A HERMENEUTIC PHENOMENOLOGICAL STUDY OF WOMEN'S EXPERIENCES OF POSTNATAL DEPRESSION AND HEALTH PROFESSIONAL INTERVENTION

Victoria Heather Williamson

R.N, B.A (Hons) Master of Social Science (Counselling)

The Department of Clinical Nursing

The University Of Adelaide

April 2005

A thesis submitted for the degree of Doctor of Philosophy of the University of Adelaide,

Adelaide, South Australia

THE UNIVERSITY OF ADELAIDE
CANDIDATE'S CERTIFICATION

This work contains no material which has been accepted for the award of any degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text.

I give consent to this copy of my thesis, when deposited in the University Library, being available for loan and photocopying

Signed…

Dated…

CONTENTS PAGE………………………………………………………..ii

<u>Appendices</u>

<u>Articles by the Candidate Published in Peer Refereed Journals</u>

Williamson .VH & McCutcheon, H., (2002) Postnatal Blues. *Singapore Nurses Journal*, April- June, 2002 Vol 29 no 2 pp: 32 -36

Williamson, V.H and McCutcheon, H (2003) Postnatal Depression: The Dark Shadow, *In Midwifery and Mental Illness*, Ausmed Publications, Victoria. May, 2003.

Williamson, V.H & McCutcheon, H (2004) Postnatal Depression, A review of the literature. *Australian Midwifery Journal*, Journal of the Australian College of Midwives, November 2004. 17 (4) p 11-16

GLOSSARY AND DEFINITIONS OF TERMS

Adjustment Disorder: (In psychiatry), a disorder experienced when difficult life transitions, such as the birth of a baby, occur. For example, in the postnatal period this refers to the normal mood difficulties experienced by people who have just become parents and are struggling to adapt to big life changes.

Affect: (In psychiatry) a pattern of observable behaviours that are the expression of a subjectively experienced feeling state (i.e. emotion). (DSM-III R 1987, p. 391).

Antenatal depression: Depression experienced during the Antenatal Period.

Antidepressant medication: Medication prescribed by a Medical Doctor for the purpose of treating or alleviating depression.

Antenatal Period: The period of pregnancy when a child grows in the womb before birth.

Bi-polar Disorder: A psychiatric disorder wherein mood swings cycle from intense excitement and mania, to deep depression. Used to be thought of as "manic depression".

Caesarean Section: An abdominal operation created to surgically remove a child when vaginal birth is obstructed or unsafe for mother or child (e.g. in cephalo-pelvic disproportion or breech presentation in the child).

Cognitive-Behavioural Therapy: Counselling used especially in depression. It works by straightening out thinking which can make a mood such as depression or anxiety worse. The idea is that emotion follows thought, therefore realistic and more positive thinking and problem solving can help patients to heal from depressive episodes.

Crèche: A child-minding facility.

Dasein: A German word, which means, "Being there". A Heideggarian term, relating to human existence (Gelven, 1989, p. 31).

DSM – IV: Diagnostic and Statistical Manual (of psychiatric disorders). IV- number four.

Electro-convulsive Therapy (ECT): A psychiatric treatment for depression done by electrical stimulation of the brain.

Epidural Block: A spinal anaesthetic.

Episiotomy: A surgical cut to the perineal area, which is done when the baby needs, needs more room to emerge during birth.

Forceps Delivery: A birth where surgical forceps are used to help to lift the baby out during the birth process.

Gadamer: A student of Heidegger's, a phenomenologist and philosopher. Came up with the idea of the "hermeneutic circle" and "fusion of horizons" in his book ***Truth and Method*** (Gadamer, 1975).

Gestalt Therapy: Psychotherapy based on wholistic principles, as in Gestalt two-chair work, where a patient can work through deep-seated emotional issues and grieve long-standing emotional losses.

Heidegger: German philosopher and student of Husserl, and later devised a different approach to phenomenology to that of Husserl. Wrote ***Being and Time (1962)*** Main difference from Husserl is (let's return) "to the facts themselves" but had the idea that there is "no such thing as an uninterpreted fact" (Heidegger 1962).

Hermeneutical: As in "hermeneutical". This was firstly a method used to decipher ancient, sacred texts, especially where the meanings appeared unclear. This term has now come to mean a philosophy and a method of interpretation of texts.

Husserl: German philosopher, (d.1938) Known as "the father of phenomenology".

In-vitro Fertilisation (IVF): Surgical treatment of an infertile mother, which involves implantation in the womb of a pre-fertilised egg.

Lactation: when a new mother is producing milk to feed her infant.

Lived Experience: "our immediate, pre-reflective consciousness of life" (van Manen, 1990).

Marce Society: A society for the study of childbirth and early infant care begun in France, last century.

Multipara: A woman who has had more than one birth.

Oestrogen: A hormone, which is especially profound during pregnancy, a female hormone.

Perinatal Period: The time period near, and just after the birth.

Phenomenology: The study of a thing (Roberts and Taylor, 1997).

Postnatal period: The period after the birth, when the child is still an infant.

Postpartum period: The period after the birth (partum=delivery).

Post Traumatic Stress Disorder (PTSD): (from Psychiatry) Post-traumatic Stress Disorder, an acute stress reaction to a severe trauma, first called "shell shock" as it was experienced by soldiers returning from the trenches in WW1.

Primipara: A woman giving birth to her first child.

Progesterone: Another female hormone instrumental in pregnancy and in the menstrual cycle.

Prolactin: A hormone instrumental in milk production for lactating women.

Psychosis: A period of separation from reality, hearing or seeing unreal events and believing they are true.

Psychotropic Medication: Medication used in psychiatry to help with psychiatric conditions, e.g. Lithium in treatment of psychosis.

Puerperium: The immediate period after the birth, i.e. in the first few days or weeks.

Randomised Control Trial (RCT): A form of research involving large numbers of participants and statistical examination of results.

van Manen: A phenomenological researcher and follower of Heidegger and Gadamer who came up with a way to study "lived experience" using six steps to apply during the research process. His book Researching Lived Experience (1990) was extensively used during this project.

ABSTRACT

Much information is available through the print and other forms of media about pregnancy, parenthood, and the birth process, but significantly less information exists about postnatal depression or about how to cope with the often-painful realities of childbirth and parenting. Even less information exists about the effectiveness of caregiver intervention, especially from the point of view of womens' remembered experience. This study helps to fill the information gap identified in the literature.

This is a hermeneutic phenomenological study guided by the ideas of van Manen (1990). I interviewed women who had experienced postnatal depression and health professional intervention, and asked them about their experiences. Some of the questions were, "What are the types and quality of health professional interventions provided for you by health professionals treating your postnatal depression?" "Which interventions did they use that were helpful for you, and which interventions were unhelpful?" The interviews were open-ended and tape-recorded, took one hour each, and the data was allowed to unfold naturally.

The data were transcribed and analysed, then interpreted using the philosophical underpinning of phenomenology to guide my interpretation.

The search for meaning in the text, and my attempts to make sense of the findings resulted in the development of two major themes, the first being Dual Reality and the second being Interventions, each theme had three sub-themes. Within the theme of Dual

Reality were the sub themes of Behind the Mask, the Stresses involved in Being a New Mother, and The Depression Experience. Within the theme of Interventions were the three sub themes of Getting Help (the helpful interventions), Lack of Support, (the unhelpful interventions), and the Need for Education and More Services for Postnatal Depression (the missing interventions). The helpful and unhelpful health professional interventions were examined, some were positive and helped the women to heal from postnatal depression, and others were unhelpful (or simply absent), and the women were not assisted in their recovery.

A number of recommendations are made and also suggestions for further research are included as a result of the findings of this study.

DEDICATION

This thesis is dedicated to all women survivors of postnatal depression, and those professionals who care for them. In particular, I dedicate this work to the twelve brave, wonderful women who shared their stories so willingly and openly with me.

And

In memory of my friend and mentor, the Late Dr. Haydn Moore Williams (Aug 28, 1922 – April 13, 2004), a fine lecturer in English who gave me valued support and encouragement to develop intellectually, professionally and personally from my late teenage years into my adult life.

ACKNOWLEDGEMENTS

Chapter One

Introduction

Postnatal Depression (PND) is a serious and remarkably common mood disorder experienced by women after childbirth. Women describe this experience in heartrending ways:

> I was transformed from a competent lawyer into a new mother crippled with doubt, confusion, and unshakeable sadness. Too terrified to hold my baby, I cried even more than she did. My nightmarish postpartum depression lasted for months… (Balk, 1990, p.38).

My interest in this topic came from working as a counselor at a local community women's centre. A number of women I spoke with suffered from this condition, and I listened to their stories. One impression that stayed with me long after leaving the centre was the difficulty some women experienced when seeking help from health professionals, and how long some had remained without diagnosis or treatment. One such woman had developed ongoing depression after the birth of her last child twelve years previously. Their stories and experiences fuelled my interest in this area.

The objective of this study was to understand the experiences of women with postnatal depression when seeking and receiving help from health professionals, including child and maternity health nurses, midwives, counsellors, social workers, and doctors, including psychiatrists. I chose to interview women and ask them about their lived experience of this phenomenon. I felt that in doing so I might discover new information to add to the limited existing body of knowledge on this particular subject. My hope was that dissemination of the research findings would result in

health professionals gaining new information, which would positively affect their care of women with PND in terms of improved situation-specific interventions.

Statement of the Research Question

From the experiences described earlier the following research questions were formulated: "What was the womens' experience of postnatal depression? In particular, what was their experience of intervention from health professionals?" I asked the participants, "What are the types and quality of health professional interventions provided for you by health professionals treating your postnatal depression? Which interventions did they use that were helpful, and which interventions were unhelpful?

Significance of the issue

Much information is available through the print and other forms of media about pregnancy, parenthood, and the birth process, but significantly less information exists about Postnatal Depression or about how to cope with the often-painful realities of childbirth and parenting. According to Miller (2002) for many first-time mothers, the experience does not match their expectations and perceived pressure from other women can inhibit them from talking about difficulties they may be experiencing.

Figures vary, but it appears that PND affects somewhere between 10 to 15% of mothers (Cox, 1987) but this percentage may be even greater. In the United States the reported incidence of PND has ranged from 10% to 26% (Beck, 1992). Recent Australian figures state that PND affects 14% of postnatal women, and may affect the same number antenatally (Buist, 2004). The Marce Society (a European postnatal

education association formulated last century) indicates a huge variation on incidence factors, from 6.8% to 20% at 6-8 weeks postpartum (Taylor, 1997). Kumar and Robson (1984) have concluded from their work that childbearing does have a deleterious effect on the mental health of women and this is supported by Cox (1993) who has reported that a three-fold higher rate of depression was found within five weeks of childbirth compared with a group of women without children. Often women are too ashamed or afraid to seek professional help, or when they do visit their doctor, their condition is not recognised and they are offered help which is seen as either irrelevant or lacking in empathy or practical solutions (Cox, 1983a; Richards, 1990). Furthermore, according to Beck (2002) the most significant factor in the duration of postnatal depression is the length of the delay to appropriate treatment. According to Gold (2002) postpartum psychiatric illness consists of a highly prevalent group of disorders whereby patients generally seek help first from primary care physicians rather than mental health professionals. While severe postpartum depression and psychosis are easily recognised, milder or more insidious forms of depression can easily be missed. Heightened sensitivity to and screening for such psychiatric disorders in the postpartum period can facilitate recognition and consequently expeditious treatment.

It has been suggested that postnatal affective disorders are exclusive to Western culture and associated with the rapid change for women during the transition to parenthood, and yet studies show the psychiatric state of females in the puerperium to have similar rates of depression across the world. Cox (1979) did a comparative study of women in semi-rural Uganda (depression rate 10%) and Scotland (depression rate, 13%) revealing similar rates of depression between the two groups of women.

Huang and Mathers (2001) undertook a study comparing British and Taiwanese women, and found similar levels of depression in women from each culture; 18% in the U.K. and 19% in Taiwan, respectively. Similar results have been obtained in Japan (Okano and Nomura, 1995), and in Chile (Jadresic, 1992), although Japanese females expressed more somatic symptoms than psychological symptoms. From these studies it appears that despite great differences in numerous factors such as social customs, the environment, medical support, and money, similar percentages of women experience PND throughout the world. These earlier studies are supported by the findings of Oates, Cox, Neema, Asten, Glangeaud-Freudenthal, Figuredo, Gorman, Hacking, Hirst, Kammerer, Klier, Seneviratne, Smith, Sutter-dallay, Valoriani, Wickberg and Yoshida (2004), who reported that postnatal depression was a universal condition with similar rates in different countries.

Postnatal Depression – An overview

Defining Postnatal Depression

The literature in this area is controversial in defining Postnatal Depression. Some authors make the distinction between transient depression as a normal reaction to childbirth experienced by many women that does not require intervention (the so-called "three-day blues") and the prolonged debilitating mood-disordered condition experienced by a much smaller percentage of women (Dix, 1987; Bewley, 1999). None of this is to be confused with puerperal psychosis, which is another very serious illness that involves psychotic episodes appearing within the first postnatal week (Dean and Kendall, 1981). It is by far the least common mood disorder, affecting only about 0.1% to 0.2% of all recently delivered mothers, but it is the most serious of

these disorders, in terms of the potential risk of harm to mother and infant, and is associated with the greatest risk of suicide and homicide (Davidson & Robertson, 1985). However, Fossey, Papiernik, and Bydlowski (1997) suggest that the "three-day blues" is predictive of longer-term PND and even long-term depressive illness. Other authors have also written that the "baby blues" precedes or predisposes a woman to postnatal depression (Paykel, Emms and Fletcher, 1980; Glover, Liddle and Taylor, 1994). Therefore three mood disorders can appear in the first year after giving birth: the maternity blues (otherwise known as the three-day blues or the baby blues) the very serious and rare puerperal psychosis, and postnatal depression. They are differentiated on the basis of time of occurrence, clinical presentation, and clinical course.

For the purpose of this research PND is defined as a specific syndrome. It is also to be distinguished from Adjustment Disorder, which occurs in many women as they struggle to adapt to life-changes after giving birth and assuming the responsibilities of parenting (DSM-IV, 1994). For the purpose of clarity in this research, the Diagnostic and Statistical Manual for Mental Disorders (DSM-IV) criteria to define women suffering from Postnatal Depression (American Psychiatric Association, 1994) has been adopted. This definition allows for a major unipolar depressive disorder occurring during the first postnatal year. This does not include bipolar depressive disorder, which is classified as puerperal psychosis when it appears after childbirth. The DSM-IV gives a specific period of onset: depressive symptoms occurring within four to six weeks of giving birth and lasting for at least two consecutive weeks. The DSM-IV says that in general, the symptomatology of a postpartum major depressive episode does not differ from the symptomatology of non-postpartum mood episode,

and so is basically an episode of major depression with a "Postpartum Onset Specifier" if occurring four weeks after the delivery of a child. (DSM-IV, American Psychiatric Association, 1994 p.386). The DSM- IV refers to a postpartum onset as an indicator to distinguish PND from Major Depression in the general population. PND is therefore major depression happening specifically 4 to 6 weeks after childbirth.

Clinical Presentation of Postnatal Depression

While it appears that maternal depression is similar to depression in non-maternal women, the reasons for that depression are different and sometimes women present in clinical settings with irritability and somatic symptoms and fears for their children as the reason for consultation. So the depression may be missed in primary care, unless aware and vigilant health professionals ask specific questions (Hopkins, Campbell & Marcus, 1989; Holden, 1996; Sharp, 1996). Some women will also attempt to appear as the perfect wife and mother, denying depressive feelings and symptoms, so without requiring the women to complete a relevant questionnaire such as the Edinburgh Postnatal Depression scale (Holden, Cox & Sagakovsky, 1987, Williamson & McCutcheon, 2002), making diagnosis difficult.

Sometimes women will present in primary care expressing anxieties related to painfully negative feelings about their baby, or even delayed bonding. Women may express worry about lowered libido, fears about returning to work, strain on their marriage, difficulty balancing housework and childcare, social isolation causing lack of confidence, fears of inadequacy as a mother causing lowered self-esteem, anxiety, irritability, tearfulness and physical symptoms such as back pain and headaches (Sharp, 1996). Sleep and appetite disturbances, as well as lethargy and fatigue may be

missed as symptoms of depression because they are seen as "normal" for new mothers, and so vegetative symptoms such as inability to get up in the morning may not show up as depression during this phase of life, as clearly as cognitive or mood changes (Purdy and Frank, 1993). Some women experience non-stop thoughts or fears about harming their infant through deliberate intention or inadequacy as mothers, and some feel so desperate that they contemplate or even attempt suicide (Sharp, 1996). Some women also experience powerful feelings of guilt and confusion (Cox, 1989). Sometimes a poor relationship with a woman's own parents may exacerbate feelings of frustration or depression (Murray, Cox & Chapman, 1995) and the depression may act as a trigger for women to relive painful memories. In some cases, traumatic childbirth experiences where the lives of the mother or the baby have been endangered, may trigger symptoms specifically found in Post-Traumatic Stress Disorder (Allen, 1998). A traumatic birth can cause the existence of PTSD, which then aggravates PND (Allen, 1998).

Barnett and Fowler (1995) have suggested additional symptoms for PND to the classical DSM- IV symptoms of depression which are: significant weight gain or weight loss due to increased or decreased appetite; insomnia or hypersomnia; loss of libido; fatigue or energy loss; sense of hopelessness; decreased ability to concentrate or make decisions; suicidal ideation and planning; feeling sad or empty with constant or spontaneous crying; psychomotor agitation or retardation; and overwhelming inappropriate feelings of worthlessness or guilt. The additional symptoms are:

- extreme, possibly unreasonable disappointment in labour, delivery, breastfeeding, or other aspects of motherhood
- decreased interest in social contact and lack of social confidence
- decreased desire for any physical contact with their partner

- feelings of inadequacy, failure, inability to cope

- feelings of anger (especially aimed at the partner)

- experiencing a range of anxiety from mild agitation to extreme panic

- fear for and sometimes of the infant

- fear of being alone with or going out with the infant

- distressing thoughts of wanting to leave or running away

- fear of being unattractive, rejected, or unwanted by the partner; and

- fear of harm to or death of the partner

Barnett & Fowler, (1995 as cited by NHMRC, 1999, p.17)

Summary of Chapters

This thesis is presented in a linear fashion with Chapter One, an introduction to the thesis, offering a background to my study and a statement of the research question. The succeeding chapters provide specific information about this research. In chapter two an overview of the literature on postnatal depression, is presented including particular interventions, which health professionals currently use and believe to be effective.

Chapter 2

In this chapter, the literature on postnatal depression is summarised and the gap in existing knowledge on this subject and the topic under investigation is discussed. The gaps in the literature support the purpose and aims of this study.

Chapter 3

In this chapter, I explore the basics of phenomenology, my chosen philosophical underpinning to the research method of this project, and examine its philosophical concerns and some of the history of its evolution. Phenomenology can be quite difficult to grasp, yet due to its humanistic and ineffable qualities, it is useful to nursing research and enquiry.

Chapter 4

In this chapter the methods of data collection, the study setting, the participants, and ethical issues are discussed. The six steps of van Manen plus the method used for data analysis and interpretation are also described. Care is taken to address the issue of reliability and creditability in phenomenological research and the organisation of my data in this project.

Chapter 5

In this chapter, the personal stories of the participants are presented. Their stories are provided to situate them as individuals or the "parts" of the text (the participants) before relating them to the "whole" as is methodologically consistent with hermeneutic phenomenology (van Manen, 1990). Their stories outline the circumstances that led to their diagnoses of postnatal depression and subsequent health professional interventions. I have written the stories in the order that the women were interviewed.

Chapter 6

In this chapter, I describe the process of analysis of the transcripts of the participants, and present the key words, concepts, sub themes and themes. The search for meaning

from the transcribed interviews and my attempts to make sense of the findings result in the development of two major themes: Dual Reality and Interventions, and six major sub-themes. Tables, which help to explicate this, are also included in this chapter and in Appendices 8 and 9.

Chapter 7

This chapter describes the interpretation of the sub-themes and themes

Chapter 8

In this chapter, the implications of the findings are discussed and suggestions made with the intention of informing health professional interventions for women with PND. The concluding thoughts to this body of work are also included.

<u>Summary of Chapter One</u>

This chapter introduced the topic of my research and my reasons for having an interest in this area. The purpose of the research, the research question, and the significance of the issue of postnatal depression were also summarised. Included was a definition and description of postnatal depression and its characteristics. A summary of the chapters in this thesis was also provided.

Chapter Two

Literature Review

<u>Introduction</u>

This chapter summarises existing research literature about postnatal depression. The literature included in this review covers the significance of the issue of PND, the risk factors for PND, fathers with PND, studies concerning midwives and PND, and health professional interventions which include the prevention, detection and treatment of PND. It is intended to paint a picture of the current knowledge of postnatal depression as it stands in 2004. The purpose of this literature review was to identify any gap in existing literature.

For this literature review I undertook a comprehensive search of the Internet, and also the following databases: Medline, Cumulated Index of Nursing and Allied Health Library (CINAHL) and PsychINFO, Best Evidence and the Cochrane database of Systematic Reviews, together with other articles individually retrieved from the internet, which have revealed a solid amount of information on a range of issues pertaining to PND. Search terms included "postnatal depression and help", "postnatal depression and intervention" 'postnatal stress", "postnatal depression", "posttraumatic stress disorder and childbirth", "childbirth", "postnatal depression and prevention", "midwives and postnatal depression", "fathers and postnatal depression", and "postnatal distress". A National Health and Medical Research Council (NHMRC) systematic review of literature on Postnatal Depression up until 1999 was available, and provided considerable information on the research available to that point. I also scanned library catalogues and local bookshops for recent publications on Postnatal Depression. This chapter summarises existing research literature on postnatal

depression, and with the exception of seminal texts covers the time period from 1980 – 2004. This time frame was chosen because excellent work in the area of postnatal depression was done in the 1980's.

Significance of PND

Postpartum Depression has devastating effects on mothers, and also on partners (Ballard & Davies, 1996; Boath, Pryce & Cox, 1998; Meighan, Davis, Thomas & Droppleman, 1999; Osfield, 2000) and may indeed have adverse consequences on the behaviour and development of young children (Cox, 1987; Whiffen & Gotlieb, 1989; Beck, 1992; Lauch, Esser & Schmidt, 1998; Sinclair & Murray, 1998; Rigby, Sanderson, Desforges, Lindsay, & Hall, 1999, Craig, 2003). Furthermore, according to Cox (1987), at the end of one year postnatally only fifty percent of women have recovered from PND and children of depressed mothers may show behaviour disturbances at three years or cognitive defects at four years. Sadler (1998) conducted a study that showed 70 percent of boys with mothers who experienced postnatal depression developed behaviour problems at school and suggested ways in which community nurses could help. It therefore appears that PND can have long-term damaging effects on the whole family. Even intergenerational negative effects may occur, with daughters of postnatally depressed mothers experiencing PND with their own children; postnatal depression pre-disposing women to a risk of future depressive episodes, and failure of bonding between mothers and children causing psychological problems and social difficulties (O'Hara, 1987; Murray & Cooper, 1996; Murray & Cooper, 1997a; Sluckin, 1998). There is also evidence that dysfunctional parenting may lead to failed relationships in adulthood (Taylor, 1997).

A recent British paper (Raynor, Sullivan & Oates, 2003) raises the point that for the first time ever in history, suicide is now the leading cause of maternal deaths in the U.K. This haunting reality illuminates the need for antenatal screening in an attempt to detect pregnant women who are at risk of mental health problems. This article proposes that timely intervention of antenatal screening for postnatal depression and serious mental illness is a most important public health issue. The authors assert that the early detection of emotional difficulties is the key to helping and supporting vulnerable groups of women and their families, thus preventing such mortality. This mortality of new mothers may even be higher, but for the fact that the baby has a protective influence on the will to live of this group of people. Professor Anne Buist, program director of the Australian BeyondBlue Postnatal Depression Initiative, has said that for women with PND, the rate of suicide is lower than that for other depressive illnesses. Buist puts this down to the baby, saying a lot of women would prefer not to wake up and have thoughts of harming themselves but refrain from doing so because of the baby (Harvie, 2003).

Prevention of PND

A new initiative has been created in Australia to tackle the problem of PND. According to a news article by the journalist Jeni Harvie (2003), in the Sydney Morning Herald, this recent program was started to help with prevention of postnatal depression (smh.com.au/specials/health science viewed March 1, 2004) The Beyond Blue National Postnatal Depression Program aims to identify women with antenatal and/or postnatal depression with a view to improving the transition to motherhood. The program director, Professor Anne Buist, has stated that if women at risk of PND go undetected and they have a second baby, the PND gets worse (Harvie, 2003, p 2).

Professor Buist suggested that early intervention for PND will limit ill effects on the mother and may also reduce the negative impact on the mother/child relationship. This program is in its third and final year and has been sharing information about PND through major maternity hospitals, child health clinics and doctors' offices around Australia. By the end of 2004 it hopes to have reached more than 200,000 women. It has also gathered detailed data on 15,000 women, beginning in pregnancy and following them through after the birth, in a bid to understand the illness better. Buist hopes that by the end of the screening program all health professionals will ask pregnant women about their mental health as well as their physical health. Michelle Fletcher, the Chair of Beyond BabyBlues, is also quoted in Harvie's article (2003, pg. 2) as saying:

> PND firstly needs to be de-stigmatized. Because it is put in the "mental health basket" there is a lot of stigma still attached to women feeling they are failing as mothers if they have PND. Women have to learn to be honest and admit they are not coping. Doctors also need to be saying, "The baby is fine but how are you?

This program stresses early intervention as PND can affect the well being of the baby as well as the mother over time, and those women who suffer Antenatal Depression are at risk of developing postnatal depression (Buist, 2004). Belinda Horton, the current co-ordinator of PaNDa, the Post and Antenatal Depression association in Victoria, commented in Harvie's article in the Sydney Morning Herald that childhood behaviour problems could be linked to undiagnosed and untreated PND. The association of PaNDa (www.panda.org.au) was created in Victoria to provide information and counselling for women suffering from PND.

Prevention of PND

According to Buist (2003), depression is a common problem in the general population and is projected to be one of the major health issues facing the world in 2020. Given that women are twice as likely to suffer from depression, and are at particular risk in the childbearing years, the children from infancy can also be affected with long-term ramifications for the whole of society. The perinatal period thus is a crucial time to identify depression, and offers an excellent opportunity to screen women due to their increased contact with health services. In order to do so, Buist argues, services need to re-evaluate their priorities, and assess barriers to screening. Such barriers include attitudes to mental illness, anxiety about how to deal with mental illness in health professionals who are not trained in this area, and resource implications. It is argued that without attempting to identify and remedy these deficiencies, change will not occur. According to Peart and Grigg (2002) the direction of support for PND is also important. In their paper they argue that a range of health professionals, including midwives, and mental health nurses, come into contact with women with PND, but there is often little attempt to integrate maternity and mental health approaches. These authors stress that more collaborative frameworks of care are vital if health professionals are to adequately meet the needs of postnatal women.

Risk factors for postnatal depression

It appears that women with a history of clinical depression are much more likely to experience PND than those who have no such history (Payket, Emms & Fletcher, 1980; Cox, Connor & Kendall, 1982; Cox, Rooney & Thomas, 1984; Kumar & Robson, 1984; Frank, Kupfer & Jacob, 1987; Unterman, Posner & Williams, 1990; Campbell, Cohn& Flanagen. 1992; Beck 1996a; O'Hara & Swain, 1996; Areias,

Kumar & Barros, 1996a; Bernazzani, Saucier & David, 1997). Yet a history of depression can also interact with other factors to increase the likelihood of PND, such as obstetric complications (Cooper & Murray, 1995) or difficulties in the partner-relationship (Watson et al., 1984). Depression during pregnancy is linked with postnatal depression and it is noted that women with a poor marital relationship are especially vulnerable to the development of PND (Paykel, Emms & Fletcher, 1980; Kumar & Robson, 1984; Elliott, 1984; O'Hara, 1986; Boyce, Parker & Barnett, 1991; McGill, Benzie-Burrows & Holland, 1995; Zeikowitz & Milet, 1996, Chan, Levy & Chung, 2002).

A perceived lack of social or emotional support, especially from a woman's partner or own parents places a woman at risk for PND (O'Hara, Rehm & Campbell, 1983; Chan, Levy & Chung, 2002, Harvie, 2004). Lack of a confidante, and living in a share-house with people other than a partner can also be a risk factor (Paykel, Emms & Fletcher, 1980). A family history of affective disorder (Mrazek & Haggerty, 1994) can be a risk factor and so is single parenthood, because of all the stresses of having to care for an infant alone (Brugha, Sharp & Cooper, 1998). A build up of life stressors may also place women at risk, as childbirth is stressful enough without adding unemployment or poor housing to the equation. Health problems in the infant are depressing for a mother, as is problematic infant behaviour (Whiffen, 1990) and stress related to childcare issues have been consistently associated with PND (Cutrona, 1983; O'Hara, Varner & Johnson, 1986). Also, cases of PND can be linked to the severe maternity blues (Kumar, Marks & Jackson, 1995a). It can also be hypothesised that a negative cognitive style can place some women at risk for developing depression at any stage of life, even PND. (A negative cognitive style refers to a

pattern of looking at events in a negative way without attempting to find a positive aspect to them.) Women's negative birth experiences, including the absence of a desired support person and the perceived unhelpfulness of delivery staff have been linked to PND (Brown & Lumley, 1994).

Hormonal changes can also be a risk factor for PND, particularly in early onset PND after a bout of severe maternity blues; however, the literature is equivocal on this. It is possible that sudden postnatal hormonal changes may act as a trigger in these cases, but there is a need for further research in this area (Alder & Cox, 1983; Glover, 1992; Taylor, Adams & Glover, 1994; Sichel, Cohen & Robertson, 1995). Other possible risk factors for postnatal depression include a recent bereavement or grief for a previous loss such as a miscarriage (Cox, Connor & Kendal, 1982), adolescent age (Cooper & Murray, 1995), premature delivery (Kumar & Robson, 1984), Aboriginality (Druett, Murphy & Macarty, 1993), ambivalence about parenthood (Kumar & Robson, 1984), childhood sexual abuse (Buist & Barnett, 1995) physical illness (Mrazek & Haggerty, 1994), and controlling and powerful in-laws (Chan, Levy & Chung, 2002). It is important to note that risk factors increase the likelihood of postnatal depression; however, they are not necessarily direct causes. In contrast, protective factors include a good marital relationship, the availability of good support systems, optimism and self-esteem in the mother, and proper preparation for the physical and psychosocial changes of parenting (NHMRC, 2000).

Fathers and Postnatal Depression

Postnatal depression can also affect fathers with 10 percent of partners of women with PND also suffering depressive symptoms (Harvie, 2003). Professor Anne Buist

(Harvie, 2003) suggests that first time fathers can be very stressed and this stress can lead to depression especially because of significant stress about gender roles. The men can be trying to be "sensitive new age males" doing fifty percent of the childcare but also feel significant pressure to be the breadwinner for a young family. This mix of different expectations on men is not easy to bear psychologically and a number of men do suffer accordingly. Harvie (2003) reports on a study done at Flinders University by Corkindale (2003). This study of 312 first-time fathers found that many men suffered frustration and unhappiness during their partner's pregnancy and the early postnatal period, particularly due to the deterioration of their personal and sexual relationship. This relationship can decline for a year or more after the birth and men's well-being and mood can be negatively affected. The research team found that four to five percent of the men studied could be classified as having clinical depression (Harvie, 2003). It is also apparent that depression in the partner can aggravate a woman's own depression, as a depressed partner gives less support (Campbell, Cohn & Flanagan, 1992).

Morse, Buist and Durkin (2003) undertook a study in Australia examining men's adjustment to fatherhood and the subsequent implications for obstetric health care. The objective was to assess factors affecting first-time fathers and their transition to parenthood. The study used a longitudinal repeated measures design in which participants were interviewed in mid-pregnancy and completed assessments in late pregnancy, the early postpartum, and at four months postpartum. Two hundred and twenty five first time fathers were recruited from a major obstetric hospital in Melbourne, Victoria, from 1995 – 1998, via their partners. The men were seen separately from their spouses and questions about their parity history, existing social

support, satisfaction with their marriage, anxiety, frustration, and gender role stresses were completed at each time. The Edinburgh Postnatal Depression Scale (Holden, Cox, and Sagovsky, 1987) was used to measure prenatal and postnatal distress in the men. The results found men initially experienced high distress at the first assessment in pregnancy, where there was an over-representation of younger men in part-time employment and shorter-term relationships. Most men experienced a decline in their anxiety post-partum. Lower relationship satisfaction was linked to distress, as was gender role clashes both pre and postpartum for these men. Their distress also affected their attachment to their infants as it does with women. The conclusions drawn from this study were that although most men do deal effectively with the transition to fatherhood, a small group of distressed men have continued problems in their role as partner and parent and that if more attention could be paid to their anxieties antenatally, the men, their partners and infants may all benefit (Buist, Morse & Durkin, 2003).

Detection of Postnatal Depression

To date, research in the area of PND has focused primarily on health professional screening methods of the detection of depression and PND, and health professional treatments for women with PND. There are a number of standardised measurements used in the detection of postnatal depression, such as the Beck Depression Inventory; but there is evidence that these screening procedures for depression may not suit the postnatal period specifically (O'Hara, Neunaber & Zekoski, 1984, Affonso, Lovett, & Paul, 1990; Huffman, Lamour & Bryan, 1990; Campbell & Cohn, 1991). Some of the normal changes women report during pregnancy and the postnatal period such as decreased energy, sleep disturbance and lowered libido are symptoms of depression,

and the potential overlap of depressive plus normal postnatal symptoms led to the development of new measures such as the Edinburgh Postnatal Depression Scale (EPDS) (Holden, Cox & Sagovsky, 1987), designed to screen large numbers of women for PND. Routine screening of postnatal women can help overcome the overlap of depressive symptoms, perinatal events, and womens' and health professionals' difficulty in recognising PND. Such screening can be made more effective with a specifically designed instrument such as the EPDS (Holden, Cox & Sagovsky, 1987). There is evidence that health professionals only recognise about half the cases of PND that present in their setting (Briscoe, 1986) and that health professionals can improve the detection of postnatal mood disorders following specific training and using good clinical judgment plus a screening questionnaire like the EPDS (Ring & McLean, 1994; Holden, 1996).

The EPDS was first developed to help health professionals to screen postnatal mothers for depressive symptoms after childbirth (Holden, Cox & Sagovsky, 1987). The authors examined several existing depression scales such as the Scale for Anxiety and Depression (Bedford & Foulds, 1978) and eventually selected 13 items, after a pilot test of 100 women, as items most likely to detect PND. Items were written in the past tense as short statements of common symptoms of depression, such as "I have felt sad or miserable" and "I have been so unhappy that I have had difficulty sleeping". The subject then indicates her response based on the way she has been feeling for the past week on a four-point Likert scale. The test is completed in pencil and was found to be easy for women to understand and use, and it has also demonstrated a high reliability, validity and specificity in detecting depressive

symptoms in postnatal women who score 12 or higher (Holden, Cox & Sagovsky, 1987).

The scale, according to Holden (1994) is a reliable reflection of women's mood at the time of completion and a useful indicator of those who may be suffering from depression. The EPDS has been validated in a range of countries, including the UK (Holden, Cox & Sagovsky, 1987) Australia (Boyce, Stubbs & Todd, 1993) Sweden (Lundh & Gyllang, 1993), New Zealand (Holt, 1995); Chile (Jadresic, Araya & Jara, 1995), Canada (Zelkowitz & Milet, 1995) the United Arab Emirates (Ghubash, Abou-Saleh & Daradkeh, 1997), Italy (Carpiniello, Pariante, & Serri, 1997) and South Africa (Lawrie, Hofmeyer, & De Jager, 1998a). The EPDS has been widely used across a range of countries and validations of translated versions have been reported from countries as diverse as Japan (Okano, Nomura & Kumar, 1998), France (Chabrol, Bron & Le Camus, 1996) and South Africa (Lawrie, Hofmeyer & De Jager, 1998a). An Australian study (Matthey, Barnett & Elliott, 1997) also used the Arabic and Vietnamese translations. Beck and Gable (2001) undertook a validation of a new postnatal depression screening scale, the PDSS, which unlike the EPDS was written in the context of new motherhood. They assessed the construct validity of this new tool using psychometric testing and found it also ready for use in the routine screening of mothers.

However, one of the most useful aspects of the EPDS is that does avoid discussing culturally recognisable postnatal changes (such as lack of sleep due to an unsettled baby) as symptoms and administering the scale can encourage women to open up and talk about their problems. This is because marking such comments on paper as "I feel

sad…" has the potential to create an opening for discussion. According to Barclay and Lie (2004) and Newall (2004) the Edinburgh Postnatal Depression Scale can also be useful for predicting Postnatal Depression when given out two or three days postnatally. These authors suggest that it could be used routinely while mothers are still in the maternity ward to identify women at risk for postnatal depression quickly and cost-effectively. In countries where discharge from maternity units is within two days, the scale could be usefully administered even earlier (Newall, 2004).

Treatments for Postnatal Depression

Treatment for postnatal depression falls into four basic categories, pharmacological biological, psychosocial and combinations of pharmacological and psychosocial interventions.

Biological interventions focus primarily on the theory that postnatal depression is a physical illness with a biological cause (i.e. changes in hormone or neurotransmitter levels) linked to specific physiological events that occur with childbirth. Some claims exist that physical causes should be able to be located (Harris, 1996), however this has not been substantiated. George and Sandler (1988) argued that the results of endocrine research in puerperal mental illness are not very encouraging and the aetiology of symptoms in the postnatal period is still unclear (Ussher, 1992; Gregoire, 1995; Wisner & Stowe, 1997). Dalton (1971) has hypothesised that postnatal depression may be due to women having difficulty adjusting to the marked changes in hormone levels from late pregnancy to the early puerperium, but this is not supported by existing research. Proponents of the hormonal approach recommend increasing and stabilising progesterone levels for treatment of PND (Dalton, 1980) but not all authors

agree with this approach (Wisner & Stowe, 1997). Furthermore, according to Hammarback, Backstrom and Holt (1985) there is some evidence that extra progesterone may make depressive symptoms worse. It appears that progesterone contraceptives should be used with caution in women with PND. Oestrogen therapy, according to Lawrie, Herxheimer and Dalton, (1999) may be of modest value in a late stage of severe postnatal depression, but its role in the prevention of PND has not been evaluated.

Psychotropic medication may be administered by a medically qualified health professional, normally as an adjunct to some form of counselling, but not always. Appleby, Warner and Whitton (1997) conducted a randomised controlled trial of fluoxetine, an antidepressant medication and cognitive-behavioural counselling in postnatally depressed women. They found that fluoxetine and cognitive-behavioural counselling is effective for non-psychotic depression in postnatal women, and that taking fluoxetine alone was more helpful than taking a placebo.

Debriefing women after giving birth was the subject of a study by Allen (1999), wherein over 50% of women interviewed had talked to health professionals about their experiences. The results highlighted the need for health professionals to safeguard the psychological well being of childbearing women, and suggest that offering postnatal women the opportunity to talk remains a key element of sound midwifery and health visiting clinical practice. The link between nursing practice and nursing research is powerful as patient treatment, advice, education, counseling and emotional support, are all incorporated into the role of the nurse.

An example of this is in the paper written for midwives, _**Birth**_ magazine, where the authors discuss feeling in control during labour, the concepts, correlates, and consequences of feeling in control or not in control at the time of their labour. In this paper, Green (2003) discusses the idea that many studies have revealed that a sense of control in labour is a major contributing factor to a woman's birth experience and her subsequent sense of well-being in the postnatal period. The study examined definitions of being in control, such as the women feeling in control of themselves, or in control of the staff and the way they were treated during the birth experience. Questionnaires were sent to women one month before birth to assess their preferences and expectations around the labour and then again at six weeks after birth to assess their psychological outcomes. Data are presented from 1,146 women and three control outcomes were considered; feeling in control of what staff do to you, feeling in control during contractions, and feeling in control of one's own behaviour. The results showed that women reported feeling less likely to be in control of staff (39.5%) than in control of their own behaviour (61.0%). About one-fifth of the women surveyed felt in control in all three options, whereas one-fifth did not feel in control in any of them. Multiparas felt more in control than women having a baby for the first time. Those women who felt in control of staff reported this to be associated with being treated with respect and as an individual, being able to get comfortable during the experience, and perceiving staff as considerate of their needs. Feeling cared about by the staff emerged as being enormously important to these women. All three-control outcomes contributed independently to a sense of satisfaction with the birth experience and were linked to later mental health in the women. The author concluded that it was important for women to have all three types of control over their experience of labour and that caregivers have the potential to make a significant

difference to a woman's experience of childbirth, sense of satisfaction and emotional well-being.

There is evidence that professional and/or social support may help women in the treatment of postnatal depression (Ray & Hodnett, 1997). Bishop (1999) related that medical intervention and support and other appropriate help from supportive peers and family was effective in her recovery from PND. Her experience was that PND was a treatable illness and that effective help given at the right time led to a positive outcome.

Information given by health professionals in the postnatal period can also be seen as a postnatal depression support. Hey and Feu (2003) examined the effectiveness of informational support in reducing the severity of postnatal depression in Taiwan, and they found that Taiwanese women who received informational support about postnatal depression six weeks after giving birth experienced lower EPDS scores at three months postpartum than those who did not receive this information. The conclusion that these authors came to was that in Taiwan at least informational support about postnatal depression given to women during the postnatal period could contribute to psychological well-being.

One study of an intervention was an Australian pram-strolling study (Currie & Develin 2002). This program looked at pram strolling as a way to well-being and also as part of prevention or treatment for postnatal depression. In Sydney, a survey of 500 mothers with children under five years involving telephone interviews (n = 450) and focus groups (n = 50), showed that 87% of mothers surveyed used a pram for

incidental activities, whilst 47% used the pram specifically for exercise. Factors preventing mothers exercising more included poor weather lack of time, and poor quality paths to walk on. Ninety-two percent of mothers believed that pram walking would increase mental well-being, and 87% felt that it would help to reduce postnatal depression (PND). However, feedback from the focus groups expressed less confidence in the program's ability to benefit mothers with PND. The outcome was that pram-walking programs would need to be marketed carefully to avoid the stigma associated with PND and successfully target mothers at risk.

Several treatment options also exist for postnatal depression in the counselling area and they include one-to-one counselling, cognitive-behavioural therapy, psychotherapy, group treatment, Gestalt therapy, support strategies, and couples counselling if the partner-relationship is distressed. Counselling and support groups may be useful for women with mild depressive symptoms or difficulties adjusting to the new parenting role, but severe depression often involves the need for a combination of antidepressant medication and psychotherapy, and possibly even hospital treatment on an inpatient or outpatient basis (NHMRC, 2000). A recent innovation has been the inclusion of day hospital/ outreach services for women with postnatal depression (Brockington, 1996). An Australian example of this is a postnatal depression ward (www.wch.sa.gov.au/dmh/helenmayo.html, viewed May 6, 2004). An inpatient mother and infant facility exists to care for women with PND at a mental health campus of the hospital and an outpatient facility is also available to patients. Day Patient Services are run in a separate location from the Inpatient Unit from 10am to 2.30pm on Wednesdays and is staffed by an occupational therapist, a clinical psychologist and a community nurse. Two groups are run during the day which

address women's needs both as individuals and as parents. The aim of this service is to offer new knowledge and styles of handling problems so that women could have shorter admissions to hospital or even avoid hospitalisation altogether. To date, well controlled studies are needed to estimate the effectiveness of inpatient and outpatient services for women with unipolar postpartum depression, as the combination of treatments received (such as medication, supportive counselling, group therapy altogether) makes evaluation complex but necessary (NHRMC, 2000).

Rogers (1951), a prominent author on practical counseling techniques, developed a technique of client-centred individual counselling, which is still used today. This involves a health professional listening to a client and discussing issues with them in a non-judgemental way, thereby helping people develop suitable solutions for their problems. This can be done by a medical officer, community nurse, social worker, psychologist or trained counsellor. Individual psychotherapy is more in-depth than counselling; it aims to resolve problems while looking at the underlying factors or patterns, which increase a client's vulnerability to these difficulties. Many different models for psychotherapy exist, from Gestalt Therapy to Cognitive-behavioural therapy, and they are usually conducted by specifically trained mental health professionals such as clinical psychologists or psychiatrists. Couple counselling/ therapy is also generally conducted by skilled counsellors specifically trained in the area, and can be useful for a new mother and her partner as they negotiate the life-changes both before and after birth which can lead to relationship tension. Group treatment is also a useful adjunct to individual therapy; self-help groups (conducted by people who also experience PND), support and treatment groups are available. Support groups are usually conducted by health professionals such as social workers,

or a community mental health nurse, and treatment groups are normally conducted by a trained mental health professional. These groups are held over a definite time period, such as 10 weeks, and a participant normally has an initial assessment prior to the first group meeting (NHRMC, 2000). Psychiatric liaison services to obstetric units improve the antenatal detection of women at risk of developing postnatal depression and offer appropriate follow-up throughout the pregnancy and postnatal period (Appleby, Fox & Shaw, 1989).

Parenting Groups in Australia

A recent paper from Australia discussed the relevance of groups in the prevention of postnatal depression. Hanna, Edgecombe, Jackson and Newman (2002) studied the importance of first-time parent groups for new parents. They wrote about the fact that first-time parent groups are offered to all new parents in Victoria, Australia, through the Maternal and Child Health Service, which has funding from local and state governments. Parents who join attend eight sessions, which emphasise parenting skills, social support and relationship development in order to increase parenting skills and confidence. This paper stresses the importance of these groups claiming that they are a worthwhile source of social support and health education at a time of early discharge from hospital after birth and changing family structures.

Although there are some challenges to the running of these groups, first-time parents are said to benefit by developing social networks, gaining self-confidence, and receiving relevant information on child health and parenting and that maternal and child health nurses play a key role in facilitating these groups. Gillieatt, Ferroni and Moore (1999) agreed with the previous author on the value of parenting groups

especially for new parents. In their paper, the findings of a small exploratory study of the longer-term effects of postnatal participation in parenting groups facilitated by state-funded community child health nurses are explored. The authors also say that whilst short-term evaluation of such groups appears favourable, Australian literature indicates a lack of research examining their longer term impact and the role, if any, that they play in the establishment and continuity of informal support for new mothers.

Anecdotal data from the experience of nineteen first-time mothers who had participated in thirteen different groups between them run by a Metropolitan Health Service in Western Australia were analysed. The majority of women had developed supportive relationships and were still meeting in spite of the fact that one third of the women had relocated homes and most groups were continuing to meet fortnightly for at least a year and then less regularly. The responses showed that the women saw these groups as integral to their well-being as well as a source of new and significant friendships and important practical support. According to the majority of respondents, the chance to be in these groups was vitally important to them and one of the most valuable assets available to a new mother and important in the maintenance of good mental health.

As midwives are often involved in running such groups, and they are so often involved with caring for women with postnatal depression, it is worth looking at the literature in relationship to them.

Midwives and Postnatal Depression

Midwives are in a unique position to be involved in the prevention and treatment of postnatal depression. Gibson (2001) pointed out that midwives could possibly help women avoid developing postnatal depression by dismantling the myths and taboos affecting new mothers. Bott (2001) also made the point that midwives could indeed make a difference to the mental health of these women by deepening their awareness of PND and that this would place them in a better position to provide individualised women-centred care. According to Bott, midwives needed to be aware that while the postnatal period was a significant time, the whole childbearing period was a risky time for women in terms of developing psychotic and non-psychotic mental health disorders. Bott commented that if midwives were aware of the signs and symptoms of potential PND they could carry out their practice in such a way as to aim to minimise this condition. Nolan and Alcock (1998) described an action plan for midwives on the subject of PND and also suggested that by taking certain actions during pregnancy such as educating women, midwives were in a good position to help prevent this common illness.

Tong and Chamberlain (1999) undertook a study on the midwives' perspective of postnatal depression. The purpose of this study was to investigate midwives' knowledge of postnatal depression and their awareness of the risk factors for the women to get PND in a maternity unit in a tertiary hospital in the Sydney Metropolitan area. A purposive sample of seven full-time midwives took part in semi-structured interviews using Colazzi's phenomenological approach. The results indicated that, although these midwives had an adequate knowledge of postnatal

depression, they were not actively involved in strategies to decrease the incidence of it. The midwives reported that poor adaptation to motherhood and lack of adequate support systems made the women vulnerable to postnatal depression and that a major discrepancy between womens' expectations of motherhood and the birthing experience could lead to PND. One difficulty the midwives had in preventing the PND during the course of their work was a lack of time in getting to know individual women and building rapport. The researchers did suggest that the midwives educate the women about PND but so far none had adopted this practice of education. In addition, these particular midwives did not suggest any strategies for the antenatal period despite knowing that vulnerable women could be identified at this time.

It would also appear that midwives have an important role to play in postnatal depression screening. According to Tully, Garcia, Davidson and Marchant (2002) midwives in England and Wales were responsible for 57% of screening for postnatal depression and 27% of antenatal screening. The researchers sent out questionnaires to all the maternity units in England and Wales with an 87% response rate and found that only 16% of maternity units provided training for midwives to undertake screening. The study showed that while these maternity units were involved in screening for antenatal and postnatal depression, training, referral and support systems appeared inadequate. In addition, Stewart and Henshaw (2002) were aware that midwives in England had a role in screening and educating women about the prevention of postnatal depression. They conducted a study to determine midwives knowledge of perinatal mental health disorders. A questionnaire survey of midwives was undertaken in two health districts in order to examine the level of knowledge they had about the prevalence of these disorders, their experience in dealing with them,

their confidence in their skills, and what further skills they felt they needed. An exploration of midwives' interest in learning more about the disorders and perceptions of their potential role were included to gauge what type of programme should be developed in the future. Results from the data of 266 responses showed that midwives had some knowledge about the prevalence and types of these disorders and most felt they had a role to play in the management of them. However, very few midwives had specific training in this area and many identified several areas of practice they would wish to improve before taking on such a role. It is important not to overlook the educative and counselling role of the midwife in the detection, screening and treatment of women with postnatal depression.

In general, it can be seen that definitive conclusions about the relative effectiveness of different approaches to treatment for postnatal depression cannot be reached because of the lack of sufficient numbers of controlled trials for intervention in postnatal depression. It does appear that individual and group treatment approaches with multidisciplinary input using a range of intervention options are likely to be effective, but more research is required to clarify this position. Non-directive counselling is useful for mildly depressed women, and it appears that cognitive-behavioural therapy together with antidepressant therapy may be an effective treatment for women with moderate to severe postnatal depression. It can also be noted that biological interventions such as antidepressants, hormonal therapies, and electroconvulsive therapy (ECT) have been widely advocated without adequate demonstration of the effectiveness or the applicability of these treatments for postnatal depression. Randomised controlled trials with large, representative samples of postnatally depressed women are needed to compare different treatment modalities, examine the

effectiveness of different treatment components, and determine which treatments are most useful for women with mild to serious postnatal depression (NHMRC, 2000). An RCT is of course an excellent approach to this question, however I chose hermeneutic phenomenology with its in depth approach to the experiences of the twelve women I interviewed. I believe that studying something in miniature and in depth can give a snapshot of the whole, and I discuss this much more in chapter three, Methodology.

More research is also needed to identify specific interventions that would be useful in the prevention of postnatal depression. It is clear that sound scientific evidence about prevention is still lacking and such information would be useful in planning programmes of prevention and early intervention for women with PND. Health professionals need adequate information and training in the area of both preventative care of women at risk of PND and intervention for women with PND. This is because many nurses and medical staff have been shown to be wary and uncomfortable dealing with psychiatric and psychological difficulties in patients (Whitehead & Mayou, 1989; Lepper, DiMatteo & Tinsley, 1994; Oerman, 1994). There is evidence from Britain and Australia, which shows that, effective skills' training for health professionals in this area does improve treatment and detection of the condition of PND (McClarey & Stokoe, 1995; Watts & Pope, 1998). Further research into possible approaches to this area is clearly desirable.

Studies of women seeking help for postnatal depression

Very few studies investigating women's experiences of being treated for postnatal depression were identified during this literature search and review. However,

Holopainen (2004) looked at the experience of women seeking help for postnatal depression. This study sought to explore women's experiences of support and treatment for PND. However, it concentrated mostly on womens' experiences of support, rather than their experiences of treatment. Seven in-depth interviews of women were conducted and analysed using the phenomenological method described by Creswell (1998). The findings indicated that for the women, partners provided the most support. The women did not know where to seek or find professional help and often were helped and monitored by the maternal health nurse who monitors and guides the progress of their babies' development. Hospital programs were criticised for not informing and involving family and the women were also dissatisfied with hospital doctors and their GP's claiming they had limited time for counseling and preferred instead to hand out medication to alleviate symptoms but which also reinforced feelings of inadequacy. The recommendations from this study were to involve families and also to make more use of the unique position that midwives and child and youth health nurses have in assessing new mothers.

In the United Kingdom, Higgins (2001) wrote a paper interpreting research and critically reviewing four PND studies. This paper adopted the approach that evidence-based practice is seen as the best way of ensuring that patients and clients receive optimum care from health professionals. However, a gap in information was found concerning studies that explore thoughts and feelings of the women concerned, thereby making PND research more relevant to mothers and building a more comprehensive picture of this illness.

Arborelius and Bremberg (2003) examined the supportive and non-supportive qualities of child health nurses in Sweden as they looked after stressed mothers of infants. These women were not defined as PND sufferers specifically, but they were defined as women under strain in their role as new mothers. They aimed to find out how the strained mothers perceived the support they received from the Swedish child health nurse. Twenty-four mothers from nine child health centres were interviewed when each had a child at eight months of age. In addition, mothers were asked to report their perceptions of their own parenting competence by completing a questionnaire. The results showed that five components of the nurses support could be discerned: positive emotional support, support of the parental role (either positive or negative), positive informational support, and pressure to accept social norms on childcare. A third of the mothers said they found strong positive support, lessening depressive symptoms and favourable perceptions of their parenting ability. Another third of the mothers reported negative contacts with the nurses and persisting depressive signs and symptoms, and unfavourable perceptions of their parenting competence. The nurses' pressure for the mothers to adapt to particular social norms of childcare seemed to affect the latter group of mothers more negatively. The authors came to the conclusion that in order for nurses to support strained mothers effectively, it was necessary to clarify and resolve conflicts between different objectives.

Contradicting Data in Existing Studies of Postnatal Depression

Major gaps exist in the treatment literature for women with postnatal depression particularly as it relates to the experiences of the women concerned and much of the data is equivocal in that some studies show one result, and others, say something else entirely. One such example of this is an article by Enkin (2001). This article

comments on work by Small, Lumley, and Donohue (2000) which discussed a study of midwife-led debriefing to reduce maternal depression after operative childbirth. Enkin argues that the midwife-led debriefing did not reduce the women's postpartum depression as compared to the women having the birth experience without being debriefed.

In contrast, Lavender and Walkinshaw (1998) conducted a randomised controlled trial looking at the useful treatments for distress after childbirth. Their conclusions were that women who are traumatised after childbirth find that listening; support, counselling, understanding, and explanation of their experience are the most useful treatments. However, these authors also state that little evidence is available from randomised controlled trials of the relative efficacy of such treatments as a postnatal intervention. They conducted their study in a regional teaching hospital in northwest England. One hundred and twenty postnatal primigravidas were allocated by sealed envelopes to receive the debriefing intervention (n = 56) or not (n = 58). The outcome measure was the Hospital Anxiety and Depression (HAD) scale administered by postal questionnaire three weeks after delivery. The results of this trial were that the women who received the debriefing intervention were less likely to have high depression or anxiety scores after the birth when compared with the control group who did not receiving any formal debriefing. Consequently, the authors drew the conclusions that support, understanding, counseling, and explanation given to women by midwives in the postnatal period was beneficial to women's psychological well-being. The authors go on to say that maternity units do have a responsibility to develop a service, which offers all women the option of attending a debriefing session to discuss their experience of labour (Lavender and Walkinshaw, 1988).

Need for further Information on the Documented Outcomes for treatment of PND

Apart from the few studies cited above there appears to be little information and a need for further information about the documented outcomes for women who have experienced health professional intervention for Postnatal Depression. The greatest need for information highlighted in the literature belongs particularly to the women's remembered experience of PND and treatment (Colton, 1988; Holden, 1989; Griepsma, Marcollo, Cherry, Vary & Walton, 1994; Parke and Hardy, 1997; Whitton, Warner, Appleby & Faragher, 1997; Sheppard, 1997; and Thomas, 1997).

Summary

In this chapter I presented a discussion of the research to date and identified a gap in the literature which involves the literature on treatment outcomes of PND, particularly qualitative studies examining the experiences of postnatally depressed women and their perceptions of helpful or unhelpful health professional interventions. It appears that further research is needed, especially in relation to how women feel about the help provided by health professionals when dealing with their PND. The gap identified in this literature review supports the purpose and aims of this study.

In the next chapter the philosophical underpinning and theoretical framework for this study are presented.

Chapter 3

Methodology

Introduction

In this chapter the methodology chosen for the research is presented. The philosophical underpinnings of phenomenology are discussed and include comments on the work of van Manen (1990) whose approach and methods of analysis informed that aspect of my research.

The movement of phenomenology (Spiegelberg, 1982) has its basis in a philosophical paradigm, and the pioneers of the phenomenology were Edmund Husserl, and his student, follower, and later a leader in his own right, Martin Heidegger (1889-1976). This chapter examines the work of these philosophers in relation to the development of phenomenology, as well as the ideas of Heidegger's student, Hans Georg Gadamer (born 1900) who is also a leading philosopher in phenomenological thought.

The work of the French philosopher, Maurice Merleau-Ponty whose writings have also been influential in the development of modern hermeneutic phenomenology is also briefly presented because his ideas, like those of Heidegger and Gadamer, have also been informative of the philosophy underpinning my research. Included are the researcher's personal thoughts and a brief critique of phenomenology.

There is also a discussion of phenomenology in nursing – its drawbacks, as well as its value and a presentation of ways to help overcome any potential difficulties presented by phenomenology as the chosen methodology for this research.

Phenomenology

Phenomenology, the word, is derived from the Greek word "phenomenon", meaning, "to show itself" (Ray, 1994 p. 119) and this root shows the essence of phenomenology; for in research, phenomenology is used to seek the core of experience, the essence of it. What does it mean and how does it feel to experience chronic illness, postnatal depression, addiction and so on? Positivistic studies give helpful information, and certainly have their place in cultural knowledge, but they do not attempt to portray the experiences of people as they encounter various phenomena. This was both the appeal and contribution of phenomenological research to my study; to gain a sense of the lived experiences of women who had postnatal depression and health professional intervention.

Definition of Phenomenology

Phenomenology is difficult to define simply: Professor Ken Ruthven's question (from an English lecture at Adelaide University in 1980): "can one Eff the Ineffable?" is appropriate when related to this approach, philosophy and method of research. Morse and Field (1996) have said that phenomenology is the study of experience and Cohen (1987) talked about it as the study of phenomena, or the appearance of things. Parse (1981) discussed phenomenology as the study of phenomena as it unfolds; therefore it appears that this approach attempts to uncover the quicksilver of human life and experience. Roberts and Taylor (1997) define phenomenology simply as the study of a thing (or entity), and Polit and Hungler (1999) mentioned in their glossary that phenomenology is a qualitative research tradition, with roots in philosophy and psychology, which focuses on the lived experiences of human beings. According to

van Manen, anything that presents itself to consciousness is potentially of interest to phenomenology, whether the object is real or imagined, empirically measured, or subjectively felt (van Manen, 1990).

Historical development of phenomenology

Emmanuel Kant (1974 – 1804) was the philosopher who helped to create a landscape wherein phenomenology could seed and blossom. He distinguished between two forms of reality, noumenal reality (things in themselves) and phenomenal reality, or the appearance of things as they are perceived, conceived, thought of and interpreted (Stumpf, 1994, Palmer, 1994). The perceivable world was that studied by phenomenologists at that time as the noumenal world was thought to be inaccessible (Fitzgerald, 1995). This was because the instant a human being observed or engaged with an event or even an object it became a "phenomenon".

Since the time of Rene Descartes (1596 – 1650) and the period we call the Enlightenment, traditional scientific views have dominated the Western world (Fitzgerald, 1995). This was the time when knowledge was separated from religion and it was thought possible for humankind to examine both the human dimensions of life together with the natural world without referring to religiosity. It was thought that knowledge could be found through a rigorous method of detached scientific observation (Stumpf, 1994). Cartesian thinking involves a scientific binary position that involves learning, which by nature is abstract, rational, and atemporal, and it has been challenged by new approaches, especially in the human sciences. These new perspectives have included humanistic, feminist, and critical theory (Fitzgerald,

1995). They have included the concept of epistemology and ontology (Cohen & Emery, 1994)

Much has been written about the theoretical assumptions of phenomenology (Husserl, 1960 trans; Heidegger, 1926, trans 1962; Husserl 1964 trans; Husserl, 1965; Kockelmans 1967; Husserl, 1970; Gadamer, 1975 trans; Gadamer, 1976 trans; Krell, 1977; Husserl, 1980 trans; Heckman 1986; Dreyfus 1991) however one way to begin to look at the history of phenomenology is to study a few of the ideas of the well-known philosophers, Husserl and Heidegger before looking at Merleau-Ponty and moving on to the ideas of van Manen, a contemporary phenomenologist popular in nursing (Roberts and Taylor, 1997).

The Philosophies of Husserl and Heidegger

Philosophy blends the disciplines of epistemology ("how do we know?") and ontology ("what is being?") (Cohen & Omery, 1994). Within the roots of phenomenology are these ideas of epistemology and ontology, and they were important to Husserl and Heidegger respectively. As well as this, the philosophy of phenomenology as developed by Husserl and Heidegger is upheld by the transcendental and eidetic (descriptive) and hermeneutic (interpretative) ideologies (Cohen, 1987; Cohen and Omery, 1994). Examples of the proponents of these are Van Kaam and Colaizzi (Husserlian phenomenology) and van Manen (Hermeneutic phenomenology). Husserl developed phenomenology in contra-distinction to Positivism and the way it was applied to human concerns (Cohen, 1987).

Positivistic studies addressed the observance of external reality, but Husserl wanted to create a new science in phenomenology, one that observed individuals in their natural context, not as part of contrived situations (Cohen, 1987). According to Jennings (1986) Husserl also developed phenomenology because he was concerned about the direction of philosophy at that time. He was concerned that after Descartes all philosophy had taken a scientific worldview as its starting point, which is different to our subjective experience (Benner, 1994).

Husserl wanted philosophy to take into account a position of "conscious recognition" which involved human perception of objective reality. According to Thompson (1990) Husserlian phenomenology began as a search for the philosophical foundations of logic and then evolved into a study of the logical structures of consciousness. The natural attitude was Husserl's attempt to describe that relationship of ordinary consciousness to our ordinary experience, and that it is possible to approach this consciousness from a different standpoint (Walters, 1994). "Intentionality", that is having a clear intention to observe a phenomenon with as pure a mind as possible, and 'bracketing', the desire to "bracket out" or remove from an observation ones own pre-conceived notions, were the methods of achieving conscious recognition and therefore pure description (or 'essence') of a phenomenon (Fitzgerald, 1995). He looked for a truth that had universality about it, and could be carried across time and not be bound to an individual, time and place. In order to do this, he chose to suspend the natural attitude and open his consciousness to a naïve or innocent mind-state. He believed that the essence of phenomena could be seen and felt clearly, freed from all the cultural clutter absorbed by the ego. His dictum was "Zu den Sachen selbst" or "To the facts (or things) themselves" (Husserl, 1911 p.116). Wallace Stevens, an

American poet, once wrote a poem with a title, which Husserl no doubt would appreciate: "Not Ideas about the Thing, but the Thing Itself." (Stevens, cited by Hunter, 1968)

Thus "Transcendental Phenomenology" was born. Husserl wanted this phenomenology to gain acceptance as a "rigorous science", and he created his own three-step approach which contains "Anschanng" - looking at a phenomena, being conscious of that phenomena, "intentionality" and "bracketing" which involves separating the phenomena from one's own beliefs and experiences (Fitzgerald, 1995).

The first of Husserl's three key ideas involved "Anschanng: "looking at". This form of phenomenological intuition involved imagination; looking at a phenomenon with a child-like innocence, open eyes, a sense of wonder (Oiler, 1982) and empty of all pre-conceived ideas and theories. The reality of whether this is actually possible is one of the issues in relation to Husserlian phenomenology. The second idea, "intentionality" addressed the existence of material reality set against a positivistic background. Husserl knew that consciousness was always "intentional" because it was "consciousness of "something – self-being always aware of the outside world (Baker, 1992). Intentionality is an idea, which holds value, and traditional phenomenology also holds the idea of intersubjectivity – the idea that meaning is contextually constructed as an inter-subjective phenomenon. Men and women create meaning in interaction with the world, and one another (Morse and Field, 1991).

The third idea, perhaps his most notable, is "Bracketing". Husserl had been a mathematician before he became a philosopher and so he took the mathematical

method of brackets in an equation being the part one attends to first, and he re-invented this for philosophy. This term now meant to hold back pre-conceived and pre-learnt feelings, traditions, beliefs and ideas. To "bracket out" this information and suspend belief therefore uncovered the essence of an experience (Cohen and Omery, 1994; Ray, 1994). Husserl used the combination of bracketing, awareness of the intentionality of consciousness, and phenomenological intuiting and then meditated on the phenomena. This he called "transcendental subjectivity", whereby transcendental could be understood as conferring meaning via the knowing ego, or self, reflecting on itself (Ray, 1994). He then called this an epoche, or a phenomenological reduction (Cohen and Omery, 1994). Husserl's position has a methodological element to it, which seems to suit the way nurses in general understand research to be: methodical, with the researcher as a detached observer. Husserl preferred to have the researcher "detached" from the research, so they could observe the phenomenon properly, with "wide-open eyes" clear of any preconceived ideas (Oiler, 1986).

Husserl had wanted his student and fellow philosopher, Martin Heidegger, to build on his work in phenomenology, but Heidegger's early work, ***Being and Time***, (1962) was significantly different despite extending Husserl's ideas. Husserl was deeply offended by Heidegger's ideological disagreement with transcendental phenomenology and they became intellectual adversaries. Heidegger was skeptical about Husserl's phenomenological reduction. He argued that one couldn't begin an analysis of the self (and therefore of other people) from an isolated "I" of pure consciousness, or from the bracketed out purely rational "Doubting" ego of Descartes (Walsh, 1996). He did not approve the idea of the Cartesian subject who was separate

and who could distance oneself from the world and its objects. Instead he saw the world as indivisible from personhood; observations, thoughts, feelings and experiences were intertwined and in fact very difficult to separate. He observed that bracketing and standing back from a phenomenon could not succeed if the self is involved in the world and this involvement is part of conscious experience and knowing. In fact, according to Heidegger we awake to find ourselves thrust into this world and have a deep-seated inner knowing that precedes conscious knowing (Walsh, 1996).

Heidegger agreed with the dictum "to the facts (or things) themselves" or "lets get back to what matters" (van Manen, 1990, p.184), but declared that there could be no such thing as an uninterpreted fact. Facts speak for themselves, but through the lens of interpretation. These lenses vary, depending on the viewer and his or her experience. So whilst Husserl wanted a phenomenology clear of interpretations, Heidegger's phenomenology is unashamedly interpretative and hermeneutic.

Heidegger's philosophy departs from the need to maintain objectivity and includes background practices and one's natural standpoint as part of Being. "Being" is a central concept to Heidegger –concerned "Being-in-the-world is vital to human interests and could not be pursued through traditional Cartesian objectification. Clarity, to Heidegger, comes not as separate from the world, but by Being-in-the world, and examining those modes of Being. This clarity could be found through "Dasein", (loosely translated as "Being There") which, involved:

> Looking at something, understanding and conceiving it, choosing access to it – all these ways of behaving are constitutive for our enquiry…This entity which each of us is himself and which includes

inquiring as one of the possibilities of its Being, we shall denote by the term, **Dasein**. (Heidegger, 1962, p.27)

Heidegger's revolutionary work, ***Being and Time***, (1962) looked at the need for an "analytic reconstruction of "Being" as exemplified by "Dasein" (Fitzgerald, 1995, p. 70). He examined ways of "Being" called "existentials", coming up with concepts such as "Understanding," "Fallenness", "Care" and so on. "Fallenness" describes how acculturation and learned modes of being can divert one from one's own self, truth and purpose - in so far as one behaves according to the cultural prescription one is said to be "fallen". With "Care" things and other Daseins matter, they are important – care is the human way of "Being-in-the-world." That is to say, one cares about what happens to one in one's world.

My desire for this study was to interpret the essence of phenomena, rather than just describe it, so that led to my choice of Heideggarian phenomenology as opposed to that created by Husserl. I also personally believe it is difficult to completely "bracket out" one's interpretation of a phenomenon, and so have chosen to follow the ideas of Heidegger and fuse the horizon of the researcher's beliefs and experiences, and that of the participants.

Hermeneutical Phenomenology

Heidegger is famous for developing hermeneutic phenomenology. Hermeneutics was an approach to interpretation of phenomena. Hermeneutics, the word, is derived from the Greek word, "*hermenuin:* to interpret" (Odman, 1988). The Greek god Hermes, in mythology a winged messenger and interpreter for the mythological gods of ancient

Greece, was thought to be responsible for changing the unknowable into a form that humans could understand. What had been a scholarly method for dealing with sacred texts when the meaning was obscure in the bible and other texts became known as hermeneutics (Walsh, 1996). Now it is known as both a philosophy and method of interpretation, and it would seem that Heidegger believed that man's existence in the realm of Being was unavoidably hermeneutical (van Manen, 1990).

The Heideggerian hermeneutic perspective has potent implications for research – in particular, research in the human and caring vocation of nursing. Using this perspective, nursing researchers would be therefore less occupied with conventional notions of validity and bracketing preconceptions and more concerned with how researchers could use their foreknowledge (preconceptions) to deduce meaning from their phenomena in workable ways, even practical ways to change or improve practice. The researcher would be more concerned with uncovering meanings about "what it is to be" than with describing experience, and the best way to relate to the phenomena under investigation. It is as if Heidegger has a lens to view the world from the inside, with the help of all the senses, including intuition. To understand the world of women who have had Postnatal Depression, and to gain a picture of the helpful and unhelpful health professional interventions, one would need the privilege of listening to their experiences. When interviewing these women one must pay close attention to their stories, listen without judgment and encourage the flow of their conversation, then afterwards attempt to locate and reveal the meanings of these stories. This is part of the intersubjectivity and the role of the researcher in Heideggerian research.

Hans Georg Gadamer and Hermeneutics

Hans Georg Gadamer was a student of Heidegger and he developed four concepts, which may be seen as relevant to nursing research methodology. They are ideas, but not a research method or formulae in themselves, as Gadamer, like Husserl and Heidegger, was a philosopher and not a researcher. Gadamer's book, ***Truth and Method*** (1975) was first published when he was 60 years of age, and is pure philosophy, not a treatise on research methodology. Yet, in my opinion, Gadamerian thought refines and builds upon the work done by Husserl and Heidegger and can be usefully incorporated into research work. Gadamer's four concepts are: (1) Prejudice, (2) the Fusion of Horizons (3) the Hermeneutic Circle and (4) Play (Gadamer, 1975). Gadamer takes the position outlined by Heidegger, that all existence is hermeneutical and builds on that by focusing on the idea that any situation in which human understanding occurs is always an understanding through the lens of tradition and language.

Prejudice

Prejudice to Gadamer means a judgment that is formed before all the facts and elements, which create and determine a situation, have been completely examined (Gadamer, 1975). Prejudice in this context is not a negative thing; more a form of pre-understanding or pre-judgment, fore-meanings, knowledge and awareness of, say, what it is to be a mother with postnatal depression. It is well worth being aware of one's prejudice when conducting a phenomenological study as the researcher is an instrument of the research and ones prejudice informs the language one uses.

Fusion of Horizons

Gadamer speaks of the "horizons" – that is, the prejudice of fore-knowledge which the nurse could use as a concept of the first "horizon of understanding'. Then this horizon expands as one chooses to examine the initial interpretation, and re-examines it, in the light of what is revealed in the text (e.g. of this study). This is connected with Heidegger's idea of (let's return) "to the facts themselves" but also, there is no such thing as an uninterpreted fact (Heidegger, trans 1962). One can use one's own interpretation, based on prejudice, but anchored in the "facts" (the experiences) of the research subjects: in the case of this study, women who have experienced postnatal depression. From this marriage of horizons a new, richer, and more developed understanding can grow which is greater than the original understanding – a "Fusion of Horizons". This Fusion of Horizons is continually in flux and flow because constantly we need to test, expand, and maybe even leave behind our prejudices.

Our own history also influences our horizons. Horizon, then, is a clear and poetic metaphor, which according to Gadamer represents a range of vision that includes everything which can be seen from a particular vantage point (Gadamer, 1975).

Hermeneutic Circle

This process of interpretation is circular rather than linear; the interpretation, which occurs in a circle, is dynamic in nature, it has no bottom, top, beginning or end, no subject-object distinctions. It is called the "Hermeneutic Circle". It is proposed that interpretation in the human sciences, takes place within the hermeneutic circle in order to avoid a possible loss of meaning (Walsh, 1996). An example of how this

concept could be applied to research is contained within the interviews undertaken in my research. The participants' stories were not linear, instead, they were contextual, moving back and forth in time, "tying-off" some stories; introducing others; telling me what had happened to their friends, partners, relatives, and so on. These stories were analogous to the Hermeneutic Circle in that they moved between the "whole" of the subject under discussion (motherhood, depression, womanhood, childhood) to the "part" which was under scrutiny in the project (interventions for women with Postnatal Depression). So, within the hermeneutic circle, the whole can be understood by study of the particular, and the particular, with reference to the whole. This is to say that in my research, the hermeneutic circle applies to all the participants. For example, studying phenomena by moving between the experience of individuals and developing the interpretation of the experience as a whole by looking at the shared experiences of the individuals.

Play

Gadamer's final concept under discussion is Play, which had a range of forms. In the form I have used to construct the philosophical underpinnings of this thesis, Gadamer does not orient himself towards interpretation from an objectivistic or subjectivist position; rather, he participates as a "player" (Gadamer, 1975). This uses the analogy of a game; the player has his or her perspective and experience yet they are absorbed into the whole game. This neatly avoids overt subject and object distinctions. Play and the fusion of horizons interplay like the light and shade in an Impressionistic painting: these ideas have an appealing freshness and spontaneity about them which enable us to enter the circle and dialogue with the text to create an understanding in which the "fit" is right and I have found this a natural and useful approach.

The next section describes the work of Merleau-Ponty and how his ideas have flowed on from Heidegger and Gadamer to underpin my research

Phenomenology: Merleau – Ponty

Gabriel Marcel (1889 – 1973), Jean-Paul Sartre (1905 – 1980) and Maurice Merleau-Ponty (1905 – 1980) were the leaders of the "third phase" or French phase of phenomenology. The first phase of phenomenology was called the preparatory phase and the second phase was called the German phase. Embodiment and Being-in-the-World are the primary concepts of this third phase. Embodiment means the fundamental awareness of and belief in certain concepts and that all acts are constructed on the foundations of perception and a basic awareness of phenomena (Streubert and Carpenter, 1999). These phenomenologists further explicated being-in-the-world and emphasised just how important it was to describe, "lived experience" which is given in the perceived world. This phase saw phenomenology change considerably as a dynamic philosophy as the different philosophers offered their own interpretations and perceptions of phenomenology. Maurice Merleau-Ponty along with Husserl observed that phenomenology asks for the nature of a phenomenon, for that which makes something what it is – and without which it could not be itself (Husserl, 1982; Merleau-Ponty, 1962)

It is also worth noting that in his preface to his 1962 work, ***Phenomenology of Perception***, Merleau-Ponty asked the direct question, "What is phenomenology?" This is because phenomenology is essentially an orientation to enquiry and therefore can be elusive: phenomenology can be practiced and identified as a manner or style of

thinking, it existed as a movement before arriving at complete awareness of itself as a philosophy (Merleau-Ponty, 1962: xi). The Lifeworld was an important concept to Merleau-Ponty (1962) as he considered that different individuals inhabit different lifeworlds at different times. There are four "existential" lifeworlds which people are supposed to inhabit regardless of their situation and these are: Lived: space, time, body and other (Jones, 1998). Merleau-Ponty articulates phenomenology as an existential mode of being, experienced through the body, the aim of which is to concentrate on achieving a direct and primitive contact with the world as it is immediately experienced (Merleau-Ponty, 1962). He said simply "the world is not what I think but what I live through…" (Merleau-Ponty, 1962, p xvii). This idea is a key aspect to the philosophical ideas behind my research and builds on the ideas of Heidegger and Gadamer and the concept of intersubjectivity. These ideas have also informed the work of van Manen, who believed that even although lifeworld existentials can be differentiated, they cannot be separated and that they form an "intricate unity" (van Manen 1990 p. 105).

Merleau-Ponty took a position somewhere between Heidegger and Husserl, accepting the existential and self-interpreting "being" and yet adopting phenomenological reduction (Jones, 1998). Still, he is illuminating as he reminds us that:

> … The most important lesson which the reduction teaches is the impossibility of a complete reduction…we are in the world, our reflections are carried out in the temporal flux…which we are trying to seize, there is no thought that embraces all our thought (Merleau-Ponty, 1962, p.xiv).

Phenomenology and Nursing

Phenomenology is popular in nursing research as this approach helps to understand the lived experiences of people (Spieglberg, 1965). In the human sciences and in

nursing, phenomenology concerns itself with the study of things within human existence, because it values the meaning people ascribe to their experiences (Roberts and Taylor, 1997). The prime intent of phenomenology in this case is to discover, explore, and describe uncensored phenomena (Spiegelberg, 1965) of the things themselves, as they are immediately given (Roberts and Taylor, 1997). Van Manen (1990, p.9) says that phenomenological research is the study of lived experience,

> … The lifeworld – the world as we immediately experience it pre-reflectively rather than as we conceptualize, categorize, or reflect on it (Husserl, 1970b; Schutz and Luckmann, 1973). Phenomenology aims at gaining a deeper understanding of the nature or meaning of our everyday experiences.

Many types of phenomenology exist which all propose to explore the nature of a thing directly by going to its source (Spiegelberg, 1976) and so phenomenology does allow nurses to explore the lived experience of people involved in a nursing practice or experience of any kind (Roberts and Taylor, 1997). Morse and Field (1996) say that the purpose of phenomenology is to identify the richness of an experience and that this provides rich, insightful reflections for the reader.

Nursing seems to be as much an art as it is a science, and phenomenological studies are becoming increasingly popular with nurse researchers as demonstrated by multiplicity of nursing research using phenomenology. It would seem that many nurses are drawn to the idea of closely examining patients' experiences. After all, nurses are the ones who spend most time with patients, talking to them, listening to their stories and feelings, contacting the doctor when necessary. Nursing is a unique discipline deeply involved in the human side of healing and illness. It is the nurse, by the patient in the darkest of night, who is likely to hear the patient's deepest thoughts and fears and feelings, more so than other health practitioners.

According to Morse and Field (1996) the outcome of research using qualitative data is new information. This new information is intended to inform theory even though phenomenology does not have theory development as its intention or purpose, and because the theory, which arises, is inductively derived; and therefore has applicability to human experience.

The researcher is not letting existing theory drive the research (Morse, 1992) but instead in the later stage of analysis the researcher compares the information, which has arisen from the data to any pre-existing theory. The continual comparison between the two questions of "what is right, my data or the literature?" forces a researcher to be constantly thinking about the project (Morse and Field, 1996). Theory, which arises from phenomenological research, allows for what is learned, what arises from the study, rather than proving an existing idea: so emerging understandings of an experience when applied to nursing can theoretically inform practice. Phenomenology is an inductive process of research and reasoning which can result in the identification of certain patterns, eventually leading to the formulation of hypotheses or the advancement of general theories which can then be tested deductively (Morse and Field, 1996).

A critique of Phenomenology in Nursing Research

Phenomenology is a human science (or art) that is poetical: it helps us to uncover the essence of an experience in a new way, to see a phenomenon with different eyes. As such, it is a discipline, which is evolving at a steady rate and is subject, of course, to limitations and amateur attempts. One issue of concern is that many nursing

researchers lack philosophical understanding of phenomenology (Ray, 1994). This, of course, clouds the credibility of research in a new discipline. Paley (1996) warned nurses about calling their research Husserlian phenomenology. He says quite baldly that:

> The project of identifying the "essential structure" of a phenomenon, typically adopted by the nurse researchers who cite Husserl as an authority, comes close to being unintelligible…while the methods used in phenomenological nursing research may still have some legitimacy, they cannot achieve what they are alleged to achieve, and they should be detached from the framework of Husserlian ideas and terminology which is supposed to justify them (Paley, 1996, p.187).

In his conclusion to this article, he says that there is an absence of convincing accounts of what "essences" are and how they are derived, and that the idea that it is possible to identify the "essence" or the essential structure of phenomena is unintelligible, so therefore:

> Nurses are not entitled to make use of Husserl's terminology and they should abandon their attempts to ground phenomenological research, of the kind being currently reported, in his philosophy (Paley, 1996, p.192).

Most critics of phenomenology in general and as applied to nursing in particular are not as cautionary as Paley, but there is literature addressing the methodological question of "how do you do phenomenological research?" (Morse & Field, 1996). This question of how one does it is vital for the credibility of the research. As Cohen and Omery (1994) indicate, a number of recent reports have lacked a discussion of the method or lacked references to support the method that was described in the research paper (Cohen and Omery, 1994).

It is of course important to mention the work of the scholar Michael Crotty, who was very serious and critical about phenomenological research and how it has been used

by modern nursing scholars. Crotty (1996) discussed North American nurses' recent phenomenological research. He is distinctly critical of nurses who attempt to use phenomenology for their research. The specific criticism he aims at these nurses is that they fail to recognise the "newness of what they are doing" (Crotty, 1996, p2) and he says they use methods, which are incongruent with traditional phenomenology. He believes that "new" phenomenology is far too subjective and that nurses who rely on it do not recognise the value of what they are not doing. In relation to hermeneutic phenomenology, Crotty (1996, p; 76) says that nurses are not seeking what "manifests itself" in experience but are instead focusing on the meaning of what the subject has made of that experience. He also believed that nurses simply "dressed" their phenomenological studies in "Heideggarian livery" rather than created a genuine attempt to apply Heidegger's notions to their research (Crotty, 1996, p.76). Of course there has been much counter-critical reaction of nursing scholars to these claims, such as Benner (1996, p. 258) who said Crotty is viewing this in a "familiar pattern of malestream thinking" which turns up as a total rejection of nursing phenomenologists and their work, and she says that his tone is pejorative throughout and lacks objectivity.

However, he is not the only critic of phenomenology in nursing, he is in good company with Paley and Draucker (1999) who also critiqued Heideggarian hermeneutical nursing research. Here, over 25 research reports claiming to be based on Heideggerian interpretative phenomenologies were reviewed: focusing on two critical issues. Firstly, do the reports show a confluence of participants and researcher understanding as required by the Heideggerian tradition? Secondly, do Heideggerian ideas enrich and inform the studies' findings? This literature review reveals wide

variations with regard to how the published reports reflect these two issues. Drauker (1999) put forward two recommendations. Firstly, that Heideggarian nurse researchers seek to create a new narrative literature which allows for flexible and creative presentation of interpretative findings whilst demanding adherence to sound, interpretative scholarship and secondly, that we strengthen our partnerships with philosophers and other scholars so ideas from Heideggarian interpretative phenomenology and other sources can not only guide our methods, but make the findings even richer (Draucker, 1999).

Another problem with, or criticism of, phenomenology has been concerned with the language itself. Cohen and Omery (1994) have said that language used by phenomenologists has never been described as "clear". Could this be due to a lack of philosophical understanding, at times? Or do some of these scholars simply belong to the Bureau of Confusiology? Some of these articles written by phenomenologists are filled with convoluted language, which makes their argument problematic to understand.

There is also the concern of lack of adequacy of rigour (the trustworthiness of a study) in phenomenological research (Sandelowski, 1986). This is a common attack of critics, downgrading the merit of this approach. Whilst scientific rigour was of immense importance to Husserl, the question has been asked, "whether qualitative inquiry belongs in the domain of science at all?" (Sandelowski 1986). Some say it is too artistic, too poetic, too descriptive and interpretative to be anything other than an art form. But, phenomenology, done carefully, is like nursing or medicine – it is both an art form and a science, both pragmatic and poetical. Perhaps phenomenology

needs to be recognised as its own form – not as an approach born out of science. According to Sandelowski (1986), applying the criteria of one research tradition to another is basically "self-justification" because these criteria favor the research tradition that generated them.

Koch (1994) attempted to address the problem of establishing rigour in qualitative research. In her (1994) study of geriatric patients, she talked about the decision trail and argued that the trustworthiness of a study can be established if the reader can audit the events, actions and influences of the researcher. The preparations undertaken before the patient interviews could take place were described, as was the literature recording the process of the interviewer's experience. Her study aimed to express the concerns of older patients admitted to the acute care sector, and took place in two elderly care wards in a UK hospital. Fourteen patients were interviewed, and their concerns were expressed in themes such as depersonalization, routine geriatric care, and deprivation of care and geriatric segregation. She described her preparations undertaken before the patient interviews took place, and showed the researcher's participation as part of the existential phenomenological research process. Her work included journal entries, media reports, her own personal value position, and so on. Reference was also made to significant literature in the article.

Beck (1994) also addressed this problem of reliability and validity in phenomenological research. Beck wrote that reliability and validity are two areas where the criteria of logical empiricism appear to be imposed on phenomenology as a research method. Cross-paradigmatic communication does result in problems because the same words can have differing meanings. The point is made that one cannot

assume validity and reliability share the same meaning in both logical empiricism and phenomenology.   Even amongst the three most commonly used methods of phenomenology in nursing research, a lack of consensus exists regarding these issues of validity and reliability. Colaizzi (1978), Giorgi (1973, and Van Kaam's (1969) methods are contrasted and compared regarding their position on these issues. Guba and Lincoln's (1999) four major criteria for rigour in qualitative inquiry, applicability, truth-value, neutrality, and consistency are suggested as offering phenomenologists an appropriate alternative to the logical positivistic terminology.

However, nursing research using qualitative data despite its difficulties (which can be overcome by the thoughtful researcher) is well worth doing. Trustworthiness in phenomenology can be measured by the "phenomenological nod" which is another way of saying how a reader can relate to the material in a study, either through his/her own experience or imaginatively. Marilyn Ray suggests

> The richness, really, is how well somebody else can use it. Does this have any relevance or validity in the context of my practice? (Ray, 1994, p.117)

 Morse and Field (1996 p. 158) put it this way: "qualitative research often has a powerful effect on practice, on policy change, and most importantly, on humanistic practice". There is no better reason for undertaking phenomenological research in nursing.

 Summary

This chapter has explored the basics of phenomenology, and examined the philosophical concerns and some of the history of its evolution. Phenomenology is quite difficult to grasp, yet due to its humanistic and ineffable qualities, it can, if

chosen, be useful to nursing research and enquiry. It is my approach of choice when researching the lived experience of women with postnatal depression who have received health professional intervention.

In the next chapter the methods used to collect and examine data for this research are discussed.

Chapter 4

Method

Introduction

In this chapter, the research design for the study is presented. Information is included on the participants and their recruitment, ethical issues, the study setting, the data collection techniques and the intended outcomes of the study. The techniques used for the analysis of the data are also discussed.

The method: overview

One could describe a method in research as the steps, procedures and strategies for gathering and analysing the data in an investigation. Roberts and Taylor (1997) have suggested that the researcher can arrange personal and methodical steps in interpretive research to analyse data in order to locate meanings in a text. Such steps differ between researchers, such as those suggested by Van Kamm (1969), Colaizzi (1978) and van Manen (1990). There is no universally accepted method for data analysis; however, it does need to be congruent with the philosophical position that underpins the study in this case, phenomenology. I chose van Manen's (1990) six methodical steps to assist me in exploring the experiences of women with mild to serious Postnatal Depression and the helpful or unhelpful interventions they received from Health Professionals.

Study Design

This is an interpretive hermeneutic phenomenological study relying on the critical reflection and memory of the participants. Phenomenology is a human science, which

strives to interpret and understand rather than simply explain and observe; hermeneutics is concerned with the description and interpretation of experience (Morse, 1991, p.56). The simultaneous application of both approaches provides a useful pathway to search for meaning in research. Roberts and Taylor (1997) describe phenomenology as the study of a thing, and Polit and Hungler (1999) suggest that phenomenology is a research tradition with roots in philosophy and psychology, which focuses on the lived experience of humans. Therefore, an interpretive approach is ideal when posing these research questions: "What does it mean and how does it feel to experience Postnatal Depression? What does it mean and how does it feel to experience helpful and unhelpful interventions by health professionals?"

The six steps of van Manen provide a workable overview for a project of this nature, even although the steps are very broad. Van Manen observed that although method is one mechanism to undertake research, it is important to avoid fixed signposts as they do not necessarily determine a method and do not support the flexible philosophy of phenomenological hermeneutics (van Manen, 1990). However, he does outline six methodical procedures, helpful to the conduct of hermeneutic phenomenological research. While these six procedures are neither absolute nor fixed, I found them a useful guide when dealing with the phenomena under investigation. These six steps are:

1. Turning to a phenomenon of interest

2. Investigating experience as we live it

3. Reflecting on the essential themes which characterise the phenomenon

4. Describing the phenomena – the art of writing and rewriting

5. Maintaining a strong and orientated relation to the phenomenon

6. Balancing the research context by considering the parts and the whole

(van Manen, 1990, p. 30)

These steps are linked by a time – sequential process, there is a logic to them, yet there is a backwards and forwards motion that occurs when comporting oneself to the data (Fitzgerald, 1995). One might write about the phenomena, then consider one's position in relation to it, write some more, consider the parts and the whole, write some more, and then consider one's position, and so on. This is the backwards and forwards, pendular and circular motion that is involved in the hermeneutic circle (Gadamer, 1975).

The circular interpretation is dynamic in nature; it has no bottom, or top: no beginning or end; no subject-object distinctions. The process of play, wherein the researcher is absorbed into the research, is constructed to join the researcher and text in order to avoid subject-object distinctions (Walsh, 1996). Therefore play and the fusion of horizons interplay like the light and shade in an Impressionist painting; and these ideas have a freshness and vitality which enable the researcher to enter the circle and dialogue with the text to create new understanding. This is the process that I followed in this thesis.

Despite the circular nature of van Manen's steps, the first two steps could be considered to be linear. This is because one turns to the phenomenon of interest, asks a research question, and then begins an investigation, in my thesis, by interviews. Some backwards and forwards movement was noted even in these early phases,

however, I had to constantly remember the research question and check that the methods of trying to answer the question were appropriate.

The Six Steps of van Manen

1. Turning to a phenomenon of interest

This first step (van Manen, 1990, p.31) is to make sense of some aspect of human experience and explore an aspect of human existence. Van Manen describes phenomenological research as being "given over" to a quest, a true task, a deep questioning of something and that phenomenological research does not exist in a disembodied fashion, it is always the project of someone, an individual who sets out to make sense of an aspect of human existence. One must remember that a phenomenological interpretation is always the interpretation of one researcher only, and there will be room for other interpretations that may be richer, deeper, or complimentary (van Manen, 1990, p.31). In essence, this first step involved the formulation of the research questions. These were: "What is the experience of women with mild to serious Postnatal Depression and health professional intervention? What are the helpful interventions from health professionals for these women and what are the unhelpful interventions?" When I analysed the data, I continually referred to these questions, to ensure that the methods used remained appropriate to answer them. This step was continuous throughout the research process.

2. Investigating experience as we live it

Phenomenological research aims at establishing renewed contact with original experience. Merleau-Ponty (1962) suggests that turning to the phenomena of lived experience means re-learning to look at the world by re-awakening the basic

experience of the world. It is like Husserl's "turning to the things themselves" or *Zu den Sachen (*Husserl, 1911/80, p. 116). In essence, the researcher actively explores the chosen category of the lived experience in all its modalities and aspects (van Manen, 1990) for example, doing interviews of patients who experienced postnatal depression. While conducting this research I attempted to re-live and re-learn the nature of the participants' original experiences as they had related them to me. The phenomena were the experiences of postnatal depression in the lives of 12 women, and their experiences with health professional intervention. In order to understand these phenomena, it was necessary to enter the lives of those who have lived the experience. To do this task I chose unstructured interviews with the women concerned, to seek their experiences as treatment receivers. The women were asked to describe their postnatal depression and the efforts of the health professionals who treated them, and to tell in their own words the story of the helpful or unhelpful interventions they experienced during the treatment period. These perspectives were intended to add depth and breadth to our understanding of the lived experience of postnatal depression and health professional intervention.

3. Reflecting on essential themes which characterise the phenomenon

Van Manen says that a true reflection on lived experience is a reflective and thoughtful grasping of what renders an experience its special significance and that phenomenological research "makes a distinction between appearance and essence, between the things of our experience …" (van Manen, 1990, p. 31). This involves a bringing into focus what tends to be obscure and evades the intelligibility of our natural life. Consequently, it is a good idea to understand the meaning of a phenomenon in terms of units, structures or themes of meanings. In this study, I

selected statements, words or phrases while re-reading or repeatedly listening to the audiotaped individual interviews. These statements or phrases formed the beginnings of sub-themes and themes that gave meaning to the phenomena.

4. Describing the phenomena – the art of writing and rewriting

Doing phenomenological research involves a "bringing to speech" of something, and thoughtful description of phenomena can be a writing activity. Language and thinking are hard to separate, as in Merleau Ponty's phrase, "when I speak I discover what it is I wished to say" (Merleau-Ponty, 1973, p 142). So phenomenology is the application of language and thoughtfulness to an aspect of lived experience. Van Manen (1990) has also said that writing is an important part of the research process. I intend to make visible to the reader the feelings, thoughts and attitudes of women who have suffered from Postnatal Depression and who have had health professional intervention, and make visible their feelings and thoughts about these interventions. Chapters are included that outline the events that led to participants developing postnatal depression (chapter 5), the themes and how they were developed (Chapter 6), and a discussion of these themes together with recommendations for health professionals from the women interviewed (Chapter 7). It is worth remembering that this is a non-linear process represented as a linear document.

5. Maintaining a strong and orientated relation to the phenomenon

Phenomenology is an approach to research that is very demanding of the researcher in the sense that one must remain devoted to the fundamental question or notion and to avoid being sidetracked. It is important to approach the task with integrity and be animated by the object in a full, human sense and not to settle for superficialities or

falsities (van Manen, 1990). Van Manen (1990) also informed researchers that we should retain a strong and orientated relationship to the phenomenon under investigation throughout the research process and be aware of one's own preconceived opinions and conceptions, memories and experiences. It can be useful to record these in a journal or a diary throughout the research process, and to be aware of the difference between one's own preconceived notions and the thoughts of the participants. It is possible for these thoughts, feelings, and beliefs to be included as data, through the "fusion of horizons" process outlined by Gadamer (1975). They are not data in the usual sense, but can help the researcher in the process of interpretation of data.

Koch (1994) recommended the inclusion of a "decision trail" as part of the work in order to confront the problem of establishing rigour in interpretive research. Koch (1994) suggests that the trustworthiness of a study can be established if the reader can observe the thoughts, actions, and decisions of a researcher, and so these are included as part of this thesis. I have done this and the material in the appendices includes work for the audit trail (see appendices 6, 7, 8 and 9). Examples of data and analysis are present from the early stage of conducting and transcribing interviews, through the preliminary analysis and the later analysis of sub-themes and themes.

6. Balancing the research context by considering the parts and the whole

One must constantly measure the overall design of the study or text against the significance that the parts play in terms of the overall structure of the text. Sometimes one must step out of studying the parts and look at the total, and at how each of the parts contribute to the whole. The researcher constantly scrutinises the phenomenon

under investigation by moving between the parts of it and the whole picture. This step matches the hermeneutic circle that Gadamer introduced (Annels, 1997). Van Manen (1990) offered a procedural step which is the back and forth movement of the researcher and the text, while Gadamer offers a philosophical perspective about hermeneutic issues, called the "Fusion of Horizons" (Gadamer, 1975). Furthermore, van Manen (1990) has explained that to construct a text, a circular process involving continual dialogue between seemingly meaningful words, phrases and concepts, and questioning these sections of the text to ask 'what is really being said here?' is part of the analysis process. Initially, this involves the individual text (that is the participant's stories). Once emerging words and concepts develop from these individual parts they were then reviewed and questioned in light of the whole perspective and questions such as "Is this concept shared or different from other perspectives?" "What does this mean in relation to the phenomena?" were asked. One must remember such things as: "Is the study grounded in a proper examination of the question?" (van Manen, 1990). This process was in constant flow for me as I carried out this project. So therefore, all six steps of van Manen flow one into the other, and backwards into a spiral, with the sixth step burrowing into the first step, as one remembers the research question.

Participants

Inclusion Criteria

Participants in this study were eligible for inclusion if they met the following criteria:

- Women who experienced postnatal depression and who had been diagnosed and treated by a health professional.

- Women with PND who had been discharged from formal PND care for at least 12 months.

- Women who had been treated no more than 10 years from the initial diagnosis of PND.

- Women over 20 years of age.

The definition of PND used in this study comes from the Diagnostic and Statistics Manual – IV, which states PND, is a post-natal onset of major depression, which begins 4-6 weeks postnatally and can last up to a year. It is not puerperal psychosis, which has an onset in the first post-natal week, or maternity blues, which begins 3-5 days postnatally and lasts up to 14 days (American Psychiatric Association, 1995, p.386).

I chose to interview women who had completed treatment for PND 12 months beforehand. This time period was chosen, as it was perceived to be an adequate timeframe to avoid potential distress that may be raised for these women by talking about their PND too early. The maximum time period of 10 years was chosen to ensure that the interventions the women chose to talk about were contemporary. In addition, I expected that over time, interventions and treatment of PND would have changed.

Exclusion Criteria

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

- Self referring women

- Women under 20 years of age.

Women who self-referred as postnatal depression sufferers were ineligible for inclusion because they might not have had health professional intervention or had a definitive diagnosis of postnatal depression. Although it is acknowledged that women

under 20 years of age may experience PND, they were not included as they may have additional issues related to teenage motherhood that may have impacted on their experience of PND and helpful and unhelpful interventions.

The Recruitment Process

Several recruitment strategies were undertaken to identify potential participants for this project including advertising on notice boards of key institutions and "snowball sampling". These strategies are discussed in the paragraphs below.

The participants were recruited from two large government institutions (which care for women with PND and their children) public hospitals, churches and a local primary school (See appendices I – IV for the advertising material, information sheets, and consent forms used during the study). The advertising material and information sheets were displayed on notice boards in the hospitals, schools, universities, doctors' surgeries, and even a local church.

Contacting key people in suitable organisations

I telephoned the head office of each main government organisation that deals with women with PND, and made an appointment to see the CEO to speak to them regarding my project. After each meeting with the CEO I asked for a group meeting with members of staff and described my project to them and asked the staff members if they knew of any suitable participants. Each institution had to give their own permission for me to recruit participants through them. Individual staff members distributed the material to other staff members and potential participants. When staff members recommended a participant for this project, they either passed me their contact details and I made telephone contact with them, or they approached the

participant on my behalf. I regularly telephoned each staff member to check if there was any interest from potential participants and if there was, I made telephone contact directly with those women to see if they were interested in participating, and if so, to arrange the interview.

I also held meetings with other people in important positions in these organisations such as a charge nurse of a ward and I requested that they distribute my advertising material. They agreed to display notices in their offices or waiting rooms about the study.

Snowball Sampling

Word-of-mouth from participant to participant, known as "snowball sampling" (Patton, 2002), was another method employed to recruit participants. Patton (2003 p 237) describes snowball or chain sampling as an approach for locating information-rich key informants in research. The idea of this strategy is that as the "snowball" increases, key contacts suggest additional key individuals to the researcher from the organisations where participants were being recruited (Patton, 2002, p.237). Some key individuals were suggested by more than one key contact. I contacted such people who were mentioned to me, and asked if they knew of any potential participants for this project.

Participant numbers

Twelve women participants were recruited into this study, as this was the number at which 'saturation' of the data was reached. Saturation is where little new information is generated by the research and the data is seen to be repeating itself (Morse and Field, 1991a). Morse (1991a, p 141) also claimed that saturation is a myth and when

researchers begin a new sample they often find a new perspective on the experience. This left me with a dilemma. Should I conduct additional interviews? How should I treat any new information? After dialoguing with the text I decided that the information was being repeated, that the research question was being answered and that conducting further interviews was unlikely to add new data.

Ethical issues

Ethics approval was obtained from The University of Adelaide Ethics Committee prior to commencing this study. As this research was concerned with the effects of interventions on people, a number of important issues needed to be considered. First, was the concept of "do no harm" (Morse, 1989). The participants gave up their time and shared confidential and sensitive material for the research without financial gain and it was essential that they did not suffer any pain or discomfort through the process. Every effort was made to ensure that the women involved were not put at risk of abreaction from the shared emotional pain. I listened sensitively, and also provided the names of counselors if required. If a participant seemed at all unsure about the project before consent was obtained then the interview was not undertaken.

Participants were provided with plain language information sheets, which included the name and telephone number of the Chairman of the Research Ethics Committee of the University of Adelaide. Prior discussions and written material (see appendices I – V) were provided to each participant well in advance of the interview (an advertising sheet, a consent form with the participants rights spelled out clearly, and a plain language information sheet explaining the study) enabled all participants to begin their interview fully aware of what was involved. My telephone number was also

made available if the participants needed to debrief after the interview. The participants were informed of their right to withdraw at any time if they chose and that they could stop the interview at any time. Any questions they had were answered in full before they signed a consent form. This consent form was a legal document requesting the participant to give informed consent to take part in the study if they chose to do so, and was signed by each participant. It also reaffirmed their rights as volunteers in this study, such as the freedom to withdraw at any time (see appendix V).

Respect for human privacy was also observed both in the conduct of interviews and in the writing up of results where all identifying material was removed. The participants had the issues of confidentiality and anonymity discussed with them before the study began. The participants were promised that all the data would be kept confidential and all identifying material in the thesis would be changed, and that the transcripts would be kept in a locked cabinet for seven years.

Interview technique (Data Collection).

Interviews form an essential part of data collection for many studies (Sorrell & Redmond, 1995). The manner in which interviews evoke respondents' recall, information, feelings and expression has a direct impact on the quality of the resultant data obtained (Drew, 1993). The researcher is a key instrument in interpretive research and therefore good interview techniques are vital (Sorrell & Redmond, 1995). I made sure to use skill in listening for and interpreting meaning in order to respond appropriately to the flow of information.

According to Sorrell and Redmond (1995) respondents should believe that what they have to say and their participation is important to the research. Interview strategies such as remaining attentive, providing non-verbal cues such as nods, moving closer to the respondent and maintaining eye contact do communicate interest and encourage the flow of communication. I was also aware that the interchange in the relationship between each respondent and me could enrich the data via the flow of conversation and information sharing between us (Sorrell & Redmond, 1995).

The interview technique has a number of advantages and disadvantages as a method for data collection. An individual interview has advantages because the researcher can sensitively ask the participants about their experiences, and allow the stories to flow unhindered. The possibility also exists that participants may become overwhelmed by the intensity of a one-on-one interview (Sim, 1998). I discussed this possibility with each participant, and checked that they felt comfortable expressing their opinions and sharing their stories. I also reminded them that they were free to share as much or as little as they wished and that they could stop the tape or the interview at any time. One disadvantage of an individual interview is that some of the participants could be unwilling to answer the research question and be participating in interviews for different, undisclosed reasons (Morse, 1996). However, it was evident from their responses that each participant was interested in adding to the research and they shared their experience in an open and positive way. They spoke openly and freely about their experiences and all said during the interview that they felt comfortable about taking part in the research.

The interviews were conducted either in the home of the participant, in my work environment, or in a place convenient for the participant. As the 12 women participants were recruited from snowball sampling or through key hospital contacts, it was not appropriate to interview the women from the place of recruitment. Office space was sparse and crowded, and it was noisy and provided little privacy. The hospital ward was not appropriate because participants were interviewed twelve months after discharge and no longer in-patients.

The interview technique involved both semi-structured questions and unstructured questions. I used some semi-structured questions to begin to open the flow of data towards the research question. In order to elicit information about postnatal depression and health professional intervention, the following semi-structured questions were asked of the twelve women:

- Can you tell me about your experience of Postnatal Depression?
- What happened in your interactions with health professionals?
- What did you experience as helpful?
- What did you experience as unhelpful?
- Is there anything you would like to have been done differently, and if so, how?

The data were allowed to flow in a conversational, rather than a directed manner. I listened and observed the participants closely, noted their body language and tone of voice and gave non-directive prompts when the flow of narrative flagged, or needed a more detailed turn. If they became distressed I gave them the opportunity to talk about that, or to discontinue the interview and debrief the experience with me, or to continue

the interview, depending on their needs. I sat, listened and asked open-ended questions which were deliberately unstructured such as:

- Can you tell me a little more about that?

- What do you mean, exactly?

- What do you think led to this happening?

- What would you prefer to have happened?

- What happened next?

- How did this make you feel?

It was important to encourage the women respondents to share their stories and to uncover meanings in their experience. I wanted the participants to describe the experience, and wanted to know how the participants felt, thought, and acted in order to give a rich picture of the lived experience of PND and health professional intervention (Sorrel and Redmond, 1995).

If the participant did not want to continue with a line of conversation this was respected. I used a range of gentle verbal and non-verbal prompts, such as "mm-hmm," "uh-huh" "yes" and "oh really?" nodding of the head, leaning forward and other forms of body language as mentioned earlier.

Organisation of the data

Polit and Hungler (1999) suggest that the search for concepts of importance and themes actually starts the moment data collection commences. Once the interviews were completed, the tapes were played and re-played and meditated upon, and then transcribed verbatim. I chose to transcribe immediately, while the tape-recorded

interview was fresh in my memory. If the participants' voices or words sounded unclear on the tape, I could still recall what was said and copy the data down accurately. When the interview was transcribed, any identifying characteristics related to either the participants or institutions were changed. I made notes in diary form about the participants including tone of voice, body language, laughing, crying, as well as my own response to their stories and words. This was included as part of the decision trail for this project. Notes about each participant were filed under their assumed names to go with the transcript.

Analysis

According to Patton (2002) phenomenological analysis seeks to grasp and make clear the meaning, structure, and essence of a lived experience of a phenomenon for a person and a group of people and transform data into findings. Guidance, such as that offered by van Manen (1990) is helpful during the analytic approach and method, but in the end the outcome remains unique for each inquirer according to the fusion of horizons, which develops as the researcher dialogues with the text (Gadamer, 1975, van Manen, 1990).

The first part of analysis began in the reading of the data collected. Reading, according to Dey (1993) is not a passive act in qualitative data analysis. Reading is compared to digging the soil before preparing a garden – the soil is loosened and it is possible for the seeds of one's analysis to put down roots and grow (Dey, 1993 p. 83). One may have a few ideas already to fertilise this soil, but the fruits of these may be slow to emerge. Nevertheless, when they do, they will be stronger. My ideas began to seed during the data collection process, and strengthen through the reading process,

and were changed many times or altered shape during analysis and interpretation. Patton (2002, p. 436) suggests that the fluid and emergent nature of naturalistic inquiry makes the distinction between data gathering and analysis far less absolute than one might expect. In the course of conducting my interviews, ideas about directions for analysis occurred and specific patterns began to take shape.

Development of sub-themes and themes

Reading and re-reading the transcripts of the twelve participants, and also replaying the tapes allowed their thoughts, feelings, and stories to filter through my mind. I began the written analysis process by writing and analysing all twelve individual case studies (presented in chapter 5), considering the "parts" and then I gathered together the twelve womens' stories and considered the "whole" and moved backwards and forwards in the hermeneutic circle to attempt to make sense of the phenomenon.

Key words and phrases were cut and pasted into a series of tables in a Microsoft Word document, searching for implicit and explicit themes. This process involved extracting and tabulating words of participants or statements of ideas by participants into sections, which were grouped under key words (links), concepts, sub-themes, and finally, themes. The key words are also known as "links" discussed later, in the analysis chapter (Chapter 6). This search for sub-themes and themes involved a coding process as I was reading and continuously interacting with the data, and asking the interrogative quintet "who, what, when, where, why?" of it (Dey, 1993 p 83). The approach here was to go beyond the data, to think creatively about the data, and the result was a mixture of data reduction and data complication (Coffey & Atkinson, 1996). According to Coffey and Atkinson (1996, p.30), coding is generally used to break up and segment the data into simpler, general categories, and at the same time

to expand the data in order to formulate new questions and levels of interpretation. The tables containing the words/phrases of participants (which were grouped according to ideas), contained keywords, e.g. "so little sleep/ pretending to cope/ having trouble breastfeeding" and the resulting concepts, e.g. 'exhaustion/ the appearance of coping/ feeding difficulties" and subsequent sub-themes and themes.

This was an involved process, taking considerable time to complete. I had to remove ideas, words and phrases that seemed to repeat from the data and segment portions of it in order to locate the concepts, sub-themes and themes (Coffey & Atkinson, 1996, p.30). The segmented data was then re-organised as part of a process of re-contextualisation (Coffey& Atkinson, 1996). The analytic work lay in establishing and thinking about the linkages of the concepts/sub themes, and the coding was a way of linking my ideas about the data to the data itself. The coding was a process, which did enable me to identify meaningful data and set the stage for interpretation of it (Coffey & Atkinson, 1996, p. 27). With the data thus reduced into concepts/sub themes that were similar, I was able to retrieve chunks or segments of textual data that shared a common meaning (Coffey & Atkinson, 1996).

<u>Structural Analysis</u>

Structural analysis followed the written work of van Manen (1990) and Streubert and Carpenter (1999). Van Manen (1990, pg. 92) offers three methods for isolating thematic statements. Van Manen says that generally one can take three approaches towards uncovering or isolating thematic aspects of a phenomenon in some text (van Manen, 1990, p. 92) The first approach he calls the wholistic or sententious approach, the second is called the selective or the highlighting approach, and the third is called the detailed or line-by-line approach (van Manen, 1990, p. 93)

The wholistic reading approach involves referring to the text as a whole and asking, "What sententious phrase may capture the fundamental meaning or the main significance of the text as a whole?" (van Manen, 1990, p. 93). We then attempt to express this meaning by formulating such a phrase. The selective reading approach involves reading a text or listening to a text several times and inquiring which statements or phrases appear to be especially revealing about a phenomenon or the experience being described. These statements are then underlined, circled or highlighted. In the case of this study, they were highlighted. In the detailed reading approach, the researcher looks at every single sentence or cluster of sentences and asks, "What does this sentence, or sentence cluster, reveal about the phenomenon or experience being described?" (van Manen, 1990, p 93). For this study, all three approaches were used, and how they were applied together with the findings are more fully described in chapter six. It is worth noting that as I studied the lived experience descriptions from my participants. I began to discern the sub-themes, which emerged and noted certain experiential sub-themes recurring as a commonality in the descriptions. We held onto those sub-themes by lifting appropriate phrases and capturing in simple statements the main thrust of the meaning of each sub-theme as suggested by van Manen (1990, p. 93).

I also followed the ideas of Streubert and Carpenter (1999). They wrote of structural analysis as involving the identification of patterns of meaningful connections followed by another observation of the whole text in order to extract significant meaningful words or phrases relevant to the entire project. The words and phrases, which were highlighted in a word document, were extracted from the transcript, carefully labelled (e.g. Danielle, line (L) 20-23) and pasted into a new document,

using the cut and paste properties of Microsoft word. There was constant checking and rechecking to ensure all textual extracts were correctly labeled. Once all data were collected using this cut and paste function, the new documents were collated and separate files created for them. These were then re-read, to check for similar or different ideas, and to check that the words, concepts and ideas that stood out during the reading as being significant or meaningful to the participant were included. Sometimes these extracts contained differences, but when looked at in light of the 'whole' developing picture they linked together under broad concepts, sub-themes and themes. Once I completed the highlighting, a word or phrase was placed in a separate column to represent the main idea. Each phrase was categorised, which allowed for clusters of similar ideas and concepts to emerge. The statements, phrases, words and ideas were the beginning of the sub-themes and themes, which represent the meaning of the phenomenon under investigation.

Themes

Van Manen (1990) describes a theme as an attempt to capture the phenomenon we try to understand. Both explicit and implicit themes were revealed during data analysis. Explicit themes were those themes that were easily revealed, or those issues that stood out more readily as meaningful or important during analysis. These issues stood out early in the analysis process as being meaningful. Implicit themes were identified during the data analysis process. Implicit themes are the meaning behind the words. There was often a "hidden meaning" behind large volumes of text that emerged after I sifted the parts from the whole. These implicit themes appeared when I dialogued with the text and dwelled with the data (van Manen, 1990). They were not necessarily obvious on a first reading of the text. This meticulous process is part of the "fusion of

horizons" as discussed by Gadamer (Annells, 1995). The experience, words and phrases of the participants intersected with my own thoughts and ideas, and this was part of the flux and flow of the fusion of horizons of lived experience.

Gadamer

I also chose to be informed by the work of Gadamer (1975) to supplement and extend the six steps of van Manen. The notions I borrowed from Gadamer (1975) were used in a new way, to inform my study, and not in a way he had originally intended when he first wrote them. These notions involve the hermeneutic circle of understanding, prejudice, the fusion of horizons, play and the idea of lived experience (Annels, 1995). The hermeneutic circle (the art of understanding a lived experience) was chosen to understand the lived experience of women with postnatal depression who had health professional interventions. Prejudice is an awareness of the author's own judgement of a situation before all the elements have been considered, but it is not something to be cast aside, rather Gadamer (1975) considers it to be an advantage. Furthermore, Gadamer (1975) said that trying to eliminate one's own concept in interpretation is not only impossible, but also absurd.

Therefore the "fusion of horizons" is a link between the researcher's "prejudice" and the subject at hand. It changes constantly as one dialogues with the text, a horizon is not just a rigid frontier, but something which moves with one thereby inviting one to move further (Gadamer, 1975). This idea involves a continuous fusion of the historical horizon with the present horizon, and it occurs through "play" where the researcher moves between their thoughts about the subject on hand and the subject matter itself. Play is best done in a playful spirit, rather like a person playing with a

bat and ball (Walsh, 1996). It also occurs through dialoguing with the text and this brings about understanding of a subject under inquiry. Hermeneutical inquiry therefore should aim for a fusion of horizons between the interpreter and the text (Annels, 1995).

Interpretation

Interpretation of the data deals with the meaning I have made of the data and how it has been translated through this process into findings. Roberts and Taylor (1997, p. 337) indicate that interpretation is the step of "working with forms of analysed information so that statements can be made about what they mean in the light of the intentions, methods, and processes of the research." Patton (2000, p. 480) describes interpretation as:

> … Going beyond the descriptive data. Interpretation means attaching significance to what was found, making sense of findings, offering explanations, drawing conclusions, extrapolating lessons, making inferences, considering meanings, and otherwise imposing order on an unruly but surely patterned world.

Qualitative research findings are open to multiple interpretations (Roberts & Taylor, 1997) because of the context-dependent and relative features of qualitative research approaches. For example, researchers and participants will place their importance on various aspects of the phenomena. The audit trail which evolves from the description of the analysis process included here is intended to help the reader to follow the rationale for my interpretations, that is, why particular words or phrases were selected and how I linked them together and what I understood them to mean for these people.

Analysis generally precedes interpretation, although in a phenomenological project the process of searching for meaning is often intuitive and begins with data collection

and is blended through the analysis phase in a spiral and integrative process. As language is the basis of phenomenological research and words are the main source of interpretation, the approach I used required a high degree of familiarity with the text (Roberts & Taylor, 1997) and it was also important to remind myself of the research aims and question. This re-orientation was necessary in the transition from analysis to interpretation in order to stay focussed when checking for congruency between the findings and the original aims, objectives, methods and processes of this project (Roberts & Taylor, 1997, p. 342).

Describing interpretation involves making intellectual leaps, connections and intuitive grasps (Roberts & Taylor, 1997). Gadamer did suggest that the I- Thou relationship in which open-ness to the other, and willingness to have one's historical views modified, creates a dialogical relationship (Gadamer 1975, p. 323). In this he was advocating the need to be open to and even surprised by what could emerge in interpretation.

The interpretation in this thesis is discussed more fully in Chapter Seven. There, using the hermeneutic circle, and the interaction between the parts of the data (the twelve individual interviews) and the whole (the total image of themes generated by putting the parts of the data into a whole picture). I will discuss and interpret the differences and similarities between the sub-themes and themes found in the interviews. The interpretation of the meanings found in this thesis will be displayed in full.

The Hermeneutic Circle

The hermeneutic circle was used in the interpretation phase of this study by moving forward and backward with the data, starting with the present moment. According to Streubert and Carpenter (1999) this process includes several steps, which can gainfully be employed whilst being guided by van Manen. First the text was read carefully to ensure familiarity, and then I read and re-read each transcript, and simultaneously played the tapes over and over. This step involved dwelling with the data (van Manen, 1990). Important ideas, words and phrases were highlighted on each transcript. According to van Manen (1990), one must be aware of the parts and the whole. Therefore, in choosing significant phrases or words within a particular transcript one must maintain a mental picture of the mass of data. Thus the whole process is indeed circular, pendular, and even spiral, from the first step of van Manen, to the last.

Establishing Trustworthiness (The Decision Trail)

Sandelowski (1986) discussed the problem of rigor in research that collects qualitative data and she also believes that the word "rigor" has a harshness, which takes us away from the sensitivity and versatility of good qualitative studies. Lincoln and Guba's (1985) ideas are more appropriate to interpretive inquiry than the inappropriate use of the terms validity and reliability. Sandelowski (1986) believes that the measures taken to safeguard trustworthiness are complex and that the researcher needs to examine them carefully, and that seeking convergence from participants in a study could be inappropriate.

Guba and Lincoln (1989) appeal to the criteria of credibility (truth value), applicability, transferability, and dependability of a study and claim that it is credible

when it presents faithful descriptions and when readers confronted with the experience find it recognisable. Should differences be observed, then the researcher must show how each theme was derived from the descriptions, and this is done by returning to the text to make sure all the conclusions are grounded firmly in the data or explained by the researcher's interpretive scheme (Koch, 1994).

I did this by checking and rechecking the memos written after each interview, which recorded such things as my own beliefs, the response and emotional state of the respondents, and my thoughts and ideas as a result of the interview. I then measured my conclusions against this and the participants' stories at every phase of analysis. I reviewed each theme thoroughly and worked through it by dialoguing with the text (van Manen, 1990) and did not allow each theme to be finalised until I was convinced by re-reading, checking and discussion, that it was a faithful representation of my perception of truth in the text. Truth-value is subject-oriented, it is not decided in advance by the researcher (Morse and Field, 1996, p118), and it can emerge as a surprise from the words in the text. Credibility can be measured by reporting the perspectives of the informants as clearly as possible. I have situated their stories in the study in the next chapter, chapter five, Participants.

Leininger (1994) also addressed the issue of credibility (otherwise known as truth value, and believability) of a piece of research. She argued that the main threat to credibility is too little time spent understanding the lived experiences of the people studied, and that one must return to the informants to check the emerging analysis. I have returned to a number of informants and asked them to review some of my early analysis and to read the transcript, and offered them all a copy of the finished thesis.

Leininger (1994) like Koch (1994) also recommended the use of audit trails and cautioned that one must understand data within a holistic context – which naturally includes events, actions, communication and otherwise relevant contextual and environmental factors. Rodgers and Cowles (1993) also identified areas where documentation ought to occur. They thought that ordered and dated field-notes were important to place interviews within context. For example, if a participant smiled, that would be present to the interviewer long before a laugh might appear on a tape. If a participant cried softly, or her eyes misted over, this would not necessarily be known by any but the interviewer.

Hence, field notes, which are dated, or even scribbled in the margin of a transcript at the correct point, are important. Most of my transcripts either had detailed notes as a separate file as memoranda, or notes in the margin. If an expression of emotion was very clear or relevant, it was included in data quoted in analysis and in the interpretation chapter (Seven). One must look for patterns or repeated experiences, and I chose to do that in my analysis of the data. Changes in approach to the data when collecting it, together with the rationale for this, also should appear in memos (Morse and Field, 1996). For example, as themes and concepts begin to emerge in the interview, the interviewer might ask the participant to "say a little more about that, please?" It is important to be able to explain at what point in the interview, things changed direction, if they did so. And I also made sure that when I did my recording, I wrote thorough descriptions of what happened.

As indicated I also took notes and memoranda in diary form after each interview, taking special note of the participants' emotional reactions during the interview

particularly if they became distressed or if their mood lightened at any time. Koch (1994) suggested including a "decision trail" as part of a work in order to establish rigor in qualitative research. She argued that the trustworthiness of a study could be established if the reader can audit the events, actions, and decisions of the researcher. Samples of "themes" tables for the audit trail are included in the analysis chapter and also in appendices 8 and 9. They demonstrate how I moved, in analysis, from the thoughts and verbal expressions of the participants, to the themes, which emerged in the final results of this study. Appendix 6 contains a sample of some of notes attached to one of the transcripts, to demonstrate the decisions I made as a researcher conducting and re-reading an interview. Such decisions were even as simple as when to stop questioning the participant, or when to change a line of inquiry. Appendix 7 shows a very early example of a thematically analysed interview, which was then written up as a participant's story, ("Christine's Story").

My engagement with the subject matter was also complex and prolonged and lasted several months and some authors such as Polit and Hungler (1999) comment that such engagement with the research material is part of the credibility of research. This is not necessarily so, but one way to establish research credibility is to determine whether the participants recognise the findings as true to their experience. The women who had experienced PND were given the opportunity to review the transcripts. Some of the participants were eager to read the early phase of analysis and have commented that they consider the preliminary analysis to be faithful to their experience, as they believed they had related it. In addition, if the reader experiences a spark of recognition, termed the "Phenomenological Nod" (van Manen 1990, p.27) that is a powerful indication that the results of the project are credible. Van Manen also said

that a good phenomenological description is collected by lived experience and recollects lived experience – is validated by lived experience and it validates lived experience, and he called this the "validating circle of inquiry", and that in order for one to become adept at this validating process one has to learn to insert oneself in the tradition of such scholarship (van Manen, 1990, p 27). For me, such insertion in the tradition of phenomenological scholarship was a process, which involved a thoughtful comportment of myself as researcher towards the data.

Summary

In this chapter the methods of data collection, the study setting, the participants, and ethical issues were discussed. The six steps of van Manen plus the method used for data analysis and interpretation were also described. Care was taken to address the issue of reliability and creditability and the organisation of the data, and the audit trail was discussed, with reference to the Appendices, which are included in the thesis as examples for the audit trail.

The next chapter, Participants, includes the stories of the 12 women interviewed and their experiences with postnatal depression and health professional interventions.

Chapter 5

The Participants

Introduction

In this chapter the personal stories of the twelve women participants are presented. Their stories are provided to situate them as individuals or the "parts" of the text (the participants) before relating them to the "whole" as is methodologically consistent with hermeneutic phenomenology (van Manen, 1990). Their stories are presented as short vignettes and outline the circumstances that led to their diagnoses of postnatal depression and subsequent health professional intervention. These stories are written in the order that the women were interviewed.

Kate's Story

Kate is a psychologist, married to a dentist, and they have one child, a three-year-old baby boy, George. George is the result of IVF treatment for infertility, born when Kate was nearly 40 years old. Kate was recruited to this project by a notice in a local hospital. She was interested in the project and happy to be involved. The interview was conducted in her home at the kitchen table. During the telling of her story, Kate became tearful at times and cried quietly for a while before continuing.

Kate related that she was forced out of her job by a difficult boss who had been looking for an opportunity to get rid of her and used her maternity leave as an excuse. This was extremely painful and she also found the environmental change of being home with a new baby and the isolation of late parenthood, a great shock even

although she had a wonderful, supportive spouse, who helped out in every possible way. She considered her baby to be a very good baby.

After she returned to employment doing simpler work with less responsibility because her boss had changed her role, her mood became one of great sadness, and guilt. She was afraid her suffering over her previous job, which had become unattainable, would be transmitted to the baby and ruin his infancy. She was breastfeeding and also running an investigation for unfair dismissal against her place of previous employment and she felt rage and sadness over being hurt at a time of great vulnerability (new motherhood).

The search for support was hard. She decided to return to her old workplace, which had a counselling section for employees. There she shared her whole story. Although the counsellor listened, she was not sympathetic and offered little help.

Working part time in a different job, she tried another employee assistance counsellor. This counsellor was male and he advised "little steps" as in making small decisions each day to make her life more manageable, and told her she was a highly intelligent woman and she would work it out. She related feeling angry at asking for help and being told she could cope for herself.

Kate felt debilitated by her unhelpful treatment by the counsellor. She then visited a GP who gave her sleeping pills and who also made the off-hand comment that work was not important.

She indicated that that particular intervention was not useful and she reapplied for her old job, in the hope of restarting her career, but this did not eventuate.

Kate found a crèche for her baby, as she had begun to lose the loving feeling towards him and needed time off. This was helpful, but the whole experience was painful. She wanted to take her baby to her old hospital for health checks but found it too painful to be among her previous colleagues so her mother in law did it for her. Much of her expected support was not available, and she found it frustrating that as a professional, articulate woman, she could not access the right kind of help.

Kate had regained control at the time of interviewing, by taking time out to love her child and family and to remember that this was her ultimate goal. Work was reduced to an academic exercise to obtain money to pay the bills. She related that she found treating her career in this manner was extremely distressing, but counselling had not worked for her. Fortunately she finally found some support in looking for new work through the Union where she had an affiliation.

Elle's Story

Contact was made with Elle through snowball sampling. On first meeting Elle appeared friendly but a little apprehensive, however she soon relaxed and talked freely throughout the interview process. The interview was conducted in the kitchen of her home.

Elle is a 38-year-old housewife, clothing designer, mother of four children, married to a farmer. She was 31 years of age when diagnosed with Postnatal Depression after

the birth of her daughter, her first child. Her PND worsened with the arrival of four children in four years, as she had to cope, mostly alone, with four infants isolated on their farm while her husband was working. She had PND with all her children, mildly with the first child, then increasing in severity.

Elle believed her emotional trauma in getting pregnant initially, using the IVF program, followed closely by four traumatic births laid the groundwork for PND. She also acknowledged the intense vulnerability felt by women at this time. Elle hid the difficulties she was experiencing and her true emotions from other people.

Elle felt a sense of isolation, a separation from herself and others during her experience of postnatal depression. She believed she had missed out on the joy of early parenthood. Any positive mood was replaced by a dull flat numbness. She wanted to run away. She lost memories of her children's infancy, and during the telling of her story became tearful at this point. She indicated that anxiety manifested itself through overprotective behaviour towards her children and the stress this created for her meant she was unable to get the break from her children she desperately needed. She was up all night checking for cot death. She explained how the difficulties of having four children close together made life very hard, the constant physical labour and exhaustion all exacerbated her PND.

Elle became wary about showing her true feelings in public and felt lonely in private. The difficulty that she faced was she needed help, but could not ask for it. She felt she had no right to bother other people with her problems. Five months after the birth of her fourth child she was hospitalised for PND. She had an enforced rest and did not

need to care for her children, except for the baby who was admitted with her. Calls to her room were stopped for five days, while she cried and slept and spoke only to her partner and doctor. Once her condition was diagnosed and she no longer had to hide her feelings, she experienced relief and was surprised to discover people were understanding and helpful. She found that an antidepressant prescribed by her General Practitioner gave her the strength and courage to be able to reach out to friends and family and tell them what had been happening to her.

Elle was concerned that other women should not feel the pressure to hide their true feelings and as she recovered, she tried to seek support from groups for women and couples who had experienced PND but these were hard to source. Elle emphasised her passion about the need for increased community awareness of postnatal suffering in women and that is why she agreed to be part of this research.

Annie's Story

Annie is in her thirties, the wife of a farmer, and mother of one child, a daughter. She was recruited to this project via "snowball sampling". Initial contact was made by phone and she indicated her interest in the project and that she was happy to be involved. The interview was conducted in the living room of her home.

Annie was hospitalised for PND, given medication, and even now, is still having regular meetings with her psychiatrist three years after her release from hospital and emergency treatment. She is grateful to her supportive partner and for the excellent health professional care she received. Annie is also a poet and she has used this outlet to describe her feelings about PND. Annie kept a journal during the time she was in

hospital, for two weeks in a general psychiatric ward and seven weeks in a specialised mother-baby clinic for women with Postnatal Depression. She had thought of trying to get the journal published, decided against it but found it therapeutic to write. Annie hid her PND from herself and others for a long time and suffered from painful emotions, such as anger, fear and guilt about PND.

The bond between herself and her baby daughter was too strong, it felt constricting; she experienced it as suffocating, and then came a kind of phobic reaction to her child. She felt a complete eclipse of self, as if the child were weighing her down:

> We were almost so bonded that it was like dragging me down…I was imagining that I had a rock strapped to my back that meant I couldn't stand up and that meant we were so entwined that we couldn't separate.
> (Annie p.17, L: 303-308)

Avoidance of her child increased as the baby grew older, and the unpleasant emotion was not a conscious choice. Annie would go to work, get home after 7 pm, or have a trip to town and visit friends. This avoidance strategy worked well until Annie went to live on a farm, away from her other distractions and supports, but just with her husband and child. Even then, she found it hard to admit to herself that she had a problem.

Full realisation of her condition came when the baby was 15 months old, 9 months after the first inkling of the depression had started. Annie came across a previous child and maternity health nurse's written comment that said she was enjoying motherhood, and Annie denied it vehemently.

She began the search for help and had some simple counselling from a community social worker, but that was not enough. A G.P gave her anti-depressants, which helped slightly, but eventually she was hospitalised in a private psychiatric hospital. Hospital staff were not trained to deal specifically with PND, but Annie rested and had time away from her baby. While in this hospital she wanted to be left alone, but also sought nurturing from the staff, and she found this experience difficult. She waited till a place in a specialist mother and baby psychiatric unit became available, and then spent seven weeks in there where she thought, wrote, attended therapy and groups on motherhood and postnatal depression, underwent changes of medication and struggled to reconnect with her child. She has high praise for the medical and nursing staff in that unit, and for her psychiatrist who has continued to be a supportive influence in her life.

Her medication has been changed and increased, since leaving hospital, but Annie feels as if her life has improved dramatically. Her relationship with her child is much better, but she and Sam decided not to have more children. She has only one regret; that she had not been treated earlier.

<u>Jane's Story</u>

Jane is a thirty eight year old registered nurse, married to a supportive husband, who is also a nurse. They have two children, a boy aged ten and a girl aged seven. She was recruited to the research via a doctor who treats women with Postnatal Depression. On first telephone contact Jane was eager to be involved in the study and the interview was conducted away from her home.

Jane talked freely and during the interview became quite emotional as she shared her story. Postnatal Depression took her completely by surprise, as she was a health professional and had even worked as a Midwife. Postnatal Depression was something that she helped others recover from, not something that she personally expected. It pervaded the first year of her first child's life. The birth was traumatic, both for mother and child. Jane's labour was induced, as the baby was overdue, and it was a long, hard, exhausting labour, with insufficient pain relief due to an ineffective epidural block and finally the baby "came out like a cork from a bottle" (Jane, p. 1, L: 9 - 10) and she ended up with a third degree perineal tear.

Her son was an extremely difficult baby. From the moment he was born he "screamed continuously" (Jane, p. 1, L: 14) to the extent that even the nursing staff in the maternity hospital were pleased to see him go. The situation failed to improve after going home, as the baby screamed all day and she only managed to get two hours sleep at night. After a few months Jane's hold on sanity was beginning to crumble.

Jane coped by putting the baby in the sling and walking for miles every day, as this was the only thing that seemed to calm him down. She is a slender woman but she lost enormous amounts of weight, due mostly to the stress, and the fact that she was trying to breastfeed. She felt pressure to cope alone, no matter how difficult it was. She was a health professional and did not want to admit to failure. Some of her friends guessed there were problems, but she did not tell them.

This determination not to be depressed meant that for months she denied that anything was wrong. She did not share her feelings with a health professional until six months

after the birth. Her doctor, both a friend and a counsellor, diagnosed Jane with PND and talked to her about it on a regular basis. Breastfeeding was difficult and she had doubts about her lactation in that she was worried she was not making sufficient milk for her baby's growth. Despite this, Jane persevered for eleven months, not wanting to admit failure in that area either. Later, when her baby was on the bottle, he did settle somewhat and she wished she had taken the step to bottle-feed with formula nine months earlier.

Jane suffered from frustration, anger and intense guilt about the way she approached motherhood. There were moments when she thought of smothering her child to stop him screaming and to get some sleep. The "Johnson and Johnson" advertisements on television infuriated her. The Arcadian image of peaceful motherhood was so distant from her experience. When people admired her child, she genuinely wanted to give him away. The heartache of her experience was constant. All she could remember from the first year was the gloom. She couldn't remember his first walking, his first step, any of his baby milestones. The need for sleep obliterated everything, as did the sorrow.

Returning to work was helpful; looking after adults rather than being the carer of a crying baby. She was still depressed, but returning to work aided her recovery quicker than anything else. Her husband was supportive, as was her doctor, and a neighbour. They were fortunate in finding excellent day-care facilities for Tom, with a woman who managed him well. Her daughter was born two years later and all their lives are moving on successfully.

Danielle's Story

Danielle is a 30-year-old woman, married with two children; a boy aged five and a girl aged three. She was recruited in to this research via advertising at a hospital with a unit for women with Postnatal Depression. First contact was made with her at a support group where she worked as a volunteer and then the interview was conducted at her home. Danielle had a very positive approach to being involved in the study.

Postnatal Depression took over her life when her son, at the age of two, and her daughter, aged 4 months, stopped sleeping and her life turned into a nightmare. She put her experiences to paper and produced a letter that was published in a local women's newsletter.

Her first pregnancy was uneventful, but she experienced difficulties with her second pregnancy, suffering from nausea from six weeks through to term. Her partner who had been unemployed found work and was too busy to help with the toddler, and her son stopped sleeping and Danielle found herself awakened six to eight times a night. By the time she gave birth to her daughter she was exhausted, stressed and anxious. Life was difficult, and then her daughter also developed a habit of wakefulness when she was four months old. Fractured sleep, stress and breastfeeding took its toll. Danielle became tearful, felt guilty, inadequate, isolated, withdrawn, irritable and overwhelmed. She lost contact with friends because she did not welcome visitors and failed to leave the house. Making a basic decision was almost impossible. She became overtaken by a sense of guilt and failure, her thoughts became confused and she became forgetful. She also denied to herself that she had a problem and tried to appear

to be coping. At a child health checkup a nurse gave her a booklet on Postnatal Depression to read and Danielle recognised her symptoms.

She took her daughter to a mothercraft hospital and during her period there her daughter started to sleep through the night, and she also took some steps to improve her daily life. She found childcare and a cleaner for her house. She visited her GP and was given medication, at first being given an ineffective dose of an anti-depressant, and then she was admitted to a specialist mother and baby postnatal depression unit where she was reassessed and her medication was changed for the better. She also attended a postnatal depression support group every week, which she found helpful. There she found acceptance, understanding, and learnt that she was not alone. Accepting that she had had the condition of PND was the first step for her, and the most difficult.

Olivia's Story

Olivia is 38 years old, a lawyer, married to a surgeon, and they have two children. Olivia responded to the invitation to be interviewed because she heard of the project socially. She was keen to be involved and the interview was conducted in the kitchen of her home.

Olivia experienced Postnatal Depression at the age of 31, after the birth of her daughter Louise, her first child. She found parenthood a shock after years of career and married life as part of a double income couple. She had enjoyed her independence and was astonished at the effect a sudden return to the traditional roles of mother/housewife had on her well being after the birth of her baby. She had little

previous exposure to young children. She also was disappointed in the corporate world's reaction to her new motherhood, believing that her professional status had dropped sharply "overnight".

Olivia found the traditional stresses of motherhood, such as the perceived need to be endlessly calm, endlessly loving to her infant hard as she was unprepared for them and only had media images of peaceful motherhood in her mind. Lack of sleep, difficulty breastfeeding, pressure to breastfeed when it was difficult, a crying baby, and the stress and loneliness of parenting all took their toll. Her own expectations of parenthood made life even more confusing.

She found the emotions overwhelming and yet could not focus her mind clearly enough to see the problem. She found Louise, her baby demanding, and this obscured good feelings for her, especially in the early days when on the advice of her obstetrician she made the decision to give up breastfeeding and bottle-feed. She was surprised at the reassurance of her obstetrician that bottle-feeding was a good idea, and after seven frustrating days in the maternity hospital, she discharged herself and was rewarded by the first calm, peaceful cuddle of a satisfied baby. The experience of motherhood remained difficult, however, but she never even thought of asking for help. She found the need to hide her personal pain.

Olivia felt judged by health professionals for wanting a career. This change of identity was an enormous shock, and it gave rise to emotions of panic and anger. During these episodes she felt tempted to throw her baby across the room. Loss of her own identity was frightening: "you feel like a stranger to yourself" (Olivia, p.10, L: 291). Olivia's

journey involved finding a way to a new identity, which allowed her to be herself in a changed reality. Adapting to the change was imperative, although she suffered a major loss of independence and reduction in income, which now mostly went towards childcare.

Health professionals gave some support, such as the obstetrician who recommended bottle-feeding, and the physiotherapist who recommended a crèche while Olivia attended postnatal exercises. The crèche experience for baby and mother was such a good one that Olivia used it more, returning to work part-time. Friends were a support, although she did not reveal to them her true feelings. Her parents and in laws baby-sat to give her some relief. However, Olivia said her depression took years to dissipate, only fading once her youngest started school. Her partner was emotionally supportive, and they have since moved on to a stable family life.

Gabriela's Story

Gabriela is in her thirties, married, and the mother of one daughter. She has struggled with Bipolar Disorder and Postnatal Depression for ten years. She was recruited to the research by "snowball sampling" and was enthusiastic when telephoned about the study. She came to the researcher's home and the interview was conducted in the living room.

Gabriela gave birth to Constance three years before a definitive diagnosis of Postnatal Depression was given which resulted in hospitalisation. She had visited a psychiatrist for a year before going to hospital, but her story is full of poignant attempts to access both treatment and diagnosis, and to gain support for how she was feeling. She was

psychotic when hospitalised, and had "totally lost the plot" (Gabriela, p 1, L: 9). However, she was aware that the PND had begun shortly after her daughter was born.

Her PND manifested as a fear of bonding with her child. She left the baby in the nursery so she would not have to tend to her. She was afraid of going home, experienced difficulty breastfeeding, and had trouble sleeping. Finally, the paediatrician explained the benefits of bottle-feeding, as Connie was not gaining any weight and Gabriela freed herself from the belief she needed to struggle on with breastfeeding. Therefore once the doctor had explained that the baby would still thrive whilst being bottle-fed she relinquished breastfeeding without guilt.

She had a crying baby who was awake all night and tried to sleep during the day. Gabrielle was unable to get admitted to a specialist hospital for mothers and babies for help as they had a long waiting list. A good friend helped her instead by keeping Connie awake all day and letting her scream, then helping her sleep at night. Gabriela experienced sadness, anger, and at times blamed her family for her unhappiness, wishing that her life were back to her pre-childbirth, pre-marital state.

Despite her distress, Gabriela found it necessary to put on a front before the world, to hide her PND. Gabriele indicated that presenting a clean and neat appearance and her articulate way of expressing herself made it hard for anyone to realise she was unwell and needed help. She remarked in the interview that it was difficult to get help unless "you present completely falling apart at the seams" (Gabriela, p. 7, L: 174). However she decided she needed help and searched for a sympathetic GP, or a psychiatrist who

would listen to her, understand what she was experiencing, and give her appropriate medication.

This search was unsuccessful and Gabriela sought alternative care. She saw psychic healers and alternative therapists and tried to medicate herself, including drinking too much alcohol. Her bipolar disorder had a hormonal component, which made things even more complex combined with three weeks of mania and one of severe depression. This eventually led to a complete breakdown, diagnosis of Postnatal Depression and Bipolar Disorder, and hospitalisation in a private psychiatric hospital, where she was helped in a very secure, nurturing environment. She spent eight weeks there, and her medications were stabilised. She rested and attended group and individual therapy.

Gabrielle indicated that support from her mother and baby group was a lifesaver as it provided long-term friendship. To talk to other women and listen to their experiences was cathartic. She was unable to source a group specific to women with PND, but said that if she had, it would have been extremely helpful. However, a return to her job in the administration of a large company was help, as was excellent childcare. Gabriela has bonded solidly with her only child, who understands about her mother's illness. The balance in her household is back, her marriage is intact and lasting and she has a good network of support from family and friends.

Christine's Story

Christine is married and a mother of two children, a boy aged 5 and a girl aged 3. She has her own business and a love of writing poetry. She was recruited to this study by a

nurse who worked for an organisation, which cares for mothers and young children. Initial contact with Christine was by telephone and she indicated she was happy to be involved in the study, and the interview took place in the kitchen of her home. She is also a writer, and wrote a poem, "Postnatal", which was shared with a mothers' group and started a discussion about the realities of parenting and PND. Eventually, her local maternity nurse started using the poem almost as a diagnostic tool for PND.

Christine's first child was born after a traumatic delivery. Difficulties with her family of origin, an unsympathetic husband, and, in her view, wrong cultural expectations of parenthood and a past history of depression all contributed to her Postnatal Depression. She experienced isolation, alienation and loneliness as her PND worsened. Her history of depression made the notion of being postnatally depressed more frightening. Old unhappy childhood memories re-surfaced, where she felt her mother had been absent and not there for her. Christine "felt this all her life" (Christine, p. 47 L. 1477).

Consequently she found it important to be a stay-at-home mother for her children, although her husband did not agree due to financial problems. Christine had also worked in middle-level management and was used to a neatly organised life, and life with a baby was very different.

The birth was an induced labour, which lasted 20 hours, culminating in an emergency caesarean section. Afterwards, Christine believed she had post-traumatic stress disorder. Having a baby was such a different existence, which she said was like "moving to another planet" (Christine, p. 13 L: 632).

Christine is a well-organised woman, and indicated that she was very good at pretending to herself everything was okay and she could cope. However she did not cope all the time. Everyone else thought she did, but her husband, who lived with her, knew better. When her baby was ten months old, Christine could not stop crying. This event took place in front of a maternity and child health nurse, who recommended counselling. Christine had bizarre fantasies about hurting her child, which made her feel frightened and guilty. She had difficulty bonding after the birth, and was afraid of giving birth to her second child. This feeling was made stronger by a severe haemorrhage, which almost took her life, and so she decided against having any further children.

Christine felt anger and fear about the PND and what that did to her relationship with her son. She lost her sense of self, saying: "It was just like this whole stripping down of who you are and having to rebuild this picture of yourself again" (Christine, p 32, L: 991 – 992).

Christine found support from counselling from her child and maternity health nurse, and the mothers group she attended. She also had marriage counselling, and family counselling for her son after her daughter was born. The counselling helped her move beyond the PND to a new, more positive life with her family.

Tracey's Story

Tracey was another participant recruited via "snowball sampling". She was keen to be interviewed when telephoned and on my arrival was welcoming and relaxed. The interview was conducted in the living room of her home.

Tracey is in her thirties, a mother of three boys, married to a farmer on a large station property. Symptoms of Postnatal Depression appeared after the birth of her second child. At this time she also she developed iron deficiency anaemia (her doctor had considered iron supplements during pregnancy unnecessary). When her second baby was three weeks old she became very ill with gastro-enteritis. She then found herself suffering from low energy and "constant tearfulness".

Her low emotional and physical state was exacerbated by loneliness and isolation, particularly during the harvesting time when her husband was outside working and she was indoors with her small children due to the intense heat. Exhaustion and difficulty breastfeeding made everything appear much worse.

She decided to bottle-feed but while that meant her baby slept through the night, she was still exhausted and unhappy. People suggested she go out and that would make her feel better, but she was too exhausted to do so. The most she could manage was to sit out in the early morning sunshine on the veranda. Tracey is an outdoor person by nature, so being unable to go out, particularly if it was very hot, worsened her depression.

She experienced constant anxiety, which was relieved by the presence of her adult friends and family. When her older son stayed with a relative she was surprised she

missed him so intensely. She also cried constantly and this new experience confused her.

Her GP offered anti-depressants but these made her feel unwell with nausea and vomiting, so she discontinued them. She sought other ways to feel better including Naturopathy. Part of the assessment conducted by the naturopath revealed that she was anaemic.

Nutritional supplements from the naturopath helped to get her well and strong physically and this aided her recovery from the PND. She continued to take the dietary supplementation after her pregnancy with her third child. She also found support from some written material found in her local maternity and child health nurse's office that discussed and described PND. These pamphlets gave her a sense of recognition of her own situation and that recognition was vital to a sense of sanity.

Her husband and parents also gave her good emotional and physical support and she experienced helpful connections with other women and friends, two of whom had gone through PND themselves. Tracey also felt it was important to hide her feelings from most people in order to keep her PND a private matter

Leanne's Story

Leanne is 32, and in a partnership with her boyfriend of ten years. They have four children: two by previous partnerships and two by this current relationship. She was recruited to the research by a mother in a baby postnatal depression unit at a large hospital. Initial contact was by telephone where she indicated she was interested in

sharing her experiences. The interview was conducted at Leanne's home, at her kitchen table.

Leanne did not develop Postnatal Depression until her fourth child was four months old. At the time, she remembered wanting to find a group of mothers to visit and discuss the pain of PND, but this was difficult to arrange. Ultimately, she was hospitalised with her Postnatal Depression in a specialist mother-baby unit for women with PND.

Leanne finally found a group but the first day she went no other women appeared. She eventually befriended one other young mother, and between the two of them they made up a pamphlet entitled, '**Mums to Mums'**, to make information available on Postnatal Depression including information on symptoms. Leanne included her own story.

Leanne's stress increased, as did her crying and sleeping during the day. The baby would sleep all night, so would Leanne. She would wake up, take the older three children to school, take the baby in bed with her and they would sleep. Leanne felt guilty, but unable to do anything about this. She related watching with dismay as her boyfriend came home from work and he plus the older children did most of the chores around the house.

Leanne had found a postnatal womens support group, but that was stopped due to lack of funding and then she began to get seriously unwell with the PND. She had suicidal thoughts, and a social worker arranged for her to be admitted to the specialist mother

and baby PND clinic. Leanne went into hospital for two weeks, but she is unsure how helpful it was to her. A sympathetic psychologist was a positive influence in the clinic, but she said the doctor seemed focused mainly on how the pills were working. Leanne wanted more sympathy and found friendship from the other mothers admitted to the unit.

Leanne expressed a belief that the Zoloft she was taking and her depression meant she was carrying extra weight and this which made her feel worse, with low self esteem, but she was unable to lose weight. Leanne wanted to have a tubal ligation after the birth of her fourth child, but found that treatment difficult to access. The first hospital she applied to refused to do the operation on the grounds of her weight, which was traumatic for her, and she had to go to another hospital.

She found the most helpful intervention was for someone to listen to her painful experiences. She found the birth of her last child stressful, as it involved an emergency caesarian-section. Parenting itself was difficult, and she said she felt she lost her life to constant sleep. This she felt was a paradox as she had a loving, supportive partner, and a perfect little baby, and yet she was unable to enjoy any of it. She did recover from the PND as her children grew older, and once her youngest was back at school she returned to study. She believed there was not enough help in the community for women with PND, and she became a volunteer to help other mothers.

Sophie's Story

Sophie is a 26-year-old Spanish woman married to a bricklayer, and they have two children, a toddler and a baby aged three months. She was contacted by a counsellor

for young women and told of the research. Sophie was then telephoned and was at first wary of being involved but decided to participate and asked for the interview to be done in the living room of her home. Notes were taken by hand, as Sophie felt uncomfortable with a tape-recorder running and I as the interviewer sensed that Sophie needed to be treated with special gentleness and sensitivity. As the interview progressed Sophie relaxed, smiled, and began to talk freely.

She experienced her first attack of Postnatal Depression when her eldest was three months old. Sophie then sought counselling from a community centre. Then when pregnant with her second child and feeling very sad and anxious, she was admitted to a mother and baby Postnatal Depression unit in a large psychiatric hospital. Although the staff wanted to keep her in for longer, after two weeks Sophie felt disappointed with the hospital and the treatment she received and chose to go home.

Sophie experienced a sense of disconnection from the mainstream of life, which was aggravated for her by the treatment she received in hospital. She also had no family support beyond that of her husband and therefore was very reliant on community workers and health professionals for reassurance. When Sophie entered the psychiatric hospital she felt she received little warmth or moral support from the staff.

Sophie indicated that she eventually felt so bored, lonely and uncared-for in the hospital setting that she pretended to be "okay" earlier than her expected discharge date so she would be sent home. When the charge nurse from the psychiatric hospital rang her after her baby was born, she told them she was "fine" and did not need to be re-admitted.

The monotony and relative emptiness of the psychiatric hospital routine distressed Sophie, and she wished the staff would "run groups with clients, even games where women could meet other women, break the ice…" (Sophie, p 5, L: 119-120). She thought activity groups would have been more useful than sitting watching television, going for a walk, and just waiting for dinner.

Sophie experienced pronounced emotional discomfort with the counselling process during her PND. The nature of her past experience included a history of childhood sexual abuse, which meant that she had a fear of authority figures and needed very careful and sensitive handling, which she did not think she received in the hospital setting.

Sophie at the time of interviewing was recovering and moving forward with her life after PND. She said helpful counselors and workers in the community setting had aided this process. She was referred to a social worker by another mother who worked with adolescents and young adults. Sophie started to see the social worker regularly and this woman listened and understood her situation. This particular counsellor has a young mothers group and she went to the extent of providing transport for Sophie, which was greatly appreciated, and a crèche was provided during group time for their children.

A maternity and child health nurse did home visiting and infant health checks, which Sophie also appreciated. She felt she could ask the nurse anything. Home-based childcare was greatly appreciated also, adding much joy to the life of her family and

friendship for her toddler, plus a valued break for herself. Sophie is not planning more children, but is looking forward to a settled life for herself and her family.

<u>Kathy's Story</u>

Kathy is a twenty two year old mother of two who has a supportive partner in her husband a sales representative for a large retail firm. She was recruited to the research by a nurse who worked in maternity and child health. She was contacted by telephone and eager to be involved in the study, and the interview was conducted in the living room of her seaside home.

Kathy married young, she was 19 when she met her husband and he was on a work visa from England. She became pregnant with her first child on their wedding night. During her pregnancy Kathy was badly injured in a car accident, but the baby was fine. However the neck and back injuries sustained in the car crash resulted in Kathy suffering with chronic pain and limited ability to undertake normal household activities. Two years later, the couple bought a house, and their second child was born.

Kathy had always suffered from Premenstrual Tension and she was eventually given the diagnosis of Premenstrual Dysphoric Disorder (PMDD), the most severe of the hormonally induced cyclic mood disorders. She suffered from antenatal and postnatal depression and posttraumatic stress after the birth of her second baby. She sought help from a number of General Practitioners, and was hospitalised at the age of 20 with postnatal depression. She considered the treatment in hospital unhelpful and disrespectful and so discharged herself after one week remaining under the care of her

113

GP and a counsellor from a women's drop in centre. The counselling was supplemented by a number of courses, which Kathy found very helpful.

The sequence of events leading to her postnatal depression included the car accident when pregnant, antenatal depression, a difficult birth and stressful circumstances after the birth of her first child. Once the baby was born, her in-laws from England came to stay and Kathy found them to be difficult, controlling, and critical people. Kathy was home with her in-laws and the baby while her husband was working. The baby was lactose intolerant. She related that her mother in law tried to take over, telling Kathy what to do. The baby screamed every half an hour, vomiting up most of her feed. Her mother lived a long distance away so Kathy felt increasingly lonely and desperate. A quarrel between Kathy and the visiting in-laws exacerbated the situation into one of crisis. The screaming and shouting threw Kathy back into a childhood memory of shouting between her parents before they divorced, and she rang her stepfather and her mother. When her mother met Kathy at the airport she was distraught, and her mother looked after her while she "just lay down and cried" (Kathy, p 4, L: 123).

Kathy noted that she was better when she was given a break from the baby. However she found that looking after the baby was hard. She remembers feeling suicidal at that time, running at cars, and behaving in desperate ways. She made an appointment to see her GP and was given a referral to a mother and baby unit in a psychiatric hospital, and was admitted to the specialist unit but was not satisfied with the level of care and support she received in hospital and so discharged herself one week early.

Although she acknowledged some improvement, (especially as her in-laws returned to England), she continued to see her GP for medication. The GP referred her to a psychiatrist whom she felt was not sympathetic so she discontinued visiting him. Now she only sees her GP and a social worker at a local community centre. She wondered if her mood swings were affected by her menstrual cycles, and asked her GP about this. He confirmed this belief.

After the birth of her second child Kathy's hormones returned to their usual level of imbalance however the diagnosis of Premenstrual Dysphoric Disorder did help Kathy to put a label to what was happening. It helped also as her partner and parents now understood what was happening to her. She has returned to study and is looking forward to a positive future.

Summary

In this chapter the stories of the participants were briefly related to provide a context for the thesis and to situate the participants in relation to one another in the study. This is the very beginning of analysis, looking at the "parts" of the study, and placing them together, before looking at the whole (van Manen, 1990).

The next chapter will contain a discussion of the development of the sub-themes and themes, via the analysis of the data.

Chapter 6

<u>Twelve Women Speak:</u>

<u>Analysis</u>

Introduction

This chapter presents in detail the data analysis. In undertaking this analysis I have kept in the foreground of my thinking Patton's words: "Do your very best with your full intellect to fairly represent the data and communicate what the data reveal given the purpose of your study" (Patton, 2002, p. 433). Guba and Lincoln (1989) have said that a study is credible when it presents faithful descriptions. If any differences should be observed, it should be clear that the researcher can show how each theme was derived from the descriptions (Koch, 1994), and in this chapter I have attempted to do just that. This has been achieved by returning to the original text to make sure that the interpretations and conclusions accurately represent the information provided by participants.

This chapter provides a step-by-step account of the analysis, from the preliminary descriptive analysis of the text through the components of the analytical process to the representation of the themes that emerged from the interviews. The first section of this chapter explains the steps and processes used to make sense of the data, with guidance from the work of Gadamer (1975) and van Manen (1990). It then demonstrates how the analysis was undertaken and how it was informed throughout by the work Streubert and Carpenter (1999) and Coffey and Atkinson (1996). I have included tables to demonstrate the steps in the analysis and how themes were developed from

words to concepts to sub themes and then themes. It should therefore be possible for a reader to audit the decisions I made throughout the analytic process (Koch, 1994).

The Steps and Processes Used in this Thesis

Van Manen (1990) remarked that any description of a lived experience (such as one gained from an interview) is an appropriate source for uncovering thematic aspects of the phenomenon it describes and that some descriptions contain greater richness than others. Thus, when a person shares their world and their experience with us there is always more to gather, particularly when the fusion of horizons (Gadamer, 1975) occurs. The detail of this step will be discussed in the next section when some of the fundamental ideas of Gadamer (1975) and van Manen (1990) are presented in relation to how they were applied to the process of analysis.

Analysis informed by Gadamer (1975)

Four of the ideas described by Gadamer were used in this project: the hermeneutic circle, prejudice, the fusion of horizons, and play and they were fully described in chapter Four. These included the dynamic and circular nature of the process of interpretation, the hermeneutic circle. This concept was endemic to conducting the twelve interviews, thinking about them, and analysing them afterwards. In my analysis, I found myself moving from the parts of each interview, to the whole of that interview, and then I gathered all twelve analysed interviews together and brought together the sub-themes and themes. This was not a linear process but indeed circular and looped, as when I completed my analysis, I found myself reflecting on the research question, checking that I had answered it. So from the beginning to the end of this process I was moving backwards and forwards through the data and as I reflected on the material, my questions, and the answers, another

deeper level of the hermeneutic circle of understanding began to form. This became my interpretation of the data, described in chapter seven.

Alongside this, the Gadamerian concept of prejudice, which is a judgment formed before all the facts, which make up a situation have been examined (Gadamer, 1975) was used. I was conscious of my own prejudices, i.e. my own ideas about what it might be like to be a woman with postnatal depression, and to seek help for the PND. Diarising these prejudices helped me to be aware of them, so when I interviewed the women I was careful to adopt a non-directive mode of interviewing. In analysis, I was aware of my own pre-knowledge of the experience of PND and used that when I dialogued with the text within the hermeneutic circle. I made notes of my ideas and prejudices, and measured them against the text as I worked. At times the horizons fused really well and at other times I found myself discarding old ideas, based on the new information from the text.

The Fusion of Horizons was important especially in the process of analysis. My prejudice was the first horizon of "understanding". When I undertook the early analysis, my horizon of understanding expanded to fit the experience of the women, and then I re-examined my own prejudice in the light of what I found. The later analysis, from pure description to being analytical, involved that whole process at a deeper level. For example, I was surprised to find out how much the women preferred not to show their feelings of distress at having PND to the outer world. My first horizon of understanding had been to assume that a distressed new mother would pick up the telephone and call a health professional for help. I was astonished to discover that some of my participants even hid their PND from themselves for some time, let alone call for help, even when the health professionals offered it. As said by Danielle:

When you've been diagnosed, its easy to see that the quicker you can recognize PND the sooner you can get treated, but you spend so much time denying to yourself that you've got it…ignoring that its there, so its often really some time later that someone is told it is even there…you're often that much down the track, before you realize what's been happening and you can start to get better…
(Danielle, L: 1209 – 1215, p.25)

Consequently my horizon of understanding needed to expand to include this new data in the analysis, and to find a new name for this concept, which was "hiding PND" and a sub-theme where it belonged, "Behind the Mask". As far as Gadamer's final concept, "play" is concerned I included my perspective in the analysis process as I dialogued with the text in the context of the hermeneutic circle. I approached the ideas in a playful way (but not frivolous), cutting and pasting quotes from different interviews and putting them together under different themes, to see where they best belonged. At one point my living room table was filled with piles of data, all being sorted into different sub themes and themes at different times. All of this occurred under the umbrella of van Manen's steps of analysis

The six steps described by Van Manen: how they were applied to the analysis

The first two steps described by van Manen and used in this research were turning to a phenomenon of interest (which involved deciding upon the topic and the research question) and to investigate experience as we live it (which referred to the conduct of my twelve interviews). Steps three and four were concerned with the process of analysis. Step three, to reflect on the essential themes (both the implicit and explicit themes), which characterise this phenomenon, and step four, to describe the phenomena through writing and re-writing, are very much the process of analysis described in this chapter. Step five, to maintain a strong and orientated relation to the phenomenon, referred in my case to staying on track with the research question, and

step six, to balance the research context by checking the parts and the whole, referred to the analysis both of individual interviews and the whole mass of data seeking key words, concepts, sub-themes and themes. During the process of using van Manen's six steps my analysis was informed by Gadamer in terms of the fusion of horizons, and the hermeneutic circle but in particular step five and step six had a strong Gadamerian influence. Fusing my horizons of prejudice with the information contained in the data was particularly important during these two steps. In seeking the themes, I was also guided by van Manen (1990) in his suggested process for isolating thematic statements.

Isolating Thematic Statements

Van Manen (1990, p 92) has devised three methods for isolating thematic statements in analysis, and I used all three of these in the search for meaning in the data and the development of sub-themes and themes. These methods are the detailed reading approach, the selective or highlighting approach, and the wholistic reading approach. I could have used just one of the approaches but chose instead to use all three as I was able to apply them all to the work at hand and each approach was applicable in different ways and could be used to solicit different information.

The Detailed Reading Approach

Using the 'detailed reading approach' as suggested by van Manen (1990, p. 93), the researcher is required to look at every transcribed sentence or cluster of sentences and ask, "What does this sentence, or sentence cluster, reveal about the phenomenon?" I trawled through each transcript and assigned key words and concepts to each sentence

or cluster of sentences containing a new idea, and then tabulated these as part of the early analysis. This was my first approach to analysis.

The Selective or Highlighting Approach

The second approach van Manen suggests for isolating thematic statements is the 'selective or highlighting approach' (van Manen, 1990, p.92). I used this during my second phase of analysis. This involved reading the text and asking which statements appeared to be especially revealing about the phenomenon. These were then highlighted, copied from the transcript, and tabulated. Examples of such statements follow:

> I guess I didn't know…what was sort of normal, how everybody else compared to you, because all you would see was…everybody else out there coping, so you think, well, it must be me!
> (Danielle, L: 219 – 221 p.5)

In the preliminary analysis, this quote was highlighted, cut and pasted, and became linked to the key word **(Guilt)** which lead to the concept, **Painful Emotions**. In the final analysis, this highlighted phrase became part of the sub-theme, **Behind the Mask**, and the theme, **Dual Reality**.

The following quote, from Elle, was highlighted, cut and pasted, and linked to the key words (**nothing wrong with me/couldn't ask for help/ fear of failure**) and then, in the preliminary analysis, to the concept, **Hiding PND**. It later became part of **Behind the Mask**, and the theme, **Dual Reality**. The key words are of course, a judgement call – but this part of the analysis involved selecting phrases, which appeared particularly relevant in discerning the meaning of a text (van Manen, 1990, p 94)

> I thought there was **nothing wrong with me** and it wasn't until Mitchell said hey, come on, there is something pretty weird going on here and he

was the one that made me realize that I needed help. Cause I was…I could do it on my own, But obviously I couldn't do it on my own and I **would never ask for help** because, ah, then…**I'd be a FAILURE**!!…. Plus, you know, a lot of people said she has had four children she should be able to cope… why would you have four children if you don't think you could cope… but that is not how it works.
(Elle l 184 – 189 p 5)

Other quotations were taken from the text, grouped together based on similarity of ideas, and analysed together in the same way.

The Wholistic Reading Approach

This approach was done at the end of my data analysis. The wholistic reading approach refers to looking at the text as a whole and asking oneself which memorable phrase captures the fundamental meaning or the main significance of the text? For example, in searching for the implicit (or hidden) themes in the data, I found the phrase, "Dual Reality", to be an important representation of the data in the first theme. This is because a number of the women shared the experience of pretending to have one particular experience of motherhood, but in reality, behind closed doors, having another experience. An example of this is:

I was so good…at hiding the PND, we pretend to everybody else it's not that bad, and that's why PND isn't being recognised, we just hide it so well…
(Danielle, p.13, L: 625 – 630

Elle had this to say:

And I think because I had this mother in law that coped there was no way that I was going to let anyone know that I wasn't going to be able to cope
(Elle, p 6. L 207 - 209)

She was joined by Christine, who expressed similar sentiments:

I think people are still a little bit afraid to say, "How are you coping? What have you been feeling like? Are you getting enough sleep? And have you been teary?" … Because I was just prone to say "oh no, we are doing really well and he is now eating pumpkin …" Then I would go home and fall apart
Christine, L: 1554 -1557 p.49)

Jane said:
> I think working (as a nurse) I was very determined not to be depressed, so I denied for months and months and months because you know, that was other people! That wasn't me, I got women better, I certainly didn't suffer from PND!"
> (Jane, p.3 L: 164 -166)

This experience appeared to be shared by most of the women interviewed in the study. I decided that "Behind the Mask" was an appropriate sub-theme under which to group these experiences because they were often experienced behind closed doors and not made visible to the outside world until the individual broke down in some way, and the mask crumbled. The words "Dual Reality" became the phrase for the double experience of PND, and "Behind the Mask", the memorable phrase for the secret suffering of these women.

The preliminary analysis

The early analysis involved analysing each interview separately, or going from the parts (of the text) to the whole (van Manen, 1990). This was when I did the detailed reading approach, and the highlighting of key words, phrases, and ideas. I grouped together words used by the participants, which contained similar ideas, and then developed key words and concepts arising from these. Key words became concepts through intuitive ideas and reading and re-reading the data, dwelling with the data and dialoguing with the text (van Manen 1990). Similar ideas were grouped when going from the parts (aspects of each interview) to the whole picture of the data snapshot (the interview as a whole). I collected those ideas that appeared to be shared by participants together in groups, thought about the developing groups of similar ideas, and then went back to the data to identify key words and concepts that represented

these similar ideas. An example of this comes from the interview with Christine. An example of her words were:

> Prior to having a family I did suffer from depression - so I had had a period of two years in treatment with a psychiatrist under medication for long standing depression…It is something that is in my family
> *(Christine, p. 2, L 79 - 82)*

Key words were created in the next column to this, and these were "**participant did suffer from depression in the past**" and the concept was "**a past history of depression**" Key ideas such as these were taken from the text, linked to key words and concepts and were then gathered together for each transcript. Further examples of these preliminary developments of the data are shown in the tables below from two participants, Danielle and Annie (see table 1).

Although Annie's experience differed to that of Danielle, a sample of the tabulated analysis is included so that the reader can gain insight into the differing key concepts that were emerging from the various participants. I have also included this work so the reader can follow my decision- making process (Koch, 1994).

Table1: Representing the early analysis, with Annie and Danielle as examples Significant idea or statement (From transcript)	Linking Key words	Concept
I constantly felt **guilty** because…as a mum **I should be aware** of all that sort of stuff (clean house) and I should be looking after all that stuff (washing, dishes, etc) (Danielle, L 642- 644 p 13)	**Painful emotions: guilt, frustration, expectations**	**Painful emotions**
I felt if I would spend another minute in the company of this person (the baby)…then **my body would shut down**…that I was **going to die.** It was not that I wanted to but it was just…I couldn't stand the **agony** any longer in my body. (Annie, L – 86- 89)		
(My doctor) gave me no real follow-up after (Kay's birth) of how I was going…but then I'm also aware that in the early stages I was so **good at hiding**…the PND, **we pretend to everybody else** that its not that bad…and that's why PND isn't being recognized, we just **hide it** so well. (Danielle, L: 625 – 630, p. 13)	**Sense of entrapment, fear, panic, loss of self**	**Hiding PND**
In the maternal child health centre, the nurse would ask…how are you finding it, how are you going? I remember saying, "fine, fine" and thinking…push me, ask me again, ask me again. But of course I perfectly **convinced her that I was fine**. And yet **I wasn't consciously** aware enough to actually do anything - like, it was only a fleeting thought, ask me again. As if **I knew that I wasn't well** but I didn't know enough to actually say so…very strange. (Annie, L 86 – 96 p.5)	**Hiding PND** **Pretence, seeking acknowledgement**	
When you've been diagnosed, its easy to see that the quicker you can recognize PND the sooner you can get treated, but you spend so much time **denying to yourself** that you've got it…**ignoring that its there**, so its often really some time later that someone is told it is even there…you're often that much down the track, before you realize what's been happening and you can start to get better		

(Danielle, L: 1209 – 1215, p.25) I had one of those Christopher Green books and came across the extremely superficial post natal bit and I laid it … on the pillow on our bed and I thought when Sam comes home and sees that he might think there is something wrong… It **took another 9 months from that time to figure out what was going on.** It makes me so angry now that I was **so close to realizing what was happening**… but it hadn't quite sunk into my conscious mind. (Annie, L 90 –106 p.5 - 6) (Nurse in the chemist) took one look at me and **thought that something was wrong**, got me in and sat me down for a chat…gave me the postnatal depression leaflet to read which has got the picture of it there and all the words around it… it described all the feelings you had through PND. And I sat there and thought (laughs)…**yes, that's me**! Yes that's me! Yes, that's me…(laughs) (Danielle, L: 14 – 20, p.1) I got some photocopies of the records from maternal and child health nurses and I was flicking through them one day looking at the results of visits and personal reports and one said: "Annie is enjoying motherhood." I said with great vehemence, "That is a lie! **I never said that**!" and ripped it out and the strength of my response **shocked my partner and it shocked me too**… I had been **in denial**…So that got us both thinking. (Annie, L 121 – 131, p. 6-7)	**Denial of the condition (to self as well as others) delays treatment** **Took another 9 months to work out what was happening** **Recognition of condition – painful emotions, fears, health professional support** **Recognition of condition, shock…Seeking treatment became the next step**	**Recognition of PND leads to treatment**

Annie's experience differed to Danielle's in that she had been hospitalised in a psychiatric institution as well as in a specialist mother and baby unit for postnatal depression (Danielle had been hospitalised in a specialist mother and baby unit only). Annie experienced psychotic symptoms in the early days after giving birth, and then a low mood with anxiety for the next year and through the treatment phase, whereas Danielle's PND was expressed more through lowered mood, and yet the two women had many similarities in their experiences such as the inclination to hide PND from themselves and others. This process of early analysis outlined for Danielle and Annie was undertaken for all twelve participants (See appendix 8).

Moving from keywords and concepts to sub themes and themes

The progression of the analysis from describing the lived experience to analysing it involved pooling all the early key words and concepts (going from the parts to the whole) by gathering up the twelve participants' transcripts after individual analysis and analysing them together as a whole, looking once more for the implicit and explicit themes. This process was informed by the work of Streubert and Carpenter (1999) especially as relates to highlighting key words and ideas, van Manen (1990), with his ideas of isolating thematic statements and Gadamer (1975), especially with his ideas of moving from the parts to the whole and also the fusion of horizons and the hermeneutic circle. Coffey and Atkinson (1996) also provided useful advice on coding ideas by grouping or aggregating them in similar categories with key words and links which helped me move from the grouped thoughts of the participants, to the concepts, sub-themes and finally, themes.

The identification of patterns of meaningful connections were followed by re-reading the text as a whole as recommended by Streubert and Carpenter (1999). The words or phrases considered to be meaningful and relevant when crossing and re-crossing from the parts to the whole were highlighted and cut and pasted into a Microsoft Word document. These were then read and re-read, and groups of ideas were classified in columns of a table as "Words of Participants" then the "key words" and "concepts" (as shown in the previous participants' examples for preliminary analysis). These concepts from the preliminary analysis were then grouped together in an additional column of the table, pooled with similar concepts after much thought on which ideas belonged together, to form the sub-themes, and finally the sub-themes were gathered together similarly to inform the development of the major themes.

An example of how I approached this data classification and coding in a table within a Word document is included below. Table 2 provides an example of how the first theme, Dual Reality developed from a sub-theme, 'the Depression Experience', and can be found below, in this chapter. Table 3 in this chapter and the tables included in appendix 9 demonstrate how the second theme 'Interventions' developed from the three major sub-themes, Getting Help, Lack of Support, and the Need for Education on Postnatal Depression in the Community. These two overarching themes, six sub-themes and their associated concepts that came from keywords are demonstrated below, with statements from the participants used as exemplars for each sub-theme. Table one in appendix 9 describes how the first theme, Dual Reality, developed from the three sub-themes of "the Depression Experience", "Being a New Mother" and "Behind the Mask"

Table 2: Development of the sub-theme, The Depression Experience

Words of participants	Key words	Concepts	Sub-theme	Theme
Prior to having a family, I did **suffer from depression** – so I had had a period of two years in treatment with a psychiatrist under medication for **long standing depression**…it is something **in my family** (Christine, p.3, L: 79 – 84)	Suffer(ed) from depression, had long-standing depression, something in her family	**Bad memories of past history triggered by depression**	**The Depression Experience**	**Dual Reality**
After each child it (PND) got worse and worse and worse…I had Mollie in the middle of winter…I was stuck inside all day… three little ones and I didn't get out and about and the more I couldn't do for myself or do something for myself the worse it (PND) got…having 4 babies in four years, too much for the body…I was hospitalized…(for PND) (Elle, p 4 L: 155 – 168)	After each child it got worse…the more I couldn't do for myself the worse it got…four babies in four years, too much for the body	**Bad memories of past history triggered by depression**	**The Depression Experience**	**Dual Reality**

I discovered through the pragmatic process of reading and re-reading the data, a similarity in sets of ideas, which were then grouped together when going from the parts (the twelve individual participants' transcripts) to the whole picture of the data. Phrases from the participants were analysed, with such key words as:

> I **didn't cope** all the time. **Everyone else thought I was**. My **husband knew better.**
> (Christine, p.4 L: 124 – 125)

Below is an example of an extract from a participant's text that highlights words and concepts that were gathered together to form similar groups of thoughts from the women, and which went onto form sub-themes and themes. The example below relates to the sub-theme, **the Depression Experience** and the final theme, **Dual Reality.**

> Prior to having a family, I did suffer from depression – so I had had a
> period of two years in treatment with a psychiatrist under medication
> for long standing depression…it is something in my family
> (Christine, p. 3, L: 79 – 84)

The key words connected to this example from Christine, were "**long standing depression**. The concept, from this example, which was shared by other women, was "**prior history of**

depression". Concepts developed from a variety of key words into **Painful Emotions/ Classic PND symptoms/ Somatic expression of depression**, and **past history triggered by Depressio**n, which developed into the sub-theme **The Depression Experience** and then the overall theme, **Dual Reality.** The bad memories of prior suffering, which were triggered by the depression, fed into the depression experience, which then became part of the overall theme of dual reality.

Phrases from the participants were analysed, with such key words as:

> I **didn't cope** all the time. **Everyone else thought I was**. My **husband knew better.**
> (Christine, p.4 L: 124 – 125)

The link to this idea (and others offered by different women in interviews) was **pretence,** and the concept was **Hiding PND**, which became part of **Behind the Mask.** This sub-theme is outlined in more detail in Appendix 8, Table I.

To further highlight these steps described above I will return to the earlier example taken from Christine's transcript:

> Prior to having a family, I did **suffer from depression** – so I had had a period of two years in treatment with a psychiatrist under medication for **long standing depression**…it is something **in my family** (Christine, p.3, L: 79 – 84).

The key words in this excerpt were '**suffer[ed] from depression'**, '**long standing depression'** and '**in my family'**. The concept that formed from these examples was '**bad memories of past history triggered by depression**'. Similar concepts such as this were shared by other participants, for example:

> … I felt great about having Ellie… but I didn't have so much time plus I really didn't have any help. …After each child **it** [**the depression**] **got worse and worse and worse**, and I think it was just because there was only 14 months between Annie and Ellie. I had Mollie in the middle of winter and I think

probably Mollie's birth probably triggered it [**the depressive feelings**] off more because I was stuck inside all day… I mean…and I had you know… three little ones and I didn't get out and about and the more I couldn't do for myself or do something for myself **the worse it got**…after I had Adam it obviously it was just all too much. If it was having 4 babies in four years, **too much for the body**…when I was **hospitalized** [**for PND**] then it all came out to friends and family and things like that... (Elle, p 4 L: 155 – 168)

Elle's example relates to how her PND was exacerbated by the birth of each of her four children, culminating in hospitalisation after the last one was born. Key words were, 'after each child **it (the depression) got worse**, the more I couldn't do (something for myself) **the worse it go**t, having four babies in four years, **too much for the body,** I was **hospitalised (for PND).** Although Elle used different words, the concept, **related to the depression (or triggered by the depression**) that developed, was shared by both participants.

I found using tables to be a simple and straightforward way to organise the data during analysis. I understand that this approach is a reductionist technique despite the fact that interpretation is, in essence, reductionist; but for me it helped to group ideas, links and concepts in this practical format. It helped me to pick up a table of a sub-theme and scan it, and work out if more data needed to be added or removed and put into another one, and it helped me to sort the information intuitively whilst I processed it visually.

Originally I cut and pasted a large number of quotes into several different tables and as I have mentioned, my dining room table was covered with this work for some time. Then as I re-read, thought about it all, and dialogued with the text, I refined the concepts in each table from the words of the participants, to the key words, the concepts, the sub-themes and themes. This pragmatic step was a useful one in the creative phenomenological process that I undertook.

I found myself thinking about the work almost continuously, sometimes without even realising it and at times had flashes of intuition about a concept. These flashes occurred at odd times, such as when showering, driving the car, or even when I woke up from sleep. The rest of the time I had groups of ideas from the transcript cut and pasted into piles on the dining room table and on a series of Word Documents and I would move them into different categories to see how the ideas fitted. Some of this process involved intuition, but most of it involved intensive and concentrated logical work. I was "noting patterns of themes, counting phenomena occurring in the data, and comparing and contrasting data sets" (Coffey & Atkinson, p. 47).

An example of this is the groups of tabulated similar ideas in words of participants, such as "I loved the day programs (group education) about the reality of parenting" (Danielle, p 21, L 1015) and "If we had lived one hundred years ago…you would have all seen it (parenting in action) from childhood…you watched people breastfeed. We have all had none of that, it's all so sanitized and clinical but nobody knows a damn thing about the reality of it" (Christine, p 52, L 1634 – 1637). And from Jane: "It might have helped me if some people had talked to me beforehand and said, "look, there are just some babies which are really revolting" (Jane, p 5, L 249). These and other similar ideas were pooled together and links were created such as **teaching groups on the reality of parenting would be useful** in the treatment and prevention of PND and postnatal stress. These links were gathered together and helped to form concepts (in this case, the collection of ideas called **health professional help ideas**) and these were then grouped into similar ideas, which created sub-themes (such as the **need for education about postnatal depression in**

the community), which was part of the major theme, **Interventions.** Interventions is one of the two major themes, the other one being Dual Reality.

The theme of Interventions

The first sub-theme for the theme Interventions was Lack of Support. The other two sub-themes, The Need for Education on Postnatal Depression in the Community and Getting Help are represented in Appendix Eight. This theme, **Lack of support**, began with the words of participants, which were grouped together along the lines of similar ideas. Thus when Sophie complained about a lack of health professional support, she said:

> I found the nurses very strict and cold when I entered the hospital, I found no friendly greeting, I wanted a bit more nurturing, a bit of support, a bit of "Come in, how are you? (Sophie, p 1, L: 18 –20)

Leanne also felt desperate for some help and emotional support from a professional when she was in hospital:

> I believe that if you've been assigned to a nurse then they should introduce themselves to you, and then when the nurse goes they should say "bye"… its manners, and like, you have a table there, and me and this other girl were having breakfast there and this nurse walked in and she walked right past us and she didn't say a thing! She walked past and we went "Good morning!" and looked and laughed at each other! (Leanne, p. 30 L: 10 – 17)

Danielle also felt unsupported in hospital, an inpatient unit for women with PND, and in need of more guidance and care. This was especially on the weekends when there were no structured group activities:

> They (the hospital ward) had nothing, absolutely nothing, to do on a weekend, so I sat around, doing absolutely nothing… (Danielle, L: 336 – 337, p 7)

This linking idea in the analysis became **hospital not giving emotional support** and the concept became **discouraging treatment in hospital** and the sub-theme became **Lack of Support**, part of the theme, **Interventions**. Table 3 provides examples of this

progression from the words of the participants, the links, the concepts, sub-themes and themes. Single examples and their progression through each phase of analysis are included in this table. The other sub-themes of the theme Interventions are represented similarly in Appendix 8.

Table 3: Development of the theme, Interventions Words of Participants	Key words	Concept	Sub-theme	Theme
The nurses said, "Go ahead and talk if you want to" but there was an uncomfortable feeling…**I didn't feel free to talk to them** about how I felt, they tended to be more judgemental and that makes you feel even more depressed (Sophie, p.2, L: 35 – 38)	Hospital staff not giving emotional support	**Discouraging treatment in hospital**	**Lack of Support**	**Interventions**
I wanted to go to a psychiatrist, but I heard that he wasn't taking any new patients and then I wanted to go to another one and he had committed suicide! I went back to my GP and he **didn't really know anybody**. So I rang the mental health services and they **are not allowed to recommend anybody** (Gabriela, p. 15, L: 371 – 375)	Seeking support Not finding help, Reaching out for help Counsellor made her feel uncomfortable	**Difficulty getting help for PND** **Indifferent counselling**		
"The shrink made me feel completely uncomfortable…he asked for details about the (past sexual abuse) but he didn't seem to take me seriously…he kept making sick jokes…" (Sophie, p 3, L 56- 64)	Delay of three years between birth of child and treatment	**Delayed diagnosis**		
"I had Connie in Sept 1992 and I wasn't diagnosed with PND until 1995, I was admitted to hospital in Feb 1996…Really, I didn't get any medical intervention for a couple of years…" (Gabriela, p. 1 L: 5 – 13)	Anti-depressants were unhelpful	**Unhelpful medication**		
"(My GP recommended that I try anti depressants and I did try them but only for a short time because they made me feel really weird and I didn't like the idea…" (Tracey, p. 4 L 32 – 33)	PND makes women more sensitive Parents were unhelpful with emotional support	**Emotional fragility of women with PND** **Unhelpful**		

"This is a particular area that has a particular problem it just seems that, whether it's because we've got the PND that we're more sensitive to what they (health care workers) or…how they say things!" (Danielle, L 1046 – 1048, p. 21) ". "So we did get that sort of (practical) support but not the type where you want to sit down and have a cup of tea and **talk** to someone" (Christine, p.33, 1041-65) "The people (i.e. at work) you would think would be around, weren't around, and there was an assumption…I'm an intelligent woman, I can cope…I can sort it out"(Kate, p 11, L: 12 – 15)	Lack of support from colleagues and associates	**friends, family or workplace**		

In developing the themes during the process of analysis and then reflecting on them against the aims of the project and the research question, I had to do some thinking. Roberts and Taylor (1997) posed these questions for this phase:

- "Why did you choose those words? Are they still relevant? Would other words represent them (the themes/essences) more effectively?
- Clarify in your mind what the themes/essences mean. Try writing down the words and sentences that explain them to other people...
- Create those definitions and explanations that represent most faithfully the clearest and truest meanings you can extract from the analysed data…"
(Roberts & Taylor, 1997, p. 345).

Using these suggested questions from Roberts and Taylor (1997) and having followed the process outlined above, the sub-themes and themes underwent further review and development. Ensuring that the words, phrases and themes represented the data as closely as possible was a constant activity over the span of a year and involved much thought and reflection

Dual Reality and **Interventions** were the major themes that developed from the data. The names **Helpful Support** and **Unhelpful Support** and the **Need for Education on PND in the Community** represented the essence of the sub themes. **Dual Reality** as a theme represented the lived experience of feeling pain and acting as if everything was easy. **Behind the Mask** described the feeling of hiding the PND, and the **Experience of Being a New Mother** was integral to the experience under investigation as was **the Depression Experience**. This was the truest representation of the data that I could find. The themes were discussed at length and described in presentations and research schools and I felt them to be clear in my mind as I completed the later analysis and began the process of writing up the study.

Summary

This chapter described the process of analysis of the transcripts of the twelve women, and presented the key words, concepts, sub themes and themes. The search for meaning from the transcribed interviews and my attempts to make sense of the findings resulted in the development of two major themes, that of Dual Reality and Interventions, and six major sub-themes. Within the theme of Dual reality sits the sub themes of Behind the Mask, Stresses involved in Being a New Mother, The Depression Experience and within the theme of Interventions sits the sub themes of Getting Help (the Helpful Interventions), Lack of Support, (Unhelpful Interventions), the Need for Education and More Services for Postnatal Depression. These themes and the findings are discussed in the next chapter, which is Chapter Seven, Interpretation.

Interpretation

Introduction

The process of interpretation and the findings are discussed in this chapter. Patton (2000, p. 480) describes interpretation as:

> … Going beyond the descriptive data. Interpretation means attaching significance to what was found, making sense of findings, offering explanations, drawing conclusions, extrapolating lessons, making inferences, considering meanings, and otherwise imposing order on an unruly but surely patterned world.

The themes and their sub-themes will be discussed taking account of the literature and the philosophical underpinnings of Heidegger. The two themes that developed from the data were Dual Reality and Interventions.

Heidegger and Interpretation

As this study was underpinned by the philosophy of Martin Heidegger and Hermeneutics, it is worth revisiting some of the ideas of Heidegger and how they were applied to the interpretation process. This thesis deals with the lived experience of 12 women who suffered from post natal depression and trying to make meaning of the lived experiences as described by them: the results of my interpretation are a fusion of horizons (Gadamer, 1975). Therefore my ideas, beliefs and understandings

merged with those of the women to create a new perception of reality, which is described here.

Heideggerian research informed by Heidegger is not so much about describing experience in the manner of Edmund Husserl, but more concerned with uncovering meanings about what it is to be (Walsh, 1996). Heidegger has reminded us that we need to return to the facts of existence; to understand how something is lived, but also that there is no such thing as an uninterpreted fact. And yet according to Heidegger, one must remain grounded in one's interpretation of the matter, of the things themselves:

> …Our first, last, and constant task is never to allow our fore-having, fore-sight, and fore-conceptions to be presented to us by popular conceptions, but rather to make the scientific theme secure by working out these fore-structures in terms of the things themselves
> (Heidegger, 1962, p 195)

Van Manen explains it this way:

> Our notion of hermeneutic understanding for Heidegger was not aimed at re-experiencing another's experience but rather the power to grasp one's own possibilities for being in the world in certain ways. To interpret a text is to come to understand the possibilities of being revealed by the text
> (Van Manen, 1990, p 180)

Consequently, as I began the process of interpretation I immersed myself in the data and became part of it, seeking to understand what it was to be a new mother, and to experience PND and health professional intervention. The facts uncovered were not separate from their meaning; neither was my perception, in the end, separate from the meaning of the women's stories in the text. What is here now in this interpretation phase of the thesis is my meaning, my story as researcher, merged with the stories from the women interviewed. Heidegger has also said:

> Thus to work out the question of Being adequately, we must make an entity – the inquirer, transparent in his own Being. …This entity which each of us is himself and which includes inquiring as one of the possibilities of its Being, we shall denote by the term, "Dasein"
> (Heidegger, 1962, p 26-27).

Dasein (literally translated as "being there") refers to the ordinary act of human existence, being in the world. I interviewed women about what it was be in the world and to experience this phenomenon. The existentials, which are linked to Dasein, are Being-in-the-world, care, death, authentic existence, and time (Gelven, 1989). Care is important; a person who is being-in-the-world cares deeply and fundamentally about what is happening to them and around them. The women interviewed cared deeply about their experiences and lives and I too, as I entered their world, became a care-full researcher, concerned and caring about them. The two major themes presented are done so with acknowledgement and inclusion of the literature and with careful regard once again for Heideggarian philosophy.

The first theme, Dual reality, comprises three sub-themes, Stresses and Strains of Being a New Mother, Behind the Mask, and The Depression Experience. Dual reality involves the experience of wearing a mask of blissful, effortless motherhood as portrayed in media advertising, and having a different experience in reality that evokes negative emotions and experience, the women were living and being "behind the mask". This experience is lived in private, behind closed doors, and includes the difficulties involved in being a new mother; the experience of PND, and the pain of pretending life is easy when it is not. Sometimes the mask is even presented to oneself (in an act of self-deception) and this has implications for the treatment of PND.

Dual reality also relates to the duality of human experience; the two edges of lived experience and time. The real feelings and the performance, the moments of flashes of light and the lived dark. Dual reality in this case involves living in pain, in darkness, whilst pretending to live an existence of light. It is not unlike the strangeness of life where two kinds of existence get enfolded in time, a positive life, and a painful life. In his book, The Quality of Mercy, about the 1970's Cambodian civil war and communist revolution, the journalist William Shawcross (1984) wrote:

> I puzzle over time. Are there, as science fiction and Gnostic speculation imply, different species of time in the same world, "good times" and enveloping folds of human time in which men fall into the slow hands of living damnation?" (Shawcross, 1984, p13)

Picture two women sharing a table, each sipping a cup of tea. One could be living through hell inwardly and striving to hide it. The other woman next to her could be blissfully unaware of this and thinking about her daily life, writing a shopping list, remembering to visit the dentist. Such is the nature of Dual Reality and being "behind the mask." Picture a woman up at night, holding, and trying to comfort, a screaming child, all the while wondering why the experience was not the joyful, easy one she had expected and which is portrayed in the media. Such is the nature of Being a New Mother. Picture the same woman, dark circles under her eyes, stunned and trembling in a hospital room, or alone on a bed, staring blindly at the ceiling. Such is the nature of the Depression Experience.

The second theme, Interventions, relates to the women's views about health professionals and other interventions experienced by these women. This theme is made up of three sub-themes, Getting help (the "useful interventions"), Lack of Support (the "poor quality interventions") and the Need for Education on Postnatal

Depression in the community (which relates to the "missing interventions"). These interventions can therefore be thought of as "the good, the bad, and the missing". The helpful interventions helped the women to return to the expected state of "being a new mother", it is a healed reality, one of an improved emotional state. In fact, helpful interventions help to move the "mask" away, and aid the women to access care for the PND and experience better quality of life. Conversely, unhelpful interventions and the gaps in knowledge of PND by health professionals and family and friends inhibited women in the healing process.

In this next section the themes and sub themes are outlined and interpreted. I have used metaphor as a way to deal with the interpretation, and at times the metaphor blends with description to symbolically explain the meaning of the text. The mask, or a marionette (puppet-doll), is the metaphor I have used to indicate my interpretation of the lived experience of Dual Reality. In the second theme, Interpretation, I have used the image of crossing a bridge, to show the nature of helpful or unhelpful interventions for women with PND. The raging current below the bridge is used to indicate the "troubled waters' of postnatal depression. The bridge itself is created to indicate the movement away from difficulty, crossed with (and sometimes without) effective help. The reader is invited to absorb the metaphor as my interpretation of the lived experience of these women whilst reading this chapter.

Dual Reality

In the theme Dual reality the three sub-themes, Stresses and Strains of Being a New Mother, Behind the Mask, and the Depression Experience are woven together. The Stresses and Strains of Being a New Mother was part of the Dual Reality in the sense

that the women told of feeling exhausted and frustrated, ashamed that they struggled to care for their baby, and consequently, this fed into the Depression Experience. The Depression Experience (the lived experience of PND) was described by the women as a private experience, one not to be shared with the outside world due to a sense of personal shame. The women also described the experience of "wearing a mask to the world", pretending motherhood was easy despite the reality of it, and consequently the lived experience of motherhood and postnatal depression became a Dual Reality, one life lived publicly and one in private.

As the women spoke to me, both of the stresses and strains of Being a New Mother and of the experience of Behind the Mask, an image came to me of a porcelain doll. This doll had a fixed sweetly smiling face, and a type of light around it, which reminded me of a Madonna and Child painting from the Medieval or Renaissance art. It was surrounded by what Jane called "wonderful soft fuzzies" (Jane, p. 10 L: 23). According to the philosophy of Heidegger we are not separate from our origins, or our environment, and much of our consciousness is shared (Heidegger, 1962). We find ourselves involved with other beings, and we experience these others in our environment, they are "Beings-in-the world-with" (Walsh, 1995, p. 43). In lived experience such as "Being a New Mother", the emotional centre of each person has its own reasons for responding uniquely to situations. I am reminded of these words from the French Existentialist Philosopher, Blaise Pascal, from his early treatise; the Pensees (1660):

> Man is only a reed, the weakest in nature, but he is a thinking reed. There is no need for the whole universe to take up arms to crush him: a vapour, a drop of water is enough to kill him. But even if the universe were to crush him, man would still be nobler than his slayer, because he knows that he is dying and the advantage the universe has over him. The universe knows none of this. Thus all

our dignity consists in thought. (v.200)…It is the heart, which perceives God and not the reason. The heart has its reasons of which reason knows nothing. (v.424) (Pascal, 1660, v. 200 - 424)

Being a new mum involved living as a care-full and concerned mother in our culture, her individuality colouring her thoughts, and her perception of her experience. Yet the media, art, plus the thoughts, dreams, wishes and longings of others plus the religious ideals from Catholic Iconography of the Mother-Madonna all influenced these twelve mothers without them being able to fully process it. The daydreams belonging to the collective western civilisation which expressed what a mother "should be" took a hold in the women's consciousness. The tension between the opposites of what the women believed was expected of them as new mothers, and what they perceived themselves as actually achieving created an enormous gap, a tension, a dichotomy of reality. A non-depressed person could dismiss this concern, but people with depression can suffer a loss of confidence, excessive guilt and lowered self-esteem (DSM-IV, 1994, NHMRC, 2000, Ryan, 2004). The symptoms of depression can make women vulnerable to a sense of guilt and unworthiness, as Danielle said: "You hand over your needs the second you have a baby and you get a whole truckload of guilt! (Danielle, p 15, L: 714 –715)

The Mask/Marionette Image and the Image of the Madonna

I shall now try to explain these two images, which came to me as I dialogued with the text (van Manen, 1990) and fused my horizons of understanding (Gaudier, 1975) with that of the twelve women's stories to interpret the data. The first image, that of a puppet/doll mask which the women felt forced to wear, and then became trapped under, was my own construct based on the data. The second image is that of the

perfect Madonna, the perfect mother, and was the image to which the women aspired and how they felt they should behave as mothers. This image appeared in various guises, such as the "Johnson & Johnson" advertisements for baby powder (Jane, p 3, L: 16). The marionette mask involves the act of pretence, the women trying to appear as the perfect mother figure. This mask is like a marionette plaster cast, which slides over the real woman and moves her along, forcing her to pretend to be a certain way. It is surreal in that the woman's true feelings, if they are less than "perfect" are never revealed through the fixed tender smile on the artificial face. The Madonna image, hijacked by the media from Mediaeval and Renaissance Art and ancient religious iconography and then contorted to fit the materialism of our age, is also surreal, but women without depression seem to accept this, even though there may be a struggle at first.

The women described moving through their daily lives trying to care for their babies with a will to maintain the mask from day to day, without considering the price of it. Also the mask itself appeared to have a strength, which operated outside the woman like a cast with battery, operated porcelain limbs. Porcelain is made of clay, it is strong and at the same time fragile and can crack and break. The doll face had been fixed into a benign smile; it was plastered onto the women's faces, no matter what they were actually feeling. Frequently there were many cracks and fissures along the lines of the moving cast, but a small incident, often something very small and incidental, made the porcelain shatter and crumble onto the floor, revealing the person beneath. As the women glimpsed the way they had become, they despised what they saw, and judged it negatively. "I was just this …bloody blob who was in tears all the time" said Elle (Elle, p 24 L: 31). Christine feared she had become a

lonely woman with a tear-stained face who "didn't want to go down" into the negative spiral of depression (Christine, p 13. L: 98).

The stresses and strains of being a new mother were exacerbated under the strain of the mask, and the women's reactions to these stressors were also a sign of depression. Women who have given birth and then do **not** go on to develop PND acknowledge the stress of motherhood and also the cultural expectations of mothers but they accept that these concepts and pressures are unrealistic ideals (NHMRC, 2000). The whole idea of "superwoman" (Christine p3, L: 93) is an anathema, a mythic idea not something possible to attain, at least not for more than a few minutes at a time. The culturally imposed myth of the super-capable woman, or the superwoman, affected Christine's daily life from the day she came home from hospital. She began to demand superhuman tasks from herself straight away. She "had to get everything done", such as washing at a certain hour, preparing a meal at a certain hour, no matter what else was happening, with a scheduled time for the baby. It was like falling into the ideal of a 1950's mother, so well described in the myth of "the feminine mystique" (Friedan, 1962), which starred an unruffled, angelic mother smiling from post-war advertising images. The shock of the reality of the parenting experience upset Danielle, who complained that the hardest part of being a new parent, was not receiving a realistic "guideline of what to expect" (Danielle, p. 3 L 131-132).

People with low self-esteem can be vulnerable to the opinions of others and also to fear that other people might judge them as failures, whether or not the other people actually do so (Oliver, 2004). Elle explained that she felt social pressure to cope with her four children; because she had a "mother in law who coped" and so she decided

that she would not "let anyone know" she was struggling (Elle, p 6 L: 6). Jane's mask was well in place, and one day, it slipped accidentally and she felt attacked for her vulnerability. The grief still fresh several years later, she told me tearfully about how she once walked in a shopping mall with her screaming four-month old baby in a sling and an elderly woman cornered her and demanded why she was "with him in the sling, screaming", when he should be at home "in his cot", where he belonged (Jane, p. 4-5, L 169 – 172).

The day after completing the seventh interview I had a dream about a burning cross, and woke with that image searing my consciousness. I found myself asking whether I had entered their world in my sleep, felt something that they lived, albeit unconsciously? The burning, it was not a Ku Klux Klan image, but something, else…symbolic of birth, death, suffering, depression. The cross has always been a religious image, death and life coming together. Death transcended. I decided I had dreamed about birth, about motherhood, and about the personal cost of it. And also, about how these women had eventually transcended this experience and gone on with their lives in a new role with new responsibilities. It was about how they rose again, albeit "burnt" by their experiences. I was also reminded of the dangers of giving birth, even in today's world with modern western medicine. Birth has always been a dangerous time for mother and child. As Christine said, "people don't realize how close you can be to death" (Christine, p 25 L: 23).

In the next section the sub-themes of Dual Reality are discussed individually and then linked in the image of the real woman struggling "behind the mask", and under the plaster cast of a frozen smiling, mechanically moving, porcelain doll.

Stresses and Strains of Being a New Mother

This was the first sub-theme and it appeared to be a dominant issue referred to repeatedly throughout the interviews. It relates to the normal experience of being a new mother that can exacerbate postnatal depression, but also exists independently of it. These types of experiences are lived by most new mothers and are often the reality of parenting. Such experiences are nonetheless extremely stressful, and may increase a woman's vulnerability to depression. The participants described experiences such as exhaustion, difficulty settling the infant, difficulty feeding the infant, difficulty adjusting to the identity change of motherhood, hormonal difficulties, birthing stress, concurrent life stresses and trying to live up to cultural expectations of motherhood. Each one of these stresses, if exaggerated or if compounded by lack of support, or exacerbated by other stresses, can be a risk factor for PND (O'Hara, Rehm & Campbell, 1983; Whiffen, 1990; Brown & Lumley, 1994). At times these stresses appeared to be the genesis of the woman's PND. This was the case for sleep-deprived Jane, who had "one of those hyper-vigilant, hyper-irritable sort of babies" (Jane, p.7 L: 350). Christine explained that if she didn't get enough sleep, she would have a "melt down" and turn into "Psycho Mummy", so that her partner and children would beg her to lie down (Christine, p 44, L: 1383 – 1384). However, in one case a woman and her child were having too much sleep, and that was depressing too. Leanne grieved for all those unlived hours, and asked, "Is this living?" (Leanne, p.6 L: 204 - 216).

Difficulties feeding the infant were major stresses for some of the women. The ideal mother was a figure who could feed a child easily, and effortlessly, smiling serenely

whatever the hour. Her comfortably suckled infant would sleep then for hours. This was an awkward ideal to six of the interviewed new mothers, one almost impossible to attain. Olivia felt an enormous pressure to breast-feed and could not understand why it failed to come naturally for her. Bottle-feeding was something she had to learn quickly, because she was "afraid my daughter might starve" (Olivia, p.3 L 92). This stress made her feel very sad and far removed from the image of perfection in motherhood. Tracey found that due to her poor health and iron-deficiency anaemia, she was unable to breastfeed her baby past the age of three months. She began to use complementary feeds and then bottle-fed her son completely. She made the decision to stop breastfeeding out of necessity, because it "wasn't doing me any good" (Tracey, p. 3, L: 80). Bottle-feeding her son meant that he started sleeping all night, and she could begin to recover from some of the physical strain of early motherhood. However, the emotional strain persisted as failing to breastfeed left her feeling inadequate and falling short of the motherhood ideal. So in my interpretation, the meaning of this is that the "Madonna" image of perfection portrayed by society, is the culturally perceived norm of new motherhood and the women bore the perception that no other picture or even shades of grey were considered to be worthwhile.

Further Stressors for New Mothers

Difficult infant behaviour has been described in the literature as a major stress for new mothers (Whiffen, 1990). Along with this, informing the sub-theme of the Stresses and Strains of Being a New Mother, the women described continually dealing with high expectations of oneself as a mother added to the strain. A perceived lack of social and emotional support also places a woman at risk for PND in the literature (O'Hara, Rehm & Campbell, 1933; Chan, Levy & Chung, 2002, Harvie, 2004).

Controlling and powerful in laws have also been cited as another risk factor for PND (Chan, Levy & Chung, 2002) and Kathy described such a situation. She explained how her baby suffered from lactose intolerance resulting in a gastric reflux problem and then told about her mother in law who was staying with them and compounding the situation. Olivia felt overwhelmed by the sudden uncontrollable change in her sense of self and she was unable to reconcile this with her wish to be the perfect mother. She would wander her house asking, "How has this happened to me?" (Olivia, p 8, L: 5). Tracey found the exhaustion, difficulty feeding her new baby, and poor physical health debilitating, and in the hot summer she felt imprisoned in her home. She "didn't want to get up in the morning" as the weather was "awful…hot outside" and she felt that far from being the peaceful, smiling Madonna figure she hated "having to be shut in with the kids" (Tracey, p. 6, L; 207 - 212).

Jane's baby screamed continuously, and was only comforted by movement, positioned upright in a sling. Her experience was a long way from the Madonna ideal of calm mother with peaceful baby. She walked for miles every day, as it was the only way she could calm him. Looking after a young family was distressing for Elle, and her postnatal depression worsened with the increased workload with every child. She complained that after years of having her own time, life was too "full on" with four children (Elle, p. 4 L: 141). Danielle felt that new mothers should remember that they were part of a wider culture, and that the reality was, mothers would only have "a little influence really" over their children (Danielle, p. 21, L: 1011 – 1015). Society, schooling, other people would also play an enormous part in influencing the life of the emergent adult.

Other concurrent stresses along with the birth of a new baby made life complex and difficult for the women. Kathy told me of having been in a car accident, and being in severe pain, and needing to be x-rayed while pregnant and was aware of all the stress this caused. She was 'so scared" she would miscarry (Kathy, p. 2, L: 40 - 45). According to Whiffen, (1990), a build up of life stressors such as job loss or unemployment place women at risk of PND. This happened to Kate; she suffered the loss of her job whilst on maternity leave, and the resulting grief aggravated her PND.

Hormonal changes and the birth process can be a risk factor for PND as sudden hormonal changes can act as a trigger for it (Adams & Glover, 1994, Sichel, Cohen & Robertson, 1995). Also, difficult birth experiences and the perceived unhelpfulness of delivery staff have been linked to PND (Brown & Lumley, 1994). Indeed it has been suggested that a traumatic experience giving birth can give rise to Post-Traumatic Stress Disorder (Allen, 1998). Difficulties with hormone changes have been posited as a causal factor in PND by Huang and Mathers (2001). Three of the women interviewed made comments supporting this idea. According to Kathy, Gabriela and Tracey, hormone changes certainly had a serious effect on their moods and quality of life. Gabriela believed that there was a hormonal link to her postnatal depression and even her diagnosed condition of Bipolar Mood Disorder. She described a life of "very heavy periods" where she always suffered "bad PMT" and "uncontrollable bad moods" (Gabriela, p 11 L: 241 – 243). Kathy suffered serious monthly hormonal disruption and had been diagnosed with Premenstrual Dysphoria, which meant that she would need to be on "Zoloft for the rest of her life," (Kathy, p.6 L: 219).

Four of the twelve women interviewed told me how they perceived the physical and emotional processes of birth to have affected them. Christine experienced giving birth as dangerous and traumatic, precipitated by an emergency caesarean section and a post-partum haemorrhage, after a long labour. The whole experience was an enormous shock and far removed from the birth process she expected. (This was the effortless, straightforward labour and automatic bonding with the perfect baby, which happened to the "ideal" mother in western culture). Birth can still be traumatic, even when not immediately life threatening (Brown & Lumley, 1994). For example, Jane described her son's birth as being "very, very painful" and said she was "just exhausted" at the end of it" (Jane, p 7, L: 370 – 380). Long labour can be exhausting, but quick labour can be traumatic too. Elle told of her difficult experience where she ended up delivering her son on all fours and "dislocated her coccyx" (Elle, p. 15: 597).

The stresses and strains of being a new mother are difficult and can create a crisis of adjustment, or even an Adjustment Disorder (DSM – IV, 1994, NHMRC, 2000). These stresses certainly can create fertile soil for postnatal depression to grow and flourish. Such experiences as those expressed by the twelve interviewed women contain feelings of anxiety, frustration, grief and loss, which can be hard to share openly with other people, particularly if the woman is sensitive and fears being judged. Depression is a condition, which makes people believe that they are lesser people than others, and fear failure and negative judgement (Oliver, 2001). Consequently, the stressed and depressed mother is more likely to hide her suffering behind a mask and this leads us to the other two sub-themes belonging to the theme of

Dual Reality: Behind the Mask and the Depression Experience. The next sub-theme to be discussed is Behind the Mask.

Behind the Mask

For many mothers, the early parenthood experience stresses and disappoints them and the pressure of expectations from other people inhibits them from speaking about their difficulties (Miller, 2002) This sub-theme involves the private face behind the mask, which is the dark side of the Dual Reality of postnatal depression. It is where the researcher can lift the mask away from the woman, and enter the woman's private domain to perceive her real feelings, real experience, and private thoughts, which are otherwise unexpressed and hidden from the world. The woman might look into the mirror and judge her image as a failure, when in fact what is portrayed and reflected is a normal person, experiencing a difficult life transition. Elle told me that she "put on a front" of effortless "coping" so that her friends wouldn't work out she had feelings of depression, and would praise her, saying she "did such a wonderful job with the kids". Elle would then go home, enter her own private domain, pause, and "feel like s***" because the praise was empty and she had put on an act (Elle, p.6 L: 25 -36).

What lives behind the mask is a terror of showing pain and insecurity to the world and the need that many of the women described trying to hide the truth of their experience from other people – even health professionals who sensed that something was wrong and asked them how they were feeling. Annie felt her denial delayed her treatment, she had a subconscious awareness of her condition and she was caught between

154

wanting to share it with the child and maternity health nurse and a wish to keep silent. She told me how the nurse would ask her "how are you going?" and she would answer, saying "fine, fine," but thinking, "push me again, ask me again!" "Of course", Annie ruefully added, she "perfectly convinced" the nurse she was "fine" (Annie, p. 5 L: 86-88).

The concept of "what lies beneath the mask" is not the same idea as "The Depression Experience" although some elements are linked, such as the lived experience of the pain of depression. However, the Behind the Mask sub-theme involved the need of the women to walk in the cast of the marionette, smiling from the face of the doll, hiding their depression from the world because of personal shame. Mental illness is still a source of great fear in the general public, even though western society has come a long way from the days of Bedlam (Oliver, 2001). As Oliver (2001, p 1) says

> Try telling a mentally ill person not to feel stigmatised and he or she will tell you that you're the crazy one. Depression (including PND) is the most common form of mental illness in Australia but its widespread occurrence has not educated the wider public.
> (Oliver, 2001, www.depressionet.com.au/articles/confronting_ depression.html)

This reminds me of the "Beyond Blue" campaign on television (www.beyondblue.com.au). While helpful information, support and referral are provided by this organisation, the representation of the recovery process on television appears very easy, and somewhat unreal. I co-wrote an article on Postnatal Depression, which was published in a journal but the pictures beside it made me laugh. Although the symptoms and stressors of PND were thoroughly described in the article, the photographs the editor had chosen showed a well dressed mother with a clean baby, waving a manicured hand across a skilfully made-up face. No sign of

tears could be found on mother or child. No hint existed of fluffy slippers, discarded coffee cups or rumpled dressing gowns. The mask appeared well in place even though this article had been written with the intention of un-masking the condition both for women and health professionals (Williamson and McCutcheon, 2002).

The women described the cultural image of expected motherhood, which was the dominant archetypal image of the perfect mother. This was found in the media, and contained, in the words of Danielle; "…those lovely Johnson & Johnson advertisements where everything's happy, all the time, everything's rosy, and no mother ever gets angry with her children..." (Danielle, p. 3 L: 145-146). Such advertisements exist on television, in the newspapers, and in books and magazines and are for baby soap or shampoo, nappy care products, nappies, baby food or baby clothes. They portray a smiling baby with a serene mother, and they contain "wonderful soft fuzzies" (Jane p.10 L: 23). They are the Superwoman myth crossed with the image of the Madonna. Christine struggled with this, trying to live each the day with the "Johnson Baby commercial looming over (her) head" (Christine, p 50, L: 1). She put pressure on herself, thinking, "I must look like this person and be behaving like them," when instead, she would be "having a thought about putting the baby into the oven" (Christine, p 50 L 8 -9). This image of Madonna-style motherhood as an ideal was relentless as the perfect mother portrayed never frowned, was always immaculate, and wore spotless clothes (so did baby). No food spills, tears, spots on blouses or dirty nappies were to be found; the advertisements always showed the baby powder applied to clean, freshly washed baby bottoms.

With very little struggle the cultural image collapsed onto the women and formed the mask, the plaster marionette which covered their faces in an artificial smile and covered their bodies, moving their limbs mechanically. The puppet mask took over even for health professionals; despite the women's own lived reality. Olivia said:

> When you go for appointments you put on a front and you appear to be coping. I didn't feel inclined to tell the GP or the sister or anybody that I was getting the creeping black…and they didn't pick it
> (Olivia, p 22: L 23 -25)

Danielle explained that her doctor had failed to follow her up after her baby's birth, even though she had experienced some depression in the hospital. But she added, she was "so good at hiding…the PND". She commented that women "pretend to everybody else that (the depression) is not that bad" and consequently, that PND is "not being recognised, we just hide it so well" (Danielle, p 13, L: 625 –630). Hiding PND was a concept pivotal to the sub-theme of Behind the Mask – this described the process of not disclosing the PND, of keeping it to oneself. Elle kept frantically busy as she slipped into PND and wanted to present a perfect image. She described herself as "fanatical", saying that everything in her house had to be neat, ordered and very clean, "perfect if somebody came", because she "didn't want anybody to know the state I was in!"(Elle, p. 24, L: 19-23).

A denial of PND was also experienced by a number of the women. This sense of failure made it hard for them to admit to themselves, let alone anybody else, that they were suffering PND. Jane said that "working as a nurse" she was "determined not to be depressed" so she "denied it for months and months" because depression was for "other people". She added that she "got women better", and so therefore, she most "certainly" couldn't "suffer from PND!"(Jane, p.3, L: 164-166).

According to Beck (2002), the most important factor in the length of postnatal mental illness is the length of delay to appropriate treatment. Danielle said that the delay in facing up to PND had slowed her diagnosis and therefore her treatment. Pride contributed to the denial of depression, as did the loss of sense of self and the shock, which was part of the experience, and the guilty feelings. Elle commented that women suffering with postnatal depression did think they were "the only one" and added that "some women" were "just too proud to admit they have a problem" (Elle, p. 2 L: 9-12).

According to Cox (1989) women often experience powerful feelings of guilt and confusion as part of PND. Danielle said that a sense of guilt was also a barrier to reaching out for help, making new mothers feel that they had no rights to care for themselves. She reminded me of the story of the "burnt chop syndrome"; a phenomenon where the mother was always the person who's needs came last within a family. A mother would serve a meal of chops and mashed potato, burn one, and rather than appear less than perfect, she would eat the burnt chop herself. Danielle added that the idea of being a mother contained "no selfishness whatsoever". It involved being a "doormat…and taking care of everybody's needs – and me (mother), what needs?" (Danielle, p 15 L 11 – 13)

The tendency for many women to hide PND behind a mask is a problem for health professionals and yet one, which could be possibly, be overcome by routine screening, with an instrument such as the EPDS or the Maternal Attitudes Questionnaire. The EPDS (Holden, Cox & Sagovsky, 1987) was designed specifically

to screen large numbers of women for PND. Annie told me that if the nurse had asked her, "And how are you going?" she would have answered "fine". But had the nurse added, "Do this questionnaire, just answer this question: Do you like your child?" Annie would have burst into tears, and been diagnosed sooner (Annie, p. 26, L: 450 – 452).

This is not a foolproof idea, not all women are going to take the time to fill out a questionnaire, but for those who want to do it, it is one way for a health professional to take a glimpse behind the mask. Especially as it seems to me the women who wear such a mask are often conscientious, hard working, achieving women, concerned about "doing the right thing".

Kate was the only exception of the twelve women to this experience, as she tried to tell health professionals that she was struggling and no-body would listen. She said that this was because she was an articulate woman, a counsellor and this counted against her. Kate told me she had been metaphorically "beaten to a pulp" and added that everywhere she went because of the "language" that she used and her obvious intelligence there was an assumption from health professionals and others that "she'll be right…and she WASN'T!"(Kate, p 11, L: 21 –23).

However, most of the twelve women consistently expressed thoughts, which strengthened the notion of crying alone beneath a smiling mask to the world so that their suffering remained hidden. The next theme, the Depression Experience, concerns the day-to-day experience of living with postnatal depression.

The Depression Experience

Symptoms of PND can include anxiety about caring for their baby, negative feelings about their baby, and delayed bonding with their child (Sharp, 1996), alongside the experience of major depression as described in the DSM-IV (American Psychiatric Association, 1995). The sub-theme of the Depression Experience developed from the data to describe the lived experience of PND for these women. This sub-theme involved not only feelings that were hidden "Behind the Mask" but also PND-specific feelings and experiences, which continued on into the treatment phase and beyond. This sub-theme touched upon what it was like to be ill enough with PND to need health professional intervention. Annie was hospitalised for her PND, and much of her PND struggle concerned bonding to her child. She wrote a poem in hospital about this stressed relationship:

Postnatal Depression

You sleep.
I creep in to watch you.
Love shreds my heart,
Its brutal cloak of guilt, regret, grips.

I long to hold you,
Soothe my cuts,
Your body warm, forgiving of my failure.
You sleep,
I creep – Out.

The concepts involved in this sub-theme are the somatic expressions of depression, classic PND symptoms, painful emotions, and bad memories triggered by depression. Somatic expressions of depression involved the mind as well as the body. Christine suffered "bizarre fantasies" (Christine, p. 7, l: 200), and Kathy became "so depressed, that …I would just lie there…" (Kathy, p 1, L 31-33). Depression and anxiety seemed

to fill the lives of these women. Elle described the agitation of her postnatal depression, which emerged in a phobia about cot death. She said: "I would be up and down all night, checking, checking…I would be a mess" (Elle, p 23, L 16 – 18). This agitation occurred just before her hospitalisation, and this part of her story reminded me of a poem written by the 19th Century American poet, Emily Dickenson (1830-86):

Nature (LXXXII)

There's a certain Slant of light, winter afternoons
That oppresses, like the Heft of Cathedral Tunes-

Heavenly hurt, it gives us – we can find no Scar
But internal difference where the Meanings are

(L: 1-8)

I think this poem poignantly describes the pain of encroaching depression. And for these women the moment of collapse which led to the crumbling of the mask and their hospitalisation or treatment was one of searing pain, such as Emily Dickenson's "Seal (of) Despair

An Imperial affliction, sent us of the Air –
When it comes, the Landscape Listens –

Shadows – hold their breath
When it goes, tis like the Distance- on the Look of Death
(L: 8-16)

Including the notion of death in postnatal depression is no exaggeration; in fact, suicide is one of the leading causes of death of new mothers in western society (NHMRC, 2000, Raynor, Sullivan & Oates, 2003). The collapse of the mask, the breaking away of the marionette, is a kind of death also. As it peels away from the limbs and torso of the woman trying to breathe, and as it peels away from the tear-

soaked face, it is the death of an illusion, the end of a dream. All that is left is the pain, and the terror. The face is unmasked. Kathy described this moment, holding back tears as she did so:

> I remember running at cars…I just didn't want to be here (on this earth), I just knew I was in a very bad state; I had to do something…I ended up in hospital…
> (Kathy, p 3 L: 1 -10)

Leanne described this moment of breakdown similarly to Kathy:

> I …went downhill. I had suicidal thoughts, I was just a mess…the lady that ran (my) group organized for me to go into hospital….
> (Leanne, p 3 L: 37 – 40)

The Depression Experience involved a mind and body pain, which was all encompassing. Sometimes when the mask slipped away, the women had to find themselves all over again, as they had lost their personal identity. Christine described it as a "stripping down of who you are and having to rebuild this picture of yourself again" (Christine, p 9, L 259 – 260). The loss of an integrated, familiar sense of self became physical agony to Annie. The pressure of being with her child became unbearable, and she remembered thinking that spending "another minute" with her child meant her "body would shut down" and she was "going to die". On another level, she wanted to live, but she couldn't "stand the agony any longer" (Annie, p. 25 L: 478).

Jane looked back at her PND and believed she had lost a year of her life and wished she could remember her baby son's first year. The depression had smothered her memory, and the strain of hiding her reality behind the mask had stolen the remnants of her energy. All she could remember in the first year of his life was "the gloom". She couldn't remember his first walking, or his first step, her memory of that time had "all gone very hazy" (Jane, p.5, L: 267 –268).

The women described the classical symptoms of PND (DSM- IV, 1994, Barnett & Fowler, 1995 and Sharp, 1996). The issue of bonding between mother and baby (Sharp, 1996) was a real difficulty for the women interviewed. They described their need to bond with their children and the struggle involved in this. There was also a fear that bonding had failed, or would fail; regardless of whether or not this was the case.

Painful emotions are very much a part of PND (Sharp, 1996). Annie's sense of entrapment flourished when her daughter, aged five months, began to crawl. The entrapment turned into a panic, which grew like a strangling vine in the dark behind the mask. Annie's life became a prison. She described having to put barriers around the house, "like a cage" to keep the child in some rooms and out of others, and this turned the house into a cage "for her and a cage for me". In the end, she had to "gird her loins" to step over the fences and move into other rooms. This became unbearable and Annie related being so "frightened" of the time she and her child were alone (Annie, p 4-5, L: 64-78).

Gabriela also felt a fear of her child, and an aversion to bonding. This started in hospital, shortly after the birth. She told me that when her daughter was born, she didn't want her in the room with her, and she would deliberately leave her in the nursery so visitors would not wake the child. Unable to keep up the pretence of effortless motherhood, unable to position the mask, she convinced her doctor to get the nurses to put a sign on the door to keep visitors out. An excuse was made that she was resting. When the time came to go home, Gabriela was petrified of looking after

the child by herself, but away from the hospital environment she was able to slide behind the mask for other people. The doll moved her limbs and motivated her to keep a spotless home, to "get the house done" and to "be presentable" and make "everything look right from the outside" so that "nobody would see anything wrong" (Gabriela, p. 2, L: 41 – 42).

Tracey described feelings of overwhelming sadness, where she "kept crying all the time" and thought to herself, "this is not normal!"(Tracey, p 4, L: 96 – 98). The doll mask after all, was an image fixed into a smile, and for Tracey, that was normality, not her own sadness. Gabriela also found her anger overwhelming at times, and unable to accept it within herself, she projected it outward and blamed her family for her unhappiness, declaring that if she "hadn't had the baby everything would have been all right!"(Gabriela, p. 9, L: 211). After all, the doll never did anything but smile. The doll had no anger, no fear, and no sadness. All dark emotions were forbidden, and so her family had to carry the weight of those unacceptable emotions.

For those women with a past history of depression, the postnatal depression triggered extremely painful memories. And difficult past experiences were forcibly relived in a number of cases. Christine said that also she felt "so afraid" when she was suffering PND, even though she had experienced depression before. She reluctantly "went through a whole lot of issues" about her own "entering the world", and pain from her "parents relationship" haunted her. Her world became inflamed by a "lot of grief, and fear" (Christine, p 13, l: 399 – 403). The imperfection of her past made her even more determined to create a perfect present and a perfect future, and consequently she wore her mask with determination. I am reminded of Erik, the main character in Andrew

Lloyd Webber's (1986) production of the Gaston Leroux's (1911) novel "The Phantom of the Opera". In this tragic story, the phantom wore a mask to hide what he perceived as a "loathsome gargoyle" (his face, and his wounded nature) but beneath his loneliness, despair and pain, burned a passionate soul who:

> "Burns in Hell but secretly yearns for heaven
> Secretly, secretly…
>
> Who seems a beast but secretly dreams of Beauty
> Secretly, secretly..."
> (Lloyd Webber, 1986)

Like Christine, Kathy also remembered painful events from her childhood and family history, which is noted in the literature as a symptom of PND (Murray, Cox & Chapman, 1995). Her aim, like that of the other women, was to embody the image of Madonna-style perfection in motherhood. She remembered how difficult that was to achieve, and as she became more unwell, the mask she had created seemed to engulf her to the point where she struggled to speak. She recalled being "a stutterer as a child", and how that problem returned during those times when she felt most vulnerable. Metaphorically, whenever she tried to open her mouth to speak her truth, the mask jammed, and she "kept on talking with this really, really severe stutter" (Kathy, p 3 L: 30). The stutter distressed her as it showed to the world how far from perfection she had fallen. Shortly afterwards, she broke down completely and was hospitalised.

Elle's experience of breakdown was more of a gradual slide into darkness, with the mask slowly appearing to grow tighter and tighter, constricting her, making it harder and harder to get in touch with her thoughts and feelings and express herself in any

way. With the birth of each child her freedom was eroded. Her mother visited to help with daily tasks but there was "only so much" she could do, and only so much (due to the existence of the mask) that Elle "asked her to do" (Elle p 4, L: 6). The hidden pain intensified when Elle's third child was born in the middle of winter. She was "stuck inside all day", unable to do "something for herself". A year later her last child was born, and the pain and the pretending became "all too much". She collapsed in the main bedroom. Finally, the mask metaphorically peeled away and became a broken pile of dusty rubble in the corner. Her husband found her sobbing in despair, and straight away took her to hospital. (Elle, p 4 L: 4 –12).

This sub-theme of the Depression Experience therefore included the lived experience of the women with postnatal depression, and the classical symptoms of PND dominating their lives. These women donned a mask of pretence and tried to cope on their own, only to experience overwhelming stress and emotional breakdown and finally undergo treatment for PND.

The continuum along which the dual reality moves

The experience of Dual Reality is exemplified by the way the three sub-themes are all linked together. The Stresses and Strains of New Motherhood, link to the Depression Experience, whilst all the pain is hidden Behind the Mask, until it is broken away. This happens either because the woman has had a "breakdown" or successful interventions from health professionals and others have symbolically "prised the mask away" and helped the woman emerge and begin to heal from her PND.

Examples of these links are now summarised briefly. The Depression Experience, and the Stresses and Strains of New Motherhood, were both hidden Behind the Mask, and the sub-theme of Behind the Mask referred to the act of hiding that pain. For example, Jane complained that the stresses and strains of being a new mother meant that she got so "little sleep that (weird) things started to happen" such as she "heard whispering outside my bedroom at night" but she "knew that nobody was there" (Jane, p. 1, L: 27 – 29) Then, living Behind the Mask, and especially at work, Jane believed it was necessary to hide her feelings of PND. Elle found the need to don the mask was running her everyday life. She felt "shocking about herself" but put "on a brave front" (Elle, p 2 L 10). Meanwhile, the Depression Experience lived beneath the carefully smiling porcelain face for these women. With Jane, it manifested in her inability to bond with her baby, despite her professional knowledge of PND. Her child "could have been a baby at work for all the emotional contact" she felt (Jane, p.3 L: 9). Annie called the Depression Experience "suffocation", but never admitted that her bond between herself and her baby was "dragging her down" (Annie, p 17, L: 304). Then one day she read a statement written by a mothercraft nurse in her file saying she was "enjoying motherhood" and she suddenly felt as if a giant fissure appeared in the mask. She turned to her husband and spoke with "great vehemence": "That is a LIE! I NEVER said that!" (Annie, p 7, L: 126 - 127). The power of her response and vehement reaction shocked them both. Suddenly, the mask of pretence appeared to fracture down the middle, then peel away completely. Now her true situation had been exposed. Annie gathered up the fragments and buried them, as her long journey of getting help and successful treatment for postnatal depression began.

The women in this study all experienced a similar progression in life experience of each sub-theme under the theme of Dual Reality. The only exception to this was Kate, who tried asking for help early on, but even she felt the pressure of the mask and the need to appear to the world as a perfect Madonna-style mother. Her biggest sadness was that her PND and suffering ruined what should have been an idyllic time in her life.

The next section of this chapter examines the helpful and unhelpful interventions the women experienced from health professionals, family and friends.

Interventions

In this theme, Interventions, three sub-themes were developed from the data. The first sub-theme involved the need for education and more services for women with Postnatal Depression and the others were Getting Help and Lack of Support.

When trying to think of a way to describe this theme, an image came to me of a suspension bridge over a swirling, rapidly tumbling river. The bridge moves over the "troubled waters' of postnatal depression from the beginning of the journey of reaching out for help and ending on solid ground after receiving the effective and positive help. There are variations of quality on the bridge though: the interventions moved from the "good" or the positive interventions, where the wooden slats on the bridge are strong and solid and in good condition. At times, the bridge is broken, the slats are rotted in places and knarled, and for the women who tread on these, they can be treacherous. What was perceived as an unhelpful intervention could cause a woman to fall off the bridge and into the dangerous, swirling waters below. Whereas,

a helpful intervention could act as a rope, or a life jacket, to rescue the woman before drowning and pull her up to higher safer ground, and a poor or unhelpful intervention could hurry her descent.

A woman is very vulnerable when the "mask' which hides postnatal depression cracks and breaks – and if she receives a helpful intervention at this point, she can be pulled to higher ground. An unhelpful intervention can leave her to drown. The missing interventions act as gaps in the bridge; wooden slats which are non-existent and once again, women can fall through the gaps into the swirling, dangerous waters below. A helpful intervention can 'rescue" these women, and they all needed encouragement, and support to pull through their postnatal depression experience. When thinking of the positive interventions, I was reminded of these words by Paul Simon:

> "When you're weary, feeling small, when tears are in your eyes
> I will dry them all; I'm on your side, oh, when times get rough
> And friends just can't be found, like a bridge over troubled water
> I will lay me down…" (Simon, 1969 v. 1)

A bridge over troubled waters: such is the strength of helpful intervention. All the women wanted and sought was nurture, support, and reassurance, for someone to

> "Comfort you …I'll take your part
> When darkness comes, and pain is all around,
> Like a bridge over troubled water...I will ease your mind"
> (Simon, 1969, v. 2-3)

Simon and Garfunkel's popular song speaks simply and clearly about sincere friendship and the willingness to help. Such friendship and compassion can come from health professionals, family, friends, work colleagues and even passing strangers or neighbours for these women. I listened to many stories of receiving help, from simple encouragement to hospitalisation and therapy and concluded that the three main groups of interventions lay on a continuum, crossing a bridge. The "good'

interventions were the strong wooden slats on the bridge, the "bad" interventions, were the dangerous rotting or broken planks, and women also complained about "missing' interventions. These were interventions which were absent and acted as missing planks, nothing solid on which to tread on as they tried to cross the bridge. These were empty areas where the women fell through to the abyss below and risked drowning. Sometimes they would rise up swimming, and a helpful soul on the bridge would throw them a lifeline and help them scramble to safety. Sometimes the "unhelpful" interventions would act as an empty space also, such as when women reached out for help and were not listened to or believed. These also could become dangerous gaps on the bridge where a woman could slip, and fall, and drown in the surging waters of emotion below.

The first sub-theme, the need for more Education and more services for Postnatal Depression, acted as a gap on the bridge, as these were "missing" interventions. They were emphasised by the women at regular intervals so I have placed them first in this section of my interpretation.

Need for Education and more services for Postnatal Depression

Information given by health professionals to women and their partners in the postnatal period has been posited as postnatal depression support (Hey and Feu 2003) and the participants of this study supported this finding. Group therapy, usually led by health professionals (such as a social worker or community mental health nurse) has also been posited as helpful for women with postnatal depression (NHMRA, 2000). Four of the twelve women interviewed articulated a wish for PND- specific support groups, as those who had been able to access these found them helpful and important. They

also believed that support groups could help to de-stigmatise PND and to break down the shame and feelings of isolation suffered by women in this situation. At the time of interviewing, Gabriela said she had not found enough "outreach services for women with PND" (Gabriela, p.3 L: 118). She wanted readily available and information-rich databases that women could access on the Internet such as those found at www.Beyondblue.com.au and www.Depressionet.com.au. She also wished for leaflets to be "given to women at antenatal classes or even the hospital" and for "some kind of outreach person, a nurse for women with PND and support groups" (Gabriela, L: 119 – 122, p.3). Gabriela also left me with an impassioned plea for "support groups for women with PND" (Gabriela, p.27 L: 642).

The stigma of PND created a swirling river of shame, guilt and fear for these twelve women. These were dangerous emotional times, the threat of falling and drowning was real, especially when they reached out and asked for help. Elle felt this acutely and was concerned that other women had to battle on, trying to find help for their PND. She encouraged women to keep asking for help, even if all the response received was "buck up, get on with it, you have kids that are beautiful, etc, etc" (Elle, p. 28, L 25). She emphasised that if the first people approached, (whether health professionals, friends or family) failed to listen, "you have to go to someone else, where they will understand and **don't** let it go till someone listens!"(Elle, p. 28 L: 28).

Jane wished that she had been able to ask for such help as she struggled through her storm-blown passage of new motherhood. She thought that earlier, more realistic information given to women at the pregnancy stage would have acted as a positive

teaching which might have given her skills to use when her PND developed (or if PND should develop) and so would have helped her to walk in a steadier way. She wished that someone had "talked to me beforehand," warning her that there were "just some babies that are really revolting" (Jane, p. 5, L: 252 – 253). She also wanted women to step out from behind the mask and accept any help that is offered, and to "talk about it" (PND). Women could help each other in their journeys of motherhood, postnatal depression, and difficult babies if they spoke honestly about their experiences, sharing the stress, and if they knew that not everything was "your fault" (Jane, p 5, line 257-259).

Reflecting on her passage, her difficult walk across the symbolic bridge to healing, Elle stressed that the "most important thing" for the women, which was also "very hard to do", was "to speak to someone" and express the painful, depressed feelings (Elle, p. 25, L 30). She didn't want other women to let their postnatal depression "go on too long", or to "be frightened" to speak out, just because they "didn't have a plaster on" to show they were in pain (Elle, p 25, L 31). So in effect the mask prevented the interventions from being sought so a vicious circle emerged, and no matter how deep their suffering with depression, the women were trapped. Danielle also struggled as she made her crossing on the bridge, yet found the storm raging around her whipped her cries for help away from her face. She spoke about a problem she had encountered when visiting a healthcare worker early on with postnatal depression, saying that she and her friends had "talked about…the problem" but "ended up feeling like we've done something wrong". Danielle thought that women with PND were sometimes made to feel that they were "not quite adequate" and that

they could be left with "some sort of negative feeling" about themselves as mothers (Danielle, p. 21, L: 1047-1048).

Readily accessible literature on PND such as brochures, pamphlets, and booklets given out by the local child and maternity health nurse or found in the General Practitioner's surgery, were described as helpful to these women. They were like a map for the women as they battled through this rite of passage, a guidebook in the storm. Tracey and Danielle in particular found writings about the subject most useful. Tracey commented that "it helped to read articles on PND" and that it was particularly helpful to "have something to read and get information" (Tracey, p 11, L: 8-12). Danielle found her first solid plank on the bridge, as a nurse gave her leaflet on PND to read. As she scanned its pages, she recognised what was happening to her for the first time. She told me she "sat there and thought, yes, that's me, yes, that's me, yes, that's me!" (Danielle, p.1 L: 14 -20).

The wish to have had earlier diagnosis and treatment of PND was felt strongly by these women. Gabriela expressed a wish for a group of new mothers, or mothers of any age, who had also suffered from PND to form a support group lead by a health professional. She felt that the sharing of information and feelings with others who were "suffering the same as me" would have helped her find a steadier passage to healing from her depression. She said she would have "done something about her illness" much sooner, especially if there had been "a referral system in place" (Gabriela, p. 27, L 643 – 647).

Parenting groups, especially groups for first time mothers, have been described in the treatment literature as helpful for women with PND (Gillett, Ferroni and Moore 1999; Hanna, Edgecombe, Jackson & Newman, 2002). In this study, Leanne told me that whilst her G.P was supportive, and made good suggestions for ways to deal with her postnatal depression, all she really wanted to do was "find a group of mums" (Leanne p. 1, L: 20). The women also shared ideas specific to the care of pregnant women and they gave suggestions to health professionals to help the women make a safe crossing on their journey to healing from PND. Midwives have been described in the literature on PND as being in a good position to help in the prevention and even the treatment of postnatal depression (Gibson, 2001; Bott, 2001). In particular, Gibson (2001) has pointed out that midwives could help women from developing postnatal depression by dismantling the myths and taboos, which affect new mothers. These findings were well represented in the data, such as this comment by Jane directed to health professionals who run antenatal classes:

> If only people could warn you that things do go wrong, that you can get hurt,
> and you can get help, and that things like PND exist
> (Jane, p.10, L: 505)

Elle wished that the range of PND experiences could have been better explained, in antenatal classes, and even in the media. She described PND as being "very lonely", and remarked that just occasionally there was a story done "on TV, but they always seem to get the worst-case scenarios!" Her plea was for a "range of scenarios" of PND to be shown on television, not just stories of women "who are totally suicidal" and have "to be locked away". She wanted to see women depicted who felt "just sad" and that there be more explanation of "what goes on and what can be done for people" (Elle, p. 29 L: 15 – 22). She believed that realistic teaching about PND on the media

and in other places would help to provide a compass for women, and a realistic map as they struggled across to solid ground away from their PND.

This sub-theme, therefore, described the missing interventions for these women. Had they existed, they would have been solid planks on the bridge away from postnatal depression and towards the higher ground of a new, healed reality of motherhood. The next sub-theme, Lack of Support, described the poor interventions, which acted as broken wooden planks where the women tripped and fell into the raging currents of the river below, to sink, or drown, or receive help and rise up swimming.

Lack of Support

The literature on treatment effectiveness for women with postnatal depression is minimal (NHMRA, 2000) however it does appear from the literature that health professionals do need adequate information and training in the area of both the preventative care of women at risk of PND and the care of women with PND itself (McClarey & Stokoe, 1995). The reason for this is that many health professionals have been found to experience discomfort in dealing with psychological and emotional suffering in patients (Whitehead & Mayou, 1989). The sub-theme Lack of Support, found in this study, reflects the experience of the women reaching out for support and not receiving it at all, or receiving interventions, which were discouraging and unhelpful. Concepts belonging to this sub-theme include discouraging treatment in hospital, including a psychiatric hospital. In one case the discouraging treatment in hospital lead to a young mother with PND discharging herself early:

> I decided to pretend to be okay so I could go home (Sophie, p. 3. L: 66).

Part of her distress was caused by her unhappiness with the counselling she had received in hospital. The social worker appeared to give her no empathy and the male psychiatrist made her feel acutely uncomfortable. She said the way "he asked questions" about her "sexual abuse" upset her, as did his "taking things into his own weird sense of humour, and making sick jokes" (Sophie p.3, L: 1-9). Sophie would have been alone and adrift after this but fortunately she was able to access help in her home environment from a supportive counsellor. Difficulty getting help for PND was another concept belonging to this sub-theme. Gabriela told a story of months, metaphorically slipping and struggling on the bridge towards healing, trying to find a solid plank on which to stand. She told me that she went onto a waiting list for a psychiatrist, which was three months long, and during that time, the only crisis intervention she could get was from "Emergency". She said she would "ring up Triage" and be told that the only way they could treat her was to take her "into hospital and shove" her "into a psych ward" (Gabriela, p. 8 L: 168 – 172). However it should be noted that this is the current reality for many psychiatric patients experience distress with their illness, not just women with PND.

Whilst Gabriela was eventually hospitalised, she found that she needed a different kind of help in the early stages of PND. She described one year of waiting for appropriate care as a nightmare year of seeing a naturopath, and then "psychic healers and alternative therapists" and trying to medicate herself with alcohol, before she had a complete breakdown (Gabriela, p. 16, L: 386 – 388). Leanne, meanwhile, continued desperately to seek a group of other mothers to help her make her symbolic crossing on the bridge towards healing. This became harder and harder to achieve and she described extreme frustration as she rang up hospitals who couldn't help her, and one

which suggested a psychiatrist, but that was not what she wanted. A local psychiatric hospital had a mothers group but there was a huge waiting list, and other people said things like; "you are not in our district. We can't help you. Oh no that just closed up…we haven't got a group any more and we are having a year off" (Leanne, p 1, L 25). Finally, she found a group, and she said "the lady that ran it was fantastic," but" the first day I rocked up, and no other adult, no other mums, wanted to come!" (Leanne, p. 1, L; 30). Her frustration and loneliness was audible as she recalled this experience. Eventually, she tried to take matters into her own hands, and created her own group, called "Mums to Mums" and wrote her own pamphlet on postnatal depression to advertise the group, but that idea eventually folded, due to lack of patronage by other women.

Indifferent counselling, delayed diagnosis, receiving medication the women disliked from a G.P or a psychiatrist, and an unsympathetic family, network of friends, or workplace were all aspects of weakened planks on the bridge which lead to dangerous falls into the river below of painful emotions for these women. Medication could become a problem if perceived by the women as unhelpful. Tracey said that her GP recommended anti depressants for her, and she did "try them, but only for a short time" because they made her feel "really weird" and she "didn't like the idea" (Tracey, L: 100 – 107).

It is important also to remember the emotional fragility of women with PND, and two of the women stressed this when they spoke to me. Danielle said that "because we have got the PND, we're more sensitive" to what health professionals say and how they say it" (Danielle, p 21, L 1046). Sophie explained that even while the nurses in

hospital encouraged her to talk about her postnatal depression and her feelings, she felt uncomfortable doing so. She "didn't feel free" to talk to them about how she felt, as she felt sure she would be "judged" (Sophie, p. 2, L: 38).

Danielle also remarked on a difficulty in discussing ideas regarding effective healthcare for PND women. She remarked that care for postnatal depression was "only as good as the nurse you get" and whilst some of the nurses who had treated her had been "absolutely fantastic" she knew women who had been treated by "absolutely shocking nurses". Her further comment was that "no matter what doctor or midwife or nurse you get, it is only as helpful as the individual concerned" (Danielle, p.21 – 26, L: 1034 – 1251).

The sub-theme Lack of Support, therefore symbolically involved the metaphor of the broken or rotting planks on the bridge towards healing, which left the women struggling, hanging in mid-air, or falling and drowning in the river below as they struggled to survive their postnatal depression. The next sub-theme, Getting Help, describes the opposite experience. These were the interventions, which rescued the women, seeming to hold up a life raft or a rope to haul themselves back onto the bridge, and onto steady ground.

Getting Help

The difficulties involved in a serious lack of support were balanced in the data by stories of the women successfully getting help for their postnatal depression. Help came from friends, family and the workplace, from maternity and child health nurses, from medication, support groups, and helpful interventions in hospital (including

psychiatric hospitals). Life rafts were thrown to the women by a range of professionals (such as GP's, counsellors, nurses, and social workers) and even other agency supports such as good childcare. Interventions, which lead to diagnosis, were also perceived by the women as helpful, since they lead the women into treatment, up out of the surging current and away from the pain of untreated depression. Family and friends could also give simple interventions, which were remarkably effective. Jane described such help received from a neighbour, where her neighbour gave her coffee and bounced her baby up and down and there was a "couple of hours" where she "didn't have to be responsible" (Jane, p. 1, L: 51- 53).

The value of good childcare was stressed by a number of these women. Olivia described feeling "very guilty about using childcare" but added that once she "got into it" she just "loved it so much" (Olivia, p 16, L 16). Gabriela remarked that parents did 'feel the same' (i.e. guilty) about using day-care but it was one of the best things she did for herself and her child. Her daughter "made a couple of close friends", and the staff "do everything for you – wean them (the children), toilet train them, feed them good food". She commented that she was "very lucky" to have access to good day-care Gabriela, p. 22, L: 532 – 536).

Hospitalisation was also very helpful for the women at times, saving them from drowning in the turgid emotional currents of the river below. If the women felt cared for, listened to, supported, and understood, the hospitalisation hauled them back up on the bridge and on the way to recovery. Gabriela was cared for in the private psychiatric hospital system and found it a positive experience. She used a "private hospital" where she believed she had been "properly cared for". She considered that

the care she received was "worth the extra money for private health care" (Gabriela, p. 15, L: 366 – 367). Annie, however received help in the public psychiatric system, and felt she also received excellent care. She described it as being "a…safe environment…to everyone be nuts together" even though moving into the hospital environment was "really quite frightening" (Annie, p. 11, L: 228 – 233).

Danielle found that admission to a specialist mother and baby psychiatric unit helped her to stabilise her medication and move towards appropriate medication, which was a large factor in her recovery. She was admitted to the hospital, and "came off the Aropax". This removal from the old medication made her "sink lower" but the staff cared for her, and her psychiatrist put her onto Cipramil, which worked, and "it was really clear that it was working" (Danielle, p.3 L: 109 – 113). Meanwhile, Elle commented simply that she appreciated the help she was given from her doctor. She told me that she was "very lucky" to have care from her understanding and practical GP (Elle, p. 13, L: 18).

Appropriate anti-depressant medication was described as helpful according to Annie, Leanne, Elle, Kathy, Sophie, Danielle and Gabriela. Jane and Olivia went without it, as did Christine, and Tracey needed iron supplementation rather than an anti-depressant. Kate was offered anti-depressants and sleeping pills, but refused them, believing they were not the solution to her situation. They were never going to help her cross her bridge, what she needed and asked for was understanding and encouragement to cope with her plight. However it does appear that appropriate medication helped these women cross the bridge and feel stronger, so they could heal from the most painful effects of PND. Elle related that once she began taking Zoloft,

she felt "like a different person" (Elle, p. 2, Line 7). It is important to note that in some of the psychiatric literature medication is aimed at restoring the physiological chemical imbalance that occurs with depression (NHMRC, 2000). Some people need this medication as a starting point so that they can get over the intensive phase of depression and are able to physically work through some of the psychological issues that they need to face and deal with. Depression, it must be noted, is not just a psychological issue but also a physical illness with physical manifestations of exhaustion, tiredness, constant crying, and so on (DSM-IV, 1994). This can be as debilitating as other physical diseases such as diabetes. The combination of the drug fluoxetine and cognitive-behavioural counselling, has also been found to be an effective treatment for women with postnatal depression (Appleby, Warner, & Whitton, 1997). It would appear therefore that treatment with an effective antidepressant drug plus or just before therapy is helpful to women with postnatal depression.

Christine also had high praise for her child and youth health nurse who recognised her PND, and threw her a life raft, which enabled her to have appropriate treatment. She says she "made it apparent" that she "wasn't actually coping", that she was "completely exhausted". She then added, "We went through a process of treatment or counselling" which was effective, a "marvellous, positive situation" for Christine and her family (Christine, p. 4, L: 120 - 124).

Annie believed that she received excellent health professional care all the way throughout her stormy journey of PND, and she was grateful for this. Her psychiatrist was described as "fabulous" as were the staff in her psychiatric hospital. She thought that her GP had excellent listening skills despite her admittedly sketchy knowledge of

postnatal depression, and that she received good therapy from her psychiatrist, who was extremely insightful and supportive. She commented that "just by thinking about what she (the psychiatrist) suggested" any problem she was dwelling on would be solved (Annie, p. 16, L 329). After she had completed the main part of her therapy, Annie had a sense of overwhelming hope that "dry ground", the healed reality and a new, more positive life in motherhood, was in sight. Her words reminded me of this poem by the German author, Rainer Maria Rilke:

> **A walk**
> My eyes already touch the sunny hill,
> Going far ahead of the road I have begun
> So we are grasped by what we cannot grasp;
> It has inner light, even from a distance –
>
> And charges us, even if we do not reach it
> Into something else, which, hardly sensing it
> We already are; a gesture waves us on,
> Answering our own wave –
> But what we feel is the wind in our faces.
> (Rilke, (1902) translated by Robert Bly)

The wind in the women's faces would be the wind of hope, the sun the light of new horizons, and the walk a move towards healed reality. Getting help is about changing one's circumstances for the better, incorporating the new child and family into the picture, and moving on past postnatal depression into personal and spiritual growth and a much greater understanding of oneself and of life.

Summary

This chapter described the interpretation of interviews of the twelve women, and presented the sub themes and themes. The search for meaning and my attempts to make sense of the findings resulted in the development of two major themes, that of Dual Reality and Interventions, and six major sub-themes. Within the theme of Dual

reality sits the sub themes of Behind the Mask, Stresses involved in Being a New Mother, The Depression Experience and within the theme of Interventions sits the sub themes of Getting Help (the Helpful Interventions), Lack of Support, (Unhelpful Interventions), the Need for Education and More Services for Postnatal Depression. The helpful and unhelpful health professional interventions were grouped together and if they were positive they either helped the women to heal, and if they were unhelpful, these interventions did not assist their recovery.

In the next chapter, Discussion, the ramifications of these themes will be discussed and suggestions will be created from the data with the intention of informing health professional interventions for women with PND.

Recommendations and Conclusion

Introduction

In the art of the Impressionist painter, brush strokes are composed individually, and then they blur together. Intense concentration happens as each stroke, each definition of outline, form, light and shade are drawn together. Then, one looks at the painting as a whole and it appears blurred, close up. As one steps back, to about five feet from the painting, a picture emerges, like a photograph, but the lines are softer. An overall impression of the place, and its atmosphere, is formed. Blurred lines are formed into a larger picture of the whole, reflecting an atmosphere, and an Impression, of the phenomena painted. In this thesis I have tried to paint a picture of the lived experiences of women who had experienced mild to serious postnatal depression, and their experiences with health professionals and helpful and unhelpful interventions. The picture is painted now, and so, this chapter, Recommendations and Conclusion, looks at the whole image and answers the "so what" question – that which sits behind all research – how do we use this information to improve practice, and outcomes for women suffering from PND?

As the interpretation of the data was taking place, I also developed the impression that the women's stories were like parts in a play which unfolded, a drama with the masking and unmasking, bright daylight moments and dark secrets and the interventions of health professionals and others affected the ending to the story, the way the plot unfolded, the climax, the penultimate section of the play, and the denouement.

My aim for this research originally was that nurses and other health professionals would have their awareness raised on the issues of postnatal depression and effective and ineffective help as experienced and articulated by the women concerned. My hope was that this raised awareness would then inform clinical practice. I chose Hermeneutic Phenomenology as my underpinning methodology, believing this to be a worthwhile approach to shed light on aspects of the lived experiences of twelve women who experienced postnatal depression and health professional intervention (van Manen 1990). I believe that studying something in miniature and in depth using hermeneutic phenomenology can give a "snapshot" of the whole, in the way that a leaf can be similar to a branch and a branch similar to a tree, and a tree similar to a forest. This idea as discussed in chapter three, Methodology.

Overview of my research process

The portrait that developed from my study depicted the lived experience of twelve women who had suffered from postnatal depression and received health professional intervention. I formulated these research questions: "What was the women's experience of postnatal depression? And, in particular, what was their experience of intervention from health professionals? What interventions did they find helpful, and which were unhelpful?" Consequently, as I held the interviews, I asked the participants, "What are the types and quality of health professional interventions provided for you by health professionals treating your postnatal depression? Which interventions did they use that were helpful, and which interventions were unhelpful? Data were then collected from twelve open-ended interviews, the procedure guided by van Manen (1990) and then the data was analysed. The two themes, which emerged

from data analysis, Dual Reality and Interventions, were then interpreted in a hermeneutic phenomenological way.

Discussion: Major findings and their significance to clinical practice

I shall revisit some of the ideas discussed in the literature review and compare them to the findings of this study. My understanding from doing this study is that there is still much to be done in this area, particularly in the areas of early diagnosis and timely and appropriate interventions, which need to be appropriately funded and easily accessible. The figures in the painting, the participants, were individual studies, done with attention to detail, and then the impression which was left showed me the gaps in practice, the need for further research, and the areas in treating PND which needed more attention in terms of resources.

Prevention of PND

The program director of the Beyond Blue National Postnatal Depression Program, Professor Anne Buist, did say that if women with PND go undetected then have a second child, the PND condition deteriorates. She also thought that early interventions for PND would limit the harmful effects on the mother and aids the mother/child relationship and the family in general (Harvie, 2003, p 2). This is borne out by the women's stories: they stressed the need for early intervention and for antenatal programs, and even antenatal classes, which taught about PND. Furthermore, the women also agreed with these words, stated by Michelle Fletcher, the chair of Beyond BabyBlues,

> PND firstly needs to be de-stigmatized. Because it is put in the "mental health basket" there are a lot of stigmas still attached to women feeling they are failing as mothers if they have PND. Women have to learn to be honest and admit they are not coping. Doctors also

need to be saying, "The baby is fine but how are you? (Fletcher, cited by Harvie, 2003, pg 2).

The association of PaNDa (www.panda.org.au) was created in Victoria to provide information and counselling for women suffering from PND. Such an organisation was desired by the women, who intensely wanted information at their fingertips, and counseling support for PND.

Risk factors for PND

Risk factors for PND were documented in the health professional literature and included a prior history of clinical depression (Unterman, Posner & Williams, 1990) a difficult birth and obstetric complications (Cooper & Murray, 1995); and difficulties in the partner-relationship (Watson, 1984). Depression during pregnancy is linked with postnatal depression and the literature notes that women with a poor marital relationship are particularly vulnerable to the development of PND (Zeikowitz & Milet, 1996, Chan, Levy & Chung, 2002). The women's stories corroborate these findings; in particular, Kathy's story refers to the stress of antenatal depression and the loneliness with her partner travelling exacerbating her PND. Christine also believed that her marriage was not strong enough to navigate the life changes of a birth without counselling, support, guidance and help. Olivia in particular suffered because her husband stuck to his routine rather rigidly and left her to cope on her own, struggling to be the so-called "expert" on the baby.

A perceived lack of social or emotional support, especially from a partner or parents has already been noted as placing a woman at risk for PND (Chan, Levy & Chung, 2002, Harvie, 2004). Christine's story, in particular, bears witness to this. So does

Kathy's story, again; she longed to have her parents close by, rather than living interstate, and her in-laws were critical and upset her greatly. Lack of a confidante, and living in a share-house with people other than a partner has been cited as a risk factor (Paykel, Emms & Fletcher, 1980) and so is a family history of mood/psychiatric disorder (Mrazek & Haggerty, 1994) Christine's and Gabriela's stories testify to this, as does Kathy's. A build up of life stressors also places women at risk, along with health problems or behaviour problems in the infant. Jane tells a profound story of the stress of an unsettled infant, and a build up of life-stresses leading to the development of PND.

Women's negative birth experiences, including the absence of a desired support person and the perceived unhelpfulness of delivery staff have been linked to PND (Brown & Lumley, 1994). Christine, Jane, and Kathy spoke about this at length, and Olivia spoke of staff pressuring her to breastfeed when it was difficult for her and that this was one of the factors, which dented her self-esteem and made her transition to new motherhood much more difficult. The climax in several of these women's stories was hurried towards its conclusion with these negative birth experiences as the women found them especially painful. Birth is a time of such vulnerability; the women took every mismanaged moment and insensitive comment very much to heart. Often they did not show this to staff at the time, but revealed their feelings to me, in the interview. Elle's story was very much like this: hurtful comments from her obstetrician meant that one of her birthing experiences became a feat of endurance, and she was grateful to have a different doctor attend subsequent births.

Hormonal changes have also been cited as a risk factor for PND (Sichel, Cohen & Robertson, 1995), even though the literature is equivocal about this. However Tracey, Gabriela and Kathy all spoke of hormonal difficulties and changes being an issue for them relating to their PND. Other possible risk factors for postnatal depression in the literature included a poor relationship with a woman's own parents (O'Hara, Rehm & Campbell, 1993), (this was born out by Christine's story) a recent bereavement or grief for a previous loss such as a miscarriage (Cox, Connor & Kendal, 1982), (this was borne out by Kate's story and Elle's story) childhood sexual abuse (Buist & Barnett, 1995) (this was born out by Sophie's story) physical illness (Mrazek & Haggerty, 1994) (this was borne out by Tracey's story), and controlling and powerful in-laws (Chan, Levy & Chung, 2002) (evidenced in Kathy's story). In contrast, protective factors in the literature were found to include a good marital relationship, the availability of good support systems, optimism and self-esteem in the mother, and proper preparation for the physical and psychosocial changes of parenting. The women all made comments which bore this out; Danielle in particular spoke of wishing for good parenting groups which discussed the reality of parenting and helped one navigate the life changes with understanding and companionship.

Fathers and PND

The literature has also noted that PND can affect fathers with 10 percent of partners of women with PND also suffering depressive symptoms (Harvie, 2003). Christine spoke of stress and even possible depression in her husband, and Elle expressed sympathy for her poor husband and what he had to live through with her illness. Danielle, Tracey, and Gabriela also mentioned how difficult her PND and the life stresses they survived had been for her partner. It is also apparent from the literature

that depression in the partner can aggravate a woman's own depression, as a depressed partner gives less support (Campbell, Cohn & Flanagan, 1992). This was seen in Elle, Christine, Kathy, and Olivia's stories. Elle in particular made comments which agreed with the idea that if more attention could be paid antenatally to their anxieties, men, their partners and infants could all benefit (Buist, Morse & Durkin, 2003).

Detection of PND

Research in the area of PND has focused primarily on health professional screening methods of detection of depression and PND, and health professional treatments for women with PND. There are a number of standardised measurements used in the detection of postnatal depression, such as the Edinburgh Postnatal Depression Scale (EPDS) (Holden, Cox & Sagovsky, 1987), designed to screen large numbers of women for PND. According to Holden (1994) the EPDS is a reliable reflection of women's mood, and a useful indicator of those who may be suffering from depression. The EPDS has been validated in a range of countries such as: the UK (Holden, Cox & Sagovsky, 1987) Australia (Boyce, Stubbs & Todd, 1993) Sweden (Lundh & Gyllang, 1993), and New Zealand (Holt, 1995). Routine screening of postnatal women with such an instrument can help overcome the overlap of depressive symptoms, stressful perinatal events, and difficulty in recognising or accepting the presence of PND, and the women, particularly Annie and Elle, made comments which concurred with this thinking. The literature also shows some evidence that health professionals only recognise about half the cases of PND which present in their setting (Briscoe, 1986) and that the EPDS could certainly help with this. Kate told me that when she spoke to a GP and a counsellor about her feelings of

depression, and overwhelm she felt completely misunderstood. Annie believed that had she done the EPDS test earlier, soon after her daughter's birth, she might have been diagnosed and treated much sooner. Furthermore, according to Beck (2002) the most significant factor in the duration of postnatal depression is the length of the delay to appropriate treatment. The women stressed this repeatedly, with some of them waiting nearly a year or more after the birth of their child before being properly diagnosed with Postnatal Depression. Diagnosis is the first step to treatment, so a delay like this can have tragic consequences.

Treatment of PND

Published research on treatment options or diagnostic resources for women with PND falls into four basic categories, pharmacological treatments, biological treatments, psychosocial interventions and combinations of pharmacological interventions and psychosocial interventions. Psychotropic medication may be administered by a medically qualified health professional, frequently as an adjunct to some form of counselling, but not always. Elle believed that taking Zoloft was a huge help to her in conquering her depression, because this tablet alleviated the physical symptoms of exhaustion that accompanied depression. Danielle found Ciprimil an effective adjunct to counselling for PND, and Kathy found that taking the Zoloft her GP prescribed was the only way she could stabilise her moods after she had been diagnosed with Premenstrual Dysphoric Disorder (PMDD). In the literature, biological interventions for PND focus primarily on the theory that postnatal depression is a physical illness with a biological cause (i.e. changes in hormone or neurotransmitter levels) and is linked to specific physiological events that occur with childbirth. Some claims exist that such physical causes for PND should be able to be located (Harris, 1996).

However, George and Sandler (1988) did argue that the results of endocrine research in puerperal mental illness are not very encouraging and it seems the direct aetiology of symptoms in the postnatal period is unclear (Wisner & Stowe, 1997). However from the women's stories, it appears that biological processes and sudden hormonal changes may have been instrumental in their PND. Gabriela told me that her bipolar disorder had a hormonal link; her mood swings being intimately connected with her menstrual cycle. Tracey spoke of hormonal difficulties being a family problem and how her sister, who also had a difficult menstrual cycle, developed PND as she had. Their mother had also suffered from PND and menstrual and hormonal difficulties. Whilst this information in no way proves the association, it does alert one to the possibility of a link.

The literature described a study on debriefing postnatal women (Allen 1999). Herein over 50% of women had talked to health professionals about their experiences. The results highlighted the need for health professionals to safeguard the psychological well being of childbearing women, and suggest that offering postnatal women the opportunity to talk about their experiences was a key element of sound midwifery and health visiting clinical practice. Christine in particular complained that she had endured a very difficult birth and she wished the midwifery staff at the hospital would come to her bedside and de-brief her on the experience.

In **_Birth_** magazine, the authors discussed the concept of women feeling in control during labour. In this paper, Green (2003) discussed the idea that a sense of personal control during labour was a major contributing factor to how a woman perceives her birth experience and to her subsequent sense of well being in the postnatal period.

This notion was supported by Jane, Christine, Elle, and Kathy who shared compelling stories about feeling out of control of the birth experience and ignored or misunderstood by staff, and this had left them feeling traumatised. Birth is traumatic anyway, even a straightforward, relatively easy delivery; so it takes a special sensitivity on behalf of delivery staff to help the woman make this transition especially if it is a first baby. Here is where debriefing as a practice can help a woman to process the birth events and heal from them in her own mind. Caregivers, particularly midwives and obstetricians, do indeed have the potential to make a significant difference to a woman's experience of childbirth, sense of satisfaction and emotional well-being.

Evidence exists in health professional literature that professional and/or social support can help women in the treatment of postnatal depression (Ray & Hodnett, 1997). Bishop (1999) related that medical intervention and support and other appropriate help from supportive peers and family was effective in her recovery from PND. Her experience was that PND was a treatable illness and that effective help given at the right time led to a positive outcome. In this study the women shared stories, which concurred with this idea; Jane spoke of enormous practical and emotional support from her husband, sister-in-law and a neighbour; this was a lifesaver. Gabriela spoke of effective, positive help from a new mother's group, and positive help from her psychiatrist. Annie spoke of effective help both from social supports, such as her husband and mother, to health professional supports, such as her psychiatrist and the staff at her hospital. Tracey, Kathy, Sophie, Leanne, and Christine had similar comments to make. Danielle found that community support groups and a teaching hospital for new mothers with unsettled babies were especially helpful towards her.

The health professional literature supports the womens' views when it stated that information given by health professionals in the postnatal period could be a significant postnatal depression support. Hey and Feu (2003) examined the effectiveness of informational support in reducing the severity of postnatal depression in Taiwan, and they found that Taiwanese women who received informational support about postnatal depression six weeks after giving birth experienced lower EPDS scores at three months postpartum than those who did not receive this information. Tracey in particular found pamphlets on PND useful to read, especially once she had been diagnosed with the condition. Danielle found that pamphlets helped her to gain that all-important first step of a diagnosis. Elle remarked that informational support was a positive intervention for PND and argued that it could be taken a step further, such as on television or in the electronic media. She complained also that television depictions of women with PND tended only to show really extreme cases, such when a woman was suicidal or homicidal to her infant. Instead, she wanted to see more moderate cases of PND depicted on television and in the media, which while being less dramatic and sensationalised as the frequently shown scenarios, would provide an experience many more women could relate to.

Several treatment options are documented in the literature for postnatal depression, in the counselling area and they include one-to-one counselling, cognitive-behavioural therapy, psychotherapy, group treatment, Gestalt therapy, support strategies, and couples counselling if the partner-relationship is distressed. According to the twelve women who shared their experiences with me counselling and support groups could be useful for women with difficulties adjusting to the new parenting role, but severe

depression really needed a combination of antidepressant medication and psychotherapy, and possibly even hospital treatment with round the clock treatment by sympathetic medical and nursing staff.

Day hospital services have also been developed; and have been found to be useful, such as that run by a postnatal depression ward (www.wch.sa.gov.au/dmh/helenmayo.html, viewed May 6, 2004). Danielle attended such an outreach/day service for women with PND and found it to be a positive and supportive experience. However, she had one salutary point to make regarding effective healthcare for PND women. She remarked that care for postnatal depression was "only as good as the nurse you get" and whilst some of the nurses who had treated her, had been "absolutely fantastic" she knew of women who had been treated by "absolutely shocking nurses". Her further comment was that "no matter what doctor or midwife or nurse you get, it is only as helpful as the individual concerned" (Danielle, p 21 – 26, L: 1034 – 1251). The link between nursing practice and nursing research is powerful as patient treatment, advice, education, counselling and emotional support, are all incorporated into the role of the nurse and this is worth remembering.

Many different models for psychotherapy exist in the literature, from Gestalt Therapy to Cognitive-behavioural therapy. Normally these are conducted by specifically trained mental health professionals such as psychologists, or psychiatrists. Couple counselling and therapy and group treatment is also a useful adjunct to individual therapy; self-help groups; support and treatment groups have been cited as useful by the literature (NHMRC, 2000) and the women participants in this project.

Such groups are available, but the women, such as Elle, Christine, and Leanne, wanted them to be more numerous and more readily accessible, with shorter waiting lists. Support groups are usually conducted by health professionals (even though Leanne wanted one specifically conducted by a non-professional group of mothers) and this was a positive thing according to most of the women interviewed. Gabriela asked for a variety of groups to help postnatal women, from groups on the reality of parenting to groups specifically for women with PND, and for women having their second or subsequent child.

Answering the "So What?" Question …

The twelve women in this study had much to say about health professional interventions for PND such as parenting groups, support groups, and supportive individuals such as counsellors. The "so what?" question for health professional practice is answered by the fact that the women wanted more of everything the health professionals had written about and discussed as helpful for PND. They wanted de-stigmatisation of PND in the community, more support groups, more education antenatally and postnatally about PND and the reality of parenting and birth. They found it useful when these resources were available and they suffered when it was not available, or there were long waiting lists and a struggle to access these resources. Elle, in the country, found all kinds of PND resources were available but they were not easy to source and many involved a long drive to a city area.

Also, the "mask" that women don to hide their PND from themselves and the world during the painful and somewhat unreal experience of Dual Reality is significant for

health professionals. They need to be aware of the intensity of the mask and the need for urgent de-stigmatisation of PND so that women are less likely to become more trapped by a mask, and are more likely to seek out a health professional or tell them that they are suffering from depression.

Health professionals also need to be aware that if they have an instinct, a hunch, or an intuition that women are suffering and not admitting PND to themselves or others, they must keep gently inquiring. An instrument such as the EPDS for diagnosis can be a useful and necessary tool at times like this. Annie's story refers to this directly. Midwives have also been cited in the literature as being in a unique position to be involved in the prevention and even treatment of postnatal depression. Gibson (2001) pointed out that midwives could possibly help women avoid developing postnatal depression by dismantling the myths and taboos affecting new mothers. Bott (2001) also made the point that midwives could indeed make a difference to the mental health of these women by deepening their awareness of PND and that this would place them in a better position to provide individualised women-centred care. The women all made comments to me supporting these ideas, especially given the intimate care that midwives give women just before birth, during the birth, and in the hospital immediately afterward. Comments midwives made at such a time stayed with the women for years afterwards, and stories related by the women support this.

Also the literature has noted that midwives have an important role to play in postnatal depression screening due to their proximity to the women, (Bott, 2001) and Annie remarked to me that a questionnaire such as the EPDS handed out by a midwife or a maternity and child health nurse would have led to an earlier diagnosis of PND in her

case. However, one would need to consider the cost of this in terms of a "strike rate" in diagnosing members of the community. For example, what would it cost to organise the questionnaire? And would the number of diagnoses made make such a move worth it?

It is worth reminding health professionals of the emotional fragility of people with depression and women with PND in particular. Two women stressed this concept when interviewed. Danielle told me, "because we have got the PND, we're more sensitive" to "what health professionals say, and how they say it" (Danielle, p 21, L 1046). Sophie related that in hospital the nurses encouraged her to talk about her feelings, but she felt uncomfortable doing so due to a fear of being "judged" (Sophie, p. 2, L: 38).

So in response to the "So What?" question, my reply is that these findings show health professionals do mostly know how to look after women with PND. It is just that we need MORE…more counselling for PND women, more parenting groups, more PND-specific therapy groups, and so on. Plus these findings also show that the mask, as discussed in Chapter Seven is frequently worn by the women and can slow diagnosis of PND, which is the first step towards healing treatment. The mask is worn because of cultural ideologies, media-created dogma concerning the need to appear perfect in the role of mother, and the cultural stigma attached to having postnatal depression or any kind of "mental illness" in our society. Wearing the mask is also a symptom of postnatal depression; the women concerned are anxious, have low self esteem, and want to make a "good impression" on others, especially their peers and health professionals. Sensitive and aware health professionals whose intuition tells

them that something is askew with a new mother who otherwise "presents well" need to ask careful questions to see if they are being confronted with a "mask." This is one of the key findings of my research. Health professionals also need not to be afraid to screen women for PND and to remind clients that PND is not a shameful condition and that help is available for it.

Recommendations for practice

A number of recommendations are evident from the findings of this research. Some of these were articulated by the women who participated in this study and some come from my interpretation of the findings.

1. To increase the services available to women diagnosed with PND – whether these be counselling sessions, support groups, or information freely available in pamphlets or on the Internet.

2. Websites, which discuss PND, and depression on the Internet such as www.Beyondblue.com.au, should have wider publicity in such places as public libraries, newspapers, and on public transport so that women can know they exist and seek them out.

3. It would be worth conducting a community education programme, to try and de-stigmatise PND as a condition, therefore reducing the need for women to wear a "mask" to hide their PND. Such an education programme would need wide coverage, including on the television and in women's popular magazines.

4. Motherhood should be more realistically portrayed in the media, especially in advertising and in magazines.

5. Ante-natal Classes should contain teaching and information sessions on the reality of parenting and the possibility, signs and symptoms of PND.

6. A realistic portrayal of parenthood and possible stresses of it should be taught in schools, together with information given on PND to young people who are likely to be parents within the next decade or so.

7. Health professionals teach in antenatal classes and in postnatal health visiting that the style of birth and feeding an infant are relatively unimportant; the health of an infant and mother is paramount. Consequently those women who undergo Caesarean Sections and bottle-feed their babies because breastfeeding has proved too difficult need not feel like "failures".

8. Debriefing the birth experience by midwives or other counselling staff (even especially trained volunteers) would be useful to offer women in hospital.

9. Universal screening of all women in the perinatal period with an instrument such as the EPDS would a useful manoeuvre to discover early cases of PND. Beyondblue, the postnatal depression initiative, led by Professor John Congdon in South Australia is currently running a large-scale screening program antenatally and two weeks post-natally using the EPDS for postnatal depression in women in the Women's and Children's Hospital, and at Flinders Medical Centre.

How does one move from recommendations to action?

All too often the findings from nursing research lie on the shelf of the student/supervisor/library and little more is done to disseminate the findings or for that matter push for the recommendations to be acted on. One way of moving from recommendation to action is through one's spheres of influence. By this I mean how can I use my research findings to improve practice and therefore better patient outcomes? Who or what are in my spheres of influence and what actions will I take? Examples of persons and organisations who treat women with postnatal depression within my spheres of influence and how I shall approach them are described below. I shall describe these spheres of influence as local, national, and international spheres of influence.

Spheres of Influence - Local

I plan to approach those organisations whose remit it is to care for new mothers with young children, such as Child and Youth Health, and share my findings with them and let them know I am available to run health professional in-service training for their staff in the area of PND. I plan also to approach organisations which care for women with PND specifically, such as a mother and baby psychiatric mental health unit specifically designed to treat women with PND. Each organisation will be offered a copy of the thesis or an executive summary and I will explain that I am available for in-service teaching for health professionals in this area, to counsel women with postnatal depression, and to run Postnatal Depression Support Groups for women. I would therefore use my training as a counsellor and experience in group work, as well as my knowledge of the condition of PND to help others. I have recently met with

Professor John Congdon, from BeyondBlue, the National Depression Initiative, who is doing detailed work on postnatal depression in Australia, particularly through the internet. I described to him my findings, knowledge, expertise and availability for teaching, therapy and group work. His response was that of great interest in my findings, which correlated with some thoughts of his own. He requested an executive summary of the thesis and findings, which I will email to him. I also plan to bring my findings to Midwives' Groups through organisations such as major tertiary maternity hospitals located locally.

National Spheres of Influence

An approach will be made to the Department of Health and Hospital Services, a government Department responsible for the development of policy for health, including Mental Health. The objective is to discuss my findings with them and offer them a copy of the thesis or executive summary, the intent being to raise their awareness of the treatment needs of women with postnatal depression from the perspective of the women themselves. Also, I will attend relevant Australian conferences to present my study and findings.

International Spheres of Influence

I will be submitting papers from my thesis to international peer-reviewed nursing journals and attending international conferences such as the Third Pan-Pacific Nurses Conference in Hong Kong, and I will present my findings and recommendations to a scientific audience of nursing and academic peers.

Limitations of the study

This study was about understanding the lived experience of twelve women, and this number of participants may be considered by some as a small sample. However hermeneutic phenomenology is a way to observe the richness and complexity of experience and to provide this knowledge in depth and more women may not have provided any additional information. It became clear during the study that fewer participants would be too small a number, and more, too large, due to the sheer volume of material uncovered in the research process.

The culture of these women is that of Anglo-Celtic Australian women living at the end of the 20th and Early 21st century. I was not able to interview women from other cultures, therefore this study contains a cultural and time-specific "snapshot" and experiences of other women in other times, other cultures and other countries have not been specifically included here and yet would be enormously important in broadening our understanding of the issues for women suffering from PND.

When obtaining approval from the ethics committee for this research, the possible limitations of the study were considered; some of these ideas shared with the ethics committee are discussed in the two paragraphs below.

Phenomenology is an approach that is poetical; by using right-brain, intuitive processes as well as linear thinking processes it helps the researcher uncover the essence of an experience in a new way. It is a relatively new approach to scientific research which is evolving at a steady rate and is subject therefore to limitations and amateur attempts. One issue raised in the literature as being of concern is that many

nursing researchers lack the "philosophical understanding" of phenomenology (Ray, 1994). This clouds the credibility of research in a new discipline, and I attempted to resolve this problem with a thorough grounding of knowledge in this area of phenomenology. Chapter three, Methodology and chapter four, Method, discussed my approach to this in detail.

Recommendations for further investigation

Although the sample size in this project was small, my findings were detailed and these findings could be illuminated further by research into how to remove the socio-cultural stigma attached to a diagnosis of PND. Research into how to bring more education and support groups to the women at risk of PND, and research into increasing government funding and putting more of these supports in place would be most worthwhile for all new parents, particularly new mothers at risk of PND. However, some of these ideas suggested above may have more to do with how one uses the spheres of influence of those we know than the necessity for further research.

Conclusion

This study examined the experience of twelve women who have recently lived through postnatal depression and health professional interventions. It looked at the womens' remembered experiences and how they perceived those health professional interventions. I found two major themes, Dual Reality, which was the experience of women living with postnatal depression, and hiding it from themselves and others, and Interventions, which was in essence, how other people, especially health professionals, responded to them. In conversation with the women I discovered that in order to help people recover from PND, this condition first needs to be de-stigmatised

in the community so that women no longer need to feel they must hide their real feelings "behind a mask", but that they can ask for help without shame when they need to.

Early diagnosis is vital to prevent ongoing emotional trauma from PND and so is funding from governments so that health professional supports may be set into place. Supports such as new mothers groups and PND support groups run by health professionals are, in the third millennium, now necessary for women due to the breakdown of traditional family and cultural supports for motherhood. It is also vital to remember that caring for the new mother means that there is a flow of care to the infant, her other children, her partner, and ultimately, to the society as a whole and future generations. The resulting picture of a young woman's life can therefore be bright and attractive, reminiscent of a park on a sunny day, or grey and blurred, like a winter storm. And left untreated, PND can affect a number of generations well into the future. This is a spiralling picture of sadness, which must be avoided, if possible, with helpful interventions and early diagnosis for a woman with PND.

References

Allen, H. (1999) How was it for you? Debriefing for postnatal women: does it help? *Professional Care of Mother and Child*

Allen, Sarah (1998). A qualitative analysis of the process, mediating variables and impact of traumatic childbirth. *Journal of Reproductive and Infant Psychology*, vol 16 (2-3): 107-131

Allen, Sarah (1998). A qualitative analysis of the process, mediating variables and impact of traumatic childbirth. *Journal of Reproductive and Infant Psychology*, vol 16 (2-3): 107-131

Affleck G, Tennen H, Rowe J (1991). *Infants in Crisis: How parents cope with newborn intensive care and its aftermath*". New York, Springer -Verlag

Affonso, D.D, Lovett, S, Paul, S.M (1990) a standardised interview that differentiates pregnancy and postpartum symptoms from perinatal clinical depression. *Birth* 17: 121-130.

Affonso D, Lovett, S, Paul S (1991). Predictors of depression symptoms during pregnancy and postpartum. *Journal of Psychosomatic Obstetrics and Gynaecology supplementary* 12: 255-271

Affonso D.D, Lovett, S, Paul S (1992) Dysphoric Distress in childbearing Women *Journal of Perinatology,* 12: 235 -332

Annells, M (1996) Hermeneutic Phenomenology: philosophical perspectives and current use in nursing research. *Journal of Advanced Nursing* 1996 April 23 (4) 705 – 13

Appleby, L, Fox H, Shaw M, (1989). "The Psychiatrist in the Obstetric Unit: establishing a liaison service. *British Journal of Psychiatry*, 154: 510-515.

Appleby, L Warner R, Whitton, A (1997) A controlled study of fluoxetine and cognitive-behavioural counselling in the treatment of postnatal depression. *British Medical Journal*, 314: 932-936.

Appleby L, Mortensen P.B, Faragher E.B (1998). Suicide and other causes of mortality after postpartum psychiatric admission. *British Journal of Psychiatry* 1998; vol 173, pp 209-211.

Areias, M.E.G, Kumar, R, Barros H (1996a) Comparative incidence of depression in women and men, during pregnancy and after childbirth. Validation of the Edinburgh postnatal depression scale in Portuguese mothers. *British Journal of Psychiatry,* 169: 30-35.

Areias, M.E.G, Kumar, R, Barros, H (1996b) Correlates of postnatal depression in mothers and fathers. *British Journal of Psychiatry,* 169: 36-41.

American Psychiatric Association (1994) *Diagnostic and Statistical Manual of Mental Disorders*, Washington, American Psychiatric Association

Ballard, CG, Davis, R, Cullen P.C et al (1994) Prevalence of postnatal psychiatric morbidity in mothers and fathers. *British Journal of Psychiatry* 164: 782-788.

Ballard, C.G, Stanley, A.K, Brockington, I.F. (1995) Post-traumatic stress disorder (PTSD) after childbirth. *British Journal of Psychiatry*, 166: 525-528.

Ballard, C & Davies, R (1996) Postnatal Depression in Fathers. *International Review of Psychiatry*, 8: 65-71.

Ballard C.G; Stanley, A.K; Brockington, I.F. (1995) Post-traumatic Stress Disorder (PTSD) after childbirth. *British Journal of Psychiatry* 1995; 525-528

Baker, C., Wuest J, & Stern P.N. (1992) Method slurring; the grounded theory/phenomenology example. *Journal of Advanced Nursing* 17, 1355-1360

Balk, (1990, November). I couldn't cope with motherhood, *Working Mother*, pp 38-43.

Barnett, Dr B. (1991) Coping With Postnatal Depression. Melbourne, Australia, Lothian.

Barnett, B & Fowler, C (1995) *Caring for the family's future* N.S.W. Norman Swan Medical Communications

Barnett, B.E.W, Matthey, S & Boyce, P (1999) Migration and motherhood: a response to Barklay and Kent (1998) Recent Immigration and the misery of motherhood; a discussion of pertinent issues. *Midwifery* 14: 4-9

Bebbington, P (1987). Misery and beyond: The pursuit of disease theories of depression. *The International Journal of Social Psychiatry* 33: 13-20

Bebbington, P.E., Dean, C, Der G. (1991) Gender, parity and the prevalence of minor affective disorder" British Journal of Psychiatry 158: 40-45

Beanland C., Schneider, & Zevia (1999) Nursing Research (IST Edition) Mosby Publishers Australia.Ltd. Sydney

Beck, CT (1992) The lived experience of postpartum depression: a phenomenological study *Nursing Research* 1992; 41: 166 -170

Beck, C.T. (1994a) Reliability and validity issues in phenomenological research. *Western Journal of Nursing research.* 16 (3) 254 -267

Beck, CT (1994) Phenomenology: its use in nursing research *International Journal of nursing studies*, 1994 Dec 31 (6) 499-510

Beck, CT (1995) Screening methods for postpartum depression. *Journal of Obstetric-Gynaecologic and neonatal nursing.* May 1995 24 (4) 308 – 12

Beck, C (1995a) "The effects of postpartum depression on maternal-infant interaction: a meta-analysis. *Nursing Research* 44: 298-304

Beck, C.T; Gable, R.K. (2000) Postpartum Depression Screening Scale: development and psychometric testing. *Nursing Research* 2000 Sep-Oct; 49(5): 272-82

Beck, C.T. (2001) Predictors of Postnatal Depression, an Update. *Nursing Research* 2001 Vol 50 (5) pp 275 – 285

Bedford A & Foulds, G (1978). *Delusions-symptoms-states inventory, state of anxiety and depression manual*. Windsor, National Foundation for Education Research

Benn, C; Budge, R.C; White, G.E (1999) Women planning and experiencing pregnancy and childbirth: information needs and sources. *Nursing Praxis in New Zealand* Nov; 14(3): 4-15

Benner, P. (1994) *Interpretive Phenomenology: Embodiment, Caring and Ethics in Health and Illness.* Thousand Oaks, Sage.

Benner, P (1984) *From Novice to Expert. Excellence and power in clinical nursing practice*. Addison Wesley, Menlo Park, California.

Bernazzani, O, Saucier, J.F, & David, H. (1997) Psychosocial predictors of depressive symptomatology level in postpartum women. *Journal of affective disorders* 46: 39-49.

Bewley, C. (1999) Post-natal depression. *Nursing Standard* 13(16): 29-54.

Beyondblue: www.beyondblue.org.au/postnataldepression beyond babyblues is the education/advocacy/support group of blueVoices (viewed October 2004)

Boath, E.H., Pryce, A. J., Cox, J.L., (1998). Postnatal Depression: The Impact on the Family. England. *Journal of Reproductive and Infant Psychology*. May, 1998, Vol 16 (2-3): 199-203.

 Bott, J (2001) Postnatal depression: can midwives help?
British Journal of Midwifery 2001 Dec; 9(12): 758-62

Boyce, P, Stubbs, J, Todd, A (1993). The Edinburgh postnatal depression scale: Validation for an Australian sample. *Australian and New Zealand Journal of Psychiatry* 27: 472 - 476.

Briscoe, L; Lavender, T; Alfirevic, Z. Professional issues. Supporting women after obstetrics complications (2002) *British Journal of Midwifery* 2002 Oct; 10(10): 620-3,

Brugha, T.S, Sharp, H.M, & Cooper, S.A. (1998). The Leicester 500 Project Social Support and the development of postnatal depressive symptoms, a prospective cohort survey. *Psychological Medicine* 28: 63-79

Buckley, J (2003) Midwifery and mental health: it's never too early: pregnancy and birth define future mental health. *Midwifery Digest* 2003 Jun; 13(2): 165-9

Buist, A., Understanding Postpartum Psychiatric Disorders (1998) *Current Therapies* pp 37 – 41

Buist A. Childhood abuse, parenting and postpartum depression. *Australian and New Zealand Journal of Psychiatry* 1998; vol 32, no 4, pp 479-487.

Burns, N & Grove, S.K (2001) *The practice of nursing research: Conduct critique and utilization* (4th edition) W.B.Saunders Co., Philadelphia

Campbell, S.B, Cohn, JF, & Flanagan C. (1992) Course and Correlates of postpartum depression during the transition to parenthood. *Development and Psychopathology* 4; 29-47.

Carpienello B, Pariente, C.M, Serri, F (1997) Validation of the Edinburgh postnatal depression scale in Italy. Journal of Psychosomatic *Obstetrics and Gynaecology supplementary* 18: 280-5.

Carro, M.G., Grant K.E, & Gotlib, I.H. (1993) Postpartum depression and child development: An investigation of mothers and fathers as sources of risk and resilience. *Development and Psychopathology* 5: 567-579.

Chan, S.W; Levy, V; Chung, T.K.H; Lee-D (2002)
A qualitative study of the experiences of a group of Hong Kong Chinese women diagnosed with postnatal depression *Journal of Advanced Nursing* 2002 Sep; 39(6): 571-9

Coffey, A and Atkinson, P (1996) "Concepts and coding" in *Making Sense of Qualitative Data*, Sage Publications, London, pp 26 -51

Cohen, M. (1987). A historical overview of the phenomenological movement. *Image; Journal of Nursing Scholarship* 19 (1): 31-34

Cohen, M.Z. & Omery A. (1994) Schools of phenomenology: implications for research. *Critical Issues In Qualitative Research Methods* (Morse J. Ed) Sage pp 137 – 156

Colton, C (1988) The Baby's Fine, But how are You? The experience of Postnatal Depression. Sydney. N.S.W. Social Impacts Publications Ltd.

Cooper PJ, Murray L. Postnatal depression (1998) *British Medical Journal* 1998; vol 316, no 7148, pp 1884-1886.

Crotty M (1996) *Phenomenology and nursing research*. Melbourne: Churchill Livingstone, 1996

Cox, J.L (1979) Psychiatric morbidity and pregnancy: a controlled study of 263 semi-rural Ugandan women. *British Journal of Psychiatry*, 134: 401- 405.

Cox Jl., Connor Y, & Kendell R.E. (1982). Prospective study of the psychiatric disorders of childbirth. *British Journal of Psychiatry*, 140: 111-7.

Cox, J.L (1983a) "Clinical and research aspects of Postnatal Depression, *Journal of Psychosomatic Obstetrics and Gynaecology supplementary*, 2: 46-53.

Cox, J.L, Rooney, A & Thomas, P.F (1984). How accurately do mothers recall postnatal depression? Further data from a 3-year follow-up study. *Journal of*

Psychosomatic Obstetrics and Gynaecology supplementary 3; 1850189.

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

Cox, Jl (1989a) Can Postnatal Depression be prevented? *Midwife Health Visitor and Community Nurse* 25; 326-329.

Cox, JL (1989b) Postnatal Depression, a serious and neglected postpartum condition. *Clinical Obstetrics and Gynaecology* 3: 839-855.

Cox, Professor John (1996), Postnatal Depression, Changing Childbirth & Faltering Families, *Marce society lecture* www.cam.net.uk/home/marce.uk/pmd2.htm viewed December, 2001

Craig, E.A. (2003) Mental Illness in Women who have young children, a review of the literature. *Australian- Midwifery* 2003, March, 16 (1) 5- 9

Crompton, J (1996)Posttraumatic Stress Disorder and Childbirth *British Journal of Midwifery* 1996; 4(6): 290-294

Crotty, M. (1996) *Phenomenology and Nursing Research*. Melbourne, Australia, Churchill Livingstone.

Crotty, M (1997) Tradition and Culture in Heidegger's Being and Time, *Nursing Inquiry*
1997; 4: 88-98

Cutcliffe, J.R, & McKenna, H. P (2004) Expert Qualitative Researchers and the Use of Audit Trails. *Journal of Advanced Nursing* 45(2) 126 – 135

Dalton, K. (1971). Prospective study into Puerperal Depression. *British Journal of Psychiatry* 118: 689-692.

Dalton, K (1980). *Depression after childbirth*. Oxford, Oxford University Press.

Davidson, J & Robertson E (1985) "A follow-up study of Postpartum Illness, 1946-1978. *Acta Psychiatrica Scandivica*

Dean, C & Kendall R (1981). "The symptomatology of puerperal illness" *British Journal of Psychiatry*, 139: 128-133.

Deater-Deckard K, Pickering, K, Dunn, J (1998) Family structure and depressive symptoms in men preceding and following the birth of a child. *American Journal of Psychiatry*, 155: 818-823.

Dennerstein, L, Lehert, P, Riphagen, F. (1989) Postpartum depression - risk factors. *Journal of Psychosomatic Obstetrics and Gynaecology* supplementary 10: 53-65.

Depressionet-Symptoms of Depression http:// www.depressionet.com.au/sod.html viewed 17/11/2004

Denzin N, & Lincoln Y (Eds) (1994) *Handbook of Qualitative Research*, Sage Publications, Thousand Oaks.

Descartes, R. (1637) *Discourse on Method* trans J Veitch, 1962. Open Court Publishing Company, La Salle, Illinois.

Dey, Ian (1993) *Qualitative analysis (a user-friendly guide for social scientists*) USA Routledge New York

Dimitrovsky, I, Perez-Hirshberg, M, Itskowitz, R. (1987) Depression during and following pregnancy: Quality of family relationships. *The Journal of Psychology* 121: 213-128.

Dilthey, W (1976) The development of hermeneutics. In Rickman, H Ed and Trans (1976*) Dilthey: selected writings*. Cambridge, Cambridge University Press, 1900.

Dix, Carol (1987). *The New Mother Syndrome. Coping with Post-Natal Stress and Depression.* Allen & Unwin, Sydney Australia.

Draucker, C.B. (1999) The Critique of Heideggerian Hermeneutical nursing research.

Journal of Advanced Nursing Aug; 30 (2): 360-73

Druett, A, Murphy, E & Macarty, V (1993) *Postnatal Depression within Aboriginal Communities*. Sydney N.S.W. Health Department.

Duffy, M.E. (1985) Designing Nursing Research: The Qualitative - Quantative Debate
Journal of Advanced Nursing. 10: 225-232

Elliott, S.A, Rugg, A.J. & Watson, JP. (1983) Mood changes during pregnancy and after the birth of a child. *British Journal of Clinical Psychology*. 22: 295 -308.

Hunter, J (ed) *Modern Poets One* Faber & Faber, London, 1968

Fagerskiold, A; Timpka,T; Ek, A (2003) The view of the child health nurse among mothers. *Scandinavian Journal of Caring Sciences* 2003 Jun; 17(2): 160-8

Fitzgerald, M. (1995) *The Experience of Chronic Illness in Rural Australia*, A thesis submitted for the degree of Doctor Of Philosophy of the University of New England, Armidale, N.S.W, Australia. October 1995.

Fossey, L, Papiernik, E, Bydlowski, M. (1997). "Post-partum blues: a clinical syndrome and   predictor of postnatal depression?" *Journal of Psychom-Obset-Gynaecol* 1997 Mar; 18(1): 17-21.

Frank, E, Kupfer, DJ & Jacob, M. (1987) Pregnancy-related affected episodes among women with recurrent depression. <u>American Journal of Psychiatry</u> 144; 288-293

Friedan, Betty (1962) <u>The Feminine Mystique</u>

Gadamer H (1975) <u>Truth and Method</u> (Barden G, Cumming, J transl) London, Sheed and Ward, 1975

Gamble, J.A; Creedy, D.K; Webster, J; Moyle, W (2002) Review of the literature on debriefing or non-directive counselling to prevent postpartum emotional distress
Midwifery 2002 Mar; 18(1): 72-9

George, AJ & Sandler, M (1988). Endocrine and biochemical studies in puerperal mental disorders, in *Motherhood and Mental Illness 2: Causes and Consequences*
Eds, R Kumar and IF Brockington, London, Wright, 2: 78-112

Ghubash, R, Abou-Saleh, MT, Daradkeh, TK (1997) The validity of the Arabic Edinburgh postnatal depression scale. *Social Psychiatry and Psychiatric Epidemiology* 32: 474-6

Gibson-J (2001) Motherhood: unrealistic expectations?
Practising Midwife 2001 Jan; 4(1): 32-4

Glover, V, Liddle, P, & Taylor, A. (1994) Mild Hypomania (the highs) can be a feature of the first postpartum week -Association with later depression. *British Journal of Psychiatry* 164: 517-521.

Green, Josephine M. & Baston, Helen A. (2003) Feeling in Control During Labor: Concepts, Correlates, and Consequences. *Birth* 30 (4), 235-247.

Gregoire, A (1995). Hormones and Postnatal Depression. *British Journal of Midwifery* 3: 99-105.

Gold, L. H (2002) Postpartum disorders in primary care: diagnosis and treatment
Primary Care: Clinics in Office Practice 2002 Mar; 29(1): 27-41

Gotlib, IH, Whiffen, VE, Mount, JH et al (1989) Prevalence rates and demographic characteristics associated with depression in pregnancy and the postpartum. *Journal of Consulting and Clinical Psychology*. 57:269-274.

Griepsma, J, Marcollo, J, Cherry, F, Vary, E, Walton, V (1994). The incidence of postnatal depression in a rural area and the needs of affected women. *Australian Journal of Advanced Nursing*. 11 :(4): 19-23.

Green, JM & Murray, D (1994) The use of the Edinburgh postnatal depression scale in research to explore the relationship between antenatal and postnatal dysphoria, in

Perinatal psychiatry - use and misuse of the Edinburgh Postnatal Depression Scale, eds J.Cox and J Holden, London, Gaskell: 180-198.

Guba, Egon G & Yvonna S Lincoln. (1994) Competing Paradigms in Qualitative Research) In *Handbook of Qualitative Research*, (Denzin N, Lincoln y, Eds) Thousand Oaks, California, Sage

Hammarback, S, Backstrom, T & Holt, J (1985) Cyclical mood changes in premenstrual tension during sequential oestrogen-progesterone replacement therapy. *Acta Obstectrics and Gynaecology Scandinavica.*64: 393-397.

Hanna, B; Rolls, C (2001) How do early parenting centres support women with an infant who has a sleep problem? *Contemporary Nurse* Dec; 11(2/3): 153-62

Hapgood, CC, Elkind, G.S, Wright, JJ. (1988) Maternity blues: Phenomena and relationship to later postpartum depression. *Australian and New Zealand Journal of Psychiatry*. 22: 299-306.

Harvie, Jeni. "Screening program raises awareness" *Sydney Morning Herald*, Section: Health and Science, p 2 - 3. Date: 11/03/2004 Reference to Bluevoices, the Postnatal Depression Support Group in Beyond Blue: http://www.beyondblue.org.au/index.aspx

Hatfield, A; Robinson, E (2002) The 'debriefing' of clients following the birth of a baby
Practising Midwife 2002 May; 5(5): 14-6

Hearn, G, Iliff, A, & Jones, I. (1998). Postnatal depression in the community. *British Journal of General Practice*. 48: 1064 -6.

Heh, S; Fu, Y (2003) Effectiveness of informational support in reducing the severity of postnatal depression in Taiwan. *Journal of Advanced Nursing* 2003 Apr; 42(1): 30-6

Heidegger, M. (1962) *Being and Time*. Oxford: Blackwell Publishers

Heidegger M (1962) *Being and Time* (Macquarrie J, Robertson E, Transl) New York, Harper and Row.

Heidegger, M (1993) *Basic Writings* (Krell D.F. Ed) Harper, San Francisco.

Hendrick, V, Altshuler, L, & Cohen, L (1998). Evaluation of mental health and depression during pregnancy: position paper. *Psychopharmacology Bulletin* 34: 297-299.

Hoffbrand S, Howard, L, Crawley, H (2001) Antidepressant drug treatment for postnatal depression (Cochrane Review) from *The Cochrane Library*, Issue 2, 2001 Oxford: Update Software.

Holden, J (1996) .The role of health visitors in postnatal depression. *International Review of Psychiatry*, 8: 79- 86.

Holden, JM, Sagovsky, R, Cox, JL, (1989) Counselling in a general practice setting: controlled study of health visitor intervention in treatment of postnatal depression. *British Medical Journal,* 298: 223-226.

Holopainen, D (2002) The experience of seeking help for postnatal depression *Australian Journal of Advanced Nursing* 2002 Mar-May; 19(3): 39-44

Hopkins, J, Campbell, S.B, & Marcus, M (1989). Postnatal depression and postpartum adaptation: overlapping constructs? *Journal of Affective Disorders*, 17: 251-254.

Huang, Y.C & Mathers, N (2001); Postnatal Depression - biological or cultural? A comparative study of postnatal women in the U.K. and Taiwan *Journal of Advanced Nursing*, 33 (3): 279-287

 Huffman, LC, Lamour, M, & Bryan, YE (1990). Depressive symptomatology during pregnancy and the postpartum period; Is the Beck depression inventory applicable? *Journal of Reproductive and Infant Psychology* 64: 74-80.

Huxley, T.H, cited by Munhall, P.L. (1986) Methodological Issues in Nursing Research, Toward a Wax Apple. *Advances in Nursing Science* 8 (3) 1- 5

Jadresic, E, Araya, R, Jara, C (1995). Validation of the Edinburgh postnatal depression scale in Chilean postpartum women. *Journal of Psychosomatic Obstetrics and Gynaecology supplementary*. 16: 187-91.

Jasper (1994) Issues in phenomenology for researchers of nursing. *Journal of Advanced Nursing* 19, 309 -314

Keeves, J (Ed*) Methodology and Measurement: An international Handbook*. New York, Pergamon Press pp 63-69

Kendall, PC, Hollon, SD, & Beck, AT (1987). *Issues and Recommendations regarding use of the Beck Depression Inventory*. Philadelphia, Plenum Publishing Corporation.

Kendall, R.E, Chalmers, J & Platz, C (1987). Epidemiology of puerperal psychoses. *British Journal of Psychiatry* 150; 662-673.

Kennedy, H.P; Beck, C.T; Driscoll, J.W (2002) A light in the fog: caring for women with postpartum depression. *Journal of Midwifery and Women's Health* 2002 Sep-Oct; 47(5): 318-30

Kennerley, H & Gath, D (1989). Maternity Blues: Detection and Measurement by Questionnaire. *British Journal of Psychiatry* 155: 356-362.

Koch, T. (1994). "Establishing rigour in qualitative research: the decision trail." *Journal of Advanced Nursing*, May 1994 19 (5): 976-86.

Koch, T. (1995) "Interpretative approaches in nursing research; the influence of Husserl and Heidegger". *Journal of Advanced Nursing* 1995; 21, 827-836.

Koch, T (1996) "Implementation of a hermeneutic inquiry in nursing: philosophy, rigour and representation". *Journal of Advanced Nursing* 1996; 24, 174-84

Kooperwitz LF (1998) A *critical Approach to the Understanding and Use of Electroconvulsive Therapy and its Practical Application at the Lyell McEwin Health Service*. October 1998 Adelaide. North western Adelaide Mental Health Service Booklet.

Kretlow, F. (1989). "A phenomenological View of Illness." The *Australian Journal of Advanced Nursing,* December 1989; 7(2); 8-10

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

Kumar, R, Marks, M, Jackson, K 91995a). Prevention and treatment of postnatal psychiatric disorders. *British Journal of Midwifery*, 3: 314-317.

Lawrie, T.A, Herxheimer, A, Dalton, K. (1999) Oestrogens and progestogens for preventing and treating postnatal depression (Cochrane Review) in: *The Cochrane Library* 1, 2001. Oxford: Updated Software.

Lawrie, TA, Hofmeyr, GJ, & De Jager, M (1998a). Validation of the Edinburgh Postnatal Depression scale on a cohort of South African women. *South African Medical Journal*, 88: 1340 -1344.

Lauch, M; Esser, G; Schmidt, M.H. (1998) A meta-analysis of predictors of postpartum depression. *Nursing Research* 45: 225 -30.

Lavender, T., Walkinshaw, S.A. (1998) Can midwives reduce postpartum morbidity? A randomized trial *Birth: Issues in Perinatal Care and Education (BIRTH)* Dec 1998 25 (4) 215-9

Lincoln, Y.S & Guba, E.G (1985) *Naturalistic Inquiry* Beverly Hills C.A: Sage Publications (p105- 117

Lloyd-Webber, A. (1986) *The Phantom of the Opera*, lyrics, retrieved from the Internet: http://laurasmidiheaven.com/SheetMusic-PhantomOfTheOpera.shtml viewed Dec 2005.

Lundh, W & Gyllang C (1993) Use of the Edinburgh Postnatal Depression Scale in some Swedish Child Health Care Centres *Scandinavian Journal of Caring Science* 7: 149-154.

Leonard, V.W. (1989). A Heideggerian Phenomenologic Perspective on the Concept of the Person. *Advances in Nursing Science*. 11(4): 40-55

Lepper, HS, Di Matteo, R, Tinsley BJ. (1994) Postpartum depression: How much do obstetric nurses and obstetricians know? *Birth* 21: 149-154.

Lincoln, Y.S, & Guba, E.G. (1985) *Naturalistic Inquiry*, Beverly Hills, CA: Sage.

Manhall, P., (1994) Revisioning Phenomenology: Nursing and Health Science research, National League for Nursing Press, New York.

Mantle, F (2003) Can hypnosis reduce postnatal depression? *British-Journal-of-Midwifery* 2003 May; 11(5): 299-301

Marks, M, Lovestone, S (1995). The role of the father in parental postnatal health. *British Journal of Medical Psychology* 68; 157- 68.

Martinez-Schallmoser-L; Telleen-S; MacMullen-NJ (2003) The effect of social support and acculturation on postpartum depression in Mexican American women *Journal of Transcultural Nursing*. 2003 Oct; 14(4): 329-38

Matthey, S, Barnett, BE, Elliott, A. (1997). Vietnamese and Arabic women's responses to the Diagnostic Interview Schedule (depression) and self-report questionnaires: cause for concern. *Australian and New Zealand Journal of Psychiatry* 31: 360-9.

May, K.A. (1994). "Dialogue on origins." In Morse, J.M. (1994) *Critical Issues in Qualitative Research Methods*. (Ed Morse, J.M.) p.xii. Sage Publications, Inc, U.S.A.

Mc Carthy, S & Barnett, B. 1996.Highlighting diversity. N.S.W. Review of services for NESB women with Postnatal Distress and Depression. SWSAHS Liverpool, Sydney.

McClarey M, Stokoe, B (1995) A multi-disciplinary approach to postnatal depression. *Professional* 68: 141-143.

McGill, H, Benzie-burrows, V.L, & Holland, L.A. (1995). Postnatal Depression, a Christchurch study. *New Zealand Medical Journal* 162-165.

McHugh, N (2003) Midwives of the soul: the spirituality of birth *Midwifery Matters* 2003 Summer; (97): 4-5

Meighan, M, Davis, M.W., Thomas, S.P & Droppleman, P.G (1999)

Ménage, J. (1993) Post-traumatic Stress Disorder in women who have undergone obstetric and gynaecological procedures. *Journal. Reprod. Infant. Psychol.* 11: 221-8

Merleau-Ponty, M Sense and non-sense. Evanston: north western University Press, 1964

Merleau-Ponty, (1962) *The Phenomenology of Perception*, London, Routledge and Kegan Paul

Miller, T (2002) Postnatal care: adapting to motherhood: care in the postnatal period *Community Practitioner* 2002 Jan; 75(1): 16-8

Mitchell, G.J., & Heidt, P. (1994) The Lived Experience of wanting to help another: Research with Parse's Method. Nursing Science Quarterly, 7:3. Fall

Morse, J (1989) *Qualitative Nursing research*. Rockville, Maryland, Aspen

Morse, Janice M (1991a) *Qualitative Nursing Research* (Sage Publications, New York)

Morse, J.M. (1991b) *Qualitative Nursing Research: a contemporary dialogue*/edited by Janice M. Morse. (Revised Edition) Chicago, Sage Publications Ltd

Morse, J.M. &Field, P.A. (1996) *Nursing Research- The Application of Qualitative Approaches.* 2nd ed., Chapman & Hall, England

Mrazek, PJ & Haggerty, RJ. (1994) *Reducing Risks for Mental Disorders - Frontiers for Preventative Intervention Research.* Washington, D.C., National Academy Press.

Murray, D, Cox, JL, Chapman, G et al. (1995) Childbirth. Life event or start of a long-term difficulty? *British Journal of Psychiatry* 166: 595-600.

Murray, L. & Cooper, P.J. (1996). The impact of postpartum depression on child development. *International Review of Psychiatry* 8: 55 - 63.

Murray, L & Cooper, PJ (1997a). Effects of postnatal depression on infant development. *Archives of Disease of Childhood* Vol 77: 99-101.

National Health and Medical Research Council (NHMRC) (2000) *Postnatal Depression: An Information Paper, A systematic Review of Published Scientific Literature to 1999* Canberra, Australia.

NHMRC (2000) *Postnatal Depression, not just the baby blues* Canberra, Australia National Health and Medical Research Council
www.health.gov.au/nhmrc/publications synopses/wh29syn.htm

Nolan, P; Alcock, G (1998) Maternal mental health 3: an action plan for midwives... third and final article on postnatal depression
Practising Midwife 1998 Feb; 1(2): 20-2

Oakley, A., Rajan, L., Turner, H. (1998) Supporting vulnerable families: an evaluation of NewPin. *Health Visitor.*

Oates, MR; Cox, JL; Neema, S; Asten, P; Gelangeaud-Freudenthal, N; Figueredo, B; Gorman, L.L: Hacking, S; Hirst, E; Kammerer, M.H; Klier, C.M, Seneviratne, G; Smith, M; Sutter-Dallay, A – L; Valoriani, V.; Wickberg, B.; Yoshida, K (2004) Postnatal Depression across countries and cultures: a qualitative study. *British Journal of Psychiatry.* 184. (Supplement, 46) s 10 – s 16, Feb 2004

Odman, P.J. (1988) *Hermenutics: Educational Research methodology and Measurement: An International handbook*. Keeves, J. ed., pp. 63-69. Pergamon Press, New York U.S.A.

Oiler C (1986) Phenomenology: the method. *In nursing research: A qualitative Perspective* (Munhal, P, Oiler C Eds) pp 69-84. Appleton – Century- Crofts, Norwalk, Connecticut 1986

O'Hara, M.W., Rehm, L.P & Campbell, S.B (1982). Predicting depressive symptomatology: Cognitive-behavioural models and postpartum depression. *Journal of Abnormal Psychology* 91: 457-461.

Oermann, M (1994) Reforming nursing education for future practice. *Journal of Nursing Education*, 33. NO 5: 215 - 219.

O'Hara, MW, Rehm, LP, Campbell, S.B, (1993). Postpartum Depression: A role for social network and life stress variables. *Journal of Nervous and Mental Disease*, 171: 336-471.

O'Hara, M.W., Schlechte, J.A. & Lewis, D.A (1991b). Prospective study of postpartum blues: biologic and social factors. *Archives of General Psychiatry*, 48:801-805.

O'Hara, MW, Neunaber, DJ, Zekoski, EM. (1984). Prospective study of postpartum depression: Prevalence, course, and predictive factors. *Journal of Abnormal Psychology*, 93: 158-71.

O'Hara, MW, (1987). Postpartum blues, depression and psychosis: a review. *Journal of Psychosomatic Obstetrics and Gynaecology* supplementary, 7: 205-227.

O'Hara, MW, Zekoski, Em, Phillips, LH (1990) Controlled prospective study of postpartum mood disorders: comparison of childbearing and non-childbearing women. *Journal of Abnormal Psychology* 99: 3-15.

O'Hara, M.W (1995). Postpartum depression, causes and consequences New York, Springer-Verlag.

O'Hara, M.W (2000) Interpersonal Psychology (ITP) can assist with Postpartum Depression. *Arch Gen Psychiatry*, 57: 1039 - 1045

Okano, T and Namura, J (1992). Endocrine study of the maternity blues. *Progressive Neuro-psychopharmacology Biological Psychiatry* 16: 921-932.

Okano, T, Nomura, J, Kumar R. (1998) An epidemiological and clinical investigation of postpartum psychiatric illness in Japanese mothers. *Journal of Affective Disorders* 48: 233

Orr, A.S., (1997). Depression after childbirth: the views of women and medical students compared. *Birth.* 1997. Jun 24(2): 109-15

Oliver, Ryan (2001) Confronting Depression. Cited by www.Depressionet.com.au Source: http://www.webwombat.com.au/lifestyle/health/dpress.htm (viewed Dec 7, 2004)

Osfield, S (2000) Men Behaving Sadly, *Australian Women's Weekly*. NSW

Painter, A. (1995). Health Visitor Identification of Postnatal Depression. *Health Visitor,* April 1995 68 (4): 138-40

Pallikkathayil L, Morgan SA Phenomenology as a method for conducting clinical research. *Applied nursing research* 1991 4 (4) 195 – 201

Paley, J (1997) Husserl, Phenomenology and nursing *Journal of Advanced Nursing*, 1997 Jul 26 (1) 187 -93

Paley, J (1998) *Misinterpretive phenomenology, Heidegger, ontology, and nursing research*. April, 1998 27 (4) 817 -24

Parke, S and B. Hardy (1997). Postnatal depression: making better use of health visitors and community psychiatric nurses" *Prof Care Mother Child* 7 (6): 151-2.

Parse, R.C. A.B.: & Smith, M.J. (1985) *Nursing research: Qualitative Methods*. J. Morse

Thousand Oaks, Sage Publications: 117-133.

Parse, R (1987) *Nursing Science, Major Paradigms, theories and critiques*. Philadelphia: WB Saunders, 1987

Parse, R.R. (1996) *Building Knowledge through Qualitative Research: The road less travelled*, Nursing Science Quarterly, Chestnut House Publications, Chicago.

Parahoo, K. (1997) *Nursing Research, Principles, Processes and Issues*, McMillan press ltd, London.

Pascal, Blaise, (1660) The Pensees: (online) (Pascal, 1660, v. 200 - 424) http://www.leaderu.com/cyber/books/pensees/pensees.html (viewed December, 2004)

Patton M.Q (1980) *Qualitative Evaluation and Research Methods* 2nd Edition, Sage. Newbury Park, California.

Paykel, E.S., Emms, E & Fletcher, J 1980) Life events and social support in puerperal depression. *British Journal of Psychiatry* 136; 339 - 346.

Pitt, B. (1968). Atypical depression following childbirth. *British Journal of Psychiatry* 114: 1325-1335.

Pfost, KS, Stevens, MJ, Lum, CU (1990) The relationship of demographic variables, antepartum depression, and stress to postpartum depression. *Clinical Psychology*, 46: 588-592.

Phillips, J.R., (1993) Researching the Lived Experience: Visions of the Whole Experience. *Nursing Science Quarterly*, 6:4, Winter

Posmontier, B; Andrews-Horowitz, J (2004) Postpartum practices and depression prevalences: technocentric and ethnokinship cultural perspectives
Journal of Transcultural Nursing 2004 Jan; 15(1): 34-43

Pritchard, D.B & Harris, B. (1996). Aspects of perinatal psychiatric illness. *British Journal of Psychiatry* 169: 555-562.

Polit, D.F & Hungler, P.B., (1999) *Nursing Research, Principles and Methods*, 6th Edition, Lippincott, Philadelphia

Psathas, G (1973) *Phenomenological Sociology: Issues and applications*. New York, John Wiley and Sons

Purdy, D & Frank, E. (1993). Should postpartum mood disorders be given a more prominent or distinct place in the DSM-IV*? Depression* 1 59-70.

Raskin, VD, Richman, JA, Gaines, C (1990). Patterns of depressive symptoms in expectant and new parents*. American Journal of Psychiatry* 147: 658 -660.

Ray, KL & Hodnett, ED (1997) Caregiver support for postpartum depression (Cochrane Review) in: *The Cochrane Library,* 1: 2001. Oxford: Update Software

Ray, M (1994) "The richness of phenomenology; philosophic, theoretic and methodologic concerns". *Critical Issues in Qualitative Research Methods*. Ed. J. Morse. Thousand Oaks, Sage Publications Inc., U.S.A

Raynor, M; Sullivan, A; Oates, M (2003) Why mothers die: a public health concern *British Journal of -Midwifery* 2003 Jun; 11(6): 393-5

Richards, JP (1990) Postnatal Depression: A review of the recent literature. *British Journal of General Practice* 40; 472-6.

Reid, M; Glazener, C; Connery, L; Mackenzie, J; Ismail, D; Prigg, A; Taylor, G (2003)
Two interventions for postnatal support): *British-Journal-of-Midwifery* 2003 May; 11(5): 294-8

Rigby, A.S; Sanderson, C; Desforges, M.F.; Lindsay, G & Hall, D.M. (1999). The infant index: a new outcome measure for pre-school children's' services. *Journal of Public Health Med.* 1999 Jun; 21 (2): 172-8.

Rilke, Rainer Maria, "A Walk"/poetry archive/plagiarist.com URL: http://plagiarist.com/poetry/3217/viewed 7 December 2004

Ring, N, McLean, TM (1994) Routine postnatal depression screening and its effects on health visitor practice. *Journal of Advanced Nursing*

Roberts, D. (1998) Suicide prevention by general nurses, *Nursing-standard*

Roberts, K & Taylor, B. (1997) *Nursing Research Processes: An Australian Perspective*, Nelson Thomson Learning, Australia.

Rogers, C. (1951) *Client-centred Therapy* London, Constable.

Rose, P; Beeby, J; Parker D. (1995) Academic Rigour in the lived experience of researchers using phenomenological methods in nursing. *Journal of Advanced Nursing* 1995; 21, 1123-1129

Ryding, El; Wijma, K; Wijma, B (1998) The experiences of emergency caesarean section: a phenomenological study of 53 women *Birth.* Dec 1998 25 (4) 246 -51

Richman J, Raskin V, Gaines C (1991) Gender roles, social support, and postpartum depressive symptomatology; the benefits of caring. *Journal of nervous and mental disease* 1991; 179: 139 – 147

Sadler C (1998) Sons Behaving Badly. *Community Practitioner* 1998 Apr 71 (4) 126

Sandelowski, M (1986) The problem of Rigour in Qualitative Research. *Advances in Nursing Science*. 8(3): 27-37

Sharp, D (1996). The Prevention of Postnatal Depression, in *The Prevention of Mental Illness in Primary Care* (Eds) T.Kendrick, P.Freeling and A.Tyle.

Sheppard, M (1997) Depression in female health visitor consulters, social and demographic facets. *Journal of Advanced Nursing*, Nov 1997:26: 5: 921 -9

Sichel, DA, Cohen, LS, Robertson M (1995) Prophylactic oestrogen in recurrent

postpartum affective disorder. *Biological Psychiatry*, 38: 814- 818.

Simons, J, Reynolds, J, Mannion, J; Morison, L (2003) How the health visitor can help when problems between parents add to postnatal stress *Journal of Advanced Nursing* Nov 2003 Nov, 44 (4) 400 - 11

Sinclair, D. & Murray, L. (1998). Effects of postnatal depression on children's adjustment in school. *British Journal of Psychiatry* 1998 Jan; Vol 172: 58-63

Sheppard, M (1997) Depression in Female Health Visitor Consulters; social and demographic facets. *Journal of Advanced Nursing*, November 1997 26 (5) 921-9

Simon, P and Garfunkel, A, "Bridge over Troubled Waters" lyrics - (http:// members.aol.com/webmisstrish/botwlyrics.html viewed 7/12/2004)

Simons, J; Reynolds, J; Mannion, J; Morison, L (2003) How the health visitor can help when problems between parents add to postnatal stress. *Journal of Advanced Nursing* 2003 Nov; 44(4): 400-11 (37 refs)

Sluckin, A (1998): Bonding failure: "I don't know this baby, she's nothing to do with me" *Clinical Child Psychology and Psychiatry* 1998, Jan; Vol 3 (1): 11-24.

Small, R, Johnston, V, Orr, A (1997) Depression after childbirth: the views of women and medical students compared. *Birth 24:* 109-15.

Speigleberg, H (1982) *The Phenomenological Method*, Martinus Nijhoff Publishers, London

Sorrell, J. M & Richmond, G.M, (1995) Interviews in Qualitative Research, differing approaches for ethnographic and phenomenological studies *Journal of Advanced Nursing*, 21 1117 -1122

St Aubyn, B; Perkins, E (2003) Health visitors listening to mothers' perspectives of self-care. *Community Practitioner* 2003 Feb; 76(2): 59-63

Strass, P (2002) Postpartum depression support
Canadian Nurse 2002 Mar; 98(3): 25-8

Streubert, H & Carpenter, R.D. (1999*) Qualitative Research in Nursing* (2nd Edition) Lippincott & Co Ltd. Philadelphia

Stuart, S, O'Hara, MW (1995) Interpersonal psychotherapy for postpartum depression. *Journal of Psychotherapy Practice and Research*: 4: 18-29.

Stumpf, S. (1994) *Philosophy, History and Problems*, 5th Edition, McGraw-Hill, New York

 Sved-Williams, A.E, (1992) "Phobic Reactions of Mothers to their own Babies". Australian and New Zealand Journal of Psychiatry. December; 26 (4): 631 – 8.

Tammentie, T; Paavilainen, E; Astedt-Kurki, P; Tarkka, M (2004)
Family dynamics of postnatally depressed mothers -- discrepancy between expectations and reality *Journal of Clinical Nursing* 2004 Jan; 13(1): 65-74

Taylor, A. (1997) Postnatal Mental Disturbance, paper for the *Marce Society*, from the Internet: London, Marce society website
www.cam.net.uk/home/marce.uk/pmd.htmTaylor, A, Adams, D, Glover, V (1994) Postnatal Depression: identification, risk factors and effects. *British Journal of Midwifery* 2: 253-257.

Thomas, C. (1997). The need for collaboration in care in Postnatal Depression. *Assignment,* Spring 3 (1): 12-18.

Tripp-Reimer, T. (1984) Reconceptualising The Construct of Health: Integrating Emic and Etic Perspectives. *Research In Nursing and Health.* 7 (2): 101-109

 Tully, L; Garcia, J; Davidson, L; Marchant, S (2002) Role of midwives in depression screening. *British Journal of Midwifery* 2002 Jun; 10(6): 374-8

Unterman, RR, Posner, NA, Williams, KN (1990) Postpartum depressive disorders: Changing trends. *Birth* 17: 131- 137.

Usher, K (1995) The Ethical Implications of phenomenological Research with vulnerable participants. *Asia- Pacific Human Science Research Conference December 9 & 10, 1995 Proceedings* pp 249 – 257

Ussher, J.M (1992) Research and theory related to female reproduction implications for clinical psychology *British Journal of Clinical Psychology* 31: 129-151.

Van Kaam, A, Existential foundation of psychology. Pittsburg, PA, Duquesne University Press; 1966w

Van Manen (1990) *Researching Lived Experience: Human Science for an Action Sensitive Pedagogy*. State University of New York Press, London, Ontario.

Walsh, K. (1996). Philosophical Hermeneutics and the project of Hands Georg Gadamer: Implications for nursing research. *Nursing Inquiry* 3: 231-237.

Walters, A (1994) Phenomenology as a way of understanding in nursing. *Contemporary Nurse* 1994: 3 (3) 134 -141

Walters, A.J (1995) The phenomenological movement: implications for nursing research *Journal of Advanced Nursing* Oct 1995, 22 (4) 791 -799

Warner, R, Appleby, L, Whitton, A (1997) Attitudes toward motherhood in postnatal depression: development of the maternal attitudes questionnaire. *Journal of Psychosomatic Research* 43: 351-8.

Ward, C (2003) Migrant mothers and the role of social support when child rearing *Contemporary Nurse* 2003 Dec-Feb; 16(1-2): 74-82

Ward, B (1999) Improving the detection of postnatal depression *Professional Nurse* (1999) Oct; 15(1): 15-18

Watson, JP, Elliott, SA, Rugg, AJ (1984) Psychiatric disorder in pregnancy and the first postnatal year. *British Journal of Psychiatry* 144: 453-62.

Watts, J, Pope, S (1998) *Report on Childbirth Stress and Depression* Perth, Health Department of Western Australia.

Webster, A. (2002) The forgotten father: the effect on men when partners have PND *Community Practitioner* 2002 Oct; 75(10): 390-3

Whiffen, V.E. (1988a) Screening for postpartum depression, a methodological note. *Journal of Clinical Psychology*, 44: 367-371.

Whiffen VE, Gotlib, IH (1989) Infants of postpartum depressed mothers: Temperament and cognitive status. *Journal of Abnormal Psychology* 98: 274- 279.

Whitehead, L, Mayou, R (1989) Care of the mind *Nursing Times* 85: 49-50.

Whitten, A.R, Warner, R, Appleby L & Faragher, B. (1997). The pathway to care in postnatal depression: women's attitudes to postnatal depression and its treatment. Copyright *British Journal of General Practice 1996. Midwifery Digest (MIDIRS)*

Williamson .VH & McCutcheon, H., (2002) Postnatal Blues. *Singapore Nurses Journal*, April- June, 2002 Vol 29 no 2 pp: 32 -36

Williamson, V.H and McCutcheon, H (2003) Postnatal Depression: The Dark Shadow, *Midwifery and Mental Illness*, Ausmed Publications, Victoria. May, 2003.

Williamson, V.H & McCutcheon, H (2004) Postnatal Depression, A review of the literature. *Australian Midwifery Journal*, Journal of the Australian College of Midwives, November 2004. 17 (4) p 11-16

Wisner, K.L & Stowe, Z.N. (1997) Psychobiology of postpartum mood disorders. *Seminars in Reproductive Endocrinology* 15: 77-89

Zelkowitz, P & Milet, TH (1995) Screening for postpartum depression in a community sample. *Canadian Medical Association Journal*, 40: 80-85.

Information Sheet

Department of Clinical Nursing,
The University of Adelaide.

Project Title: "A Hermeneutic Phenomenological Study of Women's Experiences of Postnatal Depression and Health Professional Intervention"

Plain English Title: The helpfulness of health professionals for women with Postnatal Depression

Name of Researcher: Victoria Heather Williamson (R.N., B.A. (Hons), Master of Social Science in Counselling)

Project Supervisor: Dr Helen McCutcheon, University of Adelaide, Department of Clinical Nursing.
Co-Supervisor: Dr Tina Jones

Invitation to potential subjects to participate in the study

Wanted: Volunteers who are women aged over 20, and who have experienced Postnatal Depression and have received both a clinical diagnosis of PND and clinical help for the condition. They are invited to participate in a project by Ph.D student Victoria Williamson on the outcomes of interventions by health professionals for women who have experienced Postnatal Depression.

Participants will be asked to share their stories of their experiences of health professional intervention and counselling. This may be an opportunity for women to 'de-brief' their experiences in a safe and friendly setting, as well as contributing to research.

The project will involve the participants in a separate interview. The interviews will be audio-taped and participants have the right to ask for the tape to be stopped at any time. Although findings from these interviews may be published, all names and identifying material from the participants will be changed for confidentiality. All records containing personal information will remain confidential and no information, which could lead to the identification of any material will be released. The participants will be given a copy of the transcripts and the finished project.

Participants may withdraw from the research at any time. They will not directly benefit from participating in the research but hopefully will find it a worthwhile and positive experience. Should they become distressed, the names of a number of independent counsellors will become available.

Appendix 2

<u>Consent Form</u>

Protocol Name: A Hermeneutic Phenomenological Study of Women's Experiences of Postnatal Depression and Health Professional Intervention

Investigator: Victoria Heather Williamson (B.A. Hons, R.N, Master of Social Science in Counselling)

1. The nature and purpose of the research has been explained to me. I understand it, and agree to take part.

2. I understand that I may not directly benefit from taking part in the study and that I will not be paid for my contribution.

3. I understand that, while information gained during the study may be published, I will not be identified and my personal results will remain confidential.

4. I understand that I can withdraw from the study at any stage and that this will not affect my medical care, now or in the future.

5. I have had the opportunity to discuss taking part in this investigation with a family member or friend.

Name of Subject:

Signed:

Dated:

I certify that I have explained the study to the volunteer and consider that she understands what is involved.
Signed:

(Investigator)

Appendix 3

THE UNIVERSITY OF ADELAIDE
HUMAN RESEARCH ETHICS COMMITTEE

Document for people who are subjects in a research project

CONTACTS FOR INFORMATION ON PROJECT AND INDEPENDENT
COMPLAINTS PROCEDURE

The Human Research Ethics Committee is obliged to monitor approved research projects. In conjunction with other forms of monitoring it is necessary to provide an independent and confidential reporting mechanism to assure quality assurance of the institutional ethics committee system. This is done by providing research subjects with an additional avenue for raising concerns regarding the conduct of any research in which they are involved.

The following study has been reviewed and approved by the University of Adelaide Human Research Ethics Committee:

Project title: A Hermeneutic Phenomenological Study of Women's Experiences of Postnatal Depression and Health Professional Intervention

1. If you have questions or problems associated with the practical aspects of your participation in the project, or wish to raise a concern or complaint about the project, then you should consult the project co-ordinator:

   Name: Victoria Heather Williamson (phone number supplied)

2. If you wish to discuss with an independent person matters related to
   • making a complaint, or
   • raising concerns on the conduct of the project, or
   • the University policy on research involving human subjects, or
   • your rights as a participant

Contact the Human Research Ethics Committee's Secretary on phone (08) 8303 6028

Appendix 4

(Name and address of Organisation)
Dear (CEO)

I am conducting a research project into the effects of counselling for women who have experienced Postnatal Depression as my Ph.D with the Department of Clinical Nursing, the University of Adelaide. My project supervisor is Dr Helen McCutcheon and the commencement date of this project is March, 2001.From my time spent working in your organisation, I am aware that you spend a good deal of time working with distressed mothers, some of whom have experienced Postnatal Depression. My project deals with the women's remembered experiences of clinical helper interventions in their treatment of PND, and I am seeking twelve women who have had this experience, are over twenty, and are one year away from having completed therapy. (An Information Sheet, Advertising Sheet, Independent Complaints Procedure Form and Consent form, are included in this letter).

Could I please seek study participants with your help through your organisation? I am aware that my project may well need to be assessed first by your ethics committee, and am happy for this to occur. I also add that my participants would have their privacy, confidentiality, and dignity protected in every possible way. The participants would be asked to participate in one hour-long interview, and the data would be audio taped but all identifying material removed from the final project.

Kind regards,
Victoria Heather Williamson

Appendix 5

<u>**ADVERTISING SHEET**</u>

CALL FOR VOLUNTEERS

WOMEN OVER 25 WHO HAVE EXPERIENCED AND BEEN TREATED FOR POSTNATAL DEPRESSION EITHER IN A COUNSELLING OR MEDICAL SETTING. THEY MAY HAVE EXPERIENCED JUST A MILD "THREE-DAY BLUES' THROUGH TO A DEEPER, MORE LASTING EXPERIENCE OF PND WITH PSYCHOTIC EPISODES – BUT THEY MUST HAVE BEEN ON THE RECEIVING END OF HEALTH PROFESSIONAL INTERVENTION.

This is for a Ph.D thesis and Research by Victoria Heather Williamson (R.N, B.A.Hons,

Master of Social Science in Counselling)

<u>**Preamble**</u>: A moderate amount of information exists on the methods of treatment for women with Postnatal Depression, bit a gap is present in the existing knowledge about the outcomes of counselling or therapy, and what was successful for mothers in terms of comments or interventions by helping professionals. Knowledge is particularly sparse on the thoughts of the women themselves. If you have experiences in this area and feel willing or able to share your story, this is for you. It also offers you the opportunity not only to add to a needed fund of knowledge, but also to debrief your experience in a warm and friendly setting. The project will involve participants in a one-hour interview. All data in the report will be kept anonymous and confidential.

Participants will be required to give written and informed consent (a set form will be provided) prior to their participation in this project. If you are interested, please contact:

Victoria Heather Williamson   (Home phone number supplied)

Appendix 6

(Sample interview with field notes, for the Audit Trail)

Kate, Interview May 2001, with field notes. Anything directly related by Kate has been removed and all names have been changed.

10 00 am. I *arrive nervously at a large brick suburban house with a well-cared for garden, wondering about this interview and how it will go…the lawns are freshly mowed and the house is neat and tidy, despite nappies drying in the hallway and baby laundry scattered about. A lady wearing a blue tracksuit and with a friendly open face opens the door and welcomes me in, she is Kate, she says she looking forward to the chance to talk about her PND. She coughs a lot…. explains she has chronic asthma. We sit down at her wooden dining room table. I make sure she is comfortable, has signed the consent form, and is feeling okay about participating in the project. She has a packet of tissues and some Ventolin at the table, she makes coffee, and we sit down and sip. There is an almost immediate rapport between this professional woman and myself, a natural flow of warmth, she is interested in my work and we manage to put each other at ease. I decide to turn the tape on and begin the interview.*

Part transcript – with field notes.

Victoria: Basically I am just going to ask you a few questions. I am not going to lead the interview in any way. It's a study about your experiences about

Post Natal Depression and the types of clinical interventions you have had, and I am looking for your feedback and your experience. …

Kate: I'm just going to start by giving you the context in which my pregnancy occurred that's important and there are several of those that resulted in George's birth. My partner and I partnered when we were 35 and 36 respectively so up until that time I had been a single women for about 8 or 9 years…

As Kate tells her story, she becomes pensive…bites her lower lip.

Kate: I was single because I had previously partnered with a man who was an alcoholic so he was actually quite good at hiding that, so I actually thought to myself "well you need to leave and I needed to start my live all over again." But I was single by choice for a really long time doing all sorts of interesting things. I travelled the world; I did kind of really fabulous things. Like I spent a year in New York and in Calcutta worked alongside a women's collective there. Just did some really mind altering kind of things was just wonderful. When my hubby and I met um... it was kind of like when you meet the right person for you. He was the right one that is what happened for us and so we partnered and married. Within about 18 months of meeting each other! And this was amazing if you think about the fact that I decided to be single for the rest of my life...*(Throws her head back and laughs)* as you all do when you actually had a bit of a hard time.

Anyway we were really clear that we wanted to be parents and we decided that we would do all the necessary obvious things that you do to have a baby. (*Rolls her eyes, looks coy)...*

Victoria   (*I raise my eyebrows and feel the need to prompt the story, without wishing to stop the flow)* Uh-huh…

Kate   (*laughs)* and goes on "Which we enjoyed the practice but then after a year or so that the practice was not obviously quite the way to do it. So we went and had a chat to our GP, went to a fertility specialist, took some fertility drugs and we decided that that didn't even work…."

            (*Kate's story flows on from here, but it is confidential, so am deleting some of these details from this Appendix)*

Kate describes her difficulties even conceiving particularly in the shadow of a workplace bully. She explains that it is important to be relaxed when getting pregnant. I notice her pensive expression and the way she bites her lip and sense the need to be very gentle and non-directive here. She indicates she needed to talk about this issue however, as she is passionate about it, and more comfortable speaking about it than dropping the subject.

Kate: (*Sighs*) Umm…(the person at work) I think she was afraid of me because of the kind of person that I am because of my capacity …to work well… Anyway so that is within that framework that I am trying to get pregnant. You can imagine it was a really difficult time.

Victoria: Yes indeed, it must have been really hard.

Kate: Yeah Yeah. (Describes more problems in the workplace)

She draws in a deep breath. I wait, unsure what to do, and tip one head to the side in a listening attitude. Kate sips her coffee then continues.

Kate: I knew when I was pregnant that she would use that as a weapon against me…I decided not to tell her I was pregnant until really late in the piece. *(Then she describes the consequences of her pregnancy in the workplace)*

Victoria: So what happened then? *(I want to reach the part about the health professionals and their helpful and unhelpful interventions but Kate had promised to discuss these and was in full flight describing a number of very poignant and personal incidents so I wait and trust that the flow of information on those issues would come later in the interview, if not, then I would prompt.)*

Kate: The position that I was offered was (one she preferred not to have) so what did I do? (*She sits back, looks thoughtful, her eyes mist over)* I decided that I had enough of the really bad bullying behaviours… (*Kate describes the action she took, including complaining to the relevant authorities about the workplace situation. Her tears flow freely and she uses the tissues, at one*

point I hand them to her, rest my hand on her arm, check if she is okay with

this, and she indicates she wants to continue)

   So consequently I have got this wee babe in arms, I am learning to be a

mother; I have this whole environmental change. You know, that goes on

when you have a child in the house. *(She smiles, wistfully)* You know I have

go the best partner in the universe I have got to say. Totally supportive. He

couldn't feed because I was breast feeding but what he did was he would get

up and bring him into bed for me and you know be there and do those types

of things and make me a cup of tea or coffee in the morning. Wake me up

when I had fallen asleep with the baby on my lap (*both laugh*).   All that sort

of stuff. So you know I mean relationship wise really strong, firm, fabulous.

Baby fabulous - he was wonderful but then he had to be because I was mad.

(*Both laugh*). He must have read the books!!! I showed him chapter two and

said no you should be sleeping longer and so he would do it.   He would just

go and do it.

Victoria: Smart kid.

Kate: Bloody lucky for him (*both laughing*). Because on that front absolutely

           totally solid. But on the other front, which was also part of me, everything

           went to…(*Kate swears here, then tells more about her journey of re-entry*

           into the workforce) So it was within that context that George came into our

           home, which was really hard when I look back on it to think um... If you

believe in all that stuff that babies really tune into their mother I was in turmoil so where was this poor child!

(*Kate pauses for a moment.*)

Victoria: Would you like a sip of water?

(Kate nods, takes a sip, leans back in her chair; with a reflective expression on her face…I wait a moment then prompt.)

Victoria: Go on…

Kate   Well, I hope he (baby) wasn't affected but still it was a fairly traumatic time for all of us. The thing for us also in that time was that … I had a real passion for making sure that George was fine and safe as every mother does but the other thing that I had was a passion about that's it, this women has got to stop. She can't do this any more. So I can remember sitting there with my fluffy feeding my child and thinking and sitting with a number of ex staff members they had had similar things happened to encourage them to participate in this investigation.   So I was doing this community development work at home for a period of time and so yeah it was a very interesting exercise. (*She takes a deep breath and explains the then gives a small smile and I prompt her again*)

Victoria: How was that for you?

Kate   Well, there was some personal satisfaction in the fact that she had been found out but most of my satisfaction was actually in the job…and the whole experience has been (*she describes it at length*) Not okay. I have done stuff with George. I have done other things but it doesn't do much for your kind of, self-esteem. (*Tears well and start to fall*) I feel really sad about this I will cry! *Sobs.* (*I put my hand on her arm, and just sit with her quietly, letting her absorb a sense of compassion*)

Victoria: (*Soothing tone*). That's fine. That's fine.

Kate: (*Sobbing)* So poor old George he's got this kind of mum who is kind of like (*her voice trails off, she loses her train of thought, then finds it again*)…. What did I seek for support? I know you want the answer to that. (*I nod*) Well, I knew that I was definitely down the path of becoming depressed and I knew that… (*Sobbing again, blowing her nose*)

Victoria: (*I decide to just let her words flow, she would tell me freely about the interventions. My heart aches for her though. I wished there was something I could do to make it better. The intensity of her own pain has made tears prick behind my eyes and I take a deep breath*) Ah…yeah?

Kate: And I knew that (the depression) was for a lot of reasons.

Victoria: (I *speak very quietly*), Sure. (*I hand her a tissue, she is crying such a lot. I want her to feel that I care and I am listening and on her side, and this is true. I am struggling to control my own lump in the throat but choose to maintain this control as best I can't. I don't want to mess up the flow of her story or make her feel responsible for my feelings*)

Kate: The grief about losing my position and my title and my environment and all the status things that go with position and title…and, I was angry, I was vulnerable because I was just a new mother, I had to learn all the stuff about the screaming child who get sup in the middle of the night and you don't know what is wrong with it. I had to sit up and walk the floorboards with him but again that was just small moments. With George I was able to just live through them but on top of that I was falling apart at the edges…. if it was just George and me we would have been alright but it was this other stuff… (*Her sobs continue, I give her tissues and sense she wants to keep crying and talking so I let her without changing direction*)… It has been a real struggle (Kate describes this further). ... I cry now because it is still very emotional for me and it still hurts me deeply ...Like, what did I seek for support ... I knew that I was stepping down the path of becoming depressed and um, and I knew that, I knew that was for a lot of reasons. (Confidential details follow, the gist of which meant that she went to her GP and got a diagnosis of PND, but little direction on how to handle it)

Kate: I was angry um... I was vulnerable but again he (the baby) ... there were just small moments where with George I was able to live through them. .

Victoria: I can well imagine

Kate: So (once diagnosed) what support did I seek? (*Her eyes glitter angrily*). What kind of input did I want, what a f***ing laugh... (*She looks a bit hysterical, I feel concerned, but let it be*)

Kate   (*laughing*).... Really sitting back now I can laugh about it, it is a hooter. My first point of call baby in pusher…I go to the employee assistance and counselling. I go in there and I say I am so stressed, to the counsellor, first indicator. Yes, yes I know, I have been diagnosed, I am starting to go down the path (of depression) and it doesn't matter how much, you know it is physiological and psychological and you can't cope whilst the stresses are still there you personally can't touch it; you have got to get some personal control, you need discipline to get there, Blah Blah Blah…That's it. I've got to get the support I don't have now, I can't cope, and I talk to a women. I have a two-hour session with her. I told her the story I have just told you only I was probably a bit more emotional at that point and um... she then tells me for God's sake what is your boss's name and I tell her. And she goes oh yeah, we know. And I go Ahh! (This section refers to a frustrating sense of unconcern as perceived by Kate about her counsellor) And, (*Kate snaps angrily*) And I am going and you do what??? (*She throws her hands*

in the air in despair) Yes, and what response do you make? Oh, nothing! I say so like, you are supposed to be the employee assistance program, like, tell me what you do? Um.... I walked out of there after the first time going you have got no f***ing idea. You have got no idea. You are not only (aware) that I actually don't trust you because of what you have failed to do, you have failed to work with me… to look at the issues that are here and they are around all the stuff I was talking about, loss of status, value, personal self esteem, understanding, self confidence, new baby, shaking the ground, can't you see I am falling apart here? No, nothing. And follow up?

(*Kate pauses*)

Victoria: Did they follow you up?

Kate: (*Frowning*) zero.

Victoria: (*I frown too*) You needed help.

Kate: So what can I do? I went back to my GP and said I am not sleeping, I am crazy, I'm so stressed I can't face anything, I don't know what I am doing…and he said, well, that is your PND and gave me sleeping pills.

Victoria: Oh.

Kate: Which was very useful. (*Kate frowns again, rolls her eyes*). I go…Yeah!!! Not useful…

From here, Kate freely describes in detail all the unhelpful interventions she had experienced and all I need to do is gently prompt her. She pours out her story, sobs, and I listen, leaving my hand on her arm, after checking she is all right with that and she indicates yes. She indicates that it is helpful to her to share her story, and I am grateful for that. The conversation came towards a natural close. An hour has elapsed.

Kate: But I have gradually step by step gone around and recreated order in the disorder of my external life. My internal life like my family and home life is just fine. So that's what I have done and that is the way I have dealt with it. So I have tried lots of avenues but they haven't been the right ones for me.

Victoria: *(I want to affirm her for sharing such a story with me)*. You must have an incredible strength.

Kate: (*Her eyes light up*) Is it that incredible? I don't know now.

Victoria;   Yes, of course it is.

Kate: Cause it has been part of my life I think I know it is significant for me…

Victoria: The fact that you even weren't hospitalised is significant.

Kate: So for me that is why I give you my story because the more you can use

            stories to develop theory then your policy and practice comes from that…

            I nod, noting that the tape is almost at an end. Kate notes that also.

Victoria: Thank you; thank you so much for sharing that.

Kate: I did warn you I'd cry.

Victoria: *(I smile)* That's okay, I am used to it!

Kate: I am sure you are! I mean all these stories are very powerful.

Victoria: Right from the heart too.

It's time to end the conversation, so we leave the room and Kate shows me her office.

Then she shows me the door, we hug, I promise her a copy of the thesis and we wish

each other well.

Appendix Seven

As part of the preliminary analysis the stories of all twelve participants were looked at in depth before the themes were put together the first time. This was part of going from the parts of a phenomena, to the whole of a phenomena, in order to understand it (Gadamer, 1975). I wrote expanded 'themes documents" or accounts of the women's stories. As part of the Audit Trail (Koch, 1996) I have included an example of such expanded stories here: Christine's Story. I presented this, together with Annie's Story, in the Ausmed Conference in Adelaide in 2003. Both stories were also published in the Ausmed Handbook (May, 2003), which was written as an accompaniment to the delegate's presentations.

Christine's story

Christine is a professional woman, and a mother of two children, a boy and a girl. Her first child, a boy, was born after a very traumatic delivery, and her difficulties with her family of origin, an unsympathetic husband, a shock to the system with birth and parenthood due to wrong expectations led her to PND. She had been a very organized person before the birth of her children and nothing in her corporate experience had prepared her for new motherhood. She wrote a poem "**Postnatal**" for her husband, and then shared it with her local maternity and child health nurse and the other women at her parenting group. The feelings inherent in this poem touched emotions in other women with PND. Later, the poem was used as a diagnostic tool by her maternity and child health nurse. This poem is included with the permission of the author.

Postnatal (by "Christine")

You could take out the garbage, to show me that you care
The times I really need some help, I feel you're just not there.
There's washing, dishes, baby crying, dust and vacuum too,
I feel inside that I am dying, but then I cook for you.

It never ends, each day the same, my heart aches with despair
Whether sunshine or just rain, I feel like you don't care.
Baby needs my body, husband wants it too,
When I say no, I feel such guilt, our sex life's in the loo.

There's never time that's just for me, everyone else is always first
I've lost my whole identity, for my freedom I do thirst.
If I show you this poem, I fear you'll critique the rhyme,
Instead of sharing feelings, and giving me your time.

The pain it builds, inside of me, I don't know where to go,
Sometimes I want to run away, around me no one knows.
I try to talk about it all, to clarify my pain,
But I don't feel that I'm really heard, I seem like such a drain.

The chores are growing, never done, the money's in short supply,
The feelings in me overwhelm, I don't think that I can cry.
People say time will heal, and things will get better soon,
But it feels worse everyday; I'm baying at the moon.

All my times now for another, baby's smile is my reward,
And that's because I'm a mother, without him I'd be bored.
But boredom's not the issue here; it's my sanity you see,
Although I love my little Jake, I feel that I've lost me.

"Get some help, and have a rest", the mean-wells say to me,
But that's easier said than done, when you're depressed, post-natally."

Christine's story: The first early theme: Disconnection

Christine experienced a sense of isolation, loneliness and disconnection from the world and other people as she fell slowly and steadily into the experience of PND. Her past experience of depression made depression as part of parenthood especially painful for her.

Past experience of depression

> Prior to having a family I did suffer from depression so I had had a period of two years in treatment with a psychiatrist under medication for long standing depression
> (Christine, p. 3, L: 79 – 81)

> (Depression) is something that is in my family.
> (Christine, p.3, L: 82 – 84)

Depression terrified her, as she had been there before:

> I was so afraid having experienced depression… … It was that exact feeling of "please don't let it be back" here again... Because you do feel a sense of failure…!
> (Christine, p.42, L: 1321 -1336)

Old memories from her childhood resurfaced:

> I went through a whole lot of issues about my own entering into the world. My parents relationship… they weren't positive things. I went through a lot of stuff during my pregnancy … a lot of grief…and (fear about) how I was going to do this. . So you do put an enormous amount of pressure on yourself. You have got that level of awareness where you want it to be right. I think you are more prone to fall into a depression state when it isn't right because the reality is nothing is ever perfect when you are suddenly a parent.
> (Christine, p. 13, L: 399 – 409)

Being a stay at home mum was important to Christine, as she had not been raised that

way herself:

> . My mum didn't do that for me. She worked and she wasn't there (for
> me)…I felt it all my life!
> (Christine, p 47, L: 1477 – 1478)

Difficulty with her own parents

Her parents were unhelpful and at times that exacerbated the depression: Sometimes she

would shout at her mother:

> That's it! You are not having James any more…I am not coping with
> my stuff here please cope with your stuff. Be the grown ups here!
> (Christine, p. 33, L: 1021 – 1028)

> I know that my parents aren't the sort of people who will sit down and
> say "How are you feeling, love" and "What is going on…they would
> always offer to take care of James if I needed that. So we did get that sort
> of support but not the type where you want to sit down and have a cup of
> tea and talk to someone about it."
> (Christine, P.33 - 34, L: 1041 – 1065)

Expectations of motherhood (of herself)

 False expectations of motherhood, both of herself and her own capacities and the

experience of motherhood, including the birth experience, made her vulnerable to

PND.

> I came home (from hospital) and thought right, superwoman! Because I
> came from a managerial career background…I had the perfect little house
> with the perfect job and everything and I was right with the world and
> suddenly I was breastfeeding this baby and went through all this stress
> with that but I had to get everything done… do the washing here at this
> time, prepare a meal at this time and the baby had this time…
> (Christine, p. 3, L: 93 – 99)

I was completely "anal" for want of a better word in how I parented a new born baby to wearing myself out completely...I had no idea how to relax and just let it be and take care of myself first. So I didn't take care of myself and I just basically went further down and down until…I was not coping and it was (maternity and child health nurses) that pointed that out to me
(Christine, p. 3, L: 93 – 99)

I was one of these people if he (baby) was four months old and had to be weighed I would take him in on that day…that was probably very good that I was that sort of person because at least they knew me and could see what was happening
(Christine, p. 4, L: 108 – 113).

I tried to get them (children) down (to sleep) at the same time and if I could manage that I would go and have a sleep as well…but it was very hard to do this, when trying to live up to a superwoman image... It is very hard to justify the time for yourself…"
(Christine, p. L: 1411 -1424)

Expectations of motherhood: (Cultural)

(In hospital you have)…this perfect baby and so little, and you get all the flowers and the presents and you have got all this attention on you and…. It is this wonderful little world that you suddenly going to have and the reality is so very different…"
(Christine, p. 8, L: 225 – 227)

The hospital and birthing experience also fell short of her expectations severely:

I had all these great books on active birth and lets get the music and incense, the aromatherapy and the lovely music. What a joke! It was just so far removed my reality. So it was a huge stretch when I got the three day blues…But nobody came to talk to me…. they didn't which I found really disturbing.
(Christine, p. 20, L: 627 – 634)

Parenthood itself was an enormous shock, so was the PND:

> When you are dealing with a baby you don't know what you are getting until you have got it…It is like moving to another planet!
> (Christine, p. 13, L: 627 – 634)

> You have the Johnson Baby commercial looming over your head. I must look like this person and be behaving like them…when you are at home thinking I am having a thought about putting the baby in the oven… Why am I having these ridiculous thoughts what is going on in there? Crazy stuff. Yeah it is frightening!"
> (Christine, p.50 L: 1562 -1569)

At times, she emulated her own childhood:

> I have those days when I just "lose the plot" and all I can hear is my mother!
>
> (Christine, p. 15, L: 456 – 457)

Hiding PND

Christine was a well-organized woman, a professional, very good at pretending to

herself and the world that everything was okay. That she could cope, but:

> I didn't cope all that time. Everyone else thought I was. My husband knew better!
> (Christine, p.4 L: 124 -125)

Finally, after her baby was about ten months old, she broke down:

> I had gone back to work part time, which was actually a really positive thing for me at that point. But also I was heading towards having to go back to work full time, which I didn't really want to do. There was a whole lot of stress about that. And so they said, Look we really think you need to talk to somebody and hence my partner and I went and had family counselling with a social worker over a period of time.
> (Christine, p.5, L: 133 -138)

Christine wrote her poem as part of trying to show her partner what was happening for her, she shared it with her baby care nurse who shared it with a mothers group she was attending. It was part of revealing her PND to the world.

> I had given (the poem) it to the social worker's group as a part of "lets talk about this" (PND)…it really helped me to identify things and she said, "Would you mind if I give copies out to the girls here to use?" And I said, "I don't have a problem with that, if it helps somebody else well, that is terrific!" So Polly had gotten a copy of it, and knew that I was in her new parent group and approached me and said "Would you mind reading it (poem) out to the class?" And I said, "I can't read it, if I read it I will cry! It is just too morbid for me right now, but I am quite happy for you to read it out." So she read it out to the group and about five women just collapsed into tears and it started this fantastic discussion.
> (Christine, p.39L: 1235 -1243)

The women in the group were amazed at Christine's revelations:

> And the relief (showed) in their faces because they probably just saw me as this perfect little mother because I always had the right baby foods and he was a little bit older than some of the other babies in the group…. Back then I was so perfectionist and so they thought I was one of those sort of mums"
> (Christine, p.40 L: 1248 -1255*)*

Difficulty with marriage- expectations

Wrong or overly high expectations of parenthood stressed her marriage:

> Because I saw so much of my PND being linked to my marriage not with coping to the adjustment of having a child…the expectations I had of my partner weren't being matched. And Men don't have very much to change they don't have the pregnancy and the baby and the breast-feeding and all of that to alter them. They are just witness to it all.
> (Christine, p.5, L 138 - 140)

Marital stresses affected the baby:

> Even the time James was a baby and we just had one child. He would
> have a bad night if things weren't right with my partner and I… uncanny.
> (Christine, p.16, L: 480-482)

Sleep

Lack of sleep also had its effect on her mood, marriage, and ability to cope as well:

> There was a GP that I went to …he and I talked a little about PND and he
> had a different theory … this theory about PND was so much that it was
> brought on by the cheer exhaustion of being a mother and not getting
> regular sleep and how you have this suddenly break in your sleeping
> pattern. You might have had years of being a normal sleeper and what
> that does to your brain chemistry… I don't think it is fair to say it is just
> exhaustion because I believe it can get far more severe and I know that it
> is a very much of the moment thing as well.
> (Christine. 43, L: 1363 – 1372)

> (If I don't get enough sleep) I have a melt down, I do, I turn into Psycho
> Mummy…the kids and my partner say, "Mum, have a sleep, have a nap
> mum!"
> (Christine, p.44, L: 1383 – 1384)

Her parenting and PND experience had its share of painful emotions:

Painful emotions: fear (ideas of hurting child):

> I was having bizarre fantasies which I know are very much part of the
> condition (PND) and I knew that it was completely illogical and it was a
> little scary to have them but I didn't give myself a hard time about it … I
> understand how people can hurt a child if their condition is really severe!
> (Christine, p. 7, L: 200 – 206)

Anger: desperation: fear

> I definitely had yelled at the baby… I would just say I can't cope, I can't
> do this here you take the baby and go away because I have to be away
> from this right now.

(Christine, p.7, L: 212 – 215)

Hospital provided a number of stresses:

> I was the only mother who wasn't having my baby in my room with me
> during the night because I wasn't coping with it. I was exhausted…
> (Christine, p. 8, L: 240 – 241)

> At 3 am in hospital I would walk past the nurse's station and stand
> outside and smoke. And just cry because I didn't know what to do and I
> wasn't offered any help …
> (Christine, p.8, L: 230 – 236)

.
> I couldn't feed baby properly, I was recovering from surgery and I was
> just "beside myself". Absolutely beside myself! So, I was really wanting
> to be home because I felt unsupported!
> (Christine, p. 8, L: 241 – 244)

Having her firstborn in the room with her was unhelpful, as she couldn't sleep:

> I said to the girls I can't relax, I need to get some sleep and they bought
> him to me early morning for a feed when he woke up.
> (Christine, p. 29 L: 913 -915)

Painful emotions, sadness: loss

> I still feel sad…about what that did to me (PND) and with my
> relationship with my son.
> (Christine, p. 9, L: 259-260)

The loss of self was an issue:

> It was just like this whole stripping down of who you are and having to
> rebuild this picture of yourself again"
> (Christine, p.32, L: 991 -992)

Difficulty with bonding made her feel sad, especially when compared with the woman

sharing her room:

> The women next to me (in hospital) … had the baby in the bed with her
> the entire time. And I remember feeling like what is wrong with me?
> There is this woman with this peaceful little baby in bed with her and she
> is just totally relaxed. How on earth is she sleeping with that baby? I
> couldn't understand it. It just felt so foreign to see that and I was feeling
> the absolute opposite about our baby."
> (Christine, p.29-30, L: 922 -928)

Feelings of failure, especially over the birth experience, were painful also:

> You can very much feel like a failure when it (birth) doesn't turn out the
> way you anticipated!
> (Christine, p.53 L: 1671)

Traumatic Birth

The stress of a difficult birth was the genesis of PND for Christine.

> I went through a very traumatic birth, an emergency caesarean with my
> first child, 30 hours of labour and feeding distress …
> (Christine, p. 3 L: 91-93)

The birth of her first child started in a very unexpected way. Eight days overdue to give

birth, she had a "show" and was hospitalised.

> I remember feeling very depressed on the day I went into labour…I was
> quite teary and emotional. Later that day I lost, I came home and was
> very tired because I hadn't been sleeping."
> (Christine, p. 15, L 517 – 521)

Labour was long and exhausting, she had every possible intervention before the C-

section:

> I laboured all during the night. They convinced me to have pethidine to
> try to get some release so I thought okay …Not that it did very much and
> then they decided that I should be hooked up and be given the oxytocin…
(Christine, p. 15, L: 537 – 540)

Afterwards she was given an Epidural block and morning came and Christine woke
exhausted, having laboured all night. Then the staff "broke her waters" and the baby
started to show signs of foetal distress, her partner knew it but failed to tell her.
Breaking the waters was a scary experience and it was not handled very sensitively by
the hospital staff:

> I kept saying, is the baby all right? I was so drugged up. And my partner
> was like, no everything is okay…he just didn't want me to panic. When
> they went to break my waters I freaked out completely I started to have a
> panic attack, I thought you are not putting that knitting needle up there!
> And I really, really had a panic attack and they (staff) said, "No, we just
> need to do it."… And my partner just ended up swearing at them and said
> just listen to her… Will you just calm down and just leave her alone for 5
> minutes, let me talk to her and settle her down he said. She is having a
> panic attack and unless you understand what that is about you are not
> doing it!"
(Christine, p. 18, L: 561 – 570)

Her partner took charge of the situation, calming Christine down and indicating to the
staff to break her waters when she was distracted. The baby had had a meconium bowel
movement and it was apparent to the staff he was in foetal distress.

Two female surgeons were on during the night, they were good to her but they clocked
off in the morning and left and there was a shift change of doctors. Around about 6.30
that night still she was in labour and the staff were encouraging her to keep going, and

she was dilating but still only to 8 cms. Then a professor, a leading gynaecologist and teacher, strode into the delivery room with this approach:

> This professor, who was the professor of God-knows- what (Professor of "being a wanker") and my husband will tell you he was terrible, he was just revolting! He came in, bombarded into the room and we were like, exhausted and stressed. We had been there since midnight the night before. And he came in and did an examination and I mean, fortunately I couldn't feel it because I was on an epidural. He was really angry, he felt really angry about the way he did this internal and he was very aggressive and forceful. My husband thought it was quite a demeaning thing and he said "You must be having a girl; it is always the girls that keep us waiting!" And we knew we were having a boy! 'Oh, well keep going for a while" and the impression we had from that was that he was actually clocking off and he didn't want to have to be doing the job."
> (Christine, p. 19, L: 588 – 602)

Fortunately the two young female surgeons came back on to the shift and were shocked to find Christine and her husband still there, and her husband begged them to "Please do something". Within half an hour Christine was in theatre and a healthy baby boy was delivered by emergency caesarean section. Christine shuddered as she remembered it:

> It was a horrible time and a most horrible experience in that sense when they took him out and took him away, I couldn't hear him! I was going "oh my god, my god"…I didn't want the mask on my face and I really found things like that were a huge stretch for me and just felt so helpless being chopped open to get this baby out.
> (Christine, p. 20, L: 609 – 613)

She was stitched up and then she attempted to breastfeed her child in the recovery room, but after this, Christine's memory fades.

> It was all a big blur. I really don't have very clear recollection because I was so heavily drugged. I had everything, I had pethidine, gas, epidural top-ups and I wasn't me…

(Christine, p. 20, L: 617 – 619)

All her expectations of the birth and after birth in hospital experience were shattered:

> It was a really difficult thing to recover from and just such an enormous shock!
> (Christine, p. 20, L: 623)

Post-traumatic stress Disorder

Christine felt that the traumatic delivery led to a form of **Post Traumatic Stress disorder**, which then fed into her PND. That being the case, she also thought debriefing for a mother after a difficult labour and some preparation would be a good idea, and some preparation for birthing trauma would be a good idea in ante-natal classes:

> Especially when you have these late interventions. And there is all this birth plan stuff and you do all the preparatory****! Why don't they then come back to you and say listen things didn't go quite as you were hoping for, you know, how do you feel about it?
> (Christine, p.21, L: 649-651)

As she thought about this, she became quite passionate:

> Terrible things happen to women and who is out there talking to them about it? Nobody.... Absolutely no one! Unless we have got the guts to say something about it to each other and offer each other support…"
> (Christine, p.22, L: 671 –673)

The birth of her second child also ended with an emergency Caesarean section, but Christine made the decision to do it:

> I ended up bursting into tears and said, I think I should have a Caesar!
>
> (Christine, p. 23, L: 727)

But this brought on memories of the previous episode and a sense of foreboding:

> Then I had a panic attack because I knew what was ahead of me with the surgery!
> (Christine, p.23, L: 730*)*

The nursing and medical stuff helped to calm her down and the baby was safely delivered, but then Christine had a dangerous Postpartum Haemorrhage:

> I said… I am feeling hot, I am feeling hot you know please can you do something. And I just started to feel I was bleeding. Oh my God, something is wrong. I don't know what is wrong and I said to my partner something is wrong, I don't feel right, can you get someone please. Something... I just felt like I was going to pass out and I said to him I think I am going to pass out. And then - 5 people wham into the room, blankets back and bleeding everywhere!
> (Christine, p.24, L: 756 – 760"

.

The nursing staff fed the baby water; Christine was admitted to Intensive care, without her baby. They gave her a photo of her child and it was vital from her point of view to remember that birth is dangerous:

> I had a photo of my daughter. It was all quite dark when I look back. A beautiful photo of her which they taken with had a Polaroid camera and I am looking at my baby lying there, watching the TV and I thought, this is pathetic. I just had this baby and here I am clutching this photo crying, waiting for my baby. By the morning I had her in for a feed and I was doing better and we got through it okay. But you don't realize how close you can be to death. People don't associate it with childbirth any more!
> (Christine, p. 25, L: 782 – 787)

Support – Health Professionals: Theme 2

Christine found very helpful interventions with health professionals such as the mothercraft nurses where she had her baby weighed. Their help, plus her own insight and determination was the factor that helped see her through the difficult period.

I had stopped breast feeding I don't know whether that was a significant part of me having a complete melt down I had gone in there (to maternity and child nurses) for some visit and just in conversation about how are things going... I basically dropped my bundle and made it quite apparent that I wasn't actually coping very well. That I was completely exhausted… My husband being there he could talk about how I was directing that at him (how I was feeling…we could really get some issues out and see was it really about him (husband) or was it about me not coping or feeling exhausted. How could he better assist me…
(Christine. 5-6, L: 129 –183)

Counselling helped with the bonding of mother and child:

I actually took my firstborn to counselling. I did that when my daughter was born because he was struggling like most kids do. I suppose by the time she was about a year old we went into some counselling and then both had marital counselling with to help us make the adjustments again. We were both going through difficult things in our personal life and also I wanted some one on one stuff with James, which they did with us…
(Christine, p.10, L: 291-296)

Earlier difficulty bonding with her son due to the PND was overcome by working at the

relationship with effective professional help:

We are very affectionate with each other. I make a real effort to be like that with him. I have to work harder on my relationship with him because I feel I am trying to recover lost ground…I am still connected to him but I can't change what happened and I know that it affected us…
(Christine, p.9, L: 277 –286)

They (counsellors) did things like drawing exercises and play exercises and through a process of playing with James directly or being there with him to play and offering ideas. The way that he would interact with the counsellor or with watching or me the two of us play together. They would watch, they would be able to assess the relationship between us to see if there was an issue really there and they didn't feel that there really was."
(Christine, p.10, L: 314-319)

Breastfeeding her firstborn was an issue as well: Christine needed help from a nurse:

> Problems with breast-feeding in the beginning with Polly at Woodville
> who had done a day service treatment with James and myself which was
> fantastic and that really helped!
> (Christine, p.4, L: 114-117)

As she considered the health professional interventions, Christine also had these suggestions:

Suggestions for Health Professionals

The antenatal classes could have done with more realistic input:

> Honestly, learning how to breathe was a totally absolute waste of time! It
> all goes out your head anyway when you are having contractions. I saw a
> birth video… I don't think there was anything particularly useful in there
> at all!
> (Christine, p.35-36, L: 1092-1127)

She had one bad memory from the hospital where she gave birth:

> .   There was one particular midwife, on this day when I was having my bad
> day after the first child. And I call it the black dressing gown day; I had
> my husband's dressing gown on… So there is me walking, crying my
> eyes out and she was really looking down her nose at me and I thought,
> maybe she didn't like the fact that I was smoking cigarettes because it
> was not a positive thing to do. But it was weird because I remember her
> being on (duty) that following morning, and she just said something like
> you know "Are you feeling better?" Or "How are you feeling?" but
> really off hand. Like, it wasn't actually inviting in any way for me to feel
> comfortable to say: "I feel like****.   Someone tell me what to do
> now!"… It was that impression of, "Please pull yourself together!"
> (Christine, p.36-37, L: 1142-1151)

She felt that the community maternity and child nurses did a wonderful job but they needed more staff:

> I think they should have more funding and more of the nursing staff to
> provide services for the people in the community.
> (Christine, p.3, L: 73-74)

She also had some thoughts for new mothers, to avoid the trap of falling into PND:

Ideas to offer other new mums:

> Don't rush into it (parenthood). Be really clear about who you are as much as you possibly can before you go and become a parent. Because I think we can burden our children so much with our own stuff and the more you have worked on yourself before you do that the better off you will be!
> (Christine, p. 49, L: 1535 –1538)

> Talk to someone to get help, and I really would recommend a counselling service as a follow up to anyone. It is all well and good to get your baby weighed and checked that you are feeding them okay and all of those sorts of things but to really be talking to someone about how you are feeling … is crucial and I think that there is still a level of society that doesn't do that because they feel like they are invading that persons space. …I think people are still a little bit afraid to say how are you coping? What have you been feeling like? Are you getting enough sleep? And have you been teary? … Because I was just prone to say oh no, we are doing really well and he is now eating pumpkin … Then I would go home and fall apart."
> (Christine, p. 49, L: 1546 – 1557)

She wanted health professionals to offer debriefing to women who had experienced

traumatic birthing:

> I was not able to forget (a friend's) reaction when I spoke to her on the phone after she had her baby. He was three days old and I said, "So you had the baby naturally?" … It was nothing short of harrowing because she had a vaginal delivery but they did an episiotomy (and she tore) and there was forceps and there was this and there was that… It was just so far from what she was obviously expecting and there wasn't any debriefing for her… It became a constant source of stress and now they are saying that part of her ongoing physical problems could be an emotional attachment to what happened and not having cleared it!"
> (Christine, p.51-52, L: 1617-1626)

She felt that health professionals needed to share the reality of parenting and birth with

women:

> That is where society is letting women down now…If it was 100 years ago you would be in the hut you know with your mum, your grandmum, aunties and sisters, and you have all done it and have all seen it from childhood you knew all about it, you watched people breastfeed. We have all had none of that, it is all so sanitized and clinical but nobody knows a damn thing about the reality of it!
> (Christine, p.52, L: 1633 –1637)

It was worth remembering that:

> Because we have got the medical help babies and women are saved. They forget about the actual emotional process of what women have been through physically!
> (Christine, p.53, L: 1661 -16630

She felt that more talking to women about feelings was a good suggestion for health

professionals:

> You take your baby to be weighed and measured, why wouldn't you then be talking to a mother about how she is feeling? Is the house work being done and how do you feel about that?"
> (Christine, p.53, L: 1685 –1686)

This thematic analysis was set aside, and the next transcript, from Annie, was then

analysed in a similar way, followed by the transcripts from all twelve women

participants.

Appendix 8: Early analysis: examples from all 12 Participants are linked together. Some examples of a few preliminary concepts.			
12 Women	**Significant idea or statement (From transcript)**	**Linking Key words**	**Concept**
Danielle and Annie	I constantly felt **guilty** because…as a mum **I should be aware** of all that sort of stuff (clean house) and I should be looking after all that stuff (washing, dishes, etc) (Danielle, L 642- 644 p 13)	**Painful emotions: guilt Frustration, expectations**	**Painful emotions**
Annie	I felt if I would spend another minute in the company of this person (the baby)…then **my body would shut down**…that I was **going to die.** It was not that I wanted to but it was just…I couldn't stand the **agony** any longer in my body. (Annie, L – 86- 89)	**Sense of entrapment, fear, panic, loss of self**	
Danielle	(my doctor) gave me no real follow-up after (Kay's birth) of how I was going…but then I'm also aware that in the early stages I was so **good at hiding**…the PND, **we pretend to everybody else** that its not that bad…and that's why PND isn't being recognized, we just **hide it** so well. (Danielle, L: 625 – 630, p. 13)	**Hiding PND**	
Annie	In the maternal child health centre, the nurse would ask…how are you finding it, how are you going? I remember saying, "fine, fine" and thinking…push me, ask me again, ask me again. But of course I perfectly **convinced her that I was fine**. And yet **I wasn't consciously** aware enough to actually do anything - like, it was only a fleeting thought, ask me again. As if **I knew that I wasn't well** but I didn't know enough to actually say so…very strange. (Annie, L 86 – 96 p.5)	**Pretence, Seeking acknowledgement**	**Hiding PND**
Danielle	When you've been diagnosed, its easy to see that the quicker you can recognize PND the sooner you can get treated, but you spend so much time **denying to yourself** that	**Denial of the condition**	

	you've got it…**ignoring that its there**, so its often really some time later that someone is told it is even there…you're often that much down the track, before you realize what's been happening and you can start to get better (Danielle, L: 1209 – 1215, p.25)	**(to self as well as others) delays treatment**	
Annie	I had one of those Christopher Green books and came across the extremely superficial post natal bit and I laid it … on the pillow on our bed and I thought when Sam comes home and sees that he might think there is something wrong… It **took another 9 months from that time to figure out what was going on.** It makes me so angry now that I was **so close to realizing what was happening**… but it hadn't quite sunk into my conscious mind. (Annie, L 90 –106 p.5 - 6)	**Took another 9 months to work out what was happening**	
Danielle	(Nurse in the chemist) took one look at me and **thought that something was wrong**, got me in and sat me down for a chat…gave me the postnatal depression leaflet to read which has got the picture of it there and all the words around it… it described all the feelings you had through PND. And I sat there and thought (laughs)…**yes, that's me**! Yes that's me! Yes, that's me…(laughs) (Danielle, L: 14 – 20, p.1)	**Recognition of condition – painful emotions, fears, health professional support**	**Recognition of PND leads to treatment**
Annie	I got some photocopies of the records from maternal and child health nurses and I was flicking through them one day looking at the results of visits and personal reports and one said: "Annie is enjoying motherhood." I said with great vehemence, "That is a lie! **I never said that**!" and ripped it out and the strength of my response **shocked my partner and it shocked me too**… I had been **in denial**…So that got us both thinking. (Annie, L 121 – 131, p. 6-7)	**Recognition of condition, shock…seeking treatment became the next step**	

Christine	I was so afraid having experienced depression… It was that exact feeling of "please don't let it be back" here again... Because you do feel a sense of failure…!" (Christine, p.42, L: 1321 -1336)	**Painful Emotions: fear, sadness**	**Painful Emotions**
	I would just say I can't cope, I can't do this! Here - you take the baby and go away because I have to be away from this right now! (Christine, p.7, L: 213 – 215)	**Anger, frustration**	
	It was very hard… when trying to live up to a superwoman image... It is very hard to justify time for yourself…" (Christine, L: 1412 -1423)	**Pressure of high expectations of self in motherhood**	
	(In hospital you have)…this perfect baby and so little, and you get all the flowers and the presents and you have got all this attention on you and…. It is this wonderful little world that you suddenly are going to have and the reality is so very different… (Christine, p. 8, L: 225 – 227) I had all these great books on active birth and lets get the music and incense, the aromatherapy and the lovely music. What a joke! It was just so far removed from my reality… (Christine, p. 20, L: 627 – 633)	**Shock of reality**	**Shock Of Reality**
	I didn't cope all that time. Everyone else thought I was (coping). My husband knew better. (Christine, p.4 L: 124 – 125)	**Hiding PND from the world**	**Hiding PND**
	You have the Johnson Baby commercial looming over your head. I must look like this person and be behaving like them…when you are at home thinking I am having a thought about putting the baby in the oven…(Christine, p.50 L: 1562 -1568) I had no idea how to I didn't take care of myself and I just basically went further down and down until…I was not coping and it was (maternity and child health nurses) that pointed that out to me!(Christine, p. 3, L: 95 – 99)	**Nurses helped her find out what was happening, hiding PND from self**	**Recognition Of PND leads to treatment**

Kate			
	If you believe in all that stuff that babies really tune into their mother I was in turmoil so where was this poor child. I hope he wasn't affected but still it was a fairly traumatic time for all of us (Kate, p. 6, L: 10-11)	**Painful emotions:** **Fear,** **Frustration** **Sadness, grief**	**Painful Emotions**
	Most of my satisfaction was actually in the job and that has remained the case for two years now…. I have done stuff with my baby, done work experience. I have done other things but it doesn't do much for your self-esteem. I feel really sad about this- I will cry (sobs) (Kate, p.6, L : 23 - 26).		
	I knew that I was definitely down the path of becoming depressed…(Kate, p.7, L: 2)		
	Can't you see I am falling apart here? And you do nothing? (to the counsellor) (Kate, p.9, L: 16)	**Search for help,** **Being unable to find help**	**Lack of Support**
	I went to see a bloke this time (male counsellor) and …He listened to me, he advised "little steps", that's it basically it and he told me that I was extremely intelligent woman and that I would work it out! (Kate, p.9, L:23 -25)		
	The people you would think would be around (to be supportive) weren't around. And there was an assumption to those people who were closest to me. Like, I am an intelligent woman - I can sort it out, I can cope. After all I have helped other women in this sort of situation, why can't I help myself? (Kate, p.11, L: 12 - 15)	**Loneliness, despair** **Kate was an exception,** **Did not hide her PND,** **Tried to get help**	

Sophie	I found them (the nurses) very strict and when I entered (hospital) I found no friendly greeting (Sophie, p I, L: 18 – 19)	**Painful emotions: Loneliness**	**Lack of Support**
	I wanted a bit more nurturing, a bit more support, a bit of "come in, how are you?" (Sophie, p. 1, L: 19 – 20).		
	I would see the nurses come in at night with their videos that they were going to watch: why couldn't the mums and nurses watch the videos together? Then the nurses also questioned the mums' choice of movies; (commenting that) they were depressed, they shouldn't watch a thriller… (Sophie, p.5, L: 127 - 131)	**Wanted more support from nurses in psyche hospital**	
	"(Hospital food) varied, sometimes they had only sandwiches for tea …when my husband was present we would go out to the fish and chip shop just to get a decent feed." (Sophie, p.5, L: 115 – 117)	**Hospital food was uninspiring**	
	"I felt it would have been better if there had been more groups or activity groups during the day instead of sitting around doing nothing, watching T.V or going for a walk and so were other mums just to get out of the place…I got bored and lonely in Hospital"(Sophie, p. 2, L: 44-47)	**Wished for more activity groups in hospital**	
	I've been to other counselors; they don't take notice of what I'm feeling. Kirsten, she really looks after what your feeling." (Sophie, p. 3-4, L: 80 - 82)	**Found a supportive counsellor**	**Getting Help**

Gabriela	People thought I was taking the event (birth of child) very well. People don't realize that I am not well, people don't realize and people don't realize that I am in trouble now either. I'd go to the doctors and I would get myself together. …" (Gabriela, p. 2, L: 37 –39) I always wear make up apart from the time I was actually admitted to hospital when I wasn't showering and I wasn't well groomed and people thought, she really is bad…(Gabriela, p. 2 L: 50-54) So it is hard unless you present completely falling apart at the seams." (Gabriela, p. 7, L: 163 – 174)	**People did not realise the extent of her suffering**	**Not being diagnosed; Hiding PND**
	When you put your hand up and say I need help and you can't get it, it's too hard. I think most women don't ask for help unless they are really at their wits end. Women will manage and cope and cope and cope until the end." (Gabriela, p.21, L: 510-513	**Hard to get help even if you ask for it**	
	There is no family history of manic depression but when I look back I was actually obviously manic prior to having Connie and manic in my teens. In my behaviour. I was manic, Jack (husband) said I was manic, I had manic tendencies. (Gabriela, p.5, L: 97 -99)	**Bipolar history**	**Being Bipolar**
	I always had really heavy periods right throughout my life and I have always been very hormonal and I have always had PMT. Right from the very early days even pre pubescent days I'd have these moods (Gabriela, p.11, L: 241-243)	**Hormonal problems**	
	I really blamed them (family) for my unhappiness. I blamed my husband and daughter you know, "if I hadn't had the baby everything would have been all right!	**Blaming family for unhappiness**	**Painful emotions**

	(Gabriela, p.9 L:209 -211)		
	(the night of the birth) I was all alone. There wasn't anybody on the ward. My daughter was in the nursery and it was about 3 am in the morning and I couldn't ring anybody up and I couldn't talk to anybody and I was all by myself in this room. The epidural was still in and I couldn't get out of bed and I was completely alone… And I thought I have just had a baby and I am on my own… this is having a baby, is this all there is..." (Gabriela, p. 18, L: 438 –445)	**Loneliness, disappointment**	
	Connie was six weeks old I was going stir crazy and I'd worked and I really didn't know anybody in my area. And so I had seen a couple of notices up when I had gone in for the health checks and the nurse said the class was fully booked. And I burst into tears and she said well, we will take one more… a lot of the women were my age we were all first time mothers, just to listen to everyone's experiences was cathartic" (Gabriela, p. 23– 24, L: 659 – 577	**Stress of parenting**	**Stress of parenting**
	I had terrible problems breast-feeding and I bottle-fed only on the advice of the paediatrician because the hospital kept pushing me to breast-feed and they kept forcing me to keep trying. And keep going and these breastfeeding people kept sending somebody out to keep trying. To teach how to latch on and really, it was all very distressing! (Gabriela, p.19, L: 465-468)	**Feeding difficulties**	

Tracey	I was very upset but I think the (main) problem was, I really didn't have enough nutrients in my body …my iron levels were really low. (Tracey, p.1 L. 18 - 20)	Not enough nutrition in her body	Poor physical Health
	one good friend, she knew, and she knew that I'd had it from the start and she'd often come down and ring me up and say "how's it going?" and I'd either burst into tears or put on a brave face, that I was ok! …but other than that I probably didn't tell a lot of others! (Tracey, p 5. L 40-43)	Put on a brave face	Hiding PND
	People would say you needed to go out and that would help you but I didn't have the energy, I really didn't have the energy to go out, go out for the day, take (my two little boys) out, and I was just exhausted anyway (Tracey, p.5, L: 50-53).	No energy to go out	Exhaustion
	I didn't want to get up in the morning (Tracey, p.1, L: 55)	exhausted	
	I don't like being shut inside, when the weather is hot… and I just can't go out, having to be shut in with the kids (Tracey, p 9, L: 14-17)	Shut inside on hot days with kids	Stress
	I tended to go for alternative methods, I went to a naturopath, I went to a couple of different ones, just to boost my body up…get my calcium and iron levels up because my iron levels were really low… (Tracey, p. 2, L. 38- 43)	Alternative health care-naturopath	Seeking help
	I got (helpful) info from the nurse at…she had these little pamphlets (Tracey.p.10, L: 46-47l) You don't want to face it (PND) when you are about to have a baby…you think you are going to feel good automatically, you think you are going to feel wonderful…and you're going to love them, yeah, even if PND is always handed out with all the information, there's always something about it in the information you're given…like a parent hotline number (Tracey, p 12, L:21 -25)	Pamphlets were helpful	Getting help

Kathy	I'd never met them (in-laws) before, they were very British, stiff upper lip, my parents are very relaxed, easy going...I tried very hard with his mum…They were so difficult, they were real English people, drinking beer all the time, they even got my dog drunk…I ended up saying "shut up" I don't do it lightly…"(Kathy, p.2-3, L: 35-45)	**Family stress: problems with in-laws**	**Concurrent life stresses; stresses of parenting**
	My husband was at work all the time and I was spending all the time at home with his critical parents…I had no-one no one, my mum was in QLD, parents in law were no help at all, it was such hard work, so stressful…(Kathy p 3 L: 3-5l)	**Loneliness**	**Painful emotions**
	So I called my auntie… I was a stutterer as a child and it came back, due to stress, my mum was fostered out as a child…my grandmother she had lots of children and her husband left her with 8 kids…my mum was fostered out…and my mum is always paranoid that my stepdad is going to cheat on her…I still see my dad and stepmum…but they cant live together…they accepted that. (Kathy p 3, L:28 - 35)	**Remembering past pain**	**Relieving painful past**
	By the time Mary was One I was better. My hormones were funny – I went to the GP and got everything tested but the severe PMT – one doctor said I had this condition – Premenstrual Dysphoria – a very severe reaction to hormone changes, the best thing I can do is have no periods and stay on the pill (or take Zoloft for the rest of my life)(Kathy, p 10, L: 7 – l0)	**Hormone problems**	**PMDD**
Jane	He was two weeks late, I had to be induced, he shot out like a bullet out of a gun and I ended up with a 3rd degree tear" (Jane, p.1, L 9-10)	**Birth trauma**	**Stresses and Strains of Motherhood**
	He was just a very difficult baby. From the moment he was born he screamed continuously…it didn't get any better after that! He didn't sleep all day he just screamed and he would be awake every two hours at night (Jane, p.1, L: 14 -17)	**Difficult infant behaviour**	

	I had something like two hour's sleep in broken lumps for the first six months of his life. I coped for a little while but after a few months I was an absolute wreck (Jane, p.1, L: 17 -21)	**Lack of sleep**	**Painful Emotions**
	I felt hugely guilty for having those feelings and all I wanted was for him to shut up…(Jane, p.1 L: 44)	**Painful emotions: guilt**	
	Suddenly I stopped work and I felt quite isolated and I didn't have another adult to talk to. And I just found it horrendous" (Jane, p.2, L: 82-84)	**Painful emotions: loneliness**	
	I felt so lousy with Tom and work had really got me back onto my feet. I was actually still quite depressed when I went back to work, but it got me better than anything else" (Jane, p.4, L: 182 - 184).	**Work was supportive**	
	(working as a nurse) I was very determined not to be depressed, so I denied for months and months and months because you know, that was other people! That wasn't me, I got women better, I certainly didn't suffer from PND!" (Jane, p.3 L: 164 -166)	**Denial of PND**	**HIDING PND**
	I think if I had been more willing to accept help instead of trying to be super-woman, thinking I should do all this because I'm the mother. I would have been a lot better off ….but when you're a nurse you're really quite perfectionistic (Jane, p.5 L: 252 - 256	**Tried to be superwoman**	**Expectations of Self as mother**

Olivia	When…I went home from hospital I was already very tired. Because I had been trying to breast feed for an hour and a half at a time during the night and not getting proper sleep! (Olivia, p 1, L 16 - 18)	Sleep deprivation	Exhaustion
	I could not understand why I couldn't do this and I couldn't stop the baby from crying. She just wanted to be fed all the time. (Olivia, p.6, L: 12- 13)	Stresses of new parenting	Stresses of new parenting
	My self image was very different to that present reality…being myself in casuals all the time and … New mother attire. I really had trouble switching from one form of existence to another. (Olivia, p. 9, L: 7- 9)	Shock, change	
	I was washing the dishes, washing the floor bursting into tears saying in the space of two weeks I have gone from being a corporate lawyer to this … a drudge. How has this happened to me? (Olivia, p.8, L: 4-8)	Painful emotions, sadness	
	I got tempted to throw her across the room! (Olivia, p. 14, L: 29)	Anger, Frustration	High Expectations
	I… felt guilty because I wasn't enjoying it (motherhood) (Olivia, p.15, L:8)	Guilty feelings	
	I went home with the best intentions. I was going to be a really good mother, housewife…I was going to keep the house clean, I was going to keep the dishes washed and…you actually can't! (Olivia, p 6, L:7-8)	Expectations of self	
	When you go for appointments you put on a bit of a front and you appear to be coping. I didn't feel inclined to tell the GP or the sister or anybody that I was getting the creeping black. I cannot remember, I think my head was just a muddle…and they didn't pick it…" (Olivia, p. 22, L: 23-26)	Hiding PND	HIDING
	Regarding…that loss of self, that sense of shock. I did cover it up very well. It is hard for me to think what might have given them (health professionals) a clue! (Olivia, p.25, L: 7-8)	Loss of self and sense of shock	PND

Leanne	I just wanted to curl up and die (Leanne, p.12, L:9)	**Painful emotions: Distress**	**Painful Emotions**
	I got out of hospital and I was having lunch with my oldest boy at a café and we were eating, and I was crying and he asked me what was wrong and I was like saying "I don't know! (Leanne, p.9, L: 4-7)		
	I'd feel lazy, I'd just feel lazy - my boyfriend would work all day and he would come home and do the dishes. The kids… doing more than they should be doing, and I would be thinking why couldn't I do it? (Leanne, p.6, L: 23-26)	**Guilt, Exhaustion**	
	A crying, screaming baby, that's very stressful and as you know, when they're sleeping you have still got to do housework and try to get sleep yourself… (Leanne, p.21, L: 39-40)	**Stress of new parenthood**	**Stresses and Strains of Being a New Mum**
	C-section is really hard, nothing really can prepare for going into labour and then suddenly having to have a C- section …day two or three I'm walking, just walking to the toilet and someone's like: "You're doing so well!" and I'm thinking "I can't hardly walk! (Leanne, p 22, L: 9 -23, L: 22)	**Birth Trauma Difficulty coping with a Caesarean Section**	

Leanne	They (maternity and child nurses) seem to deal with the baby more than the mother. (Leanne, p 9, L:22)	**Seeking help, failing to find help, feeling ignored**	**Lack of Support**
	There was nothing, when I needed it… when I had (PND) it was just ridiculous so…. hard to get help there was just nothing… I mean, a psychiatrist, I didn't want a one on one, technical bull**** with some psychiatrist, I wanted to talk to mums! (Leanne, p.15, L: 6-9)	**Wanting a group of mums to talk to**	
	In the nurses room they have a chart. …we have got a nurse in the middle of the day. (I wouldn't know. They don't come in and say "Hi, I am Lyn, your nurse for today.") 1 think they should do that, so that to make it a bit friendlier. And then "I am going home now, Judy is going to be your nurse for the rest of the day… (Leanne, p.31, L: 1-5)	**Feeling unsupported in the hospital environment**	
	The best thing about the place (hospital) was this psychologist lady; she takes you into a little office and talks to you. She was definitely great…another couple of other girls complained about the nurses and she said that if you say anything it just makes it bad for yourself… (Leanne, p.3 L: 5-8)	**Supportive psychologist in the hospital environment**	
			Getting Help

Elle	One of the saddest things about the postnatal depression was…. A lot of the memories of the children have gone when they were little and I think that is because of the way I was feeling … which that to me is the saddest part about the whole thing. It is not can you remember when they walked, or can you remember this. You know a lot of the memories I can't, just can't access (Elle, p.21 L: 21 -26)	**Painful emotions: sadness**	**Painful emotions**
	I just couldn't cope…There was no…light of the end of the tunnel, there was nothing…I was in tears the whole time. I couldn't talk to anyone…I couldn't … It was just a bit, I don't know, not a void, but… what is the word…I couldn't concentrate on anything…I couldn't….you know just everything was a disaster you know the tiniest things were blown out of all proportion… (Elle, p.1-2, L :23- 40)	**Despair**	**Painful emotions**
	I would go out once a week… I would go shopping. My kids would be absolutely perfectly dressed and I would be too … and everyone would say "God, I don't know how you do it…" and then I'd think, "Well I'm NOT doing it!" (Elle, p.9, L: 17 - 20) (I was) Just doing everything. Nothing was left… I was totally opposite to other postnatal people I know that just can't do anything. I was the opposite; I was fanatical about my house. Everything had to be perfect if somebody came and I guess that was a way of me showing them that yes I am coping… come to my home everything is hunky dory. Because I didn't want people to know I was in the state I was in. (Elle, p, L: 27-35) It is just full on with four kids…They were just so young... I had (the first) when I was 31 so I slowly progressed to each child it obviously got worse and worse. I had (my last) when I was 36 (Elle, p.4. L: 8-14)	**Hiding PND, sense of shame** **Trying to live up to perfect Image, keeping perfect house, not wanting anyone to know the state she was in** **Stress of Parenting, pressure of four kids in four years**	**Hiding PND** **Stress of Parenting**

Table 1 Development of the first theme, Dual Reality

Words of Participants	Linking Key words	Concept	Sub-theme	Theme
When I went home from hospital I was already very tired, I had been trying to breastfeed and not getting proper sleep! (Olivia, p.1 l: 16 -18) "I really didn't have energy to go out, … and I was just exhausted" (Tracey, p 4. L: 35 - 38)	**Tired, not sleeping**	**Exhaustion**	**Stresses and Strains of Being a New Mother**	**Dual Reality**
"A crying screaming baby, that's very stressful, and you have still got to do housework… " (Leanne, p.21 L 837 -839)	**Stress**	**Stress of Parenting**		
You are cast from a situation in which you are very knowledgeable into a situation in which you really don't know what you are doing…(Olivia, p14 L 1-3) "It was all a big blur. I really don't have a very clear recollection because I was so heavily drugged. I had everything, I had pethidine, gas, epidural top-ups and I wasn't me" (Christine p. 20 L: 617-619)	**Confused, don't know what you are doing** **blurred memory; trauma**	**Identity crisis of motherhood** **Birthing trauma**		
"(I have) Premenstrual Dysphoria – a very severe reaction to hormone changes… (Kathy p 7 L: 18 -20)		**Hormonal difficulties**		
"Andrew was a big baby…he just needed to drink a lot, probably every three hours, and I found I didn't have enough for him…"(Tracey, L 34 – 42)		**Feeding difficulties**		
"My husband was at work all the time and I was spending all my time with his critical parents…I had no one" (Kathy p 3 L: 3-5l)				
		Con-current life stresses		

Work sort of knew things weren't the best but I wasn't going to admit it…. I was a nurse I'd looked after people with PND; there was nothing wrong with me. I was going to cope. (Jane, p.1 L: 35 - 36)	**Appear to cope**	**Appearance of Coping**	**Behind the Mask**	
I was so good…at hiding the PND, we pretend to everybody else it's not that bad, and that's why PND isn't being recognised, we just hide it so well. (Danielle, p.13, L: 625 – 630)	**Pretence**	**Hiding PND**		
I didn't cope all the time. Everyone else thought I was. My husband knew better (Christine, p.4 L: 124 – 125) You do at the time think like you are the only one…I mean, I was putting on a brave front, and some women are just too proud to admit they have a problem" (Elle, p.28, L:24-26)	**Brave front, too proud to admit to a problem**	**Denial of PND**		
It was like this whole stripping down of who you are and having to rebuild this picture of yourself again (Christine p 32, L: 991 – 992)	**Shock/ Loss of self**	**Loss of self/sense of shock**		
You hand over your needs the second you have a baby and you get a whole truckload of guilt(Danielle, p 15L 714-715)	**Guilt**	**Feeling guilty**		

I didn't cope… I was in tears the whole time, I couldn't talk to anyone… everything was a disaster. (Elle, p.1-2, L :23- 40)	**Not coping, no longer able to hide not coping**	<u>**Painful emotions**</u>	**The Depression Experience**	**Dual Reality**
The whole thing was a huge struggle for me – I cry now because it hurt me deeply and still does (Kate p 6 L: 25 - 26)	**Crying, struggle, Feeling hurt**	**Classic Symptoms of PND (e.g. sadness, rejection of child, acute anxiety, difficulty bonding with child, inability to cope, lowered mobility and responsiveness…etc**		
When she was born, I didn't want her in the room with me. When any visitors came I left her in the nursery because people kept waking her up, and I didn't want her to wake up because then I would have to tend to her…(Gabriela, p 1, L: 17 – 20)				
I felt if I would spend another minute in the company of this person (the baby) then my body would shut down…I couldn't stand the agony (Annie, L -: 86 – 89)	**Difficulty bonding with child, rejection**	(DSM-IV, 1995))		
I still needed, I still wanted someone with me all the time, and that wasn't really working…but if I had people with me I felt better, but I didn't have enough energy to go out! (Tracey, p.4 L: 10 -16)		**Somatic experience of depression**		
I went through a whole lot of issues about my own entering into the world, my parents relationship…they weren't positive things…a lot of grief, a lot of fear… (Christine, L 399-409, p.13)	**Not coping, anxiety**	**Old history triggered by depression**		
	Past history re-activated			

liii

Table 2. Development of the theme, Interventions: Getting Help

Words of Participants	Linking key words	Concept (Example)	Sub-theme	Theme
She (baby) had her hours all round the wrong way totally…so when she was about 12 weeks old I told my husband I just couldn't cope any more and I went to stay with my girlfriend who had a farm and I just slept for two days…my friend cured Connie and de her sleep all night…she took the baby and let her scream all night and then kept her awake all day and would not let her sleep… (Gabriela, p. 20, L: 483 – 493)	**Help from female friend, who cured baby screaming all night**	**Help from friends and family**	**Getting Help**	**Interventions**
I have the best partner in the universe, I have got to say…totally supportive. He couldn't feed (baby) but what he did was he would get up and bring baby into bed for me and make me a cup of tea in the morning and do those kinds of things… (Kate, p 5 L: 20 - 23l)	**Supportive partner**	**Helpful medication**		
Once I was on the "Ciprimil…I knew, within a couple of weeks that it was working, well, it was really clear that it was working! (Danielle, L 109 – 113 p 3)	**Ciprimil was a helpful medication**	**Help from maternity and child health nurses**		
"I was one of those people that if he was four months old and had to be weighed I would take him on that day…they (child and maternity health nurses) all knew me and they could see	**Helpful child and maternity nurses urse picked up the PND**	**Interventions which lead to diagnosis and help**		

what was happening…(Christine, p. 4 L: 108 – 113) I was very lucky…I don't know how long it (the depression) would have kept going if she (nurse) hadn't picked it up (Danielle L 79-85, p 2)		**Help from various health professionals**		
Before my breakdown and hospitalisation I went to somebody. I absolutely adored him…he was a psychologist…he taught me a lot of problem solving skills and he set a whole lot of mechanisms in place… (Gabriela, p 3, L: 67 – 70)	**Helpful psychologist** **Giving good counselling**			
They (nurses) were fantastic in looking after me, if I felt that I couldn't get out bed well, they would let me stay in but on the other hand they didn't support that behaviour either" (Annie, p 13 L 290 – 292)	**Helpful nursing interventions in psychiatric hospital**	**Helpful interventions in hospitals**		
All parents will feel the same about putting their children into day care but she made a couple of close friends that she saw all the time. And they do everything for you. They wean the babies for you. They toilet train them. They teach them how to dress themselves. They give them good food. I mean, I am lucky to have been able to send her to good day care!(Gabriela, p.22 L: 532-536)	**Helpful day-care for child**	**Help from other agency supports (eg, childcare)**		

Table 3 Development of Theme, Interventions: The Need for Education on PND

Words of Participants	Linking Key Words	Concept (Example)	Sub-theme	Theme
Women have a lot more help nowadays because of the internet…I didn't have a computer in those days (when I had PND) but if I could have had something like this where I could just log on and chat to a professional or to other mums it would have been such a help!(Gabriela, p 25 – 26, L: 613 – 618)	**Further community information would be useful (eg internet)**	**Health professional help ideas**	**The Need for Education on PND in the community**	**Interventions**
That's the thing I loved about the day programs (they were group parenting education) that they were about the reality of parenting (Danielle, p. 21, L 1015)	**Support groups needed for the reality of parenting**	**Health professional Help ideas**		
There should be support groups for women who have a second or third child. Not just new mothers. I would recommend support groups for women with PND… (Gabriela, p 27, L641 – 643)	**Support groups needed for PND**			
I got info from a nurse…she had these little pamphlets. I worked out what I had and it helped to read articles about PND… (Tracey, p. 12 L 46 - 47)	**Literature on PND is helpful**	**Health professional help ideas**		
If you can fix it (PND) in six months rather than eighteen it would be better! (Annie, L 448 – 450)	**Earlier diagnosis is needed**			
You don't want to frighten people but as long as the (PND information) is there…it is better even if you	**Need for more**	**Pregnant women**		

don't want to face PND when you are about to have a baby, you think you are going to feel good automatically, you think you are going to feel wonderful, and you're going to love your child… (Tracey, p 13 L: 22- 25)	**appropriate teaching in antenatal classes**	**specific ideas**		
The other lady…she'd had PND and…like she was really bad…and I actually did ring her and had a little chat and I did feel better because she'd been a lot worse!! After I spoke to her I definitely knew I'd had it mild!! (Tracey, p 10 L: 47 - 52)	**Women talking to each other can help each other through PND**	**Women helping women**		