**Exploring the experiences of women with postnatal depression who access community services**

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**THESIS PORTFOLIO: CANDIDATE DECLARATION**

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| **Declaration and signature of candidate** |
| I confirm that the thesis submitted is the outcome of work that I have undertaken during my programme of study, and except where explicitly stated, it is all my own work.  I confirm that the decision to submit this thesis is my own.  I confirm that except where explicitly stated, the work has not been submitted for another academic award.  I confirm that the work has been conducted ethically and that I have maintained the anonymity of research participants at all times within the thesis.  Signed: Date: |

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**Thesis abstract**

The aim of this thesis is to explore the experiences of women who access community services for postnatal depression.

Paper one is a qualitative literature review that synthesises the findings of seven empirical papers. Following a thematic analysis, a hierarchical model of five themes (External hopelessness, secrets and permission, desire for choice, loss of control and inadequate services) was developed to illustrate the experiences of women and the cultural and societal influences that impact upon these experiences.

Paper two is an empirical research paper that explores the experiences of six women who self-identify with the term postnatal depression and accessed NHS community services for support with this. Face to face interviews were completed and data analysed using a narrative approach. A single story was constructed to illustrate the shared meanings from the women’s experiences. This identified trauma, feeling unheard, the use of language and the impact of social constructs of motherhood as key narratives. The clinical application of the research is discussed as well as future research implications.

The final paper is an executive summary produced in order to provide a succinct summary of the empirical research paper. Main findings of the research are presented along with clinical implications and recommendations in the context of service development of perinatal mental health services.

**Paper 1**

**How do women experience community treatment for postnatal depression?: A review of the literature**

Word count: 7,191

Journal submission details: This paper has been written with the aim of being submitted to The Journal of Prenatal and Perinatal Psychology and Health (Appendix I). This journal was chosen due to its interest in publishing work that explores the influence of the family, society, and the environment on the pregnant mother.

**Abstract**

A systematic search of literature was undertaken to identify qualitative research papers. A thematic synthesis was performed on seven papers. A hierarchical model of five themes (External hopelessness, secrets and permission, desire for choice, loss of control and inadequate services) was developed to illustrate the experiences of women and the cultural and societal influences that impact upon these experiences. Social norms and narratives relating to motherhood contribute to a downward pressure that impacts upon the experience of receiving treatment for PND. Specialised perinatal teams that can provide in-depth and complex interventions as well as sufficient continuity of care are required.

Word count: 100

Key words: postnatal depression, community treatment, qualitative

**Introduction**

**Context of perinatal mental health**

The Centre for Mental Health (2014) state that perinatal mental health issues affect up to 20% of women and that they are of extreme importance as a public health concern due to the impact on the mother but also as “they have been shown to compromise the healthy emotional, cognitive and physical development of the child, with serious long term consequences”. It is estimated that the cumulative cost of perinatal depression, anxiety and psychosis to the National Health Service (NHS) is £1.2 billion. An investigation into the causes of maternal deaths (deaths that occur between 6 weeks and one year after the end of pregnancy) has found that whilst the number of deaths due to direct causes has decreased, there is no change in the rate of indirect causes and the figure “remains high” (MBRACE, 2015). A quarter of these deaths were attributed to psychiatric causes. The report specifically focuses on mental health concerns and makes recommendations regarding the assessment and treatment of perinatal mental health problems. Other national drivers have recommended changes to the way perinatal mental health services are delivered in response to growing concern regarding the care women receive at this time. The Joint Commissioning Panel for Mental Health (JCPMH) highlight the need for a perinatal mental health integrated care pathway to be used by all services to ensure access to services for the right people at the right time (JCPMH, 2012). Extra training on perinatal mental health for practitioners working in community services such as IAPT (Improving Access to Psychological Therapies) is also raised as an important aspect of future services as well as holistic assessments from primary care practitioners such as GPs. The National Institute for Health and Care Excellence (2016) also emphasise the need for adequate training and recommend that women who present with perinatal mental health concerns should be seen within 2 weeks for assessment and begin their therapy within 6 weeks.

**Postnatal depression**

Postnatal depression (PND) is a serious mental health concern that affects approximately 10-15% of mothers (Royal College of Psychiatrists, 2014) with first time mothers being at an increased risk (Gavin, et al 2005; Beck 2008). Symptoms of PND include tearfulness, feelings of hopelessness and sadness, loss of energy, sleep disturbances, difficulty bonding with the baby, social withdrawal and thoughts of self harm and suicide (National Health Service (NHS), 2016). PND can have severe and long lasting effects on the mother, her partner and interactions between mother and baby if left untreated. There can also be long term detrimental effects upon the child’s emotional and cognitive development (Stein, et al 2014). It is estimated that half of all cases of postnatal depression go undetected in routine clinical practice (primary care services such as general practitioners (GPs) and midwives) and for those that are identified many do not receive the evidence based treatment that they need (NHS: Improving Quality, 2015).

**Rationale for Review**

Jomeen (2012) writes that “women have been traditionally understood and explained within maternity care in largely scientific terms” but that “(psychometric) measures cannot provide us with the meaning and understanding that women themselves during pregnancy and following childbirth attribute to psychological concepts or the way in which they are culturally or socially absorbed and articulated”. Nonetheless, much of the research on postnatal depression is focused on risk factors associated with the disorder and consists of analyses of quantitative data in cross sectional and longitudinal studies (O’Hara & Swain, 1996; Beck, 2001).

There are some qualitative studies that have explored women’s experiences of PND. These papers focus on the experience of PND for women and place emphasis on exploring a number of aspects such as precipitating factors, symptomology, relationships with others, identity and adjustment (Haga et al, 2012; Coates, de Visser & Ayres, 2015; Bilszta et al, 2010). Other qualitative papers focus on demographics of the mother and often the accessibility of services for these women (Lam, Wittkowski & Fox, 2008; Wittkowski et al, 2011; Templeton et al, 2003). How women experienced the services they accessed for support is included within some papers though this is rarely the primary focus of the research. If the experience of women is more fully understood it may be possible to improve the accessibility, efficacy and standard of these services.

**Aim**

This literature review aims to provide a comprehensive and contemporary synthesis of women’s experiences of treatment for PND in the community. This is in part driven by the current national policies and guidance for improvement within perinatal mental health services.

**Method**

A qualitative literature review was carried out to explore the existing research relating to mothers’ experiences of treatment for PND. A systematic search was undertaken to identify relevant papers. A quality appraisal measure was administered to each paper and findings were synthesised. A thematic review was carried out on the results of all papers. Themes and clinical implications are discussed.

**Search strategy**

A systematic approach was taken to search the literature. Search terms were developed via an initial scope of literature and thesaurus function on EBSOhost. The search terms used for each database were as follows:

Search terms used

S1: “postnatal depression” OR “postpartum depression” OR PND OR PPD

S2: experience OR perspective OR view OR perception OR attitude

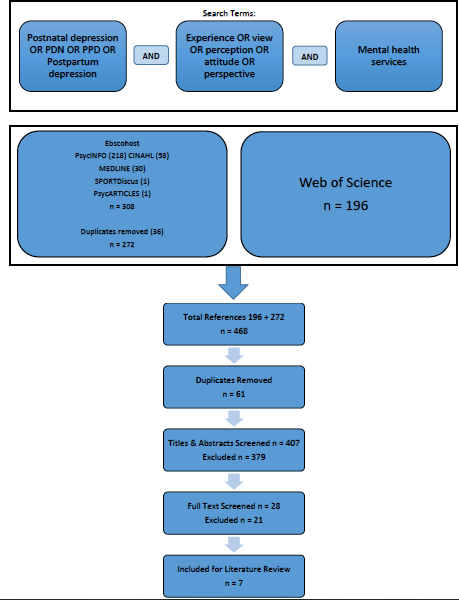
S3: “mental health services”

The following databases were searched using EBSCOhost. Web of Science and the Cochrane library were searched individually. Each term was searched either by topic or abstract. Search terms were then entered into Google Scholar and a hand search of the literature was also performed. Limiters were not applied to the searches.

EBSCOhost databases

* Medline
* CINAHL (Cumulative Index to Nursing and Allied Health)
* PsychInfo
* PsychARTICLES
* PsychBOOKS
* SportDiscus
* Ebook Collection

The literature search was performed on Thursday 15th June 2017. It produced 407 studies which were screened using the inclusion and exclusion criteria. Articles were largely excluded due to quantitative methodologies, exploring the experience of postnatal depression, exploring the experience of health care professionals or looking at screening and access to services. The full texts of the remaining 28 articles were then scrutinised further. A number of papers were excluded due to their focus being on the screening and assessment process of postnatal depression. Others were not included as it transpired that the research focused on the experience of PND rather than the services women accessed. Three papers were excluded as they explored experiences of inpatient services for PND. One paper looked at the experiences of male partners of women with PND. One paper interviewed women on a wide range of topics with only a brief section on mental health services. One article used the transcripts from recordings of a specific intervention with women as their data to explore psychological processes that occur in women experiencing PND. Twenty one papers were excluded during this final sort leaving seven papers for review. The flowchart in figure one illustrates the search strategy.



*Figure 1: flowchart illustrating search strategy*

**Inclusion and Exclusion Criteria**

Papers with mixed methodologies were excluded from the search. This was due to their use of psychometric rating scales with the addition of one or two open questions that allowed for free text. Jomeen (2012) discusses the limitations associated with using quantitative methods when researching women’s experiences in the perinatal period. She suggests that “measures cannot provide us with the meaning and understanding that women themselves during pregnancy and following birth attribute to psychological concepts or the way in which they are culturally or socially absorbed and articulated. Hence the findings lack contextual explanation” (Jomeen, 2012). The mixed methods papers that were reviewed were mostly quantitative with the addition of brief analysis of limited data extrapolate from free text responses and therefore deemed to dilute the voice of the women who participated somewhat. The papers did not provide enough emphasis on hearing the experience of women and so were excluded from this review.

Inclusion Exclusion

Qualitative methodologies Mixed methodologies

Mothers’ experiences Others’ experiences ie health care professionals

Experiences of treatment Experience of access to or screening for services

Community services Experience of treatment within

broader focus on PND

Experience of symptoms

Inclusion Exclusion

Qualitative methodologies Mixed methodologies

Mothers’ experiences Others’ experiences ie health care professionals

Experiences of treatment Experience of access to or screening for services

Community services Experience of treatment within

broader focus on PND

Experience of symptoms

Papers that explored the experience of access to mental health services for treatment of PND were also excluded from this review. This research is needed as it develops understanding of how to reach more mothers who might be experiencing distress in the postnatal weeks and months. However, the focus on access to services is not useful when exploring the experience of these services once women have engaged with them. Similarly, studies that included the exploration of screening for PND were excluded as many included participants who were assessed but not referred to a service or chose not engage in a service. Many of these papers did not have any participants who had ever engaged with mental health services.

**Quality Criteria**

The quality of each study was assessed using the Critical Appraisal Skills Programme (CASP) Qualitative Research Checklist (CASP, 2014). The tool is designed to facilitate systematic consideration of content, methodology, the process undertaken by the authors to produce the research and its future implications. The tool was selected in this literature review as it designed specifically for use with qualitative research, it is clear in its structure and multidimensional in its considerations. The CASP consists of 10 domains against which each paper was scored between 0-2 (0 = domain not satisfied; 1 = domain partially satisfied; 2 = domain satisfied). This produced an overall score out of 20 for each article which were converted into a percentage point (see table 1).

**Data Extraction**

Various data were extracted from each article (see table 1). Authors, year of publication, country, sample size, aims, method, main findings and the quality score were all included. This provided a summary for each paper and helped to guide the thematic review.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Author/year** | **Title** | | **Aims** | | **Method** | | | **Strengths** | **Weaknesses** | **Findings/clinical relevance** | | | **Quality score**  **%** | |
| McCarthy & McMahon, 2008 | Acceptance and experience of treatment for postnatal depression in a community mental health setting | | To identify the factors that influence the decision to seek and accept treatment for PND  To describe women’s experiences of treatment for PND | | Modified analytic induction using structured interviews with women recruited from community mental health teams | | | Robust methodology, lots of detail re. topic guide and how questions were modified.  Detailed and rigorous analysis process | Limited discussion regarding reflexivitiy. | Women have little control over the decision making process regarding treatment; reach crisis point then seek help.  Stigma & social norms impact experience; education and normalisation is needed from services. | | | 80% | |
| Turner, Chew-Graham, Folkes & Sharp, 2010 | Women’s experiences of health visitor delivered listening visits as a treatment for postnatal depression: A qualitative study | | To explore women’s experience of Health Visitor listening visits with a view to improve this intervention | | Framework analysis using semi structured interviews. Purposive sampling of women involved in a recent RCT. | | | Detailed recruitment and data collection sections.  Clear findings are outlined and limitations regarding biases are discussed. | Limited extracts of data to support findings | Listening visits are often insufficient in addressing PND. Researchers view the underlying cause of a woman’s PND & her susceptibility to poor mental health in general as factors that impact the efficacy of treatment. | | | 80% | |
| Shakespeare, Blake & Garcia, 2006 | How do women with postnatal depression experience listening visits in primary care? A qualitative interview study | | To explore the experiences of women who have received listening visits | | Thematic analysis of semi structured interviews. Participants recruited from community practices as part of wider study | | | Detailed methodology.  Ethical considerations are mentioned.  Critical thinking around potential change in future services | Limited discussion regarding reflexivitiy. | Listening visits were not viewed as therapeutic. Highlights multiple role of health visitors and need for greater specialist perinatal mental health presence. | | | 85% | |
| **Author/year** | **Title** | | **Aims** | | **Method** | | | **Strengths** | **Weaknesses** | **Findings/clinical relevance** | | | **Quality score**  **%** | |
| Connerty, Roberts & Williams, 2016 | Managing life, motherhood and mental health after discharge from a mother-baby unit: an IPA | | To explore how women experience community services following discharge from a mother and baby unit. | | IPA, semi structured interviews. | | | Clear rationale for use of IPA.  Analysis explained well | No mention of relationship between researcher and research.  Little contribution to future implications | Care plans for mothers in the community are needed for continuity of care. Mothers actively participate (at some point) in decision making process regarding service use | | | 75% | |
| Masood *et al*, 2015 | | Group psychological intervention for postnatal depression: a nested qualitative study with British South Asian women | | To identify barriers faced by British South Asian women who access the intervention  To identify factors which facilitated participants’ engagement with the intervention | | Thematic analysis using semi structured interviews. Participants were recruited as part of a larger RCT | Topic guide for interviews is shared and is guided by previous literature | | Unclear recruitment strategy  Are not transparent about decisions made in analysis process  Reflexivity is not discussed  Unclear findings section | | Culturally sensitive interventions may lead to better health outcomes. Social and cultural context can impact upon engagement with treatment. | 65% | |
| **Author/year** | | **Title** | | **Aims** | | **Method** | **Strengths** | | **Weaknesses** | | **Findings/clinical relevance** | **Quality score**  **%** | |
| Turner, Sharp, Folkes & Chew-Graham, 2008 | | Women’s views and experiences of antidepressants as a treatment for postnatal depression: a qualitative study | | To explore women’s views and experiences of receiving antidepressant treatment for PND | | Framework analysis using semi structured interviews. Participants recruited as part of RCT | Detailed description of data collection.  Lots of consideration regarding implication for future practice | | No discussion regarding relationship between researcher and data.  Little regarding ethical considerations | | Women’s perceptions regarding the treatment they receive may impact upon the way in which they engage with it.  Recommend more use of discussions & education regarding treatment options | 70% | |
| Myors, Schmied, Johnson & Cleary, 2014 | | ‘My special time’: Australian women’s experiences of accessing a specialist perinatal and infant mental health service | | To report women’s experiences of being a client under the PIMH team | | Thematic analysis of structured interviews. Face to face and via telephone. Participants recruited as part of larger mixed methods study | Very clear structure.  Lots of detail and justification throughout data collection.  Very clear analysis  Acknowledge relationship between researcher and research. | | Less detail provided re. methodology | | Choice and control is central within women’s positive experiences of services. The researchers view mental health services’ role as grounded in attachment theory. Resources for perinatal services to provide long term continuity of care is needed. | 95% | |

*table 1: data extracted from included articles*

**Description of papers**

Seven studies were included in the review. Four studies were from the United Kingdom and three were from Australia. All of the papers used 1:1 interviews with participants to gather data. Four of the studies looked at the experience of women who accessed a specific intervention for treatment of PND. Of the remaining three, one paper explored how women experienced services in the community following discharge from a mother-baby unit (Connerty, Roberts & Williams, 2016) and the remaining two focused on women’s experience of a particular community mental health service but not a specific intervention (McCarthy & McMahon, 2008; Myors et al, 2014). Five of the articles were nested studies that formed parts of larger Randomised Control Trials (RCT) though the studies were stand-alone qualitative papers.

Turner et al. (2008 & 2010) produced two papers using participants of the same RCT, RESPOND (Randomised Evaluation of antidepressants and Support for women with POstnatal Depression). This trial recruited women from 77 GP practices and assigned them to one of two groups: antidepressants as a treatment for PND and listening visits delivered by research health visitors (RHVs) as a treatment for PND. Participants for the qualitative studies were interviewed after their final outcome measures for RESPOND had been completed. Turner et al. (2010) interviewed 22 women about their experience of listening visits and in their 2008 study (Turner et al.) 27 women were interviewed regarding their experience of antidepressant medication. In the original trial the design allowed women randomised to receive listening visits to request medication at any time and participants who were allocated antidepressants were able to request listening visits at any time post 4 weeks randomisation. The papers found that stigma in wider society as well as women’s preconceptions and attitudes towards various treatments impacted engagement with interventions. Both studies also found that there is some uncertainty for women regarding treatment options; women were unsure how to access help or did not fully understand the treatments offered to them. The women who were interviewed about their experience of listening visits made contrasts between the RHVs and their own practice health visitors (PHVs); they mostly felt that the intervention would not work in practice due to the multiple roles that health visitors hold, their primary focus on the child rather than the mother and the women’s perceptions that they would be judging their ability to parent if they confided about their mental health needs. These findings supported those of an earlier paper by Shakespeare, Blake & Garcia (2006). Thirty nine women were interviewed about their experience of screening with the Edinburgh Postnatal Depression Scale (EPDS) and listening visits. The transcripts from 16 of those women were used for this study to analyse the experience of women who received listening visits. The authors found that the women judged their health visitors’ ability at providing therapy upon previous contacts relating to the care of their baby. Few women found the listening visits helpful and again stigma was cited by many women as having caused them to delay seeking help. McCarthy & McMahon (2008) also consider stigma and social norms surrounding motherhood in relation to their findings. In the study 15 women were interviewed about their acceptance and experience of postnatal depression. The authors found that, contrary to their original hypothesis, the women they spoke to rarely made the decision to seek and accept treatment. They describe the women as having reached a crisis point and accepting treatment at the point that they feel they have no choice. The women were unsure if what they were feeling was “normal” and due to sleep deprivation and the changes that motherhood brings as opposed to “a depression”. The authors discuss the need for women to receive adequate assessments of their needs and explicit choice regarding the treatment they receive. Again, this uncertainty amongst participants and advocacy of choice was echoed in the paper by Myors et al (2015). This study interviewed 11 women who had been seen by a specialist mental health team in Australia about their experience of the service. Participants described feeling unsure of their own feelings but also about what services were available to them. Choice and control was identified as being central to the recovery process within mental health services.

Masood et al, 2015 interviewed 17 British South Asian women about their experience of a group psychological intervention for postnatal depression. The study was part of a larger RCT. The authors discuss their findings and suggest that practical issues such as venue of intervention, childcare arrangements may have an impact on women’s engagement with services. Culture and linguistic needs are emphasised as important as well as the anonymity that group work afforded the women. The researchers state that the intervention caused the women to feel confident and empowered.

The final paper conducted interviews with eight women who had been inpatients on a mother and baby unit (Connerty, Roberts & Williams, 2016). The research focused on the women’s experiences of community services following their discharge from the unit. The researchers use the personal experiences of women to provide an insight into the decision making processes that occur when using community services. The findings contrast with previous research that suggests women are mostly passive in their recovery and the researchers suggest that women have a much more active role in the selection of services. Continuity of care as well as clear care planning are emphasised as being important in helping women to engage with services.

**Quality Assessment**

The quality scores derived from evaluation using the CASP tool ranged from 65% - 95%. Lower scoring papers lacked sufficient information about ethical considerations. Some papers cited the ethics boards that approved the research and made one other reference to confidentiality (Turner et al, 2010; McCarthy & McMahon, 2008) or consent (Connerty, Roberts & Williams, 2016). The lowest scoring papers made reference to the ethics committee associated with the research but did not mention any other ethical considerations (Masood et al, 2015; Turner et al, 2008). In contrast, the highest scoring paper provided more elaborate discussion around ethics and detailed instances whereby the research process was amended due to ethical concerns (Myors et al, 2014).

Consideration of reflexivity and the relationship between researcher and participant is largely neglected across the articles. Four of the lower scoring papers do not make reference to reflexivity at all (Connerty, Roberts & Williams, 2016; Turner et al, 2008; Turner et al, 2010; Masood et al, 2015) and another two papers offer a single sentence in relation to this aspect of the research (Shakespeare, Blake & Garcia, 2006). The authors of the highest scoring paper (Myors et al, 2014) talk in more depth about strategies they employed to promote awareness of their own thoughts and feelings. They acknowledge that one of the authors had previously worked for the service that was the subject of participants’ experiences and make reference to “ongoing reflection and discussion” amongst the researchers. It is unfortunate that the Masood et al (2015) study does not make reference to the relationship between researcher and data as there are interesting cultural factors that would be worthy of discussion. Participants were given the choice of speaking in English or their native language for the interviews. All participants chose to speak in Urdu and the interviewers were also fluent in this language. However during transcription the data was translated to English and analysed in English. The researchers do not mention if participants were asked to verify the English transcriptions (or even if this would have been a possibility). Nor do they discuss any potential impacts that this process may have had on the data and its analysis.

The study by Myors et al (2014) scored well in relation to its methodology and analysis. The authors provide clear justification for their use of thematic analysis and draw on relevant literature to explain this. The analytic process is clear and detailed which allows the reader to see how the themes were derived from the data without difficulty. Other papers received partial scores for several reasons in this area. For example, the language used by Shakespeare, Blake & Garcia (2006) changes throughout their analysis with “themes” and “factors” being used interchangeably. There is no explanation of how the final four “factors” that appear in their findings were agreed upon. The analytic process is discussed in some depth in Turner et al’s (2010) paper; they describe the software used as well as some triangulation of interpretations. However though the authors mention “deviant cases”, these are not considered elsewhere in the paper and there are a limited number of quotes used to represent their findings. There are some potential limitations regarding the design of Turner et al’s (2010) paper that should be noted. The original RCT looked to compare the effectiveness of antidepressants and listening visits for the treatment of PND and used RHVs to deliver the listening visits. Throughout the research the participants talked about the differences there may have been had these listening visits been delivered by their PHV. There were varying opinions but the researchers found that overall having the visits delivered by a RHV was advantageous. This raises questions about the usefulness of the findings as they regard the experience of an intervention that was created specifically for the research.

**Synthesis of papers**

A thematic analysis of the papers was completed as described by Braun & Clarke (2006). This method was considered more appropriate than other qualitative analysis methods due to its flexibility and ability to guide analysis of data from a position that is independent of theory and epistemology. The results section of each paper were read and re-read in order to provide the author familiarity with the findings. Notes regarding ideas about the data and its meaning were made at this stage (Appendix A). Line by line coding took place (Appendix B) with the initial notes kept in mind. This resulted in 25 codes being identified within the texts. A table of these codes and the supporting extracts from the papers can be found in Appendix C. Visual representations of each code were then made and moved into different groups as themes for the data were considered. To increase validity the extracts of data, codes and themes were continuously checked against the original data. A second reviewer also contributed to this process to further bolster the rigour of analysis. A thematic map was produced (Appendix D. One overarching theme was identified (external hopelessness) which provided context for the four main themes relating to the experience of mental health services for women with PND (secrets and permission, loss of control, desire for choice and inadequate services). Loss of control was considered a central theme that interrelated with secrets and permission, desire for choice and inadequate services. The themes are understood in a hierarchical model filtering downwards which has been illustrated in figure 2.

**External Hopelessness**

The studies that were reviewed explored the experience of interventions for PND though all of the participants talked about the wider context of these experiences. The women shared an overwhelming sense of hopelessness; they talked of a desire to get away and desperation was often mentioned in relation to their feelings before accessing services.

“I thought to myself, “You will not be coming to see me anymore because I am packing up and leaving my husband” (McCarthy & McMahon, P626)



*Figure 2: hierarchical model of themes*

“I didn’t want to die, I didn’t want to leave my kids, I just wanted someone to see how really, really desperate I felt” (Shakespeare, Blake & Garcia, P159)

A narrative of pressure ran throughout the findings of the articles. The participants discussed the stigma and pressure they felt to conform to societal ideas of motherhood. The women felt they would be “judged as poor mothers” (Turner et al., 2008: P452) by family, friends and professionals. One woman talked about her fear of people stereotyping her as a woman who abused her children (McCarthy & McMahon, 2008: P628). References were made to the assumption that motherhood is part of the natural identity of being a woman:

“You know, being a mother comes naturally. I always thought before having children it was going to come naturally” (McCarthy & McMahon, 2008: P624)

This participant’s perception of motherhood before having children herself was shaped through her experience of mothers as presented to her in the society she lives in. The same woman goes on to explain that after learning about other women with PND and feeling validated by this, she was relieved to discover that “(she) wasn’t a freak, I was just a normal person” (McCarthy & McMahon, 2008: P630). Seemingly, the experience of receiving an intervention for PND had re-shaped the participant’s view of “normal” motherhood.

External hopelessness was perceived by the author as a downward pressure that impacted the experience of interventions for the women and interacted with the other main themes throughout the findings. The codes that made up this theme (desire to get away, desperation, stigma, natural/unnatural) appeared to be strong forces with the strength evidenced in the women’s apparent loss of control.

**Loss of control**

The women’s experiences of treatment were permeated with a sense of passivity or loss of control. Perhaps due to the pressures described in the previous theme, many of the women were not active in seeking support for the difficulties they experienced. There was a sense that the women did not feel able to access services despite the distress they were feeling. They began to feel unstable, unsafe and insecure or at “breaking point”.

“I felt terrible and I couldn’t do anything about me feeling that way” (Connerty, Roberts & Williams, 2016: P958)

“I didn’t feel like I was under control, anything was under control…but I didn’t think she (HV) could do anything for me” (Shakespeare, Blake & Garcia, 2006: P160)

“It wasn’t really my decision it was more my husband’s” (Connerty, Roberts & Williams, 2016: P960)

“In one extreme case, the first contact with mental health services was when one of the women attempted suicide and was hospitalized” (McCarthy & McMahon, 2008: P627)

This loss of control continued as the women began engaging with services for treatment for PND. One woman spoke of feeling “bombarded” by a professional who came to talk to her about PND (Myors et al., 2014: P272).The women talked about their difficulty in naming their experiences and a number of studies discussed how they learned a “psychological language” or had their experiences put into words by health professionals (McCarthy & McMahon, 2008: P627; Turner et al, 2010: P237; Shakespeare, Blake & Garcia, 2006: P154). Though this was largely positive for the women it was nevertheless a passive process that the women appeared to have little control over. The voices of these women appear to be small and without a language with which they can effectively communicate their distress. This leaves the women feeling out of control and their experience feels chaotic.

**Secrets and permission**

Within the experience of treatment for PND, many women talked about withholding information. There was a sense of the women protecting themselves or perhaps trying to regain a sense of control by choosing what information to share. Women described attending therapeutic sessions in secret or not disclosing the nature of sessions to their partners. Some participants did not disclose their diagnosis or distress to friends or family.

“My husband didn’t know that I was going to these classes. I used to be home before he came back from his work” (Masood, et al., 2015: P4)

“no one actually knew about me being diagnosed with postnatal depression, my mum or anyone, no one knew, not even my partner” (Turner et al., 2010: P236)

“I didn’t want to open up to anyone and tell…family or friends about that because,…[of] the whole judgement and criticism” (Myors, et al., 2014: P272)

As well as keeping secrets from family and friends, the women also censored the information they shared with health professionals. Various reasons were given for this including a fear of being judged unkindly, an inability to express their feelings adequately, a fear of their confidentiality being broken and concern that the professional would not be able to help them.

“With my health visitor I try not to let too much out” (Tuner et al., 2010: P236)

“And she said “What’s wrong with you?” and I said “Nothing.”” (McCarthy & McMahon, 2008: P626)

As well as the women withholding information, one woman described how she felt her HV kept information to herself and how this compounded her confusion regarding the distress she was experiencing:

“no one tells you what they’re thinking in their head…she didn’t tell me what she was thinking about me and I want to know because I don’t know what it is, you know, I don’t know what it is” (Shakespeare, Blake & Garcia, 2006: P158)

The experience of treatment for PND seemed to afford the women with a sense of permission and many spoke of being “allowed” to discuss their difficulties and “unlock issues” (Turner, et al., 2010). There was a sense of relief as the participants spoke about being able to talk with health professionals. In all of the papers reviewed the process of talking to a professional was described as positive and a key aspect of the women’s recovery:

“she made us feel that it is OK and we can open up” (Masood, et al., 2015: P4)

“When [RHV name] came to see me, it was nice because it was like my time and out time and we could talk and stuff” (Turner, et al., 2010: P236)

“there was something in her approach that mde me feel that I could open up to her…and feel comfortable doing it” (Myors et al., 2014: P273)

The process of talking was an important one and participants also valued healthcare professionals training:

“The women acknowledged that the clinicians were not just like a friend but had specific skills such as the ability to really listen” (Myors, et al., 2014: P273)

However, it was recognised across the papers that after the initial relief and catharsis of “offloading”, merely talking to professionals was insufficient and participants required a deeper level of support.

**Desire for choice**

Throughout the accounts of women’s experiences of treatment for PND, participants discussed aspects that were lacking, things that were helpful and hopes that they had for the intervention that were not realised. These discussions encompassed a sense of a desire for choice. A large aspect of this theme centred on the rejection of medication and/or the medical model as an explanation for PND. Some women talked about an “ambivalence…related to their perception of PND as a very severe disorder. These women described negative attitudes toward the term PND” (McCarthy & McMahon, 2008: P627). The stigma from these women towards their care may have filtered down from cultural and societal perceptions (as previously discussed) and acted as a driving force in the women seeking alternative treatment to medication:

“They thought being on medication would imply to themselves and others that they were mentally unstable and had been unable to cope without intervention” (Turner, et al., 2008: P452)

“I didn’t want it to become something really serious. You know, I didn’t want the drugs because I didn’t want this to be serious depression” (Shakespeare, Blake & Garcia, 2006: P155)

Other women talked about medication serving as a kind of plaster that “blocked out” their distress but that their difficulties remained as they had not been addressed fully. There was a fear for some participants that their lack of choice regrading treatment options would lead to them being prescribed medication “not because this was what they needed but because this was what was available” (Turner et al., 2008: P452).

A sense of uncertainty and confusion permeated this theme in the research. This confusion was felt by the women in relation to their distress as well as their treatment options:

“Even thought I was in the field, I had no idea what was happening to me” (McCarthy & McMahon, 2008: P625)

“I was very scared because I didn’t understand why I was doing things and thinking things and feeling things” (Turner et al., 2010: P237)

“I remember saying to her ‘you’re not a therapist’, and she said ‘Don’t worry about it. I do this’.” (Shakespeare, Blake & Garcia, 2006: P159)

“It’s not clear, you know [that she could help with postnatal depression]. I just look on her as the health visitor” (Shakespeare, Blake & Garcia, 2006: P159)

Additionally the women reported a sense of confusion amongst the health professionals they sought support from. So whilst they tried to seek options and choice they were met with insufficient services that lacked direction or much evidence of shared decision making.

“when I went to see my nurse um…they did not give me any direction where to go.” (Masood et al., 2015: P5)

“you get left feeling a bit stranded and not sure where to turn, and even the workers themselves, they weren’t sure what the next step could be…” (Myors et al., 2014: P273)

**Inadequate services**

As previously stated, the themes described above are understood using a hierarchical model with overarching influences providing downward pressures that affect the experience of treatment for PND. Ultimately the influences and processes resulted in inadequate services for women who seek support for PND. Most of the papers in this review state that women found interventions helpful or beneficial at some point. However, all of the papers find that services are lacking in various aspects.

The resources and time that services were able to provide for the women were found to be insufficient. As well as this, several of the papers noted that continuity of care was vital in the recovery of women but that this was often not provided.

“I thought the sessions went by too quickly and 12 weeks were not enough” (Masood, et al., 2015: P5)

“Women also commented that their PHV did not have time to listen nor visit them at home”

“Fourteen of the 22 women stated that eight visits had not been sufficient” (Turner et al., 2010: P236, P237)

“A majority of the participants highlighted the need for such interventions to be ongoing” (Masood, et al., 2015: P5)

“what do you do with someone who still need you help?...people that turn out to be a more long term issue, there’s nothing”

“Patricia was not ready to be discharged from the service but because her infant was 12 months old and due to the capacity of the team, the discharge had to proceed” (Myors et al., 2014: P273)

Many participants also talked about the remit of sessions not being sufficient and that the services offered did not match the complexity of their needs:

“yet a few women talked about how they would only feel better for a few days following a visit” (Turner et al., 2010: P237)

“some participants who had received counselling had found it helpful but their mood remained low” (Turner et al., 2008: P453)

“after an initial catharsis, the listening visits seemed to lack purpose, or didn’t match the woman’s needs” (Shakespeare, Blake & Garcia, 2006: P160)

**Discussion**

This paper aimed to synthesise previous findings of qualitative papers that explored how women experience the treatment for PND in the community. A hierarchical model of interrelating factors was developed using thematic analysis. The model suggests that there are overarching, wider contextual factors that impact greatly upon the process of receiving support for PND. Societal norms and narratives relating to motherhood appear to contribute to the stigma that women feel when seeking treatment but also the stigma they attach to the term PND. Previous research has illustrated cultural representations of femininity that depict women as being able to cope with caring for a baby, domestic tasks as well as the caring of others (Choi et al., 2005). The postpartum period was viewed as a predominantly negative experience for the participants as they struggled to perform in line with this cultural discourse. However, rather than speak out at the time, the women tried harder to conform to what was expected of them by society and kept their true feelings hidden. This has been reflected in the research reviewed in this paper with many participants discussing how they kept secrets and withheld information from family and friends.

The experience of PND and receiving treatment for it appears to be unstable and unsafe. Women do not seem to have an effective language with which to communicate their distress and instead are forced to learn a new language that is dictated by services. The voices of these women seem to be unrecognised and unheard due to the significant downward pressure on their experience and this is further evidenced by the lack of qualitative research available on this topic. Women appear to be afraid to talk, confused and chaotic and this is then reflected in the services they attempt to access. It seems that current services react by encouraging speech; they develop “listening visits” – an intervention facilitated by HVs – and encourage women to talk as they are listening. However, this produces a dynamic whereby the onus falls to the women who are looking for help. Services appear to be impacted by the cultural stigma of a mother asking for help; they operate in a way which implies that something is “wrong” with the mother and she must tell us what that is. This then leads to a confusion for health professionals when women are unable to do this.

The experience of receiving treatment for PND seems to be a lonely and isolative one. Children were rarely spoken of in relation to how women experienced support or their PND; they appear to be more of a pragmatic issue in terms of accessing support. There was also an absence of men in any context of support (unless they were required to make a decision on the woman’s behalf). As a result, PND becomes solely placed with the woman from the experience of it, to accessing support, getting treatment and recovery.

**Limitations**

Ring et al. (2011) discuss the degree of variance in interpretation when conducting a synthesis of qualitative literature. The double hermeneutic created by a researcher interpreting an interpretation should not be ignored and the findings here are at risk of bias from the author’s interpretation.

The studies included in this review were from Australia and the United Kingdom. It is interesting to note that these were the only countries of origin included in the review. A possible explanation for this may be that different terminology is used in other countries that was not included in the search terms for this review. However, there were studies from a variety of countries that were screened as part of the search process (for example Delaney, Dalmida & Gaydos, 2015 [USA]; Byatt et al., 2013 [USA]; Haga et al., 2012 [Norway]) and so a more likely explanation is the lack of qualitative research that has been carried out in this specific area. The differences in the healthcare systems of Australia and the UK should be considered, particularly as some community services are self-funded by Australian citizens.

Two studies in this review explored the experience of treatments for PND that were offered specifically for the research being conducted (Turner et al., 2008; Turner et al., 2010). The impact this may have had is discussed in relation to the findings however.

The articles included in this review ranged in publication date from 2006 to 2016 and so many changes will have occurred within healthcare systems and services during this time. There is some limitation therefore in collating the experiences of women over this time period. However, many of the contextual themes that are discussed in this review will have been present and developed alongside these services and so it is suggested that the findings here are of clinical relevance.

**Clinical implications**

The current findings illustrate that services are often attempting to support women with PND without adequate resources and that the professionals who see these women are often not best placed to deliver mental health interventions (Turner et al., 2010; Shakespeare, Blake & Garcia, 2006). Studies that did evidence positive outcomes and experiences for the women were those that explored experiences of engagement with specific perinatal teams, although continuity of care within the community setting was still noted as needing improvement. As legislation in recent years in the UK has highlighted the need for perinatal mental health services to be improved upon it is important to gather a contemporary account of how women are experiencing these services. It would be important for qualitative research in this area to be completed in order to provide a platform for the women who these issues affect to be heard.

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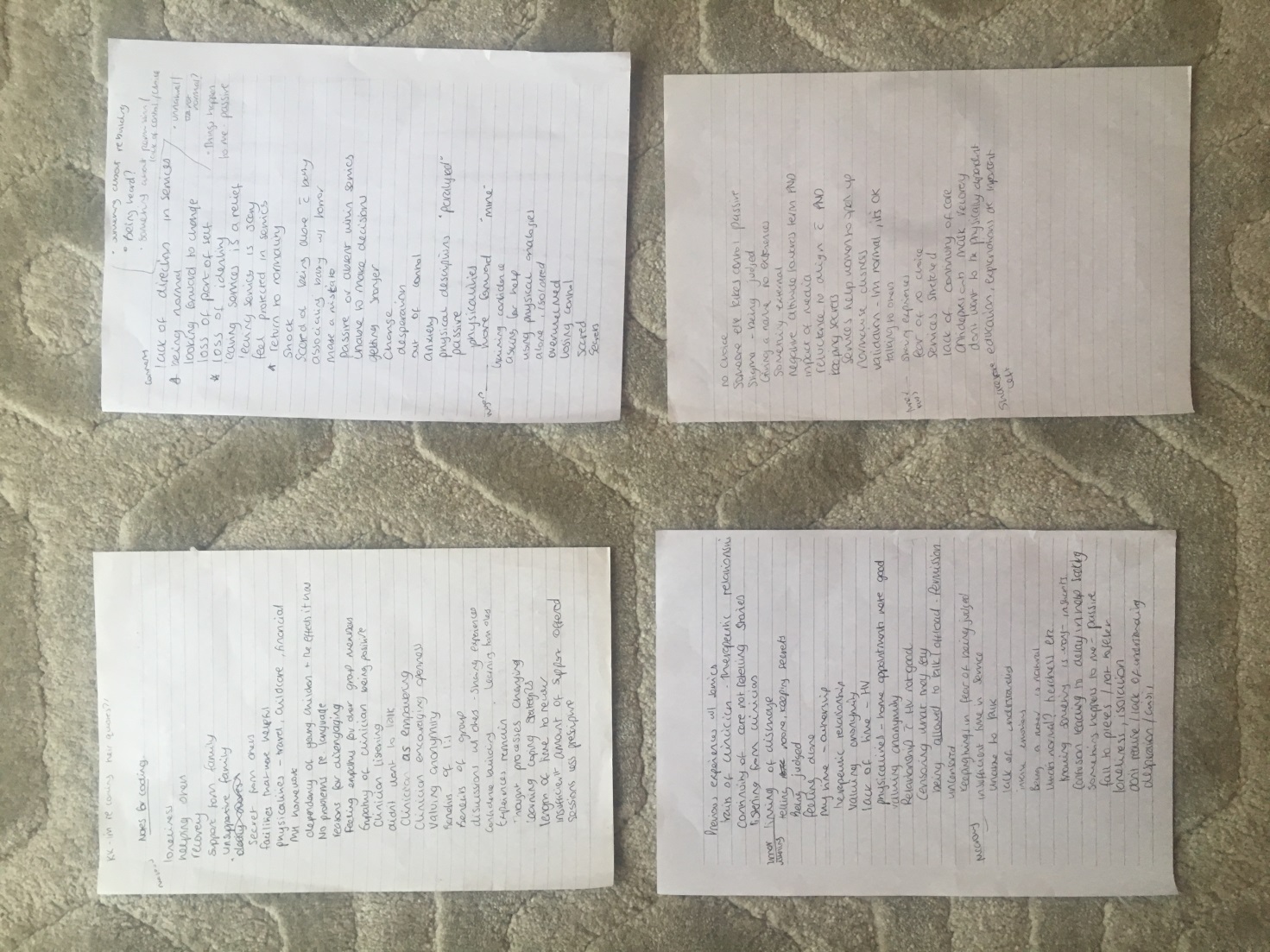
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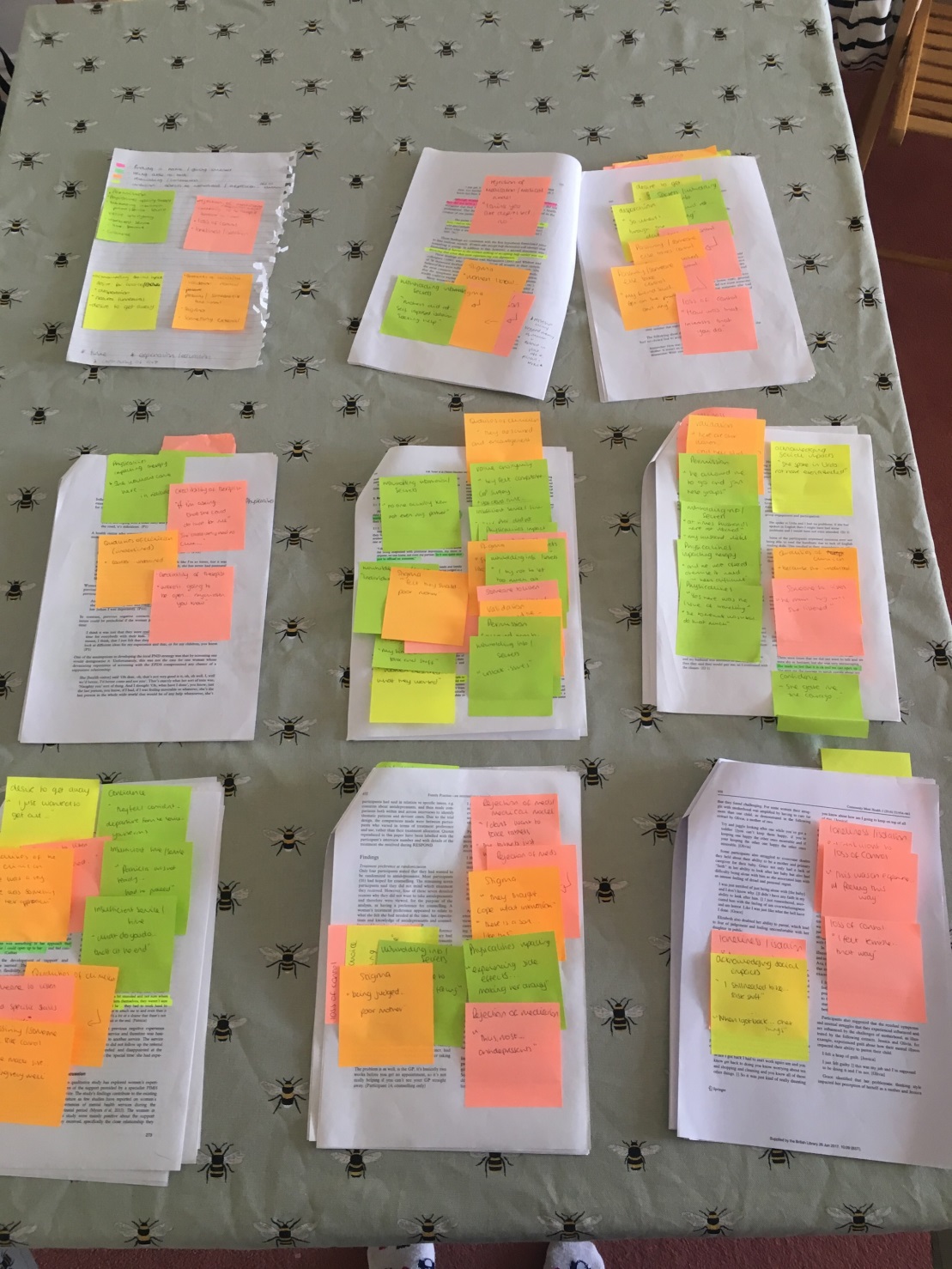
Appendix A

Notes made upon initial reading of articles



Appendix B

Line by line coding of articles



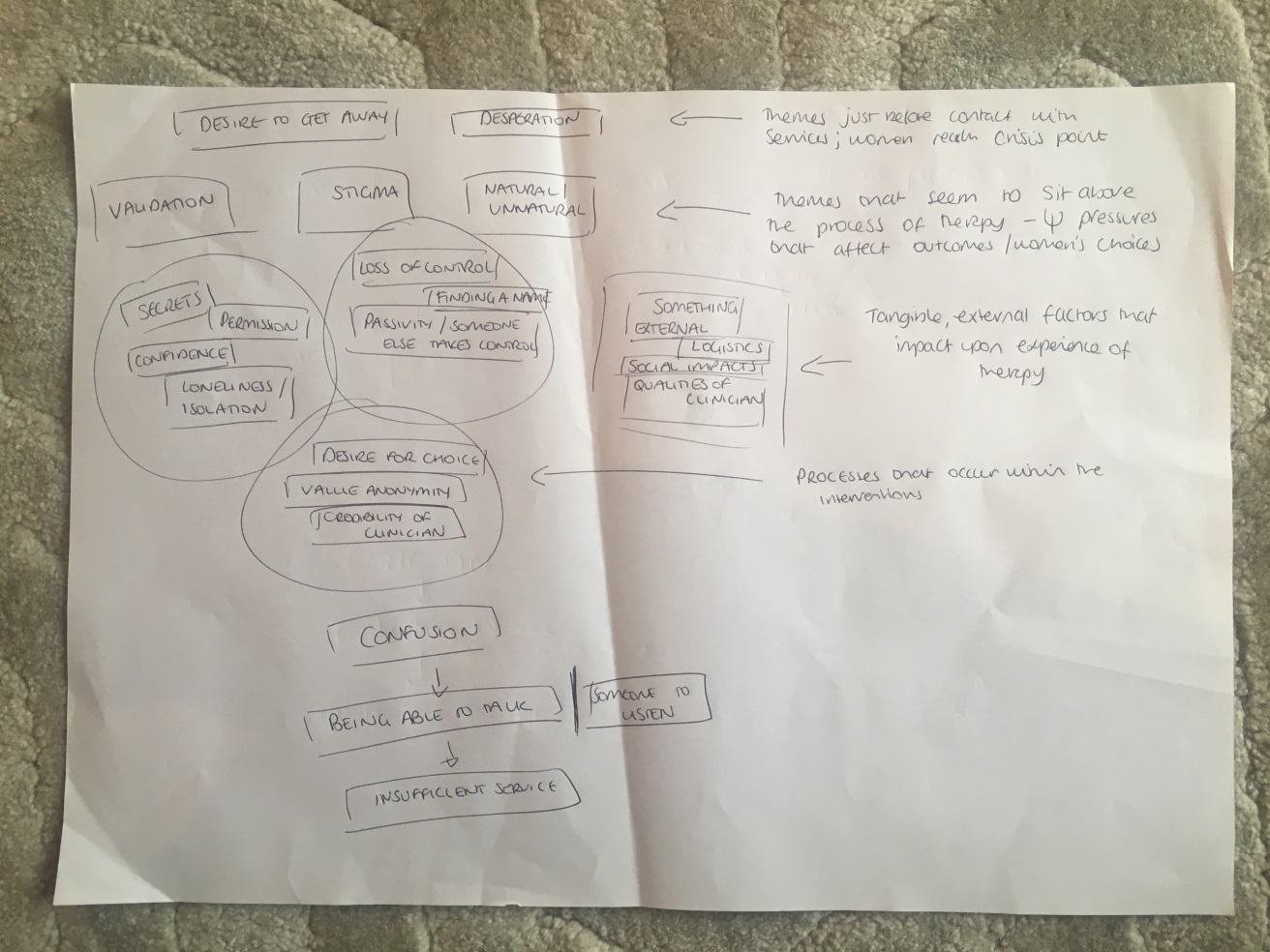
Appendix C

Table of codes with corresponding extracts

|  |  |
| --- | --- |
| **Finding a name / giving a label** | “Although women were able to describe their emotions and behaviour, they did not have a name for the experience.” (McCarthy & McMahon, P625)  “For some women the diagnosis led to reduced stigma regarding a perceived inability to cope as mothers by providing a legitimate explanation for their feelings, and they were relieved to hear that their experiences had a name.” (McCarthy & McMahon, P627).  “It is likely that through this initial discussion process with a health professional, women also learned a “psychological language”, enabling them to describe what they were experiencing.” (McCarthy & McMahon, 629).  “I think open discussion was good and felt discussions helped in overcoming my anxieties and shyness.” (Masood et al., P5)  “I was very scared because I didn’t understand why I was doing things and thinking things and feeling things and she [RHV] put things into words.” (Turner et al. [1], P237)  “Quite nice to have a label for things” (Shakespeare, Blake & Garcia, P154) |
| **Being able to talk** | “The ability to talk about their distress seems to have developed over two stages, beginning with speaking to the mental health nurse, which in turn led to disclosure to their wider circle of friends, particularly other mothers.” (McCarthy & McMahon, P629)  “[learning a psychological language] would facilitate speaking to others about their distress” (McCarthy & McMahon, P629)  “She made us feel that it is OK and we can open up.” (Masood et al., P4)  “the reported benefits related to the opportunity to talk provided by the visits” (Turner et al. [1], P236)  “So it was quite nice just to offload on someone.” (Turner et al. [1], P236)  “When like [RHV name] came to see me, it was nice because it was like my time and our time and we could talk and stuff.” (Turner et al. [1], P236)  “they knew they had an hour to talk and having the visits at home meant they could talk in private” (Turner et al. [1], P236)  “With [RHV] I feel like I could have just said what I wanted, how I wanted” (Turner et al. [1], P236)  “These participants also described how they had felt no need to talk to a counsellor: they had friends or relatives they could talk to.” (Turner et al. [2], P452)  “The tablets just block it out…it’s better but it’s still there because you haven’t talked about it.” (Turner et al. [2], P452)  “They had begun to view to antidepressants as necessary and had been envouraged by others, i.e. friends, relatives or the research health visitor” (Turner et al. [2], P453)  “talking to her made me realise that she wasn’t knocking antidepressants…” (Turner et al. [2], P453)  “there was something in her approach that made me feel that I could open up to her…and feel comfortable doing it” (Myors et al., P273)  “It’s easier to talk about something if it feels like there’s a concrete reason for it” (Shakespeare, Blake & Garcia, P154)  “really it’s the talking isn’t it that’s the helpful bit” (Shakespeare, Blake & Garcia, P155)  “I was very grateful to her that she offered her time and … you know, let me just talk” (Shakespeare, Blake & Garcia, P155)  “I think she probably nipped it in the bud…a potentially slightly more serious post-natal depression, just by being there and talking” (Shakespeare, Blake & Garcia, P156)  “For most women the ability to talk about how they were feeling during listening visits was very helpful and they recognised how useful it was to have someone to talk to from ourside their friends and family” (Shakespeare, Blake & Garcia, P159) |
| **Rebuilding / construction** | “I started to fall to pieces” (McCarthy & McMahon, P625)  “they felt confident that they wouldn’t fall apart” (Myors et al., P273)  “it feels like there’s a concrete reason for it” (Shakespeare, Blake & Garcia, P154) |
| **Confusion** | “something is wrong…but what?” (McCarthy & McMahon, P624)  “the indication was there – the intense emotions were really overwhelming. I couldn’t understand and I wasn’t handling it” (McCarthy & McMahon, P624)  “[I was] very tired all the time, which everybody says, “Oh that’s normal. You’ve got a new baby,” but it seemed to be extreme…I thought it was because I was so tired and because she wasn’t settling.” (McCarthy & McMahon, P624)  “Even though I was in the field, I had no idea what was happening to me” (McCarthy & McMahon, P625)  “A barrier to the women seeking or accepting help earlier was not knowing that what they were experiencing was depression” (McCarthy & McMahon, P625)  “I didn’t realise something was wrong with me, to be honest” (McCarthy & McMahon, P626)  “when I went to see my nurse um…they did not give me any direction where to go.” (Masood et al., P5)  “A few women said they had initially found it difficult to talk to their RHV because they were unsure of what to expect or did not find it easy to discuss their feelings” (Turner et al. [1], P236)  “I was very scared because I didn’t understand why I was doing things and thinking things and feeling things and she [RHV] put things into words.” (Turner et al. [1], P237)  “I just couldn’t because I didn’t know how to.” (Turner et al. [2], P453)  “you get left feeling a bit stranded and not sure where to turn, and even the workers themselves, they weren’t sure what the next step could be…” (Myors et al., P273)  “she didn’t tell me what she was thinking about me and I want to know because I don’t know what it is, you know, I don’t, know what is it” (Shakespeare, Blake & Garcia, P158)  “I can remember saying to her, ‘You’re not a therapist’, and she said, ‘Don’t worry about it. I do this’.” (Shakespeare, Blake & Garcia, P159)  “It’s not clear, you know [that she could help with postnatal depression]. I just look on her as the health visitor” (Shakespeare, Blake & Garcia, P159)  “I just didn’t know what the oint was. I didn’t see a purpose and she didn’t explain it clearly” (Shakespeare, Blake & Garcia, P160) |
| **Permission** | “he allowed me to go and join these groups.” (Masood et al., P4)  “were not told the nature of the sessions for fear they would not allow the participants to attend” (Masood et al., P4)  “They felt that the group allowed them to share information, and understand and explore solutions to their problems. [It] was the only platform where they had an opportunity to express their emotions and feelings in a safe environment.” (Masood et al., P5)  “I have a new child here, you know, I need to be focusing on my new child, not myself and how I might be feeling” (Turner et al. [1], P236)  “When like [RHV name] came to see me, it was nice because it was like my time and our time and we could talk and stuff.” (Turner et al. [1], P236)  “women described how they had been allowed to set the boundaries of the discussions and to focus on what they wanted.” (Turner et al. [1], P236)  “Women detailed how the RHVs’ responses had allowed them to “offload”, “unlock issues” and share their concerns” (Turner et al. [1], P236)  “It’s easier to talk about something if it feels like there’s a concrete reason for it” (Shakespeare, Blake & Garcia, P154) |
| **Impact of logistics** | “we were offered a crèche facility; I used to take him there; otherwise it would have been really difficult for me.” (Masood et al., P4)  “Yes there was the issue of travelling” (Masood et al., P4)  “The homework was useful but my children were young and I couldn’t do that much.” (Masood et al., P4)  “logistically getting somewhere with a baby when it is hard to make decisions [impacted her motivation to attend]” (Connerty, Roberts & Williams, P961)  “[having home visits meant that the women] did not need to worry about going out, being late for the appointment and what facilities would be availablefor entertaining or feeding their child.” (Turner et al. [1], P236)  “Concerns were also expressed in relation to becoming physically dependent on antidepressants, experiencing side-effects, taking medication when breastfeeding, and antidepressants affecting an individual’s ability to parent but making her drowsy.” (Turner et al. [2], P452)  “She wouldn’t come here…my health centre’s like a mile and a half down the road and when you’re not coping with a small baby and you’ve got to walk a mile and a half down the road, it’s ridiculous” (Shakespeare, Blake & Garcia, P157) |
| **Withholding information / keeping secrets** | “mothers did not speak to others about their feelings” (McCarthy & McMahon, P625)  “I thought to myself, “You will not be coming to see me anymore because I am packing up and leaving my husband.” And she said “What’s wrong with you and I said “Nothing.” (McCarthy & McMahon, P626)  “Women found it initially very difficult to talk to others about their distress” (McCarthy & McMahon, P629)  “At times the husbands were not informed about the sessions or were not told of the nature of the sessions” (Masood et al., P4)  “My husband didn’t know that I was going to these classes. I used to be home before he came back from his work” (Masood et al., P4)  “There were times that we did not want to talk” (Masood et al., P4)  “some participants felt reluctant to disclose personal issues in group settings” (Masood et al., P5)  “no one actually knew about me being diagnosed with postnatal depression, my mum or anyone, no one knew, not even my partner.” ((Turner et al. [1], P236)  “individuals explained that they had not told friends or family” (Turner et al. [1], P236)  “Interviewer: You don’t think you’d have talked to your own health visitor about it in the same way or about those things?  Participants: No.” (Turner et al. [1], P236)  “women talked about being more careful about what they said to their PHV” (Turner et al. [1], P236)  “with my health visitor I try not to let too much out.” (Turner et al. [1], P236)  “there were also women who commented that they had been careful about what they said to their RHV” (Turner et al. [1], P236)  [women were able to] “unlock issues” (Turner et al. [1], P236)  “Reasons given by participants for not wanting to visit their GP were being unable to talk to their GP about how they were feeling” (Turner et al. [2], P452)  “I didn’t want to open up to anyone and tell, … family or friends about that because, … [of] the whole judgement and criticism” (Myors et al., P272)  “no, no one tells you, no one tells you what they’re thinking in their head…she didn’t tell me what she was thinking about me and I want to know because I don’t know what it is, you know, I don’t, know what is it” (Shakespeare, Blake & Garcia, P158) |
| **Value anonymity** | “the best thing was I did not know anyone. Sometimes you don’t want to discuss your personal matters with people you know.” (Masood et al., P5)  “they felt comfortable confiding in the RHV because she was not attached to their GP surgery...it was also felt that information was less likely to get back to people they knew” (Turner et al. [1], P236)  “I know [the health visitor] wouldn’t say anything but you know it could just come out and I didn’t really want that I suppose, it’s too close to home.” (Turner et al. [1], P236)  “I’ve got friends but…it was good to have somebody from completely outside really” (Shakespeare, Blake & Garcia, P159) |
| **Insufficient service; time/structure** | “A majority of the participants highlighted the need for such interventions to be ongoing” (Masood et al., P5)  “I thought the sessions went by too quickly and 12 weeks were not enough.” (Masood et al., P5)  “You know um it was too many appointments so um so there was a whittling process” (Connerty, Roberts & Williams, P961)  “I found it expensive and not useful” (Connerty, Roberts & Williams, P961)  “Women also commented that their PHV did not have time to listen nor visit them at home” (Turner et al. [1], P236)  “Women also talked about their RHV being particularly good at listening and attributed this to the fact that she had received specific training in listening skills.” (Turner et al. [1], P236)  “yet a few women talked about how they would only feel better for a few days following a visit...over half of the women described how they felt eight visits had not been enough to address their PND.” (Turner et al. [1], P237)  “Fourteen of the 22 women stated that eight visits had not been sufficient.” (Turner et al. [1], P237)  “The problem is as well, is the GP, it’s basically two weeks before you get an appointment, so it’s not really helping” (Turner et al. [2], P452)  “some participants who had received counselling had found it helpful but their mood had remained low.” (Turner et al. [2], P453)  “I did say was there any counselling that was available that I could access and they said “not really…(and) they don’t come for you at home…” It was very difficult because I have two children to look after, in my present state of mind as well, like driving a car and catching a bus is something that would be a nightmare for me.” (Turner et al. [2], P453)  “Interviewer: You persevered with them (antidepressants)?”  Participants: I still am (laughs)…I’m too scared to come off them.” (Turner et al. [2], P454)  “Patricia was not ready to be discharged from the service but because her infant was 12 months old and due to the capacity of the team, the discharge had to proceed” (Myors et al., P273)  “What do you do with someone who still need you help? … people that turn out to be a more long-term issue, there’s nothing…you get left feeling a bit stranded and not sure where to turn…it’s a bit of a shame that there’s not a better system around that at the end” (Myors et al., P273)  “after an initial catharsis, the listening visits seemed to lack a purpose, or didn’t match the woman’s needs” (Shakespeare, Blake & Garcia, P160)  “she [health visitor] was fine to talk to and sort of, as a surrogate friend, friend really…she was trying with the visits. I told her [how I felt] and she recognised it, that I didn’t feel like I was under control, anything was under control… but I didn’t think she could do anything for me” (Shakespeare, Blake & Garcia, P160) |
| **Confidence** | “She gave me the courage to speak openly about my feelings.” (Masood et al., P4)  “I am more relaxed and confident.” (Masood et al., P5)  “I have gained the knowledge of overcoming the tension when I am dealing with my children and husband. I tell them I can only do so much at a time and they shouldn’t be expecting a lot from me.” (Masood et al., P5)  “women also reported gaining ‘confidence’ in themselves, as mothers and in particular on the ability to ‘ask for help’ in future” (Myors et al., P271)  “being the one to be able to cope…being able to say, ‘alright I can swim’…makes it easier to make that…departure from the service, if it’s on your terms, when you’re ready…jump in the deep water” (Myors et al., P273) |
| **Rejection of medication / medical model** | “and she said “I think you are depressed” and I said “No.” (McCarthy & McMahon, P625)  “This ambivalence was related to their perception of PND as a very severe disorder. These women described negative attitudes toward the term PND” (McCarthy & McMahon, P627)  “For a few women, their perception of PND as a severe disorder resulted in denial that the diagnosis applied to them. Since PND in their minds was associated with an inability to mother and even with infanticide, this did not fit with their own experience” (McCarthy & McMahon, P628)  “The wide variation in explanations for depression offered by participants in this study was somewhat surprising. Given that these women all received medication and support from the mental health services, it might have been expected that the biomedical model would dominate their explanations.” (McCarthy & McMahon, P629)  “They had thought their GP would simply prescribe antidepressants, a treatment they did not want” (Turner et al. [1], P236)  “I don’t want to take tablets” (Turner et al. [2], P452)  “The tablets just block it out…it’s better but it’s still there because you haven’t talked about it. All you’ve done is took a tablet to block it out, which is a waste of time.” (Turner et al. [2], P452)  “They thought being on medication would imply to themselves and others that they were mentally unstable and had been unable to cope without intervention.” (Turner et al. [2], P452)  “most of the participants had wanted counselling and had expressed negative views about antidepressants.” (Turner et al. [2], P452)  “despite taking medication and in some cases experiencing benefits, some participants had remained uncomfortable with the idea of taking antidepressants.” (Turner et al. [2], P453)  “I didn’t want it to become something really serious. You know, I didn’t want the drugs because I didn’t want this to be serious depression…I wanted it to go” (Shakespeare, Blake & Garcia, P155)  “[the health visitor] didn’t rush in with medication and referring me anywhere” (Shakespeare, Blake & Garcia, P156) |
| **Credibility of the clinician** | “One of the participants indicated health professionals’ lack of awareness of issues specific to ethnic minority communities and suggested that professionals such as GPs and nurse practitioners should be given culture-specific training.” (Masood et al., P5)  “Women also talked about their RHV being particularly good at listening and attributed this to the fact that she had received specific training in listening skills.” (Turner et al. [1], P236)  “If I’m asking for [emotional] help from somebody it would have to be somebody that I felt would be able to give me that and she’s[health visitor] a very nice person but I didn’t feel that she could do that for me” (Shakespeare, Blake & Garcia, P157)  “she absolutely had no clue…if you want to counsel someone who’s got post-natal depression you need to have someone who’s had it” (Shakespeare, Blake & Garcia, P157)  “I just felt that they [health visitor] weren’t really going to be open enough to look at different ideas for my experience and that, or for my children, you know” |
| **Someone to listen** | “what has been helpful is someone actually listening” (McCarthy & McMahon, P627)  “the main thing is that she listened to all of us.” (Masood et al., P4)  “Women also talked about their RHV being particularly good at listening and attributed this to the fact that she had received specific training in listening skills.” (Turner et al. [1], P236)  “The women’s accounts indicated that they RHVs had listened carefully and reflected back to the individual what she had said” (Turner et al. [1], P236)  “she listened and she asked the right questions” (Myors et al., P273)  “The women acknowledged that the clinicians were not just like a friend but had specific skills such as the ability to really listen” (Myors et al., P273)  “she’d just sit and listen. She couldn’t do much. I know she couldn’t do much but just having someone that you could sit and cry in front of and you really get everything off your chest” (Shakespeare, Blake & Garcia, P159) |
| **Loss of control** | “In general, the women did not resist someone else taking control” (McCarthy & McMahon, P626)  “My friend, she said you have got to see C (psychiatrist)…dad said “this is just getting bloody ridiculous. You need help” and mum said “get on the phone and ring”” (McCarthy & McMahon, P626)  “*Researcher:* How was that for you – to decide it is time to take medication?  *Mother:* It wasn’t an option” (McCarthy & McMahon, P626)  “In one extreme case, the first contact with mental health services was when one of the women attempted suicide and was hospitalized. Two other women finally contacted mental health services after weeks of suicidal ideation and were considered sufficiently at risk fo self harm to be hospitalized.” (McCarthy & McMahon, P627)  “women accept treatment / help from a health professional at the point they feel they have no choice.” (McCarthy & McMahon, P627)  “women rarely make the decision to seek and accept treatment / help alone. Other people are largely responsible…and for initiating the process.” McCarthy & McMahon, P627)  “I was a person who had left school, went to polytech and had worked all my life and I was used to being in control I guess.” (McCarthy & McMahon, P629)  “[Emily] “didn’t always trust [her] own judgement of things”. This was an experience that Emily struggled with and found “scary” as she was not comfortable with feeling this way.” (Connerty, Roberts & Williams, P958)  “I felt terrible and I couldn’t do anything about me feeling that way” (Connerty, Roberts & Williams, P958)  “I’ve got to do this and yeah and that was kind of really getting out of control.” (Connerty, Roberts & Williams,P959)  “it wasn’t really my decision it was more my husband’s” (Connerty, Roberts & Williams, P960)  “a fear of being prescribed antidepressants without being listened to” (Turner et al. [2], P452)  “And they said the other option is antidepressants, and they started me on antidepressants.” (Turner et al. [2], P453)  “I felt like I was losing control of my emotions when I was about 5 months pregnant” (Myors et al., P271)  “because the lady just came into the room…and then just goes ‘OK, because of your results, I’m here to talk to you’…so I felt kind of bombarded” (Myors et al., P272)  “I didn’t feel like I was under control, anything was under control… but I didn’t think she could do anything for me” (Shakespeare, Blake & Garcia, P160) |
| **Loneliness / isolation** | “this self-imposed isolation from friends, including other mothers, meant that women had less opportunity to differentiate their own level of distress from what is considered “normal”” (McCarthy & McMahon, P625/6)  “and this is quite a good feeling just to know that I wasn’t on my own” (McCarthy & McMahon, P630)  “because to me loneliness was the main reason of my depression.” (Masood et al., P4)  “Emily initially had support from in-laws…but when that support was no longer available she struggled. “Then it was like oh well that’s me then”.” (Connerty, Roberts & Williams, P958)  “[Emily] “didn’t want to be around people.”” (Connerty, Roberts & Williams,P958)  “many of the women were socially isolated and had experienced traumatic past events” (Myors et al., P271) |
| **Social impacts** | “Probably lack of sleep would be a big part. I never had good babies that slept.” (McCarthy & McMahon, P629)  “She spoke in Urdu and I had no problems. If she had spoken in English then I might have had some problems and I would have not even attended.” (Masood et al., P4)  “Because she understood what we go through, how our culture is, and how our belief systems are. She could understand us better than anyone else.” (Masood et al., P4)  “The difficulties associated with motherhood and everyday responsibilities were consistently identified as an integral component of participants’ experience of life after discharge.” (Connerty, Roberts & Williams, P957)  “When I got back I had to start work again um and you know get back to doing you know worrying about tea and shopping and cleaning and you know all of those other things.” (Connerty, Roberts & Williams, P958)  “I still needed to be the person making sure that things got done or not done and not just the task stuff” (Connerty, Roberts & Williams, P958)  “I found it expensive and not useful” Connerty, Roberts & Williams, P961)  “women who felt four or eight visits had been sufficient related their PND to needing to adjust to parenthood, having a particularly difficult time following the birth of their child, or to problems that had now been resolved, e.g. relationship difficulties. It was also apparent that some of these women…had put other sources of support in place, e.g. they had started parenting classes and made new friends.” (Turner et al. [1], P237)  “…again it’s patronising. It’s difficult to, when you know very well, when you can assess your situation very well, you’re perfectly aware of where is the problem…[discussing her husband’s unemployment and financial difficulties]” (Shakespeare, Blake & Garcia, P155) |
| **Desire for choice** | “women described how they had been allowed to set the boundaries of the discussions and to focus on what they wanted.” (Turner et al. [1], P236)  [participants feared] “being prescribed antidepressants not because this was what they needed but because this was what was available” (Turner et al. [2], P452)  “women wanted a discussion with their health visitors about the diagnosis of PND and possible treatment options” (Shakespeare, Blake & Garcia, P158)  “she had some agenda in her head…she didn’t tell me what she was thinking about me and I want to know” (Shakespeare, Blake & Garcia, P158) |
| **Desperation** | “I was really desperate and I knew something was not quite right” (McCarthy & McMahon, P624)  “So when I finally got to absolute crisis point and just couldn’t get through the day…” (McCarthy & McMahon, P626)  “In one extreme case, the first contact with mental health services was when one of the women attempted suicide and was hospitalized. Two other women finally contacted mental health services after weeks of suicidal ideation and were considered sufficiently at risk fo self harm to be hospitalized.” (McCarthy & McMahon, P627)  “I was hoping anyone [] could you know help me out” (Connerty, Roberts & Williams, P959)  “I’m taking all the help that I can get.” (Connerty, Roberts & Williams, P959)  “it would’ve been about ten to five…, the service was closing and I just rang up… [they] started seeing me within a week because they could see how desperate I was for some help” (Myors et al., P272)  “I didn’t want to die, I didn’t want to leave me kids, I just wanted someone to see how really, really desperate I felt and I wanted some help” (Shakespeare, Blake & Garcia, P159) |
| **Natural / unnatural** | “You know, being a mother comes naturally. I always thought before having children it was going to come naturally” (McCarthy & McMahon, P624)  “[I was] very tired all the time, which everybody says, “Oh, that’s normal. You’ve got a new baby” (McCarthy & McMahon, P624)  “It was just knowing…I wasn’t a freak, I was just a normal person” (McCarthy & McMahon, P630) |
| **Desire to get away** | “I thought to myself, “You will not be coming to see me anymore because I am packing up and leaving my husband”” (McCarthy & McMahon, P626)  “I didn’t want to be there in the room at that certain point in time” (Myors et al., P272)  “I didn’t think much of it, I just wanted to get out of the room” (Myors et al., P273) |
| **Qualities of clinician** | “Because she understood what we go through, how our culture is, and how our belief systems are. She could understand us better than anyone else.” (Masood et al., P4)  “facilitators’ skills such as the ability to listen and empathise, encouraging and non-judgemental attitude were recognized as important” (Masood et al., P4)  “the personal qualities of the service provider [impacted her motivation to attend]” (Connerty, Roberts & Williams, P961)  “They described their RHV as being kind, non-judgemental and understanding and as giving praise and encouragement.” (Turner et al. [1], P236)  “A few women said they did not have a good relationship with their PHV having found her critical of the way they were parenting or rather brisk in her approach.” (Turner et al. [1], P236)  “Women reported that the clinician’s interest and trhe time they gave meant that they could rely upon the clinician for support” (Myors et al., P271)  “she was a very gentle person. It was a kind of softness, it wasn’t harsh” (Myors et al., P273)  “The women acknowledged that the clinicians were not just like a friend but had specific skills such as the ability to really listen, were understanding, non-judgemental and had specific knowledge” (Myors et al., P273)  “[the health visitor] was so understanding and easy to talk to and willing to listen…”  “she was helpful…non-judgemental…there are just some people who you find are very comfortable to be with…you never fell like she’s dying to go”  “she could directly relate”  “I mean that’s the big ‘if’ isn’t it;…finding somebody that you click with”  “I felt like ten centimetres tall all the time she was there…she didn’t make me feel as though I was doing anything worthwhile at all” (Shakespeare, Blake & Garcia, P156)  “she just seemed really nice and really approachable” (Shakespeare, Blake & Garcia, P157)  “I think ti was just that they were really busy and just didn’t really have enough time for everybody with their kids” (Shakespeare, Blake & Garcia, P157)  “or maybe it’s the personality thing…the doctor that I went to see…I knew that he was very good at listening so that made it easier” (Shakespeare, Blake & Garcia, P158) |
| **Validation / normal** | “[I was] very tired all the time, which everybody says, “Oh, that’s normal. You’ve got a new baby” (McCarthy & McMahon, P624)  “this self-imposed isolation from friends, including other mothers, meant that women had less opportunity to differentiate their own level of distress from what is considered “normal”” (McCarthy & McMahon, P625/6)  “In the first stage women were able to discuss their distress with a health professional. Comments indicated that this helped normalize their distress and consequently they felt less stigmatized” (McCarthy & McMahon, P629)  “It was just knowing that someone else had been through what I had been through. I wasn’t a weirdo, I wasn’t a nutter, I wasn’t a freak, I was just a normal person suffering what mums, some mums, suffer.” (McCarthy & McMahon, P630  “a few other people sort of said “Oh I had that”…and I didn’t even know that they are on medication.” (McCarthy & McMahon, P630)  “and to me if there are other women who are lonely, they meet up and join these groups. Because of these you get to know about other people and their situations.” (Masood et al., P4)  “[the RHV] explained that what the individual was experiencing was a symptom of PND; and reassured the individual” (Turner et al. [1], P236)  “having somebody actually say ‘no it does happen, it happened to me, it has happened to “n” other people’…it’s not just her saying it” (Shakespeare, Blake & Garcia, P156) |
| **Passivity / someone else takes control** | “For many mothers the initiation of contact with mental health services was organized for them by a midwife… GP, or relative. In general, the women did not resist someone else taking control” (McCarthy & McMahon, P626)  “My friend, she said you have got to see C (psychiatrist)…dad said “this is just getting bloody ridiculous. You need help” and mum said “get on the phone and ring”” (McCarthy & McMahon, P626)  “In one extreme case, the first contact with mental health services was when one of the women attempted suicide and was hospitalized. Two other women finally contacted mental health services after weeks of suicidal ideation and were considered sufficiently at risk fo self harm to be hospitalized.” (McCarthy & McMahon, P627)  “women rarely make the decision to seek and accept treatment / help alone. Other people are largely responsible…and for initiating the process.” McCarthy & McMahon, P627)  “when you’re in that state of mind people just say things to you and you just don’t hear them [] it just doesn’t register” (Connerty, Roberts & Williams, P959)  “having a support plan available was essential for service use, reflecting, for some, an inability to become actively involved in post-discharge planning.” (Connerty, Roberts & Williams, P959)  “I didn’t look into it because [] I wasn’t in a state to make a, you know, decision” (Connerty, Roberts & Williams, P959)  “[a desire to get well] led Lucy to a general decision to accept and passively attend any services that were offered” (Connerty, Roberts & Williams, P959)  “it wasn’t really my decision it was more my husband’s” (Connerty, Roberts & Williams, P960)  “I think at that point I just said to myself I’ll just I’ll just go to all these appointments and see how they go and you know decide, decide later.” (Connerty, Roberts & Williams, P960)  “I started being more aware of what was happening to me” (Turner et al. [1], P237)  “And they said the other option is antidepressants, and they started me on antidepressants.” (Turner et al. [2], P453)  “she made sure that the pregnancy went smoothly…she talked to the doctors if they wouldn’t give me an answer she found it. Then after the pregnancy she was there because I wasn’t coping very well” (Myors et al., P273)  “What I really wanted was somebody to come and make the situation physically, make the situation better for me. I wanted somebody to like, I don’t know, sit me in a corner and say: ‘Look we’re going to take care of this and we’re going to make it all better for you’.” (Shakespeare, Blake & Garcia, P159) |
| **Stigma** | “[I started to think] that I am failing as a mother. Women who I know that are mothers always look sensational and have it all together” (McCarthy & McMahon, P625).  “A consequence of the shame and stigma was that the mothers did not speak to others about their feelings” (McCarthy & McMahon, P625)  “For some women the diagnosis led to reduced stigma regarding a perceived inability to cope as mothers by providing a legitimate explanation for their feelings” (McCarthy & McMahon, P627)  These women described negative attitudes toward the term PND and felt stigmatized” (McCarthy & McMahon, P627)  “My biggest fear was that I was going to be stereotyped as one of these mothers who just abused her children physically and mentally and verbally, and I was going to lose them and that was my biggest fear” (McCarthy & McMahon, P628)  “You think that you are going looney and you’re going to be put in the looney bin or something. Yeah because that is what I thought of mental health services. Go there? That’s for loopies.” (McCarthy & McMahon, P628).  “individuals explained that they had not told friends or family because they felt they should be coping or feared being judged as a poor mother.” (Turner et al. [1], P236)  “women talked about being more careful about what they said to their PHV explaining that they felt she would be more likely to judge their ability to mother.” (Turner et al. [1], P236)  [participants feared] “being judged as a poor mother” (Turner et al. [2], P452)  “They thought being on medication would imply to themselves and others that they were mentally unstable and had been unable to cope without intervention.” (Turner et al. [2], P452)  “I didn’t want to open up to anyone and tell, … family or friends about that because, … [of] the whole judgement and criticism” (Myors et al., P272) |
| **Something external** | “to know it wasn’t just me, that it was actually something” (McCarthy & McMahon, P627)  “[someone] identifying that here is something to look at…It wasn’t just me, sort of thing” (McCarthy & McMahon, P627).  “I started being more aware of what was happening to me” (Turner et al. [1], P237) |

Appendix D

Thematic map



**Paper 2:**

**Looking at more than the mother: exploring the narratives of women who self-identify with the term postnatal depression, in a socio-political context**

Word Count: 8,000

Journal submission details: This paper has been written with the aim of being submitted to The Journal of Prenatal and Perinatal Psychology and Health (Appendix I). This journal was chosen due to its interest in publishing work that explores the influence of the family, society, and the environment on the pregnant mother. This paper adheres to the requirements of the journal in having a word count of between 2,000 and 8,000 words as well as a 100 word abstract with at least three keywords.

**Abstract**

This study explored the experiences of women who self-identify with the term postnatal depression and have accessed NHS services for treatment. This research gives a voice to these women and hopes to better understand how to work psychologically with them. Six women were interviewed and narrative analysis was used to explore their experiences. A single story was constructed to illustrate the shared meanings from the women’s experiences. This depicted trauma, feeling unheard, the use of language and the impact of social constructs of motherhood as key narratives. The clinical application and implications of this paper are considered.

Word count: 97

Keywords: postnatal depression; narrative; mental health services

**Introduction**

It is widely accepted, when discussing the mental health needs of women, that the perinatal period is the period of pregnancy and first year after childbirth (Centre for Mental Health, 2014; Joint Commissioning Panel for Mental Health, 2012). “Perinatal mental health” serves as an umbrella term to cover the wide range of difficulties experienced at any point during this time including depression, anxiety, psychosis, post-traumatic stress disorder and many other conditions. The term also includes mental health difficulties that existed before the pregnancy and those that develop for the first time or are exacerbated in this period (Centre of Mental Health, 2014). “Postnatal”, “postpartum”, “antenatal” and “perinatal” are sometimes used in conjunction with a particular diagnosis to discern the point of onset or access to services. Interpreting information and statistics within the literature can be somewhat ambiguous as a result of the numerous, and interchangeable terms that are used.

**Labelling perinatal depression**

Many UK services, assessment tools and charities use the terms postnatal depression (PND) or postpartum depression (PPD) interchangeably when labelling the experience of depressive symptoms following the birth of a baby. This research used the term PND to advertise for participants with a caveat of “women who self-identify”. This was due to the researcher’s personal and professional experience of women often not receiving a formal diagnosis of PND despite going on to access relevant services and support for it.

Shaikh & Kauppi (2015) explored the label of postpartum depression (PPD) in Western society. The authors discuss that while non-psychotic, postpartum mental health disorders are conceptualised as PPD, there is a lack of consensus as to whether this is a distinct disorder or actually Major Depressive Disorder (MDD) that happens to be experienced at this time in a woman’s life. Their findings revealed that as women began to self-identify with the term, PPD became increasingly vague and confused with other perinatal mental health disorders.

The debate on diagnostic labelling, relies on the need to pathologise womens’ experiences as either being MDD or PPD following childbirth. This is perpetuated by the medical profession which continues to pathologise women’s experiences as “abnormal”. This has perhaps stemmed from a socio-political context of the developing concept of ‘motherhood’ which has caused it to be romanticised and mystified, to serve patriarchal interests (Nicholson, 1999). It can be argued that these interests are protected by creating social narratives of a “good” vs “bad” mother role: a “good” mother sacrifices herself to children, homemaking and is importantly, pleased about this. A “bad” mother struggles with her new role, fights for her own identity and equality in the responsibility of child-rearing. This is reflected politically, for example, shared parental leave from employment is now offered in the UK though this is rarely utilised by families with less than 1% of those eligible making use of the scheme throughout 2016/17 (Taylor, 2018). It is likely that stigma around men leaving the workplace to child-rear exists but also, due to pay inequality between the sexes, it is often not financially viable for families to take advantage of shared parental leave.

It is therefore important to consider this sociopolitical context of the label PND and the potential dangers of medicalising women’s experiences. However, according to Ussher (2005), there is a risk of implying that depression is an inevitable consequence of childbirth and, as such, that women do not need support. Ussher argues that this perspective may trivialise experiences that women identify as “terrifying” and “abnormal”.

**Service context**

In 2012 the Joint Commissioning Panel for Mental Health highlighted the need for a perinatal mental health integrated care pathway to be used by all services to ensure access for the right people at the right time (JCPMH, 2012). Extra training on perinatal mental health for practitioners working in community services such as IAPT (Improving Access to Psychological Therapies) was also raised as an important aspect of future services. Holistic assessments from primary care practitioners such as GPs and midwives were also called for. However, in an NSPCC report the following year, 42% of GPs surveyed said they lacked knowledge about specialist services for people with severe mental illnesses, 29% of midwives said they had received no content on mental health in their pre-registration training and 41% of mothers said that their health visitors had never asked them about depression (Hogg, 2013). The report described access to appropriate services as “a postcode lottery”.

In 2014, improving quality and access to Perinatal Mental Health services was identified as a priority in the NHS England Mandate (DOH, 2014) and NHS England Business Plan for 2014 onwards (NHS England, 2014). NHS England was asked to ensure a reduction in the incidence and impact of post-natal depression through earlier diagnosis, and better intervention and support. The Quality Network for Perinatal Mental Health Services was launched in 2007 to develop and maintain standards for mother and baby units. In 2012 this was expanded to include community services and in 2014 an update of these standards was published, informed by workshops within services. Issues raised included clear pathways and collaborative care pathways highlighting the recognition in services that some confusion regarding this process is present (Royal College of Psychiatrists, 2014).

In March 2015, following a scoping exercise by NHS Improving Quality (2015) it was announced by the Government that £75 million would be spent over 5 years, in order to provide the “right care to more women who experience mental ill health during the perinatal or antenatal period” (NHS Improving Quality, 2015, pg6.).

**The present research - women in perinatal research**

There have been a number of qualitative papers that have explored women’s access to services, which is an issue that has been raised by the current political drivers (Wittkowski et al, 2011; Templeton et al, 2003). However, how women experience services once they have accessed them is a neglected area of research.

Women in perinatal research have been largely understood via the use of psychometric measures, in scientific terms (Jomeen, 2012). However, researching in this way overlooks the need to understand how women perceive their difficulties and how society and the culture of services impacts upon their experience. Given the criticism of perinatal mental health services and the subsequent drives from government to improve upon them, it is necessary to hear the voices of women who have accessed and used these services. By doing so, this will help to improve psychological interventions used in perinatal health and at a crucial political time. In light of the confusing medical context and social constructs of motherhood, it is paramount that women’s experiences are heard in context of their social-cultural narratives.

Therefore, this study aims to:

1. Hear the voices of women who have accessed NHS community mental health services for support with self-identified “postnatal depression” using narrative research methodology.
2. Use women’s narratives to explore the role of services in the psychological care of these women.

**Method**

**Narrative research**

Narrative research seeks to explore how people make sense of their experiences and achieve personal change by creating meaningful stories for themselves and others. Stories are influenced by wider narratives, available to individuals in their social and cultural context (Wood, 1991). Therefore, exploring the link between the personal and social experience of individuals is especially suited to narrative methodologies. This paper draws on Emden’s (1998) narrative process which uses “emplotment” in the creation of “core stories” which can then be interpreted by the researcher. Previous qualitative research has found that women feel their voices are not heard by professionals when they seek support for PND (McCarthy & McMahon, 2008; Turner et al, 2010; Shakespeare, Blake & Garcia, 2006). This was another reason for narrative analysis to be chosen in this study as narrative methods emphasise keeping the stories of participants whole throughout analysis (Etherington, 2013).

**Recruitment**

Inclusion criteria

Mothers who:

* Self-identify with the label “postnatal depression”
* Have previously received NHS treatment for this since January 2014

Exclusion criteria

* Women who were receiving NHS treatment for postnatal depression at the time of recruitment
* Women under 18 years of age

Participants were recruited via an advertisement (Appendix A) placed on social media platforms by PND charities (Appendix B). Individual users of these platforms were then able to share the advertisement with their friends and followers. As a result there was a snowball element to the purposive sampling methodology.

Thirty five people responded to the advertisement. Each person was sent an email with the participant information sheet and consent form attached (Appendix C and D). A total of 21 people did not respond following this communication. Out of the remaining 14, five people were not eligible for the study (Appendix E for further details). One person lived in a remote destination and the scope of this study meant that an interview with her was not possible. One person returned their consent form but did not respond to communication to set up an interview. Interviews were arranged with the remaining seven people. One person withdrew their consent from the process before their interview, leaving a total of 6 participants in the study. Each person had returned an electronic consent form via email and also signed a second consent form at the time of interview. This was following a face to face discussion about the study, the right to withdraw and procedures in place to ensure confidentiality and anonymity (Appendix C and D).

**Ethical approval**

Ethical approval was obtained from the Faculty of Health Sciences Ethics Panel at Staffordshire University (Appendix F).

**Participants**

Six participants took part in this research. Table 1 shows their pseudonyms, basic demographic information and other relevant information.

|  |  |  |  |
| --- | --- | --- | --- |
| Pseudonym | Age Range | Ethnicity | Birth order of child |
| Ellie | 34-41 | White British | 1st |
| Wendy | Did not disclose | White British | 2nd |
| Connie | 34-41 | White British | 1st |
| Agnes | 34-41 | White British | 2nd |
| Willow | 26-33 | White British | 1st |
| Amy | Did not disclose | White British | 1st |

**Procedure**

All interviews were conducted by the researcher. Five participants chose to be interviewed at home and one person was interviewed at their place of work. Interviews were audio recorded using a digital device. Interviews were largely unstructured; the researcher began by asking the participant to “tell their story” and aimed to gather as much uninterrupted data as possible. Further prompts and questions were used such as “can you say more about that?” when necessary to elicit further information. The mean duration of interviews was 32 minutes (range 21 - 48).

**Reflexive position**

The researcher holds a feminist-constructivist epistemological position (Bohan, 1993). She is a Trainee Clinical Psychologist with a professional interest in women’s health and both professional and personal experiences of mental health difficulties following childbirth. It may be possible that elements of the women’s stories that aligned with this position and previous experience were more salient to the researcher. Equally, aspects of the stories that challenged this perspective may have been attended to less during analysis. To counter this bias, a journal was kept to aid honest reflection on each process and supervision from senior psychologists was also utilisted.

**Transcription and analysis**

The interviews were transcribed by the researcher. A reflective journal was kept in order to aid analysis and reflexivity. Initial thoughts or feelings about the transcripts were noted and the journal was revisited throughout the process. Core stories were then created by editing down transcripts following the approach of Emden (1998). All of the interviewer’s speech was deleted and the remaining transcripts were read and re-read several times. Any words or phrases that detracted from the key idea of a sentence or group of sentences were deleted.

Emden (1998) describes ‘emplotment’ as a way of making sense of a story at different levels of complexity and sophistication. There is no specific procedure regarding emplotment (Polkinghorne,1988); it is a process defined by each researcher that develops between the themes and events of a story by which the significance of each story as a whole becomes clear. Key ideas throughout each core story were identified and labelled as “subplots”. Subplots were ordered chronologically and excerpts of the story that corresponded with them were written out in a table. This process helped to keep the essence of the story at the forefront of the researcher’s mind. Units of narrative, based on Labov’s (1972) framework for understanding narratives, were then ascribed to groups of subplots in order to further make sense and find meaning within the stories. Studying the structure of people’s storytelling by using these units (abstract, orientation, complicating action, resolution and evaluation) aids understanding of how people encode information on a personal level. People rarely recount linear stories and the framework gives a chronological structure which aids analysis. An example of this process from transcript to core story can be seen in Appendix G. Tables illustrating subplots for each story can be found in Appendix H.

The analysis then moved between each participant’s core story, subplots, the reflective journal and transcripts. Shared meanings and levels of narrative across the stories were synthesised and shaped the researcher’s core story that is presented in the findings section of this report. To provide continuity, the findings are organised in keeping with Labov’s (1972) framework.

**Findings**

**Abstract**

Trauma

Each abstract reflected trauma in some way. Three of the women explicitly said that they had found their labours “traumatic”. For Connie this was physical trauma of a difficult labour and subsequent surgeries and injuries resulting from this:

*I was having an internal haemorrhage which was concealed…I ended up with wound sepsis and had to be readmitted…I had three surgeries within two weeks…that’s where I started from* - Connie

Willow described an “undignified” and painful experience of labour. She explained that she felt her labour perhaps wasn’t as physically difficult as other women’s but that the experience of the interventions and staff at the hospital made her labour and delivery a traumatic one. At times she used dehumanising language to talk about herself, for example having been “sliced in half”. Willow described a chaotic labour with many interventions and little control over these. Interestingly, the majority of Willow’s interview was focused on the abstract and orientation: her labour and birth of her child rather than the interventions she accessed. Her speech was pressured and she commented at one point “God, this is like a therapy session”. Willow had not received talking therapy or had any contact with mental health professionals and perhaps this finding shows that she needed to process the trauma she had experienced.

Ellie used one sentence to describe her experience but did not elaborate further:

*The birth I found quite traumatic -* Ellie

The remaining women discussed previous losses in the form of miscarriages and the experience of anxiety in their subsequent pregnancies resulting from this trauma. Amy described a traumatic antenatal period but an “absolutely perfect labour [and] delivery; it was lovely”. Interestingly, this participant later accessed a service aimed at women who had experienced traumatic births. The service offered women a space and time to sit with a midwife and look through their notes in order to process any difficult experiences they may have had.

**Orientation**

Internal confusion/ something isn’t right

As the participants oriented the researcher to their stories, they all described a period of internal confusion that occurred soon after giving birth. This experience was often described as difficult to articulate but something that the women felt intuitively; an instinct that they felt and in many cases motivated them to seek help.

*I just didn’t feel right…it was hard to explain but I just felt like something wasn’t right in myself…but nobody else had noticed* - Amy

*I didn’t know how I should feel. I had a vague sense that I shouldn’t feel like this but at the same time I wasn’t completely desperate* - Ellie

*I thought “I really don’t feel myself in any way, shape or form.” Didn’t talk to anybody about it…I remember thinking “I just don’t know what’s going on in my life. I just don’t know what’s happening to me”…I thought “I’m going to talk to them about this cos I just don’t feel very well”* - Wendy

*I just remember getting home and having this feeling of dread and not knowing what to do…I said to the midwife “I don’t think I’m feeling well. I’m not feeling how I should be”* - Willow

**Complicating action**

Unheard / silenced

As the women’s stories progressed and they began to engage with services, narratives of being unheard or silenced in some way became apparent. Amy explained that her health visitor told her that she was not depressed due to her score on the Edinburgh Postnatal Depression Scale (EPNDS). She often described being very proactive in her search for support:

*I felt like I was almost an obvious case that was crying out for help but had to really kind of go out there and hunt for the help myself* - Amy

Similarly, Wendy felt silenced by her health visitors and later a Community Psychiatric nurse (CPN):

*I approached her [health visitor], I remember holding my son and my daughter was crying at the time…and she pushed my red book away and said “you need to go to your GP” and I was like “OK, OK” and it was just having someone shut me down instantly. I hid in the house again. I was like “OK I’m not going to talk to her then. I don’t know what to do”.*

*I left there [the appointment with the CPN] hugely deflated thinking “…nobody’s listening to me, nobody’s giving me any drugs I don’t know what to do”* - Wendy

Wendy went on to describe her perception of the NHS as stretched and without capacity to cater for everyone in need. She voiced a fear of becoming a burden and this belief along with her perception of services served to silence her further as this excerpt shows:

*The health visitor did ring me back and the first thing she said to me was “you’re feeling a bit low” and I thought “I don’t feel low, I feel like I’m gonna fucking kill everyone”. But I said “yes, yes I am” and she went “well all I can do really is come round and listen, is that something you want me to do?” and I thought “well I know how busy health visitors are I don’t want you to come and listen to me moan” and she was like “OK, well we’re here if you need us” and that’s the last I’ve ever heard of them too.*

This is a particularly worrying element of Wendy’s story as she was having suicidal thoughts as well as thoughts to harm her husband and children; Wendy had a plan to inject her family with insulin as a way of killing them.

Agnes did engage with health visitor listening visits, though found them unhelpful:

*She’s [the health visitor] not not empathetic but it’s like just paying lip service to it a little bit so you don’t have the rapport to be brutally honest…I was feeling so ill, I just couldn’t cope with it. They just weren’t tuned into picking up on that really. No one did anything. Bit strange really -* Agnes

Agnes’ comments regarding the health visitor “paying lip service” suggest a lack of sincerity. Rather than speaking and not being heard, she suggests that the lack of rapport silenced her and she was unable to voice her difficulties. Agnes is shocked that the health visitor was also unable to pick up on her non-verbal cues of distress.

Connie’s experience was at times in contrast to these narratives of silence and feeling unheard. She was the only participant to describe a positive journey through mental health services with interventions that she thought were appropriate and tailored to her needs. Connie described feeling both listened to as well as unheard throughout her story. At times her experience was similar to that of the other women:

*After my health visitor went sick they rang me to say can you come to the clinics to get the baby weighed, I went and I said about myself, I was scoring high [on the EPNDS] and they just weren’t interested* - Connie

Here, Connie describes being silenced by the health visiting service. However, a clear narrative about being given permission to talk and health professionals truly listening and responding to her needs resonated throughout her story. This began with physical health care staff responding, or listening, to Connie’s presentation and continued with the mental health professionals she saw who allowed Connie to tell her story:

*Ironically I was seeing the practice nurses every other day and they noticed a change in me. They suggested I refer myself to the mental health team.*

*Before I couldn’t talk about it without crying and then suddenly I was talking about it like it was a story…being able to talk about those times and understand, it was the key really* - Connie

Confused services

Many of the women discussed a period of confusion from the services they accessed. For some this was regarding signposting and referring on; health visitors appeared confused as to whether the women met the remit for extra support. GPs provided interventions that some women did not feel were appropriate or that they did not understand the rationale behind.

*There were two health visitors and one of them was like “oh don’t worry about it, everything’s fine” and the other one said “would you like us to do a home visit?” and I was like “I don’t understand”…* *I felt like it was just luck really that she happened to be there and she wanted to come and see me. None of the other health visitors I saw at that clinic were as proactive as her* - Ellie

*I was the only person on the course who was there as a new mum. I felt out of place there…this isn’t what I need, this isn’t gonna benefit me* - Amy

*I don’t know whether they thought that medication was the only thing that was gonna get me out of it* - Ellie

There was a sense across the women’s stories that often there was no clear pathway regarding assessment and intervention for their mental health difficulties. One participant felt that her GP was shocked and confused when she disclosed the experiences she was having:

*The poor GP just looked at me like “Oh my God, what’s happening to you?”* - Wendy

Wendy was told by her GP that she needed medication and an urgent psychiatric referral. She never started medication as she was breastfeeding and was advised it was not safe to take antidepressants while doing so. She was never assessed by the perinatal team.

Unhelpful interventions

Alongside this confusion, all of the women experienced at least one intervention that they felt was unhelpful or inappropriate. Five of the women found the care they received from their health visitors as unhelpful in some way. As previously mentioned, Agnes was offered extra support in the form of listening visits though she did not find these helpful:

*Through the health visitor, I was flagged up with them. Through my own “I need help” and them doing an extra visit once a week for six weeks. She was basically useless. She said “You can get some counselling through [name of service]” …but she didn’t know much about it* - Agnes

Amy said she received a lot of extra support from health visitors when she contacted them to say she was struggling to breastfeed. She mentioned during these visits that her mood was low but was told she did not meet the threshold for “depression” and nothing further was done. Conversely, Connie had been identified by her health visitors as someone requiring further support for low mood but they failed to follow this up or signpost her on to other services. Ellie was identified by her health visitors as needing support for PND and they instigated the beginning of her journey through mental health services. However, she believed that her access to support had been very much dependent on luck:

*I went in with one problem and this particular health visitor picked it up but I felt like there was an element of luck and she really kind of kick started it because she was the one who wrote a letter to the GP which meant that when it came to my six week check up I talked to the GP about it which meant that the GP asked me to come back and speak to her at another point. So I feel quite lucky* - Ellie

Connie echoed this feeling that chance had played a part in some way to her receiving support:

*What’s left a bitter taste in my mouth was that I probably could have accessed [mental health services] sooner if the health visiting service had done what they were supposed to do. It is ironic that I was seeing the practice nurses because of my [physical] trauma but had I had postnatal depression following a normal birth or something I didn’t need to see them for, I just wonder at what point I would have been picked up, if at all? And that’s quite a scary thought* - Connie

Agnes and Amy were referred to support groups by their GPs. In both cases, the groups were not specifically for women in the perinatal period. Agnes described a CBT group and Amy explained that hers was a “course about worrying”. Both women were struggling with anxiety and the groups increased this:

*You could see there was people that were really depressed there and not well at all. And I worry about other people quite a lot so I went away thinking “God, they were so quiet this week. Are they gonna top themselves?” It was another layer of crap that I could have done without* - Agnes

*They referred me for a course about worrying. Which worried me even more…* *So already it was causing me more stress. But I went. I gave it a go…* *I thought “This isn’t what I need, this isn’t gonna benefit me”* - Amy

Agnes and Amy both made reference to the fact that the groups were not tailored to the needs of women in the perinatal period. Both women talked about the demographics of the other group members and feeling that those other members were struggling with very different problems to their own. Amy said that she “felt out of place there” and Agnes said that, had her group been for postnatal women, she would have found it more helpful as a “support network for each other”.

Ellie was the only participant to be referred to a perinatal mental health service. She was offered 1:1 therapy with a psychotherapist but found the experience unhelpful.

*For whatever reason, I think with that kind of therapy there needs to be a rapport between the two people involved and I didn’t get that with her…I just felt like I was sat there for an hour in this dingy room and it wasn’t nice and warm, there were no toys out for [son’s name] to play with. It was just miserable the whole thing was miserable. Maybe it was all too early for me to really talk about things in that way at that point I’m not really sure* - Ellie

In a similar vein to Agnes and Amy, Ellie commented on how the experience caused her to feel emotionally worse. This became apparent as she talked more about the logistical barriers she faced in attending the appointment:

*My dad drove me there. I’m thirty-four years old and my dad is driving me to this appointment. It was just the most depressing thing ever and I felt like a teenager, it was just awful. That whole situation really didn’t help and when I got there the woman, as I say we didn’t quite click. It didn’t work* - Ellie

Wendy saw a CPN based at her GP surgery whilst she was on the waiting list for a specialist mental health team. She described having a good rapport with the nurse and was able to disclose details about the traumatic images she was experiencing. However, she was offered no further input or advice from the clinician:

*I said “I’m just really terrified I’m gonna be like this for life is it gonna happen to me again? How am I gonna cope with it if it starts coming back and all these horrible things start happening again?” and he said “just come back to me but I think you’re probably gonna be OK now” and I was like “OK.” So I left there hugely deflated* - Wendy

**Resolution**

Helpful interventions

All but one of the women talked about at least one positive intervention they received. Connie recalled an overwhelmingly positive journey of recovery. She self-referred into a primary care mental health team and received a number of interventions including 1:1 therapy and group work. Connie described clinicians who were responsive to her needs, proactive in their treatment of her and contained and calm in their approach:

*Initially they thought I had some elements of OCD but it wasn’t until I started having treatment that she realised it was post traumatic stress disorder and started treating me for that.*

*Initially they put me into a group session and then soon the people that ran the group said “postnatal depression’s very different from a normal kind of depression mood management” and again said “don’t be surprised if after this you’re gonna need to come back into the service” and I think as the course was finishing they set [1:1 therapy] up for me again.*

*I had a period of one to one therapy which initially was something called ACT. As she got to know what I needed, mixed it in with a bit of CBT so it was more tailored. I was initially on medication as well and I decided I wanted to come off that because I felt therapy was really something that was working and wanted to do it whilst I was in therapy so I had kind of a crutch. So came off medication remained in therapy for twelve weeks or so and it mended me. Or I mended myself* – Connie

Connie mentioned several times how important she felt individualised and “tailored” care is in the treatment of postnatal depression. She spoke about this in relation to what she perceived as the strengths of the mental health team and the weaknesses of the midwifery, health visiting and GP service.

Amy and Ellie talked about being proactive in getting the appropriate support for themselves. Ellie initially engaged with the perinatal team but after finding it unhelpful, disengaged and sought a referral to an IAPT team. She found this intervention helpful. Similarly, Amy was referred for group work and given medication but said she had to “hunt out the support for [her]self”. She discontinued her medication, researched other services that may be able to help her and went back to her health visitor to ask for more support. As a result she was offered a service that she described as “extraordinary”:

*[My health visitor] arranged for me to get a little bit of support from the children’s centre…There’s a lady who supports families there…she said she normally goes out to help people who might be having financial difficulties when they’ve first had a baby or if there’s issues with maybe domestic violence or younger mums where there’s sort of maybe possible vulnerabilities. So I wasn’t really within her remit they said that it isn’t generally what they would do but there was not really anything else for someone with postnatal depression* - Amy

The second intervention that Amy found helpful was again from a service that she felt was not aimed at her as her health visitor had not suggested it but, after hearing about it from a friend, she contacted them independently:

*It’s for people who have a traumatic birth mainly or something after they’ve gone through but I thought “oh do you know what? I’d really like to see what that’s all about.” You access it through the hospital so again I did it off my own back. They sit with a midwife and go through all your notes and talk about everything leading up to having your baby* - Amy

Amy said that being able to discuss the labour and birth and relive the experience brought her a sense of closure that aided her recovery.

Willow had been told by her health visitor that she was experiencing “baby blues” but believed it was more than this. She visited her GP who prescribed antidepressant medication and saw her regularly for reviews. Willow was not offered psychological therapy and said that she had not wanted any.

*I was worried he was going to [refer me for talking therapy] and I’d go on a massive waiting list and then would have to do that before I could get Citalopram…I wanted the antidepressants…I would go and see him weekly and he would check how I was doing and make sure I wasn’t wanting to hurt myself or the baby or anything like that which I never did* - Willow

**Evaluation**

Labels

Several of the participants talked about labels and how they impacted upon their recovery and experience of mental health services. Agnes highlighted the variance of people’s understanding of psychological terms when she spoke about the label postnatal depression:

*I find that there’s this postnatal depression label. Even with my first I think I had it but I didn’t really realise because I was never depressed. I was quite manic if anything. It’s just a stupid label in a way because it’s not necessarily postnatal depression for everyone. It’s postnatal illness isn’t it?...* *But I just feel like there’s like a real lack of awareness in postnatal mental issues that aren’t depression. I mean I feel depressed over the result of things like medication but I’ve never, in the four years I’ve had children, felt that depressed by it. Just massively anxious or quite manic* - Agnes

It appears that Agnes associates the term PND with any number of postnatal mental health issues and is understandably confused and frustrated with this perceived definition. Ellie also talked about the confusing nature of labels associated with postnatal mental health difficulties and felt that they can sometimes be damaging:

*On [a charity’s] website they’ve got a helpline and it took me forever to get round to calling them because I knew they existed but their website it’s kind of deliberately vague I guess. It says “if you’re affected by postnatal depression and you want support you can call our helpline”…But people don’t get a diagnosis…people were really unwilling to use that terminology in front of me…Which meant that when it came to those helplines I felt like “am I entitled to call them?”*…*I still didn’t really feel that I was necessarily entitled to ask for that help. Because I didn’t have that label* - Ellie

In contrast, Wendy was told by healthcare professionals that they believed she was suffering from PND. She explained that being given this label significantly aided her recovery:

*Just having that label I was able to kind of pull myself out of it…. I think I had the confidence then because I had a label to talk to everybody about it whereas before I just thought I was completely failing as a mother and everyone else was doing amazing. But I think as soon as I was told “you’re really poorly, you’re really quite mentally ill” I sort of felt that “Oh OK that’s fine. Someone’s told me I’m really poorly” and I felt I could open up to anyone who would talk to me, I would tell them. I think that was the hugest thing* - Wendy

Imagined stories

Some of the women used imagined stories in parts of their interviews. At times this was in relation to their own or others’ expectations of motherhood in contrast to the reality they experienced.

*My mum offered to let us stay there but I was like, that’s a bit weird…my mother in law had invited us to live there for a couple of weeks as well and I thought “well no we need to learn how to cope ourselves-- we are grown ups -and do it by ourselves” So I just went home* - Willow

*I remember sayin’ to her at the time “These couple of other girls from the massage course, they’ve got it all together. They’re always out and about and they’re doing this and that” ­*- Amy

Many of the women imagined the lives of other women who may experience postnatal depression. Connie, Agnes, Amy, Wendy and Willow all expressed concern that as they had fought for support or felt they had been given access to it by chance, that women who they perceived as more vulnerable were at risk of being missed by services.

*I feel so frustrated that someone that actually knows a little bit about it and was literally banging the drum. How is it that I didn’t get anything when there’s people who are genuinely either clueless, or their partners have got concerns but what chance have they got of getting support?* - Agnes

At other times, some of the women imagined how their own stories may have been different. Connie talked about recent cuts in funding made to the area and that she now would not fall in a “vulnerable postcode” area.

*and I still wonder what they classify as vulnerable because they knew what I’d gone through. I might not live in a postcode which falls into one of the vulnerable postcodes but still I was vulnerable. I just hate that idea of a postcode division when actually it’s very much about the individual’s journey and history – Connie*

**Discussion**

This study explored the experiences of women who self-identified with the term postnatal depression in relation to their experiences in NHS services. This discussion further considers the elements of the narrative presented in the findings within a social context to explore the role of services in women’s mental health.

Trauma

The abstract of the findings reflects the context of trauma in which each participant’s story was set. Although the circumstances vary, the women share a subjective experience of trauma.

Connie’s story was the only one to tell a positive journey through mental health community services. Interestingly, Connie was the only participant to be left with physical injury following birth. Even though her health visitor recognised that Connie’s scores on the EPNDS suggested she was somewhat at risk, they did not refer her to mental health services. It was the physical health staff she saw, who could see the physical trauma she had experienced, that encouraged her to seek support. She was subsequently treated for post-traumatic stress disorder (PTSD). Many of the other participants talked about having to fight or hunt for support and feeling unheard. This raises questions about how “trauma” is identified within mental health services and other healthcare professions, and by whom.

The diagnostic classification for PTSD has been a much researched and controversial topic, particularly the concept of including subjective experience as an element of the diagnostic framework (McNally, 2009). Research has shown that events defined as objectively traumatic do not always result in a PTSD response (Rubin & Feeling, 2013), furthermore, events that are objectively defined as sub-traumatic (such as a relationship breakdown) can produce symptomology in line with a PTSD diagnosis (Boals & Schuettler, 2009; Gold et al, 2005). Nonetheless, subjective experience is not currently included in the Diagnostic and Statistical Manual of Mental Disorders (5th ed., American Psychiatric Association, 2013). The research already surrounding definitions of trauma and the findings in this paper all suggest that services may need to be more responsive to the experiences of women following childbirth. It appears that the current definitions of trauma that are dictated by services and professionals do not always accurately represent what is being experienced by women and as a result, women’s trauma may not be identified or treated.

Feeling unheard / finding a language

Previous research in this field has described the process of accessing mental health services for PND as a passive one; that women are seen by professionals and moved along care pathways without really becoming part of conversations regarding those decisions and thus are left feeling unheard (McCarthy & McMahon, 2008; Turner et al, 2010; Shakespeare, Blake & Garcia, 2006). A narrative of feeling unheard also ran through the stories of the women in this research which aligns with those previous findings. This shows that, although psychological services have long valued an ethos of collaborative working, women continue to experience quite the opposite when accessing mental health support in the post-partum period. A strong sense of self-help was felt throughout the women’s stories. This could be perceived as a positive representation of empowering women, however, when the wider context of participants’ stories are considered, it appears to reflect a sentiment that the services provided were not adequate. This again highlights the degree of responsiveness to women’s needs within services and raises issues about the efficacy of current assessment processes regarding these needs.

The women in this current research also felt a sense of confusion and chaos from services, which again echoes the findings of previous papers (Masood et al, 2015; Myors et al, 2014).

The findings here indicate that the language used in society to describe and explain psychological distress in the postnatal period may well compound the confusion experienced by those who experience it. The topic of labels seemed contentious for some of the women in that it had caused barriers in conversations with professionals and difficulties in accessing services. However, this was in the context of professionals resisting naming the women’s experiences as PND or using language that evoked ambiguity regarding services. Wendy was explicitly told that she was experiencing PND and “given” a diagnosis which she reported helped her immensely. Perhaps as PND becomes a priority for NHS mental health services, more widely recognised in society and reported on in the media, definitions of terms and the language used within the field require more careful consideration?

Society’s view of motherhood

A narrative about the expectations of others and the pressure this caused was heard throughout the women’s stories. This pressure came as voiced expectations from members of some of the women’s families as well as the women’s perceptions of health care professionals and society’s expectations of mothers. Willow discussed how she perceived offers of help from her family as “weird”. Both she and Ellie talked about a feeling that they should be doing things alone, they should be stronger than they felt. It is important to think about where these perceptions come from and they have been considered in feminist research previously. In their 2012 paper, Held and Rutherford discuss the construction of motherhood from the 1950s to 2012. They evaluate the changing attitudes towards postnatal mental health problems through the decades regarding causes and interventions and also highlight the assumption that remains constant: that motherhood and distress should not mix. The authors suggest that this assumption is rarely challenged. From the post war prosperity of the 1950s, in which the extended family and support networks were eroded as young couples began to live independently, to the sexual politics of more recent times, women are “expected to work, clean and raise families, and smile about it”. Held and Rutherford (2012; p119) argue that “when the most important job in the world becomes one of the most distressing, perhaps we need to look seriously, not only at the mother, but at the job itself”.

Choi et al (2005) illustrated how myths of motherhood perpetuated by society create feelings of inadequacy and shame in mothers who cannot live up to the expectations placed on them. Nicolson (1999) noted that whilst the women that she interviewed were happy to be mothers they were unhappy at the losses they suffered as a result of motherhood. This paper argues that the transition to motherhood should be seen by families, professionals and society as a healthy process towards psychological re-integration rather than a pathological response to a “happy event” (Nicolson, 1999). All of the women in the present study talked at some point about withholding information, denying themselves support in some form or feeling ashamed as a result of their perceived inability to conform to what a mother “should be”.

What is vulnerable?

A narrative regarding the positioning of the women in society could also be heard throughout the stories. Several of the participants questioned services’ definition of “vulnerable”. Amy talked about receiving an “out of the ordinary referral”, usually reserved for women who professionals would define as more vulnerable such as single parents or low income families. It is important to note that all of the women here were White British, in stable relationships with the fathers of their children and in employment. Some of the participants worried that the women they perceived as more vulnerable would not be able to access support; they felt that as they had needed to fight and struggle to get help, that women in a more vulnerable position would be missed. However, it could be argued that, as evidenced by Amy’s “unusual” referral, perhaps the inverse is true. Again, sexual politics needs to be considered here as Collins observed in 1980: “married or not, most women are single parents…motherhood can be even more difficult for women in intact families because they’re not see as being alone in their tasks” (Collins, 1980, pg115). Perhaps the fact that services and society viewed the women in this study as supported and secure meant that they were excluded from accessing help, whereas those women and families who are defined as “vulnerable” by services may access support more easily.

**Clinical implications**

The way in which trauma is perceived seems to vary greatly between professionals and the women who experience it but also within these two groups. NICE (2014, p14) define traumatic births as those that are “physically traumatic…and those that are experienced as traumatic, even when the delivery is obstetrically straightforward”. This definition recognises the subjective nature of the experience of trauma, although the findings here would suggest that physical trauma and psychological trauma are viewed very differently by services and professionals within them. This is a consideration that should be taken into account as training for primary care givers and the assessments they use are developed.

Best practice pathways for perinatal mental health are set out in NICE guidance (2014) although implementing them is not always possible given the disparity of service provision across the country. The findings in this research suggest that while service provision needs to be equitable nationwide, there is also a balance required that allows women to feel able to tell their stories to professionals, feel heard and referrals and interventions tailored to them.

In relation to these issues, the role of clinical psychologists within the development of services and training and supervision of primary care perinatal professionals is much needed. Collaborative work with health visitors and midwives regarding the consideration of transference, countertransference and the impact of working with traumatised people, as well as the variants of what that work looks like, should be considered. Traumatic countertransference and secondary traumatic stress are explored in a review of the literature about the psychological effects of working with traumatised individuals (Collins, 2003). It is noted how the care offered by professionals can be affected by service users and the traumatic content they bring to interactions. For instance, professionals may avoid eliciting or working with traumatic material, thus dissociating from the service user’s experience. With the use of effective supervision from clinical psychologists, it may be possible for midwives and health visitors to become more aware of these processes, enabling them to engage with traumatic content of mothers, truly hear their stories and respond appropriately to these.

**Strengths and limitations**

A strength of this study is its originality, highlighted by the absence of women’s experiences of NHS treatment for PND in previous research. The narrative approach used emphasised the impact of social context upon these experiences which is important when considering how services are developed. Whilst much of the research in this area is qualitative and utilises diagnostic tools to identify participants, this study invited women who self-identified with PND, thus reaching a population whose representation is limited in the literature.

A significant limitation of this study is that participants were recruited via charities’ social media platforms and websites alone. Women who are not active online would not necessarily have been able to request to participate. Those that did choose to participate may belong to a particular group of women. However, in January 2017 there were 16.6 million female, UK users of Facebook registered between the ages of 18-54 (Statista, 2018) and the use of websites and social media will have given this project good geographical reach across the UK.

The experiences that were analysed in this study all occurred prior to January 2017. As previously noted, perinatal mental health services have been undergoing significant change since 2015 and will continue to develop. The findings presented here represent a single window of time. Future, longitudinal research that recruits from perinatal mental health services and explores the experiences of women over time may be helpful to address this limitation.

**Conclusion**

This study explored the experiences of six women who self-identified as suffering from PND and had received NHS treatment for this. Their stories depicted a confusing journey through services, in which women often feel unheard. Narratives of trauma ran throughout all of the stories and yet trauma is rarely a focus of services’ assessment or intervention for PND. Distinct narratives can be heard that suggest clear pathways for PND are needed that allow for collaboration with women about the care they receive. Clarification of the labels and language that is used when discussing PND is also required. The impact of social constructs of motherhood should be considered when engaging with women, in particular how mothers who are perceived to be financially and emotionally secure are viewed by services.

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**Appendix A (i)**

Advertisement for participation in research



**Appendix B**

List of charities contacted

|  |  |
| --- | --- |
| Name of charity | Action |
| PANDAS Foundation | Advertised via Facebook and own website |
| APNI (Association for Postnatal Illness) | Declined to advertise due to exclusion criteria |
| MumsAid | Advertised via Facebook and own website |
| PNI (Postnatal Illness) | Advertised via Facebook |
| Mothers for Mothers | Did not respond to email request |
| The Smile Group | Did not respond to email request |

**Appendix C**

Information sheet

****

**Programme Director Staffordshire University**

**Professional Doctorate in Clinical** **Psychology**  College Road

Professor Helen Dent PhD Stoke-on-Trent

01782 294847 ST4 2DE

14th February 2017

**Participant Information Sheet**

**Title of the study: The experience of NHS community treatment for mothers who identify with the term “postnatal depression”**

You are being invited to take part in the above named study. This study forms part of a thesis which is undertaken as part of a Professional Doctorate in Clinical Psychology. The award is being led by the University of Staffordshire. The lead researcher is Trainee Clinical Psychologist, Eloise Lea. The aim of the study is to understand more about treatment for postnatal depression in the community.

Before you decide whether to take part in the study it is important for you to understand why the research is being carried out and what it will involve. If you have any questions about the research please contact the lead researcher, Eloise Lea.

Please read this information sheet carefully, ask any questions if you wish and take your time to decide whether you would like to be involved.

**WHAT IS THE PURPOSE OF THE STUDY?**

Postnatal depression affects approximately 10-15% of mothers. There are many studies that look at reasons why postnatal depression might happen and the risk factors for women. However, there are few studies that explore how women experience treatment for postnatal depression. This research hopes to give a voice to women who have experienced treatment for postnatal depression in the community and better understand how to work psychologically with them.

**WHY HAVE I BEEN INVITED TO TAKE PART IN THE RESEARCH?**

You have been invited to take part in the research as you have contacted the researcher after seeing a promotion for the study on one of the following websites:

PANDAS foundation

MumsAid

PNI org

You identify as somebody who has suffered with postnatal depression and have received NHS treatment in the community for this. However, to be invovled in this study the treatment must be completed and you have been discharged from the service. You also must be over the age of 18.

**DO I HAVE TO TAKE PART?**

It is your decision whether you take part in this study or not. There will be no consequences should you decide not to and it will not affect any support you might receive in the future. You may agree to take part in this study and then change your mind later on. However, should you agree to take part and complete an interview with the researcher, you will have up to two weeks following the date of the interview to withdraw your data. After this time you will be unable to withdraw your consent to take part in this study as analysis of the data may have already begun.

**WHAT WILL HAPPEN TO ME IF I TAKE PART?**

If you decide to take part you will meet with the lead researcher for an interview. This will take place at your home or Staffordshire University (whichever you prefer). The interview will last for approximately an hour. You will be asked to talk about your experience following the birth of your child, how your mental health was affected, how you accessed services and the how you experienced the treatment you received. This interview will be audio recorded on a digital device.

**WHAT ARE THE POSSIBLE ADVANTAGES AND DISADVANTAGES OF TAKING PART?**

There are no immediate advantages to you should you take part in this study. However, you will be contributing to research that will hopefully help others to understand more about the treatment women receive in the community for postnatal depression.

It is hoped that you will find participation in this study interesting and enjoyable. However, there may be times that you find recalling your experiences more difficult. I will offer support and encouragement to share your expereinces in a safe way. However, I may ask you if you would like a break from the interview if it seems that you are finding it particularly hard. We may agree to postpone the interview and continue at a later date. Alternatively, we may agree to stop the interview and not carry on at another time. These options are to ensure your safety and wellbeing.

**WILL MY PARTICIPATION IN THIS STUDY BE KEPT CONFIDENTIAL?**

All personal information given will remain confidential. Data will be stored on an encrypted memory device. All data will be recorded, stored and maintained in a way that eliminates the possibility of inadvertent disclosure. In accordance with the university’s policy, all data will be kept for 10 years, after which time it will be destroyed.

Breaches of confidentiality will only be made should the lead researcher feel that your own or someone else’s safety is at risk. In this event the researcher will usually try to talk to you about why they are going speak to someone else about what you have discussed and who that person is (for instance, the researcher’s supervisor, the police or healthcare professionals).

Your anonymity will be upheld in the publication of results; pseudonyms will be used throughout the research and no personal, identifiable information will be published.

**WHAT WILL HAPPEN TO THE RESULTS OF THE RESEARCH?**

This research is being completed as part of the lead researcher’s thesis which is required for completion of the professional doctorate in clinical psychology with Staffordshire University. As well as this, it is hoped that the research will be published in relevant academic jounals. Quotes from the recorded interviews may be used verbatim within the write up of this report. All quotes will be anonymised.

**WHO IS ORGANISING AND FUNDING THE STUDY?**

This research is being carried out by Eloise Lea a trainee clinical psychologist. The professional doctorate in clinical psychology is awarded by Staffordshire University and Eloise Lea is employed by South Staffordshire and Shropshire NHS Foundation Trust.

**WHO HAS REVIEWED THE STUDY?**

The study has been approved by the university’s ethics committee. Also, the charities who have helped to recruit participants have reviewed the study.

**WHAT IF I AM NOT HAPPY WITH THIS RESEARCH OR THERE IS A PROBLEM?**

If you have concerns about this research please speak to the lead researcher, Eloise Lea or Dr Helena Priest (details are below).

**IF I WANT TO PARTICIPATE IN THE STUDY WHAT DO I DO NEXT?**

If you would like to take part in this study please email a copy of the consent form you have received back to Eloise Lea. Please mark on the form that you are happy to participate in the research. Alternatively please telephone **01782 294007** to register your interest and a member of the research team will call you back. You will be asked to sign the consent form on the day of your interview but you are able to change your mind about taking part at any time (up until two weeks after the date of your interview). If you have any more questions regarding this research please contact Eloise Lea using the contact details below.

**CONTACT DETAILS FOR FURTHER INFORMATION**

Lead researcher: Eloise Lea

Email: [postnatalresearch@gmail.com](mailto:postnatalresearch@gmail.com)

Telephone: 01782 294007

Academic supervisor: Dr Helena Priest

Email: h.m.priest@staffs.ac.uk

**Appendix D**

Consent form

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**Programme director Staffordshire University**

**Professional Doctorate in Clinical** **Psychology**  College Road

Professor Helen Dent PhD Stoke-on-Trent

01782 294847 ST4 2DE

14th February 2017

**Participant Consent Form**

**Title of the study: The experience of NHS community treatment for mothers who identify with the term “postnatal depression”**

Name of participant:

Name of researcher:

* I confirm that I have read and understood the information sheet for the above study dated 14th February 2017. I confirm that I have had time to consider the information, ask any questions I have and have these answered in a satisfactory manner.

**Please initial box**

* I understand that my participation in this study is voluntary and I am able to withdraw my consent at any time (up until two weeks after the date of my interview) without giving reason for this.

**Please initial box**

* I understand that the information I provide will be processed and analysed as is required by this research study and according to the Data Protection Act. This includes an audio recording of the interview. I understand that this information will be anonymised and then destroyed after ten years in line with Staffordshire University policy.

**Please initial box**

* I agree to anonymised quotes from the transcript of my interview being included in any write up or publication related to this research.

**Please initial box**

* I confirm that I am over 18 years old

**Please initial box**

* I agree to participate in the above study.

**Please initial box**

Signed ……………………………………………………………………………

Date ……………………………………………………………………………….

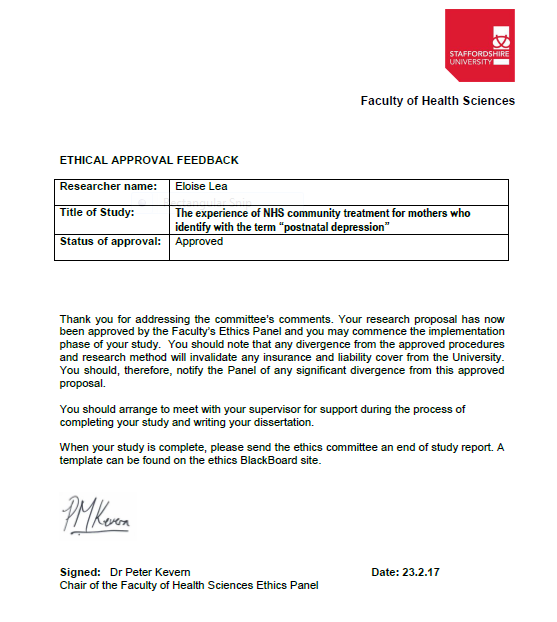
**Appendix E**

Potential participants with outcomes of their involvement

|  |  |
| --- | --- |
| Number of respondent | Outcome |
| 1 | Participated in research |
| 2 | Participated in research |
| 3 | Participated in research |
| 4 | Participated in research |
| 5 | Participated in research |
| 6 | Participated in research |
| 7 | Receiving NHS treatment for postnatal depression |
| 8 | Receiving NHS treatment for postnatal depression |
| 9 | Receiving NHS treatment for postnatal depression |
| 10 | Consented to participate, distance too great to complete interview |
| 11 | Received treatment provided by military rather than NHS |
| 12 | Received treatment 11 and 16 years ago |
| 13 | Withdrew consent prior to interview |
| 14 | Consent form received, no further contact to arrange interview date |
| 15 | Information pack sent, no further response |
| 16 | Information pack sent, no further response |
| 17 | Information pack sent, no further response |
| 18 | Information pack sent, no further response |
| 19 | Information pack sent, no further response |
| 20 | Information pack sent, no further response |
| 21 | Information pack sent, no further response |
| 22 | Information pack sent, no further response |
| 23 | Information pack sent, no further response |
| 24 | Information pack sent, no further response |
| 25 | Information pack sent, no further response |
| 26 | Information pack sent, no further response |
| 27 | Information pack sent, no further response |
| 28 | Information pack sent, no further response |
| 29 | Information pack sent, no further response |
| 30 | Information pack sent, no further response |
| 31 | Information pack sent, no further response |
| 32 | Information pack sent, no further response |
| 33 | Information pack sent, no further response |
| 34 | Information pack sent, no further response |
| 35 | Information pack sent, no further response |

**Appendix F**

Ethical approval from the Faculty of Health Sciences and Staffordshire University



**Appendix G**

Example of analysis process: Connie

Stage one: raw transcript

Interviewer: I’d like you to talk me through your story after having your daughter

C: After having her?

Interviewer: Yes

C: So you don’t want to know a bit about the, what happened during?

Interviewer: If it’s relevant to your story yes please

C: So erm (…) (…) Well I guess <LG> (( )) I don’t know where to start really. <BR> <Sigh> (…) So I, probably along with most mums, anticipated or hoped for a nice normal birth erm but I didn’t get that and it was all quite traumatic and erm (…) I erm I had to have an emergency caesarean. And which was fine, I was fine with that but unfortunately they didn’t notice a blee-, a bleeding artery erm so (…) it wasn’t until I was in recovery, I, I started, I was trying to breastfeed my daughter and started collapsing and initially I just thought I was being a wimp because I was fainting <LG> but no actually I was having an internal haemorrhage erm which was concealed and so I went back to theatre and erm lost a lot of blood and went to ITU and was separated from my daughter for about 24 hours. Erm and then we were joined, rejoined erm I had trouble feeding her because I had become (…) I had lost so much blood (Laughs at pet making noise) Erm (…) and (…) erm (…) (…) she ended up becoming dehydrated which I took a lot of the blame felt like I, took a lot of the blame for because I wasn’t obviously producing enough (…) erm (…) and then we eventually got home at day 5 (…) and then <BR> day ten I ended up (( )) sepsis and had to be readmitted and then I had like another surgery so I had like three surgeries within two weeks. Two being general anaesthetic. Erm so that’s where, that’s why I wanted to kind of just say that that’s kind of where I started from. And so immediately in the postnatal period within, in the hospital I noticed that erm I (…) and I think it was a mixture of sleep deprivation and what had gone on, kind of noticed that I thought I had, like two babies. One was li-- a bad baby and one was a good baby nothing ever materialised with that but I just f--, I kind of really recall those feelings. And when I was woken with a baby crying I was like “Oh that’s the bad baby” <LG> you know obviously it was just the one baby <LG> erm (…) and as the days went by I noticed I was kind of having like flashbacks and <BR> like kind of, I was fixating on a lot of things that had happened and then also started building concerns around something was still going to happen, especially to my daughter, Annabelle. Erm (…) (…) and then erm (…) because of th-- having to have the third surgery er my wound was kept open so I had to go every day and then every other day for wound packing and dressing at the GP’s and so I got to kno-- know the practice nurses there who (( )) kind of ((??interview)) me and erm and that was quite nice to have some sort of continuity with them. Unfortunately the health visitor who erm who was assigned to me went sick after my initial birth visit and she had done the erm (…) postnatal depression scoring and noticed that it was sort of scoring at a, a level that was abnormal and she was going to redo it but she went sick. And unfortunately despite me telling the health visitors that that was the plan and the score was in the red book, they never really (…) I guess cared to take that on <BR> but fortunately ironically I was seeing the practice nurses (…) erm er every day, every other day and they noticed a change in me I think it didn’t help that one day I came in crying <LG> and I think it was just, you know, I just felt really undignified that I was having this oo-- constant oozing wound that I was using sanitary pads on (…) to collect all the horribleness and you could just smell you know it was just (…) it was in the-- it, it was quite a warm April I remember erm (…) and I just noticed that my mood had changed I was crying all the time I just (…) erm (…) (…) just wasn’t myself at all

Stage two: deletion of interviewer’s speech and any words or phrases that detract from main ideas of the story

~~Interviewer: I’d like you to talk me through your story after having your daughter~~

~~C: After having her?~~

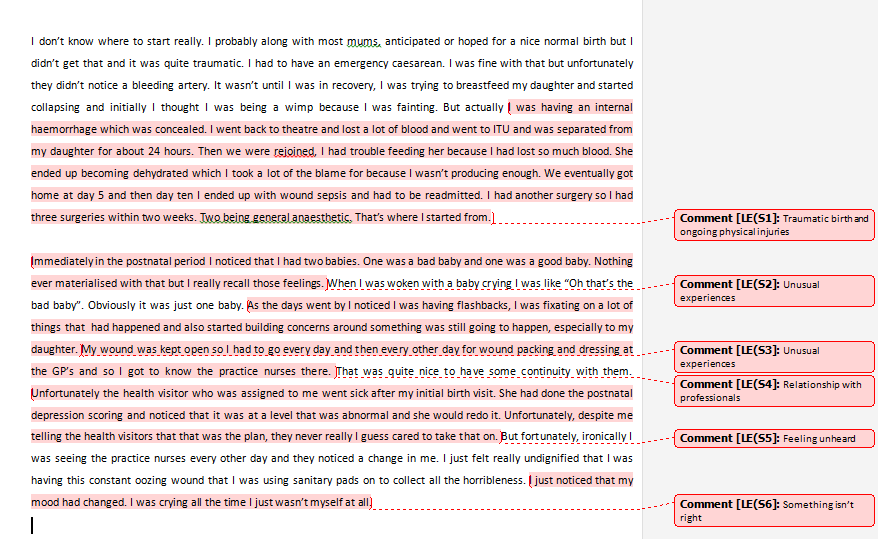
~~Interviewer: Yes~~

~~C: So you don’t want to know a bit about the, what happened during?~~

~~Interviewer: If it’s relevant to your story yes please~~

~~C: So erm (…) (…) Well I guess <LG> (( ))~~ I don’t know where to start really. ~~<BR> <Sigh> (…) So~~ I, probably along with most mums, anticipated or hoped for a nice normal birth ~~erm~~ but I didn’t get that and it was ~~all~~ quite traumatic ~~and erm (…) I erm~~ I had to have an emergency caesarean. ~~And which was fine,~~ I was fine with that but unfortunately they didn’t notice ~~a blee-,~~ a bleeding artery ~~erm so (…)~~ it wasn’t until I was in recovery~~, I, I started,~~ I was trying to breastfeed my daughter and started collapsing and initially I ~~just~~ thought I was being a wimp because I was fainting ~~<LG>~~ but ~~no~~ actually I was having an internal haemorrhage ~~erm~~ which was concealed ~~and so~~ I went back to theatre and ~~erm~~ lost a lot of blood and went to ITU and was separated from my daughter for about 24 hours. ~~Erm~~ ~~and~~ then we were ~~joined,~~ rejoined ~~erm~~ I had trouble feeding her because ~~I had become (…)~~ I had lost so much blood ~~(Laughs at pet making noise) Erm (…) and (…) erm (…) (…)~~ she ended up becoming dehydrated which I took a lot of the blame ~~felt like I, took a lot of the blame~~ for because I wasn’t ~~obviously~~ producing enough ~~(…) erm (…) and then~~ we eventually got home at day 5 ~~(…)~~ and then ~~<BR>~~ day ten I ended up with wound sepsis and had to be readmitted ~~and then~~ I had ~~like~~ another surgery so I had ~~like~~ three surgeries within two weeks. Two being general anaesthetic. ~~Erm so~~ that’s where~~, that’s why I wanted to kind of just say that that’s kind of where~~ I started from. ~~And so~~ immediately in the postnatal period ~~within, in the hospital~~ I noticed that ~~erm~~ I ~~(…) and I think it was a mixture of sleep deprivation and what had gone on, kind of noticed that I thought I~~ had~~, like~~ two babies. One was ~~li--~~ a bad baby and one was a good baby nothing ever materialised with that but I ~~just f--, I kind of~~ really recall those feelings. ~~And~~ when I was woken with a baby crying I was like “Oh that’s the bad baby” ~~<LG> you know~~ obviously it was just ~~the~~ one baby ~~<LG> erm (…) and~~ as the days went by I noticed I was ~~kind of~~ having ~~like~~ flashbacks ~~and <BR> like kind of,~~ I was fixating on a lot of things that had happened and ~~then~~ also started building concerns around something was still going to happen, especially to my daughter, ~~Erm (…) (…) and then erm (…) because of th-- having to have the third surgery er~~ my wound was kept open so I had to go every day and then every other day for wound packing and dressing at the GP’s and so I got to ~~kno--~~ know the practice nurses there ~~who (( )) kind of ((??interview)) me and erm and~~ that was quite nice to have some ~~sort of~~ continuity with them. Unfortunately the health visitor ~~who erm~~ who was assigned to me went sick after my initial birth visit ~~and~~ she had done the ~~erm (…)~~ postnatal depression scoring and noticed that it was ~~sort of scoring~~ at ~~a,~~ a level that was abnormal and she was going to redo it but she went sick. ~~And~~ unfortunately despite me telling the health visitors that that was the plan ~~and the score was in the red book,~~ they never really ~~(…)~~ I guess cared to take that on ~~<BR>~~ but fortunately ironically I was seeing the practice nurses ~~(…) erm er~~ ~~every day,~~ every other day and they noticed a change in me ~~I think it didn’t help that one day I came in crying <LG> and I think it was just, you know~~, I just felt really undignified that I was having this ~~oo--~~ constant oozing wound that I was using sanitary pads on ~~(…)~~ to collect all the horribleness ~~and you could just smell you know it was just (…) it was in the-- it, it was quite a warm April I remember erm (…) and~~ I just noticed that my mood had changed I was crying all the time I ~~just (…) erm (…) (…)~~ just wasn’t myself at all.

Stage three: identifying subplots

****

**Appendix H**

Example of subplot table

Amy

|  |  |  |
| --- | --- | --- |
| **Unit** | **Subplot** | **Examples** |
| Abstract | Anxiety in pregnancy / time in hospital | I suppose my whole pregnancy was very anxious and I didn’t enjoy it at all. I spent a lot of the time in hospital worrying that something had gone wrong because I’d had a previous miscarriage |
| Orientation | Something isn’t right | After a while, maybe about a month I just didn’t feel right. I was just so upset all the time. Just crying and very low in myself. It was hard to explain but I just felt like something wasn’t right in myself. |
| Complicating factor | I was overwhelmed and nobody was listening so I made a decision  Confusion from services - offered interventions but not what I need  Logistics caused a barrier | But then I had this night where I couldn’t stop crying. I remember one night I just sobbed like I’ve never cried before… I knew that something wasn’t right. But nobody else had noticed. I knew that I needed to do something about it cos I thought “I can’t carry on like this”. So I went to my GP and had a talk to them about how I was feeling.  I was the only person on the course who was there as a new mum. I felt out of place there… This isn’t what I need, this isn’t gonna benefit me  I went back to the GP and I was prescribed diazepam. I don’t even remember why at the time I think they thought that would help relax me. I think I had one tablet. I don’t remember another thing I was wiped out on the bed. Luckily my husband was here but it knocked me out and I thought “I am not ever takin’ another one of those again”.  We had quite a few chats about what else would help but other than this worrying course I don’t recall anything being discussed in terms of counselling or anything like that. I don’t know whether they thought that medication was the only thing that was gonna get me out of it.  It was held at a site that, where I work, they own it. I know everyone in that office and I was on maternity leave and I thought “if they see me turn up” You literally have to walk in to a buzzer door and the people that I used to work with were sitting there and I was like “how am I gonna get in without them saying ‘what are you doin’ here?’” So already it was causing me more stress. |
| Resolution | “Extraordinary” referral, support I shouldn’t have  Talking service with midwives was helpful but could have been much more so | She normally goes out to help people who might be having financial difficulties when they’ve first had a baby or if there’s issues with maybe domestic violence or younger mums where there’s possible vulnerabilities. So I wasn’t really within her remit they said that it isn’t generally what they would do but there was not really anything else for someone with postnatal depression.  It was really nice cos I had such nice memories of the delivery and it was lovely to look back at it. But actually what I wanted to go through was all the other stuff that was all the bad, all the appointments in the day assessment unit, all the monitoring for the reduced movement. Cos that was all where the worrying was. |
| Evaluation | I had to hunt for support  Professionals weren’t always open  Relationships with other mums are important to me | I did feel like I had support but I felt like I had to go and look for it myself. And looking back now I would imagine that there are people in a lot worse situations than me that wouldn’t have been able to push themselves to do that cos a lot of what I did to get through that bad time, I did myself. The people were there to support me but I had to hunt it out. And ask for it.  I felt like I was almost an obvious case that was crying out for help that had to really kind of go out there and hunt for the help myself.  I remember having a conversation with my health visitor and I got the feeling at the time that she wanted to be able to tell me things that she couldn’t.  We chat about things now that we did when our babies were born and I think “oh you make me feel normal.” We’re quite aware when we get new mums coming in. They don’t just necessarily wanna come to the group, they wanna be able to talk as well. |

**Appendix I**

Journal for submission guidelines

*The* *Journal* *of* *Prenatal* *and* *Perinatal* *Psychology* *and* *Health* accepts only original material that is not under consideration by any other publications. Articles should be word-processed and transmitted electronically to the Editor. The Editor reserves the right to edit manuscripts for length, clarity, and conformity with the journal’s style. The author should retain his/her copy. American spelling should be used. The paper should be between 2,000 and 8,000 words with a 100–word abstract and at least three keywords. (See further guidelines for submitting a manuscript in the current APA Publication Manual (2009), specifically, “Author Responsibilities” (pp. 228-231)

The journal is interested in publishing theoretical and empirical articles utilizing data gained from clinical work, experimental research, case studies, and self-report.

**Among the areas of special interest are:**

* Psychological factors that affect conception, pregnancy, labor, delivery and the post-partum period;
* The reciprocal mechanisms of interaction between the pregnant mother and her unborn and sentient child and the mother and her newborn;
* The influence of the family, society, and the environment on the pregnant mother and her unborn child;
* Evidence-based measures that will improve the emotional well-being of mothers, fathers, and newborns;
* The psychological effects of medical technology during conception, pregnancy, labor, and delivery on all parties concerned;
* Methods of prevention and intervention/resolution of prenatal and perinatal traumas with children and adults;
* Interfaces between prenatal and perinatal psychology and medicine, genetics, developmental psychology, anthropology, ethics, and the law.

**Illustrations, Figures and Tables**

* All illustrations and tables should be included separately from the manuscript (in a separate document) and should be clearly identified in Arabic numerals, showing which is the top of the illustration if this is not obvious. Legends for illustrations, which should be referred to as “Figures,” should also be included with the figures. Tables must supplement the text without duplicating it. They should include an appropriate title.
* Lettering within an illustration, figure or table should be no smaller than 8 points and no larger than 10 points, and prepared at a resolution sufficient to produce a high-quality image, that is, using computer-generated, professional-level graphic software.
* Illustrations should either be black-and-white glossy photographs or India ink drawings. Color illustrations will only be shown on the digital version. They will be converted to black and white in the print version

**APA Style**

* Formatting and referencing must follow APA style. References should be limited to work cited in the article, rather than being a bibliography of the topic.

**Paper 3:**

**Looking at more than the mother: exploring the narratives of women who self-identify with the term postnatal depression, in a socio-political context**

**Executive summary**

Word count: 1,538

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**Introduction**

This summary describes the research study entitled “Looking at more than the mother: exploring the narratives of women who self-identify with postnatal depression, in a socio-political context”. The study explored how women who self-identified with the term “postnatal depression” (PND) experienced treatment from NHS community services. It also considered the wider impact of culture and social context upon these experiences.

PND is defined by The Royal College of Psychiatristsas a serious mental health concern that affects approximately 10-15% of mothers.1 Symptoms include tearfulness, feelings of hopelessness and sadness, loss of energy, sleep disturbances, difficulty bonding with the baby, social withdrawal and thoughts of self harm and suicide.2

Six women were asked to tell the stories of their experience and these stories were then analysed using a narrative approach. Findings and conclusions were drawn from the stories that contribute to our understanding of how services, and the professionals within them, can better care for the psychological needs of women who self-identify with PND.

**Background**

In 2013, a report by NSPCC found that:

* 42% of GPs said they lacked knowledge about specialist services for people with severe mental illnesses
* 29% of midwives said they had received no content on mental health in their pre-registration training and,
* 41% of mothers said that their health visitors had never asked them about depression

Perinatal mental health services are mental health services that care for and treat women who are pregnant or have had a baby in the last year. In 2014, improving the access to and quality of perinatal mental health services was identified as a priority by The Department of Health.3 NHS England was asked to ensure a reduction in the impact of post-natal depression through earlier diagnosis, and better intervention and support.4

In 2015, it was announced by the then Government that £75 million would be spent over 5 years, in order to provide the right care to more women who experience mental health problems when they are pregnant or have had a baby in the last year.5

Research has found that women often feel unheard when accessing services for support with psychological difficulties following childbirth; they report a sense of confusion from services and a lack of an effective language with which to communicate their distress. 6-12

As the government and NHS recognise the need for improved services, and considerable amounts of funding are ring-fenced for their development, it is important to ensure that the views of the women who use them are taken into consideration.

**Aims of the research**

The aims of this study were to:

1. Hear the voices of women who self-identify as having experienced post-natal depression and have accessed NHS community mental health services for support with this
2. Use women’s narratives to explore the role of services in the psychological care of these women.

**Methods**

Participants were recruited via an advertisement that was placed on social media platforms by PND charities. Participants were invited to take part in face to face interviews to talk about their experiences in services. Thirty five people responded to the advertisement and each person was sent an email with more information about the project. To participate in the research, women had to be over 18 years of age and received NHS community treatment for PND since 2014. Women who were still receiving NHS treatment at the time of the research were excluded from the study in order for participants to be able to reflect on the entirety of their experience in services. A total of 21 people did not respond to the researcher after further information was sent out to them. Out of the remaining 14 people, 8 were eligible to be interviewed for the study. One person withdrew consent before interview and another was not able to take part due to their geographical location. A final 6 people were interviewed for the research.

There was no interview schedule, instead the women were asked to “tell their story”. The researcher used prompts and questions such as “can you say more about that?” but mostly, the women’s stories were recorded uninterrupted. The interviews were audio recorded and after they were transcribed they were analysed using a narrative approach. Narrative researchers are concerned with:

* the way stories are told
* what the stories say
* what the stories mean

Narrative research is based on the idea that stories are not constructed in isolation but are influenced by the world around them, the social and cultural context of the story teller. Because of this, research conducted with a narrative approach is well suited to explore the link between what a person experiences and how society impacts upon this.

The researcher based analysis of the women’s stories on two theories by Emden13 and Labov.14 “Core stories” were created by editing down the transcripts by identifying key ideas which were labelled as “subplots”. These subplots were then ordered chronologically by assigning each to a “unit” of the story. The units were called abstract, orientation, complicating action, resolution and evaluation. As people rarely tell stories in chronological order, the units helped the researcher look across each participants story and compare them more easily. The researcher then wrote a new core story, using the same units, to illustrate the findings from across the women’s stories.

**Summary of main findings**

* Trauma: each woman set their stories within a context of trauma. This was either experienced as physical, psychological or both. However, the way in which services perceived their experiences did not always acknowledge or recognise this trauma. Definitions of trauma varied greatly between services and the professionals within them and the women who use these services. Consideration of how professionals can be more responsive to women’s experiences and needs is required.
* Feeling unheard: this finding echoed previous research that women feel unheard when accessing services. Largely, services were not experienced as collaborative by participants. A strong sense of self-help was felt across the stories that reflected a sense of isolation in the women.
* Confusion and chaos: the women experienced confusion and chaos from professionals within services relating to how to address the problems they presented with. Pathways for referral were unclear for some and for those that initially seemed clear, the referrals that were made as a result did not feel appropriate. As well as this, language used in society and services to describe and explain psychological distress in the postnatal period may well compound the confusion experienced by those who experience it.
* Social narrative and their impact: the women talked about expectations of others (family members, professionals within services as well as wider expectations of society) and the pressure that they felt because of this. All of the women talked at some point about withholding information, denying themselves support in some form or feeling ashamed as a result of their perceived inability to conform to what a mother “should be”.
* Vulnerability: the study also found that the positioning of women in society impacts upon the care they receive. Some of the participants worried that women they perceived as more vulnerable would not be able to access support as they had struggled themselves and yet viewed themselves as more privileged. However, as well as this, several of the participants questioned services’ definition of “vulnerable” and argued that even though they did not belong to a group perceived as vulnerable by society, they were still very vulnerable. It can be argued that as services and society viewed the women in this study as supported and secure, they were excluded from accessing support. Whereas those women and families who are defined as “vulnerable” by services may access support more easily.

**Clinical implications and recommendations**

* NICE guidelines15 define traumatic births as those that are “physically traumatic…and those that are experienced as traumatic, even when the delivery is obstetrically straightforward”. The findings would suggest that physical trauma and psychological trauma are viewed very differently by services, the people who use them and professionals within them and this needs to be considered more as training for primary care givers and the assessments they use are developed.
* A balance is required that allows for the development of equitable services, available to all that provides women with a space to be heard by professionals and receive assessments and interventions that are tailored to them.
* Clinical psychologists have an important role in the development of services as well as the supervision and training of primary care workers who have contact with women in the perinatal period. It is recommended that health visitors, midwives and other primary care workers are able to access supervision with clinical psychologists regarding the impact of working with traumatised individuals. This should include the consideration of professionals’ personal experiences and attitudes towards trauma in the perinatal period and how these experiences may impact on the service they provide to the women they see in services.

**Sharing the research**

The full research project will be submitted for publication to The Journal of Prenatal and Perinatal Psychology and Health. The journal lists psychological factors that affect the post-partum period and methods of prevention and intervention/resolution of perinatal traumas among the areas of special interest. Participants who took part in the study and requested a copy of final paper will also be sent a copy.

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