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From Primary care to mental health services: The experiences of women who are referred to mental health services for postnatal depression.

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ABSTRACT

BACKGROUND

Over the past few decades, attempts have been made to classify postnatal depression, identify its causes and prevent its occurrence. Research that has asked women themselves about their experiences is limited, but is of considerable value, as it offers new perspectives and understandings about the experience of postnatal depression. To date there have been no detailed accounts written about women referred to mental health services for postnatal depression. In the light of the National Service Framework, initiatives including service users in evaluating and developing services are both timely and informative.

AIM

This study aimed to explore women's understanding of postnatal depression. Specifically, how referrals into mental health services, and other processes, impacted on such conceptions, women's self-images and feelings of control.

METHOD

Seven women were interviewed who had been referred to mental health services via their General Practitioner or health visitor for postnatal depression. Interviews were taped, transcribed and analysed using thematic content analysis and drawing on a phenomenological approach.

RESULTS

Four women in the study found the label of postnatal depression useful in providing an explanation for their distress. Feelings of stigma were experienced but were minimised, as relief about getting help was more important. These women engaged in a process of externalising postnatal depression as "an illness", enabling them to move towards positions of empowerment and acceptance. Professional interactions appeared to shape and influence women's prior conceptions of postnatal depression; helpful and unhelpful aspects of the process were identified. The other three women in the study were unable to reach a position of empowerment, appearing to be stuck in the referral process. Key factors for these women appeared to be individual beliefs

and attributional style associated with self-blame, the experience of a range of interactions that were sometimes harmful and confusing, and awaiting a response from the services.

CONCLUSION

This study has enabled access to women's experiences and views of mental health services. Helpful and unhelpful aspects of the referral process with implications for further research and clinical practice were identified. Furthermore, the widely held belief that medicalising and labelling women's distress can only be disempowering, is challenged; women adopted this as a helpful coping strategy. More research is needed to expand on these findings.

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CHAPTER 1: INTRODUCTION

Part One: What Is Postnatal Depression? - An ongoing debate

Distress in the postpartum period has attracted a great deal of research interest over the last three decades. This has largely been due to the wide range of consequences it can have for the woman herself, children and family functioning in general. It also became apparent that postnatal care was falling short of effectively meeting women's needs during this period and further understanding of its aetiology, manifestation and treatment was required in order to develop appropriate services (Riley 1995, Whitton, Appleby and Warner, 1996).

Traditionally literature has evolved to classify postnatal distress into three separate categories based on the onset of a woman's symptoms and the severity of her experiences. These categories are maternity blues (also known as baby blues), postnatal depression and puerperal psychosis. Maternity blues has been identified as a common experience following childbirth. Pritchard and Harris (1996) described symptoms such as labile mood, irritability, anxiety, hyperchondriasis and sleeplessness in the first ten days following delivery.

Puerperal psychosis lies at the other end of the spectrum and is classified by extreme symptoms such as delusions, hallucinations and disturbed sleep. This condition is thought to be rare, severe and more often than not requiring hospitalisation (Pritchard and Harris 1996).

Studies attempting to identify causal factors for puerperal psychosis have suggested that hormonal changes are responsible for this severe reaction (Stein 1982). Previous personal history of bipolar illness and a similar family history have been speculated as important contributors to an inherent vulnerability to psychotic disturbance following the stress of childbirth (Kendall, Chalmers and Platz, 1987).

The third category to emerge is postnatal depression. This is generally defined for clinical and practical purposes as, *"...a non-psychotic depressive episode that begins in or extends into the postpartum period*" (Murray and Cooper, 1997, p.5).

It has been suggested that symptom patterns associated with postnatal depression are shared with depression experienced at other times not characterised by the puerperam. However some studies have argued that there are distinguishable features to depression following childbirth. For example, one study found the only difference in symptoms of postpartum and non-postpartum depression was the degree of severity of symptoms experienced in the latter (Whiffen and Gotlib 1993, Whiffen 1991). However Riley (1995) identified more specific features, such as diurnal variation observed in the mornings and evenings in non-postpartum depression is reversed in women experiencing depression after childbirth. Explanations offered for this are that women feel exhausted by the evening, which therefore causes a peak in low mood.

Establishing a meaningful definition of postpartum depression has generated numerous debates amongst researchers, as its characteristics are not as distinct as the blues or puerperal psychosis. Although in a recent review researchers have argued that demarcation among all three "disorders" is problematic (Boath and Henshaw 2001). Indeed it is suggested that one should view the postpartum disorders as a continuous spectrum, as some women may experience extreme distress but may not be classified as officially "depressed".

Clarity with definition and symptom profile of postnatal depression is often hindered by research that is inconsistent and conflictual. Particularly with respect to conceptualisations, definitions and the theoretical standpoint from which research into postnatal depression is approached (Whiffen 1992, O'Hara 1994, Cox, Murray and Chapman, 1993, Green 1998, Kumar and Robson 1984).

The validity and clinical usefulness of the term postnatal depression has also been challenged. For instance Green (1998) states that, *"the label postnatal depression is one which will quickly be applied to any unhappy woman who has recently had a baby"*(Green, 1998, p.143).

To rule out the use of such labels would remove the comfort that can be gained from knowing that one is not alone and this can be a validating experience (Cox 1994, Mauthner, 1998a). However, unquestioning acceptance of the label may lead to misguided understanding that informs treatment and prevention of women's distress.

Postnatal research has been criticised for being misled at the outset by the assumptions of the term "postnatal", as studies that have recruited participants in the postpartum fail to identify earlier antenatal unhappiness. A number of studies are quoted that have focussed on antenatal wellbeing. They have consistently found rates of unhappiness and depression to be as high in the antenatal period as in the postpartum (Green and Murray 1994). In other studies mood was found to significantly improve from pregnancy to the second stages of the puerperum (Anderson, Flemming and Steiner 1994). Therefore, suggesting an earlier onset of low mood than the suggested three months following childbirth.

Traditional classification systems such as ICD-10 have not added clarity to the debate. ICD-10 only recently assigned a separate category to the postpartum disorders. However, this category could only be used if criteria for other psychiatric disorders are not fulfilled. The American classification system of DSM-4 has classified postnatal depression as a major depressive disorder and in a somewhat ad hoc way, has added "with post partum onset" to separate postnatal depression from other depressive episodes.

Clearly the debate goes on surrounding the very concept of postnatal depression. It is therefore not surprising that studies attempting to find aetiology of a loosely defined and understood term are struggling to yield consistent findings.

1.1 *Research into risk factors linked to postnatal depression*

Research into aetiology reflects a similar diverse and inconclusive position. If one is to look for causes of a labelled disorder, then there has to be an acceptance of an objectified entity with specific causes, symptoms and subsequent treatment options (Cooper and Murray 1995).

Taking this standpoint has proved problematic, as many aspects of postnatal depression share similarities with other depressive disorders and indeed those classified as anxiety disorders (O'Hara, 1994). Nevertheless there have been those researchers who have contributed to this area of research and the factors identified in many studies looking at risk factors can be divided into biological/ hormonal, personal/ psychological, previous psychological problems, stressful life events, socio-economic, relationships, social support, birth/obstetric factors and antenatal well-being.

1.2 *Medical and Biological Research*

This research has been confined to the change in hormone levels following childbirth, such as progesterone and oestrogen and thyroid dysfunction (Harris et al, 1989; Harris et al, 1996; O'Hara, Schlecte, Lewis and Varner 1991; Wiek 1996; Dalton 1985). However these studies are inconsistent in their results, as Harris et al (1996) found lowered levels of progesterone in depressed breast- feeding women than in non-depressed breast-feeding women, whereas O'Hara et al (1991) found no such differences. Thyroid dysfunction has also been suggested as an associated factor in a small proportion of women (Harris et al 1996).

What remains problematic is that not all women go on to be depressed after childbirth, nor is there a definitive difference between hormone levels of depressed and non depressed women. Therefore drawing aetiological conclusions from this evidence remains inconclusive and somewhat unreliable. It also takes a somewhat reductionist and polarised approach to understanding postnatal depression.

1.3 *Socio-environmental and Psychological Studies*

What is not considered is the socio- environmental and psychological context within which hormone levels are changing which may have a direct impact on the experience of distress (Thorpe and Elliott 1998). A study by Brown and Harris (1978) was one of the first to specifically look at life events and social adversity as factors influencing depression in women. They found that in non-childbearing women, negative life events such as death in the family, illness, loss of financial support and moving house all contributed to depression. It is perhaps logical then, given the similarities between depression and postnatal depression to expect negative life events to impact upon women's mood following childbirth. Research carried out supports this and has found connections between poor emotional well- being and negative life events (Thorpe, Dragonas and Golding 1992, Riley 1995). However, reflecting other consistencies no such links were found by Kumar and Robson (1984).

Research from a similar field into factors affecting women in the puerperal period has focused on social class differences as a risk factor for postnatal depression (Thorpe, Dragonas and Golding 1992, Green 1990, O'Hara and Zekoski 1988). The latter authors carried out a review looking at studies that suggest a specific association between social status and postnatal depression and only two were found, whereas Green (1990) found no association between social class and depressive symptoms. Indeed there appears to be significant classification problems when studying social status, and an academic debate about whether social status is as important as social circumstances, living conditions, unemployment and poor social support.

The influence of relationships that a woman has particularly with her partner has been put forward as a significant factor contributing to postnatal distress (Whiffen 1988, Kumar and Robson 1984; O Hara 1986, 1994; Small 1994; Boyce, Hickie and Parker, 1991; Murray, Cox, Chapman and Jones 1995; Woollett and Parr, 1997). Despite various different methodologies and measures used in these studies their findings are somewhat consistent. However the nature of the relationship between partner support and postnatal depression is not always clear and authors have suggested that it is a complex one.

For example Mauthner (1998b) in her study aimed at re-assessing the importance of the marital relationship, interviewed eighteen women who had experienced postnatal depression. In this study women made references to needing to talk to other mothers, and that these confiding relationships were as important as the marital one. Mauthner expressed some scepticism about how often in previous studies the marital relationship is considered to be the most important confiding relationship, when clearly her study does not support this. One could question how far such studies have been biased at the outset by the acceptance of the social construction of western marriages, and that a more reflexive researcher position may have been warranted.

Traditional research has often stated that marital relationships are reported as "poor" based on an objective measure of what that would mean, for example, participation in household chores and care for the baby. However, Mauthner (1998b) has found that there are more complex reasons as to why partners may not have taken part other than their unwillingness to do so. In particular she remarks upon some women wanting to do household chores as they saw it as their job, equivalent to their partner's employment. Others claimed that their partners would have been involved if it weren't for external factors that limited their involvement. Furthermore, research stating that women were unable to confide in their partners assumes that this is for reasons located within the partner. In fact Mauthner found, that women withdrew from their partners who were offering support as they felt that they did not wish to burden them or that they would not understand. Whilst Mauthner does not claim to be able to generalise her results to a larger population, it highlights the richer information that can be gained from asking women themselves about their experiences in more depth.

Social support and family relationships have also been researched in an endeavour to predict postnatal depression on the basis of their absence or dysfunction. Mauthner's (1998b) study has highlighted the significance of confiding relationships elsewhere other than the spouse to mediate against postnatal distress. Research into social support, supports this view (Riley 1995; Thorpe, Dragonas and Golding 1992; Kumar et al 1984; Small 1994).

There are also studies that have found some forms of social and family support to have a negative rather than supportive impact for women, particularly the latter. This has perhaps received more attention where women's relationships specifically with their own mother, is somewhat strained or intrusive. For example a study of British and Greek couples found that contact with the family could be a source of stress (Thorpe, Dragonas and Golding 1992), especially if a woman's mother is emotionally distant or overly critical (Riley 1995).

The former authors explored women's thinking, perceptions of their symptoms and how this can affect their decision to seek help and accept treatment. A common theme that emerged was women's reluctance to seek help as this indicated a failure to cope. It is surprising that there has not been more research carried out looking at the cognitive styles of women as this clearly has significant implications for treatment strategies adopted.

The contribution of previous psychiatric history is another area that has received a lot of attention and is perhaps to date seen as one of the most predictable risk factors for postnatal depression. Several studies have consistently reported on an association between previous psychiatric disturbance and postnatal depression (e.g. O'Hara 1994), although Kumar and Robson (1984) and Murray, Cox, Chapman and Jones (1995) did not find such a link. Previous postnatal depression with other children has also been commented on, with one study finding increased postnatal depression scores with women who had previous postnatal depression (Murray, Cox and Chapman 1995; Leverton and Elliot 1989). It has been suggested that this may in part be due to residual postnatal depression that has not been resolved and an additional birth has triggered a further episode (Riley 1995).

Studies focussing on emotional well being in the antenatal period are somewhat limited, but perhaps this is an increasing area of interest due to recent media reports. Studies that have looked at the relationship between antenatal and postnatal depression have yielded interesting findings. For example one study looked at the risk factors associated with depression in the early phase of pregnancy found that many factors that were significant for depression at other times were significant in antenatal depression (Kitamura, Sugawara, Toda and Shima 1996). Therefore it has been argued that depression in the postpartum should be viewed as one of those other times, a notion that has been supported by studies that seek to place postnatal depression on a continuum rather than defining it separately (Green 1998, Green and Murray 1994, Whiffen 1991).

1.4 *Obstetric Factors*

The actual physiological experience of being pregnant and giving birth, previous fertility problems, unplanned pregnancies and previous terminations can be broadly categorised as obstetric factors, and they too have been studied to explore their role in contributing to postnatal depression (O'Hara 1994, Kumar et al 1984, Riley 1995). However, there is a lack of consensus amongst researchers and many studies are contradictory. For example, some studies have investigated obstetric factors as risk factors for developing postnatal depression and have postulated a relationship between type and stress involved in delivery and postpartum mood disorders. For example forceps delivery and caesarean section in the presence of previous depressive episodes have been linked to depression in the postpartum (Murray and Cartright 1993; O'Hara, Schlecte, Lewis and Varner 1991).

Green (1990) found that the mode of delivery was important to emotional well being, specifically if the woman deemed additional intervention to be necessary and if she had contributed to the decision making process regarding it. However, other studies have found no such link (Warner, Appleby, Whitton and Faragher 1996; Cox 1982).

1.5 *Childcare Burden*

Some studies have looked at the number of children and the spacing between children as a risk factor for postnatal depression. For example Thorpe, Greenwood and Goodenough (1995) concluded that mothers of twins and closely spaced children were more a risk of depression than mothers whose children were more widely spaced. Indeed, the demands of smaller children particularly under the age of five are great and it is not surprising that this has been suggested as a factor contributing to postnatal depression. However it is unlikely that a direct causal link can be made between the number of children and development of postnatal depression, as the degree of support, financial circumstances and behaviour of the children is likely to impact on emotional well- being.

1.6 *Consequences of postnatal depression for mother and child*

The debate about postnatal depression as a concept and the inconsistencies in the search for aetiological clarity has dominated the literature over many years. Whilst those debates continue, there is no doubt that some women experience extremely distressing mood changes following the birth of a child, at a time which is often described by society as fulfilling, rewarding and wonderful. This next section considers some of the consequences that have been researched for the woman who develops depression, and the developing child.

For many women the symptoms associated with postnatal depression impact upon their ability to enjoy the early months and in some cases years of their child's life and development. It has also been suggested that for many women, if left untreated postnatal depression can be the start of a chronically relapsing illness that re-emerges with subsequent pregnancies and extends to years after the original episode (Kumar and Robson 1984).

One research study focussed on the impact of postnatal depression on the family (Boath, Pryce and Cox 1998). They found that partners were experiencing psychiatric symptoms themselves and were particularly concerned about changes in their partner, the effect on the children and generally feeling helpless and unsupported.

Further research has looked at mother-child interaction, the effects on children and their development. For example one study looked at the role of infant and maternal factors in the development of behavioural problems in children at eighteen months within the context of postnatal depression. Infants who were described as irritable neonates were assessed at eighteen months and no association was found between irritability and behavioural disturbance. However a significant relationship was found between the occurrence of postnatal depression and behavioural problems (Murray and Cooper 1997).

Studies looking at cognitive functioning (Cogill, Caplan, Alexandra, Robson and Kumar, 1986 and Sharp, Hay, Pawlby, Schmucher, Allen and Kumar, 1995) have found that children of depressed mothers were more constrained on intellectual tasks than children of non-depressed mothers. Furthermore, boys also appeared to struggle more than girls, suggesting that gender acts as a protective factor for girls whose mothers were depressed.

However the relationships between cognitive problems in children and postnatal depression is not as simplistic as the findings suggest, as the authors acknowledge the role of child vulnerability to such difficulties and the development of depression in the mother. A study by Edhborg, Lundh, Seimyr and Widstrom (2001) looked at maternal-infant interaction and attachments in children of high EPDS scorers and they found that children showed less joy in play and reunions with their mothers than children of low EPDS scorers. This research is supported by earlier research that reported insecure attachment patterns in children of depressed mothers (e.g. Murray 1992).

A great deal has been written about the consequences of postnatal depression for the woman, her partner and children and the above merely highlights some examples of such studies. What has become clear is that there are potential consequences, which makes the development of effective treatment strategies a worthwhile and necessary venture to prevent long term negative effects on mother and child.

1.7 *Treatment approaches to postnatal depression*

The literature on effective treatment strategies for postnatal depression is surprisingly limited in comparison to the work carried out on aetiological risk factors. However perhaps this has been hampered by a need to classify and define in line with the psychiatric and medical models of research for causes, symptoms and an inevitable treatment based on its aetiology.

Research studies into this area are ever increasing, and there has recently been a comprehensive literature review written about research into treatment for postnatal depression (Boath and Henshaw 2001). Thirty articles were reviewed and the authors remark on how the controversy surrounding the causes for postnatal depression is reflected in the range of treatment approaches studied. The types of treatment approaches are divided up into pharmacological, psychological, combined approaches of pharmacological and psychological, social support, relaxation and hormonal approaches.

1.8 *Pharmacological approaches*

Overall it was concluded that the use of anti-depressants to treat postnatal depression is somewhat problematic due to the secretion of the drug into breast milk, which perhaps explains the reluctance of GP's to prescribe such medication. Other studies have reported on the reluctance of many women to take antidepressants for reasons such as fear of addiction (Whitton et al 1996). Pharmacological treatments appear to be inadequately researched and therefore other strategies have been adopted to address this issue.

1.9 *Psychological approaches*

Several studies have utilised health visitors as vehicles for offering Rogerian, cognitive behavioural and problem solving counselling to women with high EPDS scores, perhaps because they are ideally placed in primary care to access mothers without the stigma associated with mental health services (Holden 1989; Gerrard, Holden, Elliott, McKenzie and Cox 1993; Elliot 1989; Poustie & Drumm 1997; Seeley, Murray and Cooper; 1996; Whitton et al 1996; Cooper and Murray, 1997). The latter study utilised trained therapists as well as health visitors and compared the impact of three different types of therapy, namely cognitive behavioural therapy, brief mother and baby psychotherapy and non-directive counselling.

All studies found significant improvements in the problems reported by women and the reduction of depressive symptoms compared to women who had received no treatment at all. This is a positive finding and certainly supports the efficacy of such treatments for women in the post-partum experiencing distress.

1.10 *Group treatments*

Women themselves have remarked on how talking to other women who have a similar problem has been helpful (Mauthner, 1998b). Many group treatments have been set up in order to normalise women's experiences and fulfil this identified need. A pilot study carried out by Meager and Milgrom (1996) evaluated a cognitive behavioural group programme for ten women, compared to a waiting list control group. They found a significant improvement in mood after the group programme was completed and although self- report tools measured the improvement and the study was a pilot study, the result was promising as this strategy could be offered in most community health teams (Boath and Henshaw 2001).

1.11 *Other approaches*

Other approaches such as self help groups, social support, massage therapy and relaxation have been less robustly researched. Some studies report that women found massage therapy more beneficial than relaxation (Field 1997). Furthermore, in some social support groups, whilst 90% of women reported that it was beneficial, they appeared to show less improvement in negative self image than a no intervention group (Flemming, Klein and Corter 1992). Therefore, it would seem that therapeutic interventions grounded within a sound theoretical model are clinically more effective than less theoretically sound approaches.

Previous research has already indicated that for some women postnatal depression is not postnatal but rather a re-emergence of depression experienced previously. Furthermore, it has been suggested that some women are more vulnerable than others and indeed experience depression in the antenatal period as well as in the post-partum. Given the nature of the consequences for mother and child, research has looked at the preventability of distress in the post-partum.

1.12 *Prevention of postnatal depression*

Several researchers have viewed the prevention of postnatal depression as a somewhat logical and expected venture, given that women are in contact with a variety of health professionals throughout the antenatal phase and immediately after birth (Thorpe and Elliott, 1998; Sharp, 1996). Prevention is also thought to be possible due to the presence of identifiable risk factors either before pregnancy or during pregnancy, which are clearly there for some women though not all of them. There have been several strategies proposed focussing on hormonal therapy (Dalton 1980), but more convincingly and more recently psychosocial and psycho-educational approaches promoting continuity of care and social support in the form of group and individual approaches.

Elliott, Sanjack and Leverton (1988) carried out a controlled trial of a group intervention aimed at reducing the prevalence of postnatal depression. The group aimed to provide social support and continuity of care with an additional educational component to inform women of possible negative emotions following birth to challenge romantic media images of idealised parenthood. The study yielded successful results in preventing postnatal depression particularly in first time mothers. The authors propose that health visitors and primary care services would do well to co-ordinate effective preventative strategies equally weighted with strategies for early detection and intervention. The findings of this study have been supported and utilised in further research looking at psychosocial interventions and in further training programmes for health visitors in prevention, detection and early intervention of postnatal depression (Holden 1996, Painter 1995, Gerrard et al, 1993; Elliott et al 2000b).

Early detection has been put forward as an essential strategy that primary care professionals such as health visitors are ideally placed to engage in. Screening tools have been developed to facilitate this process and one of the most widely used tools is the Edinburgh Postnatal Depression Scale developed and validated by Cox, Holden and Sagovsky (1987). It has been suggested that using this tool within primary care can aid professional judgement rather than replace it and its sensitivity has been reported to be high as the rates of detection increased once it was being used (Cox and Holden 1994).

The widespread use of the tool both within the field of research and clinical practice is encouraging and has contributed to improved detection and appropriate referrals to more specialist services for postnatal depression. However, there have been some studies that have misused it as a diagnostic tool, a function that the authors did not propose in its validation. As a result the authors have published a book referring to uses and misuses of this scale (Cox and Holden 1994) and further myths have been dispelled by Elliott et al (2000a) in her paper titled: Is the EPDS a magic wand? Few researchers would argue against the use of the screening tool within clinical practice and alongside preventative strategies it has advanced the resources available for women in the postpartum period.

With the exception of Mauthner's studies (1998a, 1998b) the majority of the literature discussed so far has resided within a positivist paradigm dominated by quantitative methodological approaches that have yielded inconsistent findings.

The dominance of the medical model that seeks to classify postnatal depression within a disease framework is reflected in research into aetiological factors. Although some research undertaken by psychologists has not accepted or proposed the adoption of a disease framework one cannot ignore how the search appears to continue to look for the "thing" that causes postnatal depression. It is increasingly important that researchers challenge this popular research endeavour by asking different questions that are significant for women themselves to further understanding of postnatal depression. By moving away from the rat race of trying to objectify postnatal depression as an entity one can move towards a clearer understanding of what it means to women to be distressed in this period and what helps them during this time.

Listening to women's views has been widely neglected within this field; however there have been some studies that focus on women's voices and perspectives. These studies mainly exist within feminist literature and researchers who have positioned themselves alongside women to explore subjective meanings for women to make fruitful contributions to ongoing research into postnatal depression.

Part Two: Research into women's views and subjective experiences in the postpartum

2.1 *The position of feminism*

The previous section outlined dominant research paradigms and endeavours undertaken by clinical researchers. This research has been characterised by a widely held view that postnatal depression is an illness to be described and prevented or that there are a range of factors that impact on an individual that has an inherent vulnerability or predisposition to becoming depressed (Brown and Harris 1978, Boyce et al 1991). These research studies have often used standardised measures to rule out any bias of subjectivity as far as possible and self-report measures are acknowledged as being a somewhat unavoidable limitation (Mauthner 1998a).

Feminist writers have criticised such research as individualist and limited given that women themselves are rarely asked for their accounts on their experiences. Furthermore it has been suggested that the medical model pathologises women instead of considering the broader socio-political context within which women live their lives (Oakley 1980; Nicholson, 2001; Small et al 1994). In an attempt to rectify gaps in research literature and develop new perspectives that challenge postnatal depression as a social construction of motherhood, feminist scholars have sought to make women's voices visible. In doing so they argue that postnatal depression is a normal reaction to motherhood and that a label only perpetuates pathology and the social control of women. Feminist research has made an important contribution to the literature as they have challenged traditional quantitative methodological approaches and legitimised the richer in depth material that can be gained from qualitative research.

2.2 *Feminist research: The social construction of motherhood*

A study carried out by Lewis and Nicholson (1998) looked at how women construct their experience of motherhood within a medical discourse. They argue that medical discourses are made available to women to understand unhappiness following childbirth, whilst women themselves view depression as a "normal" reaction to the demands of motherhood. Their paper describes data drawn from two studies that were carried out looking at women's experience of depression in a) the transition to motherhood and b) the experience of being a mother. A total of thirty- six women were interviewed, 24 in study one and 12 in study two. The women were drawn from volunteer organisations and various other sources such as antenatal clinics and health centres. In depth interviews were carried out and data analysis drew on principles of grounded theory in that women's perspectives were the main emphasis and phenomenon to be studied. They found that women positioned themselves against clinical and medical discourses. The participants saw these discourses as inappropriate as their problems were part of their everyday lives. The authors do not suggest that women were not depressed but rather that their subjective experiences are meaningful in the context of depressing life circumstances i.e. challenges of motherhood. A further finding was that women struggled to talk openly to others about negative aspects of motherhood. The authors suggested that this struggle is representative of a gap in available discourses to capture this part of the experience of motherhood. If motherhood is defined as a happy and fulfilling venture then women who feel bereaved about the loss of self and autonomy, draw upon medical discourses to explain their experience. For example, if one is ill there is a moral acceptance and explanation as to why motherhood is not being enjoyed, thus alleviating feelings of deviance.

The authors call for a reconstruction of motherhood that incorporates positive and negative aspects of being a mother so that depression can be understood as a normal reaction to motherhood. In this study the authors talked about women loosing power as motherhood is encountered and the experience of grief as a result of this is understandable given the loss experienced. Furthermore, they argue that taking on a new identity can be complex and problematic for women when the available discourses centre on individual pathology of not coping.

Woollett and Parr (1997) supported these findings about how available discourses impact on how women define their experiences. They suggested that women and men evaluate their feelings against current social constructions of motherhood. Such discourses encourage women to see themselves as deviant and to look inwards for explanations of their distress, rather than outwards to the overwhelming demands of caring for a small baby and engaging in a major life transition. It is important to consider how women construct their experiences and to acknowledge the wider political and social influences that impact on this. However one must consider the usefulness for women of seeing depression as a normal reaction to motherhood and whether this is a useful concept for women themselves.

Indeed Mauthner (1998a) highlights that for some women maintaining the medical label was useful and also provided relief. It could be argued that the relief provided is women's attempt to distance themselves from a feeling of moral deviancy caused by constructions of motherhood (Lewis and Nicholson 1998). Nevertheless the purpose of such research is to explore women's experiences from their perspective and what they find useful should not be explained away and minimised within a feminist agenda.

2.3 *Research looking at women's voices about depression*

Feminist scholars have also asked the question about what women say and do about depression, what they find helpful in their recovery and what their views are on the subject. Small et al (1994) carried out an enlightening study that addressed these very questions. Their study looked at women's views about depression in the postpartum. They interviewed forty five women who had scored twelve on the EPDS at eight months postpartum in an earlier survey. They compared them with forty five women who had been randomly selected from the earlier survey who had scored less than nine on the EPDS. Their results showed that women did talk about having depression and only one woman had disagreed with this stating that she had been tired.

This study lies in contrast with the Lewis and Nicholson (1998) study that found women rejected the medicalised label of depression. It is possible that this difference may have been due to differences in the sample populations used in the study, for example no screening tool was used in the Lewis and Nicholson (1998) study and a smaller sample was used of women recruited from volunteer organisations and health clinics.

Small et al identified several factors that women felt contributed to their depression namely, fatigue, feeling unsupported or isolated. Approximately two thirds of the women in the case group had not sought any professional help concerning their depression. The most commonly reported reasons for this were that they thought it was best coped with alone, or it was only when they had begun to recover that they realised how bad they had been. Most had sought help from a general practitioner but only a small number of women had been referred to a mental health professional. Those women who had sought professional help were significantly more likely to assign their distress to hormonal causes, however it is not clear whether this belief prompted help seeking behaviour or whether women picked up this explanation from their interactions with professionals. Furthermore, the small percentage of women that had sought help from mental health professionals continued to be depressed at follow up and had reported a variety of unhelpful responses from these professionals and GPs, which has clear implications for the way women experience those who are primarily there to help them. Women advised other women to talk about their problems and all in all those women that had received "talking" interventions experienced them as helpful, suggesting that health professionals should utilise this finding in their practice. Those women who had not sought help and had acknowledged that they only realised how bad they had been when they were beginning to feel better is a concern for health professionals. Clement and Elliott (1999) have acknowledged this problem and suggest that screening and antenatal preventative strategies for all women in the postnatal period are best utilized to target this issue.

There have been further endeavours to explore subjective meanings of women's experiences of postnatal depression in an attempt to make women's voices visible. Mauthner (1998a) carried out a study aimed at exploring and prioritising women's accounts of postnatal depression and understanding the processes through which women became depressed. Mauthner conducted the study in order to address the limitations of existing medical and feminist research, she clearly puts forward the argument that:

"While mothers are ostensibly the focus of investigation, the methods and theories adopted have, in different ways, marginalized mother's perspectives and obscured critical aspects of their experiences. Second, women's agency and active role in their lives and in their depression, and differences between mothers, have yet to be adequately theorize" (1998a, p.331).

Her criticisms of certain feminist approaches have been centred on the amplification of certain voices that devalues motherhood in favour of equality in the public and social world. Mauthner argues that this approach fails to listen to how different women experience their depression and calls for a more reflexive approach of the researcher that enables their views to be made explicit so that individual women's voices can be heard. Other researchers and academics have supported this notion of "reflexivity" in qualitative research (Maynard 1994; Mason 1996; King 1996; Parker 1994).

Mauthner (1998a) interviewed forty mothers in her study, but focussed on eighteen women who identified themselves as having postnatal depression. Mauthner adopted a "voice centred relational method" to analyse the data. It is a method that views the individual as part of a complex set of relations with others and with the social world. The results of the study yielded interesting findings. Mauthner found that women used the label "postnatal depression", as it provided an explanation for their symptoms and that they were not to blame, or going mad.

Women also appeared to be engaged in conflicts about expectations of themselves and their contrasting experiences, expectations that they should be able to cope and they should be happy and clearly they weren't. These conflicts positioned women within a moral dilemma, as they felt unable to conform to ideals about being a "good mother". In their struggle to accept these feelings they silenced them and withdrew from others, which Mauthner argues led to feelings of depression. Recovery seemed to be governed by individual acceptance of feelings and who they were and acceptance of their positive strengths. In conclusion Mauthner argues that women are not merely passive recipients of a patriarchal world or their individual pathology, but rather they actively engage with a struggle within themselves and the cultural and social context in which they live. She suggests that it is important to create a social and cultural context whereby women can voice the range of feelings they experience so they can move towards a position of acceptance and recovery.

Mauthner's study along with others in this section has highlighted the need to listen to women and this type of research given its value is somewhat limited. There has been some discussion around the use of the label of postnatal depression and the value that women appeared to place on it or the rejecting of it (Lewis and Nicholson, 1998). The use of labels and particularly psychiatric labels has generated a great deal of debate amongst academics and anti-psychiatry scholars.

Some of this debate has fuelled the service users movements such as Mind and hearing voices networks. These movements have urged services to utilise users perspectives and think about the stigma that is attached to mental health services and those who use them. However, users perspective research is still limited and there is still a clear gap in the literature to date.

The next section discusses some of the literature related to psychiatric labels, stigma and the need for the users perspective in constructing services for them.

Part Three: Overview of literature on Psychiatric labels and service users perspectives

3.1 *The issue of psychiatric labels*

There has been an ongoing debate around the issue of diagnosis within psychiatry since the early writings of anti-psychiatrists such as Laing and Szasz in the 50's and 60's. Perhaps the label that has received the most attention is schizophrenia but the criticisms of other labels and the dominance of a medical approach to psychological problems has extended to other labels such as depression. The two writers published rather influential texts such as '*The divided self*', Laing (1959) and the '*Myth of mental illness*', Szazs (1961). Laing was one of the first critical psychiatrists to suggest that those people who were labelled as "Schizophrenic", were in fact engaged in a meaningful experience that was not just about a pathological condition and he criticised psychiatry for being cold and detached. Laing's writings were seen as rather radical in that he was one of the first psychiatrists to challenge the objectification of a person's distress.

Thomas Szasz further criticised the practice of psychiatry for being coercive and fostering a culture of dependence. He argued that the very process of diagnosis was invalid and that mental illness was merely a social construction. He validated his statements by concluding that, "*no organic cause can be identified for a person's communications about themselves and the world about them*" (cited in Coppock and Hopton, 2000, p.78).

Following on from these early theorists was the notion that mental illness was not an illness but rather a label attached to those individuals that fall outside acceptable boundaries of behaviour and communication. Labelling theory was driven by an appreciation of the negative consequences of the diagnostic process, namely being seen as incapable, an invalid, deviant and not being taken seriously. Indeed Lindow (1991) sums up the experience of receiving a label for many service users:

"Once you have been labelled as having a mental health problem, it is especially difficult to have your views, opinions and experiences taken seriously" (cited in Newnes, Holmes and Dunn 1999 p.37).

3.2 *Labelling women*

A group that has experienced the consequences of receiving a label are women. Historically women have been subjected to labels of madness disproportionately to their gender counterparts. Certain labels such as hysteria were commonly used to explain women's behaviour that stepped outside the boundaries of femininity. Later labels have been used to represent "disorders" related to reproduction and the menopause for women who react in ways that that do not conform to societal expectations of female behaviour and behaviour expected in motherhood. Ussher (1991) has theorised about inherent inequalities that render the female role devalued and she suggests that within a patriarchal society masculinity is seen as a privileged role and therefore any protest of such social control is viewed as "mad" in order to maintain the status quo and powerful position of men. If this is so it begs the question of why women themselves use the labels, are they as a result of a socialisation process whereby women are opting for a forced choice, either you are mad or sick therefore to be sick is far more desirable than mad or morally delinquent. This choice renders the medical model of psychiatry as a favourable and rescuing agent, yet the labels continue to carry stigma and harmful consequences placing women in a somewhat paradoxical position.

3.3 *Challenges for mental health services*

Labelling theory, anti-psychiatry and the development of the users movement has meant that over time psychiatrists have had to develop their focus and practice in order to justify their powerful position within the mental health services. For some this has meant a closer alliance with medicine and neuroscience, whereas for others it has led them to question the usefulness of solely adopting an organic basis for diagnosis and challenge their peers to adopt a more individual approach that incorporates biological, socio-political and environmental influences to mental distress. Coppock and Hopton (2000) suggest that this shift in some of the psychiatric profession, albeit superficial in some cases, opens the door to negotiation and more open communication with other mental health professionals and service users themselves. Whilst this does not address dominant ideologies that place psychiatry and the medical profession in a powerful and potentially controlling position it enables conversations with individuals about the meaning for them of their distress. Coppock and Hopton (2000) illustrate their proposals for an improved mental health service, to address such issues:

"A truly anti-oppressive, anti-discriminatory model of mental healthcare should have the following characteristics ….it should incorporate biological, psychological and social perspectives so that whatever the views of any service user there is a starting point for a dialogue between the service user and professional which has the potential to develop into a therapeutic alliance" (Coppock and Hopton, 2000, p.168).

These academics within critical psychiatry and previous studies in this chapter have called for a greater emphasis on the users perspective both within research, clinical practice and mental health services in general. If services are to offer effective assistance that is grounded in service users identified needs, then more research is required to explore their views. The next section gives an overview of the very limited research that has been carried out relevant to this study. Its scarcity reflects the lack of attention that it has been afforded and it is a gap that this study will help to fill.

3.4 *Research into users perspectives of mental health services*

The National Service Framework, '*Modern standards and service models for mental health*' (1999) has highlighted the need to include users perspectives in the development of mental health services to promote opportunities for choice and to influence the research and development initiative to improve care and treatment of those who use services. Prior to this proposal there have been some research studies looking at users views and perspectives (Read and Reynolds 1996, Rogers, Pilgrim and Lacy, 1993). Read and Reynolds (1996) published a collection of inspiring articles written by service users about their experience of distress and contact with mental health professionals. The writings have detailed rather horrific accounts of in-patient settings but also helpful psychotherapeutic contacts with professionals and other social networks. The stories are real life accounts that are unbiased by a researchers interpretation and are a promising way forward that services ought to include in any service developments.

3.5 *Other research of users perspectives*

Alongside research that was mentioned in part two of this section, (e.g. Small et al, 1994, Woollett and Parr 1997, Lewis and Nicholson 1998, Mauthner, 1998), there have been other studies looking at both the views of health professionals and the views of women who experienced postnatal depression. A study by Small et al (1997) looked at the views of medical students of postnatal depression and the views of women themselves. The views of the medical students were assessed by a postal questionnaire that mainly included tick box options. These answers were compared to women's responses from interviews from a previous study (see Small et al 1994). Small et al (1997) found that the views of medical students differed markedly from the women's views, with the medical students views being dominated by hormonal and predisposition explanations and the women's views including broader factors. The study highlights the need for professionals to listen to women rather than the other way round and that medical student training should include a broader understanding of postnatal depression than what they appeared to draw upon.

Other research has sought to find ways of accessing user views about what they require from a mental health service and for them to also take a more active role in negotiating and effecting change. Pilgrim and Hitchman (1997) embarked on a study that set up an action group of service users who identified priorities for service change. They included, improved communication and information from professionals, advocacy for users of mental health services, somewhere to scream and shout and access to same sex professionals. Progress was reported across some of the items but not across others and Pilgrim et al suggest that whilst not all priorities were actioned, the group facilitated the development of skills and confidence for service users that gave them a voice with service managers.

In the light of national service framework proposals to include service users in research and development, some services locally and nationally have endeavoured to include users in developing research questions in order to improve services and bridge gaps between professional agendas for research and service user priorities (Thornicroft, Rose, Huxley, Dale and Wykes 2002; Townend and Braithwaite, 2002). These studies have been preceded by recognitions that improvements in services are often defined by those who work within them rather than those who use them. For example Perkins (2001) published a paper questioning whose views of services are paramount in determining effectiveness of interventions. She argues that the vast majority of research has focussed on symptom or problem reduction as a definition of effectiveness and that if clinicians determine outcomes then these will reflect agendas that are not necessarily grounded in the user's perspective.

CONCLUSION

Whilst these latter studies have begun to demonstrate an increased awareness of the need to include users in research, service development and clinical effectiveness, they are indeed few and far between. More specific research on women's perspectives has been extremely limited and mainly the product of feminist writers who are concerned to make women's experiences visible. To date there has been limited research looking at women's views of services. It seems that those that are often portrayed as women's views, are often professionals' suggestions of how to objectively improve services for women.

Services for women in the postnatal period have mainly been constructed around research into aetiological factors, preventative and effective treatment strategies proposed by academics, that are frought with inconsistencies and women have rarely been asked about their views of such services. Also women's views on being referred to mental health services for a label of postnatal depression have not been addressed. Given the findings of feminist research (reported in part two), which found that women engage in conflicts with themselves about failing to fulfil an idealised view of the perfect mother and that they could not openly express their feelings of distress for fear of being devalued (Mauthner 1998a), then how does a referral to mental health services impact on these feelings? How do women interact with the label they are given and the explanations offered to them about their distress. What sense do they make of these interactions and information and how do they arrive at a subjective meaning of being referred to mental health services?

It is hoped that this study will answer these questions and not only add to the visibility of women's voices about postnatal depression, but also make the process of how women are referred visible (a recommendation also made by Elliott et al, 2000a). Specifically, what role this process plays in shaping women's understandings about themselves, their experience and the label of postnatal depression?

This information would be valuable to those providing services, as listening to women's voices about what they experienced as helpful and unhelpful and incorporating this into service development and delivery, can only increase consumer satisfaction with the service. A further contribution will be made to existing literature on women's experiences of postnatal depression and what is significant and helpful in their recovery.

AIMS AND OBJECTIVES OF THIS STUDY

The primary aim of this study was to explore the experiences of women who are referred into mental health services, for postnatal depression after being previously cared for in primary care, and the effect of the process in which this is done.

OBJECTIVES

- How does a referral into mental health services affect women's understanding of postnatal depression?

- What does a referral into mental health services mean to women?
- How does the referral impact on women's self image and their perceptions of control and capacity to cope?
- What messages do women internalise when, on the one hand postnatal depression is portrayed as a normal reaction to the demands of the transition to motherhood and on the other their experiences are pathologised within an illness model. i.e. how do women conceptualise their problems?
- How is the process of the referral experienced and what role does the process have on impacting on women's understanding of postnatal depression, their self- image and capacity to cope.

CHAPTER TWO: METHOD

1.1 Design

The design of the study was qualitative and guided by a phenomenological approach to the data. It consisted of semi-structured interviews that were conducted with nine women who had been referred to mental health services with a label of postnatal depression. Women's accounts of their experience were then analysed using thematic content analysis drawing on some grounded theory principles put forward by Strauss and Corbin (1998).

1.2 Ethical approval

Approval for this study was gained from the ethics committee responsible for research studies carried out in the local area. The first draft was approved subject to some minor changes to the patient information sheet. Correspondence from the ethics committee can be found in Appendix 1.

1.3 Materials

These included

- A mini cassette recorder with a microphone.
- Blank audio tapes, one per participant
- A transcribing machine (Sanyo Memo-Scriber TRC 8800)

1.4 Sample

A meeting was held with the psychologist who was also the head of the psychological therapies service at a community mental health team (CMHT) resource centre. It was agreed that participants for the study could be recruited from referrals to the team. The referral letter was used as a means of identifying which women had been referred for " postnatal depression" and it was women who had received this label that was important rather than the correctness of diagnosis. The psychologist acted as a gatekeeper for the study and women were selected from caseloads, initial assessments and the waiting list. A total of 14 women were selected according to the inclusion criteria below.

1.5 Inclusion Criteria

This was developed to ensure that women selected for the study were indeed women that had been referred to mental health services for postnatal depression, having previously been cared for within primary care. The inclusion criteria developed is detailed below.

- Women must be English speaking and able to communicate with the researcher.
- Referral to mental health services must state that the reason for referral is postnatal depression.
- Women will not have waited for extensive periods of time following the referral.
- Women will not be included if already seeing mental health services for a "serious mental Illness" [1](i.e. "Schizophrenia", "manic depression", or pre existing mental health problems prior to the birth of their child).
- It will be the first time women have been referred into mental health services.

Out of the fourteen women that were selected as potential participants it transpired that one of these women had been seen by mental health services before with distress following a previous child. The psychologist wrote a covering letter to the remaining thirteen women and this was sent out with the patient information sheet devised by the researcher (see Appendix Two). The letter invited women to contact the department if they were interested in learning more about the study.

Ten women contacted the department expressing interest in the study, one of these women had changed her mind when she was contacted because she did not feel "well

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[1] These diagnostic labels have been used here for practical purposes. However they do not suggest the authors-unquestioning acceptance of such labels or the acceptance of the mechanisms through which they have been constructed.

enough" to take part. Nine women were contacted and interviewed, however it transpired that two of these women had long standing difficulties and contact with mental health services and had done for some years therefore these women were not included in the analysis. Unfortunately the psychiatrist who had also agreed to act as a gatekeeper for the study had gone on long term sick and therefore the potential participants were reduced. However a total of seven women were included in the final analysis and the researcher was able to engage in an in-depth analysis of these women's accounts.

Women were contacted by telephone to arrange a convenient time for the researcher to carry out the interview and women were given the option of either attending the resource centre or a home visit. Five of the women opted for a home visit due to childcare demands.

1.6 Participants

All the women who participated in the study had been referred to the mental health service via their GP or Health visitor. The women were white, British, age ranges between 27-37 years and all of them were from the local area. Unfortunately no women were recruited to the study who were from diverse ethnic origin and this is perhaps reflective of the under representation of such diverse cultures in the referrals to mental health services in general and in this particular local area. In order to set the women's experiences in context for the reader the author has given brief descriptions of the women who took part in the study (see Appendix three) .To preserve the anonymity of these women, fictitious names have been given throughout the text.

1.7 Procedure

1.7.1 *Consent*

Consent for the study was obtained from participants prior to undertaking the interviews. Participants were asked to re-read the patient information sheet and time was given for any questions that they had regarding the study. Information was given about how the researcher would preserve anonymity including the wiping of the tapes once the interviews had been transcribed.

Participants agreeing to take part in the study were asked to sign a consent form on the understanding that they may withdraw this consent at any time (see appendix four for an example).

1.7.2 *Interview Schedule*

An interview schedule was devised that formed a loose guide to the interviews (see appendix five). The author recognised that there are several ways of conducting interviews for the purpose of addressing the research aims.

It was thought that a loose interview guide that listed the areas to be addressed and some potential questions to ask would be appropriate for the study.

A warm up question that is often proposed in qualitative interviewing (e.g. Barker, Pistrang & Elliott 1994; Mason 1996), to ease the participant into the interview, was used in these interviews regarding women's experiences of the birth of their child.

Following on from that women were asked about several topic areas and the researcher endeavoured to let women tell their story in whichever order they saw fit. In doing so women were not necessarily asked questions in the same order and the guide served the researcher as a prompt to ensure topic areas were covered.

1.7.3 *Interviews*

These were conducted either at home or in the CMHT resource centre and were taped using a tape recorder. The interview lengths varied from one hour to two hours depending on each participant and the average length tended to be one and a half hours. After one hour had passed the participant was informed and asked if they wished to carry on.

1.7.4 *Transcription*

Each interview was transcribed using a transcribing machine as soon as possible after the interview. The tapes were transcribed verbatim and aspects of the conversation were added such as laughs, periods of distress and pauses. In total the transcriptions of the interviews generated 100,000 words.

1.8 Epistemological Positioning

Before going on to describe the process by which the data was analysed, it seems appropriate and necessary to make explicit the researcher's epistemological positioning in relation to the methodology utilised in this study and the philosophical paradigms that have surrounded research into postnatal depression.

Postnatal depression research has been dominated by a position of positivism in that postnatal depression has been objectified in an attempt to uncover the "truth" about it and its properties. This has been rigorously undertaken to the extent that feelings, experiences and diversities have been ruled out and minimised so as to prevent the seeping through of subjectivity. Such positioning has been criticised by Parker (1994) where he argues that quantitative research endeavours to reduce the chatter of participants as it threatens the objectified status of the research claims.

As a fairly new researcher I became disillusioned with the inconsistencies in the literature that appeared to continue to search for the truth about postnatal depression. Surely there can be no one single truth that encompasses one meaning but rather individual truths and meanings for each person that in turn share similarities and respective differences amongst participants accounts. In adopting this position I drew upon personal experience of working on psychiatric wards whereby "patients" were rarely asked about their feelings, beliefs and wishes about treatments, assuming that they were somewhat incapable of assigning meaning and understanding to their distress. To the extent that their views were in themselves irrelevant and only those who had access to the "real knowledge" about their problems were listened to.
My discontent with such practices has fuelled my interest and goal to find out the "truth" about people's experiences, to listen to them and afford their communications value and status within research.

In doing so I have adopted a phenomenological approach to the data in that the individual's perspectives are what they appear to be and they are a valid representation of truth. In the case of this study women are seen as experts on their experience and the meaning they ascribe to their experiences is what this study is interested in.

I have also recognised the subjectivity of such meanings and that these have been constructed within the context and influences that women have been exposed to, drawing on social constructionist traditions that acknowledge the influence of social context on construction of meaning. In the same vein the role of my own subjectivity and its influence in designing, analysing and interpreting the data has not been denied. As a way of acknowledging my interactions with the participants and the data, a reflective diary was kept through out and supervision was sought on a number of occasions (see reflexive analysis at start of the results section). Qualitative scholars have emphasized the importance of such reflexivity as an integral part of the research process (Burman 1994, Smith 1996, Parker 1994, Mason 1996, Elliott, Fischer and Rennie 1999).

1.9 Data analysis

1.9.1 *Initial coding*

The data analysis drew on the principles of content analysis (Krippendorf 1980) and grounded theory (Strauss and Corbin 1998), based on a phenomenological approach to the data. The main emphasis of analysis was on meanings of experiences and the construction of themes that sought to identify similarities and differences between women's accounts. Analysis began with a general reading through of the transcripts to familiarise oneself with the rich data that had been generated and to gain an overall feel for the data. During this initial reading I returned to the research question that was being asked of the data and thought about what was originally the focus of the research. The richness of the data generated can represent a challenge, as it is all interesting and illuminating. However, under the guidance of supervision I aimed to focus on the data that was relevant to the research questions, a process that has been advocated by qualitative scholars (Mason 1996, Pidgeon & Henwood 1996)

After an initial reading I then began with the first paragraph of the transcripts and highlighted text that was of interest to the research questions. During the initial coding the categories that were generated attempted to group the words of the participant and the communication of meaning into a category that seemed to capture experiences and the communications from different women that were found in the text. For example initial themes that were generated included prior understandings of postnatal depression, reaction to being referred, and stigma.

This process continued across all the transcripts and the categories were changed and sorted until they most appropriately reflected women's communications. In line with the research questions they included among others, aspects of the process that women reflected upon, their feelings and reactions to the label of postnatal depression and knowledge of the referral to mental health services.

When re-reading the data and the categories that had been developed I recognised that both the women's narratives and the ordering of categories appeared to demonstrate a journey of a process through various stages, which led to women arriving at a meaningful representation of their experience. Interpretations of such processes, meanings and their relevance to the research question were tested out by looking back through the data for text that supported such interpretations and text that did not. In doing this process of cycling back and forth to the data I endeavoured to understand the processes by which women had arrived at meaning (Stiles, 1993). The challenge of the analysis was to maintain the complexity of individual difference whilst recognising and conceptualising similarities across women's accounts.

1.9.2 *Use of supervision*

In order to test out the reliability of the categories that had been generated my supervisor was shown the process in which this had been achieved and agreement was obtained regarding the construction of the categories from the data. Throughout the research endeavour supervision was an invaluable entity that enabled open discussion regarding my subjectivity and somewhere that my assumptions could be challenged and made sense of. This process is expanded upon in the reflexive analysis section at the beginning of the results chapter.

CHAPTER THREE: RESULTS

Part One: Reflexive analysis

This part of the results section outlines the personal and contextual factors that influenced my decision to embark on this research study and the role of my own subjectivity in approaching the interviews, data analysis and the presentation of this research.

1.1 *Autobiographical context*

I have already mentioned my experiences of working within psychiatric wards as a nursing assistant and contact as a trainee clinical psychologist. I have realised that the users of such services are rarely asked about their thoughts and feelings about their experiences of distress and contact with mental health services. Postnatal depression has been the focus of my interest largely because of working with health visitors, running postnatal depression groups and working with women individually in clinical practice. My attention on several occasions was turned to the inconsistent literature on the causes of postnatal depression. I was also part of the development of prevention programmes with health visitors that were implemented within a local area. I began to realise that resources were in place for health visitors to refer women to the psychologist if they needed to but the dominant message that they were encouraged to offer women was that their experience was normal. If this was so then how did women make sense of a referral to mental health services? Furthermore how was this done and what did women need in this difficult period of their lives? Therefore I decided to ask these women about their experiences.

1.2 *Recruiting participants*

Whilst in the process of developing inclusion criteria for the study I began to consider how I would know whether the women actually had postnatal depression or not. What if women had anxiety or had been depressed before?

This dilemma was further exacerbated by feedback that I had received from a psychiatrist who suggested that it would be more reliable to use a standardised diagnostic interview that defined women with postnatal depression, rather than rely on referral letters. She highlighted the problem of co-morbidity of postnatal depression with other "disorders".

Through careful thought and supervision I returned to what I wanted to know about women's experiences. It appeared that whilst I thought I had set aside notions of the "truth" about the thing called postnatal depression I had been heavily influenced by the dominant literature that had sought to reveal this. What was more important was that someone had labelled women with postnatal depression and I wanted to know about their experience of this, the meaning it had for them and the process and meaning of being referred to mental health services. Therefore I chose not to agree with the psychiatrist and explained my reasons for this.

1.3 *The interviews*

The interview schedule was constructed to include topics that sought to elicit meaning about the referral, postnatal depression in the light of the referral and aspects of the process that influenced such meanings. I realised that I was asking women to comment on their experience of being referred as an associate of the department where they had attended. This placed women in a difficult position as they may have found it difficult to be critical of such processes. I attempted to clearly state that I was a university student and that their comments were confidential and would not affect the care they received.

Throughout several interviews I was aware that women wanted to talk about their experiences of living with their distress and at times it was difficult to bring the interview back to the focus of the research questions. I wondered if asking about being referred was perhaps difficult for women to separate out and not as important to these women as I had imagined. Long conversations about birth experiences suggested to me that women had not had an opportunity to talk through these experiences and whilst it was not the focus of this research, it seemed beneficial for women to go through this process.

As I began to think about women's understanding of postnatal depression I was aware that when women defined it "as an illness" this did not sit comfortably with my beliefs about postnatal depression. Women would talk about socio-environmental contexts and psychological explanations as reasons for their distress and then call it an illness. I was perplexed by what I saw as contradictory accounts. I believed was that if you were ill then the "illness" had to have specific organic elements to account for it. I pursued this somewhat throughout the initial interviews presenting different arguments to them.

Why was I doing this? I realised that as a psychologist whose professional development and education had been centred around challenging the organic basis for mental health problems and labels that gave the medical profession power to use treatments that were based on inconclusive evidence. I believed that if women thought they were ill, then why were they using more psychological and socio-environmental explanations?

In supervision we talked about occasions when I myself may have felt ill but that I may attribute all sorts of reasons for this, for example a hangover or an "off" stomach. Feeling ill was based on more than organic pathology and in trying to almost get women to commit to one explanation or the other was about my academic beliefs about illness. I was also acting on trying to clear up the debate on the "truth" about postnatal depression that I assumed women had the answer to, which again reflected the influence of the earlier dominant research about causes. This was an illuminating process for me and it enabled me to set these assumptions aside and listen more carefully to what women experienced without experiencing this uncomfortable feeling that was closing my ears to women's accounts.

1.4 *Analysis of the results*

I found this aspect of the research extremely difficult not least because of the range of qualitative theoretical approaches that can be utilised to analyse data. Qualitative interviewing generates masses of data and trying to unpack and make sense of it presented me with a challenge. At one point I became concerned that I was not adopting a purist approach and that perhaps I was drawing too loosely on varied approaches.

However returning to what I wanted to know helped me to focus the analysis and realise that thinking about data in different ways can only serve to guard against missing important information through the rigidity of a singular approach. Therefore the process of analysis drew on thematic content analysis informed by phenomenology and principles of grounded theory.

1.5 *Presentation of research*

Decisions were made in writing up this research about how to present the results section. I have already mentioned the fact that it felt as though women where describing a journey and the development of categories and themes also seemed to come together to represent a journey that women had been through from receiving the label, being referred, experiencing the process and arriving at subjective meanings. I therefore made the decision to present the results section in this way using women's words in italics to illustrate the themes generated.

Part Two: Results

Table 1. Taxonomy of emerging themes

STAGE ONE **2.1 Pre labelling experience of symptoms and prior knowledge of the label of postnatal depression**	
2.1.1 Making sense of symptoms	Its what I've been through A familiar feeling Its part of being a mum Its not fair There's something wrong with me Externalising metaphors Depersonalisation: the relationship with madness Prior conceptualisations of post-natal depression
STAGE TWO **2.2 What influences personal meaning: reflections on the process**	
2.2.1 Initial reactions to receiving label	Shock Relief I'm going mad! Acknowledging previous depression Denial or indifference Personal attribution
2.2.2 Professional interactions and explanations	It's a condition, you're ill A chemical imbalance Hormones Life events/ accumulation of stress No explanation at all It's normal for this to happen
2.2.3 Sub-themes related to professional interactions and explanations	Failing the EPDS is the first sign of postnatal depression Have to get you on the tablets I am not to be trusted
2.2.4 Reactions to being referred to mental health services	Reassurance and relief Having an expert
2.2.5 Stigma	What others think What women thought themselves Location of stigma – Psychiatric services/ medication

2.2.6 Sub-themes related to perceptions of mental health services	Normal people who need help Will I ever get out of the system
2.2.7 Previous experiences and family narratives	
2.2.8 The Process	
2.2.9 Themes relating to unhelpful processes	Waiting Not picking up on distress No time to talk and feeling misunderstood Telling me its normal
2.2.10 Sub-themes relating to unhelpful processes	Unclear communication Medication
2.2.11 Themes relating to helpful parts of the process	Being listened to Someone taking things in hand: an expert The importance of options Having experience normalised
2.2.12 Sub-themes relating to helpful parts of the process	Direct communication Knowing its an illness Medication
STAGE THREE **2.3 Personal meanings of postnatal depression and being referred to mental health services**	
2.3.1 Subjective meaning of label and experience	It's definitely an illness Towards self discovery and a position of empowerment Its me, I'm inept It's major Feeling worse and in Limbo Meanings of label

The journey can be described in three stages, 1) A pre labelling experience of symptoms and prior knowledge of the label of postnatal depression, 2) the factors that influence the development of a personal meaning of being referred and 3) the personal meanings of postnatal depression and being referred to mental health services that women have arrived at having been through the process.

It seemed important for participants to tell their tale of how it all began and enabled a fluent narrative to the rest of the interview. Furthermore it set the rest of the journey in context and how a referral to mental health services has been shaped and understood.

STAGE ONE

2.1 Pre labelling experience of symptoms and prior knowledge of the label of postnatal depression

2.1.1 Making sense of symptoms

It's what I've been through

Three of the women in the study thought their symptoms were due to what they had been through over the past months. They mainly attributed the experience of symptoms as a temporary state and as a result of events that they had expected to recover from reasonably quickly. For example Charlotte states, *I woke up one morning and I felt really weepy really low and run down. I thought I would come out of it after a couple of days.* Jane said, *at first I was very weepy, I thought it's probably just what I've been through.* Sophie talks about external factors that may have influenced her feelings, *I just felt that it was perhaps the pressures of work, with err, the birth, which was something that I didn't want.*

A familiar feeling

Two other women recognised their symptoms. They recalled similar experiences with a previous child, but hadn't realised what the problem was or sought help. Sandra explained her experience, *I was home about a week afterwards, and I just I recognised it this time, whereas with my first child I didn't recognise being depressed* *and I felt its coming on already. I could feel it.* Like wise Janice said, *I think I'd had postnatal depression first time round, but didn't have any treatment for it.*

Its part of being a mum

One woman thought that the way she was feeling was normal and that her experience was directly associated with being a mother, Lotti said *I just thought it was normal, I'd had this baby and now that was it my life forever and a day.*

It's not fair

Some of the women in the study expressed feelings of unfairness that they should be experiencing such unhappiness Sophie commented on how it was at a time when *you should be happy.* Janice felt it was unfair that she had friends who seemed to just love being with their children she said; *it's so unfair that I didn't have that.*

There's something wrong with me

For two women they were perplexed as to what was going on and attributed symptoms as being representative of something wrong with them, Rachel said *I just assumed it was something wrong with me. I just felt terrible that I didn't love this poor little helpless thing.* Charlotte also felt that whilst it was temporary it was something to do with her mind, *I just thought it was something in my mind doing it.*

The heterogeneity of the accounts reflects the individual cognitive processes that women have gone through in attempting to understand what is happening to them. However, there are some similarities, those women who saw their symptoms as temporary and largely externally influenced, those women who viewed it as a familiar experience and those who either saw it as expected and normal or something inherently wrong with them. In these early descriptions the metaphors that were used provide insight into how women viewed themselves in relation to their difficulties.

Externalising metaphors

It's like physically carrying weights but you're mentally carrying them
You're so far down on the floor that you can't get up
Its as if I was being pushed into a dark tunnel
I felt like I had a mask on and I couldn't take it off

It hit me like a ton of bricks
You just can't get out of it, you can't climb out of the pit
It's like a bolt out of the blue that hits you

Four out of the seven women interviewed utilised these metaphors and it clearly reflects the notion of, an external force acting upon them that is separate and not part of the self, almost like an invasion or a separate entity that descends upon them.

Depersonalisation: the relationship with madness

This theme was reoccurring across the interviews in women's attempts to understand what was happening to them. It represents how women's identities where challenged during this period and thoughts of madness were often quoted.

I don't know what has happened, I'm not myself anymore,
What the hell has happened to me?
You feel like you are going mad with the things you said,
I don't want them to be frightened of me so I have to put the mask on.

This represents a difficult time for many of the women in this study as they grappled with the uncertainty of their behaviour, their emotions and challenge to their sense of self.

Prior conceptions of post-natal depression

This represents women's engagement with the term postnatal depression and their understanding of its meaning before receiving the label themselves. There were varied understandings of the term and women drew on various sources of information. For example Rachel and Sophie commented on the media and books they had read as their first encounter with postnatal depression,

I've heard of it, it hadn't really entered the equation at all I was reading a book there is a very small piece in there about it, she also mentioned puerperal psychosis which frightened me out of my wits and *I'd heard it before from the media and that you just assume its people a bit fed up after they had a baby, not really having a whole lot to do with the baby is the impression you get.*

Lotti clearly stated that postnatal depression meant *hating your baby...a person with postnatal depression didn't want their baby.* Rachel thought that when you got postnatal depression they took the baby away, *I thought that's what happened when you got postnatal depression they took your baby away.*

Sandra, Jane, Rachel and Lotti thought that it was something that they would never get and made some reference to hormonal implications, *Something that you had it was hormonal, I'm not going to get that why would I get that.* Jane and Janice also commented on the role of self in postnatal depression, *If you let things get you down then they will, I didn't see it as an illness, it was an emotional state,* and *Its an inability to cope with what you could previously cope with.* Janice went on to say that it's due to, *lack of sleep, lack of time on your own...*

STAGE TWO

2.2 What influences personal meaning: Reflections on the process

2.2.1 Initial reactions to receiving label

Each woman experienced a range of reactions to receiving the label of postnatal depression. The following main themes emerged that encompassed the variety of responses.

Shock

Many of the women experienced the application of a label as a shock, for example Charlotte states, *Shocked, shocked I thought it was me being paranoid I didn't realise.* Jane talked about how she felt it was a shock to be classed as having postnatal depression as she thought you had to be really bad to suffer from postnatal depression, *It was a bit of a shock really to be classed as having postnatal depression, I thought you had to be really, really bad to suffer from postnatal depression and I wasn't.* For Jane there appeared to be a mismatch between what she perceived to be postnatal depression and her experience.

Sandra also reported feeling shocked, *At first I remember feeling quite shocked, but I also knew how depressed I was so I mean its shocking to hear it from someone else.*

Relief

A few of the women expressed relief about receiving the label as it offered some explanation for their feelings, Sophie said *I think I was relieved in a sense, you know there is actually something wrong with me, thank god.* Jane expresses relief about there being reasons for her behaviour, *..a bit of relief really I suppose because I was crying all the time and I couldn't stop it and I was snapping, so at least there was a reason for it.*

I'm going mad!

For some women the label of postnatal depression confirmed fears of madness that they had already engaged with when experiencing symptoms.

Lotti in particular struggled to even say the words, *Oh my god I'm going mad but I couldn't say the words, I thought I was mad when the words postnatal depression were mentioned.* Charlotte remembers feeling as if this meant she was going round the bend, *I just thought its me going round the bend.* Sophie *you do think you are going mad.* Rachel recalled her reactions when she first experienced the label of depression, *I remember the first time I was diagnosed I felt like some kind of freak, I felt terrible.* Although Rachel felt she had accepted a depression label a few years ago the notion of madness and dangerousness was reinforced by her fear of having the baby taken away and ending up on a mother and baby unit.

Acknowledging previous depression

For some women having a label for the symptoms they were having helped them to realise that they had been depressed before with a previous child or experienced symptoms of depression at other times. Sandra realised,.. *that I've suffered from depression before, normal depression not postnatal depression.* Janice said *I think I had postnatal depression the first time round but I didn't have any treatment for it.* Rachel stated that *it didn't really feel a lot different from being severely depressed* before although she acknowledged that the panic attacks were unfamiliar.

Denial or indifference

Lotti acknowledged that she went into a state of complete denial, *I remember thinking the midwife thinks I've got postnatal depression, I've heard them whispering about me, I haven't got that there's nothing wrong with me. I genuinely did not think I had postnatal depression.* She linked this feeling with what she thought postnatal depression was, namely hating your baby and she could not identify herself with such a label. Rachel and Jane expressed a feeling of somewhat indifference to the label, neither agreeing nor disagreeing but just going along with it. Rachel reported her reactions, *I didn't agree or disagree, I wasn't in any fit state it sounded reasonable and I just sort of went along with it,* and Jane said, *I didn't disagree, I didn't go into shock horror this can't be me...I didn't go into denial.. if that is what it is then that is what it is...she knows what she is talking about.* There was some acceptance in the latter accounts of a professional's opinion a factor that is expanded on throughout this stage of the journey.

Personal attribution

For some women the label prompted a search for personal attributes that could have contributed to getting the label and the difficulties.

For example Janice's reaction was *I actually thought I was the type of person that would get it, from my personality type, so fine. I'm a perfectionist, a control freak, having too high standards, not being adaptable.* This appeared to imply an understanding of postnatal depression that was based on psychological processes.

It was also implied in Sandra and Jane's reactions, *I'm a bit of a deep thinker, I do tend to get low and a bit stressed* and *I've always coped ok and none of it has got me down ...then all of a sudden I wasn't coping.*

2.2.2 Professional interactions and explanations

Women talked about their interactions with a variety of professionals along the journey into mental health services. General Practitioners and Health Visitors in the initial contacts and then Psychiatrists, Community Psychiatric Nurses, Psychologists and Therapists as the women entered mental health services. This study was primarily interested in the messages and explanations offered by these professionals and how interested in the messages and explanations offered by these professionals and how women used these explanations to formulate personal meaning. Several common themes were generated to reflect the range of experiences that women had with professionals.

It's a condition, you're ill

Sophie reflected on her interaction with her GP, *he just explained that this can happen it's a condition that needed treating.* Charlotte reported a similar interaction with her health visitor, *She kept saying you are ill its not in your mind you're ill and you need help* and Janice's health visitor said, *you've got depression you have got an illness.* These messages were reinforced along with other medicalised models by other medical professionals i.e. Psychiatrists and some CPNs.

A chemical imbalance

Four of the women in the study talked about how an explanation of "chemicals" was offered by mainly GPs and later by Psychiatrists to explain their experiences. One woman was informed by her GP that anti-depressants would help balance her mind, *he thought being a chemical it could balance the mind out straight.*

The other women recalled similar explanations of serotonin levels and some form of chemical imbalance. These explanations were often given to pre-empt a prescription of anti-depressant medication. Medication was a significant issue for many of the women and this will be discussed later in this section.

Hormones

This was a dominant theme and over half the women recalled this being mentioned by a variety of professionals. Rachel reflected on this being the most frequent message that she had received compared to the very detailed chemical imbalance description she had received when she first encountered depression, *but this time round I don't think anybody explained anything like that, they just said oh its hormonal.* Jane remarked on how she had been told that part of what she was experiencing was hormonal and she had *baby blues mixed in with postnatal depression.*

Life events/ accumulation of stress

This theme was often related to events surrounding the birth, events whilst pregnant or experiences as a child or with family members. These explanations were often intermingled with more biomedical ones For example Sandra recalls the psychiatrist saying *It was a chemical imbalance and that it could be related to my father and there are some drugs* (Sandra's father had committed suicide when she was younger). Four of the women recalled more psychological explanations from the Psychologist and some health visitors that reflected coping with everything, adjusting to a new situation and an accumulation of stress.

No explanation at all

Four of the women's' responses to their interactions with professionals indicated that they didn't feel that they had any explanation given to them. For example Lotti didn't recall anything being explained to her and reflected on being given a leaflet from her GP, *I don't think it ever was explained, it was the leaflet that did it.* However, looking back to reports of chemical imbalance and linking of hormones, it would appear that at some points women had been exposed to some explanations. For the women themselves they did not feel that they had had an adequate explanation and this perhaps reflects the relatively limited weighting that women gave to the explanations they were offered at the time.

It's normal for this to happen

Four of the women were told that their experiences were normal. For example Rachel said, *They both more or less said that what was happening is fairly normal, they didn't seem to talk about it as anything big or strange.* This invoked various reactions from women and will be discussed in a later section on the process of being referred.

2.2.3 Sub-themes relating to professional interactions and explanations

Failing the EPDS is the first sign of postnatal depression

One woman was told that having a high score on the EPDS was the first sign of postnatal depression. It was unclear as to whether she had been told she had "failed" or whether she had inferred that herself from her score. However her health visitor health visitor had explained that her high score was related to the beginnings of postnatal depression, Jane commented, *I failed that test miserably apparently she said that, that was the first signs of postnatal depression.*

Have to get you on the tablets

Two women recalled being told that they must start taking the tablets straight away. For example Rachel talked about her health visitor, *well the first thing the health visitor said was she'll have to get me on the tablets and I started taking them straight away.* Sandra remarked upon her similar experience with the psychiatrist.

I am not to be trusted

Rachel also reflected on a feeling that she had from her interaction with her health visitor. She reported getting the feeling that she wasn't to be trusted and it was only because her husband was also at home that she felt the risk was reduced. This had transpired because Rachel had had concerns that she may have put a pillow over her daughter's head although she knew she wouldn't she had concerns about it because of what she had read about. She commented on the impression she got from the health visitor, *the impression I got was that I was not to be trusted on my own, because she had put in my notes that the baby was not at risk because the father was at home.* Rachel found this very unsettling and felt that this would *dog her* for years to come.

2.2.4 Reactions to being referred to mental health services

This section highlights the prominent themes that women expressed about being referred to mental health services. The themes generated reflected women's' desperation by the time they accessed mental health services but also the need to have contact with an expert, someone who knew what they were doing. A third main theme was women's' interaction with stigma and how they engaged with that concept in relation to their circumstances and need for help.

Reassurance and relief

Six of the women in the study talked about relief when they were told about the referral, for example some women expressed relief about actually receiving some help, Lotti said, *It was actually relief when I knew I was coming here, thank god for that cos someone is actually going to help me,* and Sophie commented on how she felt reassured by her GP referring her, *I wasn't surprised at the decision not the way I was I just thought it can be dealt with and that's reassuring.*

Three of the women viewed the referral as a *light at the end of a dark tunnel* and again expressed relief at the thought of being helped by someone. Charlotte and Jane talked about being *pushed that far down into the tunnel* that they needed the help to get out. Sandra reported her desperation at the time, *I agreed because I was quite desperate really and I just wanted to feel better.* Therefore, for most of the women they had acknowledged how dreadful they felt and how they were relieved that there was some help out there.

Having an expert

This was a common theme and six of the women made references to needing an expert or specialist or specialist help. For example Janice found that being referred to a specialist service was empowering, *they knew how I was feeling and they knew what to do about it.* Sandra viewed the psychiatric service as a specialist service just like in other medical fields and that there are times when you need specialist help, *for me it was just like going to see a specialist and I needed that.* Sophie reflected on needing to have someone who knew more about it than you did, *you should see someone who is more aware of it than you are.*

2.2.5 Stigma

Women talked about stigma from different perspectives they talked about it in relation to themselves, how others saw them, its links to psychiatric services and taking medication. It is interesting how women engaged with feelings of being stigmatised and the location of it is significant to assimilation of meaning.

What others think

Several women made references to how they thought others would view them for being referred to mental health services. For example Rachel thought that people were frightened of the word psychiatric and she referred to them as, *big scary words, so you have to be careful what you say to people.* Charlotte talked about feeling as though others would judge her and think that she was mad, *thinking that I'm crazy,* *just people generally thinking that I'm crazy.* Jane thought that others would see it as a sign of weakness; *some people could see it as a weakness going to get help.* Lotti was concerned about both the label of postnatal depression and being referred and was preoccupied with thoughts that people would think she wanted to hurt her baby. Lotti was also concerned that other people would think she was mad, *It is seen by a lot of people that you are mad not sick.* Whereas Janice had not sought help on a previous occasion as she was concerned that having a mental illness on her records would affect her job prospects, however this time she reported feeling "that bad" that she didn't care who knew.

What women thought themselves

Sophie felt conscious of the stigma that was attached to mental health services and thought that it had taken a lot of personal commitment to agree to being referred, *there is stigma there and you are conscious of that and it takes a lot to agree to going there.* Rachel felt that although it wasn't *logical* it still remained in the back of her mind and she made references to the images that it conjured up disturbing images, *as soon as you hear the word you do have visions of big blokes in white coats strapping people to beds, it really puts me off, that is for mad people.* Rachel also stated that she tried to resist the whole thing and that it really wasn't something she wanted to be involved with.

Jane acknowledged that there was stigma attached to mental health services and it did make her feel uncomfortable. However she remarked that her counselling training had taken the discomfort away somehow, for her it was more about feeling uncomfortable that she had to get help from somewhere else. Charlotte acknowledged her initial fear of ending up on a ward but felt reassured once she realised that wasn't going to happen. Her own thoughts were that she was *weak for being referred.*

Location of stigma- Psychiatric services/ medication

Women expressed different opinions about where stigma was located for them. Charlotte, Lotti and Sophie all expressed concerns around the stigma of anti-depressants and the fear of getting *hooked. I didn't want to get hooked you hear all these stories about people getting hooked. Talking about your feelings is better than popping happy pills.* Sophie commented that taking medication was more of a concern for her; *Taking medication was more of an issue for me than going to mental health services, because I didn't want to get addicted.* The notion of *hearing stories* seemed to reflect societal messages and images of taking medication for your mood. However, Rachel took a different meaning from media messages, *I feel there is more stigma attached to mental health services than in taking Prozac, Prozac is kind of cool.* Rachel felt that going to a therapist suggested that you had a real problem not just an *every day blip.*

2.2.6 Sub-themes related to perceptions of mental health services

Already mentioned is the feeling of stigma that women linked to being referred to mental health services related to madness, being judged by others and pharmacological treatments. However there were other themes that highlight how women made sense of this experience.

Normal people who need help

Both Jane and Janice thought that people who attended this kind of service were normal people who just needed help at that particular time in their lives. Jane commented, *just normal people, that they just need some help, just like me, but I don't see it as a mental problem just that I needed help.* Janice acknowledged that people had mental health problems went there but it was no different from physical health problems although the latter is often afforded more attention. There was a sense that these women attempted to normalise their experiences and that they underwent a process of reframing having expressed initial discomfort about the referral.

Will I ever get out of the system

For two women this was a concern and the language they used reflected socially constructed labels of being in the system and the negative connotations that are often associated with that. Rachel expressed her fear of being in the system, *Well its quite frightening to be sort of in the system, am I ever going to get out of it, is it going to dog me.*

2.2.7 Previous experiences and family narratives

Throughout the interview women drew on their previous experiences and their interactions with their families to add context to their experiences.

Sophie recalled difficult times growing up in her family and her experiences of her mum being in and out of psychiatric hospitals. She recalled a time when she was sent to see a doctor and he normalised her experience as being understandable given what she had been through she remarked, *its reassuring because I've come through that so hopefully I will get through this as well, but you do worry that certain illnesses are hereditary and stuff, I don't want to end up like my mum.*

Sophie acknowledged that she was worried about the hereditary nature of certain mental health problems but felt hopeful that she would get the help she needed to come through this difficult time. Rachel remarked on how her family had always been "anti" any kind of help from mental health services and that had always stayed with her and really she should have had help for depression years ago, *it was you mustn't go to the doctor about it cos it will stay on your record and you'll never get a job and they'll take your children away from you and all these terrible things, you'll go to a looney bin.*

Sandra and Lotti talked about their fathers and how Sandra's father had suffered with depression and committed suicide. She remarked that the psychiatrist was very concerned about that and thought that that had contributed to her feelings of depression. Lotti had lost her father when she was young and had then been subsequently abused by a stepfather, she said that she had never made the link until she had read a leaflet that the doctor had given her and she said, *that leaflet could have been written about me I had everything on that leaflet.* Other women in the study made references to family narratives about *just getting on with it, it's all in your mind.*

2.2.8 The Process

Throughout the interviews women were asked to comment on aspects of the process of being referred and their interactions with professionals that they recalled. The responses given have been broken down into helpful and unhelpful parts of this process that have contributed to their experience of services.

2.2.9 Themes relating to unhelpful processes

Waiting

This aspect of the process was commented on by five of the seven women. For some of the women it was a general feeling that they had been left to get to the point of desperation. Rachel commented on her fears about the waiting process, *I think if I'd carried on feeling as bed as that, because I was suicidal at one point, it might have been too late by the time they got round to me.* Janice reinforced this point and wondered how bad she had to be for people to realise how bad she was, *I would feel what do I have to do to get some help, how ill do I have to be.*

Other women talked about the personal significance of having to wait and for Sophie and Janice they were left feeling let down, neglected and unimportant, *Not having a response, I feel very let down.* Three of the women commented at different points in the interview that they were prepared to go into hospital if it meant that they would get help. Jane and Lotti made a general comment that the waiting was too long. Jane suggested it as a fault with the whole system, *Its just a shame they can't do it a lot quicker for everyone to be honest, that's the only fault with the whole system..*

Not picking up on distress

Four of the women talked about how they felt services had not recognised the extent of the distress they were feeling. For example, Sandra and Janice talked about how they were telling the midwife and health visitor that they didn't feel right and yet they did not take this on board. This quote by Sandra highlights this point, *I told the midwife and she said oh no it doesn't start before 10 weeks, the health visitor started coming and I told her and nothing was done about it until 10 weeks.*

Rachel recalled feeling frightened and surprised that the community psychiatric nurses had not recognised her distress, *if they were trained to recognise what was going on in people's minds I would have thought they would have picked up on it and they didn't seem to.* These accounts suggest that often women do not feel listened to and that merely expressing distress is not enough. The example of Sandra telling the midwife and health visitor suggests that the professionals were confining their judgement to what research said about the onset of postnatal depression in rather a rigid fashion.

No time to talk and feeling misunderstood

Women commented on not having time to say what they wanted to say at various appointments, feeling bombarded by questions or simply people making assumptions about how they were feeling and what they could and could not cope with.

These experiences were confined to GP, psychiatric and health visitor interactions. Both Sophie and Sandra remarked on these interactions, for example Sophie recalls going to her GP and having lots of things that she wanted to say, having built up to saying them and feeling as if she was rushed in and out without having the opportunity to talk. Whereas Sandra listened to what the psychiatrist had to say about how she was feeling but went away feeling as if she had not understood her. The psychiatrist had told her what she was feeling but she hadn't felt able to disagree. She sums up her experience, *I disagreed with a lot of what the psychiatrist said, not to her face but I came out thinking no I'm not feeling like that, its not that, but frustrated that I hadn't brought it up.* Sophie also felt as though she was not being heard, *Its as if you are not being heard sometimes and you want to shout, hey this is serious I'm not joking.* Janice remembers being told that a group would not be the best way forward at the moment because she wouldn't cope with it.

However, it transpired that Janice found the group situation, when she got there, extremely helpful and thought she could have been seen a lot earlier, *the health visitor thought I would not have been able to cope with the group, but actually listening to others experiences was really helpful and if I had gone to the group earlier I would have been seen sooner.*

Paradoxically Charlotte was referred to the group having been told that this would be helpful. In fact she did not find it helpful at all and found a one to one situation more appropriate. *In a group you come away feeling miserable because you feel that everyone else's problems are being put on top of you.* Therefore, there appears to be an issue here about how on one level, women feel unable to express their needs and go along with the professional's opinion, but also professionals not listening to what women have to say and what they feel will help them, as if they are incapable of making that judgement. Other women also found this to be the case with regards to taking medication that they didn't want to take the medication in the first place, it wasn't helping them and yet their opinions were not listened to.

Telling me its normal

For some women being told that their experience was normal was not helpful and a distinction can be made here between a process of normalisation and feeling as though one is not the only one, to being told that their very distressing symptoms are normal. The latter explanation was experienced as patronizing and minimising the distress and for Rachel this was interpreted as everyone goes through these feelings and it was just that she was not coping very well.

For other women such as Janice and Lotti this was completely unacceptable, *She kept trying to tell me that what I was experiencing was normal and in my head were these alarm bells it is not normal. It is not normal not being able to breathe because you are so anxious and she just kept saying it.* Lotti commented on a similar experience with a psychiatric nurse, *She was telling me what I was feeling was normal and I knew myself what I felt wasn't normal. It is not normal to sit up all night watching over your child because you think it's going to die, that's not normal. I felt that she was patronizing me.*

2.2.10 Sub-themes relating to unhelpful processes

Unclear communication

For two of the women there was an issue around professionals not being explicit about what was wrong with them at primary care level. Lotti was given a leaflet about postnatal depression to give to her partner. She felt angry that she had to discover she had postnatal depression for herself. She felt that she should have been told exactly what was wrong with her, *I was ill and someone needed to tell me that rather than let me find out for myself.* Janice supported this view in her experience with her GP who she felt should have known and been explicit about what was wrong with her and what help was available. Sophie had been told that she had postnatal depression but she wanted someone to take control and say, *that this is going to happen and you are going to be like this but this is going to make you better.*

Medication

Four of the women did not find the antidepressants helpful not least because it caused them a great deal of concern about becoming addicted. One woman had also received ECT, which she thought had made her worse. For these women taking tablets was not the answer and they felt that talking about their problems was more appropriate. Sandra and Charlotte expressed the following; *I went on Prozac again but it didn't improve, didn't improve I just got worse and worse really. As far as I was concerned I got worse after the ECT.* And *he said you need to go on anti-depressants, he put me on a mild one at first then a stronger one and after a month I threw them away, I was frightened of getting hooked.*

2.2.11 Themes relating to helpful parts of the process

Being listened to

Not surprisingly, women talked about the importance of being listened to and how helpful this was when it was experienced. Women mainly reflected on their interactions with health visitors, psychologists and in two cases GPs. For Janice, being able to talk about her feelings and be listened to was very important, *The way she spoke to me was mainly listening, that was the main thing she did, listened to the way I was feeling, she helped like that.*

Charlotte, Lotti and Rachel also reported positive experiences of being listened to by their health visitor. Charlotte described *a weight being lifted off her shoulders* when she had been to see the psychologist, because she was able to talk things through.

Someone taking things in hand: an expert

Five of the women reported this aspect of the process as positive. It was mainly with respect to telling them what was wrong and what the next plan of action was. Jane explained what she was told by her GP, *I was told this is what is happening, this is what is wrong with me and this would be the best place to go and I found that helpful, I wasn't told to go.* Lotti talked about her first experience of attending the mental health services for a psychological assessment, *the day I came to see the psychologist was so different, I just had one session with her and she got all sorts out of me, you could tell it was a specialist service I felt like she could have made me better that day.* Lotti felt empowered by feeling as though someone could make her better although it gives the impression of handing over the responsibility to someone else, which was perhaps the most helpful part for Lotti. Janice reinforced this finding when she talked about being *stabilised* by the combination of a clinical psychologist, a psychiatrist and an occupational therapist, and she said *they knew exactly what to do with me.* Other women talked about the reassurance they experienced having gone to a service where someone would know what to do.

The importance of options

Three of the women commented on how being given options about which type of help they could receive was helpful. This was experienced at the psychological assessment stage after being referred to the mental health services. Each of these three women was given the option of cognitive behavioural counselling, psychotherapy, or attending a group. It was not clear whether all of the women were given these options although looking at what women recalled as being unhelpful they may not have done, depending on which person they saw initially. Sophie reported feeling more in control and hopeful about getting better after being given this choice, *I did feel more positive when I came away I had a choice you know three choices that I could do and I came away thinking the here and now is the best way and I will get this dealt with.* Rachel also felt more confident having opted for one of the choices, rather than just being sent to a type of therapeutic intervention that may not necessarily have been appropriate.

Having experience normalised

Knowing that one is not the only one suffering with these symptoms was helpful to some women. Charlotte commented on how helpful this was, *Knowing that I'm not the only one suffering with it, and there is help there has made me a lot happier.*

A process of normalisation is different to being told its normal. Normalisation is more about a shared experience with other women reducing the feeling of isolation. Sophie offered similar explanations of what was helpful to her, *the psychologist was* offered similar explanations of what was helpful to her, *the psychologist was good………she said don't expect too much of yourself and a lot of women experience this, which was re-assuring.* Therefore it appeared to be helpful to know that other people go through this as well as re-assurance that there is help available.

2.2.12 Sub-themes relating to unhelpful parts of the process

Direct communication

Those women who had experienced a more directive approach found it helpful. Mainly those GPs who said, this is what you have and this is what can be done about it. Jane found this helpful with her GP (see early quote) Sandra felt encouraged by her GP and said, *once she knew what it was she explained clearly what needed to be done next.* It seems that sharing distress with someone who you perceive to be able to help you and they do, is reassuring to some women.

Knowing its an illness

Janice and Charlotte talked about how knowing it was illness was helpful, for Charlotte she had thought she was *going round the bend* and that it was her so being told it was an illness was a relief. Janice commented on how the psychiatrist was really helpful as it gave her permission to feel what she was feeling and take time out to recover, *the psychiatrist was lovely he said you are ill and you need time to recover.*

Medication

For two of the women in the study medication was seen as useful once they had overcome fears and worries associated with taking anti-depressants. Rachel had talked earlier about resisting taking tablets but once she was told she really needed them and she should try them she did and they helped. Lotti reacted similarly when she finally thought she would try them as a last resort, *I started taking the antidepressants and they were good, I felt great they did me a lot of good.* The rest of the women in the study did not share these reactions and it reflects the importance of discussing carefully with women what is available and what they would like to try.

STAGE THREE

2.3 Personal meanings of postnatal depression and being referred to mental health services

2.3.1 Subjective meaning of label and experience

This section outlines the meanings of their experience that women have arrived at and further discussion of these accounts, links with other themes and aspects of the process will be presented in section four of the results section. Women talked about how they understood their experience, what meaning they had taken from being referred and how they had integrated an understanding of postnatal depression with self-discovery and personal meaning.

There seemed to be varying outcomes for women who had been through this experience. For some women they talked about a re-assessment of the label, their identity and an assimilation of meaning that was positive, temporary and an experience to be learned from. There appeared to be a process of externalisation of postnatal depression but not a complete detachment from it, in that women linked aspects of themselves in relation to it and thought about personal attributes and external factors that may have contributed to postnatal depression, without the label encompassing the whole self. It was almost as if these women saw it as in infection to get over and had learnt personal lifestyle characteristics that with adaptation and knowledge could contribute to overcoming such an infection in the future.

It's definitely an illness

Four of the women in the study had come to the conclusion that in their opinion postnatal depression was an illness and all of these women remarked on having arrived at this view even though they felt differently initially receiving the label.

Charlotte stated that, *I thought I was weak for being referred but now I can definitely see that it's an illness,* Janice supported this view, *I couldn't cope because I was ill.* Jane talked about her understanding of postnatal depression and the meaning of requiring help. *It's not a state of mind it's a physical, yeh it's a physical illness that it does it takes you, you've got absolutely no control over it. I just feel I am perfectly* *normal everyone needs help and that was my time that I needed help.* Clearly these women have reached a meaning that is non blaming and one that represents a time in one's life where help was needed, rather than a meaning that suggests an internal and stable aspect of the self that is somehow fundamentally flawed in comparison to others.

Towards self discovery and a position of empowerment

One of the research aims was to look at how women perceived themselves and whether the referral had impacted on their self- image, capacity to cope and feelings of control.

The same four women in the study who had reached an understanding about postnatal depression as an illness, also talked about self- insight that enabled them to feel empowered and more in control. In some ways these experiences appear somewhat paradoxical in that, if one is ill then control is often diminished and one would not expect to feel empowered by such a concept. However women expressed how they had developed personally through their experience. Jane commented on her thoughts and feelings, *it was a bit scary to know that I can't cope on my own all the time, its taught me that yes sometimes you do need help. I feel more at ease with myself now cause I don't have to pretend anymore, nice really. I used to feel dreadful as though I was a bad mother, but looking back I'm a human being what used to make me feel vulnerable now I see as stronger. I feel a better person for it.* This quote sums up Jane's move towards a position of acceptance, of herself and of her experience.

Other reports reflected this level of personal growth, for example Janice stated, *One of the benefits of being ill is that I have learnt so much about myself, I have learned to say no and not feel bad, I actually think I'm stronger.* It was also evident from Janice's account that she also saw her experience of distress as temporary and something that she was able to distance herself from, *Its just a phase in my life at the moment just a blip.*

Charlotte and Lotti talked about feeling more in control of their life now since the referral, Lotti quite positively states, *I'm in control of my battle now, I feel fine I know where I am going, I know what I am doing I know how I feel and I am going to deal* *with it.* The other two women who had reached similar feelings of control talked about receiving the right kind of help from appropriate professionals. For example, Janice talked about how speaking to people who knew what they were talking about helped her to feel in control. She talked about how *being in the system* allowed her to move forward.

The remaining three women in the study had arrived at rather different meanings of their experience and it is interesting to see the contrast between these women and those who had arrived at meanings that enabled a more positive outcome. Two of the women's meanings of their experience leaned towards postnatal depression as a consequence of self and a kind of internal deficit model.

The meanings are characterised by either a sense of illness that is major and ongoing or internally attributed to the self in a more global manner. There are similarities in these meanings as both have a sense of chronicity and permanence about them, not found in the four women's accounts above. These women had not undergone a period of positive reframing and personal development like the other four women. Their personal meanings were either clouded with uncertainty, a reflection of the self as "woman" or reflected within a personal context of where they were in relation to the referral process. One woman in the study reported feeling rather stuck, uncertain and abandoned. As the researcher it felt as though Sophie was in a state of limbo, she had been left this way as a result of the process and she was beginning to feel rather hopeless about the future and her recovery. These themes encapsulate the meanings of the experience for Rachel, Sophie and Sandra.

Its me, I'm inept

These words were used by Rachel to explain how she felt about the label and the process of being referred. Responsibility is located internally and there is a sense of self- blame in her statements, *having discovered to a certain extent that everyone goes through what I went through. I didn't cope and they were coping. So it just kind of reinforced the incompetence and inept. I did feel terribly incompetent.* Aside from the referral Rachel commented on her general outlook on her life that was almost a stable trait of her identity, *I already felt pretty useless, I should run away and resign.*

Depression was seen as an ongoing problem or a *re-occurrence of an existing problem.*

This confirmation about the self as inherently flawed is commented on by Sandra, *I just can't cope, its nil compared to the past, I always feel that other mothers can give them more and be better mothers, I think its just confirmed what I thought about who I was.* Sandra also talked about her feelings of guilt about the way she was with her family. Both these women tended to look inwards for explanations of how they viewed themselves.

It's major

Rachel talks about her relationship with depression in this context, *normal life for me is not being pregnant and being depressed.* There is a sense that this is a "chronic condition" that she has assimilated and accepted as part of her life.

Sandra talks about postnatal depression as a major illness that she had lost clarity on. She was no longer sure what was postnatal depression and what was normal depression, *I would call it a major illness, cos I've had it for two years now, I no longer know whether I've got postnatal depression or whether I'm just depressed.*

Feeling worse and in Limbo

Sandra reflected on how she felt since she had been referred. She commented that she had got worse and the referral had not helped her feelings of control. She said, *I've not had any control as far as I'm concerned, I got worse after the ECT, in fact I think I've probably got worse, all the tablets I'm on, lack of memory I'm still down why aren't I moving on?* Clearly Sandra felt somewhat disillusioned by her experience and was stuck in the process.

Rachel had agreed to undergo CBT treatment but was not finding it helpful at the moment and her account had a somewhat in Limbo feel to it. She said *Its not helping yet, I'll give it a couple more sessions, if nothing useful comes out of it then I'll stop, then I'll be back to square one.* Sophie was very much stuck in the process, she had been referred, gone for an assessment and was left waiting, her initial feelings of hope had gradually faded away as she had not had a response from the services. She talked about feeling abandoned and that she was stuck, unable to go any further whilst she waited for a response. *I mean you are constantly thinking you know have they forgotten me, will the letter come today, sitting alone thinking I'm going bloody mad here. I thought you'll start getting better when you go there, cos that's what you hope will happen that will help you get better, you think the service is to treat you and sort you out but its just not happening, its going on and on.*

Meanings of label

The women's understandings of postnatal depression having been through the process of being referred varied considerably according to their experiences. Sophie's understandings rather reflected where she was in the process, i.e. waiting and feeling alone, left to deal with it, *I think its like a numbness, like being in your own little world and you can't share it with anyone, you can't get out of it.* Sandra had initially explained that she thought it was a major illness but she also talked about not really knowing anything more about it since her experience of being referred. She said *I don't think I know anything about it, I don't think I know anything more about it.* Her reference to it being a major illness reflected how she felt and the length of time she had had it but she had not come to an understanding about postnatal depression, perhaps not surprising given the number of treatments she had received.

Rachel's initial response to how she understood postnatal depression was that she didn't know, but then she added that, *I kind of get the impression that it seems like women's problems, lots of research into period pains, gynaecological problems loads of stuff that women have to put up with, it was easily dismissed as hormones, It probably is that, I don't think it is that cause it doesn't really explain why some people get it and others don't, but then if I had been a coping sort of person which I'm not, oh I don't know.*

This account from Rachel is interesting as it encapsulates her engagement with different constructions around womanhood, the information she has been given and her own perceptions of the role of her self in understanding her problems. It also reflects the different discourses that are portrayed in the media and research literature. Even though hormones didn't really make sense to Rachel she did not completely dismiss this explanation, instead she returned to her role and identity as a "non-coper" to assimilate meaning.

The next part of the results section discusses some of the links between themes within the stages of women's journeys and the impact that the various processes appear to have had on shaping and influencing women's subjective experiences. The author has chosen to add this dimension onto the results section, as it appears to make the intricacies of women's journeys visible and subjective meaning understandable. The findings of this study and the implications for psychological research and practice will be discussed in relation to broader literature in the discussion section.

Part three: Making the impact of the process visible

3.1 *Why link themes?*

Some qualitative research goes no further than identifying the saliency of themes around a particular phenomenon, how often they occur, what is generated, to lead to a descriptive account or representation of meaning. According to Silverman (2000) "data without theory say nothing (2000, p.253). Therefore the researcher should always endeavour to conceptualise the phenomenon and make sense of it, which is what the author of this study has aimed to do.

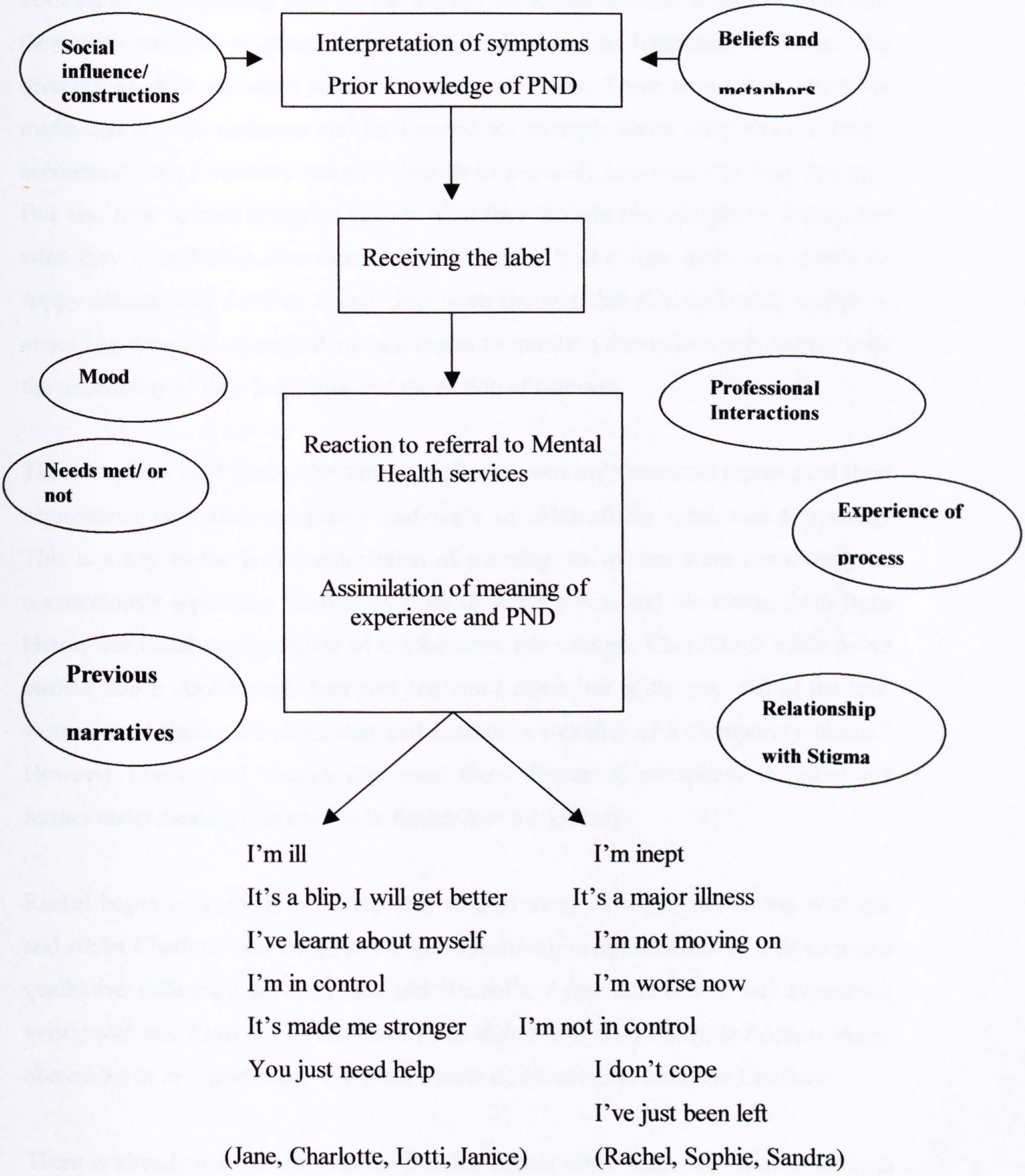
This study is concerned with exploring the meaning of women's experiences of being referred to mental health services and how aspects of the process have influenced the assimilation of meaning. Specific objectives were to explore the impact on women's self image and feelings of control and how they understood and experienced the referral. Furthermore how they conceptualised the label of postnatal depression in the light of this referral. These research questions have lead to findings that represent a dynamic process of interactions towards an understanding of meaning and how that comes about.

What has been described in the previous section is an account of the journeys that women have undertaken and the subsequent subjective meanings that women have arrived at. There were many themes generated that women experienced through the three stages of the journey. The process involved women's beliefs and positioning about themselves at the beginning and throughout the journey. Also their engagement with professionals, wider social meanings and either positive or negative experiences, that served to interact with these beliefs to contribute to the different meanings that women arrived at. For four of the women in this study, meaning was characterised by an understanding of postnatal depression as an illness, a move towards self-discovery and a position of empowerment and self-acceptance. However for the remaining three women in the study this was not the case. For these women understanding and meaning was characterised by a position of self- blame, uncertainty that had a chronic or major illness element or a sense of being in limbo.

Why then did women reach these different meanings? What has influenced such meanings and how do they interact with aspects of the journey and women's beliefs about themselves and the label of postnatal depression? The following section outlines links that can be made through women's accounts and aspects of the journey towards a theoretical framework and understanding of their experience.

There is no one core element that is situated within the journey to explain these meanings but rather it is a set of complex interactions that have taken place between the women and aspects of the journey. The diagram overleaf illustrates the relationships and interactions between the women, meanings and aspects of the journey. The meanings that women have arrived at are unpacked and linked back through the diagram using evidence from the data, to tell their story of various interactions and processes that can be tentatively theorized.

Figure 1. Diagrammatic representation of women's journeys and the factors influencing personal meaning.



3.2 *Understanding the journey and subjective meanings*

3.2.1 *The initial stage: What was going on*

Looking at the beginning stage of the journey for all the women, it became clear that they were engaged in struggles to understand what was happening to them. The diversity of these accounts reflected a range of issues. There were some dominant media and societal messages and lay theories for example about baby blues in Jane's accounts *At first I was very weepy, I thought its probably just what I've been through.* But also how women struggled against what they thought they should be feeling and what they were feeling. For example Sophie said *it's at a time when you should be happy* alternatively Lotti as a first time mum thought that this was what it was all about. As symptoms persisted women began to question themselves and engage with the uncertainty of their behaviour and the notion of madness.

The metaphors used during this time according to women's accounts represented their engagement with their symptoms and ways of externalising what was happening. This is a key factor in the assimilation of meaning, as women were consciously or unconsciously separating themselves from their symptoms and distancing them from blame, one could say a position of helplessness. For example Charlotte *It's like being pushed into a dark tunnel,* Jane *you just can't climb out of the pit.* All of the four women used these metaphors that had reached a meaning of a "temporary illness." However Sophie and Sandra also used these distancing metaphors therefore for further understanding one must look further into the journey.

Rachel began interpreting her symptoms straight away as something wrong with her and whilst Charlotte also suggested it was *something in my mind doing it* there was a qualitative difference between that and Rachel's, *I just assumed it was something wrong with me, I just felt terrible that I just didn't love this poor little helpless thing. Something in my mind doing it* implies a sense of distance, its not quite Charlotte.

There is already a sense with Rachel that her beliefs about blame are centred inwards as is the responsibility for her feelings. There is also an internalised social message here about women should love their babies instantly if not you are terrible.

The range of understanding of postnatal depression at the beginning of the process reflects the influence of dominant media messages, individual narratives and beliefs about staying well. Some conceptions that appeared to have been socially constructed through the media had clear moral implications. For example, Lotti thought that *it was hating your baby,* if one believes this or that your baby would be taken away like Rachel, then this places images of badness and dangerousness on mothers who encounter postnatal depression.

Along side these assumptions that had been developed through interactions with various social constructions, was the individual beliefs about avoiding depression and staying well. Jane talked about her beliefs about how she thought depression came about, she thought it was an *emotional state* and if you as the individual allow *things to get you down then they will.* Women also acknowledged medical discourses that they had come across, namely the hormonal explanation. Sandra commented that she had heard about that but still did not believe that she could get postnatal depression *Why would I get that* she described both her children as miracle children.

Women interchanged between messages about postnatal depression. For some women during this period they had begun a process of externalisation whilst still engaging with popular and academic discourses about postnatal depression i.e. life events, medical discourses and the role of negative beliefs. Furthermore there were themes related to ideals of motherhood such as instant love and *a time when you should be happy,* thus invoking concepts of deviance.

Hence, at this point women are holding a variety of assumptions about motherhood, postnatal depression and their role in relation to their symptoms, which have been influenced by personal assumptions, medical discourses and social constructions of motherhood. This process of holding different assumptions leaves women in an uncertain position, are they just mad (because their behaviour is strange), are they being taken over by something, or are they deviant. So what happens next to these women?

3.2.2 *Receiving the label*

What has been discussed so far is the beginning point in the process where women are feeling low and distressed and carrying a number of assumptions and fears that have been influenced by a variety of factors about what is going on. These assumptions go on to interact with receiving the label of postnatal depression.

For Lotti, Charlotte and Rachel receiving the label invoked concerns about *going mad.* Rachel having been depressed before felt that the label of postnatal depression tapped into her fears about "taking the baby" away as what she had read and what she had been socialised to within her family were messages that suggested this. However given that she had been depressed before the actual label was not so much of a problem, it was more what it implied. She recalled having gone through this when she was first told she was depressed. For Lotti this invoked a similar fear to the extent that she was not able to accept the label at first, as it would have meant identifying herself with something that she viewed as deviant.

Interestingly, other feelings reported were shock and relief. These feelings are not unlike those reported by other client groups that receive a label in fields of medicine. There is relief because there is a reason for the symptoms that have so far been confusing and have acted as a threat to women's integrity and identity as mothers and as women. For other women the shock aspect was related to assumptions of severity, for example Jane thought that *you had to be really, really bad to suffer from postnatal depression.* Even though Jane had not thought she had got postnatal depression she agreed because she believed the person who had told her *knew what she was talking about.* There is evidence here of the beginning of the role of the expert and how women engage with them. This factor became more prominent in the later stage of the journey, as women interacted with professionals.

3.2.3 *The professional as the agent of meaning*

Women's interactions with professionals exposed them to a variety of contrasting explanations about the causes for their distress. Particularly dominant were those messages about being ill, chemical imbalances of the mind, hormones and the role of life events and the normality of what was happening. These different explanations reflect the different professional orientations of the professional that was seen and women responded differently to what they found helpful and acceptable. For some women i.e. Charlotte and Janice, being told it was an illness was helpful. Women accepted this illness label as it provided a reason for their behaviour and given that initially women were engaged in a struggle between ideas of madness and distress that seemed so paradoxical to the ideals of motherhood, this label provided relief.

For some women although they had been given explanations along the way they recalled not really having any explanation at all. For example Lotti recalls being given a leaflet that was about postnatal depression to give to her partner (see part two of results section). Lotti was dissatisfied with this when she thought back to how desperate she felt and she thought that she should have been told that she was ill. This account along with Janice's highlights many of the women's needs to be seen by an expert. The same two women talked about how patronized they felt when they were told that their experiences were normal. As Lotti quite rightly argued *it is not normal to sit up all night watching over you child because you think it's going to die..*

For Rachel she was told that she must go on the tablets straight away but alongside an explanation that everyone goes through these feelings but they are not normally so long. What Rachel took from this was that her experience was normal and that she just didn't cope very well. This explanation served to exacerbate her beliefs about self- blame and inadequacy that she had voiced earlier on in the process. There were further interactions with professionals that Rachel had that weren't helpful to her. For example, Rachel was honest about her concerns about harming the baby and the health visitor had written in the notes that the baby was not at risk because her husband was there. Rachel felt unsettled by this and as if she was not to be trusted. She had become concerned that she might harm the baby from descriptions of what people could do who were depressed or who had puerperal psychosis. She felt somewhat hounded by it even when she saw a therapist. It is understandable that assessing risk was important to such professionals but perhaps more care could have been taken to be explicit about the reasons for asking and some acknowledgement given for how distressing this could be.

Sandra was given explanations about there being a chemical imbalance in the brain and that it may also be related to her father. She had not felt understood by the psychiatrist and felt that all in all she was worse than she had been before the referral. She said, *As far as I'm concerned I got worse after the ECT, in fact I think I've probably got worse, all the tablets I'm on, lack of memory, I'm still down.* Sandra was the only participant in the study that had received ECT. Clearly the combination of this and the vast array of tablets had not helped her. One cannot help but wonder if Sandra was given ECT because she felt she had been depressed for a long time, medication was not working for her and her father had committed suicide. Had the psychiatrist reacted differently to her once he realised her father had committed suicide? What were the reasons for such invasive treatments?

Sandra reported having mentioned her distress to the midwife and health visitor when she first felt low (see ***not picking up on distress***). Despite Sandra protesting that she was not right they failed to take this on board, which resulted in Sandra not feeling listened to or understood by either of the professionals. This is a clear example of the devaluing of women's and depressed women's accounts and denying them their expertise on how they were feeling. This was echoed in Janice's and Lotti's accounts around being told "it was normal."

The professional interactions that women encountered have been addressed here and further consideration of helpful and unhelpful parts of women's journeys will be considered later in this section.

3.2.4 *Relationship with stigma: Being referred to MH services.*

Knowledge of referral to mental health services appeared to bring both reassurance and relief to six of the women in the study. Women reflected on their desperation at this point and feelings of powerlessness to effect change themselves. Again this can be likened to other fields of medicine whereby if you are ill and in distress and there is a specific reason for it, then one would hope that one would be referred to an expert who knew what they were doing and how to treat it.

Women engaged with the idea about stigma in relation to what others think about such services and the internalised messages they themselves had developed. Interestingly Charlotte and Jane mentioned that either they felt weak for being referred or that other's may think that. There is a popular message around depression and other mental health problems that all you need to do is pull yourself together, whereas the same expectations are not constructed around physical illnesses. Jane had also made comments at the beginning that she genuinely thought it was an emotional state that you could pull yourself out of, so perhaps these assumptions were playing a part here.

For many of the women they acknowledged that there was stigma around mental health services but the overarching theme here was, that they felt so desperate by this point that they felt relief about getting help, rather than stigma. However, Rachel did not feel this way and consistently held disturbing visions of psychiatric wards and Victorian images of asylums. She felt more comfortable with Prozac as she commented on how that was seen as "cool". This view was not shared by many of the other women who were more concerned about medication. Women engaged with the idea of stigma by either reframing it in terms of illness suggesting that you just need help like physical illnesses, carrying it along with social constructions of madness, asylums, being trapped in the system or dismissing it as other people's problems. Women approached ideas of stigma through past experiences either personal or familial and with a set of assumptions that they had already developed before and at the beginning of the journey.

3.2.5 *What about the process: What went on here?*

The author has already mentioned some of the processes that were not helpful to women for example, not being heard or listened to, distress not being picked up and being told its normal. Some other processes that were mentioned by the majority of women was having to wait to be seen, being misunderstood or having choices made for you like Janice and Charlotte regarding the group, professionals not being explicit regarding diagnosis and what could be done about it and for some women taking medication for various personal reasons.

These unhelpful processes are extremely relevant and are from women who have experienced them first hand, all of them carry strong messages for professionals in this field.

Women were also keen to acknowledge what had been helpful in the process and it is not surprising to find that many of them are the opposite to what women had found unhelpful. For example women valued being listened to, having an expert, having a choice and having their experience normalised in the sense that one is not the only one suffering from it. Perhaps significant themes here are the role of choice, this was mainly experienced through contact with psychological therapies and women found this empowering. Indeed it combined the expert support with having some choice over treatment. Clearly with Sandra this had not really been the case, she had accepted treatment options by the psychiatrist and whilst she had consented to these she was not given a range of choices from which to make a decision. At the time of interviewing Sandra had started some therapy, which she was beginning to find useful.

3.2.6 *Getting needs met or not, feeling better or not*

Finally looking at the processes that women have been through to arrive at their meaning it is evident that the four women who were able to reframe their experiences and have personal insight were those women who were feeling somewhat better. The other three women were stuck in the process either disillusioned with the whole concept of postnatal depression, awaiting to see whether treatment would help, or just waiting and in limbo still feeling distressed. I am not suggesting that the women's mood invalidates their accounts by any means but that it may have a role to play in how women felt and recounted about their current position.

Likewise, the four women who were feeling better felt that they had been helped by therapeutic interventions and the outcome. Whereas Rachel, Sandra and Sophie had not had a positive outcome, they were stuck in the process. The results of this study and their implications for research and practice will be discussed in the next chapter.

CHAPTER FOUR: DISCUSSION

This chapter will discuss the key findings of the study in relation to the existing literature on postnatal depression and relevant broader literature. The clinical implications will also be discussed along with the strengths and limitations of the study.

1. Key findings

The primary aim of this study was to explore the experiences of women who are referred into mental health services, for postnatal depression after being previously cared for in primary care, and the effect of the process in which this was done. The researcher was concerned to explore the subjective meanings that women arrived at and how they had experienced the process of being referred.

The process of interviewing these women has demonstrated that women take an active role in this process by way of the cognitive frameworks they adopt but that there are various processes and interactions that interact with these frameworks to contribute to the meanings women ascribe to their experience.

Illness was seen as a temporary phenomenon that could be got over rather like an infection or virus and women felt empowered by their experiences and self -insight. The other three women in the study reached a position of understanding and meaning that was characterised by self- blame and an internal deficit model, a meaning that was uncertain but had a chronic or major illness element or, a sense of being stuck or in limbo halted within the process. Women's narratives followed a sequence that included initial experiences of symptoms, through to assumptions about postnatal depression, receiving the label, thoughts and feelings about being referred to mental health services, experiences of the process and an assimilation of meaning that women arrived at. The findings are discussed in relation to this sequence.

Early accounts of symptoms and prior understandings of postnatal depression

During the early stages of the journey women experienced a range of symptoms and were engaged in a struggle to understand what was happening to them. Initially women attempted to explain symptoms in terms of what they had been through. For example a difficult birth, being a bit weepy, which is a widely accepted phenomenon following birth and generally a sense that symptoms would cease after a few days. These attempts to explain and normalise distressing and unfamiliar experiences has also been found in studies exploring women's experiences of depression e.g. Gammell and Stoppard (1999). As symptoms persisted women began a process of questioning and holding a range of explanations informed by constructions of motherhood e.g. *It's at a time when you should be happy*, notions of madness, e.g. *its something in my mind doing it,* a sense that something was taking over them, *Its like being pushed into a dark tunnel* and in Rachel's case internalising the symptoms, *I just assumed it was something wrong with me.* This process of holding explanations to understand a horrible experience that women could not explain themselves was an uncomfortable position that challenged women's identities, hopes and expectations about motherhood.

The influence of ideals and social constructions of motherhood has afforded considerable attention by feminist writers. For example Lewis and Nicholson (1998) claim that the "*rhetoric of motherhood reflects the belief that the birth of the baby is a happy event and that motherhood itself is a universally fulfilling experience for women*" (Lewis and Nicholson, 1998, p177). Indeed such messages are amplified by the media, magazines written for pregnant women and perceived social norms about women as mothers. Such messages encourage women to look inwards at the first sign of a mismatch of experience from that which is expected. Women in this study engaged with this idea that it was confusing and unfair that they should feel this way but also searched to explain why they were feeling distressed.

The range of explanations indeed reflected dominant messages about motherhood, including *I'll recover after a few days* and *I should be happy*, but further attempts were made to draw on explanations including the role of the self and that something was happening to them that they could not control.

Assumptions about postnatal depression varied across women's accounts and were again influenced by dominant messages portrayed through social constructions in the media. For example *hating your baby* and beliefs that the baby would be taken away. Clearly this has moral implications if one associates postnatal depression with these beliefs. It is nevertheless a common belief held by women, Mauthner (1998a) found in her study of eighteen women who had identified themselves as depressed that they feared expressing ambivalent emotions, as they believed their children may be taken away or that they themselves may be institutionalised. This finding was consistent with the findings of other studies such as Whitton et al (1996).

Other assumptions women held were related to personal narratives about staying well such as Jane's belief that it was *an emotional state,* which could be made worse if one allows it. There were also assumptions about postnatal depression that reflected medical discourses such as the hormonal explanation. It is interesting that this explanation is the most dominant medical one given that research in this area has yielded little confirmatory evidence, yet it has filtered through into a lay theory as the most common cause and explanation for post natal depression. It is perhaps due to the common hormonal explanations that are often given to women at various stages in the life cycle to explain distress or mood change, for example premenstrual tension, menopausal symptoms and mood disturbance following childbirth. Feminist writers suggest that the continued perseverance of research into women's biological and hormonal connections to their mental distress is perhaps based on the sexist assumptions that underlie mental health services that has filtered through into common widely used discourses about women (Ussher, 1991; Nicholson, 1991).

The key factor here is that women have engaged with a variety of messages about postnatal depression, motherhood and their role in relation to their symptoms. They brought to their journeys personal beliefs, experiences and narratives, social constructions and popular explanations for distress. Therefore the findings of this study suggested that women are not merely passive recipients of the patriarchal society that constructs the ideals of motherhood, but rather that women hold individual and different assumptions about postnatal depression that are subjectively as well as socially constructed.

Receiving the label

For some women this prompted feelings of relief, largely because there was an explanation for their behaviour and distressing symptoms. This finding was consistent with Mauthner's (1998a) study that also found that women were relieved to have an explanation. In part four the author mentioned that this relief was not unlike relief experienced by other client groups. To give a somewhat crude example of what is meant by this, consider a person who for weeks has been suffering with chest pain each time they breath. He has fantasised about all kinds of reasons for this including cancer, blood clots and other terminal diseases he finally goes to the doctor who examines him and tells him he has a chest infection and prescribes him a course of antibiotics. Not surprisingly he experiences relief about this information. For some of the women in this study they had been containing an ambivalent position for quite sometime feeling depersonalised, insane in some instances and completely distressed as their sense of self was threatened, therefore they were relieved that there was a name for this unfamiliar experience.

This was not the case for all of the women in the study, for some of the women receiving the label served to reinforce prior negative conceptions they had held about the meaning of postnatal depression. For example Lotti had believed that having postnatal depression meant that *it was hating your baby* therefore she could not accept this label as it threatened her self worth and identity as a mother. Likewise Rachel had formulated fears of the baby being taken away, from family narratives and from reading books about postnatal depression and puerperal psychosis. Charlotte attributed madness meanings to the label of postnatal depression. These responses are in keeping with stigma that is often associated with psychiatric labels (Newnes et al 1999).

For other women they were shocked at receiving the label, as having postnatal depression in Jane's case meant that *you had to be really, really bad.* Jane did not think that she had postnatal depression but went along with it because she believed that the person who had told her *knew what they were talking about.* Other women such as Rachel just went along with the label because they had been so distressed. Hence reactions to receiving the label were influenced by women's prior conceptions of postnatal depression, feelings of desperation, feeling as though they had experienced postnatal depression before and feeling relieved.

Sandra, Jane and Janice's reactions to receiving the label appeared to imply an explanation of postnatal depression that was based on psychological processes. Explanations and beliefs about symptoms that people adopt have been thought to range from, psychological i.e. "It my personality" concepts of imbalance, invasion of an external force and a kind of inherent weakness that perhaps runs in the family (Salmon, 2000). Several women in the study made references to these explanations, as did the professionals that they interacted with for example *it's a chemical imbalance, it may be related to your father.*

Personality driven explanations can be seen in Janice's account where she stated that *I actually thought I was the kind of person that would get it, I'm a perfectionist.* Jane remarked on how she had always coped before but that in this instance she wasn't coping. These women looked inwards for explanations to make sense of receiving the label, but it was not in a way that was self blaming, rather Janice had acknowledged aspects of the self that explain for her why she should get "postnatal depression". During the interview she stated her comments in a way that suggested a self acceptance of these traits. It may have been that Janice was reflecting back with hindsight on how she understood it and it was difficult to ascertain whether Janice would have made these statements if she had been in a different stage of the process.

The range of these accounts reflected the cognitive heterogeneity of the women and they have emphasized the active role that women take. Previous attributions and cognitive frameworks are utilised in the construction of their meanings of the label of postnatal depression.

This active process that women engaged in to construct meaning of the labels applied to them has been reported by Whitton et al (1996) who also argue that women are cognitively heterogeneous and carry with them a range of beliefs that impact on the treatment they engage with or indeed whether they seek treatment at all. Several women in my study talked about which forms of treatment they found more acceptable. This appeared to be based on assumptions about mental health services, medication and the concurrent level of stigma that they attached to them. Women varied in their beliefs about such treatments reflecting their individuality and range of assumptions they held. However in Whitton et al's study the focus was on "maladaptive cognitions" that prevented women from seeking help rather than looking to the services offered in conjunction with such beliefs.

It was not within the scope nor the intention of this study to search for "faulty cognitions", as this would only perpetuate the pathologisation of women and omit the use women made of their beliefs and the role that professionals had in shaping these. What was important was how women had postnatal depression explained to them and how this interacted with their prior conceptions and beliefs. So it was not merely the label but rather the range of explanations and the interactions with professionals that appeared to shape and further channel women's understandings of their experience.

The role of professional Interactions

Women's interactions with professionals appeared to be significant. What women were told influenced how they conceptualised their experiences. Women interacted with GP's, and health visitors initially where they encountered a range of explanations offered to them for their distress. The predominant medical discourses made available to women were explanations of hormones, chemical imbalances in the brain and concepts of illness. Some of the women in the study commented that knowing it was illness was helpful. It seemed to alleviate previous fears of madness and give permission to adopt the sick role and take time out to recover.

Indeed Lewis and Nicholson (1998) have argued that medical discourses are available to women to explain why they are not experiencing fulfilment as a preference to the moral delinquency model, which is the only other alternative. In their study they found that women rejected medical discourses, as they were inappropriate to their experience. However the sample that they used were taken from women who were recruited from volunteer organisations and antenatal clinics and therefore such women may have made comments that reflected the early processes of attempting to understand and explain symptoms i.e. *.its what I've been through, lack of time on your* *own.* They did not interact with mental health professionals and they did not report the levels of desperation that were experienced by the women interviewed in this study.

Whilst I do not claim that the women in this sample were representative of all women's views that may have encountered low mood, as they were a unique sample recruited from a mental health service, Lewis et al do not acknowledge their methodological limitations related to participants. Therefore I am somewhat sceptical about their claims that women see depression as a normal response to the challenges of motherhood as it denies the experiences of women who do not see their distress as a normal reaction, a scepticism that is shared by Mauthner (1998a).

Further findings of the study that challenge Lewis et al's claims are how some women reacted to being told their experiences were normal. For Janice and Lotti being told their experience was normal had evoked strong reactions, and a distinction can be made between having one's experience normalised, which was helpful (Whiffen 1991) and being told it was normal. The latter was experienced as patronizing and led to women feeling devalued and misunderstood. Normalisation is often seen as a therapeutic essential to reduce alienation and negative feelings of difference. There is however a qualitative and fundamental difference from feeling like one is not the only one and that one's experience is understandable and being told that one's extremely distressing and bewildering experiences are "normal". Clearly professionals ought to be aware of their use of language when attempting to normalise women's experiences and acknowledge how distressing and invalidating being told that ones distress is normal can be.

Rachel and Sandra's interactions with professionals were interesting and both women had been depressed before. Rachel was told that her experience was normal and that everyone went through the distress that Rachel was feeling but that it didn't normally last this long. Rachel was also told that they would have to get her on the tablets straight away and queries were made about the level of risk that she posed to her child. These explanations interacted with Rachel's beliefs that she already held that were characterised by inadequacy and self- blame. Moreover Sandra, whose father had committed suicide, was told that her depression could be linked to this and that she also had a chemical imbalance. She was then subjected to invasive treatments that included electro convulsive therapy. Such treatments in the adult population are rarely given and one must question why these women's experiences with professionals were different to women who had not informed the professional of, or not experienced, prior depression.

To date I am not aware of any studies that explore treatments of women who are viewed as having long term depression rather than what professionals and particularly medics view as "pure" postnatal depression. It would be interesting to explore mental health professionals attitudes and views towards women who have a history of depression who are referred for "postnatal depression" Do they view certain episodes as "pure" postnatal depression if women have no previous history of depression? Do mental health professionals react differently to women who have suicide or severe depression in the family? Further research on a larger scale is recommended to explore these questions, as the small sample size in this study limits the generalisability of this finding.

Engaging with Stigma

Reactions to the referral to mental health services involved women engaging with the concept of stigma. Women did so by drawing on previous family narratives, societal images and messages about mental illness, personal values and beliefs regarding the location of stigma i.e. medication and/or psychiatric services. Clearly although women mentioned various concerns regarding stigma they, most of the women were able to re-frame such feelings in order to minimise rather than completely eradicate feeling stigmatised by the referral.

The desperation that women felt by the time they were finally referred appeared to override any major concerns regarding stigma, many women commented on the relief that they finally felt when they knew they were getting help. Rachel however was unable to re-frame her feelings of stigma, for her taking Prozac was the less stigmatising option. Whereas the other women felt that talking and going to see someone who could help you was preferable to taking medication.

Some of the women in the study also made references to their fears of becoming addicted to medication, e.g. Sophie, Charlotte and Lotti. Becoming addicted to anti-depressants is a fear that is often commented on in clinical practice and research exploring attitudes to treatment. For example Whitton et al's (1996) study of women's attitudes and beliefs regarding postnatal depression and treatment.

The impact of the process

What has been discussed so far is women's interactions with professionals and how they were experienced as helpful or unhelpful to women who were experiencing distress. Throughout the interview women were asked to comment on aspects of the process that were significant to them and indeed there were a number comments made that have implications for the way services are delivered for women and the overall positive or negative experiences that women had that contributed to the assimilation of meaning.

Some of the women commented on how they did not feel as if they were being heard. This was encountered with GP's, Psychiatrists, community psychiatric nurses and health visitors. This is a finding that has been reported by other studies, for example Small et al (1994) found that women who had sought professional help were often disillusioned by the responses they received.

In this study Janice did not feel that her GP understood what she was going through, Sandra came away from an appointment with a Psychiatrist feeling as though assumptions had been made that did not reflect how she felt and Lotti felt as though despite her protestations a psychiatric nurse insisted that what she was experiencing was normal.

These findings are similar to Small et al's (1994) study that was conducted over eight years ago; the striking similarity of findings of unhelpful interactions is a concern and one that services ought to attempt to change.

Women also talked about the disempowering process of having decisions made for them, for example Janice's and Charlotte's experience of being referred to a group when this felt inappropriate or being told that one would not cope with a group when ultimately this was beneficial. I am unaware of any studies to date that have explored the extent of choice that people using services are given about their course of treatment. Women in this study who had been given choices at the psychological assessment stage commented on how empowering this was therefore it would certainly seem a worthwhile venture for future research. Some research into user's perspectives and their role in shaping the services they use has begun, e.g. Pilgrim et al (1997) however there is still a sense that even though the national service framework proposes user involvement, how to implement such involvement in practice is afforded little attention.

Some participants felt that primary care staff had not recognised their distress, a finding that was also reported on by Small et al (1994). This has been an issue that has been followed up by some researchers who are concerned with early detection and prevention of postnatal depression (Elliott, 1989, Elliot et al, 2000b, Gerrard et al, 1993, Sharp 1996). However it would appear that women are still feeling as though they are left with distressing feelings that they feel ought to be recognised. Given that it is often difficult for women to openly voice these feelings (Mauthner 1998a, 1998b; Lewis et al 1998), professionals should provide the space to enable women to express concerns and be sensitive to individual women's experiences that may not conform to academic statements about onset of postnatal depression, which appeared to be Sandra's difficulty with her midwife and health visitor (see part four of results section).

The process of waiting to be seen was experienced as frustrating by the majority of the women. The hope of being referred to a specialist service soon gave way to despair, as access to such services appeared to be difficult. This aspect of the process was particularly significant for Sophie who was still waiting to be seen after being assessed by the psychologist. Sophie felt abandoned by the service, in limbo and unable to move forward. Other women commented on feeling abandoned and somewhat unimportant as they waited to be seen. This is clearly an ongoing issue for psychological services as scarce resources often lead to lengthy waiting lists.

It was also interesting to note that in the inclusion criteria for this study it was specified that women should not have waited for extensive periods of time. The service clearly felt that waiting periods were not extensive but to women themselves this was not the case. Services would do well to consider what it means to women to wait and whilst it is acknowledged that this is a difficult issue for services to address, due to lack of resources, perhaps women themselves could be involved in more emancapatory research to voice their opinions on what may help them in this period.

Finally some of the women commented on the lack of information they received from their general practitioners, this was also found to be a priority in the action group that was set up by Pilgrim and Hitchman (1997). Lotti was given a leaflet to give to her partner about postnatal depression. She felt annoyed that her GP had not been more explicit about what was wrong with her she said *I was ill and someone needed to tell me that.* Janice and Sophie supported Lotti's view, as did women who commented on a helpful part of the process being clear communication by professionals and a more directive approach that explained what was wrong with them and what could be done about it. Broader literature on physical health problems confirms this finding of needing a more directive approach.

Salmon (2000) suggests that in order to feel empowered "patients" need explanations and in some cases information. Even though they may prefer a more directive approach from their clinician, explanations and information are necessary for some people to feel empowered. Studies in mental health literature have also suggested that practitioners are often not explicit about diagnosis for a fear of stigmatising clients, however a study exploring participants willingness to attend psychiatric or psychological services for "panic disorder" found that the great majority of participants were happy to receive a diagnosis as, it meant they would get access to appropriate treatment. These participants also saw their experiences in medical and psychiatric terms and therefore it is important to match people's beliefs about their difficulties with an appropriate treatment and response (Johnson, Gold, Siemion, Magruder, Frueh and Santos, 2000).

Coppock and Hopton (2000) statements about improved health care are particularly pertinent here, where they suggest that models of health care,

"Should incorporate biological, psychological and social perspectives so that whatever the views of any service user there is a starting point for a dialogue between the service user and professional….." (Coppock and Hopton, 2000, p.168).

Women in this study were keen to acknowledge aspects of the process that were helpful and they were largely made up of the opposites of aspects of the process that were seen as unhelpful. Particularly relevant was the notion of having an expert. Clearly if one has been told that one is ill and reasons for this have been given along with information about which services would be most useful, one would feel a sense of relief when the expert on our distress was consulted. Again synonymous with parallel literature on physical health problems whilst "patients" seek information and control by way of involvement and choice in decisions made about their care, they do not necessarily want to take responsibility for their treatment (Salmon 2000).

The paradox of empowerment

Four of the women in this study viewed postnatal depression as an "illness" a view of distress that according to feminist writers is an essentially disempowering position (Rowe 1984, Lewis et al 1998, Woollett and Parr 1997). However women in this study who had reached a meaning of illness reported feeling empowered, stronger and more accepting of the self, which represents a somewhat paradoxical position. Indeed women began the journey of being referred into mental health services in an ambivalent position engaged in a struggle between ideals of motherhood, notions of madness and utter despair as they struggled to make sense of their experience in an acceptable way that did not threaten personal integrity. Receiving a label and explanations offered by professionals enabled women to distance the "self" from postnatal depression.

Findlay and Miller (1994) have pointed out that medicalisation of depressive experiences can have advantages for women. Medicalisation allowed women to shift responsibility from themselves into the hands of doctors. Gammell and Stoppard (1999) state that whilst this is empowering in the short term as women made life changes to reduce stress they tended to be changes that were ultimately disempowering in the long term. However Gammell et al's study was exploring women's experience of medicalisation and treatment of anti-depressants rather than treatment that involved psychological therapy. Indeed the women in this study medicalised the concept of postnatal depression as it allowed them to create enough distance between postnatal depression and themselves so that they could engage with therapy to reassess aspects of their personality and social circumstances, making changes that were ultimately empowering.

This process of externalisation and its usefulness within narrative therapy has been researched and practiced by scholars within the child and adolescent fields (Carr 1999) and in research utilising narrative approaches to critical incident debriefing in adults. For example Fay (2000) published a paper that explored individual narratives that were in some way confirming negative aspects of the self and functioning for adults that had been involved in critical incidents. For example, beliefs about self blame. Fay refers to the use of the narrative therapy approach that enabled externalising conversations to allow the individual to view the problem as separate from the self, making it easier to tackle the problem without seeing it as integral to the self. Therefore distancing and externalisation of distress as "an illness" adopted by the women in this study, may have been helpful to them. It allowed them to cope with their distress and engage with it in a manner that was empowering. Further qualitative research with a larger sample of women is warranted to explore the usefulness of externalisation and its relation to empowerment for women distressed in the postnatal period.

Moreover, women in this study did not conform to a singular explanation of illness that closed the door to other factors that they thought may have contributed to their distress. They saw their experiences as temporary and a kind of *blip* or *phase in their life* that had meant they needed help on this occasion.

Women were able to reframe aspects of stigma and minimise it by the beliefs they adopted regarding postnatal depression and see their experience of being referred to mental health services as a learning experience. Perhaps women were only able to reach such meanings in the light of a positive therapeutic outcome and because they felt better. This outcome meant that unhelpful aspects of the process were experienced but that overall their position of meaning was positive despite these processes. Clearly the greatest influence for these women were professional explanations and how women integrated them within their own cognitive frameworks to cope with and re-frame their distress in an acceptable way for them.

Stuck in the process

The remaining three women in the study had not reached such meanings and a position of empowerment and in Sandra and Sophie's case this is not surprising. Sandra had been subjected to a range of treatments such as ECT, a plethora of medication that did not seem to help and an experience of a process that had lead to her feeling confused, worse and let down by those who she thought would help her. Sandra viewed postnatal depression as a "major illness" a meaning that is understandable given the length of time she was experiencing distress and the failure of recommended extreme treatments to offer her any relief. Sophie had been left in limbo waiting for the mental health services to contact her and in the meantime she was loosing hope about ever feeling better. As a result she remained confused and alone and her understanding of postnatal depression reflects this, a *numbness, like being in your own little world and you can't share it with anyone.*

Rachel had also experienced aspects of the process that were unhelpful and she appeared to have an attributional style of self- blame and inadequacy that interacted with the explanations she was offered. She also had feelings of stigma about being in the system that she was unable to minimise, which meant she was unable to reach a position of empowerment. Rachel was also waiting to receive treatment and had therefore not experienced any beneficial self-insights or acceptance that the other four women had.

The failure of services to meet the needs of these women ought to be heeded by those who are involved in service development and women themselves should be included in such developments to ensure that their needs are indeed appropriately listened to. This supports suggestions that have been made by Perkins (2001) who has claimed that clinical effectiveness ought to be evaluated from the agendas of those who use them rather than those who work within them. Further research is required if the national service framework agendas for user involvement are to be put into practice.

This study has contributed to the lack of research on user's perspectives and has highlighted some implications for the delivery of services based on women's accounts.

2. Methodological issues and limitations

The findings of this study must be evaluated and interpreted within the context of the methodological approach taken, including the sample of participants recruited. There are a number of methodological issues that were significant to the present study.

Sampling

The data generated in this study was derived from in depth interviews with seven women who had been referred to mental health services for postnatal depression. The sampling strategy was originally based on the premise that in some way there would be a discreet group of women who had no previous history and that "postnatal depression" would have been their first experience of mental distress. This reflects the influence of the literature that dominates postnatal depression research and perhaps the search for such a sample was based on a somewhat false distinction of postnatal depression as a discreet entity. Therefore women who had been referred not surprisingly had either been referred before to psychiatric services or had been depressed before either following the birth of a child or at another point in their lives. Therefore it was difficult to identify women who had not been seen by mental health services before.

The psychology department acted as "gatekeepers" for recruiting participants, which resulted in two interviews being carried out with women who were not included in the study because of their longstanding connections with mental health services. The study had originally planned to recruit 10-15 participants and unfortunately this was not possible (for reasons discussed in the method section) Therefore, the limited number of participants reduced the possibility for more diverse accounts of women in this setting. However smaller sample sizes are often used in qualitative research particularly when an in depth analysis is possible owing to the richness of data obtained. Indeed Parker (1994) concludes that, *"the aim is to provide an in- depth examination of the meanings at work rather than skim over as wide a surface as possible"* (1994, p.12).

The participants that were recruited were also at different stages in their contact with mental health services. Some women were off the waiting list, some women were at the start of therapy and other women had been through the process and were at the end of their engagement with mental health professionals. This meant that it was difficult to ascertain the chronological positioning of women's accounts and to what extent they were retrospective.

Interviewing

Throughout the interview process I became aware that there appeared to be a continual "pull" between the questions that I wished to ask in order to do justice to the research questions and women's agenda about what was significant and important to them, which of course was of research interest. For example I was concerned to ask women about their experience of being referred to mental health services and women themselves wanted to express their experiences of having postnatal depression and how dreadful they had felt. It seemed that my research question was not at the top of their agenda. Therefore it was not always clear when women were talking about the referral and when women were talking about their overall experience. Indeed for women themselves they felt so dreadful that the referral itself was not as important as *getting help*. This is recognised as a limitation of the study but was interesting in itself as it yielded information about what was important to women.

Diversity

Women recruited for this study were white and in heterosexual relationships, it is therefore acknowledged that the sample is limited on the grounds of sexuality and cultural diversity. Unfortunately there was no opportunity to recruit women to the study to include such diversities due to the lack of referrals to the service in general. However it is recognised that further research is warranted to include the views of these women.

The research setting

Women were unique in that they had sought help from professionals and had agreed to be seen by mental health services. Therefore conclusions cannot be made about other women with postnatal depression and whether they would make use of the medical model in the same manner. Furthermore these women were extremely depressed and they commented on their desperation by the time they were referred, which lies in contrast to other studies recruiting samples from other sources (e.g.

Lewis et al 1998). However it was the purpose of this study to explore women's views of a referral to mental health services and how the process in which this was done impacted on the meanings that women ascribed to the label and their experience. The meanings that these women ascribed are illuminating and relevant to clinical psychologists and practitioners who have contact with such women.

Data analysis

The study was concerned to explore the meanings for women and the most appropriate method for exploring these meanings was a phenomenological approach to the data. In contrast to other feminist research I did not explore or adopt a gendered approach. However women weren't on the whole talking about their experience in gendered terms. Different types of qualitative analysis may have yielded interesting findings regarding the language women used to describe and conceptualise their experiences particularly the discourses that women utilised themselves and from others. This study has not adopted a discursive approach although certain discourses have been studied in their relation to meanings. It would be interesting to engage in further research that adopted a discursive approach to the data including those used by professionals.

3. Further evaluation of the study

Elliott, Fischer and Rennie (1999) have published several guidelines for evaluating qualitative research studies within psychology and related fields. They propose that qualitative research should consist of 1) Owning one's own perspective, 2) situating the sample, 3) Grounding in examples, 4) Providing credibility checks, 5) Coherence, 6) accomplishing general versus specific tasks, 7) resonating with the reader. The present study will be evaluated taking each guideline in turn.

Owning one's own perspective

By acknowledging my epistemological positioning and autobiographical context I have attempted to make explicit my perspective in approaching this study. My reflexive processes in designing the study, carrying it out and analysing the data have been visible to the reader.

Situating the sample

Descriptions of the research participants have been given as far as possible to preserve confidentiality of the participants (included in Appendix Three). The context within which the sample was recruited has also been discussed earlier on in this chapter.

Grounding in examples

In order to achieve transparency of the themes generated in this study I have used the participants' own words to illustrate the themes that have been constructed.

Providing credibility checks

Supervision was used to check the constructions of categories and whether they reflected what the participant was communicating. Unfortunately I was unable to take the transcriptions and the constructed themes back to the original participants and I recognise that this would have increased the validity of the themes and provided useful feedback for the participants. However it is my intention to share the findings of study with the participants before any publication of the research. The participants have been informed of my intentions.

Coherence

I have described and presented the understanding of women's experiences as a journey through various stages of the referral process in order to add coherence and readability to the study. Appropriate summaries of the generated themes have been included and a diagrammatic representation has been included to illustrate the links that have been made.

Accomplishing general vs. specific tasks

This study has attempted to understand the meanings for women of being referred to mental health services with a label of postnatal depression. General tasks were to explore meaning and more specific tasks were to understand the processes that women went through and were exposed to in arriving at the meaning. Further understandings of how postnatal depression was conceptualised by these women has been demonstrated. The limitations of the sample have been discussed.

Resonance with the reader

This will be judged through examination of this report.

4. Implications of the study

4.1 *Implications for clinical practice*

The following summary illustrates the implications for clinical practice that were discussed earlier on in the chapter.

General implications

- Women should be given time to talk and express their experience from their perspective. Harmful assumptions were made about what would be helpful for some women.
- Normalisation is helpful for some women but care should be taken not to minimise and invalidate distress experienced.
- Thorough information should be given and communicated to women explicitly by the professionals they encounter, as women did not appreciate vagueness. The explanations given to women regarding the causes of their distress should reflect the diverse literature and not just those that imply a chemical imbalance. This fed into some women's fears about madness and gave them a singular option of medication.
- Women should be treated as experts on how distressed they feel for some women they felt as though their views were not taken on board, which hindered their access to services.
- Women should be given choice about what they feel would help them and how they would like to proceed.
- Women experiencing distress in the postnatal period are a diverse group and individual differences and their capacity to know what they need should be respected when decisions are made about their care.

Implications for clinical psychologists

- Clinical psychologists are ideally trained and placed to offer training to other professionals who are directly involved with women in the postnatal period. Training would be valued in consultation and communication skills and in offering alternatives to medication and ECT.
- For some women the label of postnatal depression and understanding it as an illness was helpful therefore psychologists should work with women's perspectives and take on board women's coping strategies.
- Women valued being given a choice about psychological treatment options, this was experienced as empowering and should be transferred across a range of clinical problems.
- Waiting periods are a problem and psychologists would do well to consult with the clients that use their services and multidisciplinary members to tackle this problem rather than relying on the "lack of resources" argument.
- Externalisation of the problem was useful for some of the women in this study, if women are viewing it as a separate entity distanced from themselves a solution focussed approach may be useful and less stigmatising for these women as it allows them to step back from the dominant and often damaging social ideals of motherhood.

4.2 *Implications for future research.*

This study has highlighted that for some women the label of postnatal depression was useful. Conceptualisation of postnatal depression as an illness seemed to help women create some distance between themselves and their difficulties. Their use of externalisation was interesting and further more quantitative research to explore this process with a larger sample would be worthwhile. More qualitative work could also involve the exploration of women's use of "illness" in greater detail and depth and this may also involve a discursive approach and participants who have not sought help for their symptoms of depression.

A tentative question arose about the use of narrative therapy that utilises externalising conversations with women who are already beginning to view their symptoms in that way. A larger study could be conducted to compare this type of therapy with other interventions and the subsequent outcomes and women's satisfaction with the approaches.

Waiting periods were experienced as frustrating and unhelpful for the women in this study. In line with national service framework initiatives on involving user's in research and practice it would be useful to involve women who use services, not just for postnatal depression, to gain their views on what would be helpful in this period.

There was also a tentative question that arose from how professionals reacted to two women in the study who had been depressed before. Although it was not clear how women presented their previous depression to these professionals there appeared to be more medicalised and severe treatments given, particularly the woman who received ECT. Were these women viewed as having long- term depression? It would be interesting in the light of the debate of whether postnatal depression exists on a continuum, to see how professionals view women and aspects of their care in the postnatal period if they have been depressed before. Whether they react to and treat women differently whom they believe are suffering from a "purer" form of postnatal depression.

5. Conclusion

The aims of this study were to explore the meanings of a referral to mental health services for women labelled with postnatal depression, who had previously been cared for in primary care. Further aims were to consider how the referral impacted on women's concepts of postnatal depression, their self- image and feelings of control. Aspects of the process were also considered to explore their impact on how women ascribed meaning to their experiences. Qualitative research exploring women's perspectives has been limited and to date research has been dominated by quantitative studies that have sought to objectify women's experiences of postnatal depression. The present study has demonstrated that for some women the label of postnatal depression is useful as it provides an explanation for their distress and behaviour that has challenged their identity. Moreover feelings of stigma related to a referral to mental health services were experienced, but overriding the meaning of this was relief, as women clearly felt desperate for some help. Furthermore some of the women engaged in an externalising process that resulted in postnatal depression ultimately being viewed as "an illness", which enabled women, somewhat paradoxically to feel more in control of their symptoms and engage in a process of self discovery, acceptance and empowerment. This finding has challenged some literature that claims medicalisation and empowerment cannot co-exist (Gammell and Stoppard 1999) and highlights the notion that women use "illness" in different terms to academics as they include socio-environmental, psychological and biological explanations.

Professional interactions that women experienced appeared to have an effect on shaping, altering and reinforcing women's understanding of postnatal depression. However women themselves approached such interactions with their individual beliefs and narratives and played an active part in the assimilation of meaning, thereby supporting research that proposes the cognitive heterogeneity of women in general and the postnatal period (Whitton 1996).

Other women in the study appeared to have experienced a range of professional interactions like the others but were stuck in the process and referral journey. The key factors for the more negative outcome for these women appeared to be 1) individual beliefs about their distress characterised by self-blame, 2) a range of harmful treatments that had left the woman confused about postnatal depression and what could help and 3) desperately requiring and desiring help but being stuck in the process.

Along side the clinically relevant concepts that have emerged regarding how women cope and conceptualise their difficulties and experiences. This study has enabled access to women's views of services that is often overlooked, and the effects of processes that women encounter along the journey into mental health services. These processes have been made visible in this research and there are important messages to mental health professionals who are primarily there to help women.

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APPENDIX ONE

NHS
Health Authority

COMMITTEE
comprising three sub-Committees in and

20 April 2001

Dear

Application Number: M114/01
Title: Post-natal Depression and experiences of services

Thank you for your letter of 30 Mar 01 supplying amendments as requested by Sub-Committee of LREC at the meeting held on 22 Mar 01. The Chairman, acting under delegated authority, is satisfied that all the points raised have been addressed. There is therefore no objection on ethical grounds to the above named study. This study is **Approved**.

Conditions of Approval

- Any amendments to the study must be approved by this committee
- The study must start within three years of the date of this letter
- Any serious unexpected adverse reactions must be notified to the committee
- You complete the interim report form sent to you at the end of each year
- You complete a final report at the end of the study

The following items were reviewed in connection with the above study.

Ability of Investigator and staff to perform the proposed research	Approved
Suitability of the premises and facilities	Approved
Protocol	Approved
Protocol Amendments	Approved
Methods of Initial Recruitment to Study	Approved
Compensation for Investigator's Participation	N/A
Patient Information Sheet	Approved
Patient Consent Form	Approved

Treatment of Subjects: Approved

Compensation for Subjects Participation: N/a

Other: Application Form amendments - Approved

We wish you every success with your study.

Yours sincerely

Approved by Chairman
Signed by
Administrator

Vice Chairman, Sub-Committee of LREC

Please send all correspondence to:

LREC Administrator
c/o Centre for Public Health Research

APPENDIX TWO

PATIENT INFORMATION SHEET

TITLE OF STUDY: “ From Primary Care to Mental Health Services: The experiences of women with post-natal depression who have been referred to Mental Health Services ”.

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with friends, relatives, your GP or any other professional you have contact with if you wish. Please ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

Aims: To explore the experiences of women who are referred into Mental Health Services, for post-natal depression after previously being cared for by GP's and Health Visitors.

- This research is interested in your views, individual experiences and your thoughts and feelings about the label post-natal depression.
- How you have experienced the referral being made and how you understand it.
- Whether the way the referral was made has had an impact on you in any way.

Why have I been chosen?

You have been invited to take part because of your recent referral to Mental Health Services. Previously you may have just had contact with your Health Visitor or GP and this will be the first time you have seen either a Psychologist or Psychiatrist.

I am interested to know what your experiences have been of services and whether this has affected how you understand the term post-natal depression.

Other women have also been asked to take part as they are in a similar situation. Altogether there will be about 10-15 women taking part.

Do I have to take part?

Taking part in this research is entirely voluntary. If you do decide to take part you will be given this information to keep and an initial appointment will be made with myself to discuss any queries you may have. You would then be given a consent form to sign. If you decide to take part you are still free to withdraw at any time and do not have to give a reason. This will not affect the standard of care you receive.

What will it involve?

1. An initial meeting with myself so that I can meet you and answer any queries that you have. I will also inform you of the kinds of questions that I may ask.
2. This will take place at [redacted] Resource Centre or [redacted] Resource Centre.
3. After the initial meeting you will be asked to attend again for about an hour and a half so that I can ask you about your experiences. This session will be tape recorded just so that I don't miss anything you tell me. I can also visit you at home for the interview if this is more convenient.
4. Your name and anything that identifies you will be anonymous and the tapes are for my sole use to go over what we discussed. The tapes will not be listened to by anyone else. After I have gone through the tapes they will be destroyed.
5. Once I have finished going through all the meetings I have with women, I may contact you again to give you feedback if you wish.

What are the disadvantages of taking part?

I can see no major disadvantages of taking part. It will involve you giving up your time and perhaps arranging childcare facilities for the session.

I also understand that when you are not feeling yourself it can be difficult to answer questions and sometimes upsetting. I wish to assure you that the information will be confidential and complete respect will be given, however you are feeling.

What are the advantages of taking part?

1. Talking about your experiences will enable professionals to hear your side of the story and services could well be adapted to better meet your needs at this difficult period.
2. The information you give will help to further psychological understanding of distress after childbirth.

Confidentiality

All information collected during this research will be anonymous and kept confidential. Your therapist will be aware of your taking part, so they may be available to you to talk if you wish.

What will happen to the results of the research study?

The results of the study will be written up as part of a piece of work needed to complete the research part of a Doctorate in Clinical Psychology. In the future the results may be published in a psychological journal and you will be informed if you wish if this is going to happen. Again your identity will be anonymous in any report.

Who is organising the research?

My name is [redacted] and I am currently a second year student on the Clinical Psychology Course at [redacted] University. This research is being supervised by a Research Tutor, [redacted] and a Clinical Psychologist, [redacted] If you have any queries I will be happy to discuss them.

APPENDIX THREE

Information regarding participants

Sophie

Sophie was a 27yr old woman who lived in a council house in a semi rural area. She was married and had three children. She was employed as a care worker in a residential home. A member of Sophie's family had spent periods in a mental health unit and Sophie and her brother's and sisters had been taken into care as children. Another family member had problems with alcohol and painkiller addictions and she describes her past as a bit turbulent. Sophie had contact with a psychiatrist once as a child. On this occasion she had been referred by her GP.

Lotti

Lotti was 29yrs old and lived in a new estate just outside the town, she did not work. At the time of interviewing she was married and had four children. Lotti's father had died when she was young. and her family life had been distressing. Her health visitor had referred Lotti to the mental health services and she had initial contact with a CPN as part of the screening process to the CMHT. Lotti had had a stressful pregnancy and birth and there were complex family relations.

Jane

Jane was 30yrs old and lived in a council house close to the town centre. She had three boys. She had had a traumatic pregnancy on two occasions and what appeared to be negligence on the behalf of the maternity staff. She was not working at the time of the interview but had undergone training in counselling and was hoping to pursue that as a career. There were alcohol problems in the family and Jane described her childhood as not being an easy ride. She had been referred by her GP to a practice counsellor who had then referred her to the CMHT.

Sandra

Sandra was married with two children and was 37 yrs old. She lived in a fairly affluent area in a large house. She was not at work at the time of the interview and did not disclose her occupation. Sandra had thought that she had suffered from depression for a long time but had not previously sought help. Her father had committed suicide when she was younger and had also suffered from depression. Sandra had been referred to the service by her GP.

Rachel

Rachel was 32 years old, married with one child and lived in a council house within the local area. She had had longstanding fertility problems and a difficult pregnancy. Rachel felt that she had been depressed before. At the time of the study Rachel was not working and she did not disclose the nature of her employment. The health visitor had referred Rachel to the mental health services and a community psychiatric nurse had carried out an assessment.

Charlotte

Charlotte was 35 years old and married with two children. She lived in a town house close to the town centre. She was employed as a public servant. The health visitor had referred Charlotte to the mental health services and she did not recall being depressed before.

Janice

Janice was 31yrs old and married with two children. Her first child had learning difficulties and she recognised that she had been depressed before with this first child. She was a nurse and at the time of the interview she was building up to returning to work. She remarked on her complex relationship with her mother that had caused difficulties for her. Janice also saw a psychiatric nurse in the first instance before she attended a group at the resource centre.

APPENDIX FOUR

APPENDIX 1

Centre Number: :
Study Number:
Patient Identification Number for this trial:

CONSENT FORM

Title of Project: From Primary care to Mental Health services : The experiences of women with post-natal depression who have been referred to Mental Health services.

Name of Researcher: Trainee Clinical Psychologist.

Please initial box

1. I confirm that I have read and understand the information sheet dated .... (version ....) for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected. ☐
3. I understand that sections of any of my medical notes may be looked at by responsible individuals from [company name] or from regulatory authorities where it is relevant to my taking part in research. I give permission for these individuals to have access to my records. ☐
4. I agree to take part in the above study. ☐

Name of Patient	Date	Signature
Name of Person taking consent (if different from researcher)	Date	Signature
Researcher	Date	Signature

1 for patient; 1 for researcher; 1 to be kept with hospital notes

APPENDIX FIVE

INTERVIEW GUIDE

Scene setting

1. What is your story, ie from pregnancy to having child to present day?
2. Did you have any concerns about becoming a mum.
3. What was the birth like?
4. What was your health visitor like did you get on?
5. When did you first realise that you felt different than you thought you should?
6. What did you think was wrong?

Meaning of PND

1. When did you first come across the label of PND?
2. What did they say that meant?
3. What did it mean to you?
4. What were your first thoughts about it?
5. What did you feel about that label being applied to you?
6. Did you agree with it?
7. How was it explained to you? i.e. physical terms, illness, psychological, emotional?
8. Did your understanding of the things you were feeling differ from the explanations you were offered.
9. Have people suggested other ways of understanding it? If so what and who?

Process Mechanics

1. Did you have to fill in a questionnaire about your feelings?
2. Had you received something called "listening visits" from your health visitor?
3. Had you been to your GP? What was your experience of this?
4. What did your GP or Health visitor say about the problems you were having?
5. When did you first learn about being referred to mental health services?
6. What was the process of being referred, how was it done, what information did you receive re the reasons?
7. What information were you given about the referral? ie why it was necessary
8. Did this contradict previous information about PND?
9. Were you surprised at the decision to refer?
10. How did your Health visitor explain it to you?
11. How did Clinical psychologist/Cpn explain this to you?
12. Were the two accounts different?
13. Was the decision to refer you to mental health services a joint one, if not would it have been better for you if it were?
14. How much control did you feel you had over this decision?
15. Would you have liked anything to be done differently

Impact of referral

1. How did you feel when you were told about the referral, what were your initial thoughts?
2. Has this impacted upon your relationship with your health visitor/GP?

3. Has this had any impact on your relationships with family and friends?

Stigma

1. Did you tell anyone about this referral?
2. Was there anyone you didn't want to tell about it?
3. Why was this?
4. Have you found it difficult or easy to tell people that you are coming for this help?
5. What reaction have you had from people? Were you surprised?

Feelings of mental health service

1. What were your concerns about being referred, did you have any strong feelings about it?
2. What did it mean to you to be referred into this service?
3. Generally how do you understand a service of this kind?
4. What do you think or know about people who attend here?
5. More specifically what did it mean for you?

Self image

1. Did the referral change the way you see yourself personally and within society?
2. Did you feel differently about your skills, identity, your capacity to cope?
3. Has this referral changed the way you think about who you are?
4. Change the way you see your role in/and relationships?
5. Do you feel that other people think differently about you?
6. Since this referral, how do you see yourself in relation to other mothers?
7. Did you feel differently before this referral?

Control

1. How much control do you feel you have over your problems?
2. Did the referral change this in any way?

Meaning post referral

1. What do you think PND is at this point?
2. Has your understanding changed in any way since you first heard the term used?

Key words List

Meaning of PND
Feelings about mental health service
? changed understanding of PND
Stigma

How much control
Self image
Internalised messages
Impact of process of referral
Mechanics of it what did women think about the process