves and others in terms of an either/or formulation, in which self and other were seen as separate and oppositional, rather than as connected and interdependent. They had not felt that both they and the other might both express their feelings within a relationship. Rather, their care and concern for their significant others had led them to remove themselves from their relationships, in order to 'protect' others from their difficult feelings.

3. Voicing their needs and fear of being misunderstood

The mothers had also feared being misunderstood by others. For some, this fear had been based on a previous experience of voicing their needs, and feeling rejected by others, as I discuss below. However, many of the mothers had silenced their voices even in the absence of such rejection and inattention. They had believed that, unless others had had similar experiences to their own, they could not possibly understand their feelings. These mothers had not even *attempted* to seek understanding. Frances said: "I didn't think people would understand ... People don't understand unless you've actually been through it".

As I noted in Chapter Three, the nine depressed mothers who described positive relationships with their partners, had nonetheless found this support to be limited because they had experienced neither motherhood, nor depression. Frances explained that her husband had "been as understanding I think as any man who doesn't really understand what you're going through can be". Pam made a similar comment:

> Jim was really good, how he stayed married to me, I don't know ... He was brilliant, but it wasn't the same ... You'd say 'I feel like this', and he'd go 'Yes, I know' and you'd think 'You don't know because you've never been through it' ... It's like any experience you have in life ... So that is what I found difficult, I always wanted to talk to somebody who'd been through it and knew what I was going on about.

Moreover, many of the mothers had felt their own mothers would not understand their feelings, partly because attitudes and practices had changed since they had had young children. They felt their own mothers neither dwelled on, nor discussed, *feelings,* adopting the view that, as a mother, 'you just get on with it and cope':

> I just couldn't [tell my mum] ... I didn't want to do that ... for all my mum's very, very kind and very sympathetic and everything ... she probably thought ... I ought to get myself sorted, you know, 'pull yourself together', a bit stiff upper lip and grit your teeth and get on with things. (Louise)

They had also felt they could not confide in friends who did not have children themselves, because they believed these women would not understand their experiences. This was particularly the case for the first-time mothers whose friends had tended to be mostly working women without children (see Chapter Three). Penny explained how before becoming a mother she had mixed with "all the fashion-conscious-have-a-good-time-friends, where now it's the mumsy-we-love-our-children-we-want-the-best-for-our-children-friends". During her depression, she had felt distanced from her working friends, and had not yet formed friendships with other mothers with young children. She had therefore felt she had no one to talk to:

> Because of my life style before I had Adam ... I never used to be with women with children. We were all with jobs ... We were all the same kind of people, none of us knew anything about children. So of course when I had Adam, I didn't know anybody with children ... So all my friends, none of them had children, so I couldn't talk to them.

However, even the women who *had* known other mothers with young children, had felt unable and unwilling to talk to them, because they had not experienced *depression*:

> *So it's even hard to turn to other mothers for help?*
> Oh yeah. I didn't tell any of them until it came up in conversation a while ago. 'What?', [they said], 'You never said anything, *why* didn't you tell me?'. But I don't think any of them would have been able to help, even if I had done. (Caroline)

Thus, the majority of the mothers in my study felt the only individuals who would have understood their feelings were other *depressed* mothers. I return to this issue in Chapter Six.

4. Voicing their needs and fear of rejection and moral condemnation

The mothers' concerns about "burdening", and being misunderstood by, others centred around their fear of rejection and moral condemnation. As I pointed out in Chapter Three, however, these fears appear to have been, in part, out of proportion to the reality of the situation. The mothers', largely unspoken, beliefs about their own inadequacy had grown larger and larger, as they had withdrawn further and further from genuine dialogue with others. At the same time, their fears about how others might react to them, had also grown out of perspective, and they had experienced them as increasingly unspeakable. Consequently, several mothers had found that when they had eventually voiced their feelings, others had not rejected them as they had expected.

Frances, for example, had not told her twin sister about her experiences until several months into the depression. When she had eventually confided in her she found that contrary to her fears, her sister was "marvellous", and Frances attributed her movement out of depression virtually entirely to the care and understanding her sister had given her:

> I told my sister ... I hadn't even told her, and when I told her she was *absolutely marvellous* ... it was the best thing I ever did because she helped me such a lot, and quite honestly, if it hadn't been for her, I think I would have topped myself because she just talked to me.

Although the mothers' fears had resulted, in part, from their loss of perspective, in some cases, they had been grounded in their experiences of rejection. Monica, for example, had often expressed anger at her husband and his lack of support. During her depression, he had left her on several occasions for a period of several days or weeks. In order to avoid further conflict, Monica had not persisted in voicing her feelings to her husband. (The mothers' experiences of being silenced and rejected by others are examined further below).

Other mothers believed their partners, and others, *might* have rejected them had they disclosed their needs and feelings. Dawn had feared that if she said "too much", her husband might leave her. For the sake of preserving her relationship, she had silenced her own voice:

> I'm a little bit afraid of saying too much and he'll leave me, 'cos I don't want to be left. Things may not be perfect in our relationship, but I still love him enough to want to hang on to him ... I'd hate to drive him away

> because I've said something, and I'd hate to be left alone with two children to bring up ... I wouldn't want to be a single parent.

The mothers' fears of being left alone with their children were grounded, given the economic hardship often faced by single mothers (Graham, 1984).[2] Dawn's decision had made sense economically, even if it had left her feeling emotionally and psychologically isolated within her relationship.

Many of the women also expressed a strong fear that they might have been rejected by other mothers, had they revealed their feelings:

> Like I said about going to the NCT group, if ... I'd given myself to them and said 'Look folks, you knew me as I was, but I really feel bad now' ... would they have all rallied round and hugged me and said 'No, it's fine' ... or would they have felt a bit embarrassed and thought 'Oh God ... what do we say now' ... I think I didn't want to try that out in case it went the wrong way. (Sonya)

As I discussed in the previous chapter, the first-time mothers had withdrawn from other mothers with young children because they had believed their experiences were 'different' and 'abnormal' in comparison. Part of this silence and removal had resulted from their fear of rejection.

5. Discussion

The mothers' *beliefs* about the meaning of voicing their needs and feelings to others had accounted for much of their silence and withdrawal. During their depression, they had constructed themselves and others in such a way that they had seen no way of claiming a voice within their relationships. Indeed, the mothers themselves were aware that much of their depression had resulted from these constructions. They had heard a voice inside their heads telling them they would be rejected if they disclosed their feelings. This internalized moral voice had guided their actions, and led them to withdraw from others.

Sonya, who was still depressed at the time of the interview, gave a striking and lucid account of these processes. She wanted to tell her best friend Clare, who had no children herself, about her feelings of depression. Although part of her knew that Clare would not reject her, another part told her she would. The "fear of rejection", she said, was preventing Sonya from confiding in Clare:

---

2 Oakley (1993: 146) notes that "an oft-quoted fact is that by the year 2000 in countries such as the UK and the USA, the poverty population is expected to consist entirely of women and children living on their own".

> I'd love to sit [Clare] down here and tell her the whole lot, and then, if you like, in my book, I'd expect her to walk out and say 'You're a terrible person, I never want to see you again'. But she won't do that, but that's what my brain is telling me people will do, that they'll say 'My God, we thought you were okay, but ... you're telling us all this now'. But people are not like that, are they, they don't say 'You are dysfunctional therefore we don't want to know you', but that's how I feel inside ... If you like, if I open up and show them that core in the middle, are they going to stab it and say 'Ugh' ... They're not going to say 'Well fine, you're still you, this is part of you, this is an experience you're going through' - yes, it's the fear of rejection when they know the full story.

Sonya was aware that her depression was in part something she was "doing .... to [her]self". She was expecting other people to respond negatively to her, even though she *realized* these negative "words" and "thoughts" were probably "not there", but were being put there by her:

> I grind myself down before I go to things ... I'm putting words in people's mouths, and putting thoughts in their heads that are not there. But I'm doing it to myself, but I don't know why I do this ... If I walked in and just felt that there were good feelings coming towards me, then I'd be fine. But I just walk in and think 'God, they think I'm a terrible person'.

The voice that told her she would be rejected drowned the other voice that assured her she would be greeted by a warm and sympathetic response. As she explained, although her fear of rejection was a "reality [that] is only mine ... you can't convince me that it is":

> All this thing about being paranoid about expecting people not to be sympathetic ... if only I could cut that part of my mind out then I'd be a perfectly normal, fun-loving, happy individual, who never had any worries ... This mind thing, it's sort of, how do you find a solution to changing your mind's attitude? It's like, if I say to you 'I'm not going to see so and so this afternoon, 'cos I don't think they'll be glad to see me', that reality is only mine, but you can't convince me that it is.

In sum, the mothers' withdrawal from their relationships had been based, in part, on their beliefs and fears about how others might react had they voiced their feelings. In many cases, the mothers' actions had been 'unnecessary', in the sense that they had later found that others did not reject them when they had disclosed their feelings. In other cases, however, their beliefs had been reinforced by their experiences of difficult relationships with others.

II. Silencing of the self: the mothers' experiences of difficult relationships

In this section I examine the mothers who had felt unsupported by partners, mothers, and mothers-in-law. These difficult relationships had confirmed the mothers' own constructions described above, and had reinforced their moral beliefs that they should remain silent and withdraw their own needs and feelings. In the previous chapter, I discussed how the first-time mothers' encounters with other mothers, and their relationships with significant others, had similarly facilitated their exclusion of their own needs within their relationships with their children. Here, I examine analogous processes by highlighting how the first-time and subsequent mothers' difficult relationships with partners, mothers and mothers-in-law had facilitated their social withdrawal.

These mothers described removing themselves from their relationships because they encountered three types of difficulties.[3] First, they had felt that others had expected them to "cope" single-handedly, and had therefore failed to *offer* either practical or emotional support. They believed *others* had removed themselves from these relationships, expecting that the mother should neither need, nor request any help:

> There wasn't any help, and there was this sort of feeling ... 'Well, you should get on with it anyway ... it's no big deal, you've had a baby, that's all you've had' ... It's actually very difficult for someone to ask for help ... as a mother you're expected to cope and it's seen as very negative by everybody, it's as if most people can't deal with it. (Helen)

The importance of help which is offered, as opposed to asked for, has been noted by other researchers. O'Connor (1992) for example, points out that it is now being increasingly recognized that the most supportive relationships may be those which provide assistance, without it being asked for, and/or support which is offered in such a subtle way that no-one loses face or has to admit their need for help. Jordan (1992: 4) makes a similar point:

> People ... sometimes wish that another person will know what is wanted without their having to state it directly; the care is considered better when another person is tuned in to our unstated needs.

Second, these mothers felt that when they had asked for help, and sought to confide in partners, mothers or mothers-in-law, the latter had failed to listen or respond to their needs. A third issue concerned the "uneven balance" they had experienced within these relationships, in which they had felt they were giving more to the relationship than the other had been.

---

3 A fourth issue was the one discussed in the previous chapter, in which the mothers had felt that those around them had been critical and judgemental.

1. 'The struggle to claim a voice'[4] within relationships with male partners

Here I consider the eight mothers who described having difficult relationships with their partners.

(i) Partners' lack of initiative

These mothers had felt their partners had assumed and expected that they would, and should, single-handedly carry out all tasks and responsibilities relating to the household and childcare, including where the mother had been in full-time paid employment. Their partners' lack of involvement in the home and in childcare had left the mothers with the bulk of the household 'work', and had left them feeling unsupported in practical terms. It had also left them feeling emotionally unsupported and distanced from their partners for several related reasons.

The mothers had felt emotionally drained by the responsibility of having to look after the children and take care of household tasks, single-handedly, and by their sense that life in their home would have come to a stop had it not been for them. Helen explained that "If I died, he'd have *no* idea about anything that went on with the house ... how bills were paid or what happens to Ben [the child]".

The fact that their partners had not helped meant the mothers had felt they had no understanding of their day, their feelings, or their lives as mothers:

> He has no idea, *no* conception of what it's like to look after kids on his own, 'cos he's *never* done it. I've *never* left him on his own with the children ... he's never offered to look after them ... That's very frustrating when you're having a hard day and they *don't know* what it's like. (Dawn)

Their lack of support had also left the mothers feeling emotionally cut off from their partners because they had experienced this lack of practical assistance as a lack of care, love and concern *for them*:

> I am responsible for transporting Ben to and from nursery every day ... If, for instance, Simon was on a late [shift] on Thursday, so that means he doesn't have to get to work until one, if I was Simon, I'd say 'I'll take Ben up to nursery, you have a lie-in'. Oh no, I have to *ask* him to take Ben to [nursery] on the Thursday. And I'm not sure how much of that is *him* or how much that is a man and just not seeing that these sort of things need doing ... or that it would be nice to give me a break. (Helen)

---

4 Expression borrowed from Gilligan (1988c: 17).

Practical help was therefore important not only because it would have alleviated the amount of physical work to be done, but also because, to the mothers, it had symbolized care.

The fact that partners had not shown an interest in being actively involved in the lives of their children had left the mothers feeling emotionally disconnected from their partners for two reasons: first, they felt they were not sharing this child that they and their partner had, in most cases, planned together, and both wanted;[5] and second, they did not understand why their partners had not shared the interest that they themselves had in the children:

> I wanted him to be a bit more involved with them ... I think that worried me a little bit as well, because I wanted him to be one of these fathers that *absolutely* adored them ... and played with them, and he'd never play with them, he'd tolerate them, but he didn't really play with them in the way that I would have liked to see him playing. (Frances)

Finally, there had also been a moral dimension to their partners' behaviour. The mothers' perceptions of their partners' lack of support had increased their beliefs that they should be able cope on their own, and had thus added greater 'volume' to the internalized moral voice which had told them that mothers should be self-sufficient:

> I assumed that this was just another up and down and I'd get through it ... I would be strong and cope ... [but] I think when there's a strain like [having to work full-time against my wishes] it tells on us, and unless I can be strong and work through it when I'm feeling vulnerable and can't cope with it, that's when [my husband] finds it hard. (Sandra)

(ii) Seeking practical help

Despite these strong moral messages, the mothers had nonetheless attempted to voice their practical and emotional needs. However, they had felt their attempts at seeking practical help from their partners had been consistently rejected and they had felt silenced within these relationships. They described how, when they had asked for assistance, their partners had told them their need for help was *their* "problem"; they were "nagging" them; or they were being "difficult". As Sandra said, "I very much get the impression ... I'm being difficult if I'm insisting that I need some help". In other cases, the mothers said their partners had simply failed to respond at all. Following what they had experienced as repeated rejection, and in order to protect themselves from further rejection and disappointment, they had decided it was "better" to "keep quiet" - it was no longer "worth"

---

5 See Table 8 Appendix 6 for information on the degree to which the child after whose birth the mothers became depressed was planned and/or wanted.

asking because when they had asked they had reached a situation of "stalemate". Frances explained: "I soon learnt not to rely on my husband. I find it better, I suppose. I like to be independent, I'd rather not rely on him".

The mothers explained how at an *emotional* level, "it's not worth asking" after a while, it was "easier to do it yourself than asking". In other words, they had felt it had been easier to withdraw themselves and their needs from their relationships altogether. Helen gave a clear account of this position:

> We used to have this *rota* to get up and feed Ben, so the other person could have another sort of half an hour lie-in. But even though we knew what the rota was, I was still having to remind Simon that it was time to get up and give Ben breakfast. So it's just not worth it to me any more, I just get up. It's not worth asking ... In the past month, I've just changed, I've decided it's not worth it ... We've discussed it a lot and he says 'Well honestly, I'll do it, of course I'll do it', if I ask him. Well I mean by asking it's actually easier to do it yourself than asking, isn't it?

At some level, it had been 'easier' for these women to silence their voices, even if they had done so at great cost to themselves. Persistence had led to conflict - as Sandra said: "If I don't just plough the line then I'm being awkward and difficult" - and in order to avoid conflict, the mothers had withdrawn.

(iii) Voicing their feelings

Amongst the eight women who had felt unsupported by their partners, a number had, at some point, shared their difficult feelings with their partners, even if only after several months into the depression. It had taken Frances a year to tell her husband about her depression. When she had done so, he had been "very supportive". Others, however, had felt their partners had failed to be sympathetic:

> He's a typical man, he doesn't understand what women go through. He thought I was just being stupid ... I couldn't talk to him 'cos he didn't listen practically ... When I was in tears, I tried to explain to him then, but he didn't have much time for it all. (Monica)

> [He comes] home, he's tired ... and I say 'I've had a terrible day, I feel ill, it's never going to end' ... and he says 'Look, I don't want to hear all this, everybody else is asking me for answers' ... So what I do then is say 'Okay ... let's not talk about it' ... So I hadn't shared it with him 'cos he hasn't got the capacity to share it ... So all the time there was that little unresolved bit at the end of the day. I wanted to put out what I'd felt but it was negative, therefore it was just yet one other negative thing that was coming at him. (Sonya)

Faced with what they had experienced as overwhelming rejection from their partners, these mothers had withdrawn their difficult feelings from these relationships. Sonya, for example, described her husband's unwillingness to listen to her, and his lack of understanding for her need to see a psychotherapist - she explained that "He doesn't mind me going to a psychotherapist but ... the bills do mount up and ... He said to me 'I'd rather you had a few more golf lessons than run up bills on a psychotherapist'". Eventually, she had come to "protect" him from most of it - "we don't ... discuss it at length", she said.

(iv) The 'uneven balance' of relationships with partners

The difficulties these eight mothers had experienced had involved more than simply their partners' lack of practical and/or emotional involvement. Helen, Tina and Frances explained how "very supportive" and caring their husbands had been. Similarly, Tina and Sandra described how very involved their partners had been with their children, both emotionally and practically. They described a deeper problem, however, which had been their sense of an "uneven balance" within these relationships. In speaking about this issue, they constantly drew on the metaphor and image of a balance. They spoke about "one-sided" partnerships which were not "equal"; relationships in which there had been a "disturbed ... equilibrium" and where they were "not finding the happy medium"; relationships as a "tug of war", which had not been "reciprocal", or on an "even keel".

Each mother had her own definition of what constituted an "even", "reciprocal", "equal" or "balanced" relationship, and they spoke about the 'uneven balance' in different ways. All these mothers, however, had felt there had been an absence of balance in their relationships. In some cases the partners appeared to have been minimally, if at all, involved; these mothers had wanted greater participation from their partners. In other cases, partners *had* been made practical and/or emotional contributions but the mothers had felt they were involved on their own terms rather than on the mothers' terms. They had felt their partners had helped them, when and how *they* (the partners) had wanted to, but not necessarily when and how *the mothers* had desired support.

Sonya felt that while she had changed her life to take care of her daughter Suzie, her husband had made no such equivalent changes in his life, and had made no attempts to meet her half way:

> I have bent towards him, and I have said 'Right, I'm looking after Suzie' ... but I just feel that there's not that same reciprocal 'Okay, I'll try and be home at seven, two nights a week'.

What Sonya had found most difficult was "the total unbending nature of it - that he doesn't say 'We need the money, I need to work hard, but if I could come home an hour earlier, it relieves you a bit'".

Tina, on the other hand, felt her husband had been 'good' with the children, and had been there for her emotionally. Despite his overtly supportive behaviour, she had not found this helpful. She had felt that, in exchange for his support, he had expected her to then "be there for him, all the time, emotionally":

> He'd run round with cups of tea keeping me happy ... To everybody else, I mean, [he seems like a] very *good* husband, but at what cost do you see? ... He would do things for me but, in a way, I was then expected to be there for him all the time, emotionally, and ... giving, well everything, every bloody everything ...
> *So was he there for you emotionally?*
> No, not at all, nothing, I just had to be giving all the time.

Similarly, Helen explained that her partner Simon had showed her the more obvious forms of emotional support, such as being "supportive", "caring" and "loving". However, the fact that he had not seen what needed to be done, practically, had meant that his emotional support had lost its meaning and value because care as "physical effort" had been absent:

> [My partner] is very supportive ... he does give me emotional support. He often doesn't, again, see things ... He doesn't see that things do get you emotionally wound up, like this business of taking Ben to nursery on a Thursday morning, if he's around. That actually gets me emotionally wound up, rather than physically wound up, but he can't actually see it. But no, he is very supportive, he's very caring and loving ... there's no two-ways about that, and he's very good with Ben.
> *So when you were feeling emotionally low, and during the particularly bad bits, he was very much there was he?*
> Yes, but ... I'd still have to ask him to get breakfast ... He was *there*, and [he'd say] 'I worry about you' and all this sort of business, but wouldn't actually see that a help to that would be physical effort.

These mothers had experienced an uneven balance within their relationships; their partners had offered help on *their* own terms rather than on the *mothers'* terms, or at least half way between the two. In wanting "balance", these mothers were not saying that they had *necessarily* wanted "equality" in the sense of equal contributions by themselves and their partners to housework and childcare. Rather, they had wanted their relationships to be more reciprocal and mutual, they had wanted more 'give and take' from both sides. They had felt such mutual change and accommodation, however defined, had been absent from their relationships.

In conclusion, these eight mothers had felt unsupported by their partners because the latter had failed to *offer* support of their own accord and to *respond* to the mothers' needs when they had requested help. They had also felt that if their partners had been involved, practically and/or emotionally, this had been on the latter's terms while their own terms had not been taken into account. The difficulties these mothers had encountered with their partners had led them to eventually withdraw their needs and feelings from these relationships.

2. 'The struggle to claim a voice' within relationships with mothers and mothers-in-law

I now consider the eight women in my study who had felt unsupported by their own mothers, and the five women who had encountered similar problems in their relationships with their mothers-in-law. The nature of these difficulties were similar to those described in relation to male partners.

(i) The emotional and moral significance of lack of practical support

These women had felt dissatisfied with the practical help their mothers and mothers-in-law had given them because they had failed to *offer* such assistance. Helen explained that her parents-in-law "are practically very supportive but only if they're asked ... they won't offer specifically ... which I personally don't find very helpful. I think people need to see what you want without being asked".

The lack of support had held emotional and moral significance for the mothers. Petra explained how her mother's failure to offer help had left her feeling unloved and uncared for:

> What used to really upset me [was that] I couldn't understand what she was thinking by [not helping me] ... what was she thinking about me, she obviously didn't care about me, bother about us at all, didn't she ever think what I was doing five days a week?

They had also experienced the lack of practical assistance as a *moral* issue; they had wanted moral reassurance in mothering their children which they felt they had not received. This lack of reassurance had further eroded the mothers' self-confidence, as Petra explained:

> I ... felt as if I was left alone with this baby and I didn't want to be ... Looking back, I think my mum thought that she was doing the best ... she wasn't to interfere it was my baby but on the other hand I wanted someone

> to help me and tell me if I was doing it right or to show me what to do ... I still look for someone's approval whether I'm doing it right or wrong.

The women had also felt that, underlying the absence of support from mothers and mothers-in-law, were moral issues concerning the role of 'mother'. The fact that Petra had not been offered help in looking after her son had reinforced both her belief that she "should" be the one to be looking after him anyway, and her guilt at wanting some time to herself:

> I just needed somebody who could be there, that I could call on, that ... would just take over. But I never went out, you see, never went out in the evenings. I never had anyone look after Joshua. I felt I couldn't leave him, I felt guilty. I felt that ... I'd taken on this baby and I should be there no matter what, and it just sort of got ridiculous in the end ... I just got obsessed with not going out and, on the other hand, nobody sort of said 'Go out, let me look after him ... for a day while you go out or something'. Nobody said that.

These women believed others had expected them to be self-sufficient, autonomous, independent individuals who should be able to manage with their daily tasks single-handedly. Sandra was particularly articulate upon this point. She had felt her husband, her parents and her parents-in-law had all assumed that if she had "a problem coming up, I'll make my own arrangements". This assumption, she said, had meant she had not been offered help by them:

> I think everybody is just assuming I'll be here and ... all the things will be done ... and I find that hard. I think they assume if I've got a problem coming up I'll make my own arrangements. I don't know quite what they think I'm supposed to do in these situations.

Sandra's expectation that "everybody would take part in bringing ... up" her daughter had clashed with her parents, parents-in-law, and husband's ideas: they "didn't look on it like that". Their expectation had been that: "it was my role now, you're mum, you do this this and this". Sandra explained:

> As soon as I had her ... I thought, 'Well I've done my bit, this is now somebody else's problem'. Of course it wasn't, it was the start of *my* problem. I assumed it would be ... a universal thing ... everybody would take part in bringing her up, and other people didn't look on it like that, you know, it was my role now, 'You're mum, you do this, this and this'. So yes, I suppose I had the wrong ideas, I assumed that if I couldn't cope then other people ... would take over ... but it didn't work out like that.

Sandra felt that becoming a mother had not changed her own understanding of her relationships. She had assumed that she was still in a mutual relationship with those around

her. As she said: "I assumed ... that if I couldn't cope then other people ... would take over". In contrast, Sandra felt her parents, parents-in-law and husband had come to hold different expectations of their relationships to her once she had become a mother. They had removed themselves from their relationships, assuming that she would, or should, not need their help.

(ii) Seeking practical help

Despite the lack of support, the mothers had attempted to bring their needs and difficult feelings into these relationships; in spite of this, their words had gone unheard.

Several women had felt that when they had asked for practical help, their mothers and mothers-in-law had not responded. Helen said: "the thing I felt was when I did ask for help, it wasn't given anyway" - "the person I asked for help, from my mother, she denied it". Sandra's striking account of her desperate attempts to seek help from her husband Bob, and her parents, illustrates what she had experienced as their repeated failure to respond to her needs:

> I got *really* upset when I had to go for the appointment for my ear, to find out about whether I could have an operation ... Bob was going to have some days off and then he said 'Well I don't know whether I can or cannot get the time off'. And then mum and dad ... said 'Well, we'll only stay ... if Bob can't get it off'. It wasn't 'Well we'll stay *anyway*, whether Bob is there or not'. And I suddenly thought 'Well ... it'll come to Friday and Bob won't know whether he's off, and mum and dad ... won't want to stay' and ... so I got really cross about it and I said 'Well just ... forget it, the lot of you, I'll take Alice with me to the hospital, which is not really what I want to do, I want to go there *on my own* and have that time to myself'. I think Bob took it off in the end, after a lot of hassling and saying ... 'This is *one thing I want, I want that hour of that day to me* and I want somebody to look after Alice - will somebody please help?' ... That was really stressful 'cos neither of them were going to take on the responsibility, nobody would say 'Look, it's alright, yes I'll do it' ... It was really frustrating ... You ask for help sometimes but ... it doesn't get taken on board, as you're screaming out to say *please* will somebody do this ... That's difficult, I think ... as time goes on, it gets easier, 'cos you just come to the conclusion that ... it's better to just get on and do it yourself, but it doesn't make for a close relationship, does it? - 'cos you become isolated ... you go off and do your own thing and I find that hard to cope with.

Sandra's experience had led her to conclude that "it's better to just get on and do it yourself"; that is, it had been better to act *as if* she had been on her own. Sandra had taken *herself* out of her relationships with her partner and family, because she felt they had removed themselves from these relationships, given their refusal to respond to her needs, or to take an active part in caring for Alice. But Sandra also explained how this move of

hers "doesn't make for a close relationship ... 'cos you become isolated ... and I find that hard to cope with". In taking herself out of these relationships, Sandra had come to feel increasingly alienated from others and herself, and had become depressed.

(iii) Voicing their feelings

These women had also believed that neither their mothers nor mothers-in-law could accept their negative feelings. Petra had tried to express her feelings to her mother, who seemed not to have heard her words:

> I was trying to tell my mum how I was feeling, from inside of me, telling her all my feelings, and that I didn't want to go out, and I didn't want to stay home. I found it hard, and our whole family was there, and she said 'You don't want to go out, you don't want to stay in, what *do* you want to do?' in a loud voice, in front of everybody, and I thought 'Oh my God', I felt awful.

Her mother's response had led Petra to withdraw from her. She explained that: "you certainly could not tell her how you were feeling".

Similarly, Helen, who had been studying part-time for a doctorate during her depression, had also tried to confide in her mother:

> I did say to my mum how I felt ... when I really hit rock bottom ... [but] she keeps going on about this *bloody* thesis, it means a lot to her, for one reason or another, me doing this *sodding* thesis and so she keeps going on about it - 'Have you done work tonight on it?' ... and I say, 'Mum ... I feel *really* low, I'm so fed up I don't know what to do with myself', and the next day she'd phone up and say: 'Have you done any work on your thesis?' She had no acknowledgement at all for what you'd just said, so ... there was no support there either.

Her mother's failure to acknowledge her feelings had led Helen to silence her voice within this relationship - "I wouldn't tell her my inner secrets", she said.

Sandra explained that she had changed since having her daughter, and with her depression. When she became upset she now showed her emotions in a way she had not done before:

> I assumed that this was just another up and down and I'd get through it ... I would be strong, and cope, and perhaps the hardest thing for everybody else is this time, I didn't. Thinking about it, I think that's probably the crux of it, this time *I cracked,* I just sort of said, 'That's enough, that's it, I've had it', and threw an absolute wobbly ... [My parents] ... just can't cope with me going a bit funny ... they can't understand it if I get tired or upset

> or something ... I think [my mother] feels disappointed that I can't cope ... You see, I wasn't the person she knew, because I'd been through all this and I wasn't coping, but she couldn't take that on board really, and even now, she can't really.

Sandra had felt she had needed an accepting, caring and responsive environment in which she could be herself, show her vulnerability, have her feelings acknowledged and be accepted for whom she was. However, Sandra had found this was something her mother had been unable to provide:

> I still get cross with her at not being able to just put her arms around me and say 'Look, it's alright ... calm down, just go and sit down and have a cup of coffee'.

Consequently, she had withdrawn from her relationship with her mother (and parents), and had become isolated as a result. She now felt "a bit lost" as to who to turn to "if things really do go wrong":

> I think the main problem is ... I haven't got one main person I can really go to ... If I'm really in difficulty ... I'd have to think about where I would go for help. If I was really stuck, then I'd go to mum and dad because I know they wouldn't let me down ... but I couldn't really break down on them ... let go, or really have a good holler ... I think sometimes I feel a bit lost with help if things really did go wrong.

The women had also interpreted their mothers' attitudes and behaviour in moral terms. These had reinforced their own beliefs that, either having, or expressing needs and negative feelings was unacceptable. As a result, they had kept their experiences to themselves, in order to comply to what they had believed others expected of them. They had regarded silence as a way of ensuring acceptance by others, and securing their relationships.

I have discussed the ways in which the mothers had felt unsupported by their partners, mothers and/or mothers-in-law. They had felt these individuals had failed to offer support, and had rejected and silenced them when they had attempted to voice their needs. Consequently, they had felt hurt by, and isolated from, their partners and family. The attitudes and behaviour of these individuals had reinforced the mothers' culturally-derived beliefs that they should neither have, nor express, their needs and ambivalent feelings. For emotional and moral reasons, the mothers had withdrawn from their relationships.

III. The cultural context

The mothers' experiences need to be placed within a broader cultural context. Both their own constructions of themselves in relationship to others, and their actual experiences of these relationships, had been informed by wider cultural beliefs about what it means to be a mother, woman and individual within our society. The mothers spoke about these social norms and expectations through the concept of "coping". This term, and what they understood by it, underpinned their constructions of themselves and others, and is therefore key to understanding their silence, withdrawal and depression.

As I discussed above, the mothers had felt under pressure to show themselves and others that they could "cope". They had defined 'coping' as being "self-sufficient", "strong" and "independent". Sandra explained that coping had meant being "strong" and "work[ing] through it when I'm feeling vulnerable and can't cope" and to do so *on her own*. Coping, they said, had meant not showing their vulnerability to others, and acting *as if* they had been on their own, *as if* they had not been embedded within a web of relationships. If, as they explained, coping had implied self-sufficiency, then coping had also necessarily *precluded* the possibility of mutual relationships. As they had defined it, coping had entailed a state of non-relation.

Graham's (1982) excellent analysis of the concept of coping and what it means for a mother to cope is useful here. In her research on women's experiences of motherhood (not postnatal depression), Graham (1982: 114) has highlighted how the "ideology of coping" lies at the heart of the way motherhood is constructed and experienced within our society. She points out that "the definition of motherhood" is that of "a perpetual state of coping" (1982: 104).

One aspect of the meaning of coping that Graham has drawn attention to, which is particularly relevant here, is that coping implies "deny[ing] yourself a voice" and carrying out your duties in silence. "The best mother is one who is seen but not heard", writes Graham (1982: 105):

> To cope, according to the dictionary, means to 'contend quietly' and to 'grapple successfully'. To cope is to handle the vicissitudes of your daily life with equanimity and efficiency. This ideal of unobtrusive competence appears to express the essence of what it means and what it is to be a mother. Mothers are copers: they are individuals who can handle the pressures of their life calmly and effectively. (1982: 103)

Graham further points out that "coping equals self-effacement" and that the concept of coping "sensitizes us to the way in which women's roles are so constructed that their successful enactment commits the woman to a life of self-negation" (1982: 105). Graham's analysis shows how coping entails the mother removing her self, effacing her self, negating her self. Her argument emphasizes the ways in which mothers are constructed as selfless creatures, tending to the needs of others but having no needs of their own.

Graham analyses the significance of coping in terms of what it means for the individual mother, and for society. Her focus is on the way this concept "can help us understand the way society sees mothers and how mothers see themselves" (1982: 101). She suggests that:

> Coping is the everyday concept used to describe (and prescribe) what mothers do. The concept of coping thus represents the everyday face of the ideology: it is the medium through which the ideology of motherhood is translated into individual experience. (1982: 105)

However, the material in this chapter also illustrates how the concept of coping is central to the ways in which these mothers had constructed and experienced their *interpersonal* relationships, and not just their relationships to society. Indeed, the data from my study show that 'the ideology of coping motherhood' is actually *experienced* by individual mothers *through* and *within* their interpersonal relationships. Graham's analysis can therefore be usefully extended by exploring the meaning of coping within a relational context, and by taking 'relationship', rather than 'individual' and/or 'society', as the unit of analysis. From a relational view-point, coping means not so much selflessness and self-sacrifice in an *abstract* sense, but rather the mothers' actual removal of themselves within their own *lived out* relationships *with others*.

A second way in which my findings extend Graham's work is through the notion of resistance. It is important to highlight that the mothers had been consciously behaving *as if* they had no needs. Though they had been *aware* of their strong needs and feelings, they had not brought these into their relationships. This point is critical because it shows how these mothers had not been passively 'absorbing' ideologies of the selfless and self-sacrificing woman who tends to the needs of others. On the contrary, they had been *both resisting* these ideologies, *and conforming* to them. In other words, they had been *self-consciously* fulfilling what they had perceived as the 'right' way to behave, while *at the same time* questioning these cultural definitions of the 'good' woman.

The mothers had been sensitive not only to cultural expectations of *mothers,* but also to wider notions about what it means to be a mature individual within our society.

Relational psychologists have noted that self-reliance, self-sufficiency, independence and autonomy are taken as the hallmarks of maturity and adult development within our culture (Gilligan, 1982; Gilligan *et al.*, 1988; Jack, 1991; Jordan, 1992). Stiver and Miller (1988: 2) point to "the tendency in our culture to admire and value more stoical responses and to devalue intense open expressions of sadness and grief". And Jordan (1992: 5) writes that:

> ... we live in a cultural milieu that does not respect helpseeking and that tends to scorn the vulnerability implicit in our inevitable need for support. The ethic of individuality and self-sufficiency still takes precedence over an ethic of mutuality.

Consequently, "the open expression of needs is seen as weak" (Jordan, 1992: 4) while, silence, stoicism and a denial of feeling are defined as strength. Within our society, a woman "who loves strongly and weeps strongly; is strongly terrified and has strong needs" (Marge Piercy; cited in Nairne and Smith, 1984: 14) is not regarded as a strong woman but as weak, needy, demanding, and dependent (Jack, 1991; Jordan, 1992).

The state of coping is therefore a fundamentally non-relational one in two ways. First, inherent within the notion of coping are social conventions of femininity, and expectations that the 'good' mother cares for others in a selfless and self-sacrificing way. Second, the concept of coping also encompasses notions of self-sufficiency and self-reliance, and the expectation that a 'mature', 'adult' and morally worthy individual meets her or his own needs single-handedly. Attempting to live out these constructions of the meaning of coping had left the mothers in my study feeling profoundly disconnected from others. They had equated moral goodness with selflessness and self-sufficiency, and had behaved *as if* they had neither needs nor feelings, thereby withdrawing from their relationships.

These mothers had felt it was particularly the expression of strong negative feelings that was culturally unacceptable in motherhood. They had felt there was a general silence over postnatal depression. Postnatal depression, they said, was "a taboo subject" which was "swept under the carpet". They blamed the "textbooks" for idealizing motherhood, and for suggesting that "having a baby is wonderful *but* as a footnote you might get postnatal depression". However, the mothers placed most of the blame on the antenatal classes, and on the fact that "your *feelings* really were never discussed", or if they were, it was "just briefly baby blues". "Nobody ever mentioned depression", they said:

> *Did you know about postnatal depression?*
> *No* this is one of the *grave* mistakes that health visitors *and* midwives make - you go to antenatal, they teach you *everything* about labour ... but they

> *never, ever* mentioned how *awful* you can feel, how really tired you can feel. (Dawn)

When Celia, who experienced postnatal depression with her first child, made a point of raising the subject at the antenatal classes she attended when pregnant with her second child, Melissa, she had felt dismissed for introducing what was regarded as a "taboo subject":

> When I first mentioned it when I was having Melissa ... it was obviously a real taboo subject, the midwife did not want it to be discussed, there were new mothers there and it was like ... 'let's not be doom and gloom'.

The mothers explained that this silence also reigned amongst mothers themselves. They said that the isolation of depressed mothers is perpetuated because depressed mothers do not speak about their difficult feelings, and because mothers in general tend to express only positive feelings:

> *So you've never known anybody with [postnatal depression]?*
> No, well nobody's ever said anyway [laughs] that's the trouble though isn't it nobody says. (Petra)

Although the mothers had been aware that talking to another depressed mother would have helped them overcome their feelings, and despite the fact that some had known other depressed mothers during their period of depression, they had not revealed their feelings.[6] Celia and Frances, for example, had known each other while they had both been depressed. However, neither had realized that the other was depressed. Frances explained:

> Celia, at the time, lived in the village ... and we were ever so close and ... all this time we went through all this on our own. This is what's so funny about postnatal really ... you don't want to show it ... But she was going through it at the time and it wasn't until I actually said something to her that she said 'I've been going through the same', and you'd think that we would have cottoned on wouldn't you really.

The cultural context in which these mothers' experiences were embedded was one in which a range of feelings in motherhood is not considered acceptable, and a mother who fails to express unreserved happiness is constructed as deviant and pathological, as noted in Chapter Four. Such a context made it that much harder for these mothers to express their

---

6 Celia and Frances had been friends before either had become depressed, as had Celia and Marcia. Dawn, Petra and Pam all met through the postnatal depression support group set up by Dawn; Sonya and Sandra lived in the same village and had been put in touch with each other by the health visitor who knew they were both feeling depressed; Sonya and Vera were in telephone contact as Vera was 'counselling' her as part of the support Sonya was getting from the Association for Postnatal Illness. Only Celia and Frances, and Celia and Marcia had known each other at the time that they had been badly depressed. The other mothers had contacted each other as they had emerged, or were emerging from, the depression.

negative or ambivalent feelings. Many researchers have made a similar point, noting that because mothers "are supposed to be happy, and other feelings will not be acknowledged or validated" (Gruen, 1990: 263), mothers tend to keep silent about their difficult feelings, and present an impression of maternal competence, for fear of being pathologized and labelled a 'bad mother' (Graham, 1982; Grossman *et al.*, 1980; Gruen, 1990; Jebali, 1993; Price, 1988; Richardson, 1993). This silence had led to the mothers' depression. As Miller (1987: 77) points out, depression results from the absence of "vitality", which she defines as

> ... the freedom to experience spontaneous feelings. It is part of the kaleidoscope of life that these feelings are not only cheerful, 'beautiful' and 'good'; they also can display the whole scale of human experience, including envy, jealousy, rage, disgust, greed, despair and mourning.

I emphasize that it is the mothers' subjective constructions of the cultural context that are under discussion here. As I pointed out in Chapter Four, the fact that motherhood can be a difficult experience which can result in depression in some women, is receiving wider coverage within childcare manuals, the media and popular books on the subject. However, neither these particular mothers, nor those around them, appear to have drawn upon these ideas. The mothers had constructed the social and ideological context in such a way that it had felt impossible for them to speak the true nature of their thoughts and feelings.

IV. Understanding the relational disconnection of postnatal depression

1. Disconnection from others

During their depression, the mothers had withdrawn from social contact. The first-time mothers had removed themselves from their relationships with their children. First-time and subsequent mothers had withdrawn from significant others, other mothers with young children, and health professionals (see Chapter Six). This social withdrawal had been based on the mothers' beliefs about, and experiences of, these relationships; and also on their interpretations of cultural definitions of what it means to be a mother, a woman and an individual within our society.

At this time in their lives, they had felt their moral worth had depended on their conforming to social norms and expectations. In order to be accepted by others, and therefore secure their relationships, they had withdrawn their own needs and feelings from, and had remained silent within, these relationships. As they had done so, they had become involved in 'fraudulent' or 'inauthentic' relationships, for these were relationships in which

they could not openly express themselves. When in the company of others, they had "acted out a role" and "played a part". They had felt like a "pretender" and a "fraud", because they had "put on a front" and "put on a good face", of a "happy", "cheerful", and "coping" mother, while inside they had felt "miserable", "terrible" and "screwed up":

> You put on an amazing face sometimes for people's benefit ... I used to put on a good face ... I'd get made-up, and I'd wash my hair, and I'd look cheerful and bounce around in the sun and be this happy person that I used to be, and nobody would guess, nobody could tell. But as soon as I shut the door when I got home, I used to feel really miserable. (Dawn)

> I ... sort of hid it every time somebody come round ... I try and put on a front for people. As soon as they gone, I sort of, because of all the things I held back, it all come out as soon as they left. (Monica)

The mothers had been so successful in their pretence, that many had convinced others of their happiness, and this had made it harder for the mothers to admit their true feelings. Celia explained:

> Everyone was sort of complimenting me right from the beginning - 'Oh ... what a marvellous mother you are' - and I think they all put me on a pedestal, and I mean even the health visitor had me go down the health centre to give a talk with Katie about ... motherhood and what it's like and she was saying: 'Look ... she's a really successful breastfeeder ... and what a healthy child', and so I found it very hard to make people realize that, well, I know it all looks like that but I don't feel like that. I didn't want to shatter people's illusions I suppose, so it made it harder for me to go and say to them 'Well actually', 'cos I think from the outside, I mean it didn't affect my care of Katie in any way. (Celia)

In attempting to avoid conflict and secure the love of others, the mothers had presented what they had believed to be the accepted and acceptable way to be a mother. This act, however, which had been 'designed' to preserve their relationships, had paradoxically led to their *felt* loss of these relationships. In becoming involved in inauthentic relationships, the emotional value of these relationships had been lost. They explained that a relationship in which they had no voice had not *felt* like a relationship. This paradoxical move have been noted by relational psychologists (e.g. Brown and Gilligan, 1992; Jordan, 1992; Kaplan, 1984). Stiver (1990; cited in Jordan, 1992), for example, writes that "the effort to retrieve some sense of connection through surface accommodation and compliance leads to an increasing sense of isolation and loneliness".

2. Disconnection from the self

Within a relational perspective, "relationship *and* identity develop in *synchrony*" (Surrey, 1985: 10), and therefore "the outer 'real' relationship and the inner sense of

relationship" are to a degree inseparable (1985: 11). Surrey (1985: 11) points out that "the capacity to 'become one's own mother', that is, the internalizing of the attentive, listening, caring relationship to oneself ... does not occur in isolation but within relationship". The relational nature of the self means that alienation from others goes hand in hand with alienation from the self. Consequently, the mothers described the disconnection from others as coinciding with a disconnection from themselves. As they had hidden their feelings from others, they had also denied them to themselves:

> I fought it so desperately ... I didn't really want to know, I sort of thought 'Well yes, I have got a problem, but I want to cope with it' ... You're trying to deny that it's actually happening to you ... You're fighting it a lot at first, saying 'This isn't happening to me and it won't happen to me and I won't let it'. (Sandra)

Disconnection from others and themselves lay at the heart of their depression. As Sonya clearly explained, by not coming to terms with her experiences and her feelings, and by not accepting herself for whom she was, her depression continued:

> My psychotherapist says: 'What would it hurt if you were yourself, if you slumped in the corner and said, 'Look, I'm ill, this is how I am, take me or leave me". I can't do that. 'Would that have been so terrible?', and in my mind, yes, I'd think - well none of those people will want to know me when I'm well because they've seen me so bad, you see? So I always have to appear to be in control and not ill ... which makes the illness go on longer ... I'm accepting points now from ... the psychotherapist, she is saying 'If you pretend it didn't happen, or just hide from it or whatever, it's not going to go away, because if you don't walk into it and accept that this is an experience that I have to face ... then it's gonna linger on' ... And like now, when I said to her I was feeling so much better and I want to ... put this under the carpet a bit, I'm already trying to do that ... As soon as I'm well for five minutes I'm thinking, 'Right, it was bad but we don't want to talk about that now' but that's denying it, d'you see? But I find it painful to say 'I've been through it, it wasn't a nice experience, but it's made me stronger'. I know all those things logically, but in my heart of hearts, in a way, I wanna say 'No, that wasn't me ... this is me', which is not positive for recovery, is it?

Here, I would like to quote again from Anna, another mother who took part in my study, whom I cited in Chapter Two. Anna had felt low after her daughter's birth, but she said she had not experienced postnatal depression. Having experienced clinical depression (unrelated to motherhood) at the age of 19, Anna was extremely articulate about why, although she had found motherhood "difficult" and had felt "down" and "low", she had not felt "depressed depressed", and did not feel that her own experience was that of "postnatal depression". I asked Anna what she thought the difference was between feeling low and feeling clinically depressed. Her definition of postnatal depression was the following:

> I think ... perhaps having the same feelings that I was having but really not being able to sort of come to terms with them and to really let them get on top of you ... One of the things that I learnt from ... being depressed before was that you have to have room for your feelings, and there are times when you don't feel happy or you feel angry or you feel sad, and that you shouldn't pretend that you don't feel those feelings. So when I felt low, I didn't pretend that I didn't feel low. And I think ... my interpretation of being sort of depressed in that respect is feeling low and feeling really bad about feeling low.

These last two quotes by Sonya and Anna are vital to understanding the nature of depression, and how it differs from other forms of low mood. They indicate that what characterized postnatal depression was the mothers' denial to themselves of their own difficult feelings, and an inability or unwillingness to accept and come to terms with them.

Stiver and Miller's (1988) excellent paper on sadness and depression illuminates the nature of the depression experienced by the 18 mothers in my study. As I discussed in Chapters One and Two, Stiver and Miller (1988: 2) have argued that, unlike sadness which is a "feeling state", depression is a "nonfeeling state" in which "feelings are hidden", and in which the woman can neither experience nor express her feelings. Petra, one of the mothers in my study, clearly articulated this point. She explained that when she had first emerged from the depression, she had "started feeling feelings back again", and this had contrasted with how she had felt during the depression:

> [Depression is] like the end of the world really. You've got nothing to live for, that's what it's like ... It's a bit like you're just stuck in this room and you can't get out, and there's nothing for you, and it doesn't matter how many things you think about that are good, they don't feel good. It doesn't create any feeling inside you, it's just like you've died inside.

Stiver and Miller (1988), and other relational theorists (e.g. Bernardez, 1988; Fedele and Harrington, 1990; Kaplan, 1984) have argued that when feelings, such as anger and sadness, are not experienced, expressed and validated, depressive reactions develop. They point out that what is key to this expression of feelings is the relational context - both interpersonal and cultural - in which the woman is embedded. If this context is inadequate, such that the woman feels she can neither experience nor express her feelings, the conditions are set up which can lead to depression. The argument put forward by Stiver and Miller (1988: 4) fully supports the position arrived at in this thesis:

> Our basic notion is that many women who suffer depression have not been able to experience their sadness and, most important, have not been able to experience it within a context of empathic and validating relationships. There is one major reason why this occurs: The people in the surrounding context of relationships (and often society) in general do not recognise that a disappointment or loss has occurred. Alternatively, they may recognize that

> some kind of loss has occurred, but they do not recognize its significance or magnitude *for* the woman. Not only do they not help the woman acknowledge the loss, they often actively prevent her from doing so and, therefore, contribute to severe confusion and self-doubt. Sometimes the woman initially may have some sense of her feelings, but people around her are conveying the strong message that she shouldn't have them. There's no reason to have them; so if anything is wrong, it must be that something is wrong with her.

My argument in this thesis is that the mothers were unable and unwilling to experience and express their feelings, because of the ways in which they had constructed and experienced themselves, their relationships with others, and the cultural context in which they were living.

Summary

In this chapter I have sought to understand the processes through which all the mothers in my study had been led to withdraw from their relationships (other than those with their children), and had become disconnected from themselves and others, and thereby depressed. I have highlighted three processes.

First, the mothers had silenced their voices because of their beliefs about themselves and their relationships. During the depression, they had constructed having, and expressing, their needs and feelings as a moral failure on their part. They had also believed that voicing their needs would "burden" others; this had seemed a selfish and morally reprehensible act. Moreover, they had refrained from confiding in others through their fears of being misunderstood, rejected or morally condemned by others. They had expected that expressing their feelings within their relationships would harm themselves and others, lead to conflict and result in the loss of their relationships. In order to preserve their relationships, they had withdrawn from them.

Second, I discussed how, in some cases, the mothers' beliefs and fears had been reinforced by their difficult relationships with partners, mothers or mothers-in-law. These mothers had felt unsupported by these individuals, either because the latter had assumed the mother should be able to cope single-handedly and had therefore failed to offer practical and emotional support; or, because these individuals had failed to respond to the mothers' requests for such help, and the latter had felt rejected and silenced. These difficult relationships had further contributed to the mothers' silence and withdrawal.

Third, I highlighted the role of the cultural context in these processes. The concept of 'coping' was central to the mothers' accounts and experiences of this cultural context. I

noted that the state of coping precludes the possibility of mutual relationships in two ways. First, inherent within the notion of coping are social conventions of femininity, and expectations that the 'good' mother cares for others in a selfless and self-sacrificing way. The expression of needs, and ambivalent feelings, by mothers tends to be considered unacceptable within our society. Second, the concept of coping also encompasses notions of self-sufficiency and self-reliance, and the expectation that a 'mature', 'adult' and morally worthy individual meets her or his own needs single-handedly. The cultural devaluation of help-seeking behaviour had reinforced the mothers' moral beliefs that they 'should' be able to 'cope' without resorting to others. Cultural sanctions against the open expression of needs and vulnerability, and of what is perceived as 'weakness', made it that much harder for these mothers to claim a voice within their relationships.

I concluded the chapter by documenting how the mothers' withdrawal of their needs and feelings from their relationships had led to their sense of disconnection from others and themselves. The mothers associated this relational disconnection with their depression.

In the following chapter, I show how the mothers' emergence from their depression was linked to their ability and willingness to disclose their feelings, to their sharing these within understanding and non-judgemental relationships, and to their accepting themselves for whom they were.

Chapter Six

Moving out of Postnatal Depression

Chapter Six

Moving out of Postnatal Depression

> Slowly I came to understand the paradox contained in "my" experience of motherhood; that, although different from many other women's experiences it was not unique; and that only in shedding the illusion of my uniqueness could I hope, as a woman, to have any authentic life at all. (Adrienne Rich, 1986: 40)

Introduction

The advantage of carrying out a retrospective study is that I have been able to trace some of the changes that the mothers underwent in their movement out of depression.[1] The fact that they agreed to talk to me about their experiences is itself an indication that they had emerged from, at least the worst part of, the depression. By looking at the changes in these mothers' lives over the course of their depression, it is possible to investigate, in a preliminary way, the theoretical ideas put forward so far.

The aims of this chapter are two-fold, and are reflected in its structure. First, I examine the forms and sources of help that fostered the mothers' movement out of depression. I explore three sources of support: the women's personal relationships with significant others; health professionals; and other mothers with young children.[2] Second, I examine the processes through which the mothers came out of the depression. I discuss the changes that took place in their relationships, their understandings of themselves, and their orientations towards social norms and expectations of women and mothers.

Before considering these issues, I want to highlight an important point regarding the mothers' move out of depression. As I have documented throughout this thesis, the mothers had experienced the depression as a state of paralysis, in which they had felt unable and unwilling to voice their feelings to others. In previous chapters, I have described this process in their relationships with partners, relatives, friends and other mothers with young children. However, the mothers had felt equally paralysed in seeking help from health professionals or lay organizations.[3]

---

1 At the time of the interview, eight mothers said they had fully emerged from the depression, four were still on their journey out, and six still felt depressed.

2 See Table 1 in Appendix 6 for a summary of the sources of professional and lay support received by the mothers.

3 Other researchers have also noted the difficulties depressed mothers experience in contacting professional and non-professional sources of help (e.g. Gruen, 1990; Keeley-Robinson, 1983; McCord, 1984).

The mothers explained it had been "*very* hard to go to the doctor". It had often been partners, mothers, and friends who had had to assist them in seeking support from health professionals. Although the mothers had been "crying out for help", they had been reluctant to *admit* this need. As a result, the majority of the mothers had *delayed* getting help, in some cases for as long as a year after the depression had set in. This had had important consequences, for the sooner the problem had been identified, the sooner the mothers had emerged from the depression.[4] The two mothers who had had the most short-lived depressions - six weeks - explained that this had been thanks to their general practitioner (GP), who had "nipped it in the bud" by encouraging them to talk about their feelings, and by spending time listening to them.

The mothers had found it equally difficult to contact lay organizations such as the Association for Postnatal Illness, Cry-sis and the Meet-A-Mum Association. They had needed somebody else to contact the organization *for* them. Similarly, many explained they would have liked to have gone to a postnatal depression self-help group, but that they would have needed "some help getting there ... some emotional help". One of the main problems the mothers had faced was that they had only begun to reach out for help once they had actually felt better, and after they had been through the depression, mostly on their own:

> I couldn't talk to family and friends until I was at a certain point in recovery ... I didn't want to ... You just want to get better, and then once it started getting better, you could then like explain how you were feeling. (Tina)

There were many reasons why they had found it difficult to seek professional or lay support. Some were similar to those discussed in previous chapters in relation to their other relationships, including the fear that their children might be taken away, and feeling that they did not have the 'right' to call upon health professionals. The mothers also mentioned their fear of being locked away in an "asylum". Finally, many had had difficulties identifying the nature of their feelings, and realizing they had postnatal depression, as Fiona explained:

> I put my hand to [my son's] throat ... and I actually had to hit him back to get him breathing again ... and I knew then there was something wrong but I still didn't go to the doctor ... 'cos I couldn't figure out what it was ... It was about a year after I started feeling bad that I actually went to the doctor and told him how I was feeling 'cos I didn't know what it was that was

---

4 Indeed, the "recovery rate" for postnatal depression is over 90% if it is recognized and 'treated' (Cox *et al.*, 1987). If not, it has been shown to last up to four years (Kumar and Robson, 1984).

> wrong with me. I thought it was just that 'I'm feeling tired and it's catching up on me because I'm getting up during the night to see to him'.

The nature of depression, and the difficulties depressed mothers experience in seeking help, have important implications for policy and intervention programmes (see Chapter Seven). An important consideration within any such programmes will be that the help should preferably be brought *to* the mother, rather than relying on the mother finding support herself.

I. The nature and sources of key relationships in the mothers' move out of depression

1. Relationships with significant others

Although the mothers' relationships with partners, relatives and friends had often changed as a result of the depression, and once the women had emerged from it, changed relationships with these individuals had rarely instigated the move out of depression. As I discuss below, relationships with other mothers had played a primary role in this process, followed by the secondary importance of health professionals.

There were a few cases, however, where significant others had been instrumental to the mothers' journey out of depression. For example, when Frances eventually spoke to her sister, she found she had "just sat with me and listened to me". This, Frances explained, had been a turning point; it had made her realize that her sister "cared enough to care ... for me to get better". A friend who had listened to Frances had also helped her feel she was being cared for:

> One of my [friends] ... sent off to the phobia society, 'cos ... I'd got this phobia about superstition, and just knowing that somebody's actually cared enough to send off for something like that helped ... It's a feeling of not being alone ... You feel that you're totally alone when you've got something like this, and the fact that somebody actually cares enough to spend five minutes with you was nice.

Understanding that others cared about them and loved them was mentioned by several mothers. During the depression, they had felt abandoned by "everybody", and had felt "nobody" was there for them. Realizing that this was not the case had been an important step in moving out of the depression. For Rachel, "cementing" her relationship with her mother by "talking about how we were feeling, which we'd never really done before", had been critical for her: "it was important for me to understand that she did the

best she could ... but that she still loved me". Rachel associated her move out of depression with the moment when she had come to realize her mother *did* love her:

> I remember just thinking 'My God, my mother loves me', and ... although I knew it in my head, I never really understood it, and then the depression lifted.

In order for them to realize that others were there for them, they had had to first voice their needs, and trust that others would "stand by" them, and not reject them. As Sonya said, the ability to "trust human nature" was an important initial step in their journey out of depression.

As I have pointed out in previous chapters, several mothers had found that when they had confided in others, they had not been rejected or condemned, as they had feared. They *had* felt others had accepted and understood them. The ways in which the mothers' relationships had changed over the course of their emergence from the depression had therefore involved a two-way process: a change within themselves, and/or a change within the other person. In order to appreciate that they *were* loved and cared for, the mothers themselves had had to voice their needs and feelings, and renew their relationships with others. In doing so, the other person had become aware of the mother's experiences, and had been in a better position to offer the support she had needed.

2. Professional sources and forms of support

(i) Antidepressant medication

Twelve of the 18 mothers in my study had taken antidepressants[5] during the time of their depression,[6] and it was the GP who had prescribed these.[7] On the whole, the mothers had felt unhappy about taking such medication. There were several reasons for this: they had feared addiction; they had felt they "should" be "strong" enough to be able to manage without antidepressants; some of the mothers had been unhappy about taking any type of medication while breastfeeding; and they had felt debilitated by the side effects.[8] The mothers had been particularly concerned that these side effects might affect their ability to

---

5 Mothers with postnatal depression tend to be prescribed antidepressant medication (e.g. Jebali, 1993; Kendall-Tackett, 1993).

6 The mothers had taken antidepressants for one month to three years, with an average of 11 months (see Table 1 in Appendix 6). Only one woman was still on antidepressants at the time of the interview.

7 The most common sequence of events was, either for the mother to go directly to the GP, or for her to be sent to the GP by the health visitor. These mothers were prescribed antidepressants upon their first visit to the GP.

8 Side effects include: dry mouth, drowsiness, constipation, urinary hesitancy, blurred vision and confusion (Cox, 1986; Kendall-Tackett, 1993; Rogers *et al.*, 1993; Cookson, 1993).

care for their children. Despite these reservations, most of the women who were prescribed antidepressants had agreed to take them, even if they had only started taking them several months after they had first been prescribed. They said they had felt desperate to help themselves in some way, and taking antidepressants had made them feel they were doing something positive towards helping themselves.

The mothers concurred that the antidepressants had helped them - they had "lifted the depression". Petra explained that "they pull you out of a hole that's too deep for you to get out of". However, they also felt they had needed an extra "something" which was to be able to *talk* to somebody about their distress.[9] What had "really" helped, they said, or what they had "really" needed and wanted, was to talk about their feelings:[10]

> I went to see the doctor and he was hopeless, absolutely hopeless ... He just stuck me on drugs ... I took them, and I think I did feel calmer although really, any amount of drugs that you take, I don't think if you've got a problem up here [pointing to her head] is gonna help you, you *need* to be able to talk to someone. (Frances)

These mothers all felt that there had been an "underlying problem" which had needed to be addressed by talking, and that the medication was just something that had "covere[d] it up":

> In an ideal world, I'd have someone ... to talk to without any limits. I think that would have done more good than tablets would ... I think it gets to the *root* of the problem, whereas tablets just sort of cover it up ... Talking about something is a lot better way of getting it all out in the open, than to sit and fester with it and just pile more pills on. (Dawn)

It is interesting that in describing themselves, the women used the image of a seedling struggling for light. Dawn spoke about needing to get to the "*root* of the problem". Rachel talked about having to do a lot of "growing" as a result of "lots of different issues coming to the surface" after having her child. These women seemed to be describing parts of themselves struggling to emerge, and needing to talk in order "to get it all out of your system", and let this emerging self out into the open. They highlighted the importance of talking about what lay underground, deep within them, in order to bring to the surface that part of the self they had buried. Although the antidepressants had helped these mothers,

---

9 Researchers note that the effects of antidepressants are enhanced when combined with therapeutic listening and social support (e.g. Holden *et al.*, 1989; Kendall-Tackett, 1993). However, I wonder whether if mothers are encouraged and enabled to talk at the very early stages of their depression, and even before their difficult feelings actually become depression as such, antidepressants might be bypassed altogether. It seems that antidepressants might only be necessary when the depression is quite advanced.

10 In their survey of the views of the users of mental health services, Rogers *et al.* (1993: 146) also found that talking treatments "fared better in the eyes of our respondents than drugs or ECT. Psychotherapy and counselling are perceived as desired alternatives or adjuncts to a medical regime".

they had also contributed to their silence and withdrawal. Tina captured this most vividly when she drew an analogy between giving medication to a depressed mother, and giving sweets to silence a child's cries:

> It's a bit like ... if a child falls over, 'Oh here have a sweetie', instead of being able to take them in your arms and let them cry and let them scream and just hold them. It's just the same, isn't it?

(ii) The general practitioner

The mothers recognized, but also felt unhappy, that the GP's only role seemed to be prescribing antidepressants, rather than talking, or listening to them voice their feelings:[11]

> What I really needed ... was somebody to talk to and ... I know you can go and see your GP, but they've just not got time to talk, and that's fair enough, I don't expect that. But I did need ... some more help. I just wanted to talk in depth about how I felt, and why I felt that way I did. (Louise)

> There's no way a GP can talk to you long enough to get it all out of your system ... The GP isn't enough ... Her job is to give you the medication, to keep an eye on you, to listen to you every two weeks and then decide whether you're ready to ... decrease the medication. I'm not saying she's just a pill-pusher, but I appreciate it's not the medium to talk for a long time. (Sonya)

While the mothers understood the constraints of time and resources under which the GP was operating, and that the GP could not offer the service they wanted - namely, to be able to talk "in depth" about their feelings - they did feel that the GP had two important functions that he or she sometimes failed to fulfil: first, to recognize the problem; and, second, to suggest other forms of help that the mothers might want, or were explicitly requesting, but that the GP him or herself was not in a position to offer.

Health professionals, and especially GPs and health visitors, had a potentially important role to play in identifying and validating the mother's distress, given the mothers' difficulties in admitting their feelings both to others and to themselves.[12] The mothers often described the moment when the GP had recognized their difficulties as a "turning point":

> Once I'd seen the doctor, and once someone had taken notice and said ... 'You're not very well, are you? Let me help you', then things started to get

---

11 This was one of the main complaints made about GPs in Rogers *et al.*'s (1993) study cited above.

12 Midwives can also play this role (see Ball, 1987).

better ... I remember once she had said that, then everything started to get better. (Caroline)

Those mothers who felt their GP had not identified the problem pointed out the importance of GPs being better informed and educated about postnatal depression, so they could recognize, and respond to, the mothers' needs:

> I think ... doctors need to be a bit more clued up too, and not to pass you off and say 'Go home and get yourself out', 'cos that's just like a nail in the coffin. (Celia)

Many of the mothers also felt it was the GP's responsibility to suggest some form of counselling they might receive on the National Health Service (NHS). Some said very little help had been offered to them:

> I think what upset me, was that I had to keep asking for the help. I feel my GP ... should have referred me to the community nurse, I don't think I should have had to ask for it ... I mean whether ... I didn't present myself in a way which made her think, 'This girl needs help', I don't know ... But I really did need somebody to talk to, and if the GP can't do it, she's really got to try and help me find someone who can. (Louise)

As Louise explained, it was perhaps not always simply a case of the mother not being offered help. Just as I described the two-way nature of relationships with partners, relatives and friends, similar processes seemed to be at work regarding help from health professionals. Some mothers might not have clearly articulated their need for help, and consequently health professionals might not have necessarily realized that they needed support.

However, there is no doubt that a number of these mothers had encountered unsympathetic and unhelpful GPs. Fiona, whose husband was in the army, explained:

> The local doctors have not really got any idea what it's like being in the army. They've not got any sympathy for you. It's a case of 'Well, you wanted kids and you wanted to be where you are, so get on with it and don't come down here ... and give me your troubles. I've got better things to do. You're just being silly, pull yourself together'.

Some found their GPs had actively opposed their requests for some form of counselling:

> The doctor ... put me straight on [antidepressants] and ... I didn't want to go on tablets. I said I didn't need tablets, I just needed someone to talk to ... and the doctor actually put up a fight about giving me the counsellor, it was between me and the health visitor that got the counsellor, the doctor didn't want it. She just wanted to shove me on the tablets. (Petra)

Several mothers had seen "supportive" GPs.[13] These were defined as GPs who had suggested other forms of help, such as asking the health visitor to visit the mother on a more regular basis, or offering the mother the option of seeing a community psychiatric nurse, a psychiatrist or some other type of counsellor on the NHS. Some mothers had found their GPs themselves to be supportive, because they had been able to "talk" to them, and be "listened to". They felt their GPs had given them "time" to express their feelings:

> The lady doctor, she was *really* wonderful ... she sat and ... she *talked* to me ... and that's *really* what was needed, somebody to be able to listen to you ... [When] I saw the woman doctor ... suddenly it was just better. (Tina)

> [The GP] ... is very motherly ... she's not criticizing, she takes you as you are ... she listens ... she doesn't condemn you for it happening. (Sandra)

> It was really just reassurance ... he said ... 'I understand, you're perfectly entitled to feel like this'. That made *so* much difference. (Helen)

(iii) The health visitor

Given the difficulties the mothers described in identifying that they had a problem, and in seeking help, health visitors were also ideally placed, both to recognize the mothers' difficulties, and to *bring* help *to* her.[14] As Keeley-Robinson (1983) points out, "the health visitor is well placed to detect what might otherwise remain a hidden problem". Health visitors were often described as potential, or actual, "life lines" to the outside world. Sonya graphically conveyed the potential role of the health visitor:

> It's this holding my hand out to one other person and feeling that I don't need to be ashamed of breaking down ... But in that isolation in the summer, I wasn't reaching out, and that's why the health visitor was the one who'd have to come in and say 'I'll reach out for you' - do you understand? - 'Either I'll come myself, or someone will come round and talk to you'. But because you're so numbed, you can't take the initiative therefore you can't reach out yourself. (Sonya)

The mothers defined a supportive health visitor as one who visited the mother on a regular basis. They had felt it was important to know that their health visitor was "there"

---

13 Many of the mothers saw several GPs, and in some cases, might have had a difficult encounter with one GP, and a positive encounter with another.

14 Kumar (1982) also comments on the key role the health visitor can potentially play in promoting health and preventing illness, both emotional and physical. He points out that, in spite of a system of postnatal care, with repeated contact between health care professionals, the mother and baby, the great majority of postpartum psychological difficulties remain unnoticed.

for them if they needed her, that she would listen to them, and visit at a set time and date, however often these visits happened to be:

> My doctor and my health visitor were very, very helpful, very good ... they were just there. Any time I needed them, they were there. And the health visitor came round every day to make sure both me and the baby ... was alright. (Sophie)

Although the role of the health visitor is to visit the mother fairly intensively for the first six weeks after the birth, and then on a less regular basis, a surprisingly large number (five) of mothers in my study found their health visitors had not visited them at all. They had found this particularly difficult:

> [My health visitor] was *negative* support, not positive support at all ... she didn't come ... Even when my GP asked her to come and see me, she didn't come ... I mean, I went to the baby clinic with him regularly when he was a baby, she never picked up on any of what I said and how miserable I was. (Helen)

The mothers felt that identifying postnatal depression was an important role for the health visitor. Again, Keeley-Robinson (1983: 12) has noted that "it is important that if the health visitor suspects that a woman is depressed, she should bring the issue into the open" because "it is not easy for mothers to freely admit that they are not coping with something they believe everyone else manages without difficulty". Vera felt it was important that her health visitor had identified the nature of her feelings:

> The health visitor ... said 'I think maybe you've got a bit of PND' ... and ... she was ever so good, she said 'I'll come in and see you every day'.

Celia found that her health visitor had not recognized her feelings, which is what she would have wanted:

> *So what kind of support would you have wanted?*
> I would have wanted some sort of acknowledgement or recognition of it, perhaps for the health visitor ... initially to have said 'You've got this, don't worry' ... You need someone to recognize it and to take the burden of trying to cope with it all yourself.

As I mentioned above, in some cases, the mother herself might not have actually asked for help, or responded to support that might have been available. The inadequate support the depressed mothers felt they had received was a two-way process, not simply a case of the mother being a 'passive victim' of circumstances. Tina explained:

> You see, when the health visitors come round 'Any problems?', 'No, everything's fine' ... I mean it's classic isn't it, you get somebody coming round to visit you ... to make sure you're healthy and your baby's fine and, 'Are there any problems?', 'Oh no no no'. Again it's, 'I can't ... take up your time, I'm not that important', type of thing, isn't it? It's the attitude of women and how we've been brought up not to make a fuss.

Given that, on the one hand, the mother herself might be reluctant or unable to express her need for support to the health visitor, and that, on the other hand, the health visitor might actually find it difficult to identify mothers who are experiencing difficulties, a number of the mothers in this study suggested that in addition to health visitors, there should be a professional to deal with postnatal depression specifically. The mothers used terms such as "a postnatal depression visitor" and a "support worker or counsellor" who would work alongside the health visitor, but whose role would be to deal with the emotional aspects of motherhood. The mothers felt strongly that such a professional would greatly improve the situation of mothers experiencing difficulties or depression (I discuss this further in Chapter Seven).

(iv) 'Talking treatments'

Apart from the GP and the health visitor, nine mothers had also seen a community psychiatric nurse, a psychiatrist, and/or some type of counsellor or therapist, either on the NHS or privately. Two other mothers had seen practitioners of complementary medicine including an osteopath, a herbalist, a healer and a homeopath (see Table 1 Appendix 6). On the whole, the mothers felt the support they had derived from these professionals had been beneficial, and the qualities they had valued in these encounters were: having the time to talk in depth about their emotions, feeling that they were being listened to, and understood, by someone whose attitude was non-judgemental, being reassured that their feelings were shared by other mothers, having their feelings validated, and being made to feel that what they were experiencing was legitimate:[15]

> This community psychiatric nurse ... was excellent, she was very, very understanding ... in a completely non-judgemental way, in that she would just let me rattle and rattle and rattle and she was very, very sympathetic ... I wanted to talk in depth, you know, like we have done today. I expect this is very therapeutic for me sort of getting it out of my system. (Louise)

> I could go in there [to the psychiatrist] and say exactly what I was feeling and I couldn't always say that to family members or friends or anybody. It's easier to talk to someone you don't know and get it all off your chest so ... I felt better because I could just go to him and shout ... and cry. (Pam)

---

15 Other researchers have documented the beneficial effects for depressed mothers of being able to talk about their feelings to a non-judgemental person (e.g. Cox, 1986; Holden *et al.*, 1989).

In sum, what was important about the help the mothers had received from health professionals was not so much the exact *source* of this help and *who* had given it to them, but rather the *quality* and *nature* of these encounters. These were relationships in which the mothers felt they could speak freely and unreservedly, about a range of feelings and experiences, in the knowledge that they would be heard, understood, and accepted for whom they were.

3. Lay organizations and the importance of talking to other mothers

The majority of the mothers in my study felt that although they had benefitted from the professional support they had received, they had actually needed a different "kind of support", either, in addition to, or instead of, this professional support. They had wanted to talk to another mother who had shared feelings similar to their own:

> I just needed somebody to talk to, rather than a psychiatric nurse. But that's the only option they could come up with, which is a shame, 'cos there's all these other associations[16] ... you definitely need somebody who's been through the same. (Sandra)

> The ideal sort of support would be just to be with people that you trust ... and people that'll let you say whatever you're feeling, so maybe with other women that are feeling similar things. (Rachel)

When I asked the mothers who, and what type of support, had been, or would have been, most valuable to them, over two thirds (thirteen) explained that it had been, or would have been, another mother. Those who had spoken to another mother had either turned to female relatives or friends whom they had previously felt unable to talk to. Alternatively, they had formed new relationships with other mothers, met through informal channels such as postnatal depression support groups, lay organizations such as the Association for Postnatal Illness and Cry-sis, or at mother-and-baby clinics. Others had found it helpful to talk to health professionals who also happened to be mothers themselves.

The mothers felt it was not *necessarily depression* that other mothers had to have experienced, but rather "similar feelings" to their own, whatever they understood by "similar feelings". For some, it had been important to share similar fears and anxieties in looking after their babies. For others, it had been the difficulties of looking after two young children close in age. For others, it had been finding another mother who had also found that loving her child had not come 'naturally' or 'instinctively'. Most of the mothers,

---

16 Sandra was referring to the Association for Postnatal Illness and to postnatal depression support groups.

however, had wanted to talk to other *depressed* mothers specifically.[17] It had therefore been important for them to speak to someone who had shared the particular feelings and experiences that were most salient to them, whatever these might have been.

The majority of the women had experienced talking to another mother as the turning point in moving out of their depression, even where the mothers had felt supported by partners, relatives, and in some cases friends. Penny is a good example here. Despite the fact that she had lived close to her large and supportive family, and had a very caring and understanding husband, Penny nonetheless had felt unable to talk to these individuals about her feelings. She explained that it had been another mother whom she had derived most support from:

> My mum was quite helpful but ... you don't like to let your mum know that you can't cope ... I just didn't want [my family] to know ... You're embarrassed about it ... but another mother ... whose children are the same age, going through the same feelings as you, gives you someone to talk to.

The women felt they had needed contacts with other mothers who had also experienced difficulties in motherhood. Many said they had wanted to attend a self-help group with other depressed mothers, where they could freely express their feelings:[18]

> I wanna just sit down in a circle of people and ball my eyes out or scream, that's what I want. (Sonya)

> There's only so much you can do as an individual. I think it's something that needs to be ... talked about and brought out. As Sonya said, we need a group to go to, there needs to be some sort of support network. (Sandra)[19]

Thus, it was not simply that the professional support the mothers had received had been inadequate, or that their relationships with partners, family or friends had been poor. Rather, it seemed that the mothers had wanted and needed a *very particular* "kind of support". An open and honest relationship with another mother, in which both were prepared to admit their feelings to one another, had enabled them to realize that their

---

17 Miles (1988) also found that the women in her study felt that individuals with personal experience of psychological problems came nearest to understanding their own feelings, and if available were the best choices for confidences and support.

18 Four mothers had been, or were still currently going, to a postnatal depression support group. One of these, Dawn, had set up a group herself, and two other mothers in my study were attending it. Twelve mothers said they would have liked to go to a postnatal depression support group. The main reasons why they had not were the following: they had not been informed about such a group; it had not occurred to them that there might be one; they had been unable to find one. Only two mothers said they would not have attended a group. Rachel explained that she was using complementary medicine and therapy and she felt that a group would not have been sympathetic to this approach. Sophie explained that she was not "one of these groupy people".

19 Sandra and Sonya lived in the same village and knew each other.

difficult feelings were shared by others. This had been critical to their move out of depression.

I now examine which aspects of these friendships with other mothers were most valued by the women in my study. I begin with Louise's account of her friendship with Judy, a woman she met in a health centre waiting-room a year before I interviewed her. Louise told me that this encounter had been "the beginning of a really good friendship":

> Judy was ... someone who was prepared to be honest about their feelings ... If I find somebody who is receptive ... I don't mind telling them exactly how I feel about things, and we've always been like that, Judy and I. She's one person I can talk to and say exactly how I've been feeling and not thinking 'Oh, she must think I'm a dreadful mother' ... We appeal to each other, because we're both very honest and we're very open and we just say how we feel and we don't judge each other at all ... That's one friendship that is very, very valuable because it was somebody else who was prepared to admit that they were having trouble. (Louise)

Louise's words encapsulate the different aspects of these women's friendships with other mothers that they found most valuable. These were: the ability to be honest about their feelings - honesty which, ultimately, had broken down the silent isolation of their experience; speaking within a "receptive" relationship in the knowledge that their voices would be heard and understood; and knowing that they would not be judged, condemned or rejected for their feelings.

Petra further highlighted the value of friendships with other women who had also found motherhood difficult. Petra had needed, not only to voice her feelings, but to do so within a *receptive* relationship - in the knowledge that her words *would* be understood:

> You see, people like ... Dawn are the sort of people that you can actually turn to, that can listen to you, 'cos even though my sisters try, they haven't been there, whereas Dawn has, and she can understand, and that makes such a difference.

The mothers felt they would be listened to and heard by other mothers who had experienced similar feelings; they would understand their experiences and realize how important it was for them to talk about their feelings:

> [Depression] is a very hard thing to explain to somebody who's never ... felt it. I think that's one of the reasons why it was nice to have people like Celia, because she actually knew [what I meant] when I said, 'But I can't tell anyone' ... because that's how she felt. (Marcia)

> I think you need to speak to like-minded people or to people who know *exactly* what you're talking about because they've been through it ... Unless

> anyone's gone through depression, they've no idea what it's like ... You really want people who understand. (Celia)

In voicing their difficult feelings, and in coming to realize that others had also shared these, the mothers had felt liberated from their isolation. "Talking" to another mother had made them "realize" that: "you're not the only one"; "it wasn't just *me*"; "a lot of people feel like that"; "there are other people going through it"; "you're not isolated and you're not alone". These feelings were in sharp contrast to "feeling like the only one", which is how they had felt during the depression (see Chapter Four). Understanding that their feelings were shared by others, and indeed were "very common" had also made them realize that they were not a "freak" or an "alien":

> The whole emphasis [of Cry-sis] is on talking to somebody who's been through it themselves, and is able to reassure you a little bit that you're probably not doing anything wrong, it's just the way the baby is. And really that helped me a great deal ... And through getting involved with them, I've realized that what I was going through is something that lots of people go through ... it was really quite normal, certainly not abnormal. (Louise)

In sum, the most important and beneficial source of support for the mothers in my study had been their relationships with other mothers. These women had been able to understand their experiences of motherhood, and/or postnatal depression. However, many had also derived considerable help from health professionals, and a few had described their relationships with partners, family, or friends as instrumental to overcoming their feelings of depression. These relationships, which the mothers had valued highly and which had been key to their journey out of depression, shared the following characteristics: the time to talk in depth about the full range of their thoughts and feelings; being listened to, heard and understood by someone who was non-judgemental, accepting and able to reassure them that their feelings were legitimate and shared by others.

II. The processes through which the mothers emerged from the depression

I now explore the processes through which the mothers had emerged from the depression. The key change here was the mother's recovery of her own voice, the voice that had been present throughout the depression, and that had fought against the internalized moral voice, but that had been buried. As the mothers had moved out of the depression, the voice that spoke to them on the basis of their experiences, rather than the moral voice, began to guide their actions and their beliefs about themselves, others and cultural expectations.

1. Changed orientations towards social norms and expectations of motherhood

In confiding their experiences to other mothers, the mothers had realized that much of what they had experienced was shared by these women. This had enabled them to re-evaluate their moral judgements about how mothers and children 'ought' to behave. They spoke about moving beyond their previously-held constructions of motherhood, in which they had defined themselves and their children in rigid and monolithic ways:

> I try not to have this obsession. Like she's playing there. *Now*, I think, well that's fine ... but in the past, I've thought 'God, I should be sitting down reading a book with her, cuddling her, holding her' ... I keep putting this pressure on myself to be *'the intellectual mother'*, to hot-house her ... and I think, 'Well, I don't particularly have those skills anyway'. (Sonya)

Furthermore, they now encompassed the notions of difference and diversity, as they came to understand that all mothers, all children, and indeed all people, are individuals, and therefore different:

> Some mothers appear to be sailing through things without any hassles, but when you talk to them, there's always some problem of some sort ... So ... I think it just all depends on you as individuals. The children have parts of their parents in them, good and bad, the children are all very different, the parents are all very different. (Caroline)

Caroline drew a distinction between the image that meets the eye - that "some mothers appear to be sailing through things without any hassles" - and what she actually found out "when you talk" to these mothers - that "there's always some problem of some sort". Returning to the theme of visual versus voice metaphors, mentioned in Chapter Three, these mothers had come to understand that 'voice' and 'talking', rather than 'vision' and 'seeing', were the routes to knowing and realization. Talking to other mothers had initiated a process whereby they had begun to *question* cultural representations of motherhood:

> It wasn't the sort of peaceful, charming, little experience that you see pictured and I've since realized, by talking to other people, that it's not really like that for anybody. (Louise)

> I remember [the health visitor] saying she'd been looking after a girl who also lived in [the town] - it was her third child and she'd had [postnatal depression] quite badly ... And I'd look at her and I'd think, 'God!'. I could never believe it ... 'cos she seemed so happy ... and I couldn't believe it of her, 'cos she seemed such a sane person. But I've since learned that appearances are very deceptive. (Vera)

In talking to, rather than observing, other mothers they regained a sense of perspective, which they had lost during the depression (see Chapter Four). Sandra said that talking to another mother "puts it into perspective for both of you ... 'cos you often think 'Well .... is it just me?'". Shifting their perceptions of themselves, others and the world around them appears to have been critical to the movement out of postnatal depression, as Sonya realized:

> Instead of being hard on myself, I should think 'Well, look at her, she *looks* fine but ... maybe she's got problems'. And I think this is part of the recovery process, being able to do that.

These findings are supported by Morris' (1987) research which showed that the move out of postnatal depression was accompanied by shifts in the mothers' constructs of the actual versus ideal self as mother, and the actual versus ideal child.

2. Changed understanding of themselves

Shedding their rigid and monolithic constructions of themselves and others, and realizing that experiences vary across individuals, had enabled the mothers in my study to appreciate that their own experiences and feelings were valid and morally acceptable. As they moved out of depression, they had come to adopt a different moral stand-point to the one they had held during the depression. Rather than blame and condemn themselves, they now accepted themselves, and their children, for whom they were. As they emerged from the depression, the condemnatory moral voice had faded away, as their own voice became louder and stronger:

> Now that I'm getting better I think 'Well ... it just happened, it's a fact of life, it has changed me. And when I'm out of it, it might have changed me for the better because I'll have more understanding of other people if they're in it' ... I'm trying to ... get away from thinking ... it's my fault. (Sonya)

Nonetheless, the mothers had found it difficult to fully 'let go' of their feelings of guilt. At the time of the interview, several mothers still felt a great sense of responsibility towards their children's well-being. However, as they had emerged from the depression, they were no longer *dominated* by this guilt, and compulsion to be the "perfect" mother. While this part of the self was still there, it was in the background rather than the foreground. The mothers were aware of it, but kept it at bay, while their confidence in their own knowledge and experience increased. Vera, who was towards the end of her journey out of depression, explained:

> Even now as a mother, I'd always think 'Well maybe I could do a bit more' ... I worry, and I'll always worry, nothing will change me and now I realize, I accept things in myself now. Like [my son's not] talking, I worry to death about it ... I think it's my problem. Anything sort of with him ... no matter what, I think it's my fault. But at least now I think, 'At the end of the day, all I can do is ... love him as much as I can, make him feel secure, cuddle him, not be cruel to him ... and that's all I can do', and ... I try to be as good as I can.

The inner conflict I described in previous chapters seemed to subside as the mothers stopped fighting against themselves and came to accept themselves and their children for whom they were. They now felt their own perspective was a morally valid one. They came to accept that "none of us are perfect and we just do the best we can at the time":

> I remember just crying my eyes out, 'cos I realized I loved Seamus so much ... even though he'd upset me. And ... from that day on, I felt I just started to accept the way he was, rather than fighting against it all the time - saying 'You shouldn't be like this, you should be quiet, you shouldn't be crying'. I just started, for some reason, accepting the way he was and saying, well, he was just Seamus, that's just the way he was and I was just gonna make the best of it. And I feel that by accepting it, that did help me to sort of overcome the feelings that I got about him. (Louise)

The mothers also spoke about "letting the standards go", standards which, during the depression, they had felt under pressure to uphold and fulfil. As they moved out of the depression, they spoke about how they had no longer felt under moral pressure to "try to be this perfect mother". They had realized that they needed to take care of themselves, *as well as* others. Moreover, they understood that in meeting *both* their own and their children's needs, not only did *they* benefit, but, ultimately, so did their children. Celia explained this position very clearly:

> I look at some mothers and I think 'Aren't they good. They do this and that with their child ... they're totally unselfish' ... But I think I know my own short-comings, I know how much now I can give ... When I try to do more things, something will be compromised and if at the end of the day, it made me short-tempered because I was trying to be here, there and everywhere, then I think that would be a compromise for the children ... I think at the end of the day ... it's accepting the sort of person you are and your own capabilities and not trying ... to be something that you're not.

In the previous chapter, I described depression as the mothers' inability and unwillingness to come to terms with their feelings. Conversely, the mothers' ability and willingness to accept themselves for whom they were had been fundamental to their move out of depression. Only then, had the inner division and conflict subsided, and the moral voice become fainter.

As I noted above, central to this moral re-evaluation of themselves were their experiences of talking to others, especially other mothers. The realization that their experiences were shared by others led the mothers to a different moral stand-point. They no longer saw their own experiences as unique, 'abnormal' and 'bad'. They came to realize that: "I wasn't an incapable mother", "I wasn't a useless mother", "I am not such a terrible person". Penny explained:

> I daren't even mention cot deaths to anyone, not even my husband. And I just mentioned it to [my friend] and ... I'll never forget her when she said, every morning, she stood at her son's door and she'd take a deep breath and she'd say 'Is he gonna be dead today?', and she went in. And I thought I was the only person who thought like that, and then I found out she did as well. So then I talked to other mums and then I found out 95% of the mums all felt the same, so I wasn't an incapable mother ... every mother thought like that, it wasn't just *me* ... so I wasn't a useless mother.

Thus, as the mothers moved out of the depression, and as they spoke to others, they seemed to undergo a simultaneous moral re-evaluation of themselves, others, and cultural definitions and expectations.

3. Changed understandings of their relationships

Through both the professional help they received, and their relationships with other mothers, the women in my study came to understand that their feelings were not universally condemned by others. Those who had attempted to confide in partners, mothers and mothers-in-law during the depression, realized there were *other* relationships, especially those with other mothers, in which they could express their feelings without being silenced or blamed. The mothers who had not even risked revealing their feelings, recognized their fears had been, in part, unfounded and that others *were* there for them when they *did* ask for help. Throughout the journey out of depression, the mothers built a trust in other people, a trust that others would not necessarily reject or condemn them:

> If I was gonna get depressed [again] then I'd know what to do about it ... go and talk to someone ... There are people there to help you, if you need help, and none of these people have had their children took away from them. So I know ... you don't have to be scared about telling somebody if you're not feeling how you're supposed to. (Penny)

Throughout this process, they gradually recovered their own voices and built up their own strength. They began to appreciate the importance of voicing their needs and feelings. In addition, they had no longer feared the reactions of others, and possible rejection. Through strengthening their belief in their own perspectives, they had stopped perceiving themselves through the eyes of others. Consequently, they had no longer felt

under pressure to change themselves in order to comply to some external image or expectation. They now felt others should accept them as they were - if others chose not to, "it's just tough":

> I don't worry what people think any more. Before I had Adam ... my friends used to come round, my house used to be ... immaculate ... I was so house-proud. But now, they take me as they find me. If they don't like the way I am, they're not friends ... So instead of worrying what my house should look like, and what I should look like, I just enjoy myself more, I don't worry so much about what other people think. (Penny)

> [The depression] has made me realize I'm not perfect, it doesn't matter if you're not perfect, people have to accept you .... I could admit a lot of things to people that I'd never admit before. I can ... be honest, like I had psychiatric care ... and I think, well, if they think 'Oh God, she's funny' that's their problem .... I think, 'Well, it's your loss not mine' ... That's changed me, I'm definitely like that now, 'It's just tough' ... I can admit all things like that and I realize people don't sort of shrivel up and think 'Oh', you know, 'cos I think everybody's quite complicated in their own way. (Vera)

They felt that, through their experiences of depression, they had changed. The depression had made them "better" people, they said, because they were now able to be more "honest" with themselves and others. They were prepared to admit their feelings and be open about who they were, their experiences, and their own limitations as mothers and individuals.

The mothers did not arrive at this changed understanding of themselves and others unproblematically. Some had clearly found it difficult to accept what felt to them like 'a new self'. This was particularly expressed by the mothers who were still in the process of emerging from the depression, in contrast to those who had come out of it several months or years before the time of the interview. Sandra, for instance, was still struggling with her feelings of depression. She said she had changed, but "probably not for the better", because the depression "has brought out the bad side in me". She added that this "is probably good in a sense", illustrating the way in which she was still confused in her definitions of 'good' and 'bad'. Sandra seemed to realize that the ways in which she had changed were ultimately for the "better", but the internalized moral voice still had some grasp over her. She was still involved in an on-going struggle in which this voice told her that her emerging self was "hard", had "lost its niceness", and was a "bad" self. Sandra illustrates this transition *in progress*, and how difficult and painful it was for some mothers:

> *And do you feel you've changed as a person since having her?*
> Yes, but probably not for the better ... I think this has actually brought out the bad side in me, which is probably good in a sense. I think I went *years* of ... whatever I was asked to do, or people wanted me to do, I did ... I

> think that's why they've all found it quite a shock because, suddenly, this nasty little beast has come out in the middle of it. I'm a bit sad because it's made me hard, I've lost my niceness in a way, but I presume that will slowly come back with experience and realization and accepting it. But ... it's brought out a bad side in me, a side I didn't really know I had ... I assumed I would be alright with her and I wouldn't have all these ... bad feelings and emotions ... but there was obviously a hidden side to me that nobody knew about.

Sandra's account highlights this process of questioning and reassessing moral standards, and what is best for whom. As I pointed out in previous chapters, it is likely that the mothers in my study, and perhaps mothers in general, would find it difficult to shed altogether this moral voice. Nonetheless, the mothers were now more inclined to understand that it was "better" to express their needs, even if this engendered conflict, and appeared to others as 'bad' and selfish behaviour.

As the mothers came to understand the importance of retaining their own voices and needs within their relationships, they spoke about being more honest with others. When Sandra looked to the future, she felt the kind of relationship she wanted with her own daughter Alice would be one in which Alice could honestly express her vulnerability, and Sandra would be able to embrace her feelings:

> I'm hoping that when she grows up ... I'll be able to talk, I won't say 'Go away, I can't cope with you throwing a wobbly' ... I'm hoping that'll be a positive thing to come out of it.

In speaking about wanting more honest relationships, the mothers spoke a great deal about wanting to be open with other mothers. As I pointed out in the previous chapter, they recognized that one of the problems in postnatal depression is that mothers tend not to admit their difficult feelings to each other. They now felt determined to break this communal silence amongst mothers, because they saw that this silence had isolated them, and led to their depression. The knowledge they wanted to pass on to other mothers has a potentially important role to play in strengthening the voices of mothers who speak about the true nature of their feelings and experiences, thereby countering cultural ideals of mothers and children.

Furthermore, because these mothers felt they had not found the right kind of support, namely other mothers to talk to, they either wanted to, or had, become involved in helping other depressed mothers in a number of ways. Dawn had set up a postnatal depression support group. Sonya and Sandra also wanted to organize such a group in their village. Sonya said her "mission" was now to "pass on information to help other people ... like talking to you". She also considered "one day, maybe being a counsellor". Caroline

had set up a postnatal group in her village for first-time mothers. Vera and Louise had joined Cry-sis and become telephone counsellors for women experiencing difficulties. Louise had also been involved in giving talks to postnatal groups about the difficulties of having a crying baby. Celia became the postnatal depression helpline counsellor for her regional branch of the National Childbirth Trust. Other mothers, such as Frances and Penny, had helped in more informal ways by having mothers whom they knew were having difficulties round for a cup of coffee, in order to reassure them that their experiences were shared by others. Other mothers, such as Petra, told their health visitors that they were willing to talk to any other local mothers whom the health visitors thought were having problems.

Thus, the majority of the mothers in my study wanted to help other mothers. They regarded the provision of such help as important, not only for others in similar situations, but also for themselves. By helping others, they felt their experiences were valued by those who needed help. They also felt that their experiences were valued by lay organizations, who had called upon them to share their experiences with others. Other researchers have similarly noted that helping others is also a way of helping oneself (e.g. Rogers *et al.*, 1993).

V. Concluding discussion

My study shows that the mothers found their way out of their depression through the recovery of their voices, and through talking about the difficult feelings they had previously kept buried. These findings are supported by existing research (e.g. Cox, 1986; Elliott, 1984, 1989; Gruen, 1990; Holden *et al.*, 1989; Morris, 1987; Nicolson, 1989). As Jack (1991: 190) notes in the context of depression:

> When we consider women's depression from a relational perspective, the metaphor for movement out of despair becomes dialogue. Dialogue ... provides a way to come into new forms of relation with others, with the self, and with the world beyond the self.

The mothers also emphasized that it was talking within a receptive, responsive and non-judgemental context, in which their feelings would be acknowledged and accepted, that they had found particularly valuable (see Fedele and Harrington, 1990). Such "open" and "honest" relationships have been found to be crucial to women's mental health. As Miller *et al.* (1991: 10) point out, "mutuality is the fundamental property of healthy, growth-enhancing connections". Relationships based on 'mutual empathy' and 'authenticity' "suggest a way of being 'present' or joining together in which each person is emotionally available, attentive, and responsive to the other(s) and to the relationship"

(Miller *et al.*, 1991: 10). The mothers felt such relationships had allowed and enabled them to voice and accept their emotions, and feel that their experiences were legitimate. Such relationships were key to moving out of depression. As Stiver and Miller (1988: 3) write:

> The major task in therapy is to help our women patients who are depressed move from that nonfeeling and defensive state to an affective experience in which their sadness can be recognised and validated.

It is interesting that, for the mothers in my study, the actual source of this relationship - that is, the actual person whom they spoke to - was, in one sense, a relatively minor issue. During the depression, they had felt that "everybody" had abandoned them, and that they had "nobody" to talk to. Hence, as soon as they had been able to speak to *one* person, who had accepted their words without criticism and condemnation, the depression seems to have lifted. *However*, talking to other mothers was also critical to the majority of the women in my study. These relationships had been valuable either in addition to, or instead of, relationships with significant others and health professionals, because mothers had wanted to confide in someone who had shared their experiences of motherhood and/or depression.

A central finding of my study therefore concerns the role of depressed mothers' relationships with other mothers in the onset, maintenance, and movement out of postnatal depression (also see Chapters Four and Five). This represents an important contribution to existing research on the role of interpersonal relationships in postnatal depression, which has tended to over-emphasize marital and parental relationships, while friendships with other mothers have received little attention.

This omission can be explained in a number of ways. As several researchers have pointed out, social support is generally assumed to be co-terminous with the marital relationship (e.g. Oakley and Rajan, 1991; O'Connor, 1992). A related assumption within much research on social support and mental health is that relationships with partners are primary and more conducive to women's happiness and well-being than are other relationships (O'Connor, 1992). Furthermore, because mothers' lives tend to be viewed in terms of a home/work split, thus neglecting their involvement in local community and networks that transcend such boundaries (Bell and Ribbens, 1994; O'Donnell, 1985), the importance of friendships with other mothers has been over-looked. This neglect possibly reflects the related assumption made within feminist research that motherhood is by definition an isolating activity restricted to the home (see Chapter One).

In this study, however, the mothers' friendships with other mothers were important in several ways. In Chapter Four, I documented how the first-time mothers' perceptions of other mothers had informed their moral evaluations of their own performances. It was in part through these relationships that they had interpreted normative representations of motherhood. Based on their observations of other mothers, they had constructed their own experiences as 'different', 'abnormal' and a moral failure on their part. Feeling ashamed of their feelings, they had withdrawn from further contact with other mothers, and had thereby created limited, or no, opportunities for their feelings to be contradicted by these women. This withdrawal from other mothers seems to have been linked to the onset of their depression.

In this chapter, I have shown that talking to other mothers, and discovering that their experiences had not been unique, was key to the move out of depression for all of the mothers. Realizing that other mothers experienced similar feelings to their own had enabled them to re-evaluate their own competence and moral worth, and question normative constructions of mothers, children and individuals. In this sense, relationships with other mothers provided the women with the possibility of an open and "political resistance" (Brown and Gilligan, 1993: 17), which was instrumental to emerging from the depression. Urwin (1985) has argued a similar point in relation to non-depressed mothers. She has highlighted how mothers' friendships with each other can lead them to resist normative images presented in the childcare literature, by enabling them to see child development differently and re-evaluate their own positions.

My study also shows that relationships with other mothers differed in important ways from relationships with male partners (or with their own mothers and mothers-in-law). Mothers who had felt supported by their partners, nonetheless found this help to be limited. They felt that having experienced neither motherhood, nor depression, their partners could not understand their feelings. A supportive partner was not necessarily sufficient because the nature of this help was not always the 'kind of support' they had wanted or needed. Mothers who had difficult relationships with partners expressed the need for more balance within these relationships, *as well as* their need for relationships with other mothers.

My study therefore suggests that relationships with other mothers were as important as the quality of their relationships with male partners. This finding is supported by Cutrona's (1984) study; she found that the strongest predictor of postnatal depression was the availability of companionship and feelings of belonging to a group of similar others, rather than the quality of intimacy with the husband. Furthermore, O'Connor's (1991)

research shows that women (not mothers specifically) who lacked a confiding relationship with a female friend were just as likely as those who lacked a confiding relationship with their husband to have poor psychiatric health. Further research has also found that friendships with other women can be as important as partners in times of stress and psychological difficulties (e.g. Keeley-Robinson, 1983; Komarovsky, 1967; Miles, 1988). Although partners might be understanding and caring, it might be that what mothers want and need at this particular moment in their lives are relationships with other mothers, and other depressed mothers, who have a much deeper and personal understanding of their experiences. Consequently, it is important that future research consider the role of mothers' relationships with each other, and bear in mind that a mother's partnership cannot necessarily satisfy all her emotional needs.

A further finding which has emerged from my study concerns the importance of talking to other mothers in the context of a support group. This was the type of support the mothers had valued most. This finding is corroborated by Cox's (1986: 48-49) observation that "one of the most important developments in the prevention and treatment of postnatal depression has been the establishment of self-help support groups". Indeed, the small amount of research on such groups (e.g. Morris, 1987), as well as anecdotal accounts (e.g. Jones, 1984; McKears, 1983), point to their effectiveness. Handford (1985) gives an excellent characterization of the value of these groups to depressed mothers. She notes the following five components: (i) confidentiality - being able to discus their depression in a safe setting; (ii) counselling - talking to another woman who has been 'through it' has a cathartic effect; (iii) focusing upon herself, her needs, thoughts and feelings; (iv) sharing - discovery that her feelings are similar to those of other women; (v) support - being caring towards others in the group.

The results of my study also shed light on a wider question concerning the relationship between the quality of interpersonal relationships and mental health. Many researchers note that "very little is known about the mechanisms through which social relationships enhance mental health" (Cutrona, 1984: 378), as well as physical health (D'Arcy and Siddique, 1984; Mueller, 1980; Oakley, 1988; Oakley *et al.*, 1990; Thoits, 1982). Several hypotheses have been put forward, including the following four: (i) relationships affect health directly; (ii) relationships improve health by acting as a buffer to stress; (iii) relationships make stress less likely; (iv) relationships facilitate recovery from illness or crisis (Oakley, 1992). Although the present study was not designed to address these questions, it does suggest that relationships enhance feelings of well-being in a number of different ways, which encompass elements of each of the four positions above. My study also highlights two particularly important aspects of health-promoting relationships in the

context of this research: first, these relationships were *mutual* ones in which both parties expressed their feelings and needs; second, healthy relationships were those in which the mothers could freely express a *range* of feelings and thoughts, and have these accepted by others.

The help the mothers received from family, partners, health professionals and other mothers, in particular, paved the way for their emergence out of depression. Through these relationships, their own understandings of themselves, of others and of normative prescriptions of motherhood shifted in such a way, that they spoke of the depression changing them and "making" them "a better person". When speaking about women's movement out of postnatal depression it therefore seems inappropriate to speak in terms of 'recovery', a word which suggests returning to a previous state. Perhaps a more appropriate term is that of 'transformation' (Jordan, 1992) given that the mothers reached a changed understanding of their relationships to themselves, others and cultural expectations.

This changed understanding reflected a different moral position adopted by the mothers. They now felt it was morally right for them to have a voice within their relationships. This shift in moral stand-point can be understood in terms of the developmental progression described by Gilligan (1982) in the ways in which women think about moral dilemmas in their lives. Gilligan has described how, within the context of an ethic of care, women move through three moral perspectives. In the first, there is a focus on caring for the self in order to ensure survival. In the second position, the morally 'good' is equated with caring for others in a selfless and self-sacrificing way. Here,

> moral judgment relies on shared norms and expectations. The woman at this point validates her claim to social membership through the adoption of societal values. Consensual judgment about goodness becomes the overriding concern as survival is now seen to depend on acceptance by others. (1982: 79)

In the third perspective, the self and other are seen as *interdependent*, and it is now regarded as morally right to care both for the self and for the other. Here, moral goodness is defined as honesty and truth. The self is understood in terms that transcend social conventions and roles, and in terms that reflect the self's experience of itself.

The mothers' depression, as well as their move out of it, can be understood in terms of their progression from the second to the third perspective. During the depression, the mothers had defined caring for others, and being in relationship with others, in rigid and monolithic ways, in which care for the self and care for the other had been seen to be in

opposition. Here, moral goodness was equated with selflessness and self-sacrifice, and consequently the mothers had withdrawn themselves from their relationships (see Chapters Four and Five). As they had moved out of the depression, however, they had increasingly attended to an inner judgement. They had brought their own needs, feelings and voices into their relationships. They spoke about wanting honest relationships in which they could reveal the true nature of their thoughts and feelings. They described reaching a different understanding of themselves and others, in which it was morally acceptable for them to attend to their own experiences, while at the same time take the needs of others into consideration. They came to understand the interdependence of their own needs and those of others, and to realize that relationships in which both they and others had a voice were mutually beneficial.

The important point about the position the mothers reached when they had moved out of the depression, was that here, they had felt at one with themselves as mothers and individuals, however they happened to define the meaning of being a mother and individual in our society. Willard (1988: 243) makes a similar point when she notes that those mothers in her study who were able to combine motherhood with employment in terms of their own experiences, rather in terms of cultural scripts, "were less depressed even when they had limited choices". Breen (1975: 11) spoke about a similar experience within those mothers in her sample whom she defined as 'well-adjusted'. She noted that this position "does not automatically imply either that [the mother] must conform or that she must give up her individual creativity or that she must fight her social environment". Similarly, for the mothers in my study, it was not simply that they had either rejected, or embraced, cultural ideals. Rather, a positive resolution of difficulties and conflicts had been found, in whichever way individual mothers felt was best for them *and* those whom they loved. In accepting themselves (and their children) for whom they were, the conflict between their ideal and actual self had diminished. They had reached a position in which they had been 'at peace' with themselves, and therefore others; and as Gilligan (1991: 23) points out, "psychological health consists, most simply, of staying in relationship with oneself, with others, and with the world".

Chapter Seven

Conclusions

Chapter Seven

Conclusions

> ... putting together many individual voices has produced a resounding chorus. The exhilaration and the wisdom in this chorus tell us of many visions of life, different for different women and powerfully different from the reality that now holds sway. (Emily Martin, 1989: 203)

In this chapter I first draw out a number of general conclusions from my study. I then move on to highlight the policy implications of this research in terms of prevention and intervention programmes for depressed mothers. I also consider the significance of this research to health professionals. Finally, I outline a number of potentially fruitful areas for future investigations.

I. Conclusions drawn from the present study

This thesis set out to address the questions of how and why some mothers become depressed following the birth of their child. In order to explore these issues, I carried out a retrospective, qualitative study of the lives of 40 mothers of young children living in Britain. Eighteen of these had experienced postnatal depression following the birth of their first, second or third child, and the core of the thesis has focussed on these mothers' accounts.

The starting point of my research was that learning about postnatal depression depended on listening to the voices of depressed mothers, and that existing research in this area has failed to represent these perspectives. This omission has occurred for several reasons. Eliciting mothers' views does not feature as part of the methodology adopted within medical research on the biochemical origins of postnatal depression. Where mothers' accounts have been considered, for example, in the 'social factors' studies, they have been interpreted as 'distorted' perspectives, which say little about the 'objective' 'truth' of the mother's situation. Feminist research *has* emphasized the need to include mothers' personal narratives, but these have tended to be interpreted from a male, public-world perspective only. Depression is understood to result from the lack of autonomy, independence, power and paid employment that is assumed to accompany motherhood (Chapters One and Two).

I have suggested that, to date, women's accounts of their experiences of postnatal depression have not been listened to, or understood, 'on their own terms'. By this, I mean

that existing studies have failed to maintain distinctions between: the mothers' perspectives and the researchers' own views; and the mothers' voices and existing theoretical categories (Chapter Two). This thesis documents the value of listening to women's voices in, and on, their own terms. I have demonstrated how close attention to their narratives takes us beyond existing frameworks in important ways.

I argued that, based on the accounts given by the 40 mothers in my study, present conceptualizations of women's emotional responses to motherhood are problematic. Medical-psychiatric research posits a dichotomy between happy, 'normal', 'healthy' motherhood, and depressed, 'abnormal', 'pathological' motherhood. As a critique of this construction, feminist researchers have argued that, far from being a pathological condition, depression constitutes a 'normal' response to motherhood in our society (Chapter One). However, these theories in which difference is either pathologized, or denied, did not fit with the views held by the mothers in my study. According to their accounts, mothers can experience a *range* of feelings, both positive and negative. Seventeen of the 40 women in my study had found motherhood relatively unproblematic, and thus depression cannot be said to be a 'normal' response to motherhood. The mothers also pointed out that negative feelings are not necessarily 'pathological'. They said mothers could feel a *range* of *negative* emotions, but that there were clear differences between feeling 'low', and experiencing 'postnatal depression'. Five mothers in my sample said they had had periods of low mood which they distinguished from postnatal depression; and 18 defined their experiences as postnatal depression. Consequently, there were important differences between and amongst the 40 mothers' feelings, which have not been adequately conceptualized within existing theories (Chapter Two).

In my review of current research on postnatal depression, I suggested that there had been no qualitative, in-depth studies, to date, of mothers' experiences of postnatal depression specifically. I therefore decided that I would focus on the 18 mothers who said they had experienced postnatal depression (Chapters One and Two).

Analysis of these mothers' accounts led me to challenge existing formulations of postnatal depression, which have taken either the individual, or the socio-political context, as the unit of analysis. Current research conceptualizes depressed mothers as victims either of individual deficiencies, or of a hostile socio-political context (Chapter One). However, the 18 depressed mothers in my study did not describe themselves in these terms. Their accounts reflected a set of *complex* and *dynamic* interrelationships between themselves, others and society, at the heart of which lay an *active* self. In order to make sense of these mothers' experiences, and understand how these narratives could advance current debates,

I adopted a relational perspective. Within this theoretical framework, the self is defined in a context of relationship, and the goal of development is 'relationships' rather than individual self-development (Gilligan, 1982; Jack, 1991; Miller, 1986a).

The thesis documents how the 18 mothers' depression was characterized by, and resulted from, a profound sense of relational disconnection, in which they had felt unable and unwilling to voice their feelings and needs within their relationships with their children, partners, relatives, friends, other mothers with young children, and health professionals (Chapters Three, Four, Five, Six). I argued that this experience constituted the essence of their depression, not simply an 'added factor' and one of many correlates of postnatal depression, as current research suggests. I also demonstrated how this social withdrawal was distinct to, and occurred irrespective of, the experiences of physical isolation and unsupportive relationships, which existing research on the role of interpersonal relationships in postnatal depression has documented. The latter formulations assume a passive construction of the self, and a unidirectional understanding of relationships. My study indicates that depression results not only, or necessarily, from a lack of *received* support, but from the mother *actively removing herself* from her relationships (Chapter Three).

Chapters Four and Five explored why and how the mothers had withdrawn from others during their depression. I drew distinctions between the first-time, and subsequent, mothers' experiences. Only the 12 first-time mothers had held idealized, moral, and monolithic expectations of motherhood. These had conflicted with their experiences of mothering their particular child. In resolving this conflict, these women had felt under pressure to change their own experiences in order to conform to normative constructions of the 'good', selfless mother. In prioritizing their children's needs over their own, they had removed themselves from their relationships with their children, and become alienated from themselves and depressed. The mothers' interpersonal relationships were central to how they had constructed and experienced their children, and themselves as mothers. It was in part through their encounters with other mothers that they had interpreted normative representations of motherhood, and morally evaluated their own performances. Furthermore, the mothers' exclusion of their own needs and feelings in caring for their children had, in some cases, been facilitated by what they had felt was the critical and blaming attitude of partners, relatives, friends or health professionals. The mothers' denial of their own experiences had also been facilitated by the cultural context in which they were living. In particular, the notion that mothers who fall short of normative definitions of 'good' mothering damage their children, or have them taken away and put into care,

operated as a powerful sanction against the expression of negative or ambivalent feelings by these mothers (Chapter Four).

Although only the first-time mothers had removed themselves from their relationships with their children, all had withdrawn from partners, relatives, friends, other mothers with young children, and health professionals. This withdrawal had come about through their feeling under pressure to 'cope' single-handedly and be self-sufficient without calling upon others for emotional or practical support. Cultural constructions of the 'mature', 'independent', 'autonomous' individual who meets her or his own needs, and the devaluation of help-seeking behaviour, made it difficult for the mothers to accept or express their needs and feelings. This cultural context had reinforced their moral beliefs that 'good' mothers 'cope' without resorting to others (Chapter Five).

Many of the mothers had not even attempted to seek help from others. They had believed their moral worth as mothers depended on denying their needs and vulnerability to others. They had feared that, in voicing their feelings, they might be rejected and morally condemned. For some, these beliefs and fears had been reinforced by their difficult relationships with partners, mothers or mothers-in-law. The mothers felt that the latter had either lacked initiative in offering help, or, when they had asked for support, it had been denied to them. The attitudes of these individuals had contributed to the mothers' silence and withdrawal, because the latter had felt emotionally wounded, and morally reprimanded for having, and voicing, needs and negative feelings. In order to preserve their own integrity, and their relationships, the mothers had withdrawn from these individuals (Chapter Five).

The critical point underlined by my study is that all the mothers had felt disconnected from others and themselves - this experience had characterized their depression. However, the mothers differed in the routes they took to this point of disconnection. There were differences in the precise issues over which the mothers felt their expectations conflicted with their experiences. Pressure to live up to idealized constructions of mothers and babies featured in the first-time mothers' experiences of disconnection and depression. There were also subtle differences amongst the first-time mothers, and in which particular aspects of motherhood there had been a conflict between their experiences and their expectations. Pressure to conform to a cultural ethic of individuality and self-sufficiency was articulated by all 18 mothers.

The identification of an underlying psychological process that was common to all 18 mothers - namely, that of relational disconnection - raises the possibility that depression

in women (and possibly men) at other times of the life cycle (e.g. in mothers of preschool children, depression in women without children, and depression around the time of the menopause) might also be characterized by this underlying process. However, the differences between depressions at these different times might lie, again, in the precise issues over which the individual encounters conflicting expectations, and experiences, of her/himself.

An important finding of this thesis is that depressed mothers are not helpless and passive victims of either their bodies, psyches, social circumstances, or a hostile socio-political context, as current research tends to suggest (see Chapter One). The mothers in my study had taken an active role in the construction of their experiences. This was apparent in several ways, most obviously in the mothers' active withdrawal from their relationships. They also spoke about actively interpreting and constructing for themselves cultural definitions of motherhood, and elaborating their own versions of what it means to be a 'good' mother or child (Chapter Four). The mothers' beliefs and expectations about motherhood had been informed, but not determined, by prevailing social constructions. Consequently, there were differences between the first-time and subsequent mothers' constructions and experiences (see Chapters Four and Five), amongst the first-time mothers as a whole (see Chapter Four), and there were also changes within individual mothers over time (see Chapter Six).

The mothers also spoke about how they had constructed and experienced their interpersonal relationships in particular ways. They were aware that their depression was, in part, a result of how they had *believed* others perceived them, even though another part of them had known that their projections were probably or possibly unfounded. In particular, they anticipated that others would reject and morally condemn them for their feelings (see Chapters Three, Four, Five).

Finally, the mothers actively resisted cultural expectations, while at the same time conforming to them. They were both moulding themselves to external representations of 'good' mothers, *and* questioning these images, and thereby resisting such conformity. The first-time mothers had actively struggled with, and resisted, cultural definitions of motherhood. During their depression, however, their resistance had been a silent one, and their outward behaviour suggested conformity on their part (see Chapter Four). All 18 mothers had also experienced a silent resistance to the separation inherent within the cultural ethic of individuality and self-sufficiency, in which individuals are expected to cope with their own needs single-handedly. During the depression, however, they had felt under pressure to fulfil their own, others', and society's expectations that they should cope on

their own, and they had consequently withdrawn from their relationships with significant others (Chapter Five).

The mothers' move out of depression was marked by shifts in their moral beliefs about themselves, others and social expectations. During the depression, they had defined caring for others, and being in relationship with others, in rigid and monolithic ways, in which care for the self and care for the other had been seen to be in opposition. They had equated moral goodness with selflessness and self-sacrifice, and they had believed acceptance by others had depended on their conforming to these cultural definitions. This had led to their social withdrawal. As they emerged from the depression, they had come to realize that it was 'better' to express their needs and feelings, even if this engendered conflict, and appeared to others as 'bad' and selfish behaviour. They reached a new understanding of themselves and others, in which it was morally acceptable for them to attend to their own experiences, while at the same time take the needs of others into consideration. They came to see the interdependence of their own needs and those of others, and to realize that relationships in which both they and others had a voice were mutually beneficial (Chapter Six).

The changes in the mothers' understanding of themselves, others and cultural expectations had come about through their eventually feeling able and willing to engage in open relationships with significant others, health professionals and other mothers with young children. Their friendships with other depressed and non-depressed mothers played a key role in these processes. Realizing that other mothers experienced similar feelings to their own had enabled them to re-evaluate their competence and moral worth, and question normative constructions of mothers, children, and individuals. Relationships with other mothers therefore provided the depressed women in my study with the possibility of an open and 'political resistance', in which they could voice their needs and feelings to others. This was instrumental to their move out of depression. Furthermore, the mothers recognized that their isolation and depression had resulted, in large part, from a communal silence amongst mothers, who feel apprehensive about admitting negative or ambivalent feelings to each other. Their 'mission' was now to help other mothers, through formal and informal channels, by sharing their experiences with them (Chapter Six). These findings suggest that establishing, and maintaining, open friendships with other mothers before, or as, mothers experience difficulties might enable them to voice their feelings from the outset and so prevent these from becoming clinical, postnatal depression. I discuss this issue further below.

Furthermore, my study shows that even in the presence of supportive relationships with male partners (and mothers and mothers-in-law), other mothers with young children were important because they provided different *kinds* of relationships. The mothers valued opportunities to share their experiences of motherhood and/or depression with women whom they *knew* would have some personal understanding of their feelings. It is therefore vital for future research to explore these issues, and counter assumptions within existing studies that male partners should, or can, fulfil all of women's emotional needs, and that if they did, mothers would be healthy and happy (see Chapters One and Six). This thesis has therefore raised important questions concerning the role of other mothers in the onset, maintenance and movement out of postnatal depression.

II. Public policy implications of the present research

The findings from my study have important policy implications in terms of prevention and intervention programmes for depressed mothers, and the roles of professional and lay sources of support.

1. Prevention

Prevention of postnatal depression is important for several reasons. In severe cases, postnatal depression can lead to suicide (Cox, 1989). It is also related to increased risk of later depression in the mother (Philips and O'Hara, 1991), including another episode of postnatal depression following the birth of a subsequent child (Braverman and Roux, 1978; Playfair and Gowers, 1981). Furthermore, research indicates that the mother's child(ren) can be affected by her mental health (Murray, 1988; Murray and Stein, 1991). Finally, a mother's depression can affect her partner's health, and her family as a whole (Gruen, 1990; Lovestone and Kumar, 1993; Kumar and Robson, 1984).

Prevention is therefore the ideal, but also the most difficult, way of helping women. Few factors allow the confident identification of women who will become depressed (Cox, 1986; Elliott, 1984). Recently, however, several researchers have attempted to develop means of identifying pregnant women who might become depressed postpartum (e.g. Leverton and Elliott, 1989; Murray and Cox, 1990). My study supports the use of such easily administered predictive scales as routine practice. In addition, my research points to the potential preventive role of support groups, antenatal classes, and the pregnancy and childcare advice literature.

(i) Antenatal education classes

Antenatal classes are potentially important in the prevention of postnatal depression through both their educational components, and the ways in which they can facilitate the development of friendships between women.

The 'social support' aspect of antenatal classes has received little research attention. For example, Combes and Schonveld (1992: 95) find that "there has been no research on whether [antenatal] classes are successful in building up support networks among women", although Hillier and Slade (1989) noted anecdotal evidence that antenatal classes did facilitate contacts between women. They found that community rather than hospital-based classes were particularly useful in this respect, and suggested that women who have recently moved to a new area should be encouraged to attend classes in their local community rather than at a hospital.

My study corroborates this point. The women who attended hospital-based antenatal classes expressed regret at not having participated in local classes, and not having met mothers who lived in the vicinity.[1] However, the majority of the depressed mothers in my study *had* met other pregnant women at antenatal classes. Following the birth, however, they had withdrawn from these relationships because they had felt 'different' and 'abnormal' compared to other mothers (see Chapters Three, Four and Five). Antenatal classes can therefore play a useful and important role by encouraging expectant mothers to talk to one another, and by informing women that, should they feel that their experiences are unique or 'abnormal', sharing their feelings with another mother is likely to reassure them.

This latter aspect of antenatal classes points to their valuable educational dimension. At present, classes prepare parents for the birth, and devote relatively little time to the postnatal period and how to care for an infant (Combes and Schonveld, 1992; Gruen, 1990; Kendall-Tackett, 1993; Moulds *et al.*, 1983). This criticism was raised by several mothers in my study:

> I blame the antenatal classes more than anything. They cover far too much on birth and ... the pain relief ... you can get, and I think they only had about one session on what it's like to actually have [the child] ... They never mentioned that babies can throw up, babies could cry ... nothing about real life. (Dawn)

---

1 The mothers in my study attended antenatal classes run by the National Health Service, locally or at the maternity hospital; National Childbirth Trust classes; and/or Active Birth classes.

They felt that if postnatal issues had been discussed, they tended to be idealized accounts. Those who had attended classes when pregnant with a second or third child commented on the more realistic depictions within these classes, compared to those for first-time mothers:

> I'd been to antenatal NCT classes, and they're very good, but I think they make it all sound a bit too ideal ... The classes do perhaps present a rather unrealistic picture because the second-time classes that we went to, we'd all had varying experiences and so we weren't going to take any of the sort of nonsense that perhaps had been thrown at us in the first classes. (Caroline)

Most of the mothers said the emotional aspects of motherhood, including the negative or ambivalent feelings mothers can experience, had not been addressed:

> [The classes] were all... about the practical aspects, it was 'what's going to happen in labour' and 'how you're gonna cope with it', pain relief techniques, and then once the baby's born breast-feeding, bottle-feeding, whichever you choose ... Your *feelings* really were never discussed ... they could have put a bit more in about your emotions. (Louise)

> We didn't really do about depression, we just done about how to breathe, to relax, how to bath the baby, how to breastfeed the baby. (Penny)

If the emotional aspects of having a baby *were* covered, it had been, at most, a consideration of the baby 'blues':

> They covered the baby blues ... but there was *no* mention of 'It could take a few weeks, months before you could start to be Jekyll and Hyde' ... And there was nothing like 'If you're having trouble come back and see us' ... I think they really should cover it a lot more, they should let some of these poor women know what they could possibly face, and if it did happen to them that there was people who could help. (Dawn)

The mothers felt postnatal depression should have been openly discussed in the same way that the 'blues' were. However, they felt the health professionals running the classes had been reluctant to address these difficult issues, as Petra explained:

> They say 'We don't want to frighten you, we don't want to give you too much knowledge, you've got enough to think about' but ... surely it would be better if they gave you ... fewer basics on the labour and a bit more perhaps on what happens afterwards.

Petra's views are confirmed by studies showing that parents criticize the classes for "avoiding or glossing over negative feelings or difficult experiences" (Combes and Schonveld, 1992: 96; see also Gruen, 1990). It appears that little time is spent on the emotional aspects of parenthood because health professionals experience a "fear of teaching

negative or difficult issues" (Combes and Schonveld, 1992: 96). However, there is no evidence that such instruction upsets or harms mothers (Cox, 1989; Elliott, 1989). Furthermore, such information would enable mothers to recognize the nature of their feelings, and hence seek help:

> I think it can be mentioned by people at antenatal clinics without worrying it's going to become a big problem ... It'd be nice to know, if you felt like that afterwards, that it struck a chord, and you'd think 'Ah, it's not strange to feel like this, I'm not failing ... the midwife did say this could happen' - and then you'd probably feel happier and more confident to go to the doctor and say 'I'm experiencing this'. (Celia)

> I think if there was more information to let people know how bad it can get and what signs to look for and who to turn to for help I think ... that would have done it, and we could have got the help when it first appeared. But there was nobody, we just had to cope with it ourselves as best we could. (Fiona)

Indeed, providing women with information about the postnatal period, the realities of parenthood, and the range of emotions parents can feel, results in significantly less psychological distress in the first postpartum months (Elliott *et al.*, 1988; Gordon and Gordon, 1960; Gruen, 1990).

My study therefore suggests that provision of information and education about postnatal depression is likely to help mothers in a number of ways: by informing them that the most important action to take if they suspect they are depressed is to talk about their feelings; by reducing the stigma attached to postnatal depression and so encourage women to reveal their feelings; by enabling mothers to identify the nature of their emotions and hence realize that they might need help; and by providing mothers with contacts and sources of professional and lay support.

Antenatal classes play a vital role in 'educating' and informing women, and facilitating contacts between them. Further research should explore how this potential can be capitalized. Non-attendance at antenatal classes is also an issue. Only a small minority of women (15-28%) attend a full, or nearly full, programme of antenatal classes (Combes and Schonveld, 1992). Those who seek formal childbirth education are more likely to be of higher socio-economic status and educational attainment, first-time parents, older, and of higher self-esteem (Combes and Schonveld, 1992; Fisher, 1993; Langer *et al.*, 1990). Consequently, classes fail to provide education for groups of women who may have greater need than those who currently attend (Combes and Schonveld, 1992). It will be important for future research to explore ways of engaging the 'hard to reach' families who might be most in need.

(ii) Antenatal and postnatal support groups

My study shows that encounters with other mothers were important in the onset, maintenance and movement out of postnatal depression. As I noted above, these findings suggest that developing, and maintaining, friendships with other mothers, in which women can voice their difficult feelings as they experience them, might prevent these feelings from becoming clinical, postnatal depression. It is therefore vital to encourage women to form friendships, and to share their experiences with each other.

Support groups are important in fostering the development of such relationships between women. As I discussed above, there is evidence to suggest that antenatal classes can function in this way. However, at present, their primary purpose is education and preparation, while their social support dimension is secondary. My research suggests that mothers would benefit from attending groups set up with the principal aim of providing support. Ideally, women would join these groups during pregnancy, or in the first few days or weeks postpartum. Such groups would be of greater benefit if they began in pregnancy, as it might be easier for mothers to discuss their fears and anxieties with women they have known for several months. Mothers should be encouraged to attend such groups, and given information about the range of groups operating within their community. Health visitors have an important role to play in encouraging mothers to make contact with each other (Newton, 1992) and informing mothers about available groups that will meet their needs. Not all mothers will want to attend such groups, but it is important to provide details to those women who might benefit from them. Optimum functioning of such groups would be ensured if they were locally-based, and if creche facilities were offered.

Elliott *et al.*'s (1988) excellent research shows that groups which enable women to talk to one another, and give women 'permission' to express negative or ambivalent feelings, can prevent postnatal depression. They designed a psychosocial intervention programme for women expecting their first or second child, who had been identified as potentially vulnerable to postnatal depression. Half these women were given an extra service in which they were asked to join a professionally-run support group. The women attended this monthly group from mid-pregnancy to six months postpartum. The group combined social support elements designed to promote positive mental health (e.g. continuity of professional care over the childbearing period; access to extra individual help; emphasis on developing friendships with other women and mothers) with educational components (e.g. realistic preparation for parenting and caring for a newborn; details about the emotional and psychological aspects of parenthood, including postnatal depression; sources of information on, or referral to, relevant local and national organizations). They

found that the prevalence of depression was significantly lower in the intervention group (12%) than in the control group (33%).

Elliott *et al.* (1988: 93) state that their "long-term aim is for similar classes to be provided as a matter of course in the prenatal system. We anticipate that Health Visitors or midwives will run such groups, with access to psychological and other services if individual referral or consultation is required". It is interesting to note that a preventive programme has recently been set up addressing several of the issues raised by Elliott *et al.*'s (1988) research. Pippin - Parents in Partnership - Parent Infant Network Ltd - aims to promote the development of positive early family and parent-infant relationships. It is designed to complement traditional antenatal classes and postnatal support, by providing education and support to women and men in the transition to parenthood. The intervention begins in pregnancy and continues until babies are three to six months old (see Parr, 1994).

At present, most support groups operate in the postnatal period. These groups, which are not specifically for depressed mothers, allow women to share their experiences with 'similar others', and realize that a range of feelings are quite 'normal' and acceptable, and that they are neither 'mad' nor different (e.g. McKears, 1983; Moulds *et al.*, 1983). Mothers value other aspects of these groups, including the friendships they develop with other mothers; the opportunity to share their problems with, and learn from, other mothers; their informal access to a health professional through the group; and the education and guidance they receive from the health professional running the group (Combes and Schonveld, 1992; Kagey *et al.*, 1981; Moulds *et al.*, 1983). Moulds *et al.* (1983: 297) note that "the greatest achievement of a group of this kind is to stimulate the beginning of social contact and friendships for these first-time mothers, who need to feel they are not alone in their new and sometimes joyful, sometimes anxious situation". My study on depressed mothers suggests that through providing mothers with opportunities to share their feelings and experiences, it is likely that these groups currently play an important preventive role in postnatal depression. Research shows that such groups are not universally available, and are less common than antenatal classes (Combes and Schonveld, 1992). The National Childbirth Trust runs postnatal groups in most parts of Britain, but these tend to dominated by white, middle-class mothers (Kitzinger, 1990). Systematic development of postnatal groups would benefit all mothers and should be encouraged.

Existing evidence, and the findings from my own study, suggest that support groups, jointly-run and attended by pregnant women, mothers, and health professionals would be valuable in the prevention of postnatal depression.

(iii) Pregnancy and childcare advice literature

Above, I discussed two important educational improvements in the context of antenatal classes and support groups; namely, the provision of realistic accounts of parenthood, and information about postnatal depression. The mothers in my study criticized not only the antenatal classes, but also the pregnancy and childcare advice literature, for their failure to include either of these elements. The manuals should therefore devote more attention to these issues.

My findings on the importance of talking to other mothers indicate that the advice given by many of these books not to listen to the 'old wives' tales of experienced mothers (see Antonis, 1981; Holland, 1992; Marshall, 1991; Oakley, 1981a; Phoenix and Woollett, 1991b) is particularly inappropriate. My research shows that withdrawing from other mothers was linked to the onset of the mothers' depression, while talking to these women enabled them to move out of their depression (see Chapters Four, Five and Six). Pregnant women, and mothers, should therefore be *encouraged*, not *discouraged*, from talking to each other.

2. Intervention

Early detection of postnatal depression is important. Most cases are unrecognized and untreated (Cox *et al.*, 1982; Kumar, 1982), and can last well beyond the first year after the birth (Cox *et al.*, 1987). The most important development in the early detection of postnatal has been the Edinburgh Postnatal Depression Scale (EPDS), a screening questionnaire used by primary care workers to detect mothers who are depressed (Cox *et al.*, 1987). This scale is administered at the six-week postnatal check-up, is acceptable to mothers and can be completed within five minutes. Health visitors recognize that the scale would greatly assist them in the detection of the mothers who were depressed (Cox *et al.*, 1987). Midwives also have an important role to play in the early detection of depression (Ball, 1987).

(i) Educating health professionals about postnatal depression

My study confirms the value of using the EPDS. The mothers said that the recognition by a health professional of their depression had been a critical step in their move out of depression. However, for many of these mothers, such identification had only occurred several months into the depression because they had felt unable and unwilling to contact health professionals (see Chapter Six). Health professionals therefore need to be

aware that depressed mothers tend to present a happy and competent façade, and that this would influence both how they present themselves to professionals and how they might respond to the EPDS. It is vital that health professionals - including midwives, health visitors, general practitioners (GP), obstetricians and gynaecologists - be 'educated' about postnatal depression, and be aware of what other 'signs' to look for. Health professionals can recognize postnatal depression provided they know what the symptoms are (Cox, 1989). Indeed, Gruen (1990) found that providing education to professionals, and information to the general public, resulted in a significant increase in early referrals and intervention. Several researchers have noted a need to educate health professionals about postnatal depression (e.g. Gruen, 1990; Hunt, 1986; Cox, 1986). My study endorses Cox's (1986: 75) statement that "the need for sustained education for professionals involved in the care of childbearing women about motherhood and mental illness cannot be over-emphasized".

There are a number of questions that will need to be explored further regarding the education of health professionals. What sort of education do they need and want? In what context should this education occur? Who should educate the health professionals? Should depressed mothers be involved in this process? Should educational workshops be multi-disciplinary, and include depressed mothers and members of lay organizations, as well as midwives, health visitors, general practitioners and mental health professionals? At present, the Association for Postnatal Illness and the Meet-A-Mum Association jointly run conferences which bring together health professionals, members of lay organizations, and mothers, both depressed and non-depressed. This approach has been successful in stimulating dialogue between these groups, and should be expanded.

(ii) Postnatal depression support groups

My findings also point to the value of 'self-help' groups designed specifically for mothers experiencing postnatal depression. The importance and effectiveness of such support has been highlighted by other researchers (e.g. Cox, 1993; Hunt, 1986; Jones, 1984; McKears, 1983; Morris, 1987).

The mothers in my study who had attended such groups derived a great deal of support from them. Others derived support from speaking to another depressed mother on the telephone, through organizations such as the Association for Postnatal Illness, Cry-sis, and the Meet-A-Mum Association. Such support had enabled the mothers to disclose their difficult feelings (see Chapter Six). Indeed, studies show that the most highly valued aspect of postnatal depression self-help groups is the opportunity for forming friendships with

other mothers who have shared similar experiences (Cox, 1986; Fones, 1984; Gruen, 1990; Morris, 1987).

Like the other forms of groups discussed above, postnatal depression groups are important not only because of the contact with other mothers, but also for their educational potential. Information about postnatal depression, and the various sources and types of help available, can be distributed and discussed.

These groups can be run with or without a health professional. The mothers in my study stressed the value of professional involvement in the leading of the group. Indeed, evidence suggests that optimum functioning of these groups occurs when they are linked with professional resources, and when depressed mothers have access to a health professional/therapist (Cox, 1986). Again, the provision of creche facilities would increase mothers' opportunities to attend a group.

One particular form such postnatal depression groups have taken is that of befriending schemes (see Cox, 1993). These schemes, such as such as Home-Start (see van der Eycken, 1990) and Newpin (The New Parent Infant Network) (see Pound and Mills, 1985; Mills and Pound, 1986), have developed in the context of provision of services to disadvantaged mothers. These services, which cater for families with children under five years of age, were set up with the stated aim of preventing child abuse and neglect. They are relevant to this discussion, however, because most users of these services are, in fact, depressed mothers with a child under one year of age (Mills and Pound 1986).

Newpin, for example, is an independent voluntary organization working with parents or other main carers suffering from depression or emotional distress (Evans, 1991). It is a professionally-run scheme, but the service is provided by volunteers from the same background as the women they befriend. Through this service mothers in difficulty are provided with intensive one-to-one support by volunteers (Pound and Mills, 1985). This scheme has been particularly successful for depressed mothers. Pound and Mills (1985) found that one third of mothers who had been clinically depressed at initial interview had completely recovered, and the remainder had improved, by the follow-up interview six to 12 months after entry into the project. My study did not include women experiencing the same degree of socio-economic deprivation as those involved in Newpin.[2]

---

2 Newpin was set up in a deprived inner city area in South East London, with one of the country's highest rates of reported child abuse. It was targeted on families with extremely limited resources in an area with high rates of unemployment and many single-parent families (Pound and Mills, 1985).

However, it does point to the need for more widespread development of such befriending schemes, and supports Cox's (1993: 6) point that "well conducted befriending schemes can make a significant contribution to the mental health of mothers and children".

My study suggests that postnatal depression support groups are of great benefit to depressed mothers. While they had not necessarily been dissatisfied with the professional help they had received, they had nonetheless wanted such lay support either in addition to, or instead of, professional help. Indeed, there is evidence to suggest that, on the whole, individuals experiencing emotional difficulties will access, preferentially, informal sources of support (e.g. Miles, 1988; Rogers *et al.*, 1993). In their survey of the views of the users of mental health services, Rogers *et al.* (1993: 80) found that

> Overall, users identified a preference for the informal social support provided by the voluntary sector. This was compared favourably with the formal, costly, professionally-dominated services provided by the state sector.

However, only four mothers in my study had attended a postnatal depression support group, although a further 12 said they would have liked to go to such a group. The main reasons why they had not were that they had not been informed about such a group; that it had not occurred to them that there might be one; that they had been unable to find one (see Chapter Six). Only two of the 18 mothers in my study said they would not have attended a group. These findings highlight the importance of health professionals, including midwives, health visitors, and general practitioners, being well-informed about possible groups in the local community and providing mothers with this information.

(iii) A 'postnatal depression visitor'

For many of the mothers in my study, neither the GP nor the health visitor had recognized their depression (see Chapter Six). Several mothers felt this was in part because health visitors, who had no children themselves, could not possibly understand a mother's experience:

> I can remember talking to the health visitor and thinking 'You haven't got a clue what it's like'. She hadn't even had children, I mean how can you be a health visitor talking to a young woman with children saying 'Oh yes I can understand' - they can't possibly understand what you're going through. (Frances)

Many of them also felt that if health visitors had neither experienced postnatal depression themselves, nor had any training in psychology, they were of little help to depressed mothers:

> [The health visitor's] very, very nice, very friendly, desperately trying to please and be pleasant ... but I didn't really feel she'd got any particular experience of what I was going through. She'd no children of her own ... and no, probably no psychology training of any kind ... and I kind of wanted to speak to somebody who knew a bit about what it was about. (Louise)

> You couldn't even explain it to the health visitor 'cos unless they've suffered it themselves, they'd be more sympathetic than most, but they couldn't really think 'Oh yes I know just how you feel', which would have made me feel a lot better at the time. (Dawn)

Consequently, the mothers suggested that an additional health professional, what they termed a "postnatal depression visitor", might usefully work alongside the health visitor. A professional, specialized in postnatal depression, would better be able to identify the problem, they said. Indeed, one of the mothers felt it was *because* her GP had experienced depression himself that he had been able to recognize her own depression. Marcia explained:

> I was lucky, because the doctor that I had at the time severed himself from depression and in fact ... he has since committed suicide and ... my doctor being a depressive himself ... recognised it.

My findings suggest that it might be important for depressed mothers to have access to professionals who have experienced parenthood and/or depression themselves.

The mothers saw the role of this "postnatal depression visitor" as offering appropriate support and advice to depressed mothers. They explained that the most important type of help they had received, and therefore would have liked earlier on, was to to be told that they needed to *talk* about their feelings. The professional's role would be to talk to the mother herself, but also to advise her to "get all the support you can and if you do start feeling down *talk* about it, *don't* ... brush it aside", as Frances put it. The professional would also advise the mother to go to her GP, but perhaps more importantly, would supply her either with the names of other mothers who had experienced similar difficulties, or with ways of contacting such mothers (e.g. through the Association for Postnatal Illness; Cry-sis; Meet-A-Mum Association).

The mothers also felt it would be important that this professional visit the mother in her home given the difficulties they experienced in reaching out for help (Chapter Six). As

*

In conclusion, my study shows that postnatal depression can be prevented if mothers voice their feelings, and are heard by others. I have indicated that there appears to be a critical time of withdrawal and silence which marks the transition from feelings of 'sadness' to feelings of depression. Consequently, my research suggests that if both professionals and mothers are aware of this critical period, and if mothers are encouraged to speak about their feelings early on, postnatal depression might be prevented. The policy issues discussed in the previous pages represent ways in which such preventive processes might be implemented. However, it is important to point out that the sample of 18 depressed mothers who took part in my study might not have been representative of the wider parent population. These women might represent a subset of all depressed mothers - a group of women who chose to speak to me, who were intent on understanding their depression, and who were particularly devoted to helping other mothers. The policy recommendations I have made are based on this small sample of women who might be over-representative of a certain type of experience of depression. It will be necessary for further research to ascertain whether these recommendations apply to the wider population of depressed mothers.

Tina explained, "if you had ... a postnatal depression visitor who actually came round to the house ... it would be so much better than actually having to get yourself over to the doctor's".

Finally, the mothers suggested that an important function for this professional would be to keep a "chart" of mothers who are on antidepressants, and get in touch with them, and possibly visit them, to discuss increasing or decreasing dosages, and when and how to "come off the tablets". Such a chart would allow professionals to keep track of which mothers were on antidepressants. Tina, for example, explained that the difficulties she experienced in actually going to the GP meant that she had had to eventually come off the antidepressants herself. She believed other women might have found it difficult to do this. She spoke about an acquaintance who "has been on [antidepressants] since her daughter was born, and her daughter is now *fourteen* and she's still on them". Tina explained that by monitoring mothers on antidepressants, the postnatal depression visitor would ensure that mothers were not simply 'abandoned' and left on antidepressants for years. The professional would be able to say: "Okay, well Mrs X has been on these tablets for so long, right, if she hasn't seen us by such-and-such we'll get back in touch with her".

The suggestions made by the mothers in my study are important ones, and need to be considered seriously. Indeed, several researchers have put forward similar proposals. Cox (1989: 852), for example, argues that "there should be identified within each health district at least two community psychiatric nurses who have a particular concern for the prevention and treatment of postpartum mood disorder and can provide essential back-up to others health professionals such as health visitors and midwives". Furthermore, Holden *et al.*'s (1989) study of the beneficial effects of supportive counselling by a health visitor to depressed mothers further supports the points made above. Holden *et al.* (1989) gave health visitors three sessions training in non-directive counselling. Mothers were identified as depressed on the EPDS; half of these were given eight weekly sessions of non-directive counselling by a health visitor. At three months postpartum, the depressive symptoms had remitted in 70% of the women in the intervention group, compared with 37% in the control group. Holden *et al.* (1989: 223) conclude that "counselling by health visitors is valuable in managing non-psychiatric chronic postnatal depression". These results, in conjunction with those of my own study, suggest that either health visitors should be given routine training in counselling skills, or an additional health professional specializing in postnatal depression should work alongside health visitors.

*

III. Directions for future research

My research suggests that the following issues would benefit from future research.

My study was carried out on a small and unrepresentative sample of mothers. Future research should ascertain the extent to which these findings speak for the experiences of other depressed mothers, in particular, non-white mothers, single mothers, and mothers from more deprived backgrounds.

Although I interviewed 22 non-depressed mothers for this study, I did not analyse their accounts in the same depth as I did the accounts of the 18 depressed mothers. An important area for future research will be to carry out a study in which the accounts of depressed mothers can be compared to accounts of mothers who have had relatively unproblematic experiences of motherhood, and to those who have felt 'low' but have not developed clinical depression. As I noted in Chapter Four, it would be particularly interesting to explore whether depressed and non-depressed mothers differ, first, in the ways in which they construct motherhood, and second, in how they resolve the conflict between their constructions, and experiences, of motherhood.

The mothers who took part in my study agreed to talk to me, and were possibly representative of less severe cases of postnatal depression. Future research would need to explore whether more severe cases of depression can also be explained by the psychological and relational processes put forward in this thesis.

Given the importance that I have placed on the relational - both interpersonal and cultural - context in which the mothers were living, an obvious way of 'testing' the ideas that I have put forward would be to carry out a similar study cross-culturally, where not only the social context, but also the ways in which individuals conduct their personal relationships, might differ. There would be a number of important methodological considerations within such a project. As I noted in Chapter One, there are considerable methodological and theoretical problems in the cross-cultural study of emotions generally (e.g. Leff, 1977), and depressive disorders specifically (e.g. Singer, 1975). The method of data-analysis I have used relies on a detailed examination of the words used by the mothers. It will therefore be important that research within a different culture be carried out by a researcher who is fluent in the local language, and has an in-depth understanding of the nuances of this language.

As I pointed out above, my identification of relational disconnection as the underlying psychological experience of postnatal depression raises the possibility that depression in women (and possibly men) at other times of the life cycle might also be characterized by this process. It would seem sensible to suggest that while the underlying psychological processes might be similar, the 'content' of the depression, that is the precise issues and conflicts involved, would be different. This question would be a fruitful area for further investigations.

Much of the research on postnatal depression has focussed on first-time mothers. In including mothers who became depressed after a second or third child, I have been able to move beyond explanations of postnatal depression that focus on the *transition* to motherhood, and put forward a theoretical framework which accounts for depression in first-time and subsequent mothers. It would therefore be valuable for future studies to similarly include both first-time and subsequent mothers in their samples.

My study was retrospective, and this methodology afforded several advantages (see Chapter Two). However, a retrospective design meant that I was not able to follow changes within individual mothers *as they were happening*. Consequently, I have not been able to determine, for example, whether the mothers' withdrawal from others was a gradual or rapid process. Nor was it possible to clearly ascertain whether the mothers had refrained from speaking to all those around them, or only certain individuals, during their depression. Another issue which remains unclear concerns the mothers' encounters with other mothers. It is possible that all 18 mothers felt unable and unwilling to speak to other mothers with young children, specifically. This question was not directly asked of the women because it emerged out of my analysis of the data. However, 16 of the 18 mothers explicitly said they had felt reluctant to talk to other mothers. The two other women did not state this explicitly, but nor did they say that they *had* spoken to other mothers (Chapter Three). It would be interesting to find out whether, in fact, *all* depressed mothers do withdraw from other mothers. If so, it would be useful to ascertain whether the *onset* of the depression is associated with the moment when they stop talking to *other mothers*, while the depression might be *maintained* by difficulties within *other* relationships. These questions would be best addressed within a larger-scale longitudinal study. Expectant first-time and subsequent mothers could be recruited in pregnancy. Ten per cent of these would be expected to develop postnatal depression. These could be interviewed at various points throughout their depression, and as they moved out of the depression.

My study focussed on the questions of why and how mothers come to be depressed following the birth of a child. My discussion of the mothers' move out of depression was

less detailed, but has highlighted that this question deserves further empirical investigations. Research should explore further both the forms and sources of support that are most beneficial to the emergence from postnatal depression, and also the psychological processes, and relational changes, that foster the move out of depression. As Gotlib *et al.* (1991: 130) has pointed out "there is ... a pressing need for future investigations of factors associated with recovery from depression".

The mothers in my study found support groups particularly valuable, and helpful in they journey out of depression (see Chapter Six). However, as noted above, little research has been carried on such groups; on the ways in which they help mothers, and on their optimum functioning. It would be interesting to carry out an ethnographic, longitudinal study of a self-help group. This could entail taking part in all the group meetings, as well conducting individual interviews with members of the group. This would allow the researcher to trace changes within individual mothers, in parallel to changes and developments within the group.

The mothers in my study were all living with a male partner and it was apparent that these men had experienced considerable difficulties themselves during the time the mothers had been depressed. Research on these men, on their own experiences, and on the kinds of support they might need would also be an important area of investigation.

As I have emphasized throughout this thesis, if postnatal depression is to be understood, and if future research is to bring new insights into the nature, and origins, of depression following childbirth, it is essential that such research enquire into the *subjective* perceptions, constructions and experiences of individual mothers. The mother's depression must be understood from her own perspective, for such research to be of any value. If objective assessments *are* made (e.g. of partners' contributions to household tasks and childcare; of the child's temperament; of breastfeeding difficulties) these should be regarded as additional sources of information, and not as a substitute to, or more 'scientific' assessment of, the mother's subjective evaluations.

Finally, one of the most fruitful ways in which our understanding of postnatal depression can be improved, and depressed mothers can therefore be helped, is by research being carried out by multi-disciplinary teams, using a multi-method approach combining qualitative and quantitative methodologies. Communication and consultation between psychologists, sociologists, anthropologists, health professionals, lay organizations and mothers should be encouraged and enhanced, as together, we can reach a greater understanding of this distressing experience.

Appendices

Appendix 1

National Childbirth Trust Invitation Letter

October 1991

Are you a first-time mother with a child aged between one and two years old, and living with the father of your child? I am a research student working in the Childcare and Development Group of the University of Cambridge, and I am interested in interviewing women about their experience of becoming a mother and the wide range of emotions that women feel during this time.

Taking part in this study would involve filling in a brief questionnaire, which would be followed by an interview, about your background, your pregnancy, the birth of your child, and your experience of motherhood. The interview would last approximately two hours, and would be carried out at a time and place most convenient to you. The information collected in the course of the study would be confidential and would not be revealed to anyone. Eventually, this project will be written up as a report. However, individual mothers will remain anonymous so that they cannot be identified. It is hoped that the findings from this research project will contribute to providing better services for new mothers in the future.

If you are interested in taking part in this study, please complete and return the reply slip below, using the enclosed stamped addressed envelope. If you have any queries, or would like any further information, please ring me on (0223) 334510. If I am not available, please leave a message and I will contact you as soon as possible. Thank you very much for your cooperation.

Yours sincerely,

Natasha Mauthner

If you would like to take part in this research project, please fill in and return the following details.

Your name:

Your address:

Your telephone number:

Would you prefer to be contacted by:

phone	[ ]
writing	[ ]
either	[ ]

Appendix 2

Questionnaire and accompanying letter

CONFIDENTIAL

Name:

Date:

Please fill in the following questions. Section A is about a few of your family details. Section B concerns your feelings about being a mother, and how these might have changed since the birth of your child. Please feel free to expand on any of the questions by using the blank space provided at the end of the questionnaire.

A. FAMILY DETAILS

1. Names

a) Your partner/husband's name:

b) Your child's name:

2. Ages

a) Your age:

b) Your partner/husband's age:

c) Your child's date of birth:

3. Employment

a) Are you currently in paid employment?

If so, what is your job:

b) Is your partner/husband currently in paid employment?

If so, what is his job:

B. YOUR FEELINGS ABOUT BEING A MOTHER

These questions refer to your feelings about being a mother, and to the range of emotions that you may have felt since the birth of your child. Section a) of each question refers to what your feelings are at the moment, and section b) asks whether these feelings have changed, or remained more or less the same, since the birth. Don't worry about being very accurate with the scoring, it's only a guideline, and these are questions I'd like to talk about in the interview.

1. a) Do you feel proud of being a mother?

Not at all					very much
0	1	2	3	4	5

b) Have your feelings changed since the birth, and if so, in what way?

2. a) Do you enjoy being a mother?

Not at all					very much
0	1	2	3	4	5

b) Have your feelings changed since the birth, and if so, in what way?

3. a) Do you enjoy looking after your child?

Not at all					very much
0	1	2	3	4	5

b) Have your feelings changed since the birth, and if so, in what way?

4. Using the list of words below, can you circle **all** the words that you would use to describe your child.*

placid	alert	demanding	friendly
irritating	stubborn	stimulating	draining
independent	fascinating	exhausting	determined
talkative	aggressive	clingy	contented

Are there any other words you would use to describe your child?

---

* The use of this, and the subsequent, adjective check list is based on Green *et al.*'s (1994) use of a similar list in the Cambridge Prenatal Screening Study.

5. a) Do you feel that you are a good mother?

Not at all					very much
0	1	2	3	4	5

b) Have your feelings changed since the birth, and if so, in what way?

6. a) Do you feel disappointed by motherhood?

Not at all					very much
0	1	2	3	4	5

b) Have your feelings changed since the birth, and if so, in what way?

7. Women's feelings about becoming mothers vary a great deal. Here are some of the words that have been used by women to describe how they have felt. Could you please circle **all** of the words that describe your own feelings.

fulfilled	resentful	confident
happy	anxious	worried
nothing special	depressed	protective
maternal	beautiful	angry
invaded	powerful	out of control
ugly	in control	stressed
vulnerable	detached	serene
blooming	moody	low

Are there any other words you would like to add that describe your experience?

8. Are you thinking of having another child?

Please use this space for any additional comments that you might like to make.

Accompanying letter to the questionnaire

Date

Dear (Name),

Thank you very much for agreeing to participate in my study. I hope that you will enjoy taking part. I am writing to you with a few more details about my research project, and I am enclosing a questionnaire.

It is widely believed that when a woman becomes a mother, it is on the whole a happy, joyous and smooth experience. While this is the case for many women, for others, becoming a mother can be a difficult and exhausting time in their lives. My study is about this wide range of experiences and feelings that women go through as they become mothers for the first time. The aim of the study is to understand and recognize that every woman is different and will experience motherhood in her own unique way. It is hoped that the study will be published and made available to those caring for new mothers, so that they may have a better idea of the different needs for advice, support and facilities that women have during this period in their lives.

The purpose of the enclosed questionnaire is to give me an initial idea of how you have felt about becoming a mother. This means that in the interview, we can spend more time on what you feel has been important about *your* experience of motherhood. After you have returned the questionnaire I will be contacting you in order to arrange a convenient time for an interview.

As I mentioned in my last letter, all of the information that you give in the course of this study will remain confidential.

If you have any queries about the questionnaire, or would like any further information, please do not hesitate to ring me on (0223) 334510.

Once again, thank you for your interest and cooperation. I look forward to hearing from you.

Yours sincerely,

Natasha Mauthner

Appendix 3

Notice included in the Cry-sis Newsletters

Are you a mother of a child up to the age of 2 years old?

I am a research student working at the University of Cambridge carrying out a study on **women's experiences of motherhood**. I am particularly interested in hearing from women who experienced **early motherhood as a difficult and distressing period** in their lives.

Taking part in this study would involve filling in a brief questionnaire, which would be followed by an interview about your background, your pregnancy, the birth of your child and your experience of motherhood. The interview would be carried out at a time and place most convenient to you. The information collected in the course of this study would be strictly confidential and would not be revealed to anyone. It is hoped that the findings from this research project will contribute to a better understanding of the needs that mothers have, and to providing better services for mothers in the future.

If you are interested in taking part in this study, please call Natasha Mauthner on Cambridge (0223) 334510 or 353792, or write to me at: Childcare and Development Group, Free School Lane, Cambridge CB2 3RF.

Appendix 4

Interview Guide

Introductory comments

1. Thank you

Thank you for returning the questionnaire and for offering to take part in this study.

2. The research project

I am undertaking this research for my PhD. As I explained in my last letter to you, the study I am carrying out is about women's experiences of becoming mothers. I am interested in two things really; first, I am interested in the way women feel that they have changed since becoming mothers. And secondly, I am interested in the wide range of feelings that women have during pregnancy and after the birth, and in the ways in which these might vary in different mothers.

Would you like to ask any questions about the research project?

3. The interview

The interview has quite a loose structure, and is more of a discussion than a question-answer type of interview. The areas I would like to ask you about include your pregnancy, your experience of the birth, your feelings about motherhood, your relationship with your partner, your sources of support, and your employment situation. As we discuss these, I am interested in two aspects of your experience of motherhood:

(i) How you feel that motherhood might have changed you as a person, as well as other areas of your life;

(ii) What are the things that have been particularly important about *your* experience of becoming a mother.

If there are any questions in the interview that you do not understand, or would prefer not to answer, please tell me. Also, if for any reason you would like to stop the interview at some point, please say so. If we do not manage to finish the interview I am quite happy to come back another day, if you are happy doing that.

(Establish how much time there is in which to carry out the interview.)

4. Confidentiality

As I mentioned in the two letters that I sent to you, the content of the questionnaire and the interview will be confidential. No one else will have access to, or listen to, the tapes, and no names will appear in the final report.

5. Tape recorder

Would you mind if I use a tape recorder to tape the interview?

Interview Guide

Can I ask you why you felt that you wanted to take part in this study?

Perhaps you could begin by telling a bit about what motherhood has been like for you?

1. BACKGROUND INFORMATION

Age of the interviewee, her husband/partner and her child/children if this has not already been established
Family tree: parents and siblings (ages, occupations, marital status, children, where they live, frequency of contact)
Did your mother work when you were a child? How did you feel about this? Who looked after you while your mother was at work? What was that like?
How would you describe your childhood and adolescence?
Educational history: age at leaving school; further training/education
Marital status; length of relationship and/or marriage; how did they meet; decision to marry

2. YOUR PREGNANCY

(i) Getting pregnant

How did you feel when you first found out that you were pregnant?
How did your husband/partner feel?
Was the baby planned?

If planned Was it a joint decision? Was it an easy decision? How was the decision timed? Was it something you and your husband/partner discussed a lot? Had you always wanted to have children? And your husband/partner?

If unplanned Contraception at the time
Did you want to keep the baby? What about your husband/partner?

If unwanted Why did you decide to keep the baby? Who was involved in making the decision? Did you feel under pressure from anyone to keep it?

Any previous pregnancies: miscarriage, abortion, still birth, child who died?

(ii) Being pregnant

How did you feel during your pregnancy?
Did you feel low at any time? Why was that?
Did you have any particular physical problems?
Did you attend any antenatal classes? Did your husband/partner attend any with you?
Did you find them useful or helpful? In what ways?

3. THE BIRTH

What was the birth like?
Was your husband/partner present? Did you find him supportive?
Was the birth something that had worried you beforehand? Was it as you had expected?
How do you think you managed the birth? Did you feel in control of what was going on?
How did you feel about it being a boy/girl?
Did you breast or bottlefeed? Is this what you had intended to do? Were there any problems? How long did you breastfeed for?

4. COMING HOME

How did you feel when you first came home?
Did your husband/partner take some time off after the baby was born? How long?
Was it important to you that he should/should not be around?

Was anyone else around when you came out of hospital (e.g. family, friends, neighbours)?
How did you feel about the support that you were getting?

5. YOUR MENTAL HEALTH

If experience of depression postpartum:

In cases where the mother returned a questionnaire ask:
In the questionnaire that you sent back to me, you mentioned that you felt (here use the words *she* used to express her negative feelings) about becoming a mother. Can you tell me a little bit more about that?

(i) Feeling 'depressed'

When did you start feeling low/unhappy/depressed?*
Did you have any physical symptoms (e.g. headaches, chest pains, migraines, pins and needles in the limbs, panic attacks)?
Had you been expecting to feel this way?
Can you explain why you felt so upset/low/'depressed'?*

(ii) Past psychological difficulties

Have you experienced anything like this before?

(iii) Sources of information

Did someone tell you you had 'postnatal depression'? Who?
Did *you* think you had 'postnatal depression'?
Did you know about 'postnatal depression'? What did you know about it?
Had you read/heard much about it? Where/who from?
Was it mentioned in the antenatal classes, by your midwife, health visitor or doctor?
Had you ever known of anyone getting 'postnatal depression'?
Were you happy with the amount of information you were given/came across about 'postnatal depression'?
What is your understanding of the reasons why some women get 'postnatal depression'?

(iv) Support

Could you talk to anyone about how you felt? (husband/partner, family, friends, neighbours, doctor, health visitor) Why not/were they understanding?
What sort of help did you find most useful (e.g. an 'official' source of help such as a doctor, health visitor, psychiatrist; other mothers in similar situation; emotional; practical; baby-sitting; recognition and understanding; just someone to talk to and to listen; books, magazine articles, TV programmes about PND)?
Was there any sort of help and support you would you have wanted and did not receive?
Did you speak to any other mothers suffering from 'postnatal depression'?
Did you think about joining a group for women with 'postnatal depression'? Would you have liked to join such a group?
Overall, who would you say has helped you the most?

(v) Encounters with health professionals

Did you see a doctor about it? How soon was that after you started feeling unwell?
Was the doctor helpful? In what ways?
Were you prescribed any medication (e.g. antidepressants, tranquillisers, sleeping pills)? How did you feel about this? Did it make you feel better?
Did you see a psychiatrist? Was she/he helpful and understanding?
Did it make any difference to you that your doctor/psychiatrist should be a woman or a man?

---

* Use term used by the mother.

If no experience of depression postpartum:

Did you feel at all low during the first few days after the birth?
Was 'postnatal depression' something that you had thought about or feared before having the baby?
Did you know much about it? Where had you heard about it from (antenatal classes, books, TV, magazines, a friend/acquaintance who had it)
Do you know anyone who has had 'postnatal depression'?
Do you have any ideas about why some mothers get 'postnatal depression'?

6. BEING A MOTHER

(i) Feelings about childcare

Had you had any previous experience with babies or children?
What is it you enjoy about looking after her/him?
What is it you dislike about looking after the baby?
Have you ever thought of harming the baby?

(ii) Self as Mother

Before having your child, were you concerned at all about your ability to be a mother?
Before becoming a mother, did you have a fixed idea about what a mother ought to be like? Where did these ideas come from?
How satisfied are you with yourself as a mother? Do you think that you are a good mother?
Do you compare yourself with other mothers?
Are there any particular mothers you could say you admire? (that you think it would be nice if you were more like them?)
What kind of a mother does your husband/partner think you are?
Do you think you have changed a lot since becoming a mother? In what ways?
Do you feel that by becoming a mother you are fulfilling something within yourself?

(iii) Feelings about motherhood

Has motherhood turned out to be what you expected?
Is there anything you resent about being a mother? (responsibility, loneliness, loss of freedom)
What do you enjoy most about being a mother?

(iv) Time of her own?

Do you manage to find time to yourself?
Do you have as much time to yourself as you would like?
What sort of things do you enjoy doing during this time?
How important to you is it that you find time to yourself?

7. YOUR MARITAL RELATIONSHIP

(i) Changes in the relationship

Some mothers have mentioned that they feel that their relationship with their husband/partner changed during pregnancy and then after the birth. Have you felt this? In what ways? When did you first feel these changes? Has this worried you?
Were you able to talk to your husband/partner about these changes?
Do you feel that having a child has improved your relationship in any way?

(ii) Communication and emotional support

Are you able to talk to your husband/partner about how you are feeling and about things that might be bothering you?
Does your husband/partner give you the emotional support that you need and want?

(iii) Division of housework and childcare

Do you divide the housework and childcare with your husband/partner? How do you divide it? (e.g. getting up in the night, bathing, feeding, changing nappies, childcare, looking after child while the mother is out) How has this division changed since having the child?

Are you happy with the amount your husband/partner does? Is this what you expected? Was this something that you had discussed before having the baby? Would you like him to do more? What sort of things specifically? Have you asked him to do more? Do you think he should do more?

How do you think your husband/partner compares with other fathers that you know?

Does anyone else help you with the housework or with looking after the child? Are you satisfied with that help?

(iv) Leisure time together

Do you have as much time on your own with your husband/partner as you would like?

What do you do during that time?

8. YOUR SOCIAL NETWORKS AND SUPPORT

(i) Mapping of social networks

I would like you to draw a map of the people that are important to you in your life at the moment. If you put yourself in the middle of the page and then draw the people closer or further away from you on the page depending on how important they are to you.*

Nature of contact (does it revolve around the children, around the couple, is it a one-to-one contact)

Frequency of contact

Who would you turn to
- for advice about childcare?
- for someone to baby-sit while you go out?
- for material or financial help?
- if you had a personal problem?

What kind of support have you found most helpful since having a baby?

Overall, who would you say has offered you the most support since having a baby?

How have these networks changed since having the baby?

Did you find that you mixed more with other mothers once you became a mother yourself? How did you meet them? How often do you see them? What is it you value about your friendships with other mothers?

(ii) Her own mother

Has your mother been an important source of support? In what ways?

Has your relationship with your mother changed since having a child? In what ways?

9. YOUR EMPLOYMENT SITUATION

(i) Antenatal employment history

- occupation just before and during pregnancy
- hours of work/study
- reasons for working/studying (e.g. financial, social contact, intellectual stimulation)

What did you enjoy most about work/studying?

- stage in pregnancy when stopped work/studying

Did you intend to return to work/study? How did your husband/partner feel about this?

How did you feel after you stopped working/studying? Did you miss work/study? What aspects?

---

* This mapping out of the mothers' social networks is based on Ribbens' (1990) use of this technique.

(ii) Postnatal, and current, employment status and preferences

If currently employed/studying

Resumed at what stage postpartum; hours; preferred employment/study status
How did you decide to return to work? (i.e. in whose terms) Was it a difficult decision to make?
How did your husband/partner feel about you working/studying?
How does your husband/partner feel about mothers generally working/studying when their children are young?
Childcare arrangements and satisfaction with these
Ideally, what arrangement of paid work and childcare would you want for yourself and your husband/partner?

If not employed/studying

Preferred employment/study status
How did you make the decision? (In whose terms) How did your husband/partner feel about you staying at home/not going back to work/study?
How did/do you feel about being economically dependent?
Did/do you miss work/study? What aspects?
Ideally, what arrangement of paid work and childcare would you want for yourself and your husband/partner?

(iii) Combining employment and motherhood

Do you think it is important for a child to have one of its parents, rather than someone else, taking care of it during the day? Do you think it makes any difference whether it's the mother or the father?
Do you think it can be harmful to a child if the mother goes out to work? In what ways?
Do you think it can be good for some mothers if they go out to work? In what ways?

(iv) Future employment plans

10. LOOKING TO THE FUTURE - DEBRIEFING

Would you like to have another child? Is this something that you and your husband/partner have discussed?
Are there any things that you would want to do differently next time?
Is there anything that concerns you about having another child (e.g. further changes in the marital relationship; feeling 'depressed' again)?

There's just a few factual details I'd like to ask you:
Life events during pregnancy and postpartum period (e.g. moving house; death in family, friends, pets; illness in family, friends)
Housing conditions during and since pregnancy: house/flat; rented or owner-occupied, whether happy there, central heating, telephone, size, noise, neighbours, length of residence there
Financial situation/difficulties during and since pregnancy
Transportation: car or public transport; frequency and efficiency of service; difficulties of using public transport with a baby

11. CONCLUSION

Is there anything else that we haven't spoken about that you would like to mention?
How did you feel about taking part in the interview?

Appendix 5

POSTNATAL DEPRESSION INFORMATION SHEET: HELPFUL ORGANIZATIONS AND READING MATERIAL

Local and national organizations:

The Association for Post-Natal Illness
25 Jerdan Place
Fulham
London SW6 1BE
071-386 0868

The Association provides a range of publications, advice and information about support groups in your area, as well as one-to-one telephone support from a mother who has had, and recovered from, postnatal depression, as most mothers find it a great relief to talk to someone who really understands how they feel. The Association also runs a support service for husbands and families of sufferers, with the possibility of talking to a male volunteer if this is preferred. Write to them, enclosing a stamped addressed envelope, for further information.

Meet-a-Mum Association
58 Malden Avenue
South Norwood
London SE25 4HS
081-656 0357

M.A.M.A. offers support and friendship, both on a one-to-one basis and through a network of local groups throughout the country. Mothers with postnatal depression can be put in touch with a recovered mother. The Association also produces a booklet *"Behind the Painted Smile - an insight into Post-Natal Depression"*, which contains a report compiled after a Study Day on postnatal depression, and also personal experiences of mothers who have suffered and recovered from post-natal depression.

Cry-sis
B. M. Cry-sis
London WC1N 3XX
071-404 5011

Cry-sis offers a helpline for parents of crying babies. The central office in London can put you in touch with a telephone contact living in your area.

Home-start
(Local address and telephone number were given)

Home-start is a volunteer scheme offering friendship, support, and practical help to families with children under the age of five years old. Volunteers visit families in their own home. For further information, contact (name was given) at the above number.

The National Childbirth Trust
(Local address and telephone number were given)

The NCT offers individual postnatal support, as well as get-togethers for mothers and their children.

La Leche League

The La Leche League is a group of mothers who get together once every two weeks. They discuss breastfeeding problems, but also any other difficulties they might have. The group offers postnatal support in the form of these informal meetings with other mothers, and also by telephone support. To find out more, ring one of the La Leche League Supporters in your local area: (three names and telephones numbers were given).

Active Birth Centre
55 Dartmouth Park Road
London NW5 1SL

The Active Birth Centre offers postnatal groups with yoga and baby massage. Pre- and postnatal counselling can also be arranged. There are two regional contacts: (names, addresses, and telephone numbers were given).

Reading material:

Towards Happy Motherhood: Understanding Postnatal Depression by Maggie Comport (Corgi, 1987)

Depression after Childbirth: How to Recognize and Treat Postnatal Illness by Katharina Dalton (Oxford University Press,1989)

The New Mother Syndrome: Coping with Post-natal Stress and Depression by Carol Dix (Unwin Paperbacks, 1986)

Women Confined: Towards a Sociology of Childbirth by Ann Oakley (Martin Robertson, 1980)

Becoming a Mother by Ann Oakley (Martin Robertson, 1979)

Now that You've Had Your Baby: How to Feel Better and Happier than Ever after Childbirth by Gideon Panter and Shirley Motter Linde (Prentice-Hall, 1977)

Banish Post-Baby Blues by Anne Marie Sapsted (Thorsons Publishing Group, 1990)

Post-natal Depression by Irene Swyer (Women's Health Concern Ltd, 1979)

Postnatal Depression by Vivienne Welburn (Fontana Books, 1980)

Appendix 6

Tables

Table 1: Professional and lay support received by the depressed mothers

	GP[1]	Anti-depressants (Length of time on them)	CPN[2]	Psychiatrist	Counselling	Comple-mentary 'therapies'	Lay organiza-tions
Caroline	+	6 months					
Celia	+	10 months		+		Homeopath	
Dawn	+	9 months			Family therapy with her son		PND[3] self-help group
Fiona	+	-					
Frances	+	3 months					
Helen	+	(Progesterone which she did not take)					Cry-sis
Louise	+	4 months	+				Cry-sis; APNI;[4] MAMA[5]
Marcia	+	-					
Monica		-					
Pam	+	3 years		+			PND self-help group
Penny	+	-					
Petra	+	2 months	+		NHS[6] sex therapist		PND self-help group
Rachel	+	(Tranquillizers, off and on, for a year)				Osteopath; herbalist; healer	Cry-sis
Sandra	+	1 month	+	+	NHS counsellor		APNI
Sonya	+	1 year			Private psycho-therapist		APNI
Sophie	+	2 months					
Tina	+	2 years			Private individual counselling; NHS couple therapy		
Vera	+	several months	+	+			APNI; PND self-help group
TOTAL	17	12 (+2)	4	4	5	2	9

1 General practitioner.
2 Community psychiatric nurse.
3 Postnatal depression.
4 Association for Postnatal Illness.
5 Meet-A-Mum Association.
6 National Health Service.

Table 2: Ages of depressed mothers and their children at interview

	Age of mother at interview	Age at interview of the child after whose birth the mother became depressed
Caroline	31	3 years, 6 months (Second child 19 weeks)
Celia	30	6 years (Second child 3 years)
Dawn	25	3 years, 9 months (Second child 21 months)
Fiona	26	1 year, 11 months (First child 2 years, 10 months)
Frances	37	6 years (First child 12 years and second child 10 years)
Helen	34	12 months
Louise	33	18 months
Marcia	36	4 years (First child 7 years)
Monica	20	2 years, 6 months (First child 3 years, 4 months)
Pam	26	4 years
Penny	31	2 years
Petra	27	21 months
Rachel	29	2 years
Sandra	35	2 years, 6 months
Sonya	39	18 months
Sophie	31	6 years (First child 12 years and third child 2 years)
Tina	36	2 years (First child 10 years and second child 8 years)
Vera	28	2 years

Table 3: Ages of depressed mothers at birth of their first child, and at birth of child after which she became depressed

	Age of mother at birth of first child	Age of mother at birth of child after which she became depressed
Caroline	28 (31 when she had her second child)	28
Celia	24 (27 when she had her second child)	24
Dawn	21 (23 when she had her second child)	21
Fiona	23 (24 when she had her second child)	24
Frances	25 (27 when she had her second child and 31 when had her third)	31
Helen	33	33
Louise	32	32
Marcia	29 (32 when she had her second child)	32
Monica	17 (18 when she had her second child)	18
Pam	22	22
Penny	29	29
Petra	26	26
Rachel	27	27
Sandra	32	32
Sonya	37	37
Sophie	19 (25 when she had her second child and 29 when she had her third)	25
Tina	24 (26 when she had her second child and 32 when she had her third)	32
Vera	26	26

Table 4: Birth order of child after which the mothers became depressed

	First child	Second child	Third child
Caroline	+		
Celia[7]	+		
Dawn[8]	+		
Fiona		+	
Frances			+
Helen	+		
Louise	+		
Marcia		+	
Monica		+	
Pam	+		
Penny	+		
Petra	+		
Rachel	+		
Sandra	+		
Sonya	+		
Sophie[9]		+	
Tina			+
Vera	+		
TOTAL	12	4	2

7 Celia had a second child after whose birth she experienced no depression.
8 Dawn had a second child which exacerbated her existing depression.
9 Sophie had a third child after whose birth she experienced no depression.

Table 5: The depressed mothers' education

	The mothers' education
Caroline	O-Levels and A-Levels. Secretarial course.
Celia	University degree.
Dawn	Left school at 15 with one O-Level.
Fiona	Left school at 16 with O-Levels.
Frances	Left school at 18 with GCSEs[10]. Secretarial course. Began, but did not complete, nursing course.
Helen	O-Levels and A-Levels. Nursing qualification. At the time of the interview, she was doing a part-time doctorate.
Louise	Began, but did not complete, a University degree course.
Marcia	O-Levels and A-Levels. Journalism qualification.
Monica	Left school at 15 with CSEs[11]. Began, but did not complete, a Youth Training Scheme course to be a nanny.
Pam	Left school at 16 with O-Levels. Certificate in social care.
Penny	Left school at 17 with O-Levels.
Petra	Left school at 16 with CSEs.
Rachel	O-Levels and A-Levels. Degree course in Art.
Sandra	O-Levels and A-Levels. Nursing qualification.
Sonya	Began, but did not complete, a University degree course.
Sophie	Left school at 17. She could not remember whether she had any qualifications.
Tina	Left school at 16 with one O-Level. Course in accounts and secretarial work. At the time of the interview, she was doing a counselling course.
Vera	A-Levels. Pre-nursing qualification.

10 General Certificate of Secondary Education.
11 Certificate of Secondary Education.

Table 6: The depressed mothers' employment situation at the time of the depression

	Full-time mothers[12] (Occupation prior to birth in brackets)	Part-time paid employment	Full-time paid employment
Caroline	(Secretarial work.)		
Celia	(Media manager for a Public Relations firm.)		
Dawn	(Secretarial work.)		
Fiona	(Before the birth of her first child she had worked as a typist and as a cleaner.)		
Frances		She had been running a kennel for 4 years and was still running it at the time of the depression.	
Helen			Returned 5 and a half months postpartum as a health visitor. Helen was also doing a part-time doctorate.
Louise	(Secretarial work.)		
Marcia		Returned 5 months postpartum as a Public Relations Officer.	
Monica	(Before the birth of her first child she had been training to be a nanny.)		
Pam		Returned 2 and a half years postpartum as a Childcare Officer.	
Penny			Returned 4 months postpartum as an accounts clerk.[13]
Petra			Returned 6 months postpartum. Several part-time jobs (adding up to full-time employment) including: clerical work, cleaning, sales assistant.[14]
Rachel	(Illustrator and had worked in a bookshop.)		
Sandra			Returned 4 months postpartum as a District Nurse.[15]
Sonya	(Secretarial work.)		
Sophie	(Before the birth of her second child she had worked in a fish-and-chip shop, and as a home-help.)		
Tina	(Before the birth of her first child she had been a word processor operator.)		
Vera	(Auxiliary nurse.)		
TOTAL	11	3	4

12 Five of these mothers (Caroline, Celia, Dawn, Louise, Sonya) had conflicting feelings about whether, and how, to return to paid employment.

13 Penny returned to full-time employment against their wishes.

14 Petra returned to full-time employment against her wishes.

15 Sandra returned to full-time employment against their wishes.

Table 7: The depressed mothers' paid employment situation at the time of the interview

	Full-time mothers[16]	Part-time paid employment	Full-time paid employment
Caroline	+		
Celia	+		
Dawn	+		
Fiona	+		
Frances		Part-time auxiliary nurse. Occasional secretarial work. She was still running the kennel.	
Helen			Health visitor and part-time doctorate.
Louise	+		
Marcia		Public Relations Officer.	
Monica	+		
Pam		Childcare Officer.	
Penny		Childminder.	
Petra	+		
Rachel	+		
Sandra			District Nurse.
Sonya	+		
Sophie	+		
Tina		Worked in a creche 4 hours a week. Also a number of voluntary activities, including Home-Start 'befriender' of a family.	
Vera	+		
TOTAL	**11**	**5**	**2**

16 Although not in paid employment as such, a number of these mothers were involved in voluntary and paid activities, including 'working' for the National Childbirth Trust, the Association for Postnatal Illness, Crysis, and Befriending schemes, as well as seasonal work (e.g. asparagus picking).

Table 8: Degree to which the child after whose birth the mother became depressed was planned and/or wanted

	Degree of planning and wish for the child after whose birth the mother became depressed
Caroline	Planned
Celia	Planned
Dawn	First child "semi" planned. (Depression exacerbated after birth of second unplanned, but wanted, child.)
Fiona	Unplanned and unwanted
Frances	Planned
Helen	Planned
Louise	Planned
Marcia	Planned
Monica	Unplanned and unwanted
Pam	Planned
Penny	Planned
Petra	Planned and wanted but conceived 6 months earlier than anticipated
Rachel	"Sort of" planned
Sandra	Planned but conceived 2 years after wanted but nonetheless wanted
Sonya	Planned
Sophie	Planned
Tina	"Semi" planned but wanted
Vera	Planned

Appendix 7

Background summaries of the depressed mothers

Caroline

Caroline was 31 at the time of the interview, mother of two sons, aged three and a half years, and 19 weeks. Both boys were planned and wanted. Caroline became depressed six to 12 weeks after the birth of her first child Oliver. When Oliver was three months old, she was prescribed antidepressants which she took for six months. Within a year of Oliver's birth, Caroline had come out of the depression. Caroline did not experience depression following the birth of her second child, and was not depressed at the time of the interview.

Celia

Celia was 30 at the time of the interview, mother of two daughters aged six and three years. Both children were planned and wanted. Celia experienced depression after the birth of her first daughter Katie. She described the onset of the depression as gradual. She only realized that "something was wrong" when Katie was six months old. Celia was depressed for two years. When Katie was ten months old, the GP prescribed her antidepressants, which she started taking two months later. She remained on these for ten months. At this point, still on the antidepressants, she consulted a homeopath. Within a week of seeing the homeopath, Celia felt back to her "old self". Celia went on to have a second child and experienced no depression after Melissa's birth. Celia was not depressed at the time of the interview.

Dawn

Dawn was 25 at the time of the interview, mother of a son aged three years and nine months, and a daughter aged 21 months. Dawn had a miscarriage at the age of 19, of an unplanned but wanted child. Dawn's son was "semi-planned" but wanted. Her daughter was not planned but accepted. Dawn had been depressed since her son's birth, but her depression worsened considerably after her daughter's birth, 21 months later. She had suffered panic attacks and bad headaches. Dawn took antidepressants for nine months, from when Lisa was three to 12 months old. Dawn had seen her GP, and had been to a family therapy centre for four months of counselling for her son's behavioural problems (he bit other children, his sister and Dawn). Dawn felt she had not received the help she had needed and wanted, and this had inspired her to set up a postnatal depression support group. This was the group Pam and Petra were attending, and Sonya and Sandra had found out about at the time that I interviewed them, and were hoping to join. At the time of the interview, Dawn still had days when she felt depressed.

Fiona

Fiona was 26 at the time of the interview, mother of a daughter aged two years and ten months, and a son aged one year and 11 months. Her daughter was conceived sooner than expected, but was wanted. Two and a half months after her daughter's birth, she became pregnant a second time with her son, who was both unplanned and unwanted. Fiona had been depressed since her son's birth. Her depression set in three to four months postpartum. She was given iron and vitamin tablets by her GP. At the time of the interview, Fiona was feeling better, but still had periods of depression.

Frances

Frances was 37 at the time of the interview, mother of two sons aged 12 and ten, and a daughter aged six years. All three children were planned and wanted. She became depressed six months after the birth of her third child. She had been severely depressed for two years, and felt it had only been in the last six months - that is, nearly six years on - that she had started to "feel more normal". She first saw her GP a year after the birth, and was prescribed antidepressants, which she took for three months. Frances had experienced anorexia and depression when she was 16-17 years old.

Helen

Helen was 34 at the time of the interview, mother of 12-month-old Ben. Helen had a previous terminated pregnancy ten years before she had Ben. Ben was wanted and planned. Helen had been depressed since the birth, and still felt depressed at the time of the interview. She had seen the GP who prescribed progesterone which she did not take. She contacted Cry-sis but did not find them useful.

Louise

Louise was 33 at the time of the interview, mother of an 18-month-old son. Seamus was planned and wanted. Louise became depressed three to four weeks after his birth, and remained so for 11 months. She was prescribed antidepressants when he was three months old and took these, on and off, for four months. When Seamus was five months old, she started seeing a community psychiatric nurse and carried on doing so for six months. When Seamus was seven weeks old, she contacted Cry-sis. Later, when she started feeling better herself, and he was eight to nine months old, she got involved with Cry-sis as a 'counsellor'. Louise had also contacted the Association for Postnatal Illness, and the Meet-A-Mum Association during her depression. Louise did not feel depressed at the time of the interview. Louise had had a previous experience of depression ten years before.

Marcia

Marcia was 36 at the time of the interview, mother of a daughter aged seven, and a son aged four years. Both children were planned and wanted. A few months before her first child was conceived, Marcia had a miscarriage at four months gestation. Marcia became depressed after her son's birth. She described her depression as "mild" and short-lived (six weeks), thanks to her GP who detected it early on, and talked her through it. Marcia had experienced depression before she had children.

Monica

Monica was 20 at the time of the interview, mother of a son aged three years and four months, and a daughter aged two years and six months. Two months after the birth of her first child, who was planned and wanted, Monica became accidentally pregnant. This child was unwanted. Monica became depressed after the birth, and her mother-in-law looked after the child until it was three months old, when she was returned to Monica. Monica was depressed for a total of 18 months. At the time of the interview, she no longer felt depressed.

Pam

Pam was 26 at the time of the interview, mother of a four-year-old daughter. Charlotte was planned and wanted. Pam became depressed shortly after the birth. She experienced panic attacks and a change in personality. She had started to feel better in the four months prior to the interview. At the time of the interview, she still got panic attacks. Pam had been on antidepressant medication for three years, and came off the antidepressants a year before the interview. She saw a psychiatrist for a year. She stopped

seeing the psychiatrist a year before the interview. At the time of the interview, Pam was attending the postnatal depression support group set up by Dawn.

Penny

Penny was 31 at the time of the interview, mother of a planned and wanted son aged two years old. Penny became depressed soon after her son's birth, and remained so for 16 months.

Petra

Petra was 27 at the time of the interview, mother of a 21-month-old son. Joshua was wanted, but conceived six months sooner than expected. Petra first became depressed during pregnancy. At the time of the interview, she described herself as "much better", but still had "bad days", and had not fully emerged from the depression. During the depression, she had suffered panic attacks. Thirteen months after her son's birth, Petra sought help and consulted her GP. The latter prescribed antidepressants, which she took for two months. Petra had consulted a number of different health professionals including the GP, a community psychiatric nurse, and an National Health Service sex therapist. For the past three months, she had also been attending the postnatal depression support group set up by Dawn.

Rachel

Rachel was 29 at the time of the interview, mother of a two-year-old daughter, Becca, who was "sort of" planned, and wanted. Rachel became depressed shortly after the birth, and remained so, off and on, for a year. She was prescribed tranquillizers which she took, off and on, throughout this period. Rachel also saw an osteopath, a herbalist and a healer. She also contacted Cry-sis. She was not depressed at the time of the interview.

Sandra

Sandra was 35 at the time of the interview, mother of two and a half-year-old Alice. Alice was planned and wanted, but it took Sandra two years to conceive. By the time she had Alice, she felt the timing was wrong because her circumstances and financial situation had changed. She became depressed shortly after Alice's birth. When Alice was three months old, Sandra was prescribed antidepressants which she took for a month. She saw a GP, a community psychiatric nurse, a counsellor, and a psychiatrist. She also contacted the Association for Postnatal Illness. At the time of the interview, Sandra still got panic attacks and still felt depressed. She had recently heard about Dawn's postnatal depression self-help group and was hoping to join it. Sandra had experienced depression as a teenager.

Sonya

Sonya was 39 at the time of the interview, mother of 18-month-old Suzie, a planned and wanted child. Two years prior to conceiving Suzie, Sonya had lost a baby at 17 weeks gestation when a scan showed he had died. Sonya became depressed six months after Suzie's birth. She had debilitating physical symptoms, including panic attacks, headaches, and a churning stomach. She was prescribed antidepressants which she had been taking for a year when I interviewed her. She was still taking the antidepressants at the time of the interview. Sonya was also seeing a private psychotherapist once a week and had been doing so for four months. Four months before the interview, she contacted the Association for Postnatal Illness and since then had been counselled on the telephone by Vera (who also took part in my study). At the time of the interview, Sonya still felt very depressed. Sonya had experienced depression as a young student, and had attempted to commit suicide.

Sophie

Sophie was 31 at the time of the interview, mother of three children aged 12, six and two years. All three children were planned and wanted. Sophie had these children by three different partners. At the time of the interview, she lived with the father of her third child. She became depressed five months after the birth of her second child. The depression was short-lived - two months - thanks to her GP who recognized it and talked her through it. She was also prescribed antidepressant medication for approximately two months.

Tina

Tina was 36 at the time of the interview, mother of three children aged ten, eight and two years. The first two children were planned and wanted. The third, Emily, was "semi" planned, but wanted. Tina experienced postnatal depression after the birth of her third child Emily. She had physical symptoms including panic attacks, migraines, and disturbed vision. She saw her GP three to four months after the birth, who prescribed her antidepressants, which she was still taking at the time of the interview. She had seen a private therapist, and she and her husband had had couple therapy on the National Health Service. Tina felt better at the time of the interview. At the age of 16, Tina had attempted to commit suicide.

Vera

Vera was 28 at the time of the interview, mother of a two-year-old, planned and wanted son, Felix. Vera became depressed within days of the birth, and remained so for eight months. She experienced severe panic attacks. She consulted her GP and was prescribed antidepressants some time in the first six weeks following the birth which she took for several months. She had seen a community psychiatric nurse, and a psychiatrist. She had attended a postnatal depression support group for four months. She had also contacted the Association for Postnatal Illness, and subsequently became a telephone 'counsellor' for them. At the time of the interview, she was 'counselling' Sonya on the telephone once a week. When I interviewed her, Vera still got panic attacks, and still had days when she felt depressed.

Appendix 8

Background details about the five mothers who, in their own views, had difficult experiences of motherhood but not postnatal depression

This appendix is intended to give further details about the group of five mothers, discussed in Chapter Two, who had difficulties in motherhood but emphasized that they had not experienced postnatal depression. As noted in Chapters One and Two, I decided not to give detailed consideration to these women within the main body of the thesis because, in my view, it is mothers such as these that Oakley (1980), Romito (1990b) and Nicolson's (1988) studies were primarily concerned with. However, as I point out in Chapter Seven, an obvious area of interest for future research would be a comparative study of these women and depressed mothers. In this appendix, I provide brief background details to four of the mothers - Anna, Beatrice, Hannah and Vivien - and give a more detailed account of Ruth.

Anna

Anna was 30 at the time of the interview, full-time mother of one-year-old Rose. Anna had found motherhood difficult in the first six months after the birth. She felt very tired and Rose did not sleep well, and cried a lot. She lived in a small village where she knew few people. She felt lonely and isolated. However, the emotional difficulties she experienced centred around her problems breastfeeding her baby. Rose often threw up after a feed, which Anna found very distressing. After three months, Anna decided to bottle-feed Rose, but experienced considerable guilt at this. At the time of the interview, Anna had recently written a piece for her local National Childbirth Trust (NCT) newsletter, describing her experiences, which she read to me:

> The three months I breast-fed Rose were very traumatic and unsettled. I suppose they probably are to most first-time mothers. All she seemed to do was vomit after every feed and cry all day and I spent most of the day in tears too and sitting for hours on end trying to feed her. At my wits end I decided to experiment with bottle feeding and during the next few days I alternated two bottle feeds with two breast feeds. By the end of the week I knew that both she and I were happier with the bottle, and I decided that I would bottle feed her totally. She changed overnight from my crying bundle to a very contented baby and we never looked back. Except for all the guilty feelings I then began to have. Had I really done the best for my baby or was I letting her down? What would other people think? How on earth was I going to tell my doctor that she was now *on the bottle*, let alone face my NCT reunion class, and I very nearly didn't go. I found myself justifying my actions to everyone, and I felt such a sense of relief when I saw someone else bottle feeding their baby. All in all I worked myself up into a private frenzy. I did get over it. After all it was *my* baby and *my* body ... There is a lot of propaganda and pressure to breast feed, and rightly so, but I don't think we should forget those who *really* do find it difficult or for whatever reasons decide to bottle feed their baby. Rose is a year old this week and I'm proud to say she's never had a day's illness. Despite the guilty feelings I experienced I'm still convinced that bottle feeding was right for Rose and I.

Throughout the early difficult months, Anna explained that her husband Graham had been very supportive, emotionally, and to a lesser degree, practically. Nonetheless, she felt that Graham did not understand fully what she was experiencing. However, she had a very close relationship with her mother. They had daily conversations on the telephone, and Anna confided her problems in her mother who was a great source of support to her through the first difficult six months. Anna explained that her previous experience of depression in late adolescence had taught her the importance of acknowledging her feelings to herself and to others in order to prevent her getting severely depressed as she had been before.

Beatrice

Beatrice was 35 at the time of the interview, mother of six-month-old Jack, and on maternity leave from her job as a publisher. At the time of the interview, Beatrice was finding motherhood much easier than she had over the previous six months. She had found the first weeks frightening, exhausting and somewhat boring. The most problematic aspect of her life as a mother had been the contrast between the degree of control she felt she had previously had over her life, when she was in full-time paid work, and what she subsequently experienced as a loss of control over herself, her time and her space. She explained:

> I think the critical thing was the lack of control and I hadn't expected that, that with a small child you have no control over your life whatsoever ... and I mean I've always known that control is a very important thing to me but I hadn't realised, well, either quite how important or quite how much it would be taken away ... it was not being able to have any time to myself ... a predictable period of time ... I found *really really* hard... I mean I just made sure lots of people came to see me most days ... just to stop the sort of wall closing in ... so I must say the first month was appalling the second month wasn't much better ... and then after 3 months it got really much better, it was lovely.

Beatrice said that a crucial step towards improving her situation was for her to have more time to herself. She had arranged for Jack to have part-time childcare, and at the time of our first interview, she was debating whether and how to return to paid employment. By the time of the second interview (three weeks later), she had decided to return to work part-time.

Beatrice's close relationship with her mother, and her good friendships with other mothers had helped her through the previous months. These women seemed more central to her feelings of well-being than her relationship with her husband. She felt that the latter offered little practical or emotional support.

Hannah

Hannah was 24 at the time of the interview, full-time mother of Zoë aged 14 months. Hannah experienced mixed feelings about motherhood in the first weeks due to her "bad birthing experience". She had expected the birth to be relatively uncomplicated, and the health professionals to be supportive. In contrast, she had a long and difficult delivery, and felt that the hospital staff had failed to consult and inform her about her progress during labour. She felt very angry with the doctors and midwives, and blamed them for her negative experience and feelings. Consequently, she attributed her low mood to her disappointment about the birth, and the hospital, and not to any negative feelings about Zoë.

Hannah started to feel better 4 to 6 weeks after the birth. She found her husband very caring, understanding and supportive. She also enjoyed a close relationship with her mother. Her contacts with other mothers were limited.

Vivien

Vivien was 36 at the time of the interview, mother of Laura aged 13 months, and in full-time employment as a probation officer. Vivien found the first 2 months of Laura's life extremely difficult due to problems breastfeeding and lack of sleep. She had assumed breastfeeding would be easy and come 'naturally'. In fact, she found it very painful and suffered from abscesses and broken skin. She felt that these *physical* difficulties were "*not* something most doctors and health visitors recognize. They tell you you have a psychological block, when one knows perfectly well it's physical. I certainly was highly committed to breastfeeding". Because of this discomfort, she came to dread feeding Laura, and was often in tears. Vivien also found Laura a demanding and "clingy" baby. If she was awake, Laura was unhappy left in her cot and wanted to be held.

Vivien was able to manage the first few months due to the help of her own mother whom she describes as "extremely supportive": "More than once I rang her in tears to say I couldn't cope any more. She would come straight over, and she never criticized". Vivien also spoke about her close relationship with her husband, and about his constant practical and emotional support. Vivien's relationship with her mother-in-law, however, has been difficult. She and her husband have found her to be very critical of their childrearing practices, and unsympathetic about the difficulties that Vivien had. She blamed Vivien and her husband for their problems. Vivien had been able to contend with the "deep rift" between herself and her mother-in-law due to the support she had derived from her mother, husband and from other parents and mothers that she knew.

Ruth

At the time of the interview, Ruth was a 32-year-old mother of 20-month-old Russell. She was employed part-time as a cleaner, and also gave dance classes once a week. Ruth felt "depressed" for the first nine months after Russell was born. Ruth found motherhood difficult from the moment she first came home from hospital. She described how "becoming a mother has been the hardest and most challenging period of my life". Russell was "a very difficult baby". He didn't sleep well, he wanted to feed all the time, and she found him very demanding for the first nine months. She also found that the "relentless monotonous routine was very hard to adjust to". As Russell got more independent and settled, Ruth began to feel better.

One of the main problems for Ruth was the lack of *practical* help, in particular from her husband Tom. Ruth said that "more than anything I was disappointed with my husband". She explained that "I was depressed a lot of the time but for quite *real* reasons". Just prior to conceiving Russell, Ruth's husband Tom had had an affair with another woman. Since then, Ruth had had a difficult relationship with Tom. Furthermore, although Tom decided to stay with Ruth, and have a child with her, Ruth had been disappointed by his lack of practical and emotional involvement in the relationship, and in Russell's life. Within two weeks of the birth, Tom stopped giving Ruth practical support in caring for Russell. Tom's contribution to housework was equally minimal. Emotionally, Ruth felt disappointed in her husband's lack of involvement with Russell not only because of the absence of help *per se*, but more importantly because she wanted Tom to *want* to be involved too. Ruth explained that despite her feelings of disappointment and resentment with Tom, they rarely talked about the problems in their relationship.

Ruth said that although she felt "depressed", what she experienced was not "postnatal depression", but "marital problems". There appear to be several reasons why she did not become postnatally depressed. Rather than judge and condemn how she felt, Ruth had room for her feelings, and was able to come to terms with them. She acknowledged the importance of confronting the difficult issues in her life. Furthermore, she accepted the way she felt. Ruth said she "never let it bother [her] that much" that her feelings about being a mother were different to those of other mothers, because she "knew that a lot of people felt

exactly the same as me", 'knowledge' which she had gained from talking to other mothers about her feelings and theirs.

Ruth's accepting approach seems partly the result of her more realistic expectations and notions of what it means to be a mother. She did not hold monolithic and rigid ideals. She recognized that mothers and babies are all different. Rather than compare herself to other mothers and see *herself* as the deficient one, Ruth was able to accept that her experience was simply different, neither better nor worse, than those around her. When she saw other mothers who seemed to be coping better or having an easier time than her, she did not "let it bother me that much" because "after all we're all different people anyway, with different natures. People cope with things in different ways".

Another aspect of Ruth's ability to think of mothers and motherhood in terms of 'difference', and not 'sameness' or 'oneness', is that Ruth also recognised that there are two sides of motherhood: the public 'face' of motherhood and a quite different private reality. Ruth was aware that 'coping motherhood' can be a "facade", something that "looks" and "seems" one way but might in reality be another.

Finally, despite her difficult relationship with her husband, Ruth also had several close and responsive relationships in her life. When she did voice her feelings, people seemed to understand and respond to her words. Ruth had a "close relationship" with her mother. She also developed a close relationship with a young man, Julien, whom she had a "fling" with, when Russell was a year old. When Ruth "was going through quite a difficult time with Russell", and "was having problems adjusting to motherhood and adjusting to living with Tom", Julien offered Ruth "quite a lot of support", and "in a sense he was a great help". Julien used to "come round and see me a lot and we used to go for walks a lot", Ruth explained; "he was actually very supportive and very helpful, he always used to talk to me a lot". Ruth's friendship with Julien was a positive one in which she got "love" and "affection". Julien was an important relationship for Ruth at the time of her difficulties.

Ruth said that the "most supportive" people had been other mothers with young children "because you see them during the day", and "it helps you get through the day". Ruth was able to talk to these mothers about how she felt, and she seems to have derived a lot of 'psychological support' from doing so:

> Moaning to other mothers ... was vital, it was very important, at the time definitely ... You spend a lot of your time moaning, but it isn't really like that I don't think. It's actually just a way of helping you not feel quite so isolated in your inadequacies and incompetencies, but yes it's very important.

Bibliography

Abercrombie, N., Hill, S. and Turner, B. S. (1988) *The Penguin Dictionary of Sociology*. London: Penguin Books. (First Published in 1984)

Abramson, L. Y., Seligman, M. E. P. and Teasdale, J. D. (1978) Learned helplessness in humans: critique and reformulations. *Journal of Abnormal Psychology*, **87**, 49-74.

Aderibigde, Y. A., Gureje, O. and Omigbodun, O. (1993) Postnatal emotional disorders in Nigerian women: a study of antecedents and associations. *British Journal of Psychiatry*, **163**, 645-650.

Alder, E. and Bancroft, J. (1988) The relationship between breastfeeding persistence, sexuality, and mood in postpartum women. *Psychological Medicine*, **18**, 389-396.

Alder, E. M. and Cox, J. L. (1983) Breast feeding and post-natal depression. *Journal of Psychosomatic Research*, **27**, 139-144.

Andrews, M. (1991) *Lifetimes of Commitment: Aging, Politics, Psychology*. Cambridge: Cambridge University Press.

Antonis, B. (1981) Motherhood and mothering. pp. 55-74. In: The Cambridge Women's Studies Group. *Women in Society*. London: Virago.

Arber, S., Gilbert, N. and Dale, A. (1985) Paid employment and women's health: a benefit or a source of role strain. *Sociology of Health and Illness*, **7**, 345-397.

Arizmendi, T. G. and Affonso, D. D. (1984) Research on psychosocial factors and postpartum depression: a critique. *Birth*, **11**, 237-240.

Asch, S. S. and Rubin, L. J. (1974) Postpartum reactions: some unrecognised variations. *American Journal of Psychiatry*, **131**, 870-874.

Atkinson, A. and Rickel, A. (1984) Postpartum depression in primiparous parents. *Journal of Abnormal Psychology*, **93**, 115-119.

Atkinson, S. and Atkinson, T. (1983) Puerperal psychosis - a personal experience. *Health Visitor*, **56**, 17-19.

Attanucci, J. (1988) In whose terms: a new perspective on self, role, and relationship. pp. 201-223. In: C. Gilligan, J. V. Ward and J. McLean Taylor (eds) *Mapping the Moral Domain: A Contribution of Women's Thinking to Psychological Theory and Education*. Cambridge, Mass.: Harvard University Press.

Badinter, E. (1981) *The Myth of Motherhood: An Historical View of the Maternal Instinct*. London: Souvenir Press.

Ball, J. A. (1987) *Reactions to Motherhood: The Role of Postnatal Care*. Cambridge: Cambridge University Press.

Ballinger, C. B., Buckley, D. E., Naylor, G. J. and Stansfield, D. A. (1979) Emotional disturbance following childbirth: clinical findings and urinary excretion of cyclic AMP (adenosine 3'5' cyclic monophosphate). *Psychological Medicine*, **9**, 293-300.

Beck, A., T. (1967) *Depression: Clinical, Experimental and Theoretical Aspects*. New York: Harper and Row.

Beech, B. A. L. (1992) Women's views of childbirth. pp. 153-166. In: T. Chard and M. P. M. Richards (eds) *Obstetrics in the 1990s: Current Controversies*. London: MacKeith Press.

Belenky, M. F., Clinchy, B. M., Goldberger, N. R. and Tarule, J. M. (1986) *Women's Ways of Knowing: The Development of Self, Voice, and Mind*. New York: Basic Books.

Bell, L. and Ribbens, J. (1994) Isolated housewives and complex maternal worlds - the significance of social contacts between women with young children in industrial societies. *Sociological Review*, **42**, 227-262.

Belle, D. (1982) (ed.) *Lives in Stress: Women and Depression*. Beverly Hills, California: Sage.

Belsky, J. and Rovine, M. (1984) Social-network contact, family support, and the transition to parenthood. *Journal of Marriage and the Family*, **46**, 455-462.

Berger, P. L. and Luckmann, T. (1984) *The Social Construction of Reality*. London: Pelican Books. (First Published in 1966)
Bergman, S. J. (1991) Men's psychological development: a relational perspective. *Work in Progress, No. 48*. Wellesley, Mass.: Stone Centre Working Paper Series.
Bergman, S. J. and Surrey, J. (1992) The woman-man relationship: impasses and possibilities. *Work in Progress, No. 55*. Wellesley, Mass.: Stone Centre Working Paper Series.
Bergum, V. (1989) *Woman to Mother: A Transformation*. Granby, Mass.: Bergin and Garvey.
Bernardez, T. (1988) Women and anger - Cultural prohibitions and the feminine ideal. *Work in Progress, No. 31*. Wellesley, Mass.: Stone Centre Working Paper Series.
Berryman, J. C. (1991) Perspectives on later motherhood. pp. 103-122. In: A. Phoenix, A. Woollett and E. Lloyd (eds) *Motherhood: Meanings, Practices and Ideologies*. London: Sage.
Bhavnani, K. K. and Coulson, M. (1986) Transforming socialist-feminism: the challenge of racism. *Feminist Review*, **23**, 81-92.
Bibring, G. L., Dwyer, T. F., Huntingdon, D. C. and Valenstein, A. F. (1961) A study of the psychological processes in pregnancy and of the earliest mother-child relationships. *Psychoanalytic Study of the Child*, **16**, 9-72.
Birkstead-Breen, D. (1986) The experience of having a baby: a developmental view. *Free Associations*, **4**, 22-35.
Blair, R. A., Gilmore, J. S., Playfair, H. R., Tisdall, M. W. and O'Shea, C. M. W. (1970) Puerperal depression: a study of predictive factors. *Journal of the Royal College of General Practitioners*, **19**, 22-25.
Blum, H. P. (1978) Reconstruction of a case of postpartum depression. *Psychoanalytic Study of the Child*, **33**, 335-362.
Blumer, H. S. (1969) *Symbolic Interactionism: Perspective and Method*. Englewood Cliffs, New Jersey: Prentice-Hall.
Boulton, M. G. (1983) *On Being a Mother: A Study of Women with Preschool Children*. London: Tavistock.
Bowlby, J. (1952) *Maternal Care and Mental Health*. Geneva: World Health Organisation. (First Published in 1951)
Bowlby, J. (1965) *Childcare and the Growth of Love*. (Second edition). Harmondsworth: Penguin Books. (First Published in 1953)
Bowlby, J. (1969) *Attachment and Loss. Volume I. Attachment*. London: The Hogarth Press.
Bowlby, J. (1973) *Attachment and Loss. Volume II. Separation: Anxiety and Anger*. London: The Hogarth Press.
Bowlby, J. (1979) *The Making and Breaking of Affectional Bonds*. London: Tavistock.
Bowlby, J. (1980) *Attachment and Loss. Volume II. Loss: Sadness and Depression*. London: The Hogarth Press.
Bowles, G. and Klein, R. D. (eds) *Theories of Women's Studies*. London: Routledge and Kegan Paul.
Boyce, P., Hickie, I. and Parker, G. (1991a) Parents, partners or personality? Risk factors for post-natal depression. *Journal of Affective Disorders*, **21**, 245-255.
Boyce, P., Parker, G., Barnett, B., Cooney, M. and Smith, F. (1991b) Personality as a vulnerability factor to depression. *British Journal of Psychiatry*, **159**, 106-114.
Bradley, B. (1991) Infancy as paradise. *Human Development*, **34**, 34-54.
Bradley, B. S. (1989) *Visions of Infancy: A Critical Introduction to Child Psychology*. Cambridge: Polity Press.
Brannen, J. (1988) Research note: the study of sensitive subjects. *Sociological Review*, **36**, 552-563.
Brannen, J. (1992) Combining qualitative and quantitative approaches: an overview. pp. 3-38. In: J. Brannen (ed.) *Mixing Methods: Qualitative and Quantitative Research*. Aldershot: Avebury.
Brannen, J. and Moss, P. (1991) *Managing Mothers: Dual Earner Households after Maternity Leave*. London: Unwin Hyman.

Braverman, J. and Roux, J. F. (1978) Screening for the patient at risk for postpartum depression. *Obstetrics and Gynaecology*, **52**, 731-736.
Breen, D. (1975) *The Birth of a First Child*. London: Tavistock.
Bridge, L. R., Little, B. C., Hayworth, J., Dewhurst, J. and Priest, R. G. (1985) Psychometric ante-natal predictors of post-natal depressed mood. *Journal of Psychosomatic Research*, **29**, 325-331.
Brockington, I. and Cox-Roper, A. (1988) The nosology of puerperal mental illness. pp. 1-16. In: R. Kumar and I. F. Brockington (eds) *Motherhood and Mental Illness 2: Causes and Consequences*. London: Wright.
Brockington, I. F. and Kumar, R. (1982) (eds) *Motherhood and Mental Illness*. London: Academic Press.
Brockington, I. F., Winokur, G. and Dean, C. (1982) Puerperal psychosis. pp. 37-70. In: I. F. Brockington and R. Kumar (eds) *Motherhood and Mental Illness*. London: Academic Press.
Brown, G. W. and Bifulco, A. (1990) Motherhood, employment and the development of depression: a replication of a finding? *British Journal of Psychiatry*, **156**, 169-179.
Brown, G. W. and Harris, T. (1978) *Social Origins of Depression*. London: Tavistock.
Brown, G. W. and Prudo, R. (1981) Psychiatric disorder in a rural and an urban population: 1. Aetiology of depression. *Psychological Medicine*, **11**, 581-599.
Brown, L. M. and Gilligan, C. (1992) *Meeting at the Crossroads: Women's Psychology and Girls' Development*. Cambridge, Mass.: Harvard University Press.
Brown, L. M. and Gilligan, C. (1993) Meeting at the Crossroads: Women's Psychology and Girls' Development. *Feminism and Psychology*, **3**, 11-35.
Busfield, J. (1974) Ideologies of reproduction. pp. 11-36. In: M. P. M. Richards (ed.) *Integration of the Child into a Social World*. Cambridge: Cambridge University Press.
Busfield, J. (1986) *Managing Madness: Changing Ideas and Practice*. London: Hutchinson.
Callaway, H. (1978) 'The most essentially female function of all': giving birth. pp. 163-185. In: S. Ardener (ed.) *Defining Females: The Nature of Women in Society*. London: Croon Helm.
Calvert, J. (1985) Motherhood. pp. 51-69. In: F. Brook. and A. Davis (eds) *Women, the Family and Social Work*. London: Tavistock.
Clayton, S. (1986) Postpartum thyroiditis - an undiagnosed disease. *British Journal of Obstetrics and Gynaecology*, **93**, 1121-1123.
Cobb, S. (1976) Social support as a moderator of life stress. *Psychosomatic Medicine*, **38**, 300-314.
Cogill, S. R., Caplan, H. L., Alexandra, H., Robson, K. M. and Kumar, R. (1986) Impact of maternal postnatal depression on cognitive development of young children. *British Medical Journal*, **292**, 1165-1167.
Collins, P. H. (1990) *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment*. London: Routledge.
Combes, G. and Schonveld, A. (1992) *Life Will Never be the Same Again: A Review of Antenatal and Postnatal Health Education*. London: Health Education Authority.
Comport, M. (1987) *Towards Happy Motherhood: Understanding Postnatal Depression*. London: Corgi.
Condon, J. T. and Watson, T. L. (1987) The maternity blues: exploration of a psychological hypothesis. *Acta Psychiatrica Scandinavica*, **76**, 164-171.
Cookson, J. (1993) Side-effects of antidepressants. *British Journal of Psychiatry*, **162** (Suppl. 20), 20-24.
Cooper, P. J., Campbell, E. A., Day, A., Kennerley, H. and Bond, A. (1988) Non-psychotic psychiatric disorder after childbirth: a prospective study of prevalence, incidence, course and nature. *British Journal of Psychiatry*, **152**, 799-806.
Coote, A., Harman, H. and Hewitt, P. (1990) *The Family Way: A New Approach to Policy-Making. Social Policy Paper No. 1*. London: Institute for Public Policy Research (IPPR).
Costello, C. G. (1982) Social factors associated with depression: a retrospective community study. *Psychological Medicine*, **12**, 329-339.

Cox, A. D. (1993) Befriending young mothers. *British Journal of Psychiatry*, **163**, 6-18.
Cox, J. L. (1983) Postnatal depression: a comparison of African and Scottish women. *Social Psychiatry*, **18**, 25-28.
Cox, J. L. (1986) *Postnatal Depression - A Guide for Health Professionals*. Edinburgh: Churchill Livingstone.
Cox, J. L. (1988a) Psychiatric disorders of childbirth. pp. 555-563. In: R. E. Kendell and A. K. Zeally (eds) *Companion to Psychiatric Studies*. (Fourth edition). Edinburgh: Churchill Livingstone.
Cox, J. L. (1988b) The life event of childbirth: sociocultural aspects of postnatal depression. pp. 64-77. In: R. Kumar and I. F. Brockington (eds) *Motherhood and Mental Illness 2: Causes and Consequences*. London: Wright.
Cox, J. L. (1989) Postnatal depression: a serious and neglected postpartum complication. *Baillère's Clinical Obstetrics and Gynaecology*, **3**, 839-855.
Cox, J. L., Connor, Y. and Kendell, R. E. (1982) Prospective study of the psychiatric disorders of childbirth. *British Journal of Psychiatry,* **140**, 111-117.
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.
Cox, J. L., Murray, D. and Chapman, G. (1993) A controlled study of the onset, duration and prevalence of postnatal depression. *British Journal of Psychiatry,* **163**, 27-31.
Cox, J. L., Paykel, E. S. and Page, M. L. (1989) (eds) *Childbirth as a Life Event*. Southampton: Duphar Medical Relations.
Cox, J. L., Rooney, A. C., Thomas, P. F. and Wrate, R. M. (1984) How accurately do mothers recall postnatal depression? Further data from a 3-year follow-up study. *Journal of Psychosomatic Obstetrics and Gynaecology*, **3**, 185-189.
Coyne, C. (1985a) (ed.) *Essential Papers on Depression*. New York: New York University Press.
Coyne, C. (1985b) Ambiguity and controversy: an introduction. pp. 1-22. In: C. Coyne (ed.) *Essential Papers on Depression*. New York: New York University Press.
Croghan, R. (1991) First-time mothers' accounts of inequality in the division of labour. *Feminism and Psychology*, **1**, 221-246.
Cutrona, C. (1982) Nonpsychotic postpartum depression: a review of recent research. *Clinical Psychology Review*, **2**, 487-503.
Cutrona, C. E. (1983) Causal attributions and perinatal depression. *Journal of Abnormal Psychology,* **92**, 161-172.
Cutrona, C. E. (1984) Social support and stress in the transition to parenthood. *Journal of Abnormal Psychology,* **93**, 378-390.
Cutrona, C. E. and Troutman, B. R. (1986) Social support, infant temperament, and parenting self-efficacy: a mediational model of postpartum depression. *Child Development*, **57**, 1507-1518.
D'Arcy, C. and Siddique, C. M. (1984) Social support and mental health among mothers of preschool children and school age children. *Social Psychiatry*, **19**, 155-162.
Dalton, K. (1964) *The Premenstrual Syndrome*. London: Whitefriars Press Ltd.
Dalton, K. (1971) Prospective study into puerperal depression. *British Journal of Psychiatry,* **118**, 689-692.
Dalton, K. (1989a) *Depression After Childbirth: How to Recognize and Treat Postnatal Depressio*n. Oxford: Oxford University Press. (First Published in 1980)
Dalton, K. (1989b) Successful prophylactic progesterone for idiopathic postnatal depression. *International Journal of Prenatal and Perinatal Studies*, 323-327.
David, M., Edwards, R., Hughes, M. and Ribbens, J. (1993) *Mothers and Education: Inside Out? Exploring Family-Education Policy and Experience*. London: Macmillan.
Day, S. (1982) Is obstetric technology depressing? *Radical Science Journal*, **12**, 17-45.
Day, S. (1985) *Puerperal Insanity: The Historical Sociology of a Disease*. Unpublished Doctoral Thesis. University of Cambridge.
Dennerstein, L., Lehert, P. and Riphagen, F. (1989) Postpartum depression - risk factors. *Journal of Psychosomatic Obstetrics and Gynaecology*, **10**, 53-65.

Dimitrovsky, L., Perez-Hirshberg, M. and Itskowitz, R. (1987) Locus of control and depression pre- and postpartum. *Journal of Reproductive and Infant Psychology*, **5**, 235-244.

Dix, C. (1986) *The New Mother Syndrome: Coping with Post-Natal Stress and Depression.* London: Allen and Unwin. (First Published in 1985)

Doucet, A. (forthcoming) *Gender Differences, Gender Equality and Care: Towards Understanding Gendered Labour in British Dual Earner Households.* Unpublished Doctoral Thesis. University of Cambridge.

Doucet, A. (in press) Encouraging voices: towards more creative methods for collecting data on gender and household labour. In: L. Morris and S. Lyon (eds) *Gender Relations in Public and Private: Changing Research Perspectives.* London: Macmillan.

Dunne, G. (1992) *Sexuality, Home-Life and the Structuring of Employment.* Unpublished Doctoral Thesis. University of Cambridge.

Durward, L. and Evans, R. (1990) Pressure groups and maternity care. pp. 256-273. In: J. Garcia, R. Kilpatrick and M. Richards (eds) *The Politics of Maternity Care: Services for Childbearing Women in Twentieth-Century Britain.* Oxford: Oxford University Press.

Edwards, R. (1990) Connecting method and epistemology: a white woman interviewing black women. *Women's Studies International Forum*, **13**, 477-490.

Edwards, R. (1993) An education in interviewing: placing the researcher and the research. pp. 181-196. In: C. M. Renzetti and R. M. Lee (eds) *Researching Sensitive Topics.* Newbury Park: Sage.

Edwards, R. and Ribbens, J. (1991) Meanderings around 'strategy': a research note on strategic discourse in the lives of women. *Sociology*, **25**, 477-489.

Eichelberger, R. T. (1989) *Disciplined Inquiry: Understanding and Doing Educational Research.* White Plains, New York: Longman.

Elliott, S. (1984) Pregnancy and after. pp. 93-116. In: S. Rachman (ed.) *Contributions to Medical Psychology, Volume 3.* Oxford: Pergamon Press.

Elliott, S. A. (1989) Psychological strategies in the prevention and treatment of postnatal depression. *Baillère's Clinical Obstetrics and Gynaecology*, **3**, 879-903.

Elliott, S. A., Anderson, M., Brough, D. I., Watson, J. P. and Rugg, A. J. (1984) Relationship between obstetric outcome and psychological measures in pregnancy and the postnatal year. *Journal of Reproductive and Infant Psychology*, **2**, 18-32.

Elliott, S. A., Sanjack, M. and Leverton, T. J. (1988) Parent groups in pregnancy: a preventive intervention for postnatal depression? pp. 87-110. In: B. H. Gottlieb (ed.) *Marshalling Social Support: Formats, Processes and Effects.* California: Sage.

Emde, R. (1980) Levels of meaning for infant emotions: a biosocial view. In: W. A. Collins (ed.) *Development of Cognition, Affect, and Social Relations.* (The Minnesota Symposium on Child Development, Volume 13). Hillsdale, New Jersey: Lawrence Erlbaum Associates.

Entwisle, D. R. and Doering, S. G. (1981) *The First Birth: A Family Turning Point.* Baltimore: John Hopkins University Press.

Esquirol, E. (1845) *Mental Maladies: A Treatise on Insanity.* Philadelphia: Lea and Blanchard.

Evans, R. (1991) *Newpin: the New Parent Infant Network. National Development Strategy 1992-1995.* London: Newpin.

Fedele, N., M. and Harrington, E. A. (1990) Women's groups: how connections heal. *Work in Progress, No. 47.* Wellesley, Mass.: Stone Centre Working Paper Series.

Feggetter, G., Cooper, P. and Gath, D. (1981) Non-psychotic psychiatric disorders in women one year after childbirth. *Journal of Psychosomatic Research*, **25**, 369-372.

Finch, J. (1984) "It's great to have someone to talk to": the ethics and politics of interviewing women. pp. 70-87. In: C. Bell and H. Roberts (eds) *Social Researching: Politics, Problems, Practice.* London: Routledge and Kegan Paul.

Fisher, J. R. W. (1993) *Obstetric Intervention: Psychosocial Predictors and Psychological Consequences.* Unpublished Doctoral Thesis. Key Centre for Women's Health in

Society, Department of Public Health and Community Medicine, University of Melbourne.
Foucault, M. (1992) *Madness and Civilization.* London: Routledge. (First Published in 1961)
Freud, S. (1925) Mourning and melancholia. pp. 152-170. In: E. Jones (ed.) *Collected Papers, Volume IV: Papers on Metapsychology. Papers on Applied Psychoanalysis.* London: Hogarth Press. (First Published in 1917)
Friedan, B. (1982) *The Feminine Mystique.* London: Pelican Books. (First Published in 1963)
Garcia, J., Kilpatrick, R. and Richards, M. (1990) (eds) *The Politics of Maternity Care: Services for Childbearing Women in Twentieth-Century Britain.* Oxford: Oxford University Press.
Gard, P. R., Handley, S. L., Parsons, A. D. and Waldron, G. (1986) A multivariate investigation of postpartum mood disturbance. *British Journal of Psychiatry*, **148**, 567-575.
Gavron, H. (1983) *The Captive Wife: Conflicts of Housebound Mothers.* London: Routledge and Kegan Paul. (First Published in 1966)
Gelder, M. (1978) Hormones and post-partum depression. pp. 80-90. In: M. Sandler (ed.) *Mental Illness in Pregnancy and the Puerperium.* Oxford: Oxford University Press.
George, A. and Sandler, M. (1988) Endocrine and biochemical studies in puerperal mental disorders. pp. 78-112. In: R. Kumar and I. F. Brockington (eds) *Motherhood and Mental Illness 2: Causes and Consequences.* London: Wright.
Gerson, K. (1985) *Hard Choices: How Women Decide about Work, Career, and Motherhood.* Berkeley: University of California Press.
Gilbert, P. (1984) *Depression: From Psychology to Brain State.* London: Lawrence Erlbaum Associates.
Gill, R. (1991) On 'Significant Differences - Feminism in Psychology' by Corinne Squire. *Feminism and Psychology*, **1**, 293-296.
Gilligan, C. (1982) *In a Different Voice: Psychological Theory and Women's Development.* Cambridge, Mass.: Harvard University Press.
Gilligan, C. (1985) Methods course taught at the Harvard Graduate School of Education, Cambridge, Mass., Spring 1985. (Cited in Andrews, 1991)
Gilligan, C. (1988a) Preface. pp. i-v. In: C. Gilligan, J. V. Ward and J. McLean Taylor (eds) *Mapping the Moral Domain: A Contribution of Women's Thinking to Psychological Theory and Education.* Cambridge, Mass.: Harvard University Press.
Gilligan, C. (1988b) Prologue: adolescent development reconsidered. pp. viii-xxxix. In: C. Gilligan, J. V. Ward and J. McLean Taylor (eds) *Mapping the Moral Domain: A Contribution of Women's Thinking to Psychological Theory and Education.* Cambridge, Mass.: Harvard University Press.
Gilligan, C. (1988c) Remapping the moral domain: new images of self in relationship. pp. 3-20. In: C. Gilligan, J. V. Ward and J. McLean Taylor (eds) *Mapping the Moral Domain: A Contribution of Women's Thinking to Psychological Theory and Education.* Cambridge, Mass.: Harvard University Press.
Gilligan, C. (1990) Joining the resistance: psychology, politics, girls and women. pp. 501-536. In: L. Goldstein (ed.) Special Issue: The Female Body. *Michigan Quarterly Review*, **xxix(4)**.
Gilligan, C. (1991) Women's psychological development: implications for psychotherapy. pp. 5-31. In: C. Gilligan, A. Rogers and D. Tolman (eds) *Women, Girls and Psychotherapy: Reframing Resistance.* Binghampton, New York: Harrington Park Press.
Gilligan, C. (1993) *In a Different Voice: Psychological Theory and Women's Development.* (Second edition). Cambridge, Mass.: Harvard University Press.
Gilligan, C. and Rogers, A. (1993) Reframing daughtering and mothering: a paradigm shift in psychology. pp. 125-135. In: J. van Mens-Verhulst, K. Schreures and L. Woertman (eds) *Daughtering and Mothering. Female Subjectivity Reanalysed.* London: Routledge.

Gilligan, C., Brown, L. M. and Rogers, A. (1990a) Psyche embedded: a place for body, relationships, and culture in personality theory. pp. 86-147. In: A. I. Rabin, R. Zucker, R. Emmons and S. Frank (eds) *Studying Persons and Lives*. New York: Springer.

Gilligan, C., Lyons, N. P. and Hanmer, T. J. (1990b) (eds) *Making Connections: The Relational Worlds of Adolescent Girls at Emma Willard School*. Cambridge, Mass.: Harvard University Press.

Gilligan, C., Ward, J. V. and McLean Taylor, J. (1988) (eds) *Mapping the Moral Domain: A Contribution of Women's Thinking to Psychological Theory and Education*. Cambridge, Mass.: Harvard University Press.

Glanze, W. D., Anderson, K. N. and Anderson, L. F. (1990) (eds) *Mosby's Medical, Nursing, and Allied Health Dictionary*. (Third edition). St. Louis: C. V. Mosby.

Glaser, B. G. and Strauss, A. L. (1967) *The Discovery of Grounded Theory: Strategies for Qualitative Research*. London: Weidenfeld and Nicolson.

Glover, V., Liddle, P., Taylor, A., Adams, D. and Sandler, M. (1994) Mild hypomania (the Highs) can be a feature of the first postpartum week: association with later depression. *British Journal of Psychiatry*, **164**, 517-521.

Goffman, E. (1987) *Asylums*. London: Penguin Books. (First Published in 1961)

Goffman, E. (1990) *Stigma*. London: Penguin Books. (First Published in 1963)

Gordon, R. E. and Gordon, K. K. (1959) Social factors in the predictions and treatment of emotional disorders of pregnancy. *American Journal of Obstetrics and Gynaecology*, **77**, 1074-1083.

Gordon, R. E. and Gordon, K. K. (1960) Social factors in prevention of postpartum emotional problems. *Obstetrics and Gynaecology*, **15**, 433-438.

Gordon, R. E., Kapostins, E. E. and Gordon, K. K. (1965) Factors in postpartum emotional adjustment. *Obstetrics and Gynaecology*, **25**, 158-166.

Gordon, T. (1990) *Feminist Mothers*. Basingstoke: Macmillan.

Gotlib, I. H., Whiffen, V. E., Wallace, P. M. and Mount, J. H. (1991) Prospective investigations of postpartum depression: factors involved in onset and recovery. *Journal of Abnormal Psychology*, **100**, 122-132.

Gottlieb, B. H. (1981) Social networks and social support in community mental health. pp. 11-39. In: B. H. Gottlieb (ed.) *Social Networks and Social Support*. Beverly Hills, California: Sage.

Gottlieb, B. H. (1988) *Marshalling Social Support: Formats, Processes and Effects*. California: Sage.

Graham, H. (1982) Coping: or how mothers are seen and not heard. pp. 101-116. In: S. Friedman and E. Sarah (eds) *On the Problems of Men: Two Feminist Conferences*. London: The Women's Press.

Graham, H. (1984) *Women, Health and the Family*. Brighton: Harvester Press.

Green, J. M, Coupland, V. A. and Kitzinger, J. V. (1988) *Great Expectations: A Prospective Study of Women's Expectations and Experiences of Childbirth*. Childcare and Development Group, University of Cambridge.

Green, J. M. (1990) "Who is unhappy after childbirth?": antenatal and intrapartum correlates from a prospective study. *Journal of Reproductive and Infant Psychology*, **8**, 175-183.

Green, J. M. and Murray, D. (in press) Antenatal depression. In: J. L. Cox and J. Holden (eds) *Prevention of Postnatal Depression: Use and Misuse of the Edinburgh Postnatal Depression Score*.

Green, J., Statham, H. and Snowdon, C. (1994) *Pregnancy: A Testing Time. Report of the Cambridge Prenatal Screening Study*. Centre for Family Research, University of Cambridge.

Grossman, F. K., Eichler, L. S. and Winickoff, S. A. (1980) *Pregnancy, Birth, and Parenthood: Adaptation of Mothers, Fathers, and Infants*. San Francisco: Jossey-Bass.

Gruen, D. S. (1990) Postpartum depression: a debilitating yet often unassessed problem. *Health and Social Work*, **15**, 261-270.

Hamilton, J. A. (1962) *Postpartum Psychiatric Problems*. St. Louis: C. V. Mosby.

Hamilton, J. A. (1982) The identity of postpartum psychosis. pp. 1-20. In: I. F. Brockington and R. Kumar (eds) *Motherhood and Mental Illness*. London: Academic Press.
Hammersley, M. (1992) Deconstructing the qualitative-quantitative divide. pp. 39-56. In: J. Brannen (ed.) *Mixing Methods: Qualitative and Quantitative Research*. Aldershot: Avebury.
Hammersley, M. and Atkinson, P. (1983) *Ethnography: Principles in Practice*. London: Tavistock.
Handford, P. (1985) Postpartum depression: what is it, what helps? *The Canadian Nurse*, **January**, 30-33.
Handley, S. L., Dunn, T. L., Baker, J. M., Cockshott, C. and Gould, S. (1977) Mood changes in puerperium and plasma tryptophan and cortisol concentrations. *British Medical Journal*, **2**, 18-20.
Handley, S. L., Dunn, T. L., Waldron, G. and Baker, J. M. (1980) Tryptophan, cortisol and puerperal mood. *British Journal of Psychiatry*, **136**, 498-506.
Harding, S. (1987) (ed.) *Feminism and Methodology*. Milton Keynes: Open University Press.
Hardyment, C. (1983) *Dream Babies: Child Care from Locke to Spock*. London: Jonathan Cape.
Harkness, S. (1988) The cultural mediation of postpartum depression. *Medical Anthropology Quarterly*, **1**, 194-209.
Harré, R. (1970) *Social Being*. Oxford: Blackwell.
Harré, R. (1983) *Personal Being*. Oxford: Blackwell.
Hayworth, J., Little, B. C., Bonham Carter, S., Raptopoulos, P., Priest, R. G. and Sandler, M. (1980) A predictive study of postpartum depression: some predisposing characteristics. *British Journal of Medical Psychology*, **53**, 161-167.
Heitler, S. K. (1976) Postpartum depression: a multi-dimensional study. *Dissertation Abstracts International* , **36**, 11-B, 5792-5793.
Henwood, K. L. and Pidgeon, N. F. (1992) Qualitative research and psychological theorizing. *British Journal of Psychology*, **83**, 97-111.
Hillier, C. A. and Slade, P. (1989) The impact of antenatal classes on knowledge, anxiety and confidence in primiparous women. *Journal of Reproductive and Infant Psychology*, **7**, 3-13.
Hock, E. and DeMeis, D. K. (1990) Depression in mothers of infants: the role of maternal employment. *Developmental Psychology*, **26**, 285-292.
Hock, E., Gnezda, M. T. and McBride, S. L. (1984) Mothers of infants: attitudes towards employment and motherhood following birth of the first child. *Journal of Marriage and the Family*, **46**, 425-431.
Hoffman, L. W. (1974) Effects of maternal employment on the child - a review of the research. *Developmental Psychology,* **10**, 204-228.
Holden, J. M., Sagovsky, R. and Cox, J. L. (1989) Counselling in a general practice setting: controlled study of health visitor intervention in treatment of postnatal depression. *British Medical Journal*, **298**, 223-226.
Holland, P. (1992) *What is a Child? Images of Childhood*. London: Virago.
Holmes, T. H. and Rahe, R. H. (1967) The social readjustment rating scale. *Journal of Psychosomatic Research*, **11**, 213-218.
Hopkins, J., Campbell, S. B. and Marcus, M. (1987) Role of infant-related stressors in postpartum depression. *Journal of Abnormal Psychology*, **96**, 237-241.
Hopkins, J., Marcus, M. and Campbell, S. B. (1984) Postpartum depression: a critical review. *Psychological Bulletin*, **95**, 498-515.
Hunt, H. (1986) Women's private distress - a public health issue: strategies for psychologists working in primary care. *Medicine in Society*, **12**, 29-32.
Ingleby, D. (1981) *Critical Psychiatry: The Politics of Mental Health*. Harmondsworth: Penguin Books.
Inwood, D. G. (1985) The spectrum of postpartum psychiatric disorders. pp. 1-18. In: D. G. Inwood (ed.) *Recent Advances in Postpartum Psychiatric Disorders*. Washington: American Psychiatric Press.

Ireland, J. (1994) *Gender, Work and Identity in the Lives of Women and Men in Nursing and Engineering Trades in the South of England.* Unpublished Doctoral Thesis. University of Cambridge.
Jack, D. (1991) *Silencing the Self: Depression and Women.* Cambridge, Mass.: Harvard University Press.
Jackson, S. (1992) The amazing deconstructed woman. *Trouble and Strife*, **25**, 25-31.
Jacobsen, L., Kaij, L. and Nilsson, A. (1965) Postpartum mental disorders in an unselected sample. *British Medical Journal*, **1**, 1640-1643.
Jansson, B. (1987) Post-partum mental disorder and transcultural aspects. *Bulletin of Marcé Society,* **Summer**, 18-26.
Jebali, C. (1993) A feminist perspective on postnatal depression. *Health Visitor,* **66**, 59-60.
Jones, C. (1984) A postpartum support group. *Birth*, **11**, 244.
Jones, S. (1985) Depth interviewing. pp. 45-55. In: R. Walker (ed.) *Applied Qualitative Research.* Aldershot: Gower.
Jordan, J. V. (1992) Relational resilience. *Work in Progress, No. 57.* Wellesley, Mass.: Stone Centre Working Paper Series.
Jordanova, L. J. (1981) Mental illness, mental health: changing norms and expectations. pp.95-114. In: The Cambridge Women's Studies Group. *Women in Society.* London: Virago.
Joshi, H. (1987) The cost of caring. pp. 112-133. In: C. Glendinning and J. Miller (eds) *Women and Poverty in Britain.* Brighton: Wheatsheaf.
Joshi, H. and Davies, H. (1991) *The Pension Consequences of Divorce.* London: Centre for Economic Policy Research.
Kagey, J. R., Vivace, J. and Lutz, W. (1981) Mental health primary prevention: the role of parent mutual support groups. *American Journal of Public Health*, **71**, 166-167.
Kaij, L., Jacobson, L. and Nilsson, A. (1967) Postpartum mental disorders in an unselected sample: the influence of parity. *Journal of Psychosomatic Research*, **10**, 317-325.
Kaplan, A. G. (1984) The "self-in-relation": implications for depression in women. *Work in Progress, No. 14.* Wellesley, Mass.: Stone Centre Working Paper Series.
Kaplan, E. H. and Blackman, L. H. (1969) The husband's role in psychiatric illness associated with childbearing. *Psychiatric Quarterly*, **43**, 396-409.
Kaplan, M. M. (1992) *Mothers' Images of Motherhood: Case Studies of Twelve Mothers.* London: Routledge.
Karacan, I. and Williams, R. L. (1970) Current advances in theory and practice relating to postpartum syndromes. *Psychiatry in Medicine,* **1**, 307-328.
Keeley-Robinson, Y. (1983) Women's concepts of depression. *Health Visitor*, **56**, 11-13.
Kelly, G. A. (1955) *The Psychology of Personal Constructs.* New York: Norton.
Kelly, G. A. (1963) *A Theory of Personality.* New York: Norton.
Kelly, J. V. (1967) The influences of native customs on obstetrics in Nigeria. *Obstetrics and Gynaecology*, **30**, 608-612.
Kendall-Tackett, K. A. (1993) *Postpartum Depression: A Comprehensive Approach for Nurses.* Newbury Park: Sage.
Kendell, R. E. (1985) Emotional and physical factors in the genesis of puerperal mental disorders. *Journal of Psychosomatic Research*, **29**, 3-11.
Kendell, R. E. (1988) Affective (mood) disorders. pp. 335-361. In: R. E. Kendell and A. K. Zeally (eds) *Companion to Psychiatric Studies.* (Fourth edition). Edinburgh: Churchill Livingstone.
Kendell, R. E., Chalmers, J. C. and Platz, C. (1987) Epidemiology of puerperal psychoses. *British Journal of Psychiatry*, **150**, 662-673.
Kendell, R. E., McGuire, R. J., Connor, Y. and Cox, J. L. (1981a) Mood changes in the first three weeks following childbirth. *Journal of Affective Disorders*, **3**, 317-326.
Kendell, R. E., Rennie, D., Clarke, J. A. and Dean, C. (1981b) The social and psychiatric correlates of psychiatric admission in the puerperium. *Psychological Medicine*, **11**, 341-350.
Kendell, R. E., Wainwright, S., Hailey, A. and Shannon, B. (1976) The influence of childbirth on psychiatric morbidity. *Psychological Medicine*, **6**, 297-302.

Kennerley, H. and Gath, D. (1986) Maternity blues reassessed. *Psychiatric Developments*, **1**, 1-17.
Kenney, J. W. and Tash, D. T. (1992) Lesbian childbearing couples' dilemmas and decisions. *Health Care for Women International*, **13**, 209-219.
Kitzinger, C., Wilkinson, S. and Perkins, R. (1992) (eds) Special Issue: Heterosexuality. *Feminism and Psychology*, **2(3)**.
Kitzinger, J. (1990) Strategies of the early childbirth movement: a case-study of the National Childbirth Trust. pp. 92-115. In: J. Garcia, R. Kilpatrick and M. Richards (eds) *The Politics of Maternity Care: Services for Childbearing Women in Twentieth-Century Britain*. Oxford: Oxford University Press.
Kitzinger, S. (1972) *The Experience of Childbirth*. Harmondsworth: Penguin Books. (First Published in 1962)
Kitzinger, S. (1978) *Women as Mothers*. Glasgow: Fontana.
Kitzinger, S. (1979) *The Good Birth Guide*. London: Fontana.
Kitzinger, S. (1982) The social context of birth: some comparisons between childbirth in Jamaica and Britain. pp. 181-203. In: C. P. MacCormack (ed.) *Ethnography of Fertility and Birth*. London: Academic Press.
Klatskin, E. H. and Eron, L. D. (1970) Projective test content during pregnancy and postpartum adjustment. *Psychosomatic Medicine*, **32**, 487-493.
Kleinman, A. M. (1977) Depression, somatization and the "new cross-cultural psychiatry". *Social Science and Medicine*, **11**, 3-10.
Kohut, H. (1971) *The Analysis of the Self*. New York: International Universities Press.
Komarovsky, M. (1967) *Blue-collar Marriage*. New York: Vintage Books.
Kumar, R. (1982) Neurotic disorders in childbearing women. pp. 71-118. In: I. F. Brockington and R. Kumar (eds) *Motherhood and Mental Illness*. London: Academic Press.
Kumar, R. and Robson, K. (1978) Neurotic disturbance during pregnancy and the puerperium: preliminary report of a prospective survey of 119 primiparae. pp. 40-51. In: M. Sandler (ed.) *Mental Illness in Pregnancy and the Puerperium*. Oxford: Oxford University Press.
Kumar, R. and Robson, K. M. A. (1984) A prospective study of emotional disorders in childbearing women. *British Journal of Psychiatry*, **144**, 35-47.
Laing, R. D. (1965) *The Divided Self*. Harmondsworth: Penguin Books. (First Published in 1960)
Laing, R. D. and Esterson, A. (1986) *Sanity, Madness and the Family*. Harmondsworth: Penguin Books. (First Published in 1964)
Langer, M., Czermak, B. and Ringler, M. (1990) Couple relationship, birth preparation and pregnancy outcome: a prospective controlled outcome study. *Journal of Perinatal Medicine*, **18**, 201-208.
Leavy, R. A. (1983) Social support and psychological disorder: a review. *Journal of Community Psychology*, **11**, 3-21
Lee, R. M. (1993) *Doing Research on Sensitive Topics*. London: Sage.
Leff, J. (1977) The cross-cultural study of emotions. *Culture, Medicine and Psychiatry*, **1**, 317-350.
Leifer, M. (1977) Psychological changes accompanying pregnancy and motherhood. *Genetic Psychology Monographs*, **95**, 55-96.
Leverton, T. J. and Elliott, S. A. (1989) Transition to parenthood groups: a preventive intervention for postnatal depression? pp. 479-486. In: E. V. van Hall and and W. Everaerd (1989) *The Free Woman: Women's Health in the 1990s*. Carnforth: Parthenon.
Lewis, C. and O'Brien, M. (1987) *Reassessing Fatherhood: New Observations on Fathers and the Modern Family*. London: Sage.
Lewis, S. (1991) Motherhood and employment: the impact of social and organizational values. pp. 195-215. In: A. Phoenix, A. Woollett and E. Lloyd (eds) *Motherhood: Meanings, Practices and Ideologies*. London: Sage.
Lomas, P. (1960) Dread of envy as an aetiological factor in puerperal breakdown. *British Journal of Medical Psychology*, **33**, 105-112.
Lopota, H. (1971) *Occupation Housewife*. New York: Oxford University Press.

Lovestone, S. and Kumar, R. (1993) Postnatal psychiatric illness: the impact on partners. *British Journal of Psychiatry*, **163**, 210-216.
Macintyre, S. (1976) 'Who wants babies?' The social construction of 'instincts'. pp. 150-173. In: D. L. Barker and S. Allen (eds) *Sexual Divisions and Society: Process and Change*. London: Tavistock.
Mansfield, P. and Collard, J. (1988) *The Beginning of the Rest of Your Life?* London: Macmillan.
Marcé, L. V. (1858) *Traité de la Folie des Femmes Enceintes, des Nouvelles Accouchées et des Nourrices*. Paris: Baillère.
Margison, F. (1982) The pathology of the mother-child relationship. pp. 191-222. In: I. F. Brockington and R. Kumar (eds) *Motherhood and Mental Illness*. London: Academic Press.
Marshall, F. (1993) *Coping with Postnatal Depression*. London: Sheldon Press.
Marshall, H. (1991) The social construction of motherhood: an analysis of childcare and parenting manuals. pp. 66-85. In: A. Phoenix, A. Woollett and E. Lloyd (eds) *Motherhood: Meanings, Practices and Ideologies*. London: Sage.
Martin, B. (1984) 'Mother wouldn't like it!'; housework as magic. *Theory, Culture and Society*, **2**, 19-36.
Martin, E. (1989) *The Woman in The Body: A Cultural Analysis of Reproduction*. Milton Keynes: Open University Press. (First Published in 1987)
Martin, J. L. and Dean, L. (1993) Developing a community sample of gay men for an epidemiological study of AIDS. pp. 82-99. In: C. M. Renzetti and R. M. Lee (eds) *Researching Sensitive Topics*. Newbury Park: Sage.
Mauthner, N. (1993) Towards a feminist understanding of 'postnatal depression'. *Feminism and Psychology*, **3**, 350-355.
Mayall, B. and Foster, M. C. (1989) *Child Health Care: Living with Children, Working for Children*. Oxford: Heinemann Nursing.
McCannell, K. (1988) Social networks and the transition to motherhood. pp. 83-106. In: M. Milardo Robert (ed.) *Families and Social Networks*. Newbury Park: Sage.
McCord, G. (1984) Postpartum depression: out of the closet - and then what? *Birth*, **11**, 244-245.
McIntosh, J. (1986) Postnatal blues: a bio-social phenomenon. *Midwifery*, **2**, 187-192.
McKears, J. (1983) Group support for young mothers. *Health Visitor*, **56**, 16.
Melhuish, E. C., Gambles, C. and Kumar, R. (1988) Maternal mental illness and the mother-infant relationship. pp. 191-211. In: R. Kumar and I. F. Brockington (eds) *Motherhood and Mental Illness 2: Causes and Consequences*. London: Wright.
Miles, A. (1988) *Women and Mental Illness: The Social Context of Female Neurosis*. Brighton: Wheatsheaf Books.
Miller, A. (1987) *The Drama of Being a Child*. London: Virago.
Miller, J. B. (1984) The development of women's sense of self. *Work in Progress, No. 12*. Wellesley, Mass.: Stone Centre Working Paper Series.
Miller, J. B. (1986a) *Toward a New Psychology of Women*. (Second edition). London: Penguin Books. (First Published in 1976)
Miller, J. B. (1986b) What do we mean by relationships? *Work in Progress, No. 22*. Wellesley, Mass.: Stone Centre Working Paper Series.
Miller, J. B., Jordan, J. V., Kaplan, A. G., Stiver, I. P. and Surrey, J. L. (1991) Some misconceptions and reconceptions of a relational approach. *Work in Progress, No. 49*. Wellesley, Mass.: Stone Centre Working Paper Series.
Mills, M. and Pound, A. (1986) Mechanisms of change. The Newpin project. *Marcé Bulletin*, **2**, 3-7.
Morris, J. B. (1987) Group psychotherapy for prolonged postnatal depression. *British Journal of Medical Psychology*, **60**, 279-281.
Moss, P. and Plewis, I. (1977) Mental distress in mothers of pre-school children in inner London. *Psychological Medicine*, **7**, 641-652.
Moss, P., Bolland, G., Foxman, R. and Owen, C. (1987) The division of household work during the transition to parenthood. *Journal of Reproductive and Infant Psychology*, **5**, 71-86.

Moulds, V., Hennessy, D., Crack, P. and Murray, M. (1983) A postnatal group for first-time mothers. *Health Visitor*, **56**, 296-297.

Mueller, D. P. (1980) Social networks: a promising direction for research on the relationship of the social environment to psychiatric disorder. *Social Science and Medicine,* **14A**, 147-161.

Murray, D. and Cox, J. L. (1990) Screening for depression during pregnancy with the Edinburgh Depression Scale (EPDS). *Journal of Reproductive and Infant Psychology,* **8**, 99-107.

Murray, L. (1988) Effects of postnatal depression on infant development: direct studies of early mother-infant interactions. pp. 159-190. In: R. Kumar and I. F. Brockington (eds) *Motherhood and Mental Illness 2: Causes and Consequences*. London: Wright.

Murray, L. (1989) The Cambridge study of postnatal depression and infant development. pp. 23-37. In: J. L. Cox, E. S. Paykel and M. L. Page (eds) *Childbirth as a Life Event*. Southampton: Duphar Medical Relations.

Murray, L. and Cartwright, W. (1993) The role of obstetric factors in postpartum depression. *Journal of Reproductive and Infant Psychology*, **11**, 215-219.

Murray, L. and Stein, A. (1991) Postnatal depression and infant development. *British Medical Journal*, **302**, 978-979.

Nairne, K. and Smith, G. (1984) *Dealing with Depression*. London: The Women's Press.

Newton, J. (1992) *Preventing Mental Illness in Practice*. London: Routledge.

Nicolson, P. (1986) Developing a feminist approach to depression following childbirth. pp. 135-149. In: S. Wilkinson (ed.) *Feminist Social Psychology: Developing Theory and Practice*. Milton Keynes: Open University Press.

Nicolson, P. (1988) *The Social Psychology of 'Postnatal Depression'*. Unpublished Doctoral Thesis. London School of Economics.

Nicolson, P. (1989a) Counselling women with postnatal depression: implications from recent qualitative research. *Counselling Psychology Quarterly,* **2**, 123-132.

Nicolson, P. (1989b) Post-natal depression: implications for clinical research and practice. *Clinical Psychology Forum*, **22**, 15-18.

Nicolson, P. (1990) Understanding postnatal depression: a mother-centred approach. *Journal of Advanced Nursing*, **15**, 689-695.

Nicolson, P. (1991/1992) Explanations of postnatal depression: structuring knowledge of female psychology. *Research on Language and Social Interaction*, **25**, 75-96.

Nicolson, P. (1992) Towards a psychology of women's health and health care. pp. 6-30. In: P. Nicolson and J. Ussher (eds) *The Psychology of Women's Health and Health Care*. London: Macmillan.

Nilsson, A. and Almgren, P. E. (1970) Para-natal emotional adjustment: a prospective investigation of 165 women, Part II. *Acta Psychiatrica Scandinavica*, **47**, 62-141.

Nilsson, A., Kaij, L. and Jacobson, L. (1967) Post-partum mental disorder in an unselected sample. The importance of the unplanned pregnancy. *Journal of Psychosomatic Research*, **10**, 341-347.

Nott, P. N. (1982) Psychiatric illness following childbirth in Southampton: a case register study. *Psychological Medicine*, **12**, 557-561.

Nott, P. N. (1987) Extent, timing and persistence of emotional disorders following childbirth. *British Journal of Psychiatry*, **151**, 523-527.

Nott, P. N., Franklin, M., Armitage, C. and Gelder, M. G. (1976) Hormonal change and mood in the puerperium. *British Journal of Psychiatry*, **128**, 279-283.

O'Connor, P. (1991) Women's confidants outside marriage: shared or competing sources of intimacy? *Sociology*, **25**, 241-254.

O'Connor, P. (1992) *Friendships Between Women: A Critical Review*. Hemel Hempstead: Harvester Wheatsheaf.

O'Donnell, L. (1985) *The Unheralded Majority: Contemporary Women as Mothers*. Lexington, Mass.: Lexington Books.

O'Hara, M. W. (1985) Psychological factors in the development of postpartum depression. pp. 41-58. In: D. G. Inwood (ed.) *Recent Advances in Postpartum Psychiatric Disorders*. Washington: American Psychiatric Press.

O'Hara, M. W. (1986) Social support, life events, and depression during pregnancy and the puerperium. *Archives of General Psychiatry*, **43**, 569-573.
O'Hara, M. W. (1987) Postpartum "blues", depression, and psychosis: a review. Special issue: maternal development during reproduction. *Journal of Psychosomatic Obstetrics and Gynaecology*, **7**, 205-227.
O'Hara, M. W. and Zekoski, E. M. (1988) Postpartum depression: a comprehensive review. pp. 17-63. In: R. Kumar and I. F. Brockington (eds) *Motherhood and Mental Illness 2: Causes and Consequences*. London: Wright.
O'Hara, M. W., Rehm, L. P. and Campbell, S. B. (1982) Predicting depressive symptomatology: cognitive-behavioural models of postpartum depression. *Journal of Abnormal Psychology*, **91**, 457-461.
O'Hara, M. W., Rehm, L. P. and Campbell, S. B. (1983) Postpartum depression: a role for social network and life stress variables. *Journal of Nervous and Mental Diseases*, **171**, 336-341.
O'Hara, M. W., Schlechte, J. A., Lewis, D. A. and Varner, M. W. (1991) Controlled prospective study of postpartum mood disorders: psychological, environmental, and hormonal variables. *Journal of Abnormal Psychology*, **100**, 63-73.
O'Hara, M., Neunaber, D. and Zekoski, E. (1984) Prospective study of postpartum depression: prevalence, course and predictive factors. *Journal of Abnormal Psychology*, **93**, 158-171.
Oakley, A. (1974) *The Sociology of Housework*. London: Martin Robertson.
Oakley, A. (1976) Wisewoman and medicine man: changes in the management of childbirth. pp. 17-58. In: J. Mitchell and A. Oakley (eds) *The Rights and Wrong of Women*. Harmondsworth: Penguin Books.
Oakley, A. (1979) *Becoming a Mother*. Oxford: Martin Robertson.
Oakley, A. (1980) *Women Confined: Towards a Sociology of Childbirth*. Oxford: Martin Robertson.
Oakley, A. (1981a) Normal motherhood: an exercise in self-control? pp. 79-107. In: B. Hutter and G. Williams (eds) *Controlling Women: The Normal and the Deviant*. London: Croom Helm.
Oakley, A. (1981b) Interviewing women: a contradiction in terms. pp. 30-61. In: H. Roberts (ed.) *Doing Feminist Research*. London: Routledge and Kegan Paul.
Oakley, A. (1986a) *Telling the Truth about Jerusalem*. Oxford: Blackwell.
Oakley, A. (1986b) *The Captured Womb: A History of the Medical Care of Women*. Oxford: Blackwell. (First Published in 1984)
Oakley, A. (1986c) Feminism, motherhood and medicine - who cares? pp. 127-150. In: J. Mitchell and A. Oakley (eds) *What is Feminism?* Oxford: Blackwell.
Oakley, A. (1988) Is social support good for the health of mothers and babies? *Journal of Reproductive and Infant Psychology*, **6**, 3-21.
Oakley, A. (1990) A case of maternity: paradigms of women as maternity cases. pp. 61-85. In: J. F. O'Barr, D. Pope and M. Wyer (eds) *Ties That Bind: Essays on Mothering and Patriarchy*. Chicago: University of Chicago Press.
Oakley, A. (1992) *Social Support and Motherhood*. Oxford: Blackwell Publishers.
Oakley, A. (1993) *Essays on Women, Medicine and Health*. Edinburgh: Edinburgh University Press.
Oakley, A. and Rajan, L. (1990) Obstetric technology and maternal emotional well-being: a further research note. *Journal of Reproductive and Infant Psychology*, **8**, 45-55.
Oakley, A. and Rajan, L. (1991) Social class and social support: the same or different? *Sociology*, **25**, 31-59.
Oakley, A., Rajan, L. and Grant, A. (1990) Social support and pregnancy outcome. *British Journal of Obstetrics and Gynaecology*, **97**, 155-162.
Paffenberger, R. S. and McCabe, L. J. (1966) The effects of obstetric and perinatal events on risk of mental illness in women of childbearing age. *American Journal of Public Health*, **56**, 400-407.
Pahl, R. (1984) *Divisions of Labour*. Oxford: Blackwell.
Parr, M. (1994) *Pippin: Parents in Partnership - Parent Infant Network Ltd.* (For further details contact Mel Parr, "Derwood", Todds Green, Stevenage, Herts, SG1 2JE. Tel: 0438-748 478).

Patton, M. Q. (1990) *Qualitative Evaluation and Research Methods.* (Second edition). London: Sage.
Paykel, E. S. (1991) Depression in women. *British Journal of Psychiatry*, **158**, (Suppl. 10), 22-29.
Paykel, E. S., Emms, E. M., Fletcher, J. and Rassaby, E. S. (1980) Life events and social support in puerperal depression. *British Journal of Psychiatry*, **136**, 339-346.
Penfold, S. and Walker, G. A. (1983) *Women and the Psychiatric Paradox.* Montreal: Eden Press.
Perlman, D. (1988) Loneliness: a life-span perspective. pp. 190-220. In: M. Milardo Robert (ed.) *Families and Social Networks.* Newbury Park: Sage.
Philipps, L. H. C. and O'Hara, M. W. (1991) Prospective study of postpartum depression: 4½-year follow-up of women and children. *Journal of Abnormal Psychology*, **100**, 151-155.
Phoenix, A. (1990) Black women and the maternity services. pp. 274-299. In: J. Garcia, R. Kilpatrick and M. Richards (eds) *The Politics of Maternity Care: Services for Childbearing Women in Twentieth-Century Britain.* Oxford: Oxford University Press.
Phoenix, A. (1991a) *Young Mothers?* Cambridge: Polity Press.
Phoenix, A. (1991b) Mothers under twenty: outsider and insider views. pp. 86-102. In: A. Phoenix, A. Woollett and E. Lloyd (eds) *Motherhood: Meanings, Practices and Ideologies.* London: Sage.
Phoenix, A. and Bhavnani, K. (1994) (eds) Special Issue: Shifting Identities Shifting Racisms. *Feminism and Psychology*, **4(1)**.
Phoenix, A. and Woollett, A. (1991a) Introduction. pp. 1-12. In: A. Phoenix, A. Woollett and E. Lloyd (eds) *Motherhood: Meanings, Practices and Ideologies.* London: Sage.
Phoenix, A. and Woollett, A. (1991b) Motherhood: social construction, politics and psychology. pp. 13-27. In: A. Phoenix, A. Woollett and E. Lloyd (eds) *Motherhood: Meanings, Practices and Ideologies.* London: Sage.
Phoenix, A., Woollett, A. and Lloyd, E. (1991) (eds) *Motherhood: Meanings, Practices and Ideologies.* London: Sage.
Pillsbury, B. L. K. (1978) "Doing the month": confinement and convalescence of Chinese women after childbirth. *Social Science and Medicine*, **12**, 11-22.
Pines, D. (1972) Pregnancy and motherhood: interaction between fantasy and reality. *British Journal of Medical Psychology*, **45**, 333-343.
Pirie, M. (1988) Women and the illness role: rethinking feminist theory. *Canadian Review of Sociology and Anthropology*, **25**(4), 628-648.
Pitt, B. (1968) "Atypical" depression following childbirth. *British Journal of Psychiatry*, **114**, 1325-1335.
Pitt, B. (1978) *Feelings about Childbirth.* London: Sheldon Press.
Playfair, H. R. and Gowers, J. I. (1981) Depression following childbirth - a search for predictive signs. *Journal of the Royal College of General Practitioners*, **31**, 201-208.
Pound, A. and Mills, M. (1985) A pilot evaluation of NEWPIN: home visiting and befriending scheme in South London. *Association of Child Psychiatry*, **114**, 1325-1335.
Prendergast, S. and Prout, A. (1980) What will I do...? Teenage girls and the construction of motherhood. *Sociological Review*, **28**, 517-535.
Price, J. (1988) *Motherhood: What It Does to Your Mind.* London: Pandora.
Quadagno, D., Dixon, L., Denney, N. and Buck, H. (1986) Postpartum moods in men and women. *American Journal of Obstetrics and Gynaecology*, **154**, 1018-1023.
Reinharz, S. (1992) *Feminist Methods in Social Research.* Oxford: Oxford University Press.
Renzetti, C. M. and Lee, R. M. (1993) (eds) *Researching Sensitive Topics.* Newbury Park: Sage.
Ribbens, J. (1989) Interviewing women - an unnatural situation? *Women's Studies International Forum*, **12**, 579-592.

Ribbens, J. (1990) *Accounting for Our Children: Differing Perspectives on 'Family Life' in Middle Income Households*. Unpublished Doctoral Thesis. South Bank Polytechnic.
Ribbens, J. (1993) Standing by the school gate - the boundaries of maternal authority? pp. 59-90. In: M. David, R. Edwards, M. Hughes and J. Ribbens (eds) *Mothers and Education: Inside Out? Exploring Family-Education Policy and Experience*. London: Macmillan.
Ribbens, J. (in press) *Mothers and Their Children: Towards a Feminist Perspective on Childrearing*. London: Sage.
Rich, A. (1986) *Of Woman Born: Motherhood as Experience and Institution*. London: Virago. (First Published in 1977)
Richardson, D. (1993) *Women, Motherhood and Childrearing*. London: Macmillan.
Richman, N. (1974) The effects of housing on preschool children and their mothers. *Developmental Medicine and Child Neurology*, **16**, 53-58.
Richman, N. (1976) Depression in mothers of preschool children. *Journal of Child Psychology and Psychiatry*, **17**, 75-78.
Riley, D. (1983) *War in the Nursery: Theories of the Child and Mother*. London: Virago.
Riley, D. and Eckenrode, J. (1986) Social ties: subgroup differences in costs and benefits *Journal of Personality and Social Psychology*, **51**, 770-778.
Roberts, H. (1981) (ed.) *Doing Feminist Research*. London: Routledge and Kegan Paul.
Rogers, A. (1993) Voice, play, and a practice of ordinary courage in girls' and women's lives. *Harvard Educational Review*, **63**, 265-295.
Rogers, A., Pilgrim, D. and Lacey, R. (1993) *Experiencing Psychiatry: Users' Views of Services*. Basingstoke: Macmillan.
Romito, P. (1988) Mothers' experience of breastfeeding. *Journal of Reproductive and Infant Psychology*, **6**, 89-99.
Romito, P. (1989) Unhappiness after childbirth. pp.1433-1446. In: I. Chalmers, M. Enkin and M. Keirse (eds) *Effective Care in Pregnancy and Childbirth. Volume 2*. Oxford: Oxford University Press.
Romito, P. (1990a) Postpartum depression and the experience of motherhood. *Acta Obstetrica Et Gynecologica Scandinavica*, **69**, 1-37.
Romito, P. (1990b) *La Naissance du Premier Enfant: Étude Psycho-Sociale de L'Expérience de la Maternité et de la Dépression Post-Partum*. Lausanne: Delachaux and Niestle.
Rowe, D. (1983) *Depression: The Way Out of Your Prison*. London: Routledge.
Rutter, M. (1981) *Maternal Deprivation Reassessed*. Harmondsworth: Penguin Books.
Saks, B. R., Frank, J. B., Lowe, T. L., Berman, W., Naftolin, F. and Cohen, D. J. (1985) Depressed mood during pregnancy and the puerperium: clinical recognition and implications for clinical practice. *American Journal of Psychiatry*, **142**, 728-731.
Sandler, M. (1978) (ed.) *Mental Illness in Pregnancy and the Puerperium*. Oxford: Oxford University Press.
Sapsted, A. M. (1990) *Banish Post-Baby Blues*. Wellingborough: Thorsons Publishing Group.
Savage, W. (1986) *A Savage Enquiry: Who Controls Childbirth?* London: Virago.
Scheff, T. J. (1966) *Being Mentally Ill*. Chicago: Aldine.
Schutz, A. (1972) *The Phenomenology of the Social World*. London: Heinemann Educational Books.
Seel, R. M. (1986) Birth Rite. *Health Visitor*, **59**, 182-184.
Segal, L. (1987) *Is the Future Female: Troubled Thoughts on Contemporary Feminism*. London: Virago.
Seligman, M. E. P. (1975) *Helplessness*. San Francisco: W. H. Freeman.
Shereshefsky, P. M. and Yarrow, L. J. (1973) *Psychological Aspects of First Pregnancy and Early Postnatal Adaptation*. New York: Raven Press.
Shotter, J. (1984) *Social Accountability and Selfhood*. Oxford: Blackwell
Shotter, J. (1993) *Cultural Politics and Everyday Life*. Buckingham: Open University Press.

Showalter, E. (1987) *The Female Malady: Women, Madness and English Culture, 1830-1980*. London: Virago. (First Published in 1985)
Singer, K. (1975) Depressive disorders from a transcultural perspective. *Social Science and Medicine*, **9**, 289-301.
Sluckin, W., Herbert, M. and Sluckin, A. (1983) *Maternal Bonding*. Oxford: Blackwell.
Small, R., Astbury, J., Brown, S. and Lumley, J. (forthcoming) Depression after childbirth: does social context matter? Department of Public Health and Community Medicine, University of Melbourne.
Smith, D. E. (1975) Women and psychiatry. pp. 1-19. In: D. E. Smith and S. David (eds) *Women Look at Psychiatry*. Vancouver: Press Gang Publishers.
Smith, D. E. (1987) *The Everyday World as Problematic: A Feminist Sociology*. Boston: Northeastern University Press.
Smith, J. (1992) Pregnancy and the transition to motherhood. pp. 175-199. In: P. Nicolson and J. Ussher (eds) *The Psychology of Women's Health and Health Care*. London: Macmillan.
Smith, R., Cubis, J., Brinsmead, M., Lewis, T., Singh, B., Owens, P., Chan, E-C, Hall, C., Adler, R., Lovelock, M., Hurt, D., Rowley, M. and Nolan, M. (1990) Mood changes, obstetric experience and alterations in plasma cortisol, beta-endorphins and corticotrophin releasing hormone during pregnancy and the puerperium. *Journal of Psychosomatic Research*, **34**, 53-69.
Squire, C. (1989) *Significant Differences - Feminism in Psychology*. London: Routledge.
Stacey, M. (1981) The division of labour revisited or overcoming the two Adams. pp. 172-190. In: P. Abrams, R. Deem, J. Finch and P. Rock (eds) *Practice and Progress: British Sociology 1950-1980*. London: Allen and Unwin.
Stanley, L. and Wise, S. (1993) *Breaking Out Again: Feminist Consciousness and Feminist Research*. London: Routledge and Kegan Paul.
Stein, G. (1982) The maternity blues. pp. 119-154. In: I. F. Brockington and R. Kumar (eds) *Motherhood and Mental Illness*. London: Academic Press.
Stein, G., Milton, F., Bebbington, P., Wood, K. and Coppen, A. (1976) Relationship between mood and free and total plasma tryptophan in postpartum women. *British Medical Journal*, **2**, 457.
Steiner-Adair, C. (1990) The body politic. pp. 162-182. In: C. Gilligan, N. P. Lyons and T. J. Hanmer (eds) *Making Connections: The Relational Worlds of Adolescent Girls at Emma Willard School*. Cambridge, Mass.: Harvard University Press.
Stemp, P. S., Turner, R. J. and Noh, S. (1986) Psychological distress in the postpartum period: the significance of social support. *Journal of Marriage and the Family*, **48**, 271-277.
Stern, D. (1977) *The First Relationship: Mother and Infant*. Cambridge, Mass.: Harvard University Press.
Stern, G. and Kruckman, L. (1983) Multidisciplinary perspectives on postpartum depression: an anthropological critique. *Social Science and Medicine,* **17**, 1027-1041.
Stiver, I. (1990) Dysfunctional families and wounded relationships: Part I. *Work in Progress, No. 41*. Wellesley, Mass.: Stone Centre Working Paper Series. (Cited in Jordan, 1992)
Stiver, I. P. and Miller, J. B. (1988) From depression to sadness in women's psychotherapy. *Work in Progress, No. 36*. Wellesley, Mass.: Stone Centre Working Paper Series.
Surrey, J. L. (1985) The "self-in-relation": a theory of women's development. *Work in Progress, No. 13*. Wellesley, Mass.: Stone Centre Working Paper Series.
Surrey, J. L. (1987) Relationship and empowerment. *Work in Progress, No. 30*. Wellesley, Mass.: Stone Centre Working Paper Series.
Susman, V. L. and Katz, J. L. (1988) Weaning and depression: another postpartum complication. *American Journal of Psychiatry,* **145**, 498-501.
Swyer, I. (1979) *Post-natal Depression*. London: Women's Health Concern Ltd.
Szasz, T. S. (1972) *The Myth of Mental Illness*. Paladin: St Albans. (First Published in 1962)

Teasdale, J. D. (1983) Negative thinking in depression: cause, effect, or reciprocal relationship? *Advances in Behaviour Research and Therapy*, **5**, 3-25.
Thoits, P. A. (1982) Conceptual, methodological, and theoretical problems in studying social support as a buffer against life stress. *Journal of Health and Social Behaviour*, **23**, 145-159.
Tizard, B. (1991) Employed mothers and the care of young children. pp. 178-194. In: A. Phoenix, A. Woollett and E. Lloyd (eds) *Motherhood: Meanings, Practices and Ideologies*. London: Sage.
Tod, E. D. M. (1964) Puerperal depression: a prospective epidemiological study. *The Lancet*, **2**, 1264-1266.
Tong, R. (1989) *Feminist Thought: A Comprehensive Introduction*. London: Unwin Hyman.
Trevarthen, C. (1977) Descriptive analyses of infant communicative behaviour. In: H. R. Schaffer (ed.) *Studies in Mother-Infant Interaction*. New York: Academic Press.
Uddenberg, N. (1974) Reproductive adaptation in mother and daughter: a study of personality development and adaptation to motherhood. *Acta Psychiatrica Scandinavica*, **254**, 1-115.
Upreti, N. S. (1979) *A Study of the Family Support System: Child Bearing and Child Rearing Rituals in Kathmandu, Nepal*. Unpublished Doctoral Thesis. University of Wisconsin, Madison, WI. (Cited in Stern and Kruckman, 1983)
Urwin, C. (1985) Constructing motherhood: the persuasion of normal development. pp. 164-202. In: C. Steedman, C. Urwin, and V. Walkerdine (eds) *Language, Gender and Childhood*. London: Routledge and Kegan Paul.
Ussher, J. M. (1989) *The Psychology of the Female Body*. London: Routledge.
Ussher, J. M. (1991) *Women's Madness: Misogyny or Mental Illness?* Hemel Hempstead: Harvester Wheatsheaf.
van der Eycken, W. (1990) *Home-Start: A four-year evaluation*. Leicester: Home-Start Consultancy.
Vines, G. (1993) *Raging Hormones: Do They Rule Our Lives?* London: Virago.
Walker, R. (1985) An introduction to applied qualitative research. pp. 3-26. In: R. Walker (ed.) *Applied Qualitative Research*. Aldershot: Gower.
Wandersman, L., Wandersman, A. and Kahn, S. (1980) Social support in the transition to parenthood. *Journal of Community Psychology*, **8**, 332-342.
Watson, E. and Evans, S. J. W. (1986) An example of cross-cultural measurement of psychosocial symptoms in post-partum mothers. *Social Science and Medicine*, **23**, 869-874.
Watson, J. P., Elliott, S. A., Rugg, A. J. and Brough, D. I. (1984) Psychiatric disorder in pregnancy and the first postnatal year. *British Journal of Psychiatry*, **144**, 453-462.
Wearing, B. (1984) *The Ideology of Motherhood: A Study of Sydney Suburban Mothers*. Sydney: Allen and Unwin.
Welburn, V. (1980) *Postnatal Depression*. London: Fontana.
Westwood, S. (1984) *All Day Every Day: Factory and Family in the Making of Women's Lives*. London: Pluto Press.
Whiffen, V. E. (1988) Vulnerability to postpartum depression: a prospective multivariate study. *Journal of Abnormal Psychology*, **97**, 467-474.
Whiffen, V. E. and Gottlib, I. H. (1989) Infants of postpartum depressed mothers: temperament and cognitive status. *Journal of Abnormal Psychology*, **98**, 274-279.
Wilkinson, S. (1986) (ed.) *Feminist Social Psychology: Developing Theory and Practice*. Milton Keynes: Open University Press.
Willard, A. (1988) Cultural scripts of mothering. pp. 225-243. In: C. Gilligan, J. V. Ward and J. McLean Taylor (eds) *Mapping the Moral Domain: A Contribution of Women's Thinking to Psychological Theory and Education*. Cambridge, Mass.: Harvard University Press.
Wolkind, S. and Zajicek, E. (1981) *Pregnancy: A Psychological and Social Study*. London: Academic Press.

Wrate, R. M., Rooney, A. C., Thomas, P. F. and Cox, J. L. (1985) Postnatal depression and child development: a three-year follow-up study. *British Journal of Psychiatry,* **146**, 622-627.

Yalom, I. D., Lunde, D. T., Moos, R. H. and Hamburg, D. A. (1968) "Postpartum Blues" syndrome: a description and related variables. *Archives of General Psychiatry,* **18**, 16-27.

York, R. (1990) Pattern of postpartum blues. *Journal of Reproductive and Infant Psychology*, **8**, 67-73.

Zajicek, E. and Wolkind, S. (1978) Emotional difficulties in married women during and after the first pregnancy. *British Journal of Medical Psychology*, **51**, 379-385.

Zola, I. K. (1972) Medicine as an institution of social control: the medicalizing of society. *Sociological Review*, **20**, 487-504.