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UCC
University College Cork, Ireland
Coláiste na hOllscoile Corcaigh

# "An Exploration of the Experience of Post-Natal Depression Support Services in Cork"

Deirdre Murphy
&
Helen Skinner

CARL Research Project

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| **Name and year of course:** | Bachelor of Social Work |
| **Date completed:** | 07/05/2013 |

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- provide their services on an affordable basis;
- promote and support public access to and influence on science and technology;
- create equitable and supportive partnerships with civil society organisations;
- enhance understanding among policymakers and education and research institutions of the research and education needs of civil society, and
- enhance the transferrable skills and knowledge of students, community representatives and researchers (www.livingknowledge.org).

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# Executive Summary

## Background to the Study

A previous study conducted in 2012 in conjunction with CARL and PND Ireland highlighted the prevalence of Post-Natal Depression (PND) in Ireland (Cronin, 2012). This study revealed that 1 in 5 mothers experience some level of PND. Based on these findings PND Ireland requested further research. This study explored how mothers in Cork experienced PND support services.

## Research Aims

This research was designed to facilitate a greater understanding of how support services are accessed, delivered and experienced by mothers with PND in Cork. The researchers aimed to identify which support services were beneficial or not, to mothers with PND.

## Methodology

This study utilised both primary and secondary research. The secondary research comprised of a comprehensive literature review. This critically analysed the medical construction of Post-Natal Depression and the social construction of women's mental health issues. The recovery model within support services was examined, both from the mother's perspective and the mother-infant relationship. Support services and relevant policies within women's mental health services were also reviewed.

Primary research was conducted through personal interviews with nine mothers who had experienced PND. Five professionals were interviewed; these were a General Practitioner, a Public Health Nurse, a Community Support Worker, an Infant Mental Health Specialist and a Midwife.

## Findings

The research identified a dissonance between support services as described by professionals and support services as experienced by the mothers. Early detection, adopting a holistic, psychosocial approach and relationship building, allowing a mother to talk freely about emotional issues, were among many other services that professionals provide. However, mothers spoke of an absence of awareness and information about PND. They described 'busy professionals' and a lack of empathy from both informal and formal supports.

Many of the mothers adopted coping mechanisms in order to fulfil both personal and societal perceptions of motherhood. They spoke of 'putting on a mask', constant motion and many other methods employed to deflect attention away from their lived reality as mothers experiencing PND. How they experienced support services depended on the level of risk both they and the professionals involved attributed to PND. This focus on PND as a risk to child development diminished the effectiveness of support services available to mothers. The emotional unavailability of family and friends impacted negatively for the majority of the mothers involved in this study. Social comparison by the mothers involved also impacted negatively and impeded their ability to seek help early, as did a lack of awareness among both mothers and professionals of the symptoms of PND. PND can affect mothers regardless of their social, economic or personal circumstances.

**Recommendations**

Among the recommendations are the following:

- Discussion of PND at ante-natal clinics/classes and prior to discharge from CUMH.
- Relevant information about PND to be provided to GP's/PHN's and other professionals in direct contact with pregnant women and new mothers.
- Professionals to be risk aware not risk averse when working with mothers with PND.
- Service providers to encourage feedback from mothers about the efficiency and effectiveness of supports provided.
- Affordable Cognitive Behavioural Therapy, Psychology and counselling services to be available to all mothers.
- The geographical location of mothers with PND should not limit the availability of support services.

Among the recommendations specific to PND Ireland are the following:

- Increased frequency of support group meetings.
- Remain focused on providing support for mothers with PND during meetings.
- Create database of group members willing to become peer facilitators.
- Create a dedicated support group for partners of mothers with PND.

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Thank you to Madge Fogarty, Chairperson of PND Ireland, for allowing us to participate in this research which we hope will be of value to her organisation in the future. We would also like to thank her for identifying some of the mothers in our sample group.

We wish to thank the professionals who gave so willingly of their time and shared their expertise enabling us to produce this work.

A special acknowledgement must go the mothers who participated in this research. They welcomed us into their homes and talked about their experiences with honesty and bravery, the result of which is this finished work. We would like to dedicate this research to them.

And finally, we would like to thank our families for their patience and support which enabled us to produce this report.

# Abstract

This research was carried out of behalf of Post Natal Depression Ireland (PND Ireland) in association with Community Academic Research Links (CARL). This is an initiative in University College Cork (UCC) which works with Civic Society Organisations (CSO) by assisting them with research they wish to pursue. In this case the research will be facilitated by two final year Bachelor of Social Work (BSW) students.

The research explores the experiences of support services for mothers with post-natal depression in Cork. The research is a qualitative study based on interviews with mothers who have or had post-natal depression (PND) and professional support service providers. To facilitate this research a literature review of the social and medical constructions of post-natal depression was conducted. A previous study undertaken by (CARL) on behalf of PND Ireland in 2012, revealed the prevalence of PND and the importance of peer and professional supports in reducing the symptoms of PND. This study will make a distinctive contribution to research into how PND support services are experienced by mothers in Cork. In conducting personal interviews it will allow a depth of analysis based on the lived experiences of the mothers interviewed. It aims to identify what supports mothers with PND had access to, both professional and social supports, and whether the supports were beneficial or not. Building on this knowledge of what services are available the researchers seek to identify why support services are experienced in the manner in which they are.

# Abbreviations

| | |
|---|---|
| **AIMS** | Association for Improvements in the Maternity Services |
| **BSW** | Bachelor of Social Work |
| **CARL** | Community – Academic Research Links |
| **CBT** | Cognitive Behavioural Therapy |
| **CSO** | Civil Society Organisation |
| **CUMH** | Cork University Maternity Hospital |
| **CVNI** | Critical Voices Network Ireland |
| **G.P** | General Practitioner |
| **HSE** | Health Service Executive |
| **MDT** | Multi-Disciplinary Team |
| **NICE** | National Institute for Health and Clinical Excellence |
| **PHN** | Public Health Nurse |
| **PND** | Post Natal Depression |
| **RAPID** | Revitalising Areas through Planning Investment and Development |
| **SSRI** | Selective Serotonin Reuptake Inhibitors |
| **UCC** | University College Cork |
| **UK** | United Kingdom |
| **WHO** | World Health Organisation |

# Chapter One

## Introduction

### 1.1 Introduction to Chapter

This chapter will elaborate on the research to be conducted; it will also introduce PND Ireland for whom the research is being conducted. It will identify the rationale for working within the CARL programme in UCC. The research aims and objectives will be discussed and a concluding summary will lead into subsequent chapters.

### 1.2 PND Ireland

PND Ireland is a voluntary organisation founded in 1992 in Cork. The Chairperson (Madge Fogarty) established the organisation after having personal experience of post-natal depression and identifying the need to support mothers with their experiences. PND Ireland is active in the media, highlighting issues and raising awareness about PND. Among the services provided are a monthly support group meeting held in Cork University Maternity Hospital (CUMH), a monthly coffee morning in Mahon Point, a telephone support line available Monday to Friday 10am – 2pm, a drop in service by appointment, an emergency out of hours service, a website, an online discussion forum and a Facebook page. The Chairperson also facilitates an ante-natal class in CUMH to raise awareness in mothers and partners about PND.

In building PND Ireland over the past 21 years challenges in location, funding and finding volunteers have been addressed. It is now partially funded by the HSE. Fundraising is a continual process in order to meet the costs of running the organisation.

### 1.3 Research Rationale

This research has been conducted as a component of the Bachelor of Social Work (BSW) degree in association with Community Academic Research Links (CARL). CARL is an initiative in UCC which assists Civil Society Organisations' (CSO) with research they wish to execute.

Applications from students are invited to undertake the research and are allocated based on the application criteria. After consideration of topic outlines, the researchers together with PND Ireland and CARL representatives agreed on facilitating:

"**An Exploration of the Experience of Post-Natal Depression Support Services in Cork"**

As potential social workers the researchers are aware of PND and the many issues surrounding it. The researchers are aware of the support services provided, but recognise we have a gap in our knowledge; we do not know how mothers with PND experience these support services. Are they accessible, which ones work and how are they delivered? The researchers place great value on the lived experiences of service-users and this is the rationale behind the design of the study.

*''Service-users often have the best knowledge and understanding about their circumstances and objectives, which should therefore be followed''* (Payne, 2005:59).

This study was preceded by a literature review in 2012 undertaken by CARL on behalf of PND Ireland, which revealed that PND is experienced by almost 20% of mothers in Ireland (Cronin 2012). While PND is recognised, it is not necessarily through the personal, lived experiences of mothers. In performing primary research among mothers with PND, the researchers will provide something original and specific to Cork for PND Ireland, but may also be of value to support service providers elsewhere. The researchers opted to work with CARL as the information collected will have value to the organisation by which it was commissioned. PND Ireland was chosen by both researchers due to their interest in mental health issues. The researchers have recently completed work placements in this field, one in adult mental health services and the other in child mental health services.

Upon completion of the research it will be submitted to UCC and CARL and presented to PND Ireland.

### 1.4 Research Aims

The aim of this research is to gain knowledge from mothers with PND about support services in Cork. The researchers aim to establish an understanding of accessibility, availability and benefits of supports for mothers. This will be achieved through interviews with key professionals in service delivery and mothers with PND.

On completion of the primary research the aim is to present the findings as a report which will highlight how and where mothers gained productive supports; how the supports were instrumental in their recoveries and the areas where supports could be adapted or enhanced.

### 1.5 Research objectives

The research objectives which will facilitate achieving the research aims are:

- To conduct a study of the personal experiences of support services in Cork for mothers with PND.
- To conduct a literature review. This will generate information on PND and pertinent issues concerning PND and mother's experiences of support services.
- Collect data from:
    - A sample group of mothers, identified by PND Ireland and other sources, using semi structured interviews.
    - Key healthcare professionals who provide support services for mothers with PND.
- Provide an analysis of data collected and produce a final report.
- Present findings and recommendations to PND Ireland and the CARL committee.

### 1.6 Research Questions

The research questions were formulated by the researchers in consultation with PND Ireland. The questions acted as guide throughout the process, from the literature review to completion.

1) What support services are available in Cork for mothers with PND?

2) What support services are being or have been used by the sample group?

3) What makes a particular support service helpful / unhelpful?

4) How did the mothers experience the support service?

## 1.7 Chapter Outline

### Chapter 1 Introduction

This chapter introduces the research to be conducted. It gives a background to PND Ireland and the rationale behind the research. It also identifies the questions to be researched and the aims and objectives in carrying out this study.

### Chapter 2 Research Design, Methodology and Data Analysis

This chapter explains the research design, methodology and theoretical approach adopted by the researchers. The strengths, weaknesses, biases and ethical issues concerning this study are also discussed. The methods of data analysis chosen by the researchers are explained.

### Chapter 3 Literature Review

This chapter is informed by literature sourced by the researchers. It contains reviews from literature on PND, the social and medical construction of women's mental health, a recovery focus, support services, mother and infant relationships and policy pertaining to women's mental health issues.

### Chapter4 Analysis of Findings of Mothers Experiences

This chapter imparts the analysis of the findings of mother's experiences of support services for PND in Cork.

### Chapter 5 Provision of support services for mothers with PND

This chapter offers an analysis of the findings of the provision of support services for mothers with PND in Cork

### Chapter 6 Summary, Conclusion and Personal Reflection

The concluding chapter contains a summary of the research findings and will propose recommendations for support services for mothers with PND and additional recommendations for PND Ireland. It also contains a personal reflection from the researchers on their combined experience in conducting and completing the research.

## 1.8 Conclusion

Chapter 1 has provided an outline of the research topic and a brief explanation of the rationale behind conducting this particular research. It contains a background to PND Ireland, the aims and objectives of the research and the research questions. It states the researchers' intentions to conduct interviews with mothers in relation to their experiences of support services in Cork for PND and with professionals in relation to services provided. The researchers fully endorse the vital role service-users can provide in shaping and developing services more suited to their actual needs rather than the perception of needs by professionals. This is the first study of mother's experience of PND support services in Cork, and as such the researchers hope to generate more awareness and highlight issues requiring further research.

# Chapter Two

## Research Design, Methodology and Data Analysis

### 2.1 Introduction to Chapter

This chapter explains the research design and methodology employed. The theoretical approach adopted and the practical details of the research design and analysis will be discussed.

Methods employed by the researchers include both primary and secondary research. Primary research consists of a qualitative study of the personal experience of mothers with PND and their perceptions of the supports available to them. It will also entail interviews with five professionals in relation to the services they provide for mothers with PND. These professionals are:

- A General Practitioner
- A Public Health Nurse
- A Community Support Worker
- An Infant Mental Health Specialist
- A Midwife

Secondary research is a literature review. The rationale behind choosing these methods will be examined. The manner in which data was interpreted and the influence of the theoretical approach on this interpretation will also be considered as will the strengths, weaknesses, biases and ethical issues inherent in this study.

### 2.2 Research design and methods

Research design refers to *"the procedures the researcher uses to address a research question and its associated hypothesis"* (Wilkinson & McNeil, 1996:62). In order to retrieve the relevant information, the researchers decided to conduct personal interviews with nine mothers' who had experienced PND. This is a participatory research project in partnership with PND Ireland whose Chairperson agreed to identify the participants. However, when the Chairperson identified eleven mothers willing to participate, the researchers became aware of the potential bias inherent in this sample, as they are all current or past members of PND

Ireland. The researchers are not conducting research about PND Ireland alone, but are including it within the research aim which is an exploration of all support services for PND in Cork. In an effort to counterbalance this potential bias the researchers posted a request for volunteers, mothers who had experienced PND, on the Critical Voices Network Ireland (CVNI) Facebook page. Both researchers are members of CVNI, a group which adopts a critical psychiatry approach. There were, however, no responses to this request. The researchers sourced three participants who are not members of PND Ireland support group. Nine mothers participated in the research, six from PND Ireland and three non-members. Five mothers with PND, as identified by the Chairperson of PND Ireland, did not respond to our initial contact. We decided not to pursue them as we had a sufficient number of participants within the timeframe allowed and we did not wish to cause distress if they had changed their mind about participating. The researchers composed a questionnaire, (appendix 1), to direct a semi-structured interview, which was recorded by consent. Consent forms, (appendix 2), were presented and information sheets, (appendix 3), containing details about the research were provided. The research study was explained, how the report would be presented and any other issues the mothers' wished to discuss. The researchers provided support service telephone numbers and their own contact details if the participants had any questions needing clarification or if they changed their minds and no longer wished to participate. The interviews were conducted as much as was possible, early in the day when the participants had access to the telephone support service provided by PND Ireland. These interviews took place in the mother's home something which they appreciated, and which the researchers felt would facilitate a more frank and full discussion. The researchers contacted each participant to identify themselves, discuss the research and arrange the interview. They followed this up with a confirmation text prior to the day. The researchers drove to various parts of Cork, County and City.

The researchers had already identified a number of key professionals involved in support service provision and arranged interviews with five of them. A questionnaire was composed to direct a semi-structured interview, (appendix 4). These interviews took place in the professional offices of the participants.

The interviewees were purposive samples the researchers believed had knowledge of the phenomenon they wished to study. The researchers recognise and acknowledge that how they themselves interpret the data will be influenced by their own experience.

The researchers conducted a comprehensive literature review and selected key texts to include in this study. The focus of the literature examined was from a feminist perspective on women's mental health issues with particular emphasis on PND. It also identified the medical and social constructions of mental health, a recovery approach in mental health, support services for PND and policy in relation to the area of research.

## 2.3 Theoretical Perspectives and Methodology

This qualitative research study was influenced by the research methods which in turn are influenced by the epistemology surrounding PND. This is the theory of knowledge which investigates the origin, nature, methods, and limits of human knowledge or how do we know what we know? (Abercrombie *et al,* 2000). The researchers employed a qualitative approach. Sarantakos (2005) states, qualitative research allows an interpretation and facilitates an understanding of people's lives and reality as experienced and perceived by themselves. It also allowed this research to be flexible, reactive and to retrieve relevant information about mothers with PND experiences.

*"Qualitative data analysis aims to capture the richness and complexity of lived experience"* (Alston & Bowles 2003:203).

A quantitative research approach, which employs fixed, closed methodology, focusing on statistics and analysis after collection, would not enable us to conduct this research.

Sarantakos (2005), states that one method is not better than the other, just different *"in their nature and purpose"* (Sarantakos, 2005:49).

Due to the sensitive nature of the research the use of focus groups was dismissed as some mothers may not have felt comfortable sharing their experiences in a large group.

However, whilst qualitative research allowed a deep, multi-layered, richly detailed account of the mothers' experiences, it is subjective and local. What it did identify were common trends and patterns among the mothers' experiences and among the professionals providing support services.

An interpretative framework was chosen for this research as it allows an examination of the meaning people attach to their experiences.

This allowed the researchers to interpret this phenomenon rather than measuring availability and uptake of support services or compiling a support service directory, because each mother's experience of support services was unique. The researchers placed mothers with PND and their subsequent experience of support services within their individual social structures (Blaikie, 2010). Systemic theory was required to gain a greater understanding of other systems which directly or indirectly influenced mothers with PND. A feminist approach in tandem with interpretivism allowed for a more in-depth study. Such an approach orbits around the need to comprehend the shared experiences of women about the discrepancies in the way things are and the way they would like them to be.

*"Feminist theories are fundamental in highlighting the oppressive conditions of women and the ways in which social work can exacerbate or alleviate them"* (Orme, 2009:71).

A large amount of feminist research has been conducted by allowing women to give narrative accounts of their own experiences. (Wadsworth, 2001).

*"Attention to both the condition of being a woman and the conditions that women experience has been a feature of feminist social work since the 1970's"* (Orme 1998:218).

The researchers incorporated grounded theory which allowed them to collect and analyse data simultaneously (Glaser & Strauss, 1967), and *"develop a theory about the person, events or things under study"* (Mark, 1996:215). Grounded theory researchers use purposive samples, the individuals are chosen based on the fact that the researchers believe them to be typical of the phenomenon they wish to study.

The theoretical approaches chosen by the researchers provided,

- *"A framework for critically understanding phenomenon*
- *A basis for considering how what is unknown might be organised"* (Silverman, 2000:78).

Each interview generated new knowledge for the researchers, as this study was not about evaluating an objective reality, rather it gathered evidence about how mothers with PND understood and constructed their worldview and subsequently the importance they attached to their experience of support services .In analysing the primary data the researchers looked for emerging broad themes and common trends among mothers with PND of their experience of support services in Cork

## 2.4 Secondary Research

The secondary research consisted of a literature review. This was "*empirical research using data which already exists"* (Pole & Lampard, 2002:178). The review allowed the researchers to gain knowledge, particularly around sensitive issues which may arise while conducting interviews about a personal and painful experience. Some mothers divulged thoughts and feelings which had been suppressed. Having studied literature the researchers were prepared to some degree that this might happen.

The availability of internet resources and literature facilitated an *"unobtrusive"* method of information gathering (Robson, 2002). The researchers are aware of a potential bias in the choice of literature reviewed. Adopting a feminist approach within this research had an impact on the choice of material reviewed. Feminist writers like Ussher (2011), state women's feelings; thoughts and behaviours at particular times in their lives are a reaction to the circumstances they find themselves in, which have become pathologised by society Ussher argues that PND is fundamentally a form of curbed anger rather than a medical illness. In diagnosing and labelling PND as a medical condition Ussher feels that this justifies medicating unhappiness which she says is caused by the realities of life rather than a biomedical condition (Women's Health, The Superwoman Disease) available at: http://www.wdxcyber.com/the-superwoman-disease.html

## 2.5 The Researcher Position in Qualitative and Secondary Research

The researchers acknowledge the influence of themselves on this research. Interviews with professionals were facilitated by the researchers' prior relationships and established networks. Interviews with mothers with PND were enhanced by the fact that we are mature students with large families. Our social work training was of huge importance when discussing this sensitive, emotional subject. We were able to discuss mental health concerns in a meaningful manner, as we have an abiding interest in mental health issues.

*"Utilizing the researchers personal experience is a distinguishing feature of feminist research"* (Reinharz, 1992:258).

Some participants spoke about issues they had never discussed or remembered previously forgotten details.

Some participants spoke of the relief they felt when discussing their experiences and how the interview had a therapeutic benefit. Three of the mothers' contacted the researchers after the interviews and expressed their gratitude for allowing them to talk and make sense of their experiences. The calm, safe environment we were able to create facilitated a rich discussion. Some participants commented that being in their own homes meant they did not have to put on their 'mask', they could be themselves for the interview.

### 2.6 Inclusion and Exclusion Criteria

The researchers concentrated on the experiences of support services for mothers with PND. Many other issues were discussed by the mothers with PND and by the professionals, many of which are worthy of a comprehensive study. The researchers wished to explore whether support services are provided based on research into the impact of PND on infant mental health or are they provided solely to assist mothers with PND, or a combination of both? However, in our initial meeting with the Chairperson of PND Ireland she stated this was not an area she wished the researchers to discuss with the mothers with PND. The researchers were seeking to conduct interviews lasting for one to two hours, gathering data to achieve their research aim. Within this relatively short time frame, and without prior knowledge of the severity of PND experienced, nor at what stage of recovery the participants were at, the researchers decided that referring to this emotive issue had a real potential to cause distress. Subsequently, some of the mothers with PND referred to this issue during interviews, as did four of the professionals involved. Therefore no direct reference was made to infant mental health issues by the researchers during the interviews, but as discussed, the topic was spoken of by some of the mothers with PND.

### 2.7 Participatory Action Research

This study was conducted in partnership with PND Ireland. The Chairperson and members of the support group were an invaluable source of information allowing the researchers to critically explore the experience of engaging with support services for mothers with PND. Participating in this CARL project in association with PND Ireland allowed the researchers to accomplish two goals. Firstly we fulfilled our course criteria by conducting a research project.

Secondly our civic engagement with PND Ireland added an impetus to this research as we felt an obligation to the mothers involved to carry out the research as ethically and thoroughly as possible. As a Civil Society Organisation (CSO), PND Ireland required pertinent research into a problematic area as defined by mothers with PND. By combining the course requirements and the civic engagement with PND Ireland, the researchers were able to "*realise academic, civic, and personal development goals for students, while meeting an identified community need" (*Boland, 2011:105).

Within this participatory research we are cognisant of what Arnstein (1969:2) describes as eight levels of participation (appendix4). These are,

- Manipulation
- Therapy
- Informing
- Consultation
- Placation
- Partnership
- Delegated power
- Citizen control

The researchers discovered that three of the mothers with PND had already engaged with the media, both print and television, to highlight issues of concern and raise awareness about PND. Although there was no action element in this study, the fact that PND Ireland are keen to raise awareness through the media shows potential for further research in this area.

This community based research allowed the researchers to utilise academic literature, journals and other university based learning tools to inform us about the broader issues associated with PND. When this is combined with the research skills learned and the valuable life experiences of mothers with PND, the goal of community based research may be achieved. "*Social action and social change for the purpose of achieving social justice*" (Stroeker, 2011:8).

This research process will better equip the researchers to engage meaningfully with the communities we may work with as social workers in the future whilst also serving to demystify academia for the CSO by displaying the practical applications of the skills and theories learned over four years in UCC. This mutually beneficial relationship encourages robust social research (Bates & Burns, 2012).

### 2.8 Limitations

The biggest limitation on this research was the timeframe available. The researchers were required to conduct a literature review and design questionnaires to guide semi-structured interviews. They also had to contact participants and organise interviews, co-ordinate different time schedules, transcribe, code, analyse data and write up the research. From initiation to completion of the study the allotted time was six months. For a large percentage of this time the researchers had other college requirements and full time work placements to complete.

Challenges the researchers encountered were rescheduling interviews due to unforeseen circumstances. One researcher changed internet provider and subsequently lost internet reception for most of this study.

Another limitation was the one-sided nature of our participatory research, whereby all requests and contact between PND Ireland and the researchers was initiated by the researchers. Upon reflection, the researchers assume responsibility for this lack of engagement with the Chairperson. We travelled great distances to meet mothers in their homes, and the interviews were emotional and draining at times. The office of the Chairperson is difficult to access, located in a remote area of the CUMH campus and thus the researchers confined contact to regular telephone calls and emails. The Chairperson did not request meetings either, and it is acknowledged by the researchers that the Chairperson of PND Ireland has huge demands placed on her available time. However, at a meeting in the Chairperson's office at the commencement of the study, a full and frank discussion of her requirements for this study was carried out. We discussed what was realistically achievable, defined our roles and the Chairperson imparted valuable knowledge about PND and other pertinent issues of concern.

In tandem with the research question, the Chairperson asked the researchers to discover, if possible, why so few mothers with PND who were assisted over the years failed to return to facilitate current support group sessions? The fact that communication between PND Ireland and the researchers was mainly confined to email and telephone rather than personal contact was beneficial for this study. As a support service provider, PND Ireland could then be critically analysed within the data supplied by the participants without personal relationships or loyalties coming into play. The researchers were able to approach the research with more objectivity.

### 2.9 Ethical Considerations

When conducting the primary research we had to be cognisant of the potential for emotional distress during the interview for some of the mothers with PND. The sensitive nature of the research topic gave rise to feelings and memories of the experience returning for some of the participants. The researchers had to be considerate when writing the report to ensure confidentiality and anonymity of the mothers concerned.

When designing the research we ensured the participants were cognisant of the research and were giving informed, considered consent to participate, free from coercion. We provided the participants with an information sheet in relation to the nature of the research and how the findings would be utilised. They were given the option to withdraw consent for use of information within two weeks of the interview. We assured the participants of confidentiality and anonymity, but were concerned at times about the absence of confidentiality from some participants when discussing other mothers with PND. Upon reflection this is an issue we should have addressed at the time. In analysing the data we did not use information relating to any mother we did not personally interview. When considering the requirement for primary research we had to,

*"Think about the relevance of your research for other scholars and for 'society'* (Silverman, 2000:51).

The researchers consider this study to be relevant and may alleviate distress by informing about PND and support services.

## 2.10 Methods of Data Analysis

The researchers transcribed the tapes of the interviews. These transcripts were read and coded. Common themes were grouped together when identifiable patterns emerged. This approach to analysis prevented the researchers from *"drawing their favoured conclusions and 'cherry picking' quotes to fit"* (Newman *et al,* 2005:77).

The researchers also utilised a grounded theory approach to analysis, collecting and analysing data simultaneously (Glaser & Strauss, 1967).

In social work research the goal in adopting this approach is to *"develop a theory about the person, events or things under study*" (Mark, 1996:215).

*"There are three related levels of analysis through which interpretation may take place. There are the words and meanings offered by the research participants, fieldnotes concerning the interviewees and the nature of the interview and the use to be made of this data"* (Maynard, 2006:136).

## 2.11 Triangulation

The researchers triangulated data generated from the interviews with mothers with PND, and from the interviews with key professionals with the findings from the literature review. This served to *"minimise bias and increase the trustworthiness of findings"* (Newman *et al,* 2005:78). This also allowed the researchers to reflect on the relevance of the study when it became apparent from this triangulation that there can be a dissonance between what support service providers' state and what the mothers' experience of these services.

## 2.12 Conclusion

The research methodology employed was designed to gather the relevant data required to best answer our research questions. Primary, qualitative research was chosen because of the potential to retrieve this data. Secondary research helped inform the questions. Both methods of data collection were based on a sound theoretical framework created by the researchers, incorporating qualitative, systemic, interpretive, feminist and grounded theories.

*"Without theory research is impossibly narrow. Without research, theory is mere armchair contemplation"* (Silverman, 2000:86).

There were many factors to take account of within this study, including potential biases, ethical considerations and the possibility to cause distress by exploring what is a very emotive period in these mothers' lives. What the researchers sought to do was conduct a valid, replicable and honest representation of mother's experiences of PND support services using good theoretical perspectives and frameworks.

# Chapter Three

## Literature Review

### 3.1 Introduction to Chapter

This research seeks to explore mother's experiences of PND support services in Cork. In conducting the literature review the researchers availed of an extensive body of work. This included literature exploring PND, the social construction of women's mental health problems and the medical construction of PND. The researchers also examined the concept of recovery from PND and the ability of support services to assist this process. The impact of PND on infant mental health was also reviewed in relation to support service provision for mothers with PND. The researchers also examined social policy as applies to PND. Throughout this literature review the researchers considered how mothers with PND may experience support services especially when different concepts emerged about how mental health is constructed and how to treat it.

### 3.2 Post Natal Depression

*"Depression is a thief that steals from people – it robs them of energy, vitality, self-esteem and any pleasure they may have previously enjoyed"* (Bates, 1999: X).

Post Natal Depression (PND) is a condition which affects one in five mothers in Ireland (Cronin, 2012). Bates (1999) describes the characteristics of depression as, changes in thoughts, feelings and behaviour. It is an experience of psychological suffering, diminished sense of wellbeing, affecting sleep, appetite and energy levels. These characteristics are also present in PND in tandem with a change in routine and thoughts of inadequacy in the early stages of parenting (Welford, 2002). PND covers a spectrum of levels, ranging from mild to a severely debilitating state for some mothers. Among the factors which contribute to the development of PND are, birth experience, biological factors, personal history, images of motherhood, lifestyle changes, relationships and recent life events (Brown & Harris 1978, Bates 1999, HSE 2008, Brooker & Repper 2009, Ussher, 2011, Aware 2011). It is, however, a condition that does not discriminate (Kealy & Fogarty 2010, Clark & Fenichel 2001). It can affect women from all walks of life, regardless of it being a first or subsequent confinement.

The difficulty with defining PND is due to the myriad symptoms, causes and effects this condition has on each mother. What can be stated is that the experience of PND is unique to each mother. A common theme among definitions is a depressed mood which lasts wherein positive thoughts and feelings of joy are supplanted with negative feelings (Etchegoyen, 2000).

There are three conditions which may affect mothers after giving birth ( Kealy & Fogarty 2010, Ussher 2011, Gerhardt, 2004, Welford 2002, Foreman 1998, Aware, Nurture, HSE). The first condition is defined as the "Baby Blues" which may occur within days of giving birth. This condition induces tearfulness and *"a feeling of coming down to earth with a bump"* (Welford, 2002:3).

**"Baby Blues"** are perceived as physiological, involving hormones, and part of being human. Most cases do not go on to develop PND (Welford, 2002). The hormonal changes in women during pregnancy and after childbirth, the labour experience and physical changes along with a new infant to care for can lead to mothers feeling tired, being tearful and feeling unable to cope. These are all symptoms of 'baby blues' which should diminish within two weeks (CUMH 2012).

The second condition is **Post Natal Depression** which as Cronin (2012) reported, may be experienced by 19.7% of mothers in Ireland. It varies in severity; some mothers are disabled by it, not being able to care for themselves or their baby. Other mothers struggle but continue daily routines, disguising the symptoms of PND from those around them. PND covers a broad spectrum with many factors influencing it.

The third condition which affects mothers after childbirth is **Puerperal Psychosis.** It affects between one to two mothers per thousand. It cannot be hidden as mothers experience delusions and distortions of reality (Hunter, 2013). The range of symptoms includes hallucinations, patterns of colours, manic depression. Other features include constant bleak, destructive thoughts which are upsetting and vivid and suffering extreme highs and lows. This condition is usually responded to by medical treatment which may include hospital admission (Hunter, 2013).

All mothers experience tiredness, lack of confidence and energy and may experience guilt and anxiety to varying degrees. This then begs the question why does one mother go on to develop PND and another does not?

Or why are some mothers diagnosed with PND and others struggle without an explanation for their suffering, in some cases a diagnosis, and therefore without a trajectory for support or intervention. What prevents a mother from admitting how she is feeling and seek appropriate support and intervention? To try and answer these questions the researchers took an overview of the construction of women's depression, particularly maternal depression. Within a feminist perspective, women's depression is exacerbated by the construction of motherhood as a positive and natural experience. It is also influenced by cultural, historical and economic forces (Ussher 2011). Historically and culturally women are the primary caregivers and nurturers, this role is perceived as something that is automatic and inherent to being female.

### 3.3 Social Construction of Women's Mental Health Issues

There is a large body of literature on the social construction of women's mental health issues and PND. A common theme which emerged was the dissonance between how mothers wanted to live and their lived reality. Ussher (2011) elaborates on "*the contrast between the reality of the demands of the mothering role and idealised constructions of motherhood has been recognised by many feminists to be a cause for depression for women"* (Ussher, 2011:168).

This view is echoed by Mirkin (1994), who speaks about women's feelings of inadequacy and isolation as a natural response to the cultural messages pertaining to motherhood. These views are particularly pertinent to mothers' after giving birth. At a time in their lives when they are physically and emotionally exhausted whilst coping with the demands of a new born baby, they are vulnerable to feeling that they are not meeting expectations placed upon them, a view endorsed by Mauthner (2010).

"*Female depression could be redefined as a response to the depressing and oppressing realities of women's lives*," (Mirkin, 1994:55).

Mirkin (1994) further asserts that rather than medicating this response to their life, a psychosocial approach, addressing the oppression, deprivations and isolation some women experience would be of more benefit.

If motherhood is glorified as the 'sine qua non' (something indispensable and essential) of female fulfilment, women who do not meet these expectations are prone to stigmatisation.

It is important that this bias against women does not encroach on relationships with people who provide support. Support service providers, therapists, health and welfare professionals and social workers in tandem with informal support networks, family and friends, need to acknowledge the enormous *"pressures and impossible burdens placed on women in our own culture to be the primary and exemplary caretakers in traditional families"* (Mirkin: 64).

Mothers are bombarded with images and expectations of how they should feel, act and behave. Celebrity mothers regain their enviable figures and wax lyrical about their beautiful babies, partners and lifestyle. Advertisements rarely show a mother in stained pyjamas looking exhausted. For mothers with PND other mothers can be a source of huge distress, especially when mothers with PND compare themselves to other women, or cannot express their feelings when they appear to 'have it all', nice home, partner and baby. Welford (2002) recalls her experience of being ignored by other mothers at a mother and toddler group, "*all these years later I remember the despair and overwhelming awkwardness and anger I felt"* (Welford, 2002:64*)*.

There is considerable research to support the finding that PND is both situational and time specific rather than solely biological (Cronin, 2012, Mauthner, 2010). HSE, Clark & Fenichel, 2001, Dennis & Creedy, 2004, O'Hara 1997). This shift from a purely biological causation indicates that fathers may also be vulnerable to low moods and anxiety following the birth of a child. Fathers can experience disappointed expectations. Whether as a father experiencing low mood or as a partner of a mother with PND, a focus on men's mental health problems at this time can be beneficial to the family as a whole. Welford (2002) says men are prone to depression in the first three months after birth especially when they are committed and caring partners. Other family members including children are also affected by PND to varying degrees.

Welford (2002) also cites research which states "*women with supportive partners felt they had accumulated 'caring debts' they felt they could not repay"* (Welford, 2002:26).

A supportive partner during pregnancy, excited about the wonderful prospects of fatherhood who is confronted by the reality of a tired, stressed partner understandably feels disappointed. This disappointment serves to heighten feelings of guilt and stress for women with PND.

Thus far, women with PND may be experiencing dissonance with how they think they should be and how they are, may be experiencing disappointed expectations from their partners. They may have unhappy family members and may be living with socio economic, cultural, historical and political disadvantage. Exhausted by their lived reality, some women may find solace in a biological causation within the medical model for treating PND.

### 3.4 Medical Construction of PND – A Critical Appraisal

The nineteenth century saw the emergence of diagnosis in mental illness as psychiatry developed into a specialist area of medicine. *"Given that the new profession's main preoccupation was the management of lunacy, it focused on the codification of madness as a medical condition"* (Pilgrim, 2009: 6).

White (1996) takes a historical look at the evolution of maternal depression and how it came to be constructed by the dominant and 'knowledgeable' classes, who in turn defined what was acceptable and what interventions were required to induce compliance with societal norms. White (1996) states women who did not conform to the notion of femininity, or were deemed wanton or distressed women, or indeed those who challenged the dominant paradigm, were labelled "mad" women. They were hospitalised, institutionalised or subject to surveillance, in order to protect society from the risk they posed. This 'knowledge' has led to a tendency within mental health services for PND, to address the symptoms, the 'what' rather than the 'why 'for a large number of mothers.

*"it has become imperative for the current pattern of service delivery and the dominant practice ideologies to be subjected to critical analysis"* (White, 1996:68).

The Diagnostic and Statistical Manual of Mental Disorders (DSM) has seen rapid growth in volume with medical prescriptions available to treat a multitude of 'disorders'. The DSM IV does not recognise Post Natal Depression or Post-Partum Depression as a separate diagnosis. A woman needs to meet the criteria for a major depressive episode in addition to the criteria for Post-Partum onset specifiers (appendix 5). The state of being depressed as defined by Medline dictionary is a state of feeling sad, a mood disorder marked especially by sadness or inactivity. Difficulty with thinking and concentration, a significant increase or decrease in appetite and time spent sleeping are also symptoms.

Feelings of dejection and hopelessness, and sometimes suicidal thoughts or an attempt to commit suicide may also be present. (Medline dictionary) available at http://www.nlm.nih.gov/medlineplus/mplusdictionary.html

When considering how best to intervene with a mother with PND within a medical model, it is important to explore the theories which have led to the rise in medication as a solution to human distress. A theory which has been adopted by many health professionals and via media representation, has been accepted by a large number of people suffering distress, is the theory of depression as a biochemical imbalance in the brain. Leo & Lacasse (2007) critically analyse the serotonin theory of depression as a biochemical imbalance in the brain, especially how it is promoted in the media by large pharmaceutical companies. This theory that depression is caused by a chemical imbalance emerged in the late 1950's, and eventually the pharmaceutical companies developed Selective Serotonin Reuptake Inhibitors (SSRI) such as Prozac and Paxil. The pharmaceutical companies discovered the drug reserpine increased depressed states by reducing levels of serotonin, therefore, increasing serontin levels in the brain with SSRI's should decrease depressive states. According to Leo & Lacasse (2007) this discovery fundamentally changed psychiatry from a profession talking to people about the distress they were experiencing, to a profession treating organic diseases by prescribing medication.

*"Depression was no longer seen as just a natural response to stress, there was now an underlying biological factor which was the cause of the depression"* (Leo & Lacasse, 2007:36).

Anxiety and emotional distress is normal in peoples' lives. By medicating the brain to inhibit these feelings, *"most of the time this is not to repair a 'chemical imbalance' but simply to help contain symptoms."* (Leo & Lacasse, 2007:36).

Pilgrim (2009) claims that clinical depression is 'categorically different' from dysphoria, a state of unease or generalised dissatisfaction with life. However, when clinical depression is diagnosed labelling it as depression brings clarity to both doctor and a mother. This label, whilst some would argue is discriminatory, can serve to diminish a mother's sense of confusion about her distressing experience at the critical moment when she is seeking help. However there is currently a growth in service-user led movements adopting a critical stance to the medical model of intervention for human distress. Here in Cork, Mad Pride Ireland and the Critical Voices Network Ireland are active in encouraging this critical discourse.

The medical language used to describe depression has been cited by service-users as further disempowering them. They are no longer people in distress but 'are' bi-polar, schizophrenic, depressed, labels which cluster individuals into large groups requiring a pre-ordained trajectory of treatment. The diagnostic language used serves to re-enforce the power differentials between professionals and service-users (Tew, 2011).

Thomas Szasz, an American psychiatrist and psychoanalyst coined the term 'myth of mental illness' in 1961. He argued that mental illness is in fact a metaphor rather than a valid description of reality. He further claimed that by describing mental illness as a myth does not suggest that people are not sad, mad or frightened. He suggests that these are '*problems of living'* not *'symptoms of illness'* (Pilgrim, 2009:18). Many other professionals also critically analysed the role of psychiatry in medicating mental illness. Within a critical psychiatry movement, professionals themselves are questioning the role of medicine as the basis for treatment and recovery. According to Bracken (2012) evidence indicates that improvement in depression comes principally from interventions other than technical ones. He further argues that to fully collaborate with service users, psychiatry must be prepared to move outside the dominant current paradigm,

*"recognising that a fundamental re-examination of what mental healthcare is all about and a rethinking of how genuine knowledge and expertise can be developed in the field of mental health".* (Bracken *et al* 2012:431).

Whitaker (2010) conducted an investigation into evidence-based research which positioned psychiatrists as the experts in treating mental health problems. These experts subsequently informed public opinion and created knowledge of depression as a chemical imbalance of the brain requiring medication.

*"For the past twenty-five years the psychiatric establishment has told us a false story. It told us that schizophrenia, depression and bipolar illnesses are known to be brain diseases even though it can't direct us to any scientific studies that document this claim"* (Whitaker,2010:358).

If depression is a brain disease and therefore can affect any mother regardless of socio-economic status, psychiatrists should medicate this condition based on clinical needs alone. However, there seems to be a higher rate of prescriptions among women from lower socioeconomic backgrounds.

According to McKeown (2007) who conducted research into the prevalence of depression among disadvantaged mothers, criteria for eligibility to a medical card (free access to medical services for lower income families) has an impact on medications prescribed. He found that mother's with free healthcare were being medicated at higher levels than those who have to pay.

"*a fifth of medical card mothers are on sedatives, tranquilisers and anti-depressants, which is five times higher than the national average"*(McKeown, 2007:63).

Does depression among disadvantaged mothers have a specific biological causation? Or has society conceptualised disadvantaged mothers as being unable to address their distress with life, therefore medication is required inducing compliance?

### 3.5 Recovery from PND

A Vision for Change (2006) indicates the need to adopt a recovery perspective at all levels of service delivery in mental health. While recovery does not necessarily imply a cure, it does suggest that the individual can live a productive and meaningful life despite vulnerabilities that may persist

Recovery is an individual journey which varies according to the needs and supports available to a mother with PND. Roberts and Wolfson (2004) cited in Sapouna (2012), define recovery as a "*process of personal discovery, of how to live (and to live well) with enduring symptoms and vulnerabilities"* (Sapouna, 2012:37)

Recovery has different dimensions which may be individual to each person. It is not a definitive process and has no guaranteed end result. *"Recovery is not primarily about becoming symptom free but may be defined in social, personal and sometimes spiritual terms"* (Tew, 2011:123).

Mothers with PND perceive themselves as inadequate, have low self-esteem and struggle with life (Hunter, 2013). Within the recovery model the focus is shifted from the deficits to the strengths which can escalate in a ripple effect reducing isolation, identifying supports, building esteem and enhancing the ability to address the myriad demands placed on motherhood.

This philosophy requires a fundamental shift in understanding and responding to mental distress. Within this the voice of the service user is central (Sapouna, 2008).

This voice is heard within a collaborative partnership between the person asking for help and the "help giver" (Rapp & Goscha, 2012). Within the context of her life, a mother would be encouraged to consider what is preventing her from flourishing and from accessing the resources and supports required.

Recovery is fluid and dynamic, punctuated by good days and bad days. As a mother's confidence and emotional strength rises, the depression diminishes but may return periodically. The ability to recognise triggers and symptoms from previous episodes may be used as strength in subsequent times of distress. This demonstrates the importance of self-awareness and familiarity with the support services used in previous episodes, allowing recovery.

*"embracing the recovery philosophy is essentially about attitudinal, cultural and organizational change"* (Bracken, 2010).

Recognition and action in this regard could be facilitated by adopting a strengths based approach for mothers with PND. The challenges of living with PND, how mothers cope, what they draw on to manage are all individual strengths. Cultural and structural changes could help facilitate this by adopting a more personalised service. Often people are 'labelled' by a diagnosis which allows them access to supports and services within the healthcare system. *"Consequently, it is hard to see the person with mental illness as something other than their labels"* (Witkin cited in Howe, 2009:99).

From a social work perspective adopting strengths based practice ensures that the service-user is more than just the label applied to them. Each person has potential and strength which if acknowledged can help enhance their ability to recover. Identifying coping mechanisms and skills by which mothers have managed to the point of intervention can lead to these same skills being built upon to aid their continued recovery.

*"Far more than social workers realise, service users can and do bounce back. Most of us seem to have 'self-righting' instincts. We strive to put our lives back in order, straighten ourselves out"* (Howe, 2009:100).

It is possible to start this rebuilding by using inner strengths which mothers may not be aware they have. Identifying, naming and working from the strengths would be beneficial in recovery for mothers with PND.

### 3.6 Support Services

The National Childbirth Trust UK provides postnatal supports to mothers with PND. These are volunteer mothers themselves who offer friendship and listen. Mothers who accessed this service can become peer supporters, providing one to one support either face to face or by telephone. Formal and informal support services that mothers themselves identified as helpful are:

- Community psychiatric nurse for coping strategies.
- Network of support – family, friends, GP.
- Relaxation tapes.
- Simple daily tasks. E.g. getting dressed.
- Stop "thinking" – just "be".
- Self-care.
- Prioritise tasks.
- Anti-depressants for relief from heavy sluggish feeling.
- Employing a child-minder or availing of family babysitters.
- Find someone to talk to – counselling.
- Get out and meet people.
- Join a support group. (Welford 2002)

Cronin (2012) elaborates on supports which facilitate recovery for mothers with PND in Ireland. These include social support, peer support and support groups.

Counselling, cognitive behavioural therapy (CBT), on- line forums and telephone supports are also beneficial according to Cronin (2012).

In reviewing available support services in Ireland, the researchers identified the following services:

- **PND Ireland** is one of the primary services in Cork. This is a free service offering a monthly support group, a monthly coffee morning, an on-line forum and a telephone helpline, (Monday to Friday 10am – 2pm), an emergency out of hour's service and a drop in service by appointment. There is an active discussion forum available on www.pnd.ie. a Facebook page available at www.facebook.com. PND Drogheda & North East also has a Facebook page similar to PND Ireland. Mothers can sometimes avail of affordable counselling through PND Ireland.

- **Nurture** Post Natal Depression Support Services, are a not for profit organisation based in Dublin. They offer affordable counselling, support groups for mothers, fathers, parents and families. They have an on-line forum and Skype counselling service. They also offer a life motivational skills course (www.nurturepnd.org ).
- **Aware** is a national organisation supporting people with depression. They have a comprehensive section devoted to PND. They offer online CBT, life skills course, support groups nationwide (three in Cork), email support, online support and a telephone helpline available 7 days a week 10 am -10pm (www.aware.ie ).

- **Inpatient Care** A recent announcement stated that there are plans for a new two bed unit for mothers with puerperal psychosis to be established in Cork. This will allow mothers who need hospital treatment to remain with their baby while availing of the supports they require in this period. However, it is to be located within a new psychiatric unit rather than a maternity unit (O' Reilly, 2013).

The support services provide the majority of their information through the internet. While this is a valuable medium and widely used it may be limiting to mothers without regular internet access and those with literacy and/or computer literacy difficulties. The PND Ireland support group in Cork city is open to all mothers and offers valuable peer support. As Cork is such a large geographical county it may be impractical for mothers to travel into the city to avail of the service.

Similarly with the coffee mornings, they are also city based with the same limitations. Reproducing similar supports in wider areas would be beneficial and accessible to a larger population.

### 3.7 Mother and Infant relationships

Having a baby is a major event. It can be exciting and wonderful, developing into a relationship between mother and infant whereby both of their needs are met. It can also be difficult and challenging, especially for mothers with PND, which can impact on the infant's development. Emotional development begins during pregnancy and continues rapidly for the first two years. Stress has a negative impact on the emotional and social development of an infant. Stress increases cortisol levels which flood the infant brain, maintaining the baby in a heightened state of fear, hindering emotional, cognitive and social development. Feeling safe is the cornerstone for all human development. Gerhardt (2004), states that babies are born with a brain which requires them to be socialised into their position in society by their primary care giver. When a baby is tended by a sad, confused, deflated mother this is what the baby internalizes as reality.

"*Children of depressed parents have about a six times greater risk of succumbing to depression themselves"* (Gerhardt, 2004:123).

Ramchandani & Murphy (2013) confirm this finding, linking parental depression to increased risk of child psychopathology. A mother experiencing PND may have difficulties in forming a secure attachment with her baby which heightens her feelings of distress (Gerhardt, 2004). The majority of mothers with PND do relate well with their children with no adverse effects (Welford, 2002). It is not the depression but the manner in which a mother communicates with her baby which is crucial. With increased awareness of infant mental health, support services may be provided based on the perceived needs of the child rather than focusing on the relationship between mother and infant. White (1996) cautions against services which are focused solely on the infant and difficulties they may encounter. She advocates for support services which address the mother's mental health difficulties in tandem with the needs of the infant.

Professionals place emphasis on the quality of attachments between mothers and babies when working with mothers.

Attachment theory explains behaviour, and is central to linking life experiences from birth to adulthood. Strong attachment bonds offer an opportunity to increase self-concept, and enhance, protect or repair self-esteem (Myers, 2008). Howe (1999) credits John Bowlby's studies in the 1940's and 1950's along with James Robertson and Mary Ainsworth, as forming the basis for attachment theory. They adopted an overarching approach involving multiple disciplines, to conclude that,

*"Attachment behaviour is activated whenever young children feel distressed and insecure, and need to get into close proximity with their main caregiver"* (Howe, 1999:13).

The mother has to be emotionally available to facilitate a sense of security within the infant according to this theory. Without this security, all other activities, exploration of the world around them or a baby's internal representations of himself, based on mirroring the interactions of the mother may be hampered leading to cognitive, physical and emotional development difficulties. A baby learns about himself and others and relationships between both, from the level of responsiveness of mother to his needs. Thus he can experience a secure, avoidant, ambivalent or disorganised attachment. This then dictates how a baby interacts with his environment. Attachment theory, by emphasising the importance of emotional availability may censor mothers who feel they are emotionally unavailable. A new world view, new behaviours, new self-perceptions can be internalised by a baby by changing a mothers thoughts and behaviours or by addressing the issues, such as PND which may prevent a mother from being emotionally available to a baby.

### 3.8 Policy

There is very limited policy provision relating specifically to PND in Ireland. In 2006 A Vision for Change was adopted as policy for provision of mental health services. The vision embodied in the policy is to create and provide a mental health system which addresses the needs of the individual. It should deliver supports and interventions which promote positive mental health. It should develop a recovery approach.

Reference is made in the document to perinatal psychiatry. In 15.5.4 a recommendation is made that *"one additional psychiatrist nurse and senior nurse with perinatal expertise should be appointed to act as a resource nationally in the provision of care to women with severe perinatal mental health problems".*

The three main areas of perinatal mental health in clinical focus are depression, schizophrenia and bipolar disorder. While depression is referred to here it is concentrating on the most severe cases with little or no focus on PND as a specific cause for concern.

The World Health Organisation refers to a study by Olds *et al* (1988) which found that visits by community workers and nurses to mothers during pregnancy and after childbirth can assist in the prevention of PND. These visits have proved to be effective. Also referred to by WHO is the fact that antenatal and PND have an interaction of psychosocial and hormonal factors that elevate the risk. If inadequate social support is available to a mother there is an increase in the risk of developing PND (WHO, 2002).

The Association for Improvements in the Maternity Services (AIMS), campaigns to highlight and promote normal birth and mother friendly services. AIMS Ireland was established in 2007. They advocate for the National Institute for Health and Clinical Excellence, (NICE), guidelines to be implemented. These guidelines call for each mother to have a documented care plan, ideally in the pre natal period or as soon as possible after delivery. This should include:

- Relevant factors from antenatal, intrapartum and immediate post natal periods.
- Details of all healthcare professionals involved in both care of mother and baby along with their roles and contact details.
- Plans for the post natal period (nice.org.uk)

The guidelines aim to identify essential core care for every mother and baby that should be received within the 6 – 8 week period post-delivery based on best available evidence (nice.org.uk).

This policy concentrates on the needs of the mother and baby together. White (1996) suggests that support services which target either the mother or the baby, but not both together as a unit, can have detrimental effects. She suggests that "*for some women the prospect of involvement with both childcare and mental health services may prove to be something of a poisoned chalice, promising not improved and more relevant services but only increasing levels of coercion and surveillance"* (White, 1996:67).

This increased surveillance can serve to increase anxiety levels among mothers, particularly mothers with PND, which then increases the likelihood of PND being perceived as a risk.

When PND is perceived as a risk to the child, professionals intervene as risk assessors rather than supporting and helping a mother through this distressing period of her life. Mothers may disguise the true nature of the problems they are experiencing. This serves no-one well, particularly the child 'at risk'. PND affects the relationship between mother and infant, to varying degrees based on other factors in a mother's life; professional service providers should be aware of and intervene in a holistic way, helping to repair the relationship and support the mother. Motherhood can be hard, especially for mothers who for whatever reason come to the notice of child protection social services whose role within interventions is risk assessment of the child. Beck (2000) constructs risk, and consequently, risk assessment, as consideration of what may be happening, or what might happen, rather than what is happening. The majority of mothers with PND cope well with their parenting role especially when they receive appropriate supports and therapeutic help to overcome their PND (Welford, 2002). The challenge for professionals, and particularly for professionals working with mothers with PND, is recognising that risk assessment is filtered through a professional and personal lens. Is the professional delivery of services providing social care or control? What informs their agency policies and procedures? What is their role? On a personal level risk is filtered through perceptions of self which are influenced by lived experience, socio-economic, cultural and political (Beck, 2000). Therefore a professional's perception of risk can be experienced as a source of oppression and discrimination for mothers with PND, who are vulnerable and sensitive to criticism (White, 1996).

### 3.9 Conclusion

In reviewing some of the available literature on PND common themes emerged.

Symptoms of PND include.

- Low mood
- Anger and irritability
- Exhaustion
- Sleeplessness
- Loss of appetite

- Low self-esteem – feelings of not coping
- Anxiety – panic attacks

Post Natal Depression is an occurrence affecting one in five women in Ireland (Cronin, 2012). Mothers report tiredness, lack of confidence, guilt and anxiety as contributing factors in PND. Why? Literature on the social construction of women's mental health issues reveal the dissonance between how mothers want to live and their lived reality. There are unrealistic and high expectations placed on mothers. The medical construction of PND tends to pathologise human distress by medicating mothers. Recovery from PND is facilitated within a strengths based approach, learning to live and to live well gaining understanding and responding to the distress caused by PND. Support services in Cork for mothers with PND are limited particularly for mothers living away from the city or those with no internet access or computer literacy. Mother and infant relationships should be understood and supported as a unit, not individually. Policy in Ireland for mental health is populated by guidelines which fail to provide robust support services to mothers with PND.

# Chapter Four

## Analysis of Findings of Mothers' Experiences

### 4.1 Introduction to Chapter

In this analysis the researchers seek to better understand the meanings mothers with PND attach to their experiences, as well as identify common themes and issues among the interviewees. Among the questions asked of these mothers were what supports worked, which ones did not and what would have been useful for a mother to know? The researchers also explored with these mothers what informal or family supports they had access to and when did they realise they were struggling? The mothers were asked about their lives currently, are they still accessing support services and for any further comments.

### 4.2 Sampling

The nine mothers reflected the diversity within the spectrum of symptoms of PND and the subsequent variation in experiences of support services. They are not representative of the general population as the majority are married, homeowners with an employment income. Puerperal psychosis, a condition which affects one mother in five hundred in Ireland (Cronin, 2012): was experienced by one of the mothers interviewed in this sample group.

**Profile of Mothers interviewed**

| | Partner/Married | Employment | Supports | Homeowner |
|---|---|---|---|---|
| Mother 1 | Married | Both | PHN, G.P. Mental Health Services. PND Ireland | Yes |
| Mother 2 | Partner | Partner | G.P. Crisis Intervention Team. PND Ireland | Yes |
| Mother 3 | Married | Both | G.P. Psychologist PND Ireland | Yes |
| Mother 4 | Married | Both | Hospitalisation Mental Health | Yes |

| | | | | |
|---|---|---|---|---|
| | | | Services. PND Ireland | |
| Mother 5 | Married | Husband | G.P. PHN PND Ireland | Yes |
| Mother 6 | Married | Both | G.P. PND Ireland | Yes |
| Mother 7 | Married | Both | G.P. | Yes |
| Mother 8 | Single | No | No services accessed | No |
| Mother 9 | Married | Both | GP PHN | Yes |

## 4.3 Pregnancy and Childbirth

***"The new arrival"***

*"You are beginning a magical journey"* (Maternity, 2012).

The nine mothers interviewed reported no major problems during pregnancy, with the exception of one mother who was hospitalised towards the end of her pregnancy. They stated the ante- natal care received was adequate preparation for childbirth and caring for their baby after delivery, but received no information about PND.

*"A lot of women are not aware of PND. Actually most men aren't either".*

Currently there is an ante-natal class dedicated to PND available in the CUMH, facilitated by PND Ireland, for first time mothers only. Only two of the mothers interviewed attended ante-natal classes in the CUMH, but it was prior to the PND class being initiated. One mother attended community based classes recently, and this PND information class, available in CUMH, was not provided nor was PND mentioned in this community based service.

The other mothers', for various reasons did not avail of ante-natal classes, with one stating,

*"I saw it on television and it's in all the magazines, what did I need to go for?"*

Without exception, all of the mothers were in agreement that PND should be discussed with expectant mothers during ante-natal care or in classes, regardless of where they take place.

The mothers who attended CUMH (recent mothers) reported similar negative experiences of this unit.

*"There's no compassion in there, they literally throw you a leaflet and tell you have a read of it. I had my first child in St. Finbarr's and the staff there were lovely".*

All the mothers felt a leaflet on discharge was not enough. They were busy with their new baby at that time and felt an information pack containing various literature was *"left in the bag or thrown in a cupboard"* From their experiences of PND they all agreed that having a one to one conversation about the risks, symptoms and treatments at ante-natal visits would be beneficial to all mothers.

*"Just a five minute chat, at least it would be in your head then"*

While there is a section on PND in *Maternity the ultimate pregnancy guide* (CUMH, 2012), mothers may not necessarily read it; not one of the mothers interviewed referred to this publication, despite four of the mothers giving birth during this period. It was not a question the researchers asked, having been made aware of the book via the interview with the midwife. This would support their stated preference to have a discussion in relation to PND. It begs the question does the CUMH place an over reliance on the merits of this book to inform mothers about PND? Perhaps it is not *the bible* referred to by the midwife.

Of the mothers interviewed, six discussed their birth experience. Four mothers' described traumatic labours. Three had emergency caesarean sections. They were confined to bed afterwards and depended on others to help them with everything. Upon reflection, they cite the traumatic birth as the beginning of their anxiety and troubled thoughts. Conversely, another mother described her baby's birth as being,

"*Really quick, I didn't have time to think about it, it was so quick. I think the shock caused by the speed of it kind of started me feeling 'strange'".*

Additional stressors in the ante and postnatal periods were reported by seven mothers. There were two weddings, two house moves, two house re-constructions, two new business, a failed business, two promotions to stressful jobs and two mothers were physically unwell due to the birthing process.

*"If a life changing event happens when you are pregnant (i.e. moving house, losing your job, a death) this can be a trigger for PND. A bad birth experience can also be a trigger"* (CUMH, 2012: 149).

This publication also stresses the importance of seeking support. It recommends contacting a GP or PHN if you suspect you are experiencing PND. Good advice, but according to the mothers interviewed they did not have information or knowledge that led them to considering PND.

## 4.4 The Onset of PND

### *"I didn't know what was happening"*

All nine mothers said they did not know what was happening to them. They thought what they were experiencing was *"normal"* in the early stages of depression (up to 6 weeks). Eight out of the nine reported having difficulty sleeping and put the symptoms down to exhaustion. Only when the baby started sleeping longer and through the night did some of them realise that they were still unable to sleep and that it may not be *"normal"* to feel like this.

*"I hated the sound of birds; it used to remind me that yet again it was another night without sleep".*

Eight of the mothers went to GP's at this stage for help. They were prescribed sleeping tablets which aided some in getting rest.

All the mothers' said they did not discuss their feelings immediately with their GP as they felt ashamed, scared, confused. One mother said "*I felt stupid, really stupid"* another said when her baby was 7 months old *"I thought I was doing something wrong".* Only one mother said she recognised symptoms of PND at around 2 – 3 months from reading but she did not consciously associate the symptoms with her own struggles. Common to all nine mothers was 'racing thoughts'

*"Couldn't eat, couldn't sit, couldn't talk, racing negative thoughts. I thought I was losing my mind".*

*"It was like a dream, I lost touch with reality and I didn't know. I can remember everything everyone said to me"*

The uncertainty and lack of knowledge about what was happening came across as a common experience for all of the mothers interviewed. *"I had the baby blues before but this was different"*. As the time progressed the symptoms worsened.

*"I felt that I was after losing my mind and that I would be there forever"* .

*"Crying, crying, giving out to my husband"*

*"Even though it was me but it was like it was someone else"*

All of the mothers spoke of how they continued to struggle for months rather than weeks. They tried to maintain a 'normal' family life.

*"You don't want to go to someone and say I'm a shit mother"*.

The descriptions of their personal experiences by the mothers are all endorsed as common symptoms and behaviours associated with PND according to Welford 2002, HSE 2008, Kealy & Fogarty 2010.

## 4.5 Methods of Coping

### ***"Putting on the mask"***

All of the mothers interviewed adopted methods of coping for a period of time prior to and sometimes after seeking support. Some of them consciously avoided telling close relatives and partners that they were feeling unwell as they were *"ashamed"*. One mother said *"I thought I would take to mothering would like a duck to water"*.

When this did not happen she hid her pain and distress from her husband. She would stay in bed all day and take her shower just before her husband came home from work, pretending she had been busy all day. Another mother spoke of how she would visit her mother's home and pretend she was well.

*"I couldn't tell her because I was ashamed, and my family are really reactive. When I was in this house it was all about the PND, all about me being sick and getting through the day.*

*Down there, even though I was hiding it I could pretend. I love them and everything but they would want to fix it and fix it quick. No-one could fix it because I knew already how slow it was, and it wasn't that I didn't trust them, I know how hurt they were afterwards. It was easier for me to pretend".*

Walking was a common response of three of the mothers in attempting to cope. They told of how they would just go out walking with no real purpose, it was a means of passing time and coping with the distress.

*"I couldn't handle the baby crying so I'd put him in the buggy at 10 o'clock and 3 o'clock and just walk in all weather, he wouldn't cry then he'd sleep"*

Disguising symptoms from others was a way of coping and not saying out loud that they were struggling. *'Pretending'* and *'putting on a mask'* were commonly used phrases among the mothers.

*"You can hide anything; you can feel like your life is falling apart at the seams and that you can't live another hour, but you can hide it"*

Three of the mothers described obsessive cleaning as their way of hiding symptoms from their partners. *"I couldn't sit down so I cleaned".* Their daily routine masked their struggles. Another mother decorated a room in her home to cope with her anguish.

*"Every hour is like a day, every day is like a week. I stopped wearing a watch, I still don't wear one".*

A few of the mothers have still not told some family members about their PND, choosing to leave the mask in place.

*"Mothers are ashamed of mental health"*

## 4.6 Societal perceptions of mothers

***"How does she do that?"***

Some of the literature reviewed suggests that motherhood can be conceptualised by society at large, as a natural and beautiful experience, even though for a large number of mothers' it is not experienced like this, (Bates 1999, Welford 2002, HSE 2008, Brooker & Repper 2009, Ussher, 2011, Aware 2011),

*"Even the PND poster makes it look wonderful; it's an idyllic picture of a mother and baby".*

Mirkin (1994) says that motherhood is glorified as something essential to female fulfilment,

*"Here was my longed for baby and I was cracking up".*

The mothers' interviewed felt threatened by this imagery when their experience of motherhood did not meet the societal perceptions.

*"She must have been up since four in the morning to look like that"*

*"You are expected to be supermum"*

Ussher (2011) suggests that the construction of how women feel they should be and how they actually are may contribute to their depression.

*"Other mums can work, come home, do everything, when you feel like this it kills you"*

## 4.7 Where to go for support

***"Help me"***

Some of the mothers sought help through their own initiative; others were advised to do so by friends/partners. The initial supports ranged from going to the GP or telling somebody else how they were feeling. One mother who had been hiding it from her husband commented that *"I couldn't cope alone anymore, I told my husband and that was a massive help"* another told how *"I begged my husband for help"* she said he knew she needed help but did not know what; she went to her GP.

One mother gained support through her PHN, following weekly clinic visits with her baby the nurse picked up on the mother's symptoms and pursued other supports for her. Another mother attained initial support through a close friend who recognised the symptoms and ensured she went to her GP.

*"If it wasn't for my two friends I don't know what would have happened, I don't think my marriage would have survived".*

In general there was a reported sense of relief at having told somebody and being taken seriously.

## 4.8 Husbands/Partners role in supporting mum

***"The other half"***

Of the nine mothers interviewed five said they had very supportive husbands/partners. *"He was amazing".* These five mothers all praised their partners for their patience, believing they would not have got through the experience without their support.

*"I am convinced I would have ended up in a psychiatric unit only for him. He spent hours talking me down from the day".*

The other four mothers reported having little or no support from their husbands/partners.

*"He was useless"*

*"He didn't understand"*

*"He made things worse; he was there but not there"*

*"When I broke down at 6 weeks he was ready to walk out"*

One relationship did not last and the mother in that situation said she only began to feel *"better after he left".*

Regardless of whether or not they were supportive, all mothers suggested that men need supports in their own rights for PND. They were in agreement that education for men about PND and having someone to talk to would be of huge benefit to partners.

*"this was the hardest thing to deal with, worse than when his father died, he has no support".*

*"Whatever I went through it was a hundred times worse for him; he had no one to talk to".*

These feelings about their partners reflect Welford (2002) assertion that without proper support for partners, the *"caring debts"* accumulated by mothers with supportive partners can increase feelings of guilt and stress.

## 4.9 Emotional unavailability of mothers

### *"She's very practical"*

With the exception of two mothers', all others were very hurt by the actions of their own mothers or mothers-in-law.

*"She wouldn't be very great to talk about it but she took off the pressure by minding the kids".*

There was a high level of practical support but very little emotional support,

*"I raised five kids and I managed fine".*

The two mothers' interviewed who had emotionally available mothers of their own expressed their gratitude for this support. One mothers' support was by telephone contact (UK). Her mother had experienced PND so understood what her daughter was experiencing. The other was within easy access and her daughter went to stay with her for a period of time. .

*"The comfort of her, her smell, getting into bed with her, reassured me. She would tell me wait till Sunday, you'll feel better. It would come and then I'd say, she's right, I feel a bit better".*

Other experiences were not so positive. Two of the mothers interviewed did not tell their mother/mother-in-law. Others had mixed experiences. One mother said she was unable to talk about the depression to her own mother as she was not receptive to hearing about it and remains that way today. Others made comments which were hurtful to their daughters.

*"What right do you have to be depressed? You have a husband and a lovely home".*

While the mothers interviewed didn't gain emotional support from their own mothers they did appreciate having them around for practical purposes.

## 4.10 Medication

***"I thought I'd be on them for life"***

Eight out of the nine mothers were prescribed anti-depressants when they were diagnosed with PND. Three are currently using medication, stating they are not ready to withdraw. Five out of the eight were resistant at first to using medication as they had heard negative reports of anti-depressant usage (Whitaker 2010, Brown & Harris 1978).

*"I was afraid to take them; I thought it was the end".*

Some mothers had tried sleeping tablets first but when these failed to work they realised they needed more. *"I thought I would be on them for life"* was said by more than one mother. One mother commented that her resistance ended when she heard other mothers in a support group talk about the benefits of taking medication.

*"I was worried about sleeping and not hearing the baby crying, and becoming numb".*

The mother who did not take anti-depressants struggled without support rather than go to the GP. She said *"I didn't go because I knew he'd make me take tablets"*. She subsequently self-medicated with wine. All of the mothers' experiences of taking medication varied. For one mother who was hospitalised, she described the medication regime.

*"They had let me have my phone to keep contact with my kids. My husband brought in my I-pad and I was listening to music. One nurse took them off me and said I wasn't allowed have them. I freaked out and they said I was having another episode. They prescribed more drugs for me. I didn't take them because I'd end up like a zombie. That's what they want".*

A common theme for other mothers' is exemplified by this statement,

*"After 4 months I was level, I wasn't down but I wasn't up either I was kind of flat, numb".* The psychiatrist this mother attends recommended taking additional medication to "*enhance my moods. I said no, but he said come back and see".* Leo & Lacasse (2007) describe this practice as disguising the symptoms of distress rather than addressing the depression.

For some mothers the medication was a positive experience at the time.

*"The good side of anti-depressants isn't talked about, they stopped the racing thoughts. I could sleep".* For another mother who was physically exhausted and experiencing suicidal ideation, "*They saved me".* Most of the mothers reported the positive effects wore off after about four months *"I was coping but not feeling".* The benefits outweighed the side effects for some. *"There was a gradual improvement; it was like a weight lifted bit by bit".*

Other mothers spoke of the crippling side effects of the medication. *"the cure was worse than the cause. I sat on the side of my bed and couldn't move with the panic attacks, they were worse than the PND".* Another mother reported panic attacks also. Some said their skin crawled, and others reported suicide ideation ,*"like it said on the leaflet. That's hard to read".* Yet another mother stated,*" "I took the tablets but they made the anxiety worse".*

In coming off the medication two mothers weaned themselves off the tablets. One mother chose to come off unsupported as she felt the GP would want her to remain on medication for longer. All of the mothers who no longer take medication reported feeling better after a little while, some said they felt worse initially. One mother reported to feeling better, but feeling better again when she stopped taking contraception as well. She felt her hormones were affected.

*"I wanted enjoyment back in my life; I think the medication was stopping this"*

Most mothers who were supported in discontinuing medication were happy with the support received from their GP's.

*"My GP supported me throughout, I came off with support, the timing in coming off meds can have a reaction, I felt like me"*

One mother had an adverse reaction when she stopped taking medication.

*"At 18 months I went to GP and told him I wanted another baby. He told me I could stop taking my medication, just stop! And then what happened me? The withdrawal was absolutely horrendous. Empty retching, vomiting, the anxiety got 20 times worse."*

Subsequently she decided with her doctor to go back on medication.

A common thread among the eight mothers' who took medication was their negative perception of anti-depressants prior to taking them. When they began medication most reported improvements, which stopped after about four months. The side effects were horrendous for some mothers and withdrawing unsupported was problematic for others. The mothers who are currently not on medication reported feeling well.

## 4.11 Recovery

***"It gets better"***

Recovery for all of the mothers is a journey which is on-going, some days are good and some are bad. They spoke movingly of being at different stages in their recoveries.

- *"Two thirds of the road"*
- *"about half way"*
- *"almost there"*
- *"recovered"*
- *"Recovered but still have bad days"*
- *"pretty stable, not depressed but sometimes anxious"*
- *"Consider myself recovered, but it leaves its mark."*

While all of the mothers said they had been through confusing and painful experiences, feeling alone and desperate, there was a sense of positivity in them all around their individual recoveries.

*"I used to say nothing good can come out of this. But it does, when you get up and its sunny, you take a deep breath and think I am well and you appreciate life".*

Reflecting on their lowest point to where they are today was a common theme for each of the mothers.

*"See that bridge down there, I'm going to go down and jump off it".*

They recognised their own progress and the strategies and supports they enacted in reaching their current position. In contrast to some of the feelings of despair, fear and not knowing why they were feeling the way they did or if they would ever feel better, it was apparent that all of the mothers had embraced their recoveries with strength and determination.

*"I had dark thoughts, really dark thoughts"*

*"I thought, it would be so easy just to turn the wheel and drive off into the river there"*

*"I used to plan where I would do it"*

Although several of the mothers said they had thought about suicide they also said they had not taken any action to carry it through.

*"Thoughts come into your head but you know you're not going to act on them"*

They described their thought processes in similar ways. They said that they felt inadequate and not good enough. PND lowered their self-esteem and confidence to the degree that they felt unworthy of their roles as wife/mother.

*"They'd be better off without me"*

*"He'll meet someone else and she will look after them, they deserve better"*

Some of the experiences are still quite raw and recent; others are further along in their recoveries. All agreed that PND or the fear of developing depression never really goes away. Five of the mothers interviewed were in agreement that they were *"stronger"* from their experience. Two mothers who were pregnant at the time of interviews said that they know what to look out for this time. Another mother said of her second pregnancy and birth that she knew what to look for and sought help much sooner second time round, *"it was easier because I knew what it was"*. One of the pregnant mothers said that her previous experience could be a trigger for relapse as a result of all the professionals referring to it at her ante natal appointments. She was not questioning their need to know and for it to be on record but she said *"Don't label me, I'm happy. If they keep mentioning it they will make me depressed"*

The other pregnant mother said,

*"I'm pregnant so I cry easily. Why does everyone think it's PND coming back?"*

Other mothers gained strength and positivity from their PND experience.

*"It made me a better person; I have more empathy for people"*

*"I used to be concerned with having things. Now I just want peace of mind and my family".*

The mother's experiences of recovery is reflective of what Sapouna (2012) describes as a personal process of discovering how to live and live well with enduring symptoms and vulnerabilities.

While having dinner one evening with her husband one of the mothers interviewed was greeted with the comment *"welcome back (name)".*

### 4.12 PND Ireland Support Group

***"Knowing I'm not alone"***

There was a mixed response from the mothers' interviewed about their experience of PND Ireland support group. The six mothers' interviewed who are members spoke positively about their experience. However some of the mothers had concerns and raised areas where they thought improvements could be made. They also answered a question posed by the Chairperson to the researchers about the reluctance by mothers who were helped with their PND by the group, to return and help other mothers who are currently experiencing PND.

In the months following the birth of their babies, all of the mothers desperately sought support. Of the nine mothers interviewed, six had used the PND Ireland support group regularly, some are still attending, one mother attended once through a referral by her GP. Two mothers' were not aware of any support group. PND Ireland runs a monthly support group in CUMH. It also facilitates a coffee morning monthly. A chat room on the internet is also a service provided by PND Ireland which some of the mothers availed of.

*"I went to the group at 9mths. I found it on the internet. I found the chat line was a lifesaver because I couldn't face a group. It's an amazing service, having women there with the same symptoms is a lifesaver".*

All of the regular attendees found strength in the supports from PND Ireland when they were feeling very bad.

*"It was a weight off my shoulders, I'm not mad, I'm not going crazy, other mothers are here looking for help and they are on the medication too".*

The mothers gave varied responses to their experiences of the support group.

*"Once a month I could go to PND group and just let it out".*

*"Thank god for Madge and the girls".*

*"The first group I went to was brilliant, my husband thought I wouldn't stay but I didn't get home till gone midnight, it was brilliant".*

However, for one mother interviewed, she experienced attendance at the support group negatively.

*"It's not suitable for everyone, I found it very negative: I went in positive and came out thinking I would top myself. I was told I would never recover and to take the medication".*

She subsequently went on anti-depressants,

*"They made me feel madder. If these were supposed to help like the women in the group said then I was done for".*

Another mother who attended said,

*"It's a small room, have you seen the room it's in? It's not comfortable, sometimes the time is used for business, talking about fundraising and publicity and politicians, when it should be used for support. That's what we need"*

Some of the mothers found it difficult to be in a group and had mixed feelings about it; they all said the peer support was *"fabulous".*

*"It's hard being in a group, I'm not good to open up to people. But it's good to make friends. I stayed away at recovery point".*

What helped them in their recoveries was seeing other mothers who were worse than them join the group. This made them realise how far they had come.

*"It felt like an AA meeting. You have to be ready to do that. The first night my husband came, he sat outside. I met a girl with puerperal psychosis, and whatever way I felt I thought she was just out of a psychiatric unit after 9-10 weeks. I felt like my world had ended but when I looked at her it made me realise it can be worse"*

The uncertainty and fear of their own situation, the pain of their experiences and the desperate need to recover all contributed to the experience of the support group. All of the mothers who attended regularly achieved support on the road to recovery. They endorsed the value of peer support, knowing they were not alone and that they could discuss their feelings without being judged and to be understood was instrumental in the progress they made.

What came across clearly from the six regular attendees at the support group was the invaluable support given to them by Madge Fogarty (Chairperson of PND Ireland), who supports them individually as well as in a group setting. Conversely, a mother who attended a meeting said, *"Her (Chairperson of PND Ireland) personal story took up a lot of time when I wanted to listen to someone else. The women talked about people who weren't there and the details scared me. I wasn't going to talk because I didn't want them talking about me when I wasn't there".*

The value of the informality of the coffee morning was stressed by the mothers from PND Ireland, *"The coffee morning is really good, the kids are welcome and it's more informal, there's no big label on the door saying PND".*

Cronin 2102 presents findings that peer support is valuable as individuals embrace new knowledge when it is presented by others who have had similar experiences.

*"I still go to the coffee mornings, they're really good, I text a few of the girls in between"*

The mothers said they felt they were just regular mothers meeting up for a coffee and a chat.

The mothers who had no access to a support group said when asked 'what would have been helpful?' that *"A support group would have been good; I needed to talk to other people who understood" "Just some female company, anyone to be there, someone to talk to"*

Of The mothers who did access the services four found them through searching the internet for help, two through their GP's in and one through her PHN.

It was expressed by some of the members of PND Ireland that they find it difficult to attend meetings now that they are in recovery, as it is difficult to be around the negativity. Seeing and hearing other mothers' going through the initial, distressing stage of PND is draining on themselves emotionally. This question was posed to the researchers by the Chairperson of PND Ireland, *"where are the mothers now, why don't they come back to help support others?"* The answer to this question was given by some of the mothers interviewed,

*"It's hard to sit there and hear the distress; you kind of soak it up"*

*"I went back to a meeting recently. I found it draining and upsetting. After a day or two it wore off. I want to be able to do that because meeting the women who had got better when I was sick was great. I hung on every word, I wanted to be them. I wouldn't do it once a month I might do it a couple of times a year. I would find it too much"*

*"I wanted to do this (interview), if I can help one other mother it will be worth it, this is how I can support them, because I can't face the sadness of the women".*

### 4.13 After the interview

***"How are you now?"***

All of the mothers interviewed are in various stages on the recovery journey. They shared their experiences openly and honestly with the researchers. On agreeing to take part in the research they did not know if this process would be painful for them, talking about their experiences. Every mother said they enjoyed talking about their experience and some commented that it had helped them to make sense of what happened.

*"It actually did me good to be honest"*

*"Thank you very much, you have no idea how good it was for me"*

### 4.14 Conclusion

This chapter has examined the information gathered through personal interviews with mothers who have experienced PND. From semi structured interviews the experience from onset of symptoms to current situation was recorded allowing the researchers to interpret and present the lived experiences of mothers accurately. The analysis presented has been formed based on the narratives from the mothers in relation to their unique experiences of support services, how they benefited from them or how they did not, what they needed and what they actually had.

# Chapter Five

## Provision of Support Services for Mothers

### 5.1 Introduction to Chapter

In this section the stated aims and service provision of support services is contrasted with the experience mothers with PND had of these services. The professionals interviewed were asked about their role in the service, what they perceive as the needs of mothers with PND, the symptoms at presentation for support and the focus of their intervention. They were also asked what, in their opinion worked for mothers with PND, as well as interventions which did not. The length of interventions and other support services they may recommend were also discussed.

**Profile of Professional Interviewees**

| Title | Support Service |
|---|---|
| General Practitioner | Ante-Natal and Post- Natal Support Services |
| Public Health Nurse | Post- Natal Support Service |
| Community Support Worker | Ante-Natal and Post-Natal Support Services |
| Infant Mental Health Specialist | Post – Natal Support Service |
| Midwife | Ante- Natal and Post-Natal Support Services |

### 5.2 A General Practitioners Perspective

***"What's going on?"***

The G.P. interviewed described their role within both ante-natal and post-natal care. Assessing whether a mother has PND is based on prior knowledge of a mother and the relationship built with her over time.

*"I get to know families intimately. When doing the routines things for baby, one of the main things which women never think about is that I am observing them".*

This G.P. identified the struggles for mothers with PND as anxiety, confusion and they may find it difficult to talk to their partner, "*70% of cases involve stress between partners, explanations turn into arguments"*. The mothers may have other stresses in their lives and have an *"overwhelming sense of not coping"*. This is constantly referred to in the literature review (Ussher 2011, Kealy &Fogarty 2010, Mauthner 2010, HSE 2008, Welford 2002, Bates 1999.).

This G.P. contends that if PND is identified early, intervention required may consist of encouraging her to talk to her partner, friends and family about how she is feeling, coupled with accessing practical support enabling her to rest. A lot of mothers with PND seek help after nine or ten months when everyone assumes they are fine.

*"but as time goes on they are not enjoying their baby, not getting on with their husband or have no supports at home"*.

They eventually seek help because *"they are afraid that it is going to last forever and they are afraid it's going to impact on their child"*.

According to this G.P. at this stage there can be a resistance to medication, counselling or support groups because mothers with PND do not perceive themselves as being *"this bad"*. This G.P. spends time explaining the medication and also refers mothers with PND to PND Ireland or for counselling as well as prescribing medication. This contrasts with Whitaker (2010) who, along with other critical researchers, assert medication does not address the underlying cause of why this depression exists in the first place. He advocates for a holistic, psychosocial approach to address the depression rather than medicate human distress. When discussing the varied spectrum of PND, this G.P. expressed the opinion that,

*"You get lots of different levels of PND. Someone at the severe level is not eating, visibly depressed, possible suicidal ideation, feeling life is not worth it, and the child is suffering"*.

This definition is supported by and expanded on by Medical Dictionary available at http://www.nlm.nih.gov/medlineplus/mplusdictionary.html.

Mothers with PND do recover with support and medication according to this G.P. When they feel strong enough they are weaned off the medication.

This G.P. elaborated on the fact that many mothers who experienced PND go on to have more children and use their awareness and coping skills previously learned to recognise the potential for PND recurring and the need for early intervention.

### 5.3 Mothers' Experiences of their G. P.'s

***"He (G.P.) was brilliant, eventually"***

A shared concern among the mother's was that G.P.'s persistently failed to recognise or discuss PND. When PND was eventually diagnosed all but one mother was prescribed anti-depressants without a frank and full explanation of the medication or the possible side effects of taking medication. Only one mother interviewed reported that her G.P. immediately identified her as having PND when she went for help. *"He knows me for years and knew there was something wrong, he was brilliant"*. This G.P. contacted PND Ireland, fully explained the medication and the nature of PND. In consultation with him she gradually came off her medication and is currently pregnant. She stated *"if it happens again at least I'll know what it is and how to cope with it. It was the not knowing and thinking I was mad which was the worst"*.

Another mother described her G.P. as *"fabulous"* after her PHN referred her to her G.P. even though the G.P. had not diagnosed PND on previous visits.

*"I wished I had cancer, because I would have had my mind to fight it. There's nowhere to go, there's nothing to help you when you don't know what is wrong"*.

For this mother and six others this is how they felt when they attended their G.P. on more than one occasion and PND was not diagnosed or discussed.

*"I didn't know what the signs were or what to look for. I had heard of it, but I thought mothers who got PND didn't bond with their babies and I had bonded with mine"*

*"It wasn't until a young doctor took over that he thought I might have PND"*.

Upon reflection, these mothers feel that G.P.'s should be educated more about the symptoms of PND and how to recognise and indeed, begin a conversation about it with mothers who are distressed.

*"I went to the GP and he gave me sleeping tablets. I could argue that he should have picked up on it at that stage, but he was very good to me later on so I cannot fault him for that*".

## 5.4 A Public Health Nurse Perspective.

***"Mums are very important to babies and babies are very important to mums, even though things may be stressful"***

PHN's visit mothers' and babies within twenty four hours of receiving a birth notification from the maternity hospital.

*"Obviously the physical needs are discussed but we take a holistic approach, looking at the child, their mum and the family unit, and also the supports around them in the community*".

As PHNs have worked as midwives and in the neo-natal unit, they can discuss mothers' concerns about these experiences. *"I like to think that we can bring a sense of continuity to them".* Relationship- building especially during the initial visit, allowing a mother to discuss her needs and concerns, is encouraged.

"*We are realistic and non-judgemental and recognise that this is an emotional time. There are a lot of hormones and a lot of changes going on in her body. A mother may have the 'three day blues' but it is recognising that it can go on for longer and that these things happen. It is about being able to talk to someone and express how you are feeling".*

This PHN encourages a mother to attend her G.P. if there are concerns about her mental health.

"*We can make a referral to a support group, or a mother and baby group, or support around the PND aspect".*

The PHN is in contact with mothers at regular intervals, monitoring a baby's development. They also observe mother's and assess how they are coping within their parenting role.

*"A tool we use is the Infant Mental Health Wheel to promote supporting parents. It is lovely to feel that you have a little guide along the way, showing you things that can be expected".*

The PHN acknowledges the trauma some mothers feel after giving birth and locate PND within this period in accordance with Cronin, (2012), Clark & Fenichel, (2001). Dennis & Creedy, (2004).

Issues which this PHN is cognisant of when visiting a new mother are:

*"Their experience of labour, how they were parented themselves, how they are coping parenting, they may have had a difficult delivery, there may be financial issues and other issues which can impinge on one's family. It is about looking at the person within their own situation and at the same time, giving them time to express what they are feeling".*

In discussing support services available and evaluating their effectiveness or appropriateness in addressing the needs of a mother with PND, the geographical location assumed importance. Some communities in Cork have been classified as Revitalising Areas through Planning, Investment and Development (RAPID) areas.

"*It depends on where you are which determines what is available. It can be difficult if you live in a different area".*

Mothers with PND living in RAPID areas have access to services not available elsewhere. There is a crisis intervention team, a Multi-Disciplinary Team (MDT) which visits a mother daily and supports her within her own home.

There are other community-based services provided for mothers with PND which are delivered by community health workers and other professionals.

*"areas which might not be deemed as socially disadvantaged can be disadvantaged because they don't have a lot of these services".*

Mothers with PND living in other areas have access to a PHN and the many services they can provide.

*"It is very much about being consistent, following through, especially with a mother who is expressing negative feelings. If you have early detection of an issue and if everyone was willing to try and do different things to relieve the anxiety and stress that is the ideal. Sometimes people can have unresolved issues, not vocalising them and that can lead to them denying the issue and prevent them from seeking help".*

### 5.5 Mothers' Experiences of Public Health Nurse Services

***"I would have liked to talk to her but she was busy"***

Most of the mother's expressed reservations about sharing their feelings or admitting they were experiencing difficulties to their PHN. They had a perception of PHN as professionals dealing with child development only. Only one of the nine mothers interviewed experienced a positive support service from her PHN in regard to supporting her personally as a mother with PND. This mother attended a clinic weekly for her baby whereby her PHN recognised she had PND. The PHN *"picked up the phone, she rang Madge (Chairperson of PND Ireland), rang my G.P. and made an appointment for the next day. She actually didn't give me a choice which was brilliant"*.

This was in contrast to the other eight mothers with PND. Two PHN's identified mothers as having PND, but did not advise or intervene further, other than to tell them to go to their G.P. One mother told her PHN about her PND. This PHN subsequently visited for a child development check. *"She knew how badly I was suffering and all she talked about was the baby not crawling on her knees. If the baby didn't start crawling she would be referred to a specialist. I blamed the PND for her not crawling. It was another crutch to beat myself with. My husband got very angry with the PHN"*.

This focus by the PHN on child development rather than the mother or the mother-child relationship constructed PND as a risk factor within this distressed mother's mind, but the PND may have been interpreted by the PHN as a risk. What does this say about therapeutic interventions by PHN's? When another mother perceived criticism from her PHN about her baby's development, she said,

*"I felt they would be better off without me. He would find someone else and the kids would have a proper mum"*.

In seeking to understand the distress the mothers' interviewed expressed about interacting with PHN's, raised anxiety, deflection of questions, fear of being perceived as failing, the researchers re-examined the literature reviewed. White (1996) explores how services for maternal depression have evolved. She cites Foucault's assertion that language creates a 'regime of truth' and when coupled with professional power become 'knowledge' upon which service providers create the service which best meets their agency aims. Therefore standards are set based on agency criteria and mothers with PND may experience,

*"surveillance and monitoring under the, apparently benevolent, normative 'gaze' of the welfare and health professions".* (White, 1996:71)

Over the years theorists have presented an "idealised mother-infant" relationship which then produces healthy 'normal' adults. This representation of motherhood places a huge burden on mothers, neglecting as it does the myriad other factors within an individual mother's life. Maternal depression, including PND is constructed as a risk to this outcome, contented mother with an infant who grows into a fully functioning, autonomous citizen.

Surveillance is required to monitor the effects of PND on public health if PND is perceived as a 'risk' by PHN's. White (1996) argues the effect of increased surveillance of mothers with depression serves to heighten the anxiety these mothers are already experiencing, as discussed by the mothers' interviewed. Dominant discourse has created guidelines for assessing mothers parenting capacity and most of the mothers interviewed had an intrinsic knowledge of this, they felt they were being judged by all professionals involved.

*"If she had asked me straight out I probably would have lied. I didn't want to seem like I was failing".*

These guidelines based on the 'regime of truth' and 'knowledge' as devised by professionals seeking best possible outcomes ignores the diversity and the resilience inherent in mothers given the right type of support to overcome PND.

*"I ask whether we have the right services to meet the needs of women with depression and their children."*(White,1996:69).

If a mother with PND is "hyper" this is perceived as a risk. Conversely if a mother is inactive this is perceived as risky. If a baby is too clingy or too distant both are risks perceived to be associated with PND by some professionals. It could thus be summarised as every action or inaction of a mother and a baby may be interpreted as risky behaviour when PND is internalised by professionals as a 'risk'.

The Edinburgh Scale is a tool used by PHNs' to assess whether a mother is experiencing PND. The higher the score: the greater the likelihood that a mother may have PND. A mother interviewed reported *"I did that questionnaire (Edinburgh Scale for measuring PND: appendix 6) and I scored 10 out of 12. She should have been calling someone for me, instead she put it in a folder and that was that. Someone should be there for you on that day".*

All of the mother's interviewed thought the PHN's focus was on their babies' development. They also discussed how busy and rushed their PHN's appeared.

*"I would have liked to talk to her but the waiting room was full of mothers and babies. If I started I wouldn't stop".*

When asked what supports were experienced as unhelpful seven of the mothers interviewed said attending clinics or having a PHN visit placed them under more stress and increased feelings of *"being inadequate".*

## 5.6 A Community Support Worker's Perspective

***"Working with the mother, the family and using the community to enhance resilience"***

This community based support service is located in a RAPID area of Cork. The worker identified the needs of some of the mothers with PND in this area as isolation, deprivation, a lack of education, single parenthood and with little or no family or friends for support, as stated by Mirkin (1994). Many of the mothers living in this area grew up in the care of the state. Interventions provided by this service include reducing social isolation and talking through issues of concern for mothers with PND during home visits, "*working with the mother to get her into a good place"*

This family support service in recognition of the research into infant mental health and the impact of maternal depression provides the services of a counselling psychotherapist and a play therapist to mothers with PND to assist with attachment or relationship issues. They also provide affordable Cognitive Behavioural Therapy (CBT) or counselling.

Mothers with PND are encouraged to join relevant support groups based in the community. If no such group is available, this family support service can create one based on an identified need within the community. Mothers with PND are further encouraged to access other community based services either for themselves or their children. *"We work with the family as a unit".* Referrals to this service come from the CUMH, PHN's, G.P.'s, a community health project, self-referrals and family referrals. This support service for mothers with PND can intervene for as long as required, but only for mothers with PND living in the area.

### 5.7 Mothers experiences of Community Support Services

***"Services, what services?"***

Two of the mothers with PND lived in a RAPID area where this service is available. Neither accessed this particular service, one of them because she did not know about it, had she known she would not have accessed it,

*"I felt so bad and didn't want to see or talk to anyone. I was useless".*

One mother did have access to the crisis intervention team. This multi-disciplinary team treated her in her home, calling daily for three weeks. This team included a psychiatrist, a mental health nurse and a social worker. She was prescribed anti-depressants and was able to talk through her fears and anxieties. The team returned for a further two weeks when she experienced panic attacks as a side effect of her medication. *"They were brilliant. I didn't have to get dressed up or take the baby out on the bus and wait for hours to see somebody. They could see how I was really coping because I couldn't hide anything when I was in my home".*

Subsequent to this intervention this mother was linked into affordable (CBT) and a stress management course.

*"The therapist still phones me to ask how I am. He taught me 'it is what it is' don't be driving yourself mad looking for perfect. No one's perfect".*

This perfectly reflects Ussher (2011) views that the dissonance between "ought" and "is" is a major contributing factor in women's depression. Every mother interviewed spoke about *"failing* "as mothers, partners and women. They perceived themselves as not living up to the representation they had internalised of what a mother should be, should feel and should act. They compared themselves very unfavourably to personal, family, friends and media representations of what a mother should be. In a recent front page local newspaper (O'Reilly, 2013) an article about a planned two bed mother and baby unit in the planned new Cork psychiatric unit titled "Cork to get post natal depression hospital unit" was bordered by a picture of a celebrity telling mothers how to be a 'yummy mummy to-be' and an advertisement by a clinic to 'freeze the fat' complete with a picture of a perfectly flat stomach (appendix.7), the idealised version of a woman, but who's idealised version?

*"They would say' Jesus you look amazing the baby weight just fell off you' and I used to think that's the anxiety diet".*

The services available for mothers with PND in RAPID areas are comprehensive. Most of the mothers interviewed expressed a desire to have such services available to them based on their needs rather than their post code.

### 5.8An Infant Mental Health Specialist's perspective

***"What helps a mind to grow is the sense of being known"***

PND can have a devastating effect on some mothers, but also impacts on other members of the family, most notably, the relationship between a mother and baby. Mothers with PND may

*"feel bad about being depressed, they feel they should be happy and wonder why they can't enjoy their baby. They worry about how their baby is feeling"".*

The presence of other supports within a family serves to diminish the effect of PND on a baby. Sometimes, however, a rupture can occur in the relationship between mother and baby, requiring some form of intervention. Otherwise *"you might get the mother over the depression but you haven't helped the relationship*".

This acknowledgement of a rupture in the relationship by a mother and her ability to repair helps a baby to develop a secure attachment and enhances resilience, with the baby knowing that distressing periods can be temporary and can be overcome.

*"What we do know is if you intervene in the relationship with the mother and baby together the outcomes are better for both".*

## 5.9 Mothers perspectives on infant-mother relationships

***"All the nights standing over her cot looking at her and the guilt"***

The researchers decided not to directly question the mothers interviewed about the impact of their depression on their babies as the research aim was an exploration of their experience with support services. However, time and time again the mothers themselves and the professional support service providers spoke about their concerns from the infant's perspective.

*"I don't remember his first year. I got him christened again, just us, because I can't remember it. I never interacted with him. I never had the love until eight months".*

A mother's partner constantly asked *"do you love him? Oh God say you love him".*

Yet another mother stated *"I hope to enjoy the new baby more. I feel I missed out on a few months of the first baby".*

Another wonders about the impact her PND had on her child as she has researched this and finds it extremely painful to consider. She speaks openly and honestly with her child about PND, seeking to somehow normalise the experience and raise awareness about the condition with her child.

Other mothers did not feel PND had any impact on the baby.

*"I don't think it had an effect on the baby".*

*"It did not affect him; he is a really good child and never cries".*

Tellingly, some of the mothers raised concerns about the impact of their PND on their children and the increased risk of psychopathology for their children in the future, but none were aware of any therapeutic interventions available, or indeed if such interventions are required. This would appear to mirror the initial confusion all of the mothers interviewed had about their feelings, thoughts and behaviours prior to discovering that they had PND. This was a condition which they knew nothing about or had misinformation or misconceptions about PND. This *'not knowing'* or *"thinking I was going mad"* caused the most distress, according to all of the mothers. Subsequently, informing themselves, availing of support and treatments and embracing their recovery allowed the mothers to understand their experience.

Perhaps a similar approach might alleviate the discomfort some of the mothers are expressing about the impact of PND on their children.

### 5.10 What support service? Support for what?

***"How could I get help when I didn't know what was wrong?"***

There is a growing awareness about infant mental health. Play therapists, psychotherapists, psychologists and psychiatrists are currently providing specialised services. However, these are not the support services most of the mothers interviewed were involved with and are expensive to access.

### 5.11 A Midwife's Perspective

***"A healthy Mum and a healthy baby"***

The midwife interviewed described her role as "*caring for the mother and the baby's physical and medical needs only"*. The midwife looks after the pregnant mother for the duration of the pregnancy. She does not discuss PND with mothers ante-natal or post-natal as this is outside her remit. Her role is to prepare pregnant women for labour and offer post-natal, advice in how to care for baby and meet baby's needs. In discussion about raising awareness about the possibility of a mother experiencing PND, the midwife said *"Every mother receives a copy of 'Maternity The Ultimate Pregnancy Guide 2012/2013' which is the bible"*. This free publication by the Cork University Maternity Hospital is also available in waiting rooms at the ante-natal clinics, and the book is available from outpatient clinics in regional hospitals throughout the county. It is a comprehensive guide to pregnancy, labour and aftercare, and contains a section about PND. It gives details of PND Ireland's helpline and other services PND Ireland offers. The book describes the symptoms of PND and feelings that mothers might experience. The midwife said, *"Post-natally my focus remains on mother and baby's physical*, *medical and practical issues, but not emotional issues*". Practical and essential tasks like feeding, bathing, changing nappies are demonstrated or taught to mothers.

This midwife is very committed to her role as a midwife and nurse, meeting the medical needs of both mother and baby and enabling them to go home together with good physical health and practical advice. If there are problems after the birth for mum or baby they would be referred to physiotherapy or other specialist medical services.

Before they go home new mums are given a discharge pack. Contained within this is a leaflet about PND. It is not discussed with the mother; it is part of a standard information package. This midwife said she sometimes asks fathers to read the leaflet as they might be better placed to recognise and identify symptoms of PND sooner than a mother herself.

### 5.12 Mothers' Experience of midwives and hospital

***"They handed me a bunch if leaflets and that was that".***

All of the mothers' interviewed described being handed these leaflets and not one mother read them. Four of the mothers had difficult births. Three mothers had attended ante-natal classes where PND was not discussed. The other six mothers' did not attend ante-natal classes for various reasons including, *"I got information from the internet. What did I need to go to classes for, I was always around babies".*

In recounting their experiences of being in hospital after giving birth, most mothers' expressed a high degree of dissatisfaction. *"They wouldn't do anything for you, not even get a glass of water, and I couldn't move because my scar was weeping. I sat up straight for two nights".*

Another mother had spent three weeks prior to birth in hospital because of health problems for her and her baby. Her medical and physical needs were well taken care of and she received emotional support from the neo-natal social worker. This mother found it very therapeutic to have someone to discuss her feelings and fears with.

*"I had the baby and the social worker was gone".*

## 5.13 Conclusion

There is a discrepancy between the stated service professionals provide, and the experience of this service by the mothers interviewed. Interpreting this discrepancy the question posed for the researchers was why, what prevents some mothers with PND from availing of the therapeutic benefits provided by working with professionals? In analysing the data a common theme was the perception by the mothers interviewed of the role of the professional. G.P.'s and PHN's role, according to some of the mothers interviewed, is to ensure child development. They perceived PND as a risk to this development, therefore they put on a mask, disguising their symptoms. They could not allow themselves to be judged as failures. As White (1996) says this focus on risk assessment by professionals, whether implicit or explicit, diminishes the effectiveness of service provision.

# Chapter Six

## Conclusion, Recommendations and Personal Reflection

### 6.1Introduction to Chapter

In conclusion and upon reflection of this study, similarities between all of the mothers' interviewed become apparent. The experience of having PND, the symptoms of racing thoughts, not being able to enjoy their baby, negativity, sleeplessness, no appetite, suicidal ideation and high anxiety was similar for the majority of the mothers interviewed. The lack of awareness among each mother about PND caused huge distress.

### 6.2 Summary of Findings

Each mother interviewed had knowledge about PND, that it affected large numbers of mothers' but could not have envisioned that they personally would get PND. Why? The majority of the mothers interviewed are what their partners, family, friends and support service providers describe as successful, high achievers and intelligent women. Most of the mothers had careers, were home owners, attractive and capable women in loving, stable relationships. The mothers themselves described the "type" of mother who they originally perceived would get PND. These were mothers who did not bond with their baby, single mothers, mothers with no family or supports, mothers who had been depressed previously. The G.P., PHN and community based family support worker said they are vigilant when working with mothers who have little visible supports, who are lone parents or have been depressed previously.

Most of the mothers interviewed had great difficulty accessing support services, especially from their G.P and PHN. Could the relationship they had with these professionals have influenced this delay in identifying PND? If the G.P. had always known this mother as a capable person, then it is easier to miss the symptoms of PND or to reassure a mother that there is nothing wrong. All of the mothers described wearing a mask, disguising their symptoms out of shame, fear of being judged as bad mothers or fear of being perceived as a risk to their baby.

Every mother interviewed had experienced a lack of emotional availability from their own mothers or mothers-in-law. This lack of empathy extended to friends for most of the mothers interviewed and contributed greatly to the mothers with PND levels of anxiety and distress.

Labelling by G.P‘s was welcomed by eight mothers, yet most of them resisted medication until they felt they had no choice. Six of the mothers interviewed said they still have guilt about the impact of their PND on their partners and children.

What became apparent from this study was the impact of the birth experience, other life stressors, and the propensity for social comparison, which caused great distress for the mothers interviewed. However, all of these mothers spoke positively about embracing a recovery approach to overcome their PND. For some this recovery was aided by CBT, counselling and psychotherapy. For others it was exercise, stress reduction techniques, leaving work or going back to work. For all, it was talking, talking to their partners, family, friends or professionals. For the members of PND Ireland they received great support from attending the group meetings.

### 6.3 Recommendations

The following recommendations are based on the information and lived experiences of the mothers interviewed for the study, of the support services they accessed. These recommendations will be presented to the Chairperson of PND Ireland on whose behalf this research was conducted.

- All of the mothers interviewed wished that PND symptoms and support services be discussed at ante-natal clinics, ante-natal classes and prior to discharge from the CUMH. A discussion about PND would be beneficial at the point when leaflets and literature are being dispensed. This would raise awareness about PND for mothers. We recommend the Chairperson of PND Ireland liaise with the CUMH and explore the possibility of implementing this support service.

- Relevant information about PND should be provided for G.P.’s, PHN’s and other professionals who have direct contact with pregnant women and new mothers’. This would enable them to identify early indicators that a mother may be experiencing PND. We recommend the Chairperson of PND Ireland ensure these professionals are provided with posters and leaflets containing this information.

- PHN's should be risk-aware not risk-averse when working with mothers with PND. Constructing PND as a risk to a child or child development diminishes the effectiveness and potential of this service to address public health issues such as PND. If mothers with PND perceive that they are being observed or identified as a risk they will hide the true nature of their difficulties. We recommend the Chairperson of PND Ireland raises this issue with the PHN service.

- All support service providers should facilitate feedback from mothers with PND about the efficiency and effectiveness, or not, of their service provision. This evaluation would identify strengths and weaknesses and encourage accountability and responsibility among professionals. We recommend the Chairperson of PND Ireland encourages members of the support group to offer such feedback to any support service providers they have engaged with.

- Affordable cognitive behavioural therapy, psychology and counselling services and the services of community mental health nurses should be available to all mothers with PND. Crisis intervention teams should be accessible based on need not geographical location. We recommend the Chairperson of PND Ireland continue to source affordable therapeutic services and lobby for equal provision of services with local politicians.

**6.4 Recommendations for PND Ireland Support Group;**

Arising from the study the following recommendations will serve to enhance the effectiveness of the PND Ireland to provide support.

- **Frequency:** Weekly rather than monthly meetings and coffee mornings to better meet the needs of mothers with PND especially when they are in crisis.

- **Content:** Support group meetings to remain focused on providing support. Fundraising, media campaigns and other issues to be discussed at other times. Develop a stronger focus on recovery and positive coping skills. Levels of negativity to be monitored to prevent group contagion and increased feelings of despair or anxiety.

Group facilitation skills to be enacted allowing members present to have equal time to discuss issues of concern.

- **Peer Facilitators:** The Chairperson to create a data-base of members and past members willing to facilitate occasional meetings. We recommend the Chairperson to provide group facilitation training for volunteers.

- **Development:** In recognition of the value mothers with PND place on this support group, we recommend the Chairperson advocates for similar groups to be developed in other areas of Cork City and County.
  We further recommend that partners of mothers with PND be actively encouraged to attend group meetings or to explore the possibility of creating a dedicated mens' support group.
- **Structure:** The majority of interviewees cited the lack of awareness about PND. They stated a stronger, more visible presence would help alleviate this problem. We recommend that the Chairperson explores the potential for relocating her office and embedding it within the maternity unit, thereby raising awareness about PND and supports available.

### 6.5 Personal Reflection Deirdre Murphy

This study has been an enlightening experience for me. I was drawn to participatory research as I wanted to explore a topic and present findings which would be relevant to an organisation. PND Ireland and the topic for consideration appealed as I have a huge interest in mental health issues. Conducting a joint study with Helen was great. We were able to conduct an in-depth piece of research within a short time frame. Working together was a lovely, supportive experience.

My personal experience of the interviews with the mothers' interviewed will remain with me for a long time and will inform my future practice as a social worker. The pain, despair and distress they experienced when in the grip of PND, without knowing what PND was, and their epic journeys to and through recovery, was evident in every word spoken. Listening to them describe their quest for help, for support and their subsequent experience of support services made me angry at times.

I could feel their frustration and could empathise with their utter confusion, when the professionals involved could not correctly identify their condition, nor could their partners, family or friends. Everyone knew something was wrong, but what? This confirmed to the mothers that, yes, they were going mad and their lives will always have an absence of joy.

From the first interview I felt a responsibility towards the mothers to carry out this study to the best of my abilities. Many, many hours were spent analysing and informing myself about the myriad issues which emerged.

Early in the study, my book bag broke whilst boarding a bus. Out tumbled six books. *Madness and women, mad women, feminism etc.* The look on the faces of the young men who picked them up, and their silent surveillance of me for the journey, gave me a glimpse into how women and madness are experienced.

After the first interview, the young mother asked did I have PND previously as she felt I had a knowledge and empathy about the subject. This was something Helen and I had discussed, had we experienced PND? We both had large families and knew what it felt like to be overwhelmed by caring responsibilities at times, particularly times of stress. By the last interview I knew, having listened to the harrowing details of PND and how it is experienced what the answer was.

*Deirdre*

**6.6 Personal Reflection Helen Skinner**

As a component of the BSW I was required to undertake a research dissertation. As this was my first experience of producing a piece of work on this scale it was a challenge. The opportunity to work with a CSO and CARL gave me focus to complete a worthwhile study. The participatory research allowed me to engage with mothers who had experienced Post Natal Depression and PND Ireland, an experience which has proved invaluable in my understanding of the meaning of research from the lived experiences of sample group. Completing this research with Deirdre enhanced the experience for me as I had great support and enjoyment in the combined effort to produce the final thesis. Co-working also emphasised the value of peer support at times when we were challenged and sometimes tired.

Prior to conducting the research I thought I was well informed about PND.

Being a mother of a large family, having faced certain difficulties and stresses in raising my children allowed me to empathise with the mothers we interviewed in relation to the burdens and responsibilities of motherhood, but I soon became aware that having theoretical knowledge about PND does not compare to the lived reality.

This experience, for me, embarking on a future in social work, will remain with me. It will serve as a reminder that what I see on the outside may be a shield for something much deeper

The mothers we interviewed shared their personal stories, honestly and willingly. They described their pain, fear and feelings of despair with such emotion and clarity. They inspired me with their strength and determination to recover. When they had hope, they gripped it and didn't let it go.

*Helen*

### 6.7 Conclusion

This research has achieved its aims. We set out to gain an understanding of the experience of PND support services for mothers in Cork. In doing so, we questioned why services were experienced in this manner? What this exploratory research revealed is the discriminatory manner of some support service provision. They are located in specific geographical locations or attached to psychiatric services. How does this influence how we conceptualise mothers requiring services? Do they have to be experiencing socio-economic deprivation or have mental health difficulties? The services available to all mothers, G.P.'s and PHN's were perceived by most of the mothers interviewed as unhelpful to them personally, due to their implicit sense of being judged and assessed. Some of the mothers interviewed benefited greatly from the PND Ireland support group, where they received emotional support, especially the mothers who had little emotional support elsewhere. There are many issues highlighted within this report which would benefit from further research and add to this initial exploratory study.

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# Appendix 1

## Questions for interviews with mothers

**Family background**

1) Who lives here with you?

**Post Natal Depression**

2) When did you first realise you were struggling? - What did you think was going on? Describe what was happening for you
3) What did you do when you realised you were struggling?
4) What supports did you have?
5) What supports did you need?
6) How did you access them?
7) What was your overall experience of support services?
8) What did you find helpful?
9) What did you find unhelpful?

**Current situation**

10) How are you now?
11) Are you still using support services?
12) What would you find useful to have in place before and after birth to support mothers?
13) Any other comments

# Appendix 2

## Consent Form

I……agree to participate in PND Ireland and CARL research study conducted by Deirdre Murphy and Helen Skinner.

The purpose and nature of the study has been explained to me.

I am participating voluntarily.

I give permission for my interview with Deirdre and Helen to be tape-recorded

I understand that I can withdraw from the study, without repercussions, at any time, whether before it starts or while I am participating.

I understand that I can withdraw permission to use the data within two weeks of the interview, in which case the material will be deleted.

I understand that anonymity will be ensured in the write-up by disguising my identity.

subsequent publications if I give permission below:

(Please tick one box :)

I agree to quotation/publication of extracts from my interview

I do not agree to quotation/publication of extracts from my interview

Signed……. Date…….

# Appendix 3

## Information Sheet

### *Informed Consent Form for Research Participants*

**Purpose of the Study:** As part of the requirements for Bachelor of Social Work (BSW) degree at UCC, we have to carry out a research study. The study is concerned with exploring mother's experiences of supports for Post Natal Depression in Cork, Ireland.

**What will the study involve?** The study will involve interviewing mothers in relation to supports and their experience of them.

**Why have you been asked to take part?** You have been asked because you have experienced post natal depression.

**Do you have to take part?** Taking part is voluntary, you will be asked to give consent for interview and use of information in final report.

**Will your participation in the study be kept confidential?** It will be confidential in that we will not share your personal details with anyone else. Sample quotes will be used in the final report but will be anonymous.

**What will happen to the information which you give?** The information collected will be kept confidential from others, including college staff and community organisation (PND Ireland) for the duration of the study. Names and other personal details will not be shared or published.

**What will happen to the results?** The results will be presented in the thesis. They will be seen by our supervisor, a second marker and the external examiner. The thesis may be read by future students on the course. The study will be published on the internet in conjunction with Community Academic -Research Links (CARL) and UCC. It will also be presented to PND Ireland.

**What are the possible disadvantages of taking part?** We don't envisage any negative consequences for you in taking part. It is possible that talking about your experience in this way may cause some distress.

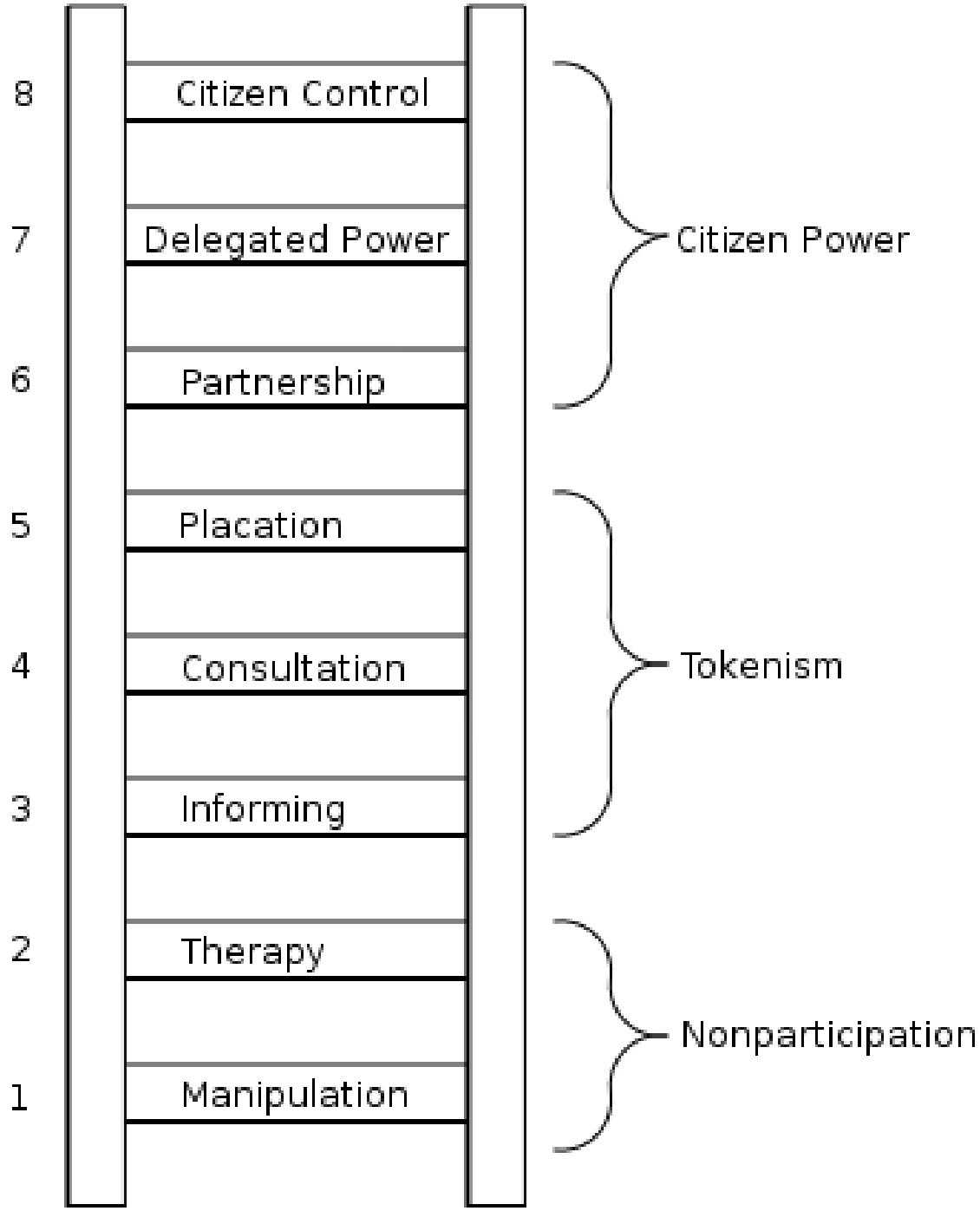
**What if there is a problem?** At the end of the interview we will discuss with you how you found the experience and how you are feeling. If you subsequently feel distressed, you should contact PND Ireland or family / friends for support.

**Who has reviewed this study?** This study has been reviewed by our supervisor and CARL committee, ethical consideration has been given to all aspects of the study.

**Any further queries?** You can contact us: Names and contact numbers provided.

# Appendix 4

**A Ladder of Citizen Participation** Arnstein, Sherry R.



# Appendix 5

## Questions for professionals

**1)** What is your role in this service?

**2)** What do you think are the main needs of women, what are they struggling with?

**3)** At what stage do mothers present with symptoms?

**4)** What supports can this service offer for mothers with PND?

**5)** What is the focus of your intervention?

**6)** In your professional opinion, what interventions work?

**7)** In your professional opinion can any interventions be unhelpful?

**8)** How long would the average intervention last?

**9)** Would you recommend any other supports beyond this particular service, if yes which ones?

# Appendix 6

## DSM-IV Diagnosis*

The DSM-IV does not recognize postpartum depression as a separate diagnosis; rather, patients with a diagnosis of postpartum depression must meet the criteria for both major depressive episode and the criteria for the postpartum onset specifier.

Criteria for Postpartum Onset Specifier:

Onset of major depressive episode must be within 4 weeks after delivery.

Criteria for Major Depressive Episode:

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least 1 of the symptoms is either 1) depressed mood or 2) loss of interest or pleasure. (Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.)
    1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (eg, appears tearful)
    2. Markedly diminished interest in pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
    3. Significant weight loss when not dieting or weight gain (eg, change of more than 5% body weight in a month), or decrease or increase in appetite nearly every day
    4. Insomnia or hypersomnia nearly every day
    5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
    6. Fatigue or loss of energy nearly every day
    7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either subjective account or as observed by others)
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B. The symptoms do not meet the criteria for mixed episode (p. 365 DSM-IV)
C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning
D. The symptoms are not due to the direct physiological effects of a substance (eg, a drug of abuse, medication) or a general condition (eg, hypothyroidism)
E. The symptoms are not better accounted for by bereavement, ie, after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation

*American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders DSM-IV TR (Text Revision)*. Arlington, VA: American Psychiatric Association; 2000. {Accessed 15/04/2013}

# Appendix 7

**Interviews with Mothers who Experienced PND.**

Interview 1. Home. 9/04/2013. 10am-12pm.

Interview 2. Home. 10/04/2013. 10am-12pm.

Interview 3. Home. 10/04/2013. 1pm-2.30pm.

Interview 4. Home. 10/04/2013. 7.30pm-9pm.

Interview 5. Home. 12/04/2013. 12pm-2pm.

Interview 6. Home. 12/04/2013. 4pm-6pm.

Interview 7.Home. 16/04/2013. 9.30am-11pm.

Interview 8. Home. 16/04/2013. 3pm-5pm.

Interview 9. Home. 18/04/2013. 9.30am-11.30am.

# Appendix 8

**Interviews with Professionals providing Support Services**

Interview 1. Office. 4/04/2013. 10.30am-12pm.

Interview 2. Office. 8/04/2013. 4.30pm-5.30pm.

Interview 3. Office. 16/04/2013. 12pm-1pm.

Interview 4. Office. 18/04/2013. 12.30pm-1.30pm.

Interview 5. Office. 26/04/2013. 2pm.-3pm.

# Edinburgh Postnatal Depression Scale [1] (EPDS)

Name: _____ Address: _____
Your Date of Birth: _____ _____
Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.
Here is an example, already completed.
I have felt happy:
Yes, all the time
Yes, most of the time This would mean: "I have felt happy most of the time" during the past week.
No, not very often Please complete the other questions in the same way.
No, not at all
In the past 7 days:
1. I have been able to laugh and see the funny side of things *6. Things have been getting on top of me
As much as I always could Yes, most of the time I haven't been able
Not quite so much now to cope at all
Definitely not so much now Yes, sometimes I haven't been coping as well
Not at all as usual
2. I have looked forward with enjoyment to things No, I have been coping as well as ever
As much as I ever did
Rather less than I used to *7 I have been so unhappy that I have had difficulty sleeping
Definitely less than I used to Yes, most of the time
Hardly at all Yes, sometimes
Not very often
*3. I have blamed myself unnecessarily when things No, not at all
went wrong
Yes, most of the time *8 I have felt sad or miserable
Yes, some of the time Yes, most of the time
Not very often Yes, quite often
No, never Not very often
No, not at all
4. I have been anxious or worried for no good reason
No, not at all *9 I have been so unhappy that I have been crying
Hardly ever Yes, most of the time
Yes, sometimes Yes, quite often
Yes, very often Only occasionally
No, never
*5 I have felt scared or panicky for no very good reason
Yes, quite a lot *10 The thought of harming myself has occurred to me
Yes, sometimes Yes, quite often
No, not much Sometimes
No, not at all Hardly ever
Never
Administered/Reviewed by _____ Date _____

[1] Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

[2] Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

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authors, the title and the source of the paper in all reproduced copies.
No, most of the time I have coped quite well

# Edinburgh Postnatal Depression Scale [1] (EPDS)

Postpartum depression is the most common complication of childbearing. [2] The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal"
depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS
score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the
diagnosis. The scale indicates how the mother has felt ***during the previous week***. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or
personality disorders.
Women with postpartum depression need not feel alone. They may find useful information on the web sites of
the National Women's Health Information Center <www.4women.gov> and from groups such as Postpartum
Support International <www.chss.iup.edu/postpartum> and Depression after Delivery
<www.depressionafterdelivery.com>.

# SCORING

**QUESTIONS 1, 2, & 4 (without an *)**

Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

**QUESTIONS 3, 510**

**(marked with an *)**

Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30

Possible Depression: 10 or greater

Always look at item 10 (suicidal thoughts)

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names of the authors, the title, and the source of the paper in all reproduced copies.

## Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.
2. All the items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

[1] Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

[2] Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199