

**MAJOR RESEARCH PROJECT**

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**Experiences of mothers who disclose symptoms of  
postnatal depression**

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of the requirements of the degree of Doctor in Clinical Psychology

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**You've got the words to change a nation  
but you're biting your tongue  
You've spent a life time stuck in silence  
afraid you'll say something wrong  
If no one ever hears it how we gonna learn your song?  
So come on, come on  
Come on, come on...**

**...You've got a heart as loud as lions  
So why let your voice be tamed?  
Baby we're a little different  
there's no need to be ashamed  
You've got the light to fight the shadows  
so stop hiding it away  
Come on, Come on...**

**...Yeah we're all wonderful, wonderful people  
so when did we all get so fearful?  
Now we're finally finding our voices  
so take a chance, come help me sing this...**

**[Read All About It - Emeli Sandé](#)**

**[\(Barnes, T., James, I., Kelleher, P., Kohn, B., Manderson, S., & Sandé, A., 2011\).](#)**



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To my Mum, thank you for helping me to become the mother I am today. Thank you for sharing with me your experiences of becoming a mother yourself and for guiding me and protecting me throughout my own journey into motherhood.

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## 1.0 ABSTRACT

**Background:** Whilst previous research has explored women's experiences of disclosing symptoms of postnatal depression (PND) to health professionals, very little qualitative research exists on women's experiences of disclosing to people in their personal support networks. Research has shown that some mothers with PND find it difficult to disclose to professionals and prefer to seek support from partners, family and friends. **Aim:** The current study aimed to explore the overall process mothers go through to disclose PND - to people with whom they have personal relationships, as well as health professionals. **Method:** Five women who experienced and disclosed PND participated in semi-structured interviews. Verbatim transcripts were analysed using Interpretative Phenomenological Analysis. **Results:** The analysis produced four super-ordinate themes: 'Trying to cope whilst making sense of experiences', 'Deciding whether to disclose: Facilitative and inhibiting factors', 'The two-way interpersonal nature of disclosure', 'Disclosure as part of a transformative process'. **Conclusions:** This study highlighted the influence of internalised expectations of motherhood and stigma surrounding PND on how mothers try to cope with their initial symptoms and on their decisions about whether or not to disclose. The participants described a cautious approach to disclosure in which they had to deal with setbacks. Consequences of disclosing were considered alongside how the disclosure process was influenced by recovery from PND.



## 2.0 BACKGROUND TO THIS STUDY

### 2.1 How I came to this study

I came to this study with my own set of beliefs, values and experiences of motherhood. As an Insider Researcher conducting research within a population to which I belong (Kanuha, 2000), and in line with the epistemology of qualitative research and the practice of self-reflexivity, I have chosen to acknowledge the impact my position may have had on my relationship with the data (Webb, 1992). I have therefore written in the first person, rather than using the more formal approach of writing from the viewpoint of the 'researcher'.

#### 2.1.1 Personal stance

My own experience of becoming a mother primarily informed my interest in this area. Towards the end of my first period of maternity leave from the Clinical Psychology doctoral course at the University of Hertfordshire, I was required to submit a Major Research Project proposal. At that stage, I was engrossed in motherhood. My emotional journey through new motherhood and the lived experiences of other new mothers around me fascinated me. Whilst I did not suffer from *postnatal depression* (PND), I found certain aspects of new motherhood emotionally challenging (e.g. feeling let down by a family member, and postnatal medical complications), and struggled to speak out about my emotions as a mother within a society that constructed motherhood as idyllic. Consequently, I began to develop a number of project ideas on motherhood and emotional difficulties.

The process of filtering ideas to establish a focus for my research began by reflecting on my own conversations with other mothers in personal and public contexts, alongside issues in wider British society. Through this process I became aware of the emotional difficulties expressed by the women I spoke to, each unique to the individual. However, a common theme was the struggle to disclose those difficulties to other people, including people in their personal support networks, particularly whilst they were in the midst of their difficulties. I became curious about factors that hinder disclosure of emotional difficulties for new mothers and the experience of disclosure within personal contexts. I was aware that disclosure was a reoccurring issue on blogs and websites about PND. Moreover, at that time there were numerous media reports about the impact of non-disclosure following a case in which a

mother with PND had not sought help for her condition and had killed her two children (Davies, 2011; Figs, 2012; Topping, 2012). Subsequently, I carried out a search of published literature on the topic of disclosure of PND. Whilst some literature existed on disclosure to health professionals, there was a clear gap in the knowledge base about disclosure to non-professionals, namely friends and family members. Therefore, understanding the whole disclosure process for women seeking help for PND became the focus of my research.

### 2.1.2 Literature search

An in-depth systematic literature search was undertaken over a three-year period (May 2012 – May 2015), ensuring comprehensive coverage of the relevant topics and minimising the potential for bias. Key psychological, medical, social science and academic electronic databases were utilised, including: Google Scholar, Web of Science, Scopus, Psyc Info, Medline and Science Direct. Search terms including ‘postnatal depression’ and ‘postpartum depression’ were used in combination with a variety of other terms linked to the different sub-sections of the literature review (see section 3.0)<sup>1</sup>. The literature search identified published journal articles and books, documents published by registered organisations (e.g. charities) and the UK government, and media reports on PND. When the available literature was limited (e.g. when it was a niche or novel area, such as models of disclosure, or national campaigns regarding mental health) reference lists of key journal articles and books were searched and consultations undertaken with the authors of relevant publications to identify additional relevant literature. Throughout the literature search process, supervisors and peers were consulted (e.g. qualified psychologists) about sources of information.

Informed by this initial search to establish a research focus, the following criteria were applied to the literature search:

Inclusion criteria:

- Papers published in English (or where translations were available)
- Peer reviewed journals
- Due to the vast extent of literature and theories related to depression, the literature search specifically focused on PND.

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<sup>1</sup> Terms included: motherhood, construction, transition, identity, definition, diagnosis, stigma, help-seeking, social support, peer support, risk factors, prevention, impact, treatment, disclosure, barriers, family, partners, health professionals, and attachment.

- Focus was also placed on theories and models related to disclosure as this process is the focus of the current study.

Exclusion criteria:

- Studies of mothers with other postnatal clinical disorders e.g. Post Traumatic Disorder
- Studies of paternal PND
- Studies looking at specific populations e.g. single or teenage mothers

In order to narrow down the identified literature, Abstracts and introductions were studied to narrow down the literature further establishing its relevance to the research question. The initial list of search terms used for a review of the literature (section 3.0) was extended and further literature was reviewed in order to inform understanding of the study's findings, particularly those which were novel (e.g. literature on entitlement) – see section 6.0.

The literature search highlighted that the majority of research on PND has focused on Western cultures (Brunton, Wiggins, & Oakley, 2011; Darvill, Skirton, & Farrand, 2010). To establish homogeneity within the study sample, I recruited mothers describing themselves as British (section 4.3.2). Therefore, studies carried out within Western cultures formed the key focus of the literature review. However, I also considered literature on mothers from other cultures, to allow comparison and to reflect the generalizability of findings in the literature base.



## 3.0 INTRODUCTION

### 3.1 Overview

This section forms a summary of the literature I reviewed in order to gain a comprehensive understanding of the topic and identify gaps in the literature, which enabled me to formulate an appropriate research question<sup>2</sup>.

The review begins with a consideration of the paradoxical nature of new motherhood in order to understand possible emotional experiences within this period. As with all clinical disorders, Postnatal depression (PND) may be a socially constructed phenomenon. After reviewing current clinically definitions, focus is placed on the importance of facilitation for mothers' disclosures and accurate screening, in order to reduce its potential impact on mothers, infants, partners and family units. Throughout the review, consideration is given to the social, relational, and political contexts surrounding PND and the review ends with a look at how these contexts can influence mothers' experiences and processes of disclosing symptoms of PND to family, friends and professionals.

### 3.2 Motherhood: Setting the scene

#### 3.2.1 Transition to motherhood

In order to understand why some mothers develop depression in the postnatal period, it is important to consider mothers' reported experiences of the transition to motherhood. The literature describes new motherhood as a major 'life-cycle transition' (Mercer, 1986; Schumacher & Meleis, 1994). It begins in pregnancy and continues for many months after the birth (Mercer, 2004). The transition can involve significant changes to a woman's life: socially, emotionally, mentally, physically and economically (Gittins, 1993).

A number of researchers and authors have started to identify the paradoxes associated with new motherhood (Bailey, 2000; Brunton et al., 2011; Darvill et al., 2010; Nicolson, 1999).

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<sup>2</sup> Throughout the review, I considered the robustness of the evidence due to my awareness of publication bias (Sterne, Egger, & Smith, 2001) and the different levels of evidence (Wright, Swiontkowski, & Heckman, 2003).

Nicolson (2001) stated that new mothers may experience positive and negative changes and losses simultaneously, identifying the following paradoxes associated with motherhood:

- enjoyment *and* restriction of a child's dependency;
- giving *and* receiving of love alongside social isolation;
- a great sense of pride and achievement, *whilst* feeling overwhelmed with responsibility for the health and development of another human being;
- establishing new friendship groups and feeling a closer connection to some family members and friends, *whilst* feeling let down or distant from others; and
- A sense of freedom from the regimented routines of paid employment, *whilst* feeling chaotic and out of control in the more fluid rhythms of life as a new mother

Indeed, in a study by Weaver and Usher (1997), women described how more positive aspects of new motherhood (e.g. the overwhelming love they experienced for their children) counterbalanced more negative aspects (e.g. the drudgery of caring for infants). However, women have reported feeling unable to talk about the negative aspects, choosing instead to fake a display of happiness (Edwards & Timmons, 2005; Nicolson, 2001; Vik & Hafting, 2012), as exemplified in the following quote<sup>3</sup>:

*"Parenthood is a seething pit of paradox... The biggest contradiction of all is that motherhood is a shockingly lovely state, yet childcare is a spectacularly ghastly activity. We're not supposed to admit it. Recently, however, I've taken to blurting confessions. People are startled."*

Briscoe (2001)

Both paradoxical losses associated with motherhood and conflicts between expectations and reality have been identified in Western and non-Western cultures (Liamputtong, 2006; Liamputtong & Naksook, 2003; Liamputtong, Yimyam, Parisunyakul, Baosung & Sansiriphun, 2004). In a study by Mauthner (1998), women reported that their recovery from PND involved acceptance and resolution of the conflicts they experienced during this transition. Nicolson (2001) stated that paradoxical losses surrounding motherhood needed acknowledgment and mourning for women to recover from them. Whilst the typical stages of grief (e.g. denial,

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<sup>3</sup> The above quote is from an article in The Guardian newspaper and is included to exemplify research evidence. Whilst I am aware that newspaper articles constitute evidence, they are influenced by the perspective of one person (journalist) within a specific context and so form a lower *level* of evidence.

anger, bargaining, depression and acceptance; Kubler-Ross, 1969) are viewed as socially acceptable in contexts beyond widowhood (Archer, 1999), the opportunity for grief in postnatal women is not (Nicolson, 2001). Surely if it is not socially acceptable to grieve for the losses experienced in motherhood, then women might be less likely to disclose the distress these cause.

### **3.3 Postnatal Depression**

Studies highlighting the paradoxical nature of motherhood identify the physical, practical, and psychological challenges of motherhood, which can play a role in the development of emotional difficulties in some women in the postnatal period (Lupton, 2000). This section begins by looking at the problems associated with current definitions of postnatal depression (PND), which is essentially a socially constructed phenomenon. Consideration is then given to difficulties screening mothers for the condition and thus establishing accurate prevalence rates, with reference to social-contextual influences on disclosure such as stigma. With a continued focus on the social and relational contexts in which mothers reside, the potential impact of PND on mothers, infants, partners and family units is explored, which leads into a review of current treatments designed to prevent / reduce the impact of PND.

#### **3.3.1 Definition**

For the purpose of this study, it is important to consider how Postnatal Depression (PND) is constructed within the social, relational, political and cultural contexts within which mothers reside. PND is currently defined in the Diagnostic and Statistical Manual of Mental Disorders (5<sup>th</sup> edition) (DSM-V: American Psychiatric Association, 2013) and International Statistical Classification of Diseases and Related Health Problems (10<sup>th</sup> edition) (ICD-10; World Health Organisation, 1992), as a major depressive episode occurring within the first 4 or 6 weeks following childbirth, respectively. However, a number of issues have arisen with these definitions, including: period of onset; defining features; the cut-off between postnatal blues and PND; and inconsistent findings regarding convergent validity – see Appendix 1. Therefore, despite a vast amount of research in this area, the term ‘postnatal depression’ remains problematic. On a theoretical level, there is discussion as to whether PND should be classified as a *disease* or a *social construction* (Thurtle, 1995).

The lack of a clear operational definition of the condition and current definitions not matching lived experiences of mothers with PND, may have contributed to the condition being underreported and branded the 'hidden depression' (Nicolson, 1998); perhaps because mothers and clinicians find it difficult to identify (Pope, Watts, Evans, McDonald & Henderson, 2000; Stewart, Robertson, Dennis, Grace, & Wallington, 2003).

### 3.3.2 Prevalence and screening

A meta-analysis of 59 studies, reported that PND was prevalent in 13% of cases in the first few months after births (O'Hara & Swain, 1996). However, research has suggested that the underreporting of PND may mean prevalence rates are significantly higher than this (Beck, 2006; Hendrick, 2003). It is therefore important to consider how mothers are currently screened for PND and how PND can go undetected.

Compared to the non-postpartum population, new mothers have increased exposure to health professionals in the postnatal and antenatal periods, meaning greater opportunities to identify and manage mild, moderate and severe mental illness (Tait & Heron, 2010). Whilst early detection and management of PND in primary care settings is important for improving health outcomes (Tait & Heron, 2010), detection can be complicated by some of the normal physical and emotional demands of new motherhood, such as sleep deprivation, low energy, changes in appetite, and heightened concern for the infant (Fitelson, Kim, Scott Baker, & Leight, 2011).

Given the challenges faced in identifying PND, researchers have developed measures to facilitate this process. However, there is debate regarding the use of measurements to identify PND. Indeed, whilst measures such as the Edinburgh Postnatal Depression Scale (EPDS: Cox, Holden, & Sagovsky, 1987) can be helpful in making a diagnosis, many women report giving unreliable responses due to the stigma surrounding PND. Instead, they have expressed a strong preference for talking about their feelings, rather than ticking boxes (Shakespeare, Blake & Garcia, 2003). Nevertheless, as it has been translated and validated within different cultures there is an advantage in using the EPDS (Cox & Holden, 1994; Rodrigues, Patel, Jaswal & de Souza, 2003).

Further, unless informed health professionals in primary care settings ask specific questions PND may be missed (Holden, 1996; Sharp, 1996). This is a dilemma as the medical language used by healthcare workers and in diagnostic tools may not reflect the sufferer's illness experience, thus inhibiting communication between the practitioner and the sufferer (Williams & Calnan, 1996), potentially contributing to the underreporting of PND (Hendrick, 2003).

#### 3.3.4 Potential impact of PND

The importance of accurate screening for PND by health professionals and the need to facilitate mothers' disclosures in both personal and professional contexts is highlighted by research illustrating the potential impact of maternal PND on the mother, infant, partner and family.

##### Impact on the mother

PND can create significant suffering for a mother at a time when personal or societal constructs of motherhood as a uniquely joyous, if somewhat tiring, experience may be incongruous with her ability to feel gratification in her new role, bond with her baby or carry out the daily tasks of caring for a new baby (O'Hara, 2009). This disconnect can reinforce her sense of isolation, guilt, helplessness and hopelessness, characteristics of the depressed state, which can perpetuate symptoms (Fitelson et al., 2011). For some women, PND can persist over long periods and be associated with recurrent depressive episodes, resulting in long-term suffering (Cooper, Murray, Wilson & Romaniuk, 2003; Josefsson & Sydsjo, 2007; Nylén et al., 2010). Indeed, one study found that women who experienced PND were twice as likely to experience further episodes of depression over a subsequent 5-year period (Cooper & Murray, 1995).

##### Impact on the infant

According to attachment theory (Bowlby, 1969; 1973; 1980), secure attachment bonds between mother and infant are crucial in establishing a secure base from which the infant can begin to explore the world (Bowlby, 1988), and this plays a role in facilitating healthy behavioural, cognitive, social and interpersonal development in the infant (Miller, 1999).

When PND influences how mothers behave and communicate with their infants (Arteche et al., 2011; Flanagan, White & Carter, 2011; Righetti-Veltema, Conne-Perreard, Bousquet, & Manzano, 2002), insecure attachments may develop (Tronick & Weinberg, 1997). Impairment of early mother-infant interaction and attachment reportedly mediates associations between PND and developmental problems in children from infancy to age sixteen (Cummings & Cicchetti, 1990; Murray, Cooper, Wilson, & Romaniuk, 2003; Murray, Fiori-Cowley, Hooper & Cooper, 1996; O'Hara & McCabe, 2013) – see Appendix 3. Indeed, preventative interventions aimed at improving the early parent-child relationship and mind-mindedness have appeared to reduce the negative impact of PND on infant development (Cicchetti, Rogosch & Toth, 2000; Kondel-Laws, Parkinson, Hensman & Laws, 2012).

Such findings emphasise the importance of mothers being able to disclose emotional difficulties and gain support. However, a silencing factor in this disclosure process may be an ongoing focus in the literature and media on the mediating role of mother-infant attachment thus perpetuating *mother-blaming* (see section 3.4.2). Feminist critiques of attachment theory have highlighted its failure to consider: the role of the wider social context in development; the infant-mother relationship occurring within the context of other relationships and social formations; primary attachment figures other than the mother; the possibility of multiple attachment figures; or the influence of later life experiences (Bronfenbrenner, 1979; Field, 1996; Jordan, 1997; Woollett & Phoenix, 1991). There is a wider relational context and this in turn can influence the disclosure process. Belsky (1984) and Sroufe (1988) suggested that the quality of care a mother can provide her infant is directly related to factors such as social support, her own childhood history, preparation for motherhood, and work and family factors, which challenges the concept of mother-blaming.

#### Impact on the partner

In a qualitative study by Meighan, Davies, Thomas and Droppleman (1999), partners of depressed mothers described their lived experiences with their partners as “the world collapses”, and that their partner’s PND “is a real crisis”. Internationally, studies have reported elevated rates of depression and other psychological disorders in male partners of depressed mothers that tends to occur some months *after* the onset of their partners’ PND (Boath, Pryce, & Cox, 2007; Lovestone & Kumar, 1993; Morse, Buist, & Durkin, 2000; Soliday, McClusky-Fawcett, & O’Brien, 1999); this time lapse may have represented an interactional process

occurring. Indeed, studies looking at the lived experiences of partners of depressed mothers have highlighted their exposure to a greater number of risk factors for developing psychological difficulties (Boath et al., 2007; Milgrom & McCloud, 1996; Zerkowitz & Milet, 1996; 1997). Interestingly, within the context of the current study, a key risk factor was a loss of social support.

Partners of women with PND have to adapt to the distress of their partners at a time when they are adapting to their own new role and identity in the transition to fatherhood, and to the presence and demands of their new baby (Davey, Dziurawiec & O'Brien-Malone, 2007). Further, for many men, their partner had previously been their main source of social support (Harvey & McGrath, 1988). Such a loss is heightened by perceived stigma that can increase spouses' reluctance to seek support from others (Meighan et al., 1999) and a view that there is little acknowledgement of the effect of PND on the father as well as the mother, with treatments aimed at mothers (Boath et al., 2007).

Paternal emotional difficulties may add to the adverse impact of maternal PND on the psychological wellbeing and development of offspring (Lovestone & Kumar, 1993). It may also impede a mother's communication and disclosure, which may have serious consequences, especially considering partners tend to be an important and initial source of support (Dennis & Chung-Lee, 2006).

### Impact on the family

Maternal PND can have a significant impact on the family unit. A number of studies have found an increased level of self-focus in mothers with PND and decreased focus on family-related goals (Salmela-Aro, Nurmi, Saisto & Halmesmaki, 2001). Studies that have looked at 'family burden' aimed to measure 'the effect of the patient upon the family', which can be extensive (Goldberg & Huxley, 1980). People living with patients with psychiatric disorder frequently have symptoms of psychiatric disorder themselves (Kuipers, 1992). The increased attention that mothers with PND require from their partners, combined with some mothers' reluctance to leave the home or be alone, has implications for partners and children in terms of missing work or school, social events, and leisure opportunities (Boath et al., 2007). Witnessing the suffering of a mother and feeling unable to help her can result in helplessness, low mood, and

increased stress in all family members (Boath et al., 2007). Clearly, there is a relational interaction at play here with all factors potentially influencing the disclosure process.

### 3.3.5 Treatment

Studies reporting the potential widespread impact of PND highlight the importance of mothers feeling able to disclose their symptoms to other people within personal and professional contexts. Disclosure is a prerequisite for support. In a professional context, this support may include a range of pharmacological, psychotherapeutic and psychosocial interventions, and other non-pharmacologic interventions, aimed at preventing or treating PND (Fitelson et al., 2011).

As with successful treatments for depression, psychological and psychosocial treatments include nondirective counselling, cognitive behavioural therapy (CBT) and interventions that address relational/social contexts e.g. Interpersonal Therapy (IPT), peer and partner support. These treatments have the advantage of removing risks of exposure to medications and the perceived stigma of being seen as a “bad mother” for requiring medication (Dennis & Hodnett, 2007; Sit, Perel, Hessel & Wisner, 2008; Turner, Sharp, Folkes & Chew-Graham, 2008).

In recent years, there has been considerable focus on the efficacy of peer support groups. This stems from research indicating mothers with PND preferred to speak to other mothers who have disclosed similar problems (Brugha et al., 1998; Caramlau, Barlow, Sembi, McKenzie-McHarg, & McCabe, 2011). Further, the NHS Expert Patient Report (Department of Health, 2004) recommended the development of lay-led self-management training programmes in order to make use of the knowledge and experiences of patients. Studies have indicated that peer support interventions can offer all three types of support (emotional, instrumental, and information; Robertson et al., 2003) and are effective in reducing depressive symptoms in mothers with PND and in preventing PND in high-risk women (Dennis, 2003; Dennis et al., 2009).

In the United Kingdom, The National Institute for Health and Clinical Excellence (NICE: 2014) guidelines has recommended that mild to moderate symptoms of PND be managed within primary care with high-intensity psychological interventions (e.g. CBT) and/or medication as a first-line treatment (Tait & Heron, 2010). For mothers suffering from severe PND or

puerperal psychosis, NICE has recommended inpatient care in specialist Mother and Baby Units. Facilitated self-help is recommended for women with persistent sub-threshold depressive symptoms, or mild to moderate depression. A lower severity threshold for treatment in the perinatal period has also been recommended due to the evidence for the adverse long-term impact on infants, mothers and partners (section 3.3.4) (Tait & Heron, 2010). However, Tait and Heron (2010) stated that in the current economic climate, the most cost-effective and clinically effective method of providing access to psychological support is unclear. Interestingly, it would appear that the recommended treatments do not necessarily address relational and social contexts; this potentially contributes to individualising discourses that locate the problem (and blame) within mothers, and thus may contribute to the stigma of PND, as explored in the next section.

### **3.4 Postnatal depression in a social context**

PND has traditionally been conceptualised as a medical condition – an ‘illness’ – and predominantly been explained by a medical model (O’Hara & Zekoski, 1988). However, the medical model has been criticised for its individualistic approach, regarding PND as a pathological condition rooted in deficiencies pertaining to the individual mother, paying less attention to the position a mother holds within a social, cultural, political and historical context and, therefore, the influence of these contexts on mothers’ experiences of having and disclosing PND (Mauthner, 1998). This section begins with a look at how women’s identities as mothers form within the contexts in which they reside, as suggested by social constructionist theory (Gergen, 1985). Accordingly, social constructions of motherhood and maternal mood will now be considered, and specific consideration given to the influence of these constructions and resulting stigma on disclosure of PND.

#### **3.4.1 A mother’s identity within a social context**

Early theories on identity (e.g. Erikson, 1968) proposed that identity is a fixed and tangible construct arrived at via progress through developmental stages. However, social constructionism has provided alternative theories (Bruner, 1990). For example, Gergen (2009) argued that identities are fluid, constructed and re-constructed in the everyday social interactions and relationships that occur within particular social, political and historical contexts. Therefore, as in any qualitative study, it is important to consider the contexts that

may have influenced the selves of the participants in the present study as mothers who experienced and disclosed PND within a Western culture.

#### 3.4.2 The social constructions of motherhood and postnatal depression

Feminist reviews<sup>4</sup> of the historical representations of motherhood in Western literature and popular press have suggested that these two sources have played a significant role in both shaping and representing social constructs of mothers and maternal mental health (Apple, 2006; Ehrenreich & English, 1978; Held & Rutherford, 2012; Walker, 2000). These reviews highlighted the social contextual factors that appeared to contribute to the pressure on women to *do motherhood* and present themselves to other people in certain ways, often in line with socially defined ideals. It is within these contexts that women make decisions about whether to disclose personal distressing experiences.

##### Social constructions of motherhood

Popular discourses around what it is to be a good mother, stem back to the mid-19<sup>th</sup> century when there was an emergence of 'scientific motherhood'; the idea that women required scientific and medical advice from professionals viewed as *experts* at child-rearing to help them raise their children healthily (Apple, 1995), reducing the authority and expertise of mothers (Held & Rutherford, 2012). The rise of mass print media allowed for wide-scale dissemination of this *expert* child-rearing knowledge (Grant, 1998). Stearns (2002) suggested that for many women throughout the 19<sup>th</sup> and 20<sup>th</sup> centuries, these strong social discourses on *good* mothering, coupled with the heavy practical demands of the job itself, made motherhood increasingly anxiety provoking.

Mid-20<sup>th</sup> century child-rearing experts were primarily rooted in the ideas of post-war psychoanalysts (e.g. Deutsch, 1944; Winnicott, 1953, 1957). These included a 'good versus bad' mother discourse and a model of mothering that involved an expectation of mothers to completely adapt to the needs of their infants, to the exclusion of their own needs and

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<sup>4</sup> Feminist literature provides a valuable critique of the social constructions of motherhood and postnatal depression. However, feminist writers take a particular stance, and it is important to consider alternative views on what they critique – for example, I was left wondering how some mothers may have benefitted from the literature associated with 'scientific motherhood' (e.g. acquired effective approaches to childcare, felt less anxious, etc.).

interests, thereby placing less importance on mothers as persons (Held & Rutherford, 2012). Held and Rutherford (2012) stated that Bowlby's work (Bowlby, 1969) placed pressure on mothers to create a secure attachment with their child by being consistently attuned to the child's deep-seated biological needs, in order for *normal* infant development to occur (see section 3.3.4 for a critique of attachment theory).

Across the second half of the 20<sup>th</sup> century, contradictory yet powerful messages regarding female roles contributed to increased tension between the ideology of the mother at home and the growing number of women needed in the post-war workforce (Hartmann, 1994; Margolis, 1984). There was an expectation for women to work *and* take care of the family (Bailey, 2000; Douglas & Michaels, 2004; Held & Rutherford, 2012). Antifeminists blamed working mothers for the tripling of divorce rates in Britain between 1960 and 1980 (Berry, 1993). Alongside this, contemporary 'pop' psychology and the self-help industry tended to focus on pathologising parental (predominantly maternal) behaviours (e.g. Bradshaw, 1988). Such factors placed pressure on mothers to meet socially constructed standards.

Towards the end of the 20<sup>th</sup> century, media representations of motherhood linked physical appearance and capabilities to the idea of a *good mother*. Some argued that representations of the *yummy mummy*, along with popular slogans such as *breast is best*, contributed to a stigma of *failed femininity* and *failed motherhood* for those mothers who could not live up to idealised standards (McRobbie, 2006; Wall, 2001). These socially constructed standards and expectations had the potential to be internalised by mothers and might therefore have influenced disclosure of experiences incongruent with idealised motherhood, such as depression.

#### Social constructions of maternal mood

Feminist interpretations of PND propose that social constructions of motherhood themselves have a causal link to the development of PND in new mothers. As with those of motherhood, social constructions of postnatal mood disturbances have changed across time (Held & Rutherford, 2012). Portrayals of the postpartum experience first received significant attention in the popular press in the 1950s. Articles at this time almost exclusively restricted discussions of postpartum malaise to a few days of 'baby blues', which they labelled a normal, self-correcting and temporary reaction (Held & Rutherford, 2012). The influence of psychoanalytic

theory at this time (e.g. Deutsch, 1944), meant a focus on changing individual mothers to make them *happy* again, rather than changing the motherhood ideal (Held & Rutherford, 2012). Psychoanalytic literature of this period began to define how the *normal* mother should feel as well as act (Deutsch, 1944). The literature portrayed a depressed mother as not adjusting to her new role, and blamed pre-existing character flaws for persistent postnatal mood disturbance rather than the stress of transitioning into new motherhood (McGowan, 1957).

With a growth of the pharmaceutical industry, the 1960s saw a shift from psychodynamic formulations that downplayed postnatal emotional difficulties to the introduction of a biologically-based psychiatric disorder termed 'postnatal depression' requiring pharmacological solution, portrayals of which began to appear in popular magazines (Herzberg, 2009; Tone, 2009). Unhappiness was characterised as a disease, thus the use of tranquilizers and antidepressants became heavily gendered (Herzberg, 2009); this is reflected in popular culture with the Rolling Stone's song "Mother's Little Helper" (Jagger & Richards, 1965), which mocked mothers for needing pills to get through the day. However, in juxtaposition, a motherhood experience was beginning to be recognised, named and voiced.

In a review of the popular press across the second half of the 20<sup>th</sup> century, Held and Rutherford (2012) illustrated an absence of any discourse acknowledging the paradoxical nature of new motherhood (section 3.2.1), despite it having been researched and documented by contemporary feminist writers (e.g. Abrams & Curran, 2009; Phoenix, Woollett, & Lloyd, 1991; and Nicolson, 1998, Taylor, 1996). Held and Rutherford (2012) concluded that unfulfilled expectations, unanticipated losses, and lack of support were insufficient in themselves to cause PND. They ended their review by suggesting that when motherhood becomes distressing, it is the role itself, not just the mother, which should be looked at seriously.

Studies comparing everyday constructions of depression in women in the literature and popular press showed the literature privileged biomedical and psychological expertise in explaining depression and promoting help-seeking, whereas magazines still tended towards an individualizing discourse about depression, pathologising and sensationalising postnatal affective disturbances (e.g. Gattuso, Fullagar & Young, 2005; Martinez, Johnston-Robledo, Ulsh & Chrisler, 2000).

The limited qualitative research on depression in motherhood in non-Western societies indicated that in some cultures PND was interpreted from social, cultural and relational contexts, removing the blame from mothers (e.g. Rodrigues et al., 2003). Due to its phenomenological nature, Interpretative Phenomenological Analysis (see section 4.2.3) and other qualitative research methodologies consider how constructions of PND vary according to social, political, historical and cultural contexts and how they influence disclosure.

### 3.4.3 PND - a socially stigmatised disorder?

Considering the social constructions and discourses of maternal mood further, feminist literature has attributed the perpetuation of stigma associated with PND to the *mother-blaming discourse* in popular press in Western societies (Held & Rutherford, 2012). Qualitative research studies have identified the main barrier to seeking earlier help for PND to be the stigma attached to an inability to cope and being a *bad mother* (McCarthy & McMahon, 2008). In recent years, people in the public eye have begun to discuss the role stigma played in their decision-making process regarding disclosure of PND (Page, 2013). In her book *Down Came the Rain: My Journey Through Postpartum Depression* (Shields, 2005), actress Brooke Shields spoke of the stigma of PND, commenting that if she had been diagnosed with any other disease, she would have sought help immediately.

It has been posited that stigma is a social construction that defines people in terms of a distinguishing characteristic or mark and devalues them as a consequence (Dinos, Stevens, Serfaty, Weich, & King, 2004). Thornicroft, Rose, Kassam, and Sartorius (2007) proposed that it comprises three elements: problems of knowledge (ignorance), problems of attitudes (prejudice), and problems of behaviour (discrimination). There is also a distinction between public stigma and self-stigma (Corrigan, 2005; Corrigan & Rao, 2012). Public stigma represents the prejudices and discrimination directed at a group with devalued characteristics by the larger population. Self-stigma occurs when people internalize these public attitudes and consequently experience numerous issues including low self-esteem and poor self-efficacy (Corrigan, Watson & Barr, 2006).

Experiences of individuals with overt stigmatised traits, e.g. being a member of a racially stigmatized group, are well researched (e.g. Clark, Anderson, Clark & Williams, 1999). Only recently have researchers begun to focus on the lived experiences of individuals with more

concealable stigmatised identities (personal information that is socially devalued but is not readily apparent to others), such as homosexuality or mental health problems (Pachankis, 2007; Quinn & Chaudoir, 2009; Serovich, Oliver, Smith, & Mason, 2005). The assumption was that they could hide their stigma and therefore escape the discrimination and prejudice faced by those with visibly stigmatised identities (Goffman, 1963; Jones, Farina, Hastorf, Markus, Miller, & Scott, 1984). However, Pachankis (2007) stated that individuals with concealable stigmatised identities face unique significant stressors, including: having to make regular decisions about whether to disclose their hidden identity; the anxiety associated with the possibility of being found out; being isolated from similarly stigmatized others; being detached from one's true self; and the efforts to conceal a stigma. This context now leads us on to direct considerations of disclosure of PND.

### **3.5 Disclosure of Postnatal Depression**

In order to seek support for PND, mothers must first disclose their symptoms to other people within social and relational contexts. However, the consequences of disclosing can involve risks as well as benefits. It is important to consider these consequences as expectations of these are likely to influence a mother's decisions about whether or not to disclose.

#### **3.5.1 Potential consequences of disclosing PND**

Self-disclosure is defined as an interpersonal process in which one expresses self-relevant aspects of themselves to others, including thoughts, feelings, and experiences (Derlega, Metts, Petronio & Margulis, 1993; Jourard, 1971). This section will present the potential risks and benefits of disclosing PND.

##### Potential risks: Disclosing stigmatized identities

As described above, for individuals with concealable stigmatized identities, such as PND, the decision to disclose is particularly complex as it may lead to harm as well as benefits (Pachankis, 2007; Quinn & Chaudoir, 2009). Fears of rejection, criticism, and stigma are some of the most commonly cited reasons for non-disclosure across a wide variety of identities (Ahrens, 2006; Black & Shandor, 2002; Chandra, Deepthivarma, Jairam, & Thomas, 2003; Clark, Lindner, Armistead, & Austin, 2003; Herek, 2009; Herrschaft & Mills, 2002; Pachankis, 2007; Quinn &

Chaudoir, 2009). As detailed in sections 3.5.3 and 3.5.4, disclosures of PND to other people in both professional and personal contexts are risky and may result in negative outcomes for the discloser.

#### Potential benefits: Disclosing emotional experiences

Theories of emotional disclosure (Rime, 1995; Stiles, 1987) have suggested that people are motivated to disclose emotional events to others. The majority of research looking at emotional disclosure focuses on intense emotional events. Interestingly, disclosures of everyday events (e.g. the practical, physical, relational, social, emotional challenges faced by new mothers) and prolonged emotional experiences (e.g. the transition to motherhood) receive less focus, despite these events being more strongly related to psychological symptoms than major life events (Kanner, Coyne, Schaefer, & Lazarus, 1981). Given the relevance to PND, we will now consider potential benefits of emotional disclosures.

#### *Individual consequences*

The emotional disclosure paradigm (EDP) associated better health with repeated disclosure of emotional experiences (Ellis & Cromby, 2009). Several research studies across cultures have found that talking about emotive experiences to people in social contexts improved emotional, cognitive and physiological adjustment to it, as well as the ability to cope with it (Jonzon & Lindblad, 2005; Lepore, Fernandez-Berrocal, Ragan & Ramos, 2004). It might also improve their self-esteem (e.g. Afifi & Caughlin, 2006) and promote a reduction in intrusive thoughts about identity (e.g. Major & Gramzow, 1999). Disclosure is also a prerequisite to accessing social support, which can positively influence well-being (Chaudoir & Fisher, 2010).

Researchers have proposed that emotional disclosure can contribute to emotional adjustment through mechanisms of desensitisation and cognitive restructuring (Harber & Pennebaker, 1992; Kennedy-Moore & Watson, 2001), rendering the experiences more understandable to themselves and to those to whom they disclose (Clark, 1993; Meichenbaum & Fitzpatrick, 1993). Therefore, verbalising emotional experiences can help define an experience for the individual and can simultaneously change the content of stress-related thoughts, memories, and the person's emotional state. Mauthner (1999) found that mothers with PND were often thankful when they discovered they had a diagnosable illness as opposed to being "crazy" or

“bad mothers”. Kennedy-Moore and Watson (2001) named this reciprocal relation between emotional experience and emotional expression the “paradox of distress”.

However, the benefits of verbalising emotional experiences are highly dependent on the social context of disclosure. In a supportive social context, individuals are more likely to engage in extended discussion and thinking about their thoughts and feelings, facilitating desensitization (Foa & Rothbaum, 1998). Other people can provide new information or alternative ways of framing an experience, facilitating beneficial cognitive restructuring (Lepore, Fernandez-Berrocal, Ragan & Ramos, 2004). However, challenging social responses is risky and may amplify the discloser’s distress if they perceive that the listener does not understand their situation or is being dismissive. These responses can impede cognitive processing as they may lead individuals to perceive that their thoughts and feelings are invalid or something to be avoided (Tait & Silver, 1989; Lepore, Ragan, & Jones, 2000). Thus, being listened to and understood appear to be an important component of the disclosure process.

### *Social support*

Considering the benefits of supportive social contexts further, disclosure can lead to the provision of social support from others within both personal and professional contexts. Social support during stressful periods has been found to be a significant protective factor against the development of depression (Brugha et al., 1998; Thoits, 2011). Poor social support is one of a number of risk factors for PND (see Appendix 2). Robertson and co-workers (2003) highlighted different types of social support: *informational* support (where advice and guidance is given); *instrumental* support (practical help such as material aid or assistance with tasks); and *emotional* support (expressions of caring and esteem). Studies have consistently found a negative correlation between PND and lack of emotional and instrumental support (Beck, 1996; Menaghann, 1990; Seguin, Potvin, St Denis, & Loiselle, 1999; Webster, Nicholas, Vellacott, Cridland & Fawcett, 2011).

Researchers have also divided social support into *perceived* support (an individual’s perception or belief that people in their support network would provide assistance in times of need) and received support (directly observed/measured support). Studies on mothers with PND have consistently found differences between perceived and received social support, partly accounted for by negative interpretations and beliefs of individuals with depression

(Robertson et al., 2003). In a study by O'Hara, Rehm, and Campbell (1983), the development of PND was strongly associated with poor perceived instrumental and emotional support from partners following childbirth and to a much lesser extent from parents and friends.

Robertson and colleagues (2003) described social support as a multi-dimensional concept with sources of support from spouse, relatives, friends or associates. The PND literature has considered a mother's spouse or intimate partner her primary source of support (Hopkins & Campbell, 2008). Indeed, research across cultures has consistently found that support from spouses and partners is a significant protective factor and mother's with PND have reported the important role of partner support in coping with depressive symptoms (Letourneau et al., 2007; Rodrigues et al., 2003; Stuchbery, Matthey, & Barnett, 1998). However, a small body of research into extended support networks has indicated that women view support from trusted female friends, family members and one's own parents as qualitatively different to partner support, and in some cases this was viewed as a more important form of support (Haslam, Pakenham, & Smith, 2006; Letourneau et al., 2007). Indeed, partners support was regarded as limited by their inability to understand the adjustments required of motherhood. Dennis and Letourneau (2007) found a negative correlation between maternal depression scores and perceived support from other mothers. Clearly, there are differences in the quality of relationships, which can in turn influence the disclosure process.

#### *Dyadic consequences*

Disclosure is an inherently dyadic exchange that can have implications for the discloser, the confidant, and their relationship. Whilst there is limited research looking at dyadic outcomes (e.g. intimacy) in the context of concealable stigmatized identities, work examining the impact of general self-disclosure in the context of personal relationships has suggested that it has the potential to yield interpersonal liking, intimacy, and trust (Chaudoir & Fisher, 2010).

#### *Social contextual consequences*

Disclosure-related experiences occur within ongoing dyadic relationships and specific social and cultural contexts (Chaudoir & Fisher, 2010). Disclosing stigmatised identities can enhance awareness of the identity, potentially reducing the stigma attached to it, thereby helping to make disclosure and openness normative in a given community (Chaudoir & Fisher, 2010).

However, people are not always willing to engage in emotional disclosure. Factors that inform predictions about the disclosure of everyday emotional experiences include socio-contextual factors, such as the support network around the individual (Chaudoir & Fisher, 2010; Kahn & Cantwell, 2012). This further highlights the influence of the relational contexts in which mothers decide whether or not to disclose their symptoms of PND.

### 3.5.2 Disclosure versus non-disclosure: relational contexts

The process of disclosure occurs between people and thus resides within a social/relational context. Zink, Levin, Wollan and Putnam (2006) described how women feel more comfortable discussing a physical experience like domestic violence than symptoms of depression due to greater levels of stigma attached to psychological conditions. Women with PND may be embarrassed about their symptoms or fear the consequences of disclosure (Kennedy, Beck, & Driscoll, 2002). Beck (2006) reported that more than half of mothers with PND go undetected and undiagnosed because they may be unwilling to reveal how they are feeling to health professionals or family (including partner) and friends (Kennedy, Beck, & Driscoll, 2002). This may mean they do not receive treatment in a timely manner (Edwards & Timmons, 2005).

Considering this relational context, qualitative research studies have reported that mothers with PND carried out a social comparison process in which they made judgements about how natural their own maternal instincts were and how well they could cope with motherhood in comparison to other mothers within their social context (Edwards & Timmons, 2005; Lauer-Williams, 2001). As their aim was to try to fit in with other mothers, they reported feeling disgrace when they perceived themselves unable to do this (Edwards & Timmons, 2005; Lauer-Williams, 2001). Lauer-Williams (2001) concluded that women with PND who chose to remain silent tended to be more concerned about their exposure to the public than their own internal experiences and well-being. Thus, Lauer-Williams (2001) proposed that choosing to remain silent might stem from a need for perfection due to their reported high expectations of themselves, and difficulty admitting they might be less than a “perfect mother”.

In a study by Edhborg, Friberg, Lundh and Widstrom (2005), new mothers with PND who did not wish to disclose their symptoms tried very hard to manage their newborn and their emotions alone. These mothers tended to assign their depressive feelings to personal

weaknesses rather than illness, working hard keep this “weakness” hidden (Edhborg et al., 2005). Edwards & Timmons (2005) found that mothers tend to assume other people will believe they cannot cope with their baby or motherhood if they disclose their symptoms. Women reported managing their need to hide their true emotions by faking a display of happiness and not disclosing (Edwards & Timmons, 2005).

The decision to disclose or stay silent is clearly a complex one for mothers across social and relational contexts. Research has identified a number of factors that can facilitate or hinder disclosure in both professional and personal contexts, which will now be considered.

### 3.5.3 Disclosure of PND to health professionals

#### Factors that facilitate or hinder disclosure to health professionals

The relational contexts within which mothers disclose include professional ones. Even though mothers with PND have a variety of interactions with health professionals in the postnatal period, research has suggested that most do not seek help from any source and only a small minority consult a health professional (McIntosh, 1993). Indeed, women have reported making a conscious decision about whether or not to disclose their feelings to their GP or Health Visitor (Chew-Graham, Sharp, Chamberlain, Folkes & Turner, 2009). Studies have cited a number of reasons for this reluctance to disclose (Chew-Graham et al., 2009; Dennis & Chung-Lee, 2006; Edwards & Timmons, 2005; Goodman, 2009; Heneghan, Mercer & Deleone, 2004):

- lack of knowledge and awareness of PND meaning mothers attributed symptoms to another issue;
- assumption that their struggles were a normal part of motherhood;
- the inconvenience of attending appointments or a lack of available appointments;
- fear of being judged and misperceived (e.g. as a *bad mother* or *unnatural*);
- fear of having their children referred to social services or losing their baby;
- lack of trust in health professionals;
- perceiving health professionals’ responsibility as their child’s health and wellbeing only;
- lack of knowledge about where to obtain professional help and what help was available;

- concern that medication would be the only treatment offered to them, which they did not feel was an acceptable treatment option.

Conversely, Heneghan and colleagues (2004) identified the following enabling factors for disclosure to their child's paediatrician:

- trust and positive communication;
- the paediatrician asking about their feelings and asking the right questions;
- respecting and valuing their opinions;
- assuming the mother knew right from wrong;
- taking time to listen to their concerns during a health care visit;
- anticipating the mother's concerns;
- having a caring approach to their child;
- having a child of their own; and
- considering the whole family environment with respect to the health and wellbeing of the child.

Clearly, there is a relational context to these processes. Additionally, for women thinking of disclosing to their GPs, factors such as having been to their GP with depression or PND in the past, being able to recognise symptoms, and having a history of taking antidepressants can influence disclosure about current PND symptoms (Chew-Graham et al., 2009).

Moving beyond the decision-making process regarding disclosure, what are the experiences of mothers who have disclosed PND to health professionals?

#### Experiences of disclosing to health professionals

As with any relational experience, confidants provide responses to disclosures. Mothers have reported that their disclosures were ignored or minimized by some health professionals, and that responses to their disclosures included disinterest, patronizing attitudes, intrusive or judgemental inquiries, being 'cut short', and being talked down to, increasing feelings of worthlessness and guilt regarding their felt inability to cope (Berggren-Clive, 1998; Heneghan et al., 2004; Holopainen, 2002). Further, in a study by Beck (1993), mothers reported experiencing emotions of disappointment, frustration, humiliation, and anger when they made an initial disclosure to a health professional.

Relational contexts for disclosure also include personal support networks, which will now be explored.

#### 3.5.4 Disclosure of PND to partners, family members and friends

##### Factors that facilitate or hinder disclosure to partners, family members and friends

Depression can be shrouded with the stigma of mental illness (Baik, Bowers, Oakley & Susman, 2005; Chew-Graham et al., 2009) and some women prefer to talk to friends and family rather than professionals about their feelings in the postnatal period (Heneghan et al., 2004). However, new mothers do not easily talk about their feelings, and this reluctance can extend beyond disclosures to professionals, to relatives and friends (Chew-Graham et al., 2009; Edhborg, 2004; Edhborg et al., 2005; Mauthner, 1999; Ugarriza, 2002; Woollett & Parr, 1997). Reasons for this reluctance are similar to those cited in section 3.5.3, particularly those related to stigma and negative judgement. Additional ones include:

- family members' reluctance to respond to the mother's needs;
- fear that speaking about their emotions and perceptions (e.g. guilt, failure, loss of control) might confirm them;
- belief that they would be 'burdensome' to whom they disclosed their feelings;
- perceptions of other people's expectations of them to cope;
- concern that revealing their depression would result in the removal of their children;
- and
- fear of being labelled mentally ill.

Additionally, in a study by Edhborg and colleagues (2005) women reported feeling pressure to be 'satisfied' with having a *nice* child, which made them reluctant to speak about their feelings with relatives and friends.

So what are the experiences of mothers who decided to disclose PND within personal contexts?

## Experiences of disclosing to partners, family members and friends: Knowledge gap

Minimal research has focused on women's experiences of disclosing postnatal depressive symptoms to those outside of the health profession (Chew-Graham et al., 2009). If mothers with PND find it difficult to disclose to professionals (McIntosh, 1993) and prefer to seek support from partners, family and friends (Heneghan et al., 2004) then disclosure within personal support networks may play an important role in their recovery. Whilst quantitative research has consistently identified social support as an important protective factor for PND (Brugha et al., 1998; Thoits, 2011) little qualitative research exists on the process that mothers go through in disclosing their symptoms of PND to family and friends. Feminist researchers (e.g. Mauthner, 1998) have carried out the limited qualitative research that does exist. This is one perspective, highlighting the silencing effect of negative responses from women's partners.

Disclosure to people in personal contexts forms part of the whole process of disclosure. It could therefore be important to understand women's experiences of this further.

### **3.6 Current Study**

#### 3.6.1 Aims of the research

The current study aims to explore the lived experiences of mothers who have gone through the process of talking about their postnatal emotional difficulties to other people throughout their support networks, including individuals who are not health professionals (i.e. family members, friends and colleagues) as well as those who are. Through a better understanding of the overall process through which women go to disclose their symptoms, it is hoped that this study might identify further ways of helping mothers with emotional difficulties to feel supported and able to disclose, thus facilitating help-seeking behaviour.

#### 3.6.2 Main research question

In accordance with the aims of the present study, the main research question was:

- What are the experiences of mothers who disclose their symptoms of PND?

## 4.0 METHODOLOGY

### 4.1 Overview

This chapter details the methodology and provides a rationale for its use. It includes my own epistemological position, the process in choosing a qualitative IPA methodology, sampling, ethical considerations, data collection and analysis, and how quality and validity were ensured. Given the dominance of quantitative research in this area, the process for methodological choice is now considered.

### 4.2 Design

#### 4.2.1 Quantitative versus qualitative approach

Quantitative research has dominated inquiry into PND, often conducted within a medical, psychiatric and experimental psychological framework, focusing on epidemiology, aetiology, prevention and treatment (Mauthner, 1999). Academic, professional and lay understandings of PND have often conceptualized it as a “disease” or “illness” (Cox & Holden, 1994). This objectivist epistemology has given rise to clinical theories of PND that fall into deterministic arguments, which pathologise and individualise mothers’ distress, and obscure the historical, political, social, and cultural context of it (Bekker, Smith & Cheater, 2011; Camic, Rhodes & Yardsley, 2003; Dalton, 1989; Mauthner, 1999).

Another criticism of quantitative studies is the difficulty in collectively interpreting inconclusive and contradictory results (Romito, 1989; Small, Brown, Lumley, & Astbury, 1994). For example, significant discrepancies exist between the results of studies reporting factors correlated with PND, including biological, psychological, social, and socio-demographic variables (O’Hara & Zekoski, 1988). Some researchers have argued that these contradictory findings exist because the studies, along with the measures used, are embedded within a positivistic paradigm in which the goal is to understand PND in an “objective” way (Mauthner, 1999). They are criticised for failing to consider how women subjectively experience the variables or how different women experience a similar event in different ways depending on their circumstances and individual meanings of these events; thus, questioning the validity of some quantitative research (Leonardou, Zervas, Papageorgiou, 2009; Mauthner, 1999).

Furthermore, differences that exist across research studies in measures used, cut-off scores on measures, and timing of administration of measures may explain inconclusive findings (Leahy-Warren & McCarthy, 2007).

In more recent years, the dominant, medical model perspectives on PND have been challenged by critical, feminist, post-structuralist and constructionist psychologists (e.g. Parker & Shotter, 1990; Wilkinson, 1996), leading to an increase in qualitative research methodologies. Qualitative approaches enable researchers to gain partial access into subjective experiences and meanings that occur within historical, political and social contexts (Bekker et al., 2011; Chamberlain, Stephens, & Lyons, 1997). This research project aims to capture an in-depth account of the lived experiences of mothers living in Britain who have disclosed their symptoms of PND, an aim best suited to a qualitative approach.

#### 4.2.2 Epistemology

As a Trainee Clinical Psychologist at the University of Hertfordshire, I have developed a social constructionist stance in clinical practice and thinking, which fits within my own personal values and ideals. I believe that there is no objective reality, but that each individual constructs their own reality and that knowledge exists within historical, political and social contexts (Bekker et al., 2011; Chamberlain et al., 1997). This is in line with phenomenologist approaches that also reject realism and are more concerned with individuals' experiences of their world (Barker, Pistrang, & Elliott, 2002). I also believe that people construct meaning and that language is the mechanism through which we make sense of life (Lock & Strong, 2010).

I, as the researcher, came to each interview with my own experiences and set of values as a white British, female, middle-class, psychologist, and a mother who experienced emotional difficulties in the postnatal period. From a constructionist perspective, the social location of a researcher influences the construction of knowledge, meaning it is important for any qualitative researcher to be self-reflexive throughout the research process (Silverstein, Auerbach, & Silverstein, 2006). See section 4.6.3 for steps taken in an attempt to achieve this.

#### 4.2.3 Interpretative Phenomenological Analysis (IPA)

Interpretative Phenomenological Analysis (IPA) is a qualitative methodology concerned with exploring and understanding the lived experience of a specified phenomenon (Smith, 2004). It involves the detailed examination of participants' *lifeworlds*; their experiences of a particular phenomenon, how they have made sense of these experiences and the meanings they attach to them (Smith, 2004). It is a methodology in its own right, rather than just a form of data analysis, and it is extensively used in clinical, health, counselling and social psychology, and other disciplines (Smith, Flowers & Larkin, 2009).

##### Philosophical underpinnings of IPA

First introduced by Jonathan Smith in 1996, the theoretical and philosophical underpinnings of the approach have been developed and refined to consider phenomenology, hermeneutics and idiography (Eatough & Smith, 2008; Larkin, Watts, & Clifton, 2006; Smith, 2004, 2007; Smith et al., 2009). Whilst these features are not unique to IPA, the way in which they have been combined and techniques used within the method identify IPA as a distinct form of phenomenological enquiry.

##### Reasons for choosing IPA

Outlined below is the rationale for choosing IPA with reference to the three aforementioned theoretical and philosophical underpinnings of IPA (Smith et al., 2009).

##### *Phenomenology*

Phenomenology is both a philosophy and methodological approach concerned with exploring and understanding human experience of a specific phenomenon by focusing on a concrete experiential account grounded in everyday life (Langdridge, 2007). Therefore, IPA connects to the core principles of phenomenology through paying respectful attention to a person's direct experience, and by encouraging research participants to tell their own story in their own words (Smith et al., 2009). IPA is also firmly anchored to key phenomenological understandings of lived experience as context-dependent and contingent upon relationships with others, coloured and shaped by social, political, historical and cultural factors (Eatough

& Smith, 2008). Smith, Flowers and Larkin (2009) asserted that IPA subscribes to social constructionism in that it sees human experiences as informed and shaped by social processes. Therefore, the qualitative framework guiding the present study is both phenomenological and social constructionist in nature allowing an in-depth exploration of participants' individual experiences of disclosing their symptoms of PND within particular contexts.

### *Hermeneutics*

Linked to its phenomenological underpinning, IPA researchers accept that an individual experiences a phenomenon in a particular and unique way and yet it is lived within a shared context in which other individuals make sense of the phenomenon. Hermeneutics is the theory and practice of interpretation of the meanings of texts (Rennie, 1999). In IPA, analysis of texts of research participants involves linguistic as well as psychological interpretations, in order to find meaning beyond the immediate claims of the individual and ideally reveal more about a person than the person might be aware of themselves (Smith, 2007; Smith et al., 2009). Double hermeneutics is the process by which the researcher attempts to make sense of the participant's world, who is also trying to make sense of his or her own world (Smith et al., 2009). Thus, there is an inevitable influence of the researcher's own experiences, values and beliefs on the process of co-construction (Larkin et al., 2006). Practicing self-reflexivity is considered essential in facilitating transparency and increasing the validity of the research (Elliott, Fischer, & Rennie, 1999) – see section 4.6.3.

### *Idiography*

One of the cornerstones of IPA is the highlighting of unique perspectives as well as shared experiences (Smith, 2004; Smith & Osborn, 2008). Therefore, IPA as a methodology entails a commitment to detail, depth and data analysis that is systematic in nature – that is, idiography. During data collection, the researcher's aim is to understand as much about one case before moving on to the next. Findings from the first case are set aside through dynamic bracketing, to allow the researcher to be sensitive and focused on each participant's unique experiences and the particular contexts in which those experiences occurred (Smith et al., 2009). At the final stage of analysis, there is a process of identifying emerging patterns to, then, construct overarching themes. However, the analysis attempts to remain faithful to the individual through illustrating the particular *lifeworld* of individual participants (Eatough & Smith, 2006).

This aim corresponds to the aim of the present study: to conduct a detailed exploration of individuals' personal experiences and the meaning they make, within a social constructionist framework.

#### IPA versus other qualitative methodologies

There was particular consideration of other forms of qualitative methodology, notably narrative psychology, in discussion with project supervisors and the research team at the University of Hertfordshire. Keeping the main research question in mind, there was a consideration of the theoretical basis and main goal of each approach.

In narrative analysis, narratives are seen primarily as co-constructed stories of past experiences; as such, they are seen as social products that exist within specific contexts (Reissman, 2008). A range of narrative methodologies exist; in general, they are concerned with ways in which people make sense and communicate experiences over time, according to the context of the individual (Reissman, 2008). Narrative methodologies also focus on the process and structure of storytelling, and how this informs sense-making (Smith et al., 2009). However, Smith and colleagues (2009) suggested that constructing a narrative is only one way of making meaning. Indeed, it has been said that language always shapes and enables our interpretations of experience (Heidegger, Macquarrie, & Robinson, 1962). The focus of the current study was on how mothers' interpreted and made personal meaning of narratives (Smith et al., 2009), which is in line with an IPA methodology (see above).

I also considered discourse analysis. Smith, Flowers and Larkin (2009) noted that language is a key resource in the process of meaning-making by both Discourse Analysis and IPA approaches. However, differences in these two approaches exist in terms of the significance placed on the chain of connection between cognition and the experience of body and self (Crossley, 2000; Smith et al., 2009). Discursive approaches emphasise the role of language in *constructing* social reality, rather than how an individual thinks, feels or gives meaning to the phenomenon being explored (Eatough & Smith, 2006). As the aim of this research was to explore how the participating mothers *made sense of* and *felt* about their experiences, IPA was considered a more suitable methodology.

### 4.3 Participants

#### 4.3.1 Recruitment

This study utilised purposive criterion sampling (Patton, 1990) to identify a sample of mothers who had suffered from PND and undergone the process of disclosing their emotional difficulties to other people. I initially recruited participants through advertisements (see Appendix 5) in quarterly publications of three different NCT (National Childbirth Trust) branches within one county in England. One advert was placed in a December edition of one branch's publication and yielded two suitable participants. However, no mothers responded to subsequent adverts in March and June editions. Therefore, the University of Hertfordshire Psychology Ethics Committee approved two additional sampling strategies:

- 1) A snowball email (with the recruitment advert attached) to 23 women and men known by myself, asking each recipient to forward it on to all mothers they knew.
- 2) Asking a manager of the nursery at a local university to forward an email detailing my research to all parents of the children who attended their establishment.

Table 1 shows the number of respondents and recruited participants from each of the four sampling methods. Most respondents contacted me from the nursery emails. This may be due to contextual factors, as the parents of the children attending the nursery are employed by the university so may have been familiar with research projects.

Table 1: Results of sampling methods

Sampling method	Number of recipients	Number of respondents	Number of respondents who met inclusion criteria	Number recruited
NCT branch publications	Approx 200	3	3	3
Snowball email	Unknown	3	1	1
Nursery emails	Approx 100	19	3	1
TOTAL:	---	25	7	5

#### 4.3.2 Inclusion and exclusion criteria

Across all methods of sampling, I asked interested mothers to contact myself via email or telephone. I then conducted telephone interviews with respondents, providing them with an opportunity to request further information about the study and providing me with an opportunity to establish each respondent's suitability for the study, according to the inclusion and exclusion criteria outlined below.

##### Inclusion criteria:

- Mothers
- Have suffered from postnatal depression - either formally diagnosed with PND or believe they met the criteria read to them in the initial telephone interview
- They disclosed their symptoms to other people
- British
- English as first language

##### Exclusion criteria:

- Mothers diagnosed with or reporting symptoms of other psychological conditions linked to childbirth, e.g. post-traumatic stress disorder
- Current psychotic illness or drug and alcohol dependency, as these conditions may create difficulty with obtaining informed consent
- Currently involved in a child protection case

In IPA, psychological similarities and differences are usually analysed within a group that has been defined as similar according to important variables related to the research problem; researchers therefore aim for a fairly homogenous sample (Pietkiewicz & Smith, 2012). Based on this study's main research question, the key inclusion criteria for this sample was being a mother who had experienced PND and gone through the process of disclosing their symptoms to others. However, a number of variables can influence experiences and understanding of motherhood and help-seeking behaviours, including culture (Oates et al., 2004). Therefore, to establish further homogeneity within the sample, I chose to recruit mothers who classed themselves as 'British' and spoke English as their first language.

I identified seven respondents as eligible to participate in the study. However, two decided not to participate after the initial telephone contact.

#### 4.3.3 The sample

I recruited five participants who were eligible for the study, based on the criteria above. Smith and co-workers (2009) argued that sample sizes of between four and ten participants were adequate for research conducted as part of professional doctorates; thus, I did not feel it was necessary to continue recruiting beyond five participants. Furthermore, the duration of the five interviews were between 59 and 151 minutes (total duration of the five audio recorded interviews was 7 hours and 49 minutes). Thus, I felt that amount plus the richness and quality of the data was sufficient to provide in depth data analysis.

Table 2: Participant details

Participant aliases	Age (at time of interview)	Ethnicity	Marital status	Education level	Number and age of children (at time of interview)	Approximate start and duration of PND
Anne	49	White British	Married	Diploma	3: 1 son, aged 9 Twin daughters, aged 5	Following birth of twins in 2007 1 year
Louise	40	White British	Married	Degree	1 daughter, aged 9 months	2012 6 months
Marie	29	White British	Married	A-levels	2: 1 son, aged 4 1 daughter, aged 1	Following birth of son in 2009 2 years
Joanne	31	White British	Married	Masters	1 daughter, aged 3	2009 1 year
Victoria	39	White British	Co-habiting partner	Masters	2: 1 daughter, aged 5 1 son, aged 1.5	Following birth of son in 2011 5 months

As illustrated in Table 2, all participants were White British, aged between 29 and 49 years, educated to A-levels or above, and lived with husbands or partners (who were the father of

their children). Aside from Louise, all participants had received a formal diagnosis of 'Postnatal Depression' by a health professional. Louise met the criteria for PND, discussed in our initial phone consultation. All participants described themselves as 'recovered' from PND at the point of recruitment.

#### **4.4 Ethical Considerations**

##### **4.4.1 Informed consent**

Following an initial telephone conversation to establish suitability, I sent an information sheet (Appendix 6) to all respondents who met the inclusion criteria and were willing to participate. This detailed the aims of the study, the benefits and risks of taking part, what participation would involve and how confidentiality would be preserved. This provided each respondent with the opportunity to make an informed decision about whether to participate in the study. The information sheet asked participants to contact me prior to the interview should they have any questions or concerns.

At the start of the interview process, I offered participants the opportunity to seek clarification and ask any questions they had. They then read and signed a consent form (Appendix 7) if they wished to participate. This allowed me to check that the participants' had read, understood and were satisfied with the key points regarding confidentiality and anonymity on the information sheet, and were aware that they could withdraw from the study at any point without any penalty and without giving a reason.

##### **4.4.2 Confidentiality and anonymity**

I informed participants of practices designed to ensure their confidentiality and anonymity. These practices were in line with the University of Hertfordshire's 'Guide to Good Practice in Research' (2004) and the British Psychological Society's 'Code of Human Research Ethics' (BPS, 2010) and are detailed below. They also served to increase the awareness of safety boundaries for the participants.

Identifying information was stored securely on password-protected files and kept confidential from the study's supervisors, the course team, trainees and other study participants. I

replaced participants' names with aliases in the transcripts and quotes. All paper documents containing identifiable information were stored in a locked filing cabinet only accessible to me.

Interviews were given codes (e.g. Interview 1) and audio recordings stored on a password-protected and encrypted USB drive. They were backed up on a password-protected computer. I made participants aware that the audio recordings would be stored for up to five years following submission of the research project for examination, after which time they would be destroyed. Participants were also made aware that anonymised transcripts of interviews might be viewed by supervisors of the research study, a qualified Clinical Psychologist (for triangulation purposes), and academic/professional assessment bodies.

I employed a transcriber to transcribe the five interviews, who signed a non-disclosure/confidentiality agreement before audio recordings were provided (see Appendix 8).

I informed participants that I would report sections of the findings from the data in a thesis as part of my qualification in Clinical Psychology. I also told them:

- the thesis would be made available online once it had been marked and passed by examiners;
- the researcher and/or projects supervisors might disseminate the findings via publication, conference presentations or teaching;
- data and findings from the study would only be made public in an unattributable format or at an aggregate level to ensure that no participant was identifiable.

I recorded contact details of the participants' general practitioners before commencing each interview. Participants were informed that their general practitioners would only be contacted should any issues of risk to the participant and/or others be identified during the interviews, but that this would be discussed and agreed with them during the interview.

#### 4.4.3 Management of potential distress

Research has found that the process of reflecting on personal experiences can be therapeutic for participants of qualitative research studies (Birch & Miller, 2000; Colbourne & Sque, 2005; Murray, 2003). However, as qualitative research aims to gain in-depth understanding of an issue, including an exploration of the reasons and context for participant's beliefs and actions,

it is often probing in nature (Richards & Schwartz, 2002). When data on sensitive topics is collected via interview, participants may experience anxiety and distress, the extent of which may depend on their own personal biographies and life experiences connected to the topic (Richards & Schwartz, 2002). The participants in this study were mothers who had all experienced PND and had disclosed their emotional difficulties to other people. As part of their answers to open-ended questions, it was possible that participants would describe potentially upsetting experiences of PND (including thoughts of causing harm to either themselves or their baby) and of disclosing to other people.

I used a number of safeguards to minimise potential distress. I informed participants prior to commencing the interview that they could withdraw from the interview and study at any point, without giving any reason, and that they could take breaks in the interview process whenever they required them. Participants were debriefed and offered support following the interview. Furthermore, they were invited to contact the researcher or primary supervisor (a qualified Clinical Psychologist) should they wish to talk about the interview or gain further support (the Information Sheet listed contact details of both individuals). I also provided participants with a Resource Sheet (Appendix 9) which provided details of five registered organisations that specialise in providing support and information to individuals suffering from PND. Finally, as a Trainee Clinical Psychologist, I had clinical skills and experience that would enable me to respond to participant distress in a validating, compassionate and containing manner.

## **4.5 Data Collection**

### **4.5.1 Constructing the semi-structured interviews**

Topics and questions for the semi-structured interview schedule (Appendix 10) were derived from a review of relevant literature and discussions with research supervisors. Care was taken throughout these two processes to limit undue influence on the interview schedule with preconceived ideas (Brocki & Wearden, 2006).

The interview schedule was structured in line with recommendations in the IPA literature (Smith et al., 2009). Questions were open and expansive to encourage participants' exploration of their lived experiences, with minimal verbal input from the researcher. The schedule consisted of twelve questions, with possible prompts, for interviews designed to last

approximately 90 minutes (Smith et al., 2009). For clarity and structure, I divided these questions into four main topics: *Postnatal Depression*, *Social Support*, *Disclosure*, *Identity* – see Appendix 10 and below. Together these topics addressed the aim of this study, which was to explore the lived experiences of mothers who have gone through the process of talking about their postnatal emotional difficulties to other people throughout their support networks. Whilst this study aimed to add to the literature on experiences of disclosing within personal contexts, topics and questions provided opportunity for participants to discuss disclosure to people in other contexts, such as health professionals (i.e. family members, friends and colleagues), as well as the study aimed to understand the overall disclosure process for mothers.

- *Postnatal depression*: My supervisor and I felt it was important to begin interviews with a set of questions that allowed the participants to recount descriptive episodes or experiences to help them quickly reconnect with their lived experience and become comfortable talking about them. For example, question 1 (see Appendix 10) was ‘How would you define postnatal depression’; prompts asked what images, metaphors and words came to mind. Based on the literature on stigma (section 3.4.3) and non-disclosure of PND (section 3.5.2), it was important to ask ‘How did you try to manage your emotional difficulties prior to disclosure?’ (question 3).
- *Social support*: The literature review identified social support as a key protective factor against the development of depression / PND (section 3.5.1). This topic was included to understand each participant’s past experiences of disclosing and reaching out to their support networks for emotional support, in order to then explore whether there was a difference in how and to whom they disclosed PND, and, if so, why this was.
- *Disclosure*: This section built on the literature reviewed in section 3.5. The aim was to understand the process of disclosure for each participant, from the expectations / fears they had prior to disclosure (e.g. question 5, ‘Can you tell me about the time when you first disclosed your experiences of postnatal depression?’) to the outcomes and consequences (e.g. question 9, ‘What was helpful / unhelpful about disclosing to other people?’).
- *Identity*: Following a review of the literature on mothers’ experiences of both having and disclosing PND within social contexts (sections 3.4 and 3.5), my Supervisor and I thought it was important to explore how participants experienced themselves

(question 10) and how they felt others may have seen them (question 11) before and after disclosure.

The final topic looked at the participants' experiences of being interviewed by another mother (see Appendix 10, question 12). An interview is a process of disclosure in itself. My position as interviewer was akin to a confidant and so the disclosure process may have been influenced by my position as another mother in relation to the participant (see section 3.5.2).

#### 4.5.2 Pilot interviews

I conducted a pilot interview to test the interview schedule and gain feedback from the participant regarding the interview process. This process led to some minor re-wording of some questions and to the inclusion of question A.1 (*How would you define postnatal depression?* – see Appendix 10) to enrich the data on participants' lived experiences.

Prior to the research interviews, as part of a bracketing process, I was also interviewed by a qualified Clinical Psychologist using the interview schedule (see section 4.6.3). This process served as another piloting of the interview schedule and led to minor amendments to the prompts.

These pilot interviews provided an invaluable experience in developing and consolidating research interview skills, and did not form part of the main study.

#### 4.5.3 Interviews within the main study

I contacted all five participants by telephone to arrange a suitable date and time to meet, at a location in which they felt comfortable and which allowed for minimal disruption to the interview process. All participants chose their homes as interview locations. Accordingly, I managed risks associated with lone working by informing a colleague about the location of the interview and contacting them before and after the interview. Interviews were audio recorded and lasted between 59 and 151 minutes. Demographic data and details of their general practitioners were collected and consent forms completed before each interview. In line with published IPA guidance, I used the interview schedule flexibly to encourage detailed descriptive accounts and facilitate further probing of answers (Smith et al., 2009).

## 4.6 Quality and validity

### 4.6.1 Quality guidelines

The inevitable subjectivity in interpretation of qualitative data has raised questions about whether reliability and validity can be achieved as vigorously as it can be with quantitative data (Brocki & Wearden, 2006). To address this issue, specific criteria for evaluating qualitative studies have been drawn up (e.g. Elliott et al., 1999; Stiles, 1993; Yardley, 2000, 2008). Whilst there is no specific method that can be applied to IPA, Smith, Flowers and Larkin (2009) favoured the 'four principles' approach of Yardley's (2000; 2008) criteria, which evaluated research from the perspective of sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance. These criteria were chosen to evaluate whether standards of quality and validity were being met in the current study – see Appendix 4 for how this attended to.

### 4.6.2 Triangulation

Common to IPA studies, I conducted a process of triangulation to establish credibility and transferability of findings and to make them meaningful to the study's readers (Smith & Osborn, 2003). By checking the analysis and validating the interpretations, triangulation ensured that the research remained untainted by researcher bias and assumptions. This process of triangulation corresponded with a social constructionist approach, wherein multiple realities exist and understanding is co-created (Burr, 1995). The process can lead to a richer understanding of the data obtained through the possibility of multiple perspectives (Smith, 1996).

In the present study, triangulation occurred via convergence of themes across the sample and supervision. I used supervision throughout the data analysis process to discuss the coherence and comprehensibility of my analyses and emerging themes. The analysis and audit documentation of one interview (Louise - Appendix 11) were reviewed by the primary research supervisor, who also reviewed a second interview and sections of the other interviews. In addition, both research supervisors checked the Results section and were in general agreement with the emerging themes. Finally, a qualified Clinical Psychologist who had previously conducted IPA research and who was independent of the present research

checked a section of Louise's transcript. The themes elicited were comparable to my own, meaning my analyses appeared to suitably reflect the content and process within the interview.

#### 4.6.3 Self-reflexivity

IPA acknowledges that the encounter between the researcher and participant influences interpretation of qualitative research data (Smith et al., 2009). Therefore, it has been recommended that qualitative researchers engage in self-reflexivity to minimise the inevitable influence of their own epistemological position and personal interests, experiences, values and assumptions on their perspectives of the participant's experience and meaning-making (Ahern, 1999; Elliott, 1999; Smith et al., 2009).

##### Establishing a research proposal

As part of my role as the researcher, I engaged in self-reflexivity from the outset. The initial stage of the process was carrying out in-depth systematic literature reviews to establish a research focus and formulate a research question. The literature reviews were driven by project ideas generated by me (see section 2.1). Through discussions with the Primary Supervisor for this research, I considered the value of the project ideas to the knowledge base versus the value of the projects to myself. These discussions, along with writing the 'Personal Stance' section of the project proposal (reviewed by the course research team), helpfully guided me towards a research project which was valuable to the knowledge base and to which I had some personal connection but sufficient objectivity.

##### Bracketing

Every researcher comes to a research project with their own ideas, preconceptions and assumptions, which can sometimes interfere with their attempt to enter into the participant's phenomenological world (Hayes, 2000). I addressed this in the current study by engaging in self-reflexivity throughout the research process, particularly through discussions with research supervisors. I also underwent a bracketing interview to address this issue, which provided an opportunity for me to be self-reflexive and acknowledge my own position as a researcher (Elliott et al., 1999). This was a particularly important process for me as an Insider

Researcher to carry out due to my personal connection to the data (Ely, Anzul, Friedman, Garner, & Steinmetz, 1991). The aim of bracketing is to minimise the influence of bias during data collection and ensure validity of the findings (Hayes, 2000). However, as Smith, Flowers, and Larkin (2009) have stated, due to the fore conception the researcher brings to the interview process, bracketing can only be partially achieved, hence why I stated my personal stance at the beginning of this thesis (section 2.1.1).

As part of the process of bracketing, I made continuous attempts to suspend my prior knowledge and experience about PND throughout the data collection process, not through denial, but by attempting to recognise, separate out and bring that knowledge to the surface. For example, in my bracketing interview, I described feeling anxious and low at times and in need of emotional support, but that reaching out to others felt impossible because of an assumption I held that people would see me as not 'coping'. Having awareness that coping was a key theme in my interview meant I was able to explore any similar experiences further, taking a curious stance and looking for differences.

#### Self-reflexivity during data collection and the write-up

To facilitate self-reflexivity in the data collection stage of the research process, I kept a reflective diary (Smith et al., 2009). I recorded my reflections before and after interviews, and discussed some of these in supervision.

### **4.7 Data Analysis**

Transcripts were analysed using the IPA procedures established by Smith and Osborn (2003, 2008) and Smith, Flowers, and Larkin (2009). The analysis also adhered to guidelines for ensuring quality within qualitative research (Elliott et al., 1999; Yardley, 2000; 2008), alongside ongoing consultation with my research supervisors (who have experience of IPA).

#### 4.7.1 Variations of analysis with larger samples

When added together, the total duration of the audio-recorded interviews for this study's five participants was 7 hours and 49 minutes. Whilst Smith and associates (2009) noted that good analysis requires sufficient time for in-depth analyses to be undertaken, they also identified

that larger samples may not necessitate the same intensity for each analysis. They asserted, "...in this case, the emphasis may shift more to assessing what were the key emergent themes for the whole group" (Smith et al., 2009, p.106).

It has been suggested that a qualitative researcher can either undertake case-by-case analyses, or use themes from one case to position the subsequent analyses – known as the 'idiographic approach' (Smith & Osborn, 2008). This is where a researcher takes a single transcript and compares the findings to other transcripts to create "...general categorisation or claims" (Smith & Osborne, 2003, p.66).

Therefore, to make the task of analysis more manageable whilst safeguarding the quality of analyses, in-depth analyses for two transcripts (Anne and Louise) were conducted, and the themes emerging from these were used to guide the analyses for the other three transcripts, still allowing for new themes to emerge (Smith & Osborn, 2003). A simple calculation revealed that, of the total duration of audio-recorded interviews across 5 participants (7 hours 49 minutes), analysing participants 1 and 2 in-depth (a total of 2 hours 55 minutes) equated to 37.31% of all data having been analysed in a case-by-case fashion.

#### 4.7.2 Individual case analysis

I used Smith, Flowers, and Larkin's (2009) approved method for the case-by-case analysis. Firstly, the audio-recordings were listened to, followed by repeated reading of the transcripts. Initial notes were then made in the first column, regarding the content, language, initial similarities/differences, concepts, interpretations, and reflections – see Appendix 11 for an example of the transcript and entire IPA process for one participant ('Louise'). I then re-read transcripts and initial notes and examined these at a deeper level, wherein I noted interpretations about what the participants may have been trying to communicate. I recorded emerging themes in the right-hand column, which required a higher level of abstraction, wherein interpretations necessitated being sufficiently general to allow space for theoretical connections between transcripts, whilst remaining grounded in the text (Smith & Osborn, 2008). In the vein of the phenomenological nature of IPA (Larkin et al., 2006), some words and phrases used by the participants became labels for emerging themes throughout each stage of the process.

Next, I sought connections across emerging themes and merged them according to their common meanings to create a final list of emerging themes. These were then clustered according to their connection with each other to create super-ordinate themes with underlying subordinate themes, with matching text extracts. I used this same process to analyse the transcripts for Anne, and examined and then clustered together the resultant super-ordinate themes and related subordinate-theme clusters, to produce a list of overall super-ordinate themes and their sub-ordinate themes across both participants.

#### 4.7.3 Group level analysis

I used the themes elicited from Anne and Louise's analyses to orient the analyses for participants 3-5. Herein, I sought repetition of themes within the data in terms of both convergences and divergences across transcripts, whilst remaining open to the need for new and additional themes. I then reconsidered and refined all of the themes, leading to a master list of themes with corresponding sub-ordinate themes for the whole sample (see Appendix 12).

## 5.0 RESULTS

### 5.1 Overview

Analysis of the five interview transcripts resulted in the emergence of four superordinate themes (see Table 3).

Table 3: Superordinate themes and corresponding subthemes

Super-ordinate Themes	Sub-ordinate Themes
Trying to cope whilst making sense of experiences	Holding the threads of my life together: Trying to be the coping mother
	Needing to cope: How perceptions of external expectations of motherhood influence mothers' internal expectations of self
	"Putting on a face": External façades as internally protective
	Trying to define and understand experience
Deciding whether to disclose: Facilitative and inhibiting factors	"I'm far luckier": Factors that influence perceived entitlement to have postnatal depression and receive support
	"You do have the worries about what people think of you": The stigma attached to postnatal depression
	"That faith that she wouldn't judge": Factors that influence the selection of confidants
The two-way interpersonal process of disclosure	"Hedging round the conversations": A cautious approach to disclosure
	"You're rebuffed right at the very beginning": Dealing with setbacks
	Perceived impact of disclosure and support-seeking on relationships
Disclosure as part of a transformative process	"I obviously wasn't going mad": Disclosure transforming perception and experience of the problem
	Disclosure facilitates opportunities for support
	Conquering postnatal depression: "It's ever so much easier to talk about something in the past"

In this section, I present and explore the super-ordinate themes and their corresponding subordinate themes. The themes are not exhaustive in covering all aspects of the participants' lived experiences. Instead, they were selected due to their relevance to the research question and form one possible account of the participants' experiences. The partiality and subjectivity of this account is part of a double hermeneutic (Smith et al., 2009: see section 4.2.3), wherein I, as the researcher, attempted to make sense of the participants trying to make sense of their own experiences. Alternative themes may have emerged for another researcher.

In line with Yardley's (2000; 2008) principles for assessing the quality of qualitative research (see Appendix 4), *sensitivity to context* will be demonstrated with the use of verbatim extracts<sup>5</sup> from each participant's transcript to support the themes that resulted from my analysis. A table illustrating the representation of themes across the five participants can be found in Appendix 12. The use of extracts ensures that the participant's voices are placed at the centre of the study whilst also providing the reader the opportunity to check the interpretations that have been made (Elliott et al., 1999).

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<sup>5</sup> To ensure anonymity, any identifying information has been replaced and included within square brackets [...]. Participants names were replaced with aliases. Where information has been added (e.g. to explain what a participant is referring to) it is shown within brackets (...). Dotted lines at the beginning or end of an extract indicate that the person was talking prior to or after the extract. To enhance readability, repeated words, minor hesitations and words such as "erm" were deleted, along with utterances such as "yeah" and "okay" by the researcher. Similarly, dotted lines within a quote indicate that a section of it was deleted for readability.

## 5.2 Trying to cope whilst making sense of experiences

The first super-ordinate theme captures what it was like for each mother as she began to experience PND, before actively disclosing to others. The mothers spoke of their need to cope, as driven by their own, and others' expectations and assumptions about motherhood. They spoke of using practical strategies and portraying façades to manage how they were feeling and to appear to others that they were coping as a mother, but these appeared to facilitate avoidance of difficult emotional experiences. Alongside their attempts at coping, the mothers tried to understand and define their experiences.

### 5.2.1 Holding the threads of my life together: Trying to be the coping mother

All five participants reported the strategies and approaches they had established in the early days of PND as they attempted to cope with how they were feeling and to appear like a 'coping mother' to others. Whilst there was some commonality amongst these approaches, each mother's strategy was also individual in nature.

I think I was trying to do things like go to bed a bit earlier, 'cause I thought well maybe it's just 'cause I'm so tired, so I was doing that and things like really trying when the girls went to sleep, at lunchtime to sort of think well I'll go and lie down perhaps it's that, I'll then feel better, I did talk to my homeopath and... she came out to see me and was very concerned about me, and she gave me some remedies and told me to go to the doctors, which I sort of, thought oh well you know it'll be fine. **(Anne)**

Anne spoke of trying to do less and rest in an effort to improve how she was feeling. She also had a history of using homeopathy to manage physical and emotional difficulties and so used this approach to compliment rest. The phrase "it'll be fine" captured her reluctance to seek professional support. Louise also shared this reluctance, initially relying on her pre-existing tendency to process emotional difficulties alone.

I was trying to manage by talking them through with myself, understanding what was wrong and knowing that, it wouldn't go on forever, and that if it got too bad there were options but those were routes I didn't want to go down so I was going to try and overcome it myself. **(Louise)**

In contrast, Victoria and Joanne spoke of trying to keep busy in a bid to cope with their emotional and psychological experiences. In the two excerpts below, there was a felt need by both mothers to get out of the house and participate in group activities for parents and babies, even when physically exhausted. This represented emotional avoidance, which may have hindered their ability to make sense of their experiences (see section 5.2.4).

...just the *weight* of it, is the flatness of life, and the, the weight of it in the mornings, gotta face the day again... I'd go to groups, I'd go out you know to make myself go out and do these things... but it was on autopilot, and I knew I had to do those things to try and help me get better... **(Victoria)**

...my usual coping mechanism was filling every waking moment so (laugh) name a day of the week and I'll tell you which playgroups are available,... so I was thinking I don't want to spend too much money but I do wanna do this and I don't wanna do this and I need to get out of the house...every day was a playgroup in the morning and a coffee date in the afternoon, at least, with the joke of a nap in the middle,... so, it was that, that series of, filling up the time, and, keeping the face on and then coming home and collapsing, and crocheting some more. **(Joanne)**

Joanne commented on how this process involved putting a “face” on (explored further in section 5.2.3). Her use of the word “collapsing” suggested her coping strategies were not effective and were potentially detrimental to her well-being. Being in “autopilot” may have prevented Victoria from fully connecting with her internal experiences but also her external experiences (e.g. groups), which may have maintained the “flatness” she spoke of.

Joanne also referred to her coping mechanism of crocheting, and in the excerpt below, she provided a striking metaphor for the function this activity served at that time. Joanne began her interview crocheting and appeared to use this activity during the interview when she was recalling highly emotive experiences. Therefore, the coping strategy of crocheting to avoid potentially difficult emotional experiences is one she adopted in talking about emotive experiences.

...in that whole time so it was pretty much any point that I had, it was sort of, in a slightly manic fashion, crocheting in order to sort of hold, hold the threads of my life together **(Joanne)**

Marie similarly spoke about trying to just get on with life as a new mother and hiding it from other people, but she also spoke of coping in a different way when in front of her husband which sometimes involved “running away moments”. This highlighted how coping mechanisms varied across contexts and relationships. As with the other participants, these strategies seemed to provide a way for her to avoid her emotional experience, with the vagueness of her memories of this time suggesting either avoidance of reconnecting with the emotional intensity or a lack of connection at the time of the experience.

...hiding it, just getting on with it, there were running away moments too... I’m scared at how vague it is already now but, I couldn’t tell you exactly when but moments of, [husband] would come home and I’d kind of just give him the baby and get in my car and go and I don’t know where I was going or if or when I was coming back I just I need to get out of here I can’t bear it... another minute more **(Marie)**

#### 5.2.2 Needing to cope: How perceptions of external expectations of motherhood influence mothers’ internal expectations of self

Throughout each interview, the pressure to “just cope” was discussed as being driven by internal and external expectations of how mothers should be. Some participants, such as Louise, explicitly referred to cultural and societal expectations; she questioned this in a way that suggested her need for *other* options for mothers in her position.

Erm, I think it’s the whole, (small pause) stiff upper lip you should cope, even amongst my NCT class... it’s still oh you’ve had a baby you cope you manage, and it’s sort of well hold on, do I just have to cope?... isn’t there something else I can do to, to, you know apart from pills or something or is this the rest of my life where it is *just* about coping and not enjoying it? **(Louise)**

Perceived expectations varied across all five participants. Anne reported disparity between how she felt she *should* be feeling and behaving following childbirth and her reality.

Specifically, there was a clear struggle to ask for practical help because of how she felt she *should* be coping at that time.

...you're not doing what you think you're supposed to be doing... that thing of that sudden rush of, "oh isn't life wonderful", you sort of wake up thinking well when is that going to kick in and I think that just total, submersion and not being able to cope and not knowing what to do...

...I remember my mum saying well why don't you pay for a cleaner or pay for some help to come in and you know take the kids off your hands, and I just thought, well financially we can't do that, and also, I don't know I suppose I felt, that I should be coping... **(Anne)**

The expectations Victoria felt that she did not meet were specific to breastfeeding her child, a common discourse within society.

... you feel like you should do it, and it's your child... I probably thought she was gonna die... the anxiety was huge, especially when she was losing weight, losing weight, losing weight, and I couldn't, there's nothing. You're not supposed to bottle feed them and then you know and so I wasn't doing what I was supposed to be doing etcetera so it's probably all the normal guilt things. **(Victoria)**

Both Anne and Victoria used phrases such as "supposed to be", "should be", "should do", "not supposed to" and "guilt", which denoted a pressure to meet fixed expectations of how to feel and behave as a mother in the early postnatal period. These expectations may have contributed to Anne's sense of not knowing how to cope, as they removed or restricted the option of seeking support from other sources. Anne's explanation of her difficulty paying for practical support suggested she had all-or-nothing thinking about coping at that stage (Burns, 1999), almost as if receiving support would have changed her from a position of coping to not coping. Anne and Victoria's use of language and repetition (e.g. "total submersion", "thought she was going to die", "the anxiety was huge", and "losing weight, losing weight, losing weight") portrayed how overwhelming and distressing their experiences were.

Both Marie and Joanne went beyond the expectations of mothers to those of women in general, noting the role of the media in influencing these expectations about coping. Marie directly implicated the media in maintaining expectation, but also referred to the process of watching and comparing women in other families and the influence this had on her need to

cope. Joanne described how portrayals of women by the media seemed to slot rattle (Kelly, 1955) between the woman who has it all and the woman who is a “complete wreck”. This may partly explain the pressure to be seen as coping and to not seek support as the only alternative position is a negatively portrayed polar opposite. One can gauge a sense of hopelessness when she claimed that it was “pointless” to blame media sources.

I guess it's mainly media isn't it, and also just the way that you watch people who've, different circumstances but split families and stuff it's, women are expect- no matter what, mum is, is the one that *generally* holds it together, so the expectation is there I think... **(Marie)**

...the society (said in mock seriousness), up there with magazines and the media you know, pointless things to blame, but I think there's an attitude that, you should be able to cope with life...

(inhales) I think it's... the woman complex generally, women are either, they either have it all, or they're a complete wreck. **(Joanne)**

### 5.2.3 “Putting on a face”: External façades as internally protective

...so if you look presentable on the outside then you feel a bit more, presentable- it's like buying, putting a coat of armour on or something. **(Louise)**

As with practical approaches to coping with everyday life and PND, participants established individual ways of managing their internal experiences when with people outside of their homes by managing how they presented themselves externally. With reference to the above excerpt, Louise felt that how one presented oneself to people in the external world had a knock-on effect on one's internal experience. Her metaphor of a coat of armour was suggestive of how strong she needed her façade to be.

Extracts from the interview with Marie are clear representations of this disparity between the true self at home (“teary” and “short-tempered”) and the façade self presented to others outside (“a big mask”). She also described a need to be seen to do “everything right”, which appeared to be driven by a sense of guilt for how she felt about her child. This approach spoke of a right versus wrong way of doing things – such all-or-nothing strategies seemed to give no room for error.

... on a practical note I was , teary sometimes I was still going out and doing stuff, but it was generally with a big mask,...

Behaviour, to the outside world, perfectly normal, I was short tempered, I was, anything to be out the house, being here was far worse than being out and about, so anything to get out, curious mix of wishing him not around, but at the same time not finding it easy to let other people look after [child]... I suppose partly because I thought if I'm having these feelings that, I don't like him, I really don't want him here, then, I have to be seen to be doing everything right **(Marie)**

Joanne also highlighted the disparity between how she was at home with her husband and how she presented herself to others outside the home. Through practice, she became effective at putting on a “face” in front of others, which resulted in surprise from those to whom she later disclosed. Her use of the phrase “playing at being mum” was striking, and suggested she used her façade to present an untrue version of herself to others to meet external expectations of being a mother. The words “exhausted” and “strung out” showed the impact “keeping up appearances” and “doing everything” had on her health. The words “keeping up” were indicative of someone trying to push themselves to be more than they naturally were or could be, perhaps to not be ‘left behind’.

...what surprised everybody, was how little I gave away, and so [husband] knew all of it, but in fact, I, I was very very good at putting on a face, and so, I had to... work quite hard at getting the right face put on, but when [husband] told a few people, about it, they, they were surprised, because the face was quite good; and so, he got, the snappishness and the withdrawn, but as far as everyone else was concerned, I was writing articles for the NCT, I was the local coffee morning organiser, I was taking [child] to all these different groups and play groups and, making things and, organising Christenings and god knows what else and so... I was exhausted and, (coughs) strung out at home, from keeping up with appearances, and doing everything that I ought, basically I was excellent at playing at being a mum **(Joanne)**

Anne's process of “denial” manifested itself through not being “as honest” about the extent of her experience. Even when she spoke to her friend who was treating her for homeopathy, Anne selectively disclosed parts of her lived experience at that time.

...I think it was also somebody, saying... this isn't right, you know there's a level of, tiredness and how you feel emotionally, I wasn't as honest, that honest with her though, 'cause I think at that point... there was sort of a bit of denial really **(Anne)**

Louise called her façade the “big smile” and reflected on the limitations of using façades.

...everybody's trying to put this big smile on “oh no it's all fine, don't worry” and then this whole thing of just trying to push it under the carpet when actually it's real and it's not going to go away... **(Louise)**

In contrast to the other participants, Victoria spoke of showing her true self by removing any “barriers” she had and disclosing to those close to her. Below she described how she could not have any barriers with her mother-in-law who was regularly around her at that time. It was almost as though there was a sense of safety in that relationship enabling her to drop the façade.

...she was around a lot more and I think I couldn't have any barriers with her at that point **(Victoria)**

#### 5.2.4 Trying to define and understand experience

This theme spoke of a sense of confusion and uncertainty experienced by the participants in the early stages of PND. Marie described uncertainty in how to construct and define her experiences as a potential barrier to sharing them with others.

**Researcher:** Was there an active process in your mind of not telling [friend] for a while?

**Marie:** Yes, probably, and also, nobody wanted to label it, nobody wanted to diagnose anything, and so it was kind of well I'm just finding this really hard, I don't know what it was I'd have said to begin with

Victoria spoke of ‘knowing but not knowing’. She expressed verbally and non-verbally her strong need for someone with experience to definitively define her experience for her and advise her what she could do.

...what I needed someone to say to me was, “you’ve got postnatal depression, this is what you need to do” (can be heard knocking on the table to punctuate her statement), right and, and because I was sort of struggling with it I knew I wasn’t well, but you’re not thinking, and [maternity nurse], she was really good, but... she hadn’t really experienced somebody with postnatal depression either, so, and I don’t think really really recog-, I knew it was postnatal depression but you don’t know what that really that is until you’ve gone through it **(Victoria)**

Victoria tentatively suggested that her maternity nurse had not recognised PND, and Marie and Louise expressed disappointment at how Health Visitors had defined their experiences. Marie described this experience as “weird” and her emphatic “No” may have represented frustration at her experience being minimised, misrepresented, or invalidated. Louise spoke of how her Health Visitor’s definition provided a prognosis that did not turn out to match her reality.

**Marie:** ... (Health Visitor) kept saying, you’ve got to let go of the umbilical cord, as though I was being too smothering or, yeah, really weird actually, thinking about it...

**Researcher:** Did that fit with your experience, that you felt that...?

**Marie:** No!

I think one of the hardest things is trying to differentiate between the baby blues, and postnatal depression I think that the health visitors and people who visit you to start with don’t really help, ‘cause like “oh it’s just the baby blues don’t worry about it, you’ll get over it” **(Louise)**

Both Anne and Joanne noted that their own lack of understanding about PND might stem from a lack of information and psychoeducation from health professionals. Anne described her struggle to understand whether her experience was normal in comparison to others following childbirth. Joanne appeared to think that antenatal sessions gave PND minimal coverage, with the focus being predominantly on childbirth.

...I think I felt very helpless and I think I really struggled between thinking is this what you do feel like having had a baby is this the norm or isn’t it the norm really...  
...I think probably that I didn’t realise, you know you’re not really given any information... **(Anne)**

...(antenatal classes) were such a load of bullshit, because in fairness they're entirely aimed at their audience who are all a load of pregnant women who are worried about how this child is going to get out of them, with the occasional bit of if you feel blue, let somebody know... **(Joanne)**

### 5.3 Deciding whether to disclose: Facilitative and inhibiting factors

This theme describes a ‘weighing up’ process preceding disclosure in which participants considered a range of factors that either facilitated or inhibited disclosure. Participants questioned whether they were entitled to experience PND, based on preconceptions of mothers with PND. They spoke of the stigma attached to PND and the fear of judgement or responses from others. Participants considered characteristics of available confidants as part of a process of selecting to whom to disclose.

#### 5.3.1 “I’m far luckier”: Factors that influence perceived entitlement to have postnatal depression and receive support

This theme highlighted how contextual factors informed participants’ judgements about whether they should or should not be feeling depressed. It captures a social comparison process in which participants questioned their entitlement to be suffering from PND in comparison to other mothers. Louise stated:

...so if you suffer from postnatal depression you really should be quite on the edge as in single parent, having to work, you know and life should be *really really* hard for you to then suffer from postnatal depression ‘cause you’ve got a reason not to cope, instead of, having a husband who helps, having a child who sleeps through the night **(Louise)**

Louise appeared to hold assumptions about mothers with PND, listing contextual factors in a way that suggested she expected certain criteria or conditions to be met to have PND. Furthermore, these assumptions and conditions appeared to hinder her acknowledgement of her difficulties. Below she described feeling particularly “lucky” because she was not suffering from sleep deprivation in comparison to other mothers around her. She chose to avoid disclosure to protect herself from criticism that could make her feel worse.

...I don’t want to talk about it a huge amount because I’m far luckier than, a lot of people so then there’s this added thing like the “well your child’s sleeping you’re still not coping, what’s wrong with you?” you know plus my husband helps an awful lot, so again it’s you know, (laughs) it, it says you can’t cope at all... so you’d feel even worse **(Louise)**

Similarly, sleep deprivation also seemed an important contextual PND criterion for Victoria, making her question the reasons for her distress at that time.

I went crying to my mum one time, *really* sobbing, questioning it, 'cause on the other hand [daughter] was a very good sleeper things like that, so I got a lot of rest... **(Victoria)**

Participants perceived 'criteria' for developing PND also seemed to be based on financial situations and lifestyle. Even within the context of her own family, Louise predicted that she would receive comments about how her "gilded life" disqualified her from receiving understanding and support. The following extract captured Louise's prediction that others made comparisons between two mothers' lifestyles in determining who had the *right* to experience PND. The comment "oh pull yourself together" suggested she predicted being construed as a hypochondriac.

... we're down here we're Southern, you know we've got loads of money and everything else and I've got loads of help, (said in a silly voice) whereas my poor sister's up there and her husband won't even let her have a cleaner, you know she's got a boy in hospital... he's young, so there's this huge sort of thing that you know we seem to live a gilded life and if I said "oh god I was suffering from postnatal depression" or anything it would just sort of be "oh pull yourself together" you know, it's, it's, "[sister]'s got it hard you haven't, stop worrying" so... I haven't even bothered talking to them about it **(Louise)**

Similarly, when Marie began to disclose her PND to work colleagues, comments she received about her lifestyle made her question her right to feel depressed and hindered further disclosure.

...someone, coming back with the comments of you've got the house you've got a lovely baby, what are you upset about? What's the real problem? Almost you've got no right to feel that way, or then snap out of it **(Marie)**

One can sense the minimisation both Marie (above) and Anne (below) may have experienced from other people's responses – inconsistent with their internal distress. I explore the impact of actual responses from others further in section 5.4.2. Anne reported feeling a pressure to

feel happy due to the expectations people had of parents who successfully conceived a child via IVF.

**Anne:** ...I think particularly with postnatal depression it's that thing that, you know there's obviously something quite odd, that you don't feel this massive euphoria, and you know particularly for us having waited so, I mean we waited a *long* time to have children, you know it just didn't happen, and I think they'd think well why would you feel awful once they did come you should be jumping with joy and...

**Researcher:** So you feel that there is an added pressure to be happy and (*Anne:* Yeah) joyful because you went through IVF?

**Anne:** Yeah

Joanne reported feeling as if she did not fit the threshold for support from a local charity after reading an advertisement about types of people it supported. It seemed the phrasing within the advertisement reduced her sense of entitlement for support.

...it's a local charity that has wonderful front page where it says, single parents, parents of disabled children, if you've lost somebody, if somebody's died in your family or you're bereaved or you're having problems, or you're just finding everything a bit difficult, (laughs) well I have none of those things but I'm still a bit shit. (**Joanne**)

The above extracts illustrated how perceived or actual assumptions of other people or organisations about the context or criteria for needing support may hinder support-seeking behaviours.

### 5.3.2 "You do have the worries about what people think of you": The stigma attached to postnatal depression

Of all five participants, Victoria was the only one who reported a drive to disclose to people in her support network. However, she contradicted this with her description (below) of a clear ambivalence in disclosing to her health visitor. Her anxiety about others judging her may have stemmed from her awareness of stigma, as illustrated in the second extract.

...then I spoke to a health visitor, and I remember filling in the Edinburgh score when they came round first and lying on it... and *then*, I just thought... I need to be truthful about this. I think you do have the worries about what people think of you...

...the thing would have been... not to tell people... because it is a stigmatised thing  
**(Victoria)**

Likewise, Louise and Anne described anxiety, even fear, about what others might think of them following disclosure, which appeared to silence them. In line with their perceived expectations of maternal coping (as detailed in section 5.2.2), they described the stigma of not being able to cope that is commonly associated with PND. Phrases such as “terrible mother” and “losing it” elucidate the extremity of the judgements they expected.

...my fears was I think that I thought that they would think what a terrible mother I was that I couldn't cope... **(Anne)**

...I was worried that *he* would then think I couldn't cope, or I was then seriously *losing* it,... so then that's, that's why I didn't tell him until, many months afterwards  
**(Louise)**

Louise disclosed her low mood to her husband very early on in her suffering but, as the extract above indicates, she struggled to disclose to him her thoughts of infanticide. Similarly, Joanne (below) described how she felt comfortable disclosing her low mood but feared the responses of others if she was to disclose her suicidal thoughts and plans.

...at no point did I fear saying I was, had low mood, was crying... What I didn't want to tell people and what I still actually probably thinking about it haven't told many people was, the blackest thoughts and the darkest days... everyone's a little bit scared of the suicide word, and so I, that would never have come up... **(Joanne)**

Marie reported how she particularly struggled to disclose her experience of not wanting her baby due to the social unacceptability of it. The repetition of “very” and the emphasis on “want” and “say” adds emphasis to this sense of unacceptability.

...very very socially unacceptable, especially the way I was feeling it, that I didn't want the baby not that I wasn't good enough for the baby but that I didn't *want* the baby you can't *say* that to people **(Marie)**

It seemed that Anne, Joanne, and Marie's fear of judgement and difficulty disclosing were more pronounced for particular (more intense) difficulties they viewed as more stigmatised. Interestingly, Louise also compared levels of stigma, but between PND and other stigmatised disorders. She described a ranking process, with PND (and associated anti-depressant medication) being judged as more difficult to disclose than having a sexually transmitted disease. As recorded in my reflective journal, admittedly, I was shocked by this comment, which may explain my laughter with Louise at that point.

...I probably would find it easier to tell them I had an STD or something like that (both laugh) than admitting that, you know I was having postnatal depression and on antidepressants... **(Louise)**

Louise went on to provide an analogy that suggested a fear of how others could make generalised assumptions about her/her child's home if they knew she had PND.

...it's like a child having nits, you think that child comes from a dirty home, whereas they don't actually... **(Louise)**

Finally, Marie's words (below) illustrate a weighing up the risk of negative judgement. Thus, it is unsurprising that most participants listed a non-judgemental stance as a preferred characteristic of their chosen confidants, below.

...a sense of not knowing how people will respond, or react, that even if the majority of people would have been supportive, not *everybody* necessarily will be, and at that point, the thought of someone reacting badly, was far worse than just hiding it... **(Marie)**

### 5.3.3 "That faith that she wouldn't judge": Factors that influence the selection of confidants

Considering the impact of judging further, each participant carried out a process of selecting which confidants to disclose to. There was commonality and individuality in participants' lists of preferred confidant factors, which they described identifying over time through long-

standing relationships. The main factor was a non-judgemental stance – see extracts from Marie, Joanne and Anne below. This seemed to enable participants to predict responses following disclosure. However, Marie also spoke of using her “sense” of who would listen and be accepting to determine her confidant.

...with [friend] I’ve known her a long time, she’s seen me go through, we both have, all sorts of things. I guess that faith that she wouldn’t judge.

...so it’s people I know, fairly well, or people that I know, I had a sense that either because of profession or other things I know about them will be accepting and listen rather than, and not to make assumptions. **(Marie)**

...because she’s somewhere between, awesomely wise, and entirely unjudgemental...

...she’s known me since the day I was born, and, you don’t need to say anything, really, for her, and she just knows **(Joanne)**

As implied by Marie and Joanne, Anne explicitly described a search for safety and security in disclosing – almost like an antidote to the fear of judgement.

... I need to feel safe with somebody I think that security and that, not being judged. You know my in-laws judged me, they’re very, I think what you want is somebody to listen to you, you know they think whatever they think you can’t stop them thinking, but you don’t need to hear their “this is what you should do, this is...” you know you need somebody to say “well what can I do what do you want me to do? **(Anne)**

Louise spoke of her preference for confidants who could share their “weaknesses”, which allowed her to feel able to speak to somebody on her “level”. It was curious that identifying a shared sense of struggling in others shifted them from a pedestal to an equal position, and that this process empowers one to disclose.

Erm, probably ‘cause we’re quite, close, and they’ve had problems as well so it’s not like talking to somebody who you’ve sort of, put up on a pedestal... idolising, you then don’t want to show your weaknesses to they’re happy to show their weaknesses to you as well, so it’s sort of, reciprocating because you say “oh god yeah I’ve got this wrong” then you know but it, it’s just being able to talk to somebody on your level **(Louise)**

Victoria also chose to confide in somebody with a shared history of depression and anxiety. However, it was a Maternity Nurse she had hired, which brought a sense that it was easier to disclose to someone in a less powerful position as an employee.

...she had had depression and anxiety in her life as well, so she understood a bit more so she was excellent, towards me like in the middle of the night, when I was up- you know wandering around with anxiety, she would you know, "it's, it's alright, it's ok... to feel like this"... so she was excellent... **(Victoria)**

For Marie, gender was a characteristic she considered important when choosing a confidant. In the extract below, she described why she found it easier to disclose to the husband of one of her antenatal group friends, despite having never disclosed to his wife. She suggested comparison and even competition were inherent in relationships with other mothers.

**Researcher:** Yeah, was it something about talking to a man or him in particular?

**Marie:** Possibly, and Joe's nice I guess I don't know, but it just it happened to come up in, it was in context with the conversation we were having, and maybe there is slightly less (pause) competition dare I say it, or a sense of comparing certainly if not competition comparison

## 5.4 The two-way interpersonal nature of disclosure

Previous themes focused on the mothers' intrapersonal processes prior to disclosure, whereas this theme describes the interpersonal nature of the disclosure process itself. It highlights the presence of the confidant in a two-way communicative process, focusing on the influence of the confidant on the development and outcome of this interpersonal process. Moreover, the focus is on the impact of the disclosed information on both the confidant and the relationship the confidant has with the discloser.

### 5.4.1 "Hedging round the conversations": A cautious approach to disclosure

...it was sort of a few people, 'cause you sort of start hedging round the conversations by saying "gosh I'm finding this really hard"... **(Louise)**

This quote represents the cautious approach all five participants took in disclosing, particularly those in their support networks with whom they did not have particularly well established or close relationships. The overall theme describes a tentative approach that appears to result from a balance between fulfilling a need to reach out to others and a need to avoid the risk of a negative outcome from disclosure. Below Marie spoke about the risk, or "danger", of confidants changing the subject following a disclosure.

I guess people don't know what to say, and it's that danger that they just change the subject... I guess I've always picked who I talk to... **(Marie)**

Joanne provided examples of how her "slow drip" cautious approach played out with other people. "Flippant remarks" were used to initiate the process, which was carried out in a step-by-step fashion as a tentative search for reciprocation, in a setting that usually involved the sharing of food/drink. She embedded words that revealed the true intensity of her experience (e.g. "hideous", "ridiculous" and "looney tune") within these flippant comments, perhaps as a way of softening the delivery of them.

...there's no way of going "do you want some cake, and by the way I've got postnatal" it, it just doesn't come up like that, and so it, it's more of a slow drip of, circumstance, and then later on you can say "oh you know how the last year's

been a bit crap, well..." and/or, these days I make flippant remarks that I hope people know who will pick up on about being on meds and stuff...

...the conversation usually turns to, gosh isn't having kids tricky? Yes isn't it, lets have more coffee da da da da, and, isn't the first year hideous oh god mine was ridiculous there was drugs a plenty, and they went, "oh real drugs?" and I'm like "oh yeah real drugs it was all good... there was a whole looney tune phase", and in those kind of terms, and then, I'd say, one in two times people go "yeah seriously" I'm like "yeah, yeah, yeah" and they'll be like, "yeah me too" I'm like "ok" and it becomes *that* conversation **(Joanne)**

Anne was cautious even when disclosing to health professionals. She admitted she was not "particularly honest" when completing the EPDS administered by her GP, and described the struggle to begin disclosing to her.

...it took me a long time to actually tell her what was going on and again she got me to do one of these survey things,... I can't remember what the score was but she did say it was high and again I wasn't particularly honest on it... **(Anne)**

In comparison to the other four participants, Victoria was much more open about disclosing her experiences to others. However, interestingly, Victoria also adopted a cautious, almost covert, form of disclosing to other mothers via the process of asking them to donate items to sell to raise money for a PND charity. This caution seemed to be context-driven, specifically, being around mothers in a private school setting. Interestingly, she speculated that subsequent behaviour from other mothers towards her might have mirrored her covert approach.

...telling people in a roundabout way so I did an NCT sale... and it was quite a big thing then emailing all the mothers at the school, saying... I'm doing it (fundraising) for these two charities and they were both postnatal depression charities... you know people gave us stuff, nobody really asked me about it or anything like that. I got the feeling that a couple of the mothers talked to me a bit more, and not nicer to me or anything like that but I got a feeling they might have had something similar, and they, therefore... empathised but nobody outright. It's a private school she goes to, so it's quite middle England, very, you know, tanned... everything's wonderful with the world... I just think hmm bet it's not like that... I think it was

probably me, telling people that I had it, and if anybody wanted to talk... I think it was a way of expressing it to other people, and getting it out there. **(Victoria)**

#### 5.4.2 “You’re rebuffed right at the very beginning”: Dealing with setbacks

This theme follows on from the previous one in that it concerns the outcome of participants’ cautious attempts at disclosing their suffering. As with earlier themes, it speaks of a silencing process. Louise recalled how a lack of reciprocation and dismissive response closed down her disclosure process.

...depending on what people... come back and say “yeah w- it is hard but we all get on with it” and you’re like ooh ok won’t take this any further, and you know and, yeah trying to find people who you could sort of go, speak a bit further with was hard, ‘cause then you’re rebuffed right at the very beginning... **(Louise)**

For Marie, the negative judgement perpetuated a cautious approach to disclosure. It spoke of a trial-and-error process in which Marie’s views of disclosing were updated via feedback from the outcome of each attempt.

**Marie:** ...someone, coming back with the comments of you’ve got the house you’ve got a lovely baby, what are you upset about? What’s the real problem, almost you’ve got no right to feel that way, or then snap out of it

**Researcher:** How did that then affect your process of disclosure after that, with other people?

**Marie:** It made me again much more cautious about who I would say what to

Anne described how her mother-in-law labelled her PND “ridiculous”, which she found unhelpful. Her laughter may be a defence against the difficult feelings this caused her.

...we did decide to tell her and when he did tell his mother and she was just not interested, she said it was ridiculous (said with venom) I think I probably was pathetic so, totally unhelpful (laughs) **(Anne)**

Joanne reported that a Health Visitor’s response to her disclosure left her feeling “belittled and dismissed”. She described a belief that these setbacks may have a more serious impact on other women who could fall “through the cracks”.

...when I went to the weekly weighing in and check-up... and said, “look, I’m finding this all a bit tricky, and I think this might not be good”, she said “well how old is she?” I said, “about 5 weeks”, and she said “Oh for God’s sake if we gave medication to everyone who said that at this stage we’d be ridiculous get out and come back another time”... even though I’m a sentient human being with knowledge of the NHS I still kind of felt belittled and dismissed... with me, I mean [child]’s Godfather’s a consultant psychiatrist... with my support network I was never going to get through the cracks... if that was the person’s one point to say, “I’m struggling”... I thought good God that’s terrifying... if that was her one mayday and she never felt able to say anything again... **(Joanne)**

Marie and Louise described attempting to disclose to the same person more than once and the impact of having to deal with setbacks each time. Marie spoke of trying and persevering repeatedly. Conversely, Louise was curious about these responses and wondered whether other mothers shut down conversations about PND because they had suffered from it themselves and felt uncomfortable discussing it.

...the disclosures I made to my mum that were fairly pointless, probably at that stage didn’t stop me trying again and being disappointed again, I had to do other stuff to get past that point. **(Marie)**

**Researcher:** And what do you think that was about?

**Louise:** Whether they were having it, as well, or didn’t want to say anything, ‘cause I did try a few times and it just, then didn’t feel right so I then just didn’t carry on

#### 5.4.3 Perceived impact of disclosure and support-seeking on relationships

Erm, it certainly sorts the wheat from the chaff in terms of your friendships  
**(Joanne)**

Within this theme, participants spoke of perceived changes to relationships after they disclosed and sought help; referring to the perceived impact on the confidant. Above, Joanne found that disclosure enabled her to learn more about her friendships and to be able to make comparisons between the qualities of those relationships. In the extract below, Joanne went on to describe how being honest led to the formation of “true friendships”. For Victoria,

disclosing to and seeking help from partners and family strengthened and improved her relationships with them.

I think because I was so good at putting on the face I think they thought that true friendships were being formed, but I was very good at the smiling and nodding thing, and it was only later when I told them what had been going on, or what was still going on, whichever way it was, that then it became a two-way relationship, does that make sense? **(Joanne)**

I think [partner] and I are stronger because we been through this together, I think I've got better relationships with some people in the family because I think you are completely at your most vulnerable, and people will want to help you... **(Victoria)**

The extract below illustrated the impact of non-disclosure on aspects of relationships with partners, such as sexual intimacy. It demonstrated a clear contrast between the distress and confusion from non-disclosure and the improved understanding and solutions from “being open and honest”. Positive consequences of disclosure are explored further in section 5.5.

...again once I'd said that to him, then I felt better 'cause I knew that he could give me a cuddle without me worrying it's going to lead to anything, so again it's being open and honest with the people that really matter, who can then understand it, and who can then work with you, instead of no-one knowing apart from yourself and then them getting upset as to why you don't wanna have sex, or you're crying the entire time... **(Louise)**

For Anne, disclosing and seeking support from the confidants led to changes in roles within those relationships. The confidants appeared to struggle with this. It seemed that the struggle with her moving further away from the state of *coping* was held more by other people, and less by herself as had previously been the case (section 5.2.), as illustrated by her phrase “that's been hard for him” and her repetition of the phrase “I think he found it very difficult”. Her phrase “I can't necessarily cope” suggested an acceptance now of holding a more fluid position, which involved moving around, and between, the polarized positions of coping and not coping.

... [husband] found it very difficult 'cause like usually I'm the one supporting him, and I think he found it very difficult to have to change the role really...  
I'm the older sister to my brother and I think my brother again, because of our childhood and things, has always thought that I'm the person that could cope and I think he's now realised that actually, I can't necessarily cope, so I think that's been hard for him, and for me, to a certain extent... **(Anne)**

Not all changes to relationships were positive. In the extract below, Anne clearly believed that the influence of disclosure on relationships varied according to how supportive the relationships were beforehand.

...I don't know I mean it's very individual you know if you've got a supportive family then, great, but if you haven't you can actually you know cause more... it's definitely caused more problems with my in-laws, than it has (R: Disclosing?) yeah I mean it's just got worse really. **(Anne)**

Marie had always had a strained relationship with her mother and spoke of her anger with how she had treated her as a child. It appeared that her mother's responses to her disclosure did not lead to the desired change in her relationship with her mother; the content of the response led to a greater "disconnect" with her. The second extract illustrates the potential impact of disclosure on the confidant, which for Marie led to a role reversal of discloser/comforter with her mother.

...I did on a couple of occasions try to talk to my mum, and the things she said, about the way things were with me as a baby, actually sometimes people say you're more forgiving of your parents once you're a parent, although I've actually found the opposite, because, I don't know, that disconnect, seems bigger maybe... now I see it now from the other side...  
... I was saying how hard I found things... she tried, and she did sort of tell me about how hard she'd found it, when I was small, but it turned into a big thing of having her wanting me to tell her that actually she'd done ok and she was fine and it hadn't... **(Marie)**

## 5.5 Disclosure as part of a transformative process

This theme described how disclosure appeared to have played a causal role in transforming how participants experienced PND and the support that was available to them. Following a transformation process, which led to a sense of conquering difficulties for the mothers in the present study, further disclosure was then facilitated.

### 5.5.1 “I obviously wasn’t going mad”: Disclosure transforming perception and experience of the problem

... well I think I felt that I obviously wasn’t going mad, there was something going on, so that was good... **(Anne)**

Participants reported that the responses they received and the conversations they had with confidants following disclosure enabled them to perceive and respond to their experiences in a different way. Anne and Joanne described a process of reframing their experiences and a realisation that they were not “mad”/“looney tune”.

**Joanne:** I think I kept on thinking if I, the more people I tell, the higher hit rate I’ll have of people agreeing with me

**Researcher:** Agreeing with you that you had postnatal depression or...

**Joanne:** No agreeing with me that they had also

**Researcher:** Right, ok

**Joanne:** I desperately wanted other people to say that they had it as well

**Researcher:** What did that mean for you if they did?

**Joanne:** That I wasn’t such, such a looney tune

Joanne appeared to have gone through a search for shared experiences in a bid to gain a enough feedback that it was normal. Louise also found that disclosure could lead to normalisation of her experience, which helped reduce the magnitude of a specific experience from a “big taboo secret” to “normal”.

...for me... as soon as you hear somebody say “don’t worry it’s normal” you’re thinking well ‘ok I actually feel a bit better’, but you know these are the sort of things that happen and, it’s not some great taboo secret that I just thought, you know I could quite happily kill my child...

...[friend] would come over here, so you would be able just to... say “look, you know I can’t, cope you know”, or, “I’m finding this really hard” and again, she’d say, “don’t worry about it babe, you know my sister’s just had a baby, she says she can’t cope either, I’m sure it’s all normal” so again it’s normalising... **(Louise)**

In addition to normalisation, reframing of the participants’ lived experiences came from the information and ideas provided by confidants following disclosure. Victoria and Louise described how the responses they received helped to reduce the magnitude of the problem.

...I remember [maternity nurse] saying to me, “the bit of your brain that you know you think with, is not working properly so how can you think logically?” ... and I think once I got that it was a bit of a chemical thing as well that helped... again it’s about then, the stigma attached to it that it’s not me, it’s a biological process that’s going wrong here, and that is like serotonin levels and they’ve come, they’ve had a big knock... it’s a chemical problem, the depression... **(Victoria)**

...as soon as you voice something out in the open it’s never as bad as you’re internalising it, so once you voice it it’s out in the open and you’ve had a bit of a laugh about it or you, or you know they’ve given you a couple of ideas... once they’ve given their input then you’re thinking actually, that’s probably not as bad as I think and I’ve just got myself in a complete tizzy over nothing **(Louise)**

For Marie, disclosure led to relief at not having to hide her experiences, which had a positive effect on her and transformed the way she behaved and managed the situation.

Some relief, some sense that I didn’t have to hide or pretend all the time, and just giving slightly more breathing space and not having to explain... **(Marie)**

### 5.5.2 Disclosure facilitates opportunities for support

By telling other people in their support network about their suffering, direct support became available to the participants. Victoria spoke of the instrumental (practical) support she received from both her mother and the maternity nurse they had hired, and who was now supporting them for no charge. The positive impact this had on her was emphasised by her words “brilliant” and “amazing”.

**Victoria:** I think people were very supportive, they were, *really* supportive, I've gotta say.

**Researcher:** How did that support manifest itself?

**Victoria:** Well my mum was around a lot... I didn't do dinner for like 4 months, basically, so they did practical help, it's brilliant, [maternity nurse] stayed I mean that's phenomenal because she charges £150 per day, and she didn't charge us anything for about 3 months, so I mean, that's pretty amazing.

Anne also spoke of the instrumental support and the company received by her mother after she told her what she was going through, expressing her surprise at the level of support she provided, but also questioning what she would have done without it. The close proximity of her mother appeared to facilitate emotional support as well.

Well I think it did change it because when I did actually tell her she was much more supportive and helpful than I actually thought she was going to be...  
... 'cause I'd already told her by then, so she was very good so she stayed in the week and then went home at the weekends and then came back, and I don't know what I would have done without her, and I did talk to her more emotionally **(Anne)**

Similarly, Louise received a combination of instrumental and emotional support from her husband. She described his emotional support - listening and taking on board what she disclosed - as limited by his ability to understand her lived experience directly. Nevertheless, the praise she received from her husband improved her mood and this may have been mediated by changes in beliefs about herself as a mother from the content of the praise (e.g. "oh you're the best mum").

...my husband's quite good because I was talking to him about it, instead of sort of, going to, to a doctor so it was a case of having somebody to listen and to understand, not that men really can but not to be judgemental, and to, to take on board what I was saying, and, he does makes sure that I do have, time as in at the weekend he will get [Child's Name] up so it's trying to take everything off me.

...he does always tend to, say to me "oh you're the best mum" you know "you're doing really well" so there's that amount of praise I'm getting which makes me feel, better **(Louise)**

For Marie, disclosing to friends 15-18 months after her first child was born led to confidants making support available to her following the birth of her second child.

I was talking to my friend who was one of the people at the dinner where I mentioned it when they were about 15-18 months old, and she was great... soon before I had [second child's name] she just one day had a, "if there's anything I can do", she was really really good (said tearfully)... **(Marie)**

Joanne was the only participant who disclosed her suffering through social media, specifically a blog and a forum for knitters with depression. This led to support from her readers. She described how her "boxes" for support were ticked by the comments a friend was able to leave on her blog after reading what she was going through.

...he occasionally commented on the blog posts with very simply but supportive lines, of just... this is very well put, and very sad, and I'm thinking of you, and you really should write a book, and, kind of thing... sort of acknowledging that it was all shit, and, in a really cheesy way praising me for my being honest... and, yeah, shout if I can do anything... that was all the boxes that I needed ticking you know that sort of... **(Joanne)**

### 5.5.3 Conquering postnatal depression: "It's ever so much easier to talk about something in the past"

...it's ever so much easier to talk about something in the past, than it is to talk about it while it's happening, not least of all with the postnatal element... **(Joanne)**

This theme portrays how disclosure felt easier for participants once they felt they had 'overcome' PND in some way and it was in the past, as exemplified by Joanne above. Louise spoke of the influence of disclosure by mothers in the public eye.

Yeah again it's... afterwards and you feeling better and stronger that you feel you can then disclose it, like all these celebrity mums that have had it like was it, Jamie Oliver's wife, yeah it's after it's happened that you then feel more able to, to say "yes I've had it and I now feel better" **(Louise)**

There were varied reasons for needing to overcome their experiences to ease disclosure. Louise envisaged that disclosing whilst experiencing difficulties would have been “too much” and described how being in a more empowered position of having “conquered” PND and being able to “look back” at it helped her to talk about it to other people beyond her initial confidants. Louise went on to describe how she needed time to pass to feel safe for the difficulties not to “come back” before she felt comfortable making further disclosures. Her phrase “yeah, I think I had a bit of postnatal depression” suggested that in the recovered position she might minimise her experience, to enable disclosure.

**Louise:** ...I think I... only told people about it after... it had finished having the symptoms, I didn't really discuss it with anybody apart from my husband and close friends while I was having the symptoms, so it was only afterwards and I could look back and say “yeah, I think I had a bit of postnatal depression” that ‘cause to actually admit that you’re, having it at the time would probably have been too, much, whereas it’s easier to admit something after it’s been over and done with and you’ve conquered it.

**Researcher:** Right, and what is it about conquering it that allows you to then feel more able to disclose?

**Louise:** Because... it’s over and done with, and it’s something that isn’t going to come back, that’s why you feel that you can do it... to then be able to say “yes, I’ve done this, it’s now been a week or a month or a year”

Victoria also spoke of feeling more able to talk about her difficulties when they were ending. She noted how disclosure at this stage might benefit other mothers by providing them with a peer and an example of how mothers have come through their suffering to feel “normal” again. The repetition and emphasis of “have” suggested that a sense of hopelessness was a significant part of her distress.

...I did investigate thinking about going to a support group, like *now*, now that I’m sort of, feeling like I’m coming out of it, and going just so that other women can see you will get through it because you *have* to be, you *have* to know that you’re going to come through it and be normal again, and be yourself again, ‘cause you do not feel the person, you do not feel yourself **(Victoria)**

The emphasis Marie placed on “shame” in the extract below highlighted the significant role this played in experiencing difficulties. She described herself as not being good at admitting

or accepting she was not okay, nor relying on other people. For Marie, recovery reduced the sense of shame she had experienced, which then made it easier for her to disclose.

It's much easier to talk about it now, I guess there's not the sense that I'm still there so not the *shame* I suppose, and it's a really hard thing to admit to yourself let alone to anyone else that actually I don't want this child I wish he wasn't here I wish he didn't exist...

...having to rely on people or accept or admit that I'm not ok, I'm not very good at that, so afterwards it's a case of well it's done but this happened is a very different thing to be saying... **(Marie)**

Conversely, Anne felt that anti-depressant medication enabled her to be in a "different place" to be able to disclose to her mother, which she had struggled to before. However, it may be that medication was a route to the recovered self for Anne.

I did talk to her more emotionally, but I think because I was on the medication I was in a different place then anyway... **(Anne)**

## 6.0 DISCUSSION

### 6.1 Overview

The aim of the current study was to explore the lived experiences of mothers who have talked about their postnatal emotional difficulties to other people within their support networks, including health professionals, partners, family members, friends, colleagues. The main research question, which formed the focus for the analysis, was:

- What are the experiences of mothers who disclose their symptoms of PND?

In order to enhance understanding of the findings and situate them within a wider context and in line with the hermeneutic cycle in IPA (Smith, 2007), new research material will be introduced alongside literature already reviewed in section 3.0. Following a review of findings, I have provided a critique of the methodology used. Implications of the findings for clinical practice and suggestions for further research then follows. The section ends with a conclusion of the findings.

### 6.2 Experiences of mothers who disclose their symptoms of postnatal depression

The four superordinate themes in this study represent parts of an overall disclosure process that participants went through. This section begins with a discussion of the first superordinate theme as this represents a distinct period prior to a disclosure of PND. I discuss the remaining three superordinate themes together as they directly relate to the process of disclosing.

During the analysis process, attention shifted towards particular psychological theories as a means of understanding the results. Across this section, I will refer to theories of social comparison processes and related research, as these best represent the relational context surrounding disclosure of stigmatized identities. The Disclosure Processes Model (Chaudoir & Fisher, 2010) is introduced in section 6.2.2, as this model aids understanding of the processes people go through to disclose a stigmatized concealable identity, such as being a mother with PND.

### 6.2.1 Trying to cope whilst making sense of experiences

Each interview in this study began with questions that explored what it was like for the participants as they began to experience PND (see Appendix 10). This section explores the first superordinate theme; it captures a process of trying to cope and make sense of internal experiences before considering whether to reach out to others. The mothers provided rich accounts of using practical strategies to manage their symptoms within themselves. It appears from my review of the literature that this is the first study to discuss experiential avoidance (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996) in relation to coping with PND. The participants also described a tendency to adopt façades to manage their external appearance to others. The façade for others excluded husbands and partners, who, in line with some previous research, formed an immediate source of support (Hopkins & Campbell, 2008). The following discussion will explore participants' attempts to cope with their experiences within themselves and in relation to others.

#### Trying to cope: coping related to the self

Previous research has found that mothers with PND who do not wish to disclose their symptoms go through a process of managing them alone (Edhborg et al., 2005). Whilst Louise spoke of employing her pre-existing tendency to engage with her internal experiences and process them alone, the other participants' coping strategies seemed to involve an avoidance of internal experiences via sleeping, "running away moments", crocheting in a "manic fashion" and generally keeping busy (see section 5.2.1). This suggested participants found it difficult to remain in contact with their unwanted internal experiences (e.g. emotions, thoughts, memories, images, bodily sensations) preferring to devote time, effort, and energy to managing or controlling them in order to gain short-term relief from the discomfort they caused. Research on experiential avoidance (Hayes et al., 2004) has argued that avoidance strategies are in fact stronger contributors to psychopathology, including depression (Tull, Gratz, Salters, & Roemer, 2004), than the content of private psychological and emotional experiences themselves (Kashdan, Barrios, Forsyth, & Steger, 2006). The paradox of experiential avoidance is that attempts to hide or inhibit experiences actually serve to increase the frequency of them and the distress they cause (Gross, 2002), as well as increasing a sense that one is being inauthentic or is disconnected from oneself (John & Gross, 2004). It may also interfere with the pleasures of being fully immersed in any activity, resulting in less frequent

positive events and dampened positive emotions (Gross & John, 2003). This may in part explain why the participants' depressive symptoms did not improve through the strategies they adopted and why disclosing their symptoms later became a necessary option for managing their experiences.

Gilbert (2010) claimed that other people help us to become comfortable (or not) with our feelings, to understand them and give them meaning. For example, internalised social expectations of maternal coping may have played a significant role in participants' emotional avoidance. The influence of social contexts on emotional experiences will now be explored.

### Trying to cope: coping related to others

#### *Social comparison processes*

In section 5.2.2, participants cited information from British culture and media as sources of internalised expectations of maternal coping to which they compared themselves. For Marie (section 5.2.2), expectations of coping also stemmed from comparisons she made to other mothers around her. Other qualitative studies have reported that mothers with PND carry out a social comparison process in which they judge how well they can cope with motherhood relative to other mothers within their social context (Edwards & Timmons, 2005; Lauer-Williams, 2001). Festinger (1954a; 1954b) claimed that humans have an innate drive to compare themselves to others to reduce uncertainty, define the self, and gain accurate self-evaluations. According to Festinger (1954a; 1954b), people are often interested in comparative judgements involving similar others, but sometimes they engage in upward and downward social comparisons which serve different functions (Kruglanski & Mayseless, 1990) – explored later in this section. So what expectations of maternal coping, resulting from these comparison processes, were reported in this study?

#### *Perceived social expectations for coping in motherhood*

In participants' accounts of perceived expectations of mothers (section 5.2.2), there was a polarisation of constructs of coping. There seemed to be no *grey area* between coping and not coping, which may have led to a fear of shifting from the position of *copier* to *non-coper*. Within the results, Joanne (section 5.2.2) described polar constructs of women ("they either

have it all, or they're a complete wreck") and labelled this the "woman complex". This polarisation of constructs of mothers/women can also be found in the psychoanalytic literature, for example in the discourse around the *good versus bad* mother (Deutsch, 1944), and in the media (Held & Rutherford, 2012) – see section 3.4.2. Participants' need to be seen as coping (e.g. Louise and Anne; section 5.2.2) alongside an apparent all-or-nothing thinking style (Burns, 1999), or slot rattling between constructs (Kelly, 1955), about maternal coping (Joanne; section 5.2.2) may have represented an internalisation of this polarisation. This is supported by research in which mothers reported staying silent about their distress (or *imperfection*) due to a perceived need for perfection, high expectations of themselves, and difficulty admitting they might be less than the "perfect mother" (Edwards & Timmons, 2005; Lauer-Williams, 2001).

Across their accounts, participants used phrases indicating a clear belief in how they *should* and *should not* have been feeling and behaving as mothers in the postnatal period (see section 5.2.2). In cognitive behavioural theory, 'should' statements have been identified as a cognitive distortion which can contribute to depression (Burns, 1999), particularly in the postnatal period when there is often a mismatch between mothers' idealised expectations and their reality (Harwood, McLean & Durkin, 2007). Considering this further, the Self-Discrepancy Theory (Higgins, 1987) postulated that we are motivated to reach a condition where our self-concept (our actual self) matches our *self-guides* (Higgins, Strauman, & Klein, 1986). Self-guides are self-state representations that act as self-directive standards, including standards of duty, or how people *ought* to be in social contexts. In accordance with this theory, participants in this study spoke of *actual: ought discrepancies* (Higgins, 1987). When there is a discrepancy between these two states (actual and ought), a *self-conflict* occurs, which can lead to a range of emotional difficulties. For example, Anne (section 5.2.2) described feeling guilt when her actual experience did not match what she felt she should experience. Guilt, a moral emotion, is an agitation-related emotion typically experienced with this type of discrepancy (Higgins, 1987). Research has supported Higgins theory but has found that self-discrepancies relate to emotional distress across the board, e.g. shame, guilt, depression and anxiety, rather than specific emotions relating to specific types of discrepancies (Tangney, Niedenthal, Covert & Barlow, 1998).

### *The need to meet social expectations: theoretical considerations*

From an evolutionary perspective, Gilbert's (1992, 1997) Social Rank Theory posited that humans are driven to gain/maintain *social rank* and status in a naturally occurring social hierarchy. Humans are also driven to seek attachment to other human beings in their social world (Gilbert 1997; 2005). To achieve these two outcomes, they use two forms of strategies. Attraction-based strategies (displays of positive social behaviours, such as the facades used by this study's participants) are used to enhance social attractiveness and meet expected social standards, thus leading to positive rewards, such as acceptance within social contexts. Threat-defence strategies are used to avoid rejection or ostracising, which might lower a person's social rank. These strategies may include the safety behaviours, or *social damage limitation* strategies (Gilbert & McGuire, 1998), used by this study's participants (e.g. non-disclosure, and potentially emotional avoidance). This leads us on to exploring participants' use of facades as a positive social behaviour aimed at meeting their needs to look like a coping mother and behave according to expected standards for mothers.

### *The use of façades*

Participants' use of façades when in the company of other people outside of the home (see section 5.2.3) may represent attempts at reducing *actual: ought* self-discrepancies (Higgins, 1987) thereby relieving self-conflicts. This presentation of façades is reflected in qualitative research in which women reported managing their need to hide their true emotions by faking a display of happiness (Edwards & Timmons, 2005) and "smiling through it" when they unfavourably compared themselves to other mothers (Vik & Hatfing, 2012). In line with other research findings, and Gilbert's (1992; 1997; 2005) work (see above), during the initial period of staying silent about their symptoms, participants tended to be more concerned with their exposure to the public than their own internal experiences and well-being (Lauer-Williams, 2001). Studies have pointed out that mothers tend to try to fit in with other mothers and report feeling disgrace when they perceive themselves as not being able to do this (Edwards & Timmons, 2005; Lauer-Williams, 2001). Research on individuals with concealable stigmatized identities has highlighted the unique significant stressors they face compared to those with overt stigmatized identities, including the efforts required to conceal a stigma (Pachankis, 2007).

### Trying to define and understand experience

Strategies that allowed participants in this study to avoid difficult emotional experiences may have also resulted from their struggle to define and understand what they were going through. Some struggled to know what was *normal* and *expected* in the postpartum period, as found in the literature (Knudson-Martin & Silverstein, 2009; McCarthy & McMahon, 2008; Templeton, Velleman, Persaud, & Milner, 2003). As Marie highlighted (section 5.2.4), not being able to define an experience made it difficult to then disclose it to others. Participants spoke of needing health professionals' to help define and even label their emotional difficulties (Victoria; section 5.2.4) in a way that was congruent with their idiosyncratic lived experience. By contrast, the reality was that some mothers in the current study received prognoses, descriptions, or advice that were incongruent with their lived reality, heightening their confusion and belittling their experience (Marie and Louise; section 5.2.4). Participants spoke of a greater need for information about how to recognise and seek help for PND (Anne; section 5.2.4) and referred to antenatal classes as a suitable point in time for information provision (Joanne; section 5.2.4).

However, reported difficulties in identifying and correctly attributing symptoms to PND (Fitelson et al., 2011; Pope et al., 2000; Stewart et al., 2003), alongside pressures and limitations of 'corporate' systems of care in the NHS (Chew-Graham et al., 2009), can restrict health professionals' capacity to facilitate disclosures of PND. Thus, there is an apparent need for both health professionals, and the organisations within which they reside, to provide space for postnatal mothers to talk and explore (with the professional) their experience to enhance accuracy of diagnoses.

#### 6.2.3 The process of disclosing postnatal depression in social contexts

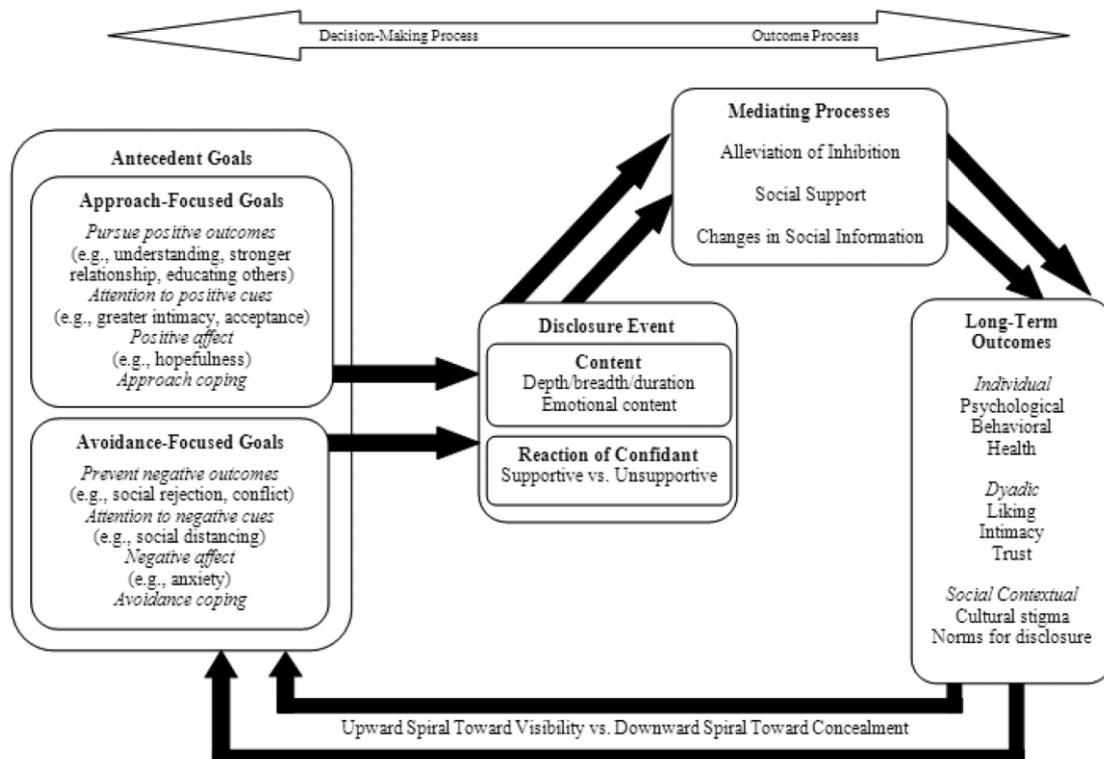
Presented below is a review of the remaining superordinate themes. Together they portray the disclosure process undertaken by participants: deciding whether to disclose, the disclosure event itself, and the transformation processes related to disclosure. A number of themes within this section support the existing literature (e.g. the influence of stigma on disclosure). However, novel findings from the current study include: the influence of perceived entitlement to have PND and receive support; the cautious process of disclosing PND; and how recovery from PND facilitates disclosure.

Deciding whether to disclose

*Disclosure goals and motivation*

In recent years, research on disclosure has focused on how people disclose concealable stigmatized identities (personal information that is socially devalued but is not readily apparent to others) such as mental health problems (Pachankis, 2007; Quinn & Chaudoir, 2009). Interpersonal disclosure is an important part of the lives of individuals who live with a concealable stigmatized identity, and decisions to disclose for the first time can be some of the most difficult to make as it may lead to harm as well as benefits (Chaudoir & Quinn, 2010; Pachankis, 2007). The Disclosure Processes Model (Chaudoir & Fisher, 2010 – Figure 1, below) has suggested that disclosure begins with a decision-making process that occurs when there is an activation of Approach-focused and Avoidance-focused goals, which affect the likelihood of disclosure in a given situation.

Figure 1. The Disclosure Processes Model (Chaudoir & Fisher, 2010)



Approach-Focused Goals reportedly drive the individual to pursue positive rewards and positive states (e.g. self-expression, self-clarification, social validation, seeking support or strengthening a relationship); and Avoidance-Focused Goals lead the individual to focus on the prevention of negative outcomes (e.g. stigma, rejection and criticism).

Theories and research on motivation and self-regulation support the approach and avoidance dimensions of this model. Elliott (1999) described a regulation of human behaviour by two separate motivational systems: the pursuit of a reward or desired end-state, or the avoidance of a punishing or undesired end-state. Gilbert's (2005) model of affect regulation (see Appendix 13) posited that emotions guide us to desired end states needed for survival and respond if we are succeeding or threatened. Similar to Approach-Focused Goals, it consists of two positive affect regulation systems that drive behaviours involving a high level of engagement with one's social environment to gain social rank and attachment to others. Similar to Avoidance-Focused Goals, the third type of affect regulation system focuses on threat and self-protection (*threat-defence* system) and drives safety behaviours (e.g. non-disclosure of PND) when it is perceived that social rank or attachment are under threat.

Research has identified the relationship between depression and approach and avoidance motivations. For example, in adolescents with high levels of depression compared to controls, Dickson and MacLeod (2004) found a deficit in approach goals and plans (steps a person takes to bring about a personal goal), along with more avoidance plans (a strategy of not doing things in order for the goal to be achieved). Disengagement from approach motivation may represent a defence mechanism for protection against personal failure (Dickson & MacLeod, 2004), such as the potential failure to be seen as a coping mother. Consistent with this, Higgins, Roney, Crowe and Hymes (1994) found that an orientation toward 'ought' self-guides associated with depression would involve a predilection for avoidance rather than approach, which helps to explain why participants in the current study were still avoiding disclosure at this stage in the disclosure process.

#### *Factors influencing decisions to disclose*

According to the Disclosure Processes Model (Chaudoir & Fisher, 2010), on activation of Antecedent Goals, decision-making will ensue regarding whether disclosure is an appropriate strategy for attaining the goal. This involves an evaluation of the potential costs versus

benefits of disclosure. Interestingly, participants in this study reported three inhibiting or facilitative factors that influenced their decisions about whether to avoid or approach self-disclosure: their perceived entitlement to have PND and receive support, stigma and judgement, and factors about the confidants.

The literature on social comparison processes has highlighted people's tendency to make comparisons to determine a subjective *entitlement function* (Kruglanski & Mayseless, 1990), i.e. what type and degree of factors (e.g. labelled 'contextual factors' in this study) are perceived to entitle one to a given level of outcome. From my review of the literature, this study's findings on entitlement related to PND appear to be novel. Participants' disclosures were hindered by their own and other people's assumptions about *thresholds* for PND and contextual factors that seemed to determine a perceived entitlement to have PND and receive support from others (section 5.3.1). In section 5.3.1, the contextual factors they considered were: whether they were "lucky" (Louise) in comparison to other mothers, what their lifestyle was (Louise and Marie), having children who slept well (Louise and Victoria) and having successful IVF treatment (Anne). Indeed, in relation to IVF, research suggests that women who conceive through assisted conception have a lowered sense of entitlement to complain or seek help due to their sense that their babies were highly desired (Fisher, Hammarberg & Baker, 2005). The *entitlement function* influences judgements concerning fairness of outcomes, which in other people can lead to various reactions (Austin, McGinn & Sasmilch, 1980), such as the minimising that mothers' in this study described.

Awareness of stigma surrounding PND, and an associated fear of being negatively judged, also hindered participants' disclosure processes, even within personal support networks (see section 5.3.2). Fears of stigma, rejection and criticism have been some of the most commonly cited reasons for non-disclosure across a wide variety of identities (see section 3.5.1). One participant (Louise; section 5.3.2) claimed that, for her, disclosing a sexually transmitted disease would have been easier than disclosing PND. This suggested a tendency to compare and perhaps 'rank' identities in terms of how stigmatising, or socially unattractive (Gilbert 1997), they were. In line with findings related to internalised expectations of maternal coping (section 5.2), Anne and Louise (section 5.3.2) feared being judged as not coping if they revealed their depression, as if somehow having PND equated to an inability to cope. It begs the question: what actually constitutes *coping*, particularly in motherhood? Anne (section 5.3.2) also reported being viewed as a "terrible mother" as an additional fear. These two fears

correspond to those reported in the wider literature (e.g. McCarthy & McMahon, 2008). However, this study extended these findings in that participants described being more fearful of disclosing some symptoms of PND, namely thoughts of infanticide, compared to others, such as low mood (Joanne and Marie; section 5.3.2). This led to partial disclosures, with some parts of their lived experiences remaining hidden or only disclosed at a much later stage (e.g. Louise; section 5.3.2). Again, this suggested that participants compared and ranked different symptoms of PND according to perceived social unacceptability (Gilbert, 1997).

### *The process of selecting a confidant*

Selecting an appropriate confidant is an important part of the decision-making process aimed at attaining disclosure goals (Chaudoir & Fisher, 2010 – see Figure 1). With participants citing a fear of how others may judge them following disclosure, it is unsurprising they expressed a strong preference for non-judgemental confidants with good listening skills (e.g. Marie, Joanne, and Anne; section 5.3.3). These are characteristics also preferred in health professionals (Heneghan et al., 2004). Participants' decisions were based on learning from prior experiences with confidants with whom they had long-standing relationships. This appeared to reduce the risk of negative outcomes, including judgement. Likewise, research has highlighted that long-standing relationships with health professionals, e.g. GPs, and a history of seeking/receiving support from them for PND or depression can facilitate disclosures (Chew-Graham et al., 2009).

Consistent with prior research (Edhborg et al., 2005), a perceived risk of being judged as weak for having PND was reported (e.g. Louise; section 5.3.3), which was managed by selecting confidants on the "same level" through a sharing of weaknesses (Louise and Victoria; section 5.3.3). This bears some resemblance to upward and downward social comparison processes described in the literature (Wills, 1981). There is a suggestion that these underlie and explain the effectiveness of peer support groups (Salzer & Shear, 2002). Research has suggested that upward social comparisons with others who are perceived as better off can lower self-regard; whereas downward social comparisons, which involve searching for others with negative situations in relation to one's own, can elevate self-regard and serve as a coping strategy (Festinger, 1954a; 1954b; Gibbons, 1986). Research has found that women, in comparison to men, tend to engage more readily in upward social comparisons with others, including unrealistically high standards of women presented in the media (Strahan, Wilson, Cressman

& Buote, 2006). Marie (section 5.3.3) referred to gender as enhancing this comparison process and suggested that it may go beyond comparison towards actively competing with other mothers, in contrast to other fathers. In support of this finding, mothers in a study by Dennis and Chung-Lee (2006) spoke of finding it impossible to talk to female friends about their feelings or problems, especially those with children the same age, due to their concern it could lead to competition.

Benefits of sharing similar experiences may also apply to therapeutic relationships. Here there is also an inherent imbalance of power between the therapist and client. One resolution to this is via therapist self-disclosure. Whilst there can be beneficial outcomes in therapy (including client openness, intimacy, trust, self-understanding and change) from this, there is also a potential risk of crossing ethical boundaries (Knox & Hill, 2003). Thus, it appears that in a variety of contexts, disclosing previously concealed information involves risk.

#### The two-way interpersonal process of disclosure

In writing about the Disclosure Processes Model, Chaudoir & Fisher (2010) stated that a major limitation of existing literature on disclosure of concealable stigmatised identities is that very little research has examined characteristics of the disclosure event itself e.g. what approaches people use to convey critical and sensitive information about their stigmatized identity. From my review of the literature, this study provides novel data on the cautious approaches used in disclosing previously concealed PND.

#### *A cautious approach*

There was a continuation of participants' risk management into the disclosure event itself (section 5.4.1). According to the Disclosure Processes Model (Chaudoir & Fisher, 2010) and associated research, people disclosing a concealed stigmatized identity may choose to 'test the waters' with their confidant by first introducing the topic and then returning to the topic after determining how the confidant is likely to react (Greene, Derlega, Yep, & Petronio, 2003; Serovich, Oliver, Smith, & Mason, 2005). Similarly, participants in this study described a cautious method of revealing their previously concealed identities to people in their personal lives and health professionals. In section 5.4.1, participants spoke of "hedging round" the conversation of PND (Louise) and using "flippant remarks" to initiate a "slow drip" process

(Joanne). Joanne spoke of making cautious disclosures in the context of eating and drinking, a context which has been identified in narrative (e.g. *Recipes of Life*; East London NHS Foundation Trust, 2013) and systemic (e.g. *Kids Time*; Cooklin, 2013) psychological practices as a helpful and safe way to facilitate social conversations and sharing of difficulties within groups. Other participants described not being fully honest with health professionals (Anne) or using covert, indirect ways of sending a message to other mothers about having PND (Victoria). This caution seemed to stem from a balance between fulfilling a need to reach out to others and a need to avoid the risk of a negative outcome from disclosure. Like the participants in this study, individuals with avoidance-focused disclosure goals have been found to be more tentative, use less direct methods of communicating, and have fewer disclosure events (Carver, 2006; Chaudoir, 2009).

### *Dealing with setbacks*

People may yield psychological and emotional benefits from positive and supportive responses to first-disclosure events (Lepore et al., 2000; Rodriguez & Kelly, 2006), which may alter their beliefs about disclosure, seeing it as a more favourable and beneficial behaviour (Chaudoir & Quinn, 2010) and perhaps less threatening to social rank and attachment (Gilbert, 1997; 2005). However, socially unsupportive or rejecting reactions from confidants can serve to silence people or make them more tentative about future disclosures (Ahrens, 2006). The setbacks experienced by participants in this study had a similar effect, despite being very varied in nature (see section 5.4.2). Some responses labelled the mothers' experiences or themselves negatively (e.g. "ridiculous" – Anne) or minimised the disclosed information (Marie), whilst other responses "didn't *feel* right" (Louise). In a personal context, Marie (section 5.4.2) had wondered whether other mothers shut down conversations about PND because they had suffered from it as well but struggled to disclose it. Similar experiences but dissimilar types of disclosure goals may be a plausible explanation for this (Chaudoir & Fisher, 2010). In a professional context, Joanne (section 5.4.2) expressed concern for other mothers without a strong support network whose one "mayday" to a health professional may act to silence them. She believed her strong support network buffered her against these negative outcomes from disclosures to health professionals, reducing the likelihood of her getting "through the cracks". This highlights the importance of the current research in further understanding disclosure and help seeking from family and friends, who have consistently been found to be a primary source of support for mothers (Dennis & Chung-Lee, 2006).

### *Perceived impact of disclosure and support-seeking on relationships*

Disclosure is an inherently interpersonal exchange that has implications for both the discloser and confidant and their relationship with each other (Chaudoir & Quinn, 2010). Disclosure introduces new information about the discloser that can change the way the confidant perceives and interact with them, and vice versa (Chaudoir & Fisher, 2010). Thus, this *change in social information* may act as a *mediating process* that influences individual, dyadic and social contextual outcomes (see Figure 1). Derlega and colleagues (1993) claimed that disclosure and indicators of relationship quality seem so intertwined that disclosure and relationships could be described as mutually transformative. Based on how confidants responded to disclosures, participants in the current study spoke of positive and negative implications for confidants and their relationships (section 5.4.3). For Joanne, revealing more of her true self led to more “true friendships” and enabled her to “sort the wheat from the chaff”. Participants described greater understanding from partners and a strengthening of their relationships with partners following disclosure (Victoria and Louise; section 5.4.3), a finding supported by research (Chaudoir & Quinn, 2010; Finkenauer, Engels, Branje & Meeus, 2004).

Similar to previous research, some disclosures led to role reversals between the confidant and discloser (Harvey & McGrath, 1988), which was difficult for either party. In section 5.4.3, Anne revealed her brother and husband found this difficult as they were used to her supporting them, whilst Marie reported having to support her mother following her own disclosure at a time when she needed support. A limitation of this study is its focus on the interpersonal nature of disclosure from the discloser’s perspective only. Both Anne and Marie highlighted that disclosure can serve to heighten pre-existing disconnections and difficulties in relationships with family members. This corresponds to research that suggests the benefits of verbalising one’s thoughts and feelings about an emotional experience are highly dependent on how supportive the social context is (Foa & Rothbaum, 1998). Therefore, this study’s findings illustrate the paradoxical nature of disclosing PND to people within support networks.

### Disclosure as part of a transformative process

The trial-and-error process participants described yielded negative outcomes that made them cautious (e.g. Marie; section 5.4.2), alongside positive outcomes, which, as discussed below, contributed to a transformation in how they experienced PND and the support available to them. This is in line with the Disclosure Processes Model (Chaudoir and Fisher, 2010), which posited that *alleviation of inhibition* and *social support* were potential mediating processes that, along with the aforementioned *changes in social information*, allow disclosure to affect possible *long-term outcomes* (see Figure 1). For participants, this transformation process appeared to result in a sense of having “conquered” PND, which then seemed to transform their perceived ability to disclose.

#### *Perceiving and experiencing the problem differently*

The mediating process of *alleviation of inhibition* (see Figure 1) is the idea that disclosure can be beneficial because it allows disclosers to cognitively or affectively process previously inhibited information (Chaudoir & Fisher, 2010). Research has found that disclosures and subsequent discussions with confidants can facilitate processes such as desensitisation and cognitive restructuring, which can help define or re-define an experience for the discloser (Clark, 1993; Harber & Pennebaker, 1992; Kennedy-Moore & Watson, 2001; Meichenbaum & Fitzpatrick, 1993). All participants in this study reported changes in how they viewed their experience of PND or how they viewed themselves in relation to their experience following disclosure (see section 5.5.1). Marie reported seeing PND as something she did not have to hide following disclosure, which provided her with “breathing space” and “some relief”. Kennedy-Moore and Watson (2001) termed this reciprocal relation between emotional experience and emotional expression the “paradox of distress”. Louise reported that her experiences were normalised by confidants, whilst Anne and Joanne spoke of how disclosure helped them realise they were not “going mad” or “such a looney tune”, respectively. Through conversations that resulted from disclosure, other participants spoke of their experiences being reframed (Victoria and Louise).

This process forms the basis of most psychotherapeutic approaches in which client-disclosure and subsequent exploration can facilitate positive ways of thinking, relating to others and behaving that enhance quality of life and well-being (Castonguay & Hill, 2012). Examples

include ‘contrast reconstruction’ in personal construct psychotherapy (Kelly, 1955), ‘cognitive challenging’ and ‘cognitive restructuring’ in cognitive behavioural therapy (Burns, 1999), and the reframing techniques in narrative and systemic therapy (Dallos & Draper, 2010; Freedman & Combs, 1996). With reference to the aforementioned ‘slot rattling’ between participants constructs of coping, it may be that post-disclosure processes (like cognitive reappraisal strategies used in psychotherapies) helps the ‘grey area’ between polar constructs to be found internally.

#### *Greater opportunities for support*

The final proposed mediating process in the Disclosure Processes Model (Chaudoir & Fisher, 2010 – Figure 1) relates to the transformation of the participants’ situation and associated struggles through *social support*. Disclosure is a behaviour that is a prerequisite to obtaining social support. While shielded from social rejection, those who keep identities concealed do not have the chance to receive emotional and physical support from their confidants (Chaudoir & Fisher, 2010). The aforementioned individual (psychological and health) and dyadic relationship benefits can be derived from disclosure if the person is socially supported rather than rejected (Smith, Rossetto, & Peterson, 2008; Uchino, 2009). In support of previous research, participants in the current study spoke of the importance of the *instrumental* and *emotional* support (Robertson et al., 2003) they received from their partners, mothers and friends – see section 5.5.2.

#### *Disclosing PND is easier following recovery*

Four participants described themselves as not having PND at the time of the interview and Victoria described herself as “coming out of it” (section 5.5.3). This indicated that positive disclosure experiences, despite some co-existing negative setbacks, eventually led to long-term consequences that collectively led to a state of recovery (see Figure 1). Previous research has focused on factors that facilitate recovery from PND (Gotlib, Whiffen, Wallace, & Mount, 1991) and people’s experiences of recovering from depression (Ridge & Ziebland, 2006) but has not looked at the influence of recovery on disclosure. This study adds to the literature on recovery from PND with the findings showing how recovery changed participants’ felt ability to disclose.

The feedback loop in the Disclosure Processes Model (Chaudoir & Fisher, 2010) demonstrated how positive long-term consequences of disclosure could lead to an *Upward Spiral Toward Visibility*. In section 5.5.3, participants stated disclosure was easier after they had “conquered” PND (Louise) and it was in the past (Joanne and Louise). Being in the recovered position meant they felt stronger (Louise), no longer had to rely on others (which Marie had struggled with), no longer felt the shame of having PND (Marie), and there was less potential for relapse (Louise). The empowerment one might assume is associated with being a *conquerer* of PND compared to the potential disempowerment associated with being a *sufferer* of it may have removed the threat to social rank and attachment described by Gilbert (1997; 2005). Frank (1997) identified people’s desire to present a *restitution narrative* about illness, i.e. to get well and stay well. This desire is described as natural, but Frank (1997) proposed that people also learn this narrative from institutional stories that model how illness is to be told. For example, television commercials of non-prescription medication suggest that for every suffering there is a remedy. The widespread influence of the media means that the restitution story has become the preferred narrative within society (Frank, 1997).

In section 5.5.3, Louise recounted celebrity mothers’ public disclosures of PND after they had recovered from it, and Victoria spoke about sharing her own experiences with other mothers in a support group context to provide them with hope regarding recovery. In line with this, researchers have proposed that people move between two motivational systems (*egosystem motivations* and *ecosystem motivations*) across the process of disclosure (Chaudoir & Quinn, 2010). Prior to and during disclosure, participants in this study seemed to report motivations that focused on satisfying the needs and desires of the self (perpetuating positive self-images, obtaining desired social outcomes and avoiding harmful ones – Gilbert, 1997), termed *egosystem motivations*. However, participants appeared to associate recovery with more *ecosystem motivations* for disclosure, which consider the well-being of others and place oneself as part of a larger human interconnectedness. Research has found that in a more empowered position, people disclose more openly, even *Broadcasting* their previously concealed identity (Corrigan & Rao, 2012), and are driven to not only share but to educate others about their experiences, often to help avoid undesirable outcomes for others (e.g. coping with their stigmatized identities alone) (Chaudoir & Quinn, 2010). Indeed, Figure 1 illustrates how an *Upward Spiral Toward Visibility*, following positive disclosure outcomes, could lead to more *Approach-Focused Goals*, which include *educating others*.

### 6.3 Methodological considerations

To ensure standards of quality and validity, I adhered to Yardley's (2000; 2008) guidelines throughout the research process. Appendix 4 details how these guidelines were met. In this section, I review methodological issues related to the IPA approach (Smith et al., 2009) adopted in the current study, which aimed to explore the mothers' experiences of disclosing their symptoms of PND.

The process of co-construction within IPA is inevitably influenced by the researcher's own experiences (Larkin et al., 2006). I conducted all interviews before the birth of my second child but I carried out data analysis afterwards. My experience of the postnatal period following the birth of my second child was inevitably different from that of my first. Listening to the bracketing interview prior to data analysis provided me with a way of staying connected to my original emotional experiences, which had played a role in the formulation of this study and which were carried with me into each interview, and were therefore important to hold in mind. Indeed, my bracketing process, and overall self-reflexivity, was a strength of this study.

It is also important to consider the potential influence of the participants' experience on the methodology. The sample was self-selected thus participants may have been drawn to the study and interested in taking part because of their postnatal emotional experiences and desire to process these within the interview process and/or pass on their stories of recovery. Indeed, some participants spoke of this as an important way to help other mothers who may be suffering. Therefore, it is possible that the current findings are representative of a vocal minority experience. Furthermore, the characteristics of the participants (see Table 2) may also limit the generalizability of findings to other mothers with PND of different class, culture, age etc. Nevertheless, in line with Miles and Huberman's (1994) criteria for qualitative sampling strategies, the sampling strategy in this study was relevant to the conceptual framework and the research question; ethical in nature; and feasible in terms of cost, accessibility and the researcher's communication skills. Furthermore, the sample generated rich information on the type of phenomena that needed to be studied; and produced believable descriptions and explanations (Miles & Huberman, 1994).

A further limitation of this study, and all qualitative research, is the limited generalizability of findings, as causal effects and mechanisms cannot be claimed. Whereas generalizability in

quantitative research is statistical and the study sample is matched to the study population to ensure comparability of characteristics, in qualitative research participants are selected by means of theoretical sampling, i.e. for their ability to provide information and develop theory about the area being studied (Horsburgh, 2003). Thus, situational, rather than demographic, representativeness is sought. The idiographic nature of IPA means a small, purposively-selected and carefully-situated sample is used to investigate how particular experiential phenomena have been understood from the perspective of particular people in a particular context (Smith et al., 2009). Whilst generalisability is not the key aim of qualitative research, Morse (1999) stated that if qualitative research is not considered generalizable, then it is arguably of little use. In the context of the current study, generalizability of the current findings refers to the extent to which *theory* developed within this study may be *exported* to provide explanatory theory for the experiences of other mothers in comparable *situations*, i.e. disclosing their symptoms of PND to other people (Horsburgh, 2003). Thus, the sample fits Miles and Huberman's (1994) criteria as it enhances the analytic generalizability of the findings. This brings us to the consideration of clinical implications of the current findings.

#### **6.4 Implications for clinical practice**

This section reviews a number of potential clinical implications that arose from the current findings. These implications apply to both the antenatal and postnatal periods. In line with my social constructionist stance, there is a focus on addressing public stigma, i.e. the prejudices and discrimination directed at a group with devalued characteristics by the larger population (Corrigan, 2005; Corrigan & Rao, 2012), in order improve the social discourses about PND and motherhood. Other implications focus on the impact of mothers' knowledge of PND and on her internal experiences, including perceptions of maternal expectations as well as self-stigma, i.e. the internalisation of public attitudes (Corrigan et al., 2006). Proposed interventions also consider partners and family members.

##### 6.4.1 Interventions in the antenatal period

###### Mindfulness training

The mothers in this study reported adopting a range of strategies that seemed to help them avoid experiencing difficult thoughts and feelings (section 5.2.1), but paradoxically this led to

a continuation and potential worsening of distress. Mindfulness training in the antenatal period may be helpful in teaching mothers, particularly those at risk of PND, skills to enhance their emotional reactions to their emotional experiences, or “meta-emotions” (Gottman, Katz & Hooven, 1997; Mitmansgruber, Beck, Hofer & Schubler, 2009). Mindfulness is the beneficial counterpart of experiential avoidance as it involves purposefully and non-judgementally paying attention to the present moment (Kabat-Zinn, 1990). Meta-emotions explicate processes in experiential avoidance/mindfulness in two meaningful ways. Firstly, meta-emotions embed a cognitive appraisal that is in contrast to the definition of mindfulness by Kabat-Zinn (1990). Secondly, the quality of meta-emotions provides information on regulatory processes operating on the target emotion. For example, mothers may feel anxious about feeling depressed, which would influence the experience of that depression, and this process differs from experiencing compassion about feeling depressed (Gilbert, 2010; Mitmansgruber et al., 2009).

Whilst mindfulness-based cognitive therapy (MBCT) has been found to be an effective treatment for chronic depression (Hofmann, Sawyer, Witt & Oh, 2010) and research has begun looking at the effects of mindfulness on prenatal stress and mood (Vieten & Astin, 2008), there is little research looking at its effectiveness in the postnatal period. However, researchers have recommended mindfulness as a treatment for PND (Hughes et al., 2009). Based on the findings of Vieten and Astin (2008), expanding mindfulness interventions to bridge between prenatal and postpartum periods by providing postnatal booster sessions could have value, especially for women with a history of depressive episodes.

### Education and preparation

Day (2007) claimed that professionals do not adequately attend to depression prior to childbirth. This would be the ideal time (pre-birth) to empower mothers and those in their support network by enhancing *mental health literacy* (Jorm et al., 1997), i.e. knowledge and beliefs about mental disorders, which aid their recognition, management or prevention. The mothers in this study spoke of a struggle to define and understand their experience and so attempted to carry on trying just to cope with it (section 5.2.4). This suggests a role for psychoeducation regarding PND, perhaps in NHS or privately-funded antenatal classes. Classes at this point may enable mothers to make more informed choices as they would know what to look out for and would have greater capacity to learn new information and make

plans to prevent, identify and/or manage any symptoms of PND (Zauderer, 2009). Other recommended strategies for this intervention (4Children, 2011; Roux, Anderson & Roan, 2002; Zauderer, 2009), include:

- Emphasising that early detection and treatment is the fastest way to recovery
- Increasing a mother's knowledge of how to meet her own needs
- Stressing the importance of and providing ideas on advance planning prior to birth, particularly regarding practical support in the postpartum period, which may prevent or reduce the fatigue, sleep deprivation, and/or social isolation that can sometimes influence the development and maintenance of PND

Research has found that supplementary antenatal classes on emotional issues can improve a mother's sense of preparedness for the possibility of mood disorders, in contrast to couples who attend only childbirth education classes (Ho & Holroyd, 2002). It may also enable women who experience distress in the postpartum phase to embrace this as a normal experience, speak about it and seek support, rather than managing the distress via experiential avoidance strategies (section 6.2.1).

#### 6.4.2 Interventions in the postnatal period

##### Health professionals facilitating disclosure and understanding

This study has highlighted the need for the provision of information about PND and where to seek professional support in the postnatal period (section 5.2.4). Whilst the current study has predominantly explored experiences of disclosing PND within personal support networks, changes in size, structure and location of family units within the last 50 years has likely reduced opportunity for mothers to discuss their experience with family and friends, thus, increasing a sense of isolation (Inglis, 2002; Smith & Mitchell, 1996). Therefore, the role of health professionals may need to expand or supplement support with the provision of opportunities for talking or 'debriefing' in which the mother gets to tell her story to help make sense of her experience (Allen, 1999). Due to research findings questioning the positive-predictive value and clinical effectiveness of the Edinburgh Postnatal Depression Scale currently used to screen for PND in the UK (Bick & Howard, 2010; Jardri & Maron, 2006), and women's reported preference for talking about their feelings rather than ticking boxes,

conversing with mothers about their idiosyncratic experiences should accompany this assessment and standard information provision. As with a research interview, multiple, open-ended questions would facilitate discussion and disclosure. So too would an open and non-judgmental approach, found to be a key facilitative factor in this study (section 5.3.4) and in the literature (section 3.5.3). If disclosures are minimised or dismissed, or a mother feels judged, this may impede her cognitive processing of her experience and she may perceive that her thoughts and feelings are invalid or something to be avoided (Tait & Silver, 1989; Lepore et al., 2000), thus inadvertently increasing the experiential avoidance identified in this study (section 6.2.1).

As in IPA research and clinical psychology practice, a professional helping a mother to understand her lived experience would be involved in a double hermeneutic process in which they would attempt to make sense of the mothers' world, who was also trying to make sense of her own world (Smith et al., 2009). The findings of the present study (section 5.2.4) highlight a need for professionals to recognise that each version of the condition varies within an overall set of possible symptoms, rather than fitting a mother's lived experience into a mould. The professional's *mould* may derive from their experiences of maternal postnatal emotional experiences (including their own), professional training undertaken, and their own values and beliefs (Larkin et al., 2006).

Based on the potential significant long-term effects and cost to the NHS and other Government services of PND on a mother, infant and family (section 3.3.4), more funding should be allocated to enhance professionals' skills through mandatory training and increasing the number and capacity of professional roles. As recommended elsewhere (Jardri & Maron, 2006), health visitors and midwives should receive support and supervision from mental health professionals regarding PND (e.g. Clinical Psychologists).

#### Modifications to individual psychological therapy

This study identified the potential impact of internalised maternal expectations (section 5.2.2), self-stigma (section 5.3.2), and disclosure setbacks (section 5.4.2) on disclosure processes and maternal mental health. Individual psychological therapy can address these to potentially help mothers cope more effectively. For example, Cognitive behavioural therapy (CBT), the current recommended first-line treatment for PND (NICE, 2014), can challenge cognitive distortions

(e.g. all-or-nothing thinking and ‘should’ statements; Burns, 1999) about the self as a mother, particularly when mood is low and following disclosure setbacks (Michaels, Lopez, Rusch & Corrigan, 2012).

However, researchers (e.g. Gattuso, Fullagar, & Young, 2005) and the NHS (National Health Service, 2014) acknowledge the limitations of individualised CBT therapy, including its focus on the individual’s capacity to change themselves (their thoughts, feelings and behaviours) without addressing wider systemic problems. Other psychological approaches should be considered, which enhance understanding and ability to cope with internalised culturally endorsed beliefs and ‘myths’ about motherhood and self-abnegation; and modify behaviours and goals to fit values rather than expectations (Michaels et al., 2012; O’Mahen et al., 2012). Narrative Enhancement and Cognitive Therapy (NECT), a new group-based treatment for internalized stigma among people with mental health problems, provides an example of how this could be achieved (Yanos, Roe & Lysaker, 2011). Mothers may also benefit from interventions that attend to self-criticism (e.g. related to coping – section 5.2.2) and shame (e.g. Marie; section 5.5.3) by enhancing self-compassion (Gilbert, 2010). The above interventions may enhance mothers’ felt ability to disclose and seek support. In addition, including partners and family members in interventions may help address difficult (and enhance positive) relational outcomes of disclosure, similar to those found in this study.

### Peer support groups

Two participants in this study (Louise and Victoria; section 5.3.3) preferred to disclose to confidants who were on the same “level” in that they shared and understood similar problems, as found in research on peer support groups (Caramlau et al., 2011). Due to the stigma surrounding PND, identified in this study (section 5.3.2) and its impact on a mother’s emotional experience and tendency to disclose, group interventions should focus on self-stigma reduction and their design could incorporate ideas from manualised programmes aimed at reducing mental health self-stigma. For example, “Ending Self-Stigma” (Lucksted et al., 2011) is a nine-session programme that includes psychoeducation, CBT strategies to influence the internalisation of public stigmas, methods to strengthen family and community ties, and techniques for responding to public discrimination. “Coming Out Proud” (Corrigan, Kosyluk, & Rusch, 2013) is a three-session programme focusing on risks and benefits of disclosure and secrecy in different settings and helpful ways to tell one’s story in different

settings. Both programmes have yielded benefits, including significantly reducing internalised stigma, stigma stress and disclosure-related stress; and significantly increasing perceived social support, perceived benefits of disclosure, and recovery orientation. The sharing of food and drink within peer group contexts may create a safe and helpful way of bringing people together to share difficulties (see Joanne’s descriptions of disclosing within this context – section 5.4.1).

### 6.4.3 Tackling public stigma

#### National campaigns and media

The internalisation of public stigma, particularly related to coping, was a pervasive issue in the current study (see sections 5.2.2 and 5.3.2). A national campaign to tackle the stigma associated with PND may be an effective approach alongside interventions aimed at supporting mothers and their families. Dumesnil and Verger (2009) carried out a review of the literature on fifteen public awareness campaigns about depression and suicide in eight countries, and despite some difficulty comparing the campaigns due to the diversity in objectives and methods, results suggested that they had contributed to a modest improvement in public knowledge of and attitudes towards depression and suicide.

The most recent campaign aimed at reducing mental health stigma and discrimination in the UK was *Time To Change* (TTC; Mind & Rethink Mental Illness, 2008). An evaluation of the TTC indicated its effectiveness in improving attitudes and intended behaviour (but not knowledge or reported behaviour), among the public in England, as well as its cost-effectiveness (Evans-Lacko, Henderson, & Thornicroft, 2013; Evans-Lacko, Henderson, Thornicroft & McCrone, 2013; Henderson & Thornicroft, 2013). A recommendation is made for the first ever campaign aimed at raising awareness of the symptoms of PND and challenging the myths and stigma attached to it, followed by an evaluation like that of the TTC campaign. Based on the link between social constructions of motherhood and those of maternal mood (section 3.4.2), campaigns should also address media representations of motherhood to include paradoxes; this may change expectations of mothers, reduce emotional avoidance and enhance disclosure and support seeking.

### Targeted interventions to reduce stigma

Targeting those who regularly come in to contact with mothers and providing information and training may reduce the stigma of PND in mothers' immediate contexts, which may then enhance disclosure. Health professionals themselves can be a significant source of public stigma linked to avoidance of disclosure and help-seeking (Schulze, 2007). This calls for the provision of mandatory training for all professionals who have contact with postnatal women (e.g. GPs, midwives and health professionals), which encourages the professional to explore, understand and be aware of their own experiences, beliefs and attitudes regarding PND.

Another public stigma change strategy described in the literature is *interpersonal contact* with members of the stigmatized group, with a moderately disconfirming example serving to counteract stereotypes and reduce levels of prejudice (Michaels et al., 2012). Antenatal classes would provide the ideal context for mothers (and fathers) who have had PND to speak about their experiences (including perceived stigma and expectations) to expectant parents. If this approach is applied to the majority of privately and NHS-funded antenatal programmes it may be an effective strategy to reduce stigma of PND across a whole generation of new parents, particularly as mothers (and fathers) are regularly exposed to other parents in their new roles.

### **6.5 Future research**

A number of potential research projects arise from this research. Explanations of this study's qualitative findings were gained by applying them to individual stages of the Disclosure Processes Model (Chaudoir & Fisher, 2010). In this way, direct connections between the stages related to specific disclosure events were not explored. It would be interesting to use longitudinal methods of data collection to help researchers understand causal patterns among the DPM components. Garcia and Crocker (2008) suggested daily diary and event-sampling field study methods to help assess antecedent goals, disclosure events, and immediate outcomes within hours or days of their occurrence.

This study's findings highlight the influence of disclosure on the relationship between the discloser and confidant, and on the confidant themselves, in an interpersonal process of disclosure. However, a criticism of this study, and the Disclosure Processes Model (Chaudoir

& Fisher, 2010) used to understand its findings, is their focus on the discloser. Chaudoir and Fisher (2010) pointed out that very little is known about the thoughts, feelings and behaviours of confidants following a disclosure of a concealable stigmatized identity, particularly for PND. Chaudoir and Fisher (2010) suggested using dyadic data collection and analysis (Kashy & Kenny, 2000) to simultaneously assess both sides of the disclosure event. This may help researchers further to understand the complex process of disclosure, and how to enhance the disclosure of PND.

There is a need for research that conducts and evaluates the effectiveness of antenatal mindfulness training (perhaps with mothers at risk of PND), and psychoeducation regarding postnatal emotional difficulties that are run by professionals (e.g. Clinical Psychologists) and form part of standard antenatal classes. Research on the effectiveness of psychological therapies (e.g. Narrative Enhancement and Cognitive Therapy – see section 6.4.2) that consider mothers' social contexts would be interesting. It would also be interesting to conduct interventions aimed at reducing public stigma at both national and local levels (section 6.4.3) and evaluate these to establish changes in attitudes and knowledge of PND.

Future research studies conducting and evaluating group interventions that focus on reducing self-stigma around PND specifically would be interesting. Their design could incorporate ideas from manualised programmes aimed at reducing mental health self-stigma, such as “Ending Self-Stigma” (Lucksted et al., 2011) and “Coming Out Proud” (Corrigan, Kosyluk, & Rusch, 2013).

A criticism of the current study, and the existing PND literature it builds on, is its focus on women who are white and in married or co-habiting unions (Brunton, Wiggins, & Oakley, 2011; Darvill, Skirton, & Farrand, 2010; Letourneau et al., 2007). Little is known about disclosure, support seeking and support provision for women in non-traditional family structures (e.g. single-mother families, cohabiting families) (Gallagher, Hobfall, Ritter & Lavin, 1997; Meadows, McLanahan & Brooks-Gunn, 2008) nor in other cultural groups living in the UK (Parvin, Jones & Hull, 2004; Templeton et al., 2003). Research comparing the process of disclosure across family structures and cultural contexts to the one described by the Disclosure Processes Model (Chaudoir & Fisher, 2010) could lead to amendments or alternative versions of the model that may then enhance cultural-awareness and sensitivity professionals who assess and discuss PND with new mothers.

## 6.6 Conclusion

The aim of this study was to explore the lived experiences of mothers who disclosed their symptoms of postnatal depression to people in their support networks, including individuals with whom they have personal relationships, as well as health professionals.

Participants described a distinct period prior to disclosure in which they were both trying to make sense of their experience and trying to cope with it. The mothers spoke of their need to cope, driven by internalised expectations and assumptions about motherhood. They spoke of using practical strategies and portraying façades to manage how they were feeling and how they appeared to be coping as a mother to other people, but these appeared to facilitate experiential avoidance. After gaining some understanding of their symptoms, participants went through a process of weighing up factors (their perceived entitlement to have PND and receive support; the stigma attached to PND; and the fear of judgement or responses from others), which then either facilitated or inhibited a subsequent disclosure. Participants considered characteristics of available confidants as part of a process of selecting to whom to disclose.

Participants went on to describe the two-way interpersonal nature of the disclosure process itself, focusing on the influence of the confidant on the development and outcome of this interpersonal process and the impact of the disclosed information on the relationship between the confidant and discloser. Disclosure appears to have played a role in transforming how participants experienced PND and the support available to them. Recovery from PND appeared to empower the participants, who described a sense of having conquered it, which then transformed their felt ability to further disclose their experiences to others.

The findings within this study had clinical implications for the antenatal period, including ways to help mothers recognise and relate differently to their initial symptoms, and for the postnatal period, with a particular focus on health professionals facilitating disclosure and understanding and on modifying current treatment approaches. Suggestions around strategies for reducing public stigma surrounding PND were considered.

## 6.7 Final reflections

Akin to motherhood, the transition into my new role as a qualitative researcher was paradoxical in nature. I experienced excitement, curiosity and pride alongside frustration, exhaustion and anxiety. To help me stay connected to my role and the research process through this journey, I held in mind the participants' reflections, made at the end of each interview, on their experiences of being interviewed, which is in itself a disclosure process. I end with one participant's reflection that emphasised to me the importance of someone sitting down, listening with interest and facilitating a mother's sharing of emotional experiences. I thank all my participants for their bravery in disclosing their experiences to me.

...I've been able to, say things quite clearly. I haven't really thought about this interview at all and was just sort of thinking oh gosh you know how do I really feel... it's helped me to voice what I was actually feeling, and to then understand those feelings so, you've then got a sort of, consistent run or you can understand so... you can then process everything yourself.

**(Louise)**



## 7.0 REFERENCES

- 4Children (2011). *Suffering in silence: 70,000 reasons why help with postnatal depression has to be better*. Retrieved from: <http://www.4children.org.uk/Files/6017b334-eb37-4db1-b2b2-9f7b00d9ea9a/Suffering-in-Silence.pdf>
- Abrams, L. S., & Curran, L. (2009). "And you're telling me not to stress?" A grounded theory study of postpartum depression symptoms among low-income women. *Psychology of Women Quarterly*, 33, 351-362.
- Afifi, W. A., & Caughlin, J. P. (2006). A close look at revealing secrets and some consequences that follow. *Communication Research*, 33, 467-488.
- Ahern, K. J. (1999). Pearls, Pith and Provocation: Ten Tips for Reflexive Bracketing. *Qualitative Health Research*, 9(3), 457-411.
- Ahrens, C. E. (2006). Being silenced: The impact of negative social reactions on the disclosure of rape. *American Journal of Community Psychology*, 38, 263-274.
- Allen, H. (1999). 'How was it for you?' Debriefing for postnatal women: does it help? *Professional Care of Mother and Child*, 9(3), 77-79.
- American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders (5<sup>th</sup> ed.)*. Arlington, VA: American Psychiatric Publishing.
- Anisfeld, E., Casper, V., Nozyce, M., & Cunningham, N. (1990). Does infant carrying promote attachment? An experimental study of the effects of increased physical contact on the development of attachment. *Child Development*, 61, 1617-1627.
- Apple, R. D. (1995). Constructing Mothers: Scientific Motherhood in the Nineteenth and Twentieth Centuries. *Social History of Medicine*, 8, 161-178.
- Apple, R. D. (2006). *Perfect motherhood: Science and childrearing in America*. New Brunswick, NJ: Rutgers University Press.

- Archer, J. (1999). *The nature of grief: The evolution and psychology of reactions to loss*. New York: Routledge.
- Arteche, A., Joormann, J., Harvey, A., Craske, M., Gotlib, I. H., Lehtonen, A., Counsell, N., & Stein, A. (2011). The effects of postnatal maternal depression and anxiety on the processing of infant faces. *Journal of Affective Disorders, 133*(1-2), 197-203.
- Ashman, S. B., Dawson, G., Panagiotides, H., Yamada, E., & Wilkins, C. W. (2002). Stress hormone levels of children of depressed mothers. *Development and Psychopathology, 14*(2), 333-349.
- Asten, P., Marks, M. N., Oates, M. R., & Transcultural Study of Postnatal Depression Group (2004). Aims, measures, study sites and participant samples of the Transcultural Study of Postnatal Depression. *The British Journal of Psychiatry. Supplement, 46*, 3-9.
- Austin, W., McGinn, N. C., & Sasmilch, C. (1980). Internal standards revisited: Effects of social comparison and expectancies on judgments of fairness and satisfaction. *Journal of Experimental Social Psychology, 16*, 426-441.
- Avan, B., Richter, L. M., Ramchandani, P. G., Norris, S. A., & Stein, A. (2010). Maternal postnatal depression and children's growth and behaviour during the early years of life: exploring the interaction between physical and mental health. *Archives of Disease in Childhood, 95*(9), 690-695.
- Baik, S. U., Bowers, B. J., Oakley, L. D., & Susman, J. L. (2005). The recognition of depression: the primary care clinician's perspective. *Annals of Family Medicine, 3*, 31-37.
- Bailey, L. (2000). Bridging home and work in the transition to motherhood: A discursive study. *The European Journal of Women's Studies, 7*, 53-70.
- Ban, L., Gibson, J. E., West, J., & Tata, L. J. (2010). Association between perinatal depression in mothers and the risk of childhood infections in offspring: a population-based cohort study. *BMC Public Health, 10*, 799-806.

- Barker, C., Pistrang, N., & Elliott, R. (2002). *Research Methods in Clinical Psychology: An Introduction for Students and Practitioners*. Chichester: John Wiley & Sons, Ltd.
- Barnes, T., James, I., Kelleher, P., Kohn, B., Manderson, S., & Sandé, A. (2011). Read All About It [Recorded by Emeli Sandé]. On *At Your Inconvenience* [CD]. London, England: Virgin.
- Barnett, B., & Fowler, C. (1995). *Caring for the family's future*. NSW, Australia: Norman Swan Medical Communications.
- Beck, C. T. (1993). Teetering on the edge: A substantive theory of postpartum depression. *Nursing Research, 42*, 42-48.
- Beck, C. T. (1996). A meta-analysis of predictors of postpartum depression. *Nursing Research, 45*, 225-230.
- Beck, C. T. (2001). Predictors of postpartum depression: an update. *Nursing Research, 50*, 275-285.
- Beck, C. T. (2006). Postpartum depression: It isn't just the blues. *The American Journal of Nursing, 106*(5), 40-50.
- Bekker, H., Smith, J., & Cheater, F. (2011). Theoretical versus pragmatic design in qualitative research. *Nurse Researcher, 18*(2), 39-51.
- Belsky, J. (1984). The Determinants of Parenting: A Process Model. *Child development, 55*, 83-96.
- Berggren-Clive, K. (1998). Out of the darkness and into the light: Women's experiences with depression of childbirth. *Canadian Journal of Community Mental Health, 17*, 103-120.
- Berry, M. F. (1993). *The politics of parenthood: Childcare, women's rights, and the myth of the good mother*. New York, NY: Penguin Books.

- Bick, D., & Howard, L. M. (2010). When should women be screened for postnatal depression? *Expert Review of Neurotherapeutics, 10*(2), 151-154.
- Birch, M., & Miller, T. (2000). Inviting intimacy: The interview as a therapeutic opportunity. *International Journal of Social Research Methodology, 3*(3), 189-202.
- Black, B. P., & Shandor, M. (2002). Calculating the risks and benefits of disclosure in African American women who have HIV. *Journal of Obstetric, Gynecologic, and Neonatal Nursing, 31*, 688-696.
- Blum, L. D. (2007). Psychodynamics of postpartum depression. *Psychoanalytic Psychology, 24*(1), 45-62.
- Boath, E. H., Pryce, A. J., & Cox, J. L. (2007). Postnatal depression: The impact on the family. *Journal of Reproductive and Infant Psychology, 16*, 199-203.
- Bowlby, J. (1969). *Attachment and loss, Vol. 1: Attachment*. New York: Basic Books.
- Bowlby, J. (1973). *Attachment and loss, Vol. 2. Separation*. New York: Basic Books.
- Bowlby, J. (1980). *Attachment and loss, Vol. 3: Loss, sadness and depression*. New York: Basic Books.
- Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development*. New York: Basic Books.
- Boyce, P. M., & Todd, A. L. (1992). Increased risk of postnatal depression after emergency caesarean section. *The Medical Journal of Australia, 157*, 172-174.
- Bradshaw, J. (1988). *Bradshaw on – the family: A revolutionary way of self-discovery*. Pompano Beach, FL: Health Communications.
- Brand, S. R., & Brennan, P. A. (2009). Impact of antenatal and postpartum maternal mental illness: how are the children? *Clinical Obstetrics and Gynecology, 52*(3), 441-455.

- Brandt, K., Andrews, C. M., & Kvale, J. (1998). Mother-infant interaction and breastfeeding outcome 6 weeks after birth. *Journal of Obstetric Gynecological Neonatal Nursing*, 27(2), 169-174.
- Breese McCoy, S. J., Beal, J. M., Miller Shipman, S. B., Payton, M. E., & Watson, G. H. (2006). Risk Factors for Postpartum Depression: A Retrospective Investigation at 4-Weeks Postnatal and a Review of the Literature. *The Journal of the American Osteopathic Association*, 106(4), 193-198.
- Brennan, P. A., Hammen, C., Andersen, M. J., Bor, W., Najman, J. M., & Williams, G. M. (2000). Chronicity, severity, and timing of maternal depressive symptoms: relationships with child outcomes at age 5. *Developmental Psychology*, 36(6), 759-766.
- Briscoe, J. (2001, January 10). I adore my son, but I'm so bored. *The Guardian*. Retrieved from: <http://www.theguardian.com/lifeandstyle/2001/jan/10/familyandrelationships.features102>
- Brocki, J. M., & Wearden, A. J. (2006). A critical evaluation of the use of interpretative phenomenological Analysis (IPA) in health psychology. *Psychology and Health*, 21(1), 87-108.
- Bronfenbrenner, U. (1979). *The Ecology of Human Development: Experiments by Nature and Design*. London: Harvard University Press.
- Brugha, T. S., Sharp, H. M., Cooper, S. A., Weisender, C., Britto, D., Shinkwin, R., Sherrif, T., & Kirwan, P. H. (1998). The Leicester 500 Project Social Support and the development of postnatal depressive symptoms, a prospective cohort survey. *Psychological Medicine*, 28, 63-79.
- Bruner, J. (1990). *Acts of meaning*. Cambridge, MA: Harvard University Press.

- Brunton, G., Wiggins, M., & Oakley, A. (2011). *Becoming a mother: A research synthesis of women's views on the experience of first-time motherhood*. London: EPPI Centre, Social Science Research Unit, Institute of Education, University of London.
- Burns, D. (1999). *The Feeling Good Handbook*. New York: Plume.
- Burr, V. (1995). *An Introduction to Social Constructionism*. London: Routledge.
- Camic, P. M., Rhodes, J. E., & Yardsley, L. (Eds.). (2003). *Naming the starts: Integrating qualitative methods into psychological research*. Washington DC: American Psychological Society.
- Caramlau, I., Barlow, J., Sembi, S., McKenzie-McHarg, K., & McCabe, C. J., (2011). Mums 4 Mums: structured telephone peer-support for women experiencing postnatal depression. Pilot and exploratory RCT of its clinical and cost effectiveness. *Trials*, 12:88.
- Carnelley, K. B., Pietromonaco, P. R. and Jaffe, K. (1994). Depression, working models of others, and relationship functioning. *Journal of Personality and Social Psychology*, 66, 127-140.
- Carver, C. S. (2006). Approach, avoidance, and the self-regulation of affect and action. *Motivation and Emotion*, 30, 105-110.
- Castonguay, L. G., & Hill, C. E. (2012). *Transformation in psychotherapy: Corrective experiences across cognitive behavioral, humanistic, and psychodynamic approaches*. Washington DC: American Psychological Association.
- Chandra, P. S., Deepthivarma, S., Jairam, K.R., & Thomas, T. (2003). Relationship of psychological morbidity and quality of life to illness-related disclosure among HIV-infected persons. *Journal of Psychosomatic Research*, 54, 199-203.
- Chaudoir, S. R. (2009). HIV/AIDS disclosure decision-making and outcomes: A longitudinal, event-based analysis. University of Connecticut, Storrs, CT: Unpublished Doctoral Dissertation.

- Chaudoir, S. R., & Fisher, J.D. (2010). The disclosure processes model: Understanding disclosure decision-making and post-disclosure outcomes among people living with a concealable stigmatized identity. *Psychological Bulletin, 136*(2), 236-256.
- Chaudoir, S. R., & Quinn, D. M. (2010). Revealing concealable stigmatized identities: The impact of disclosure motivations and positive first-disclosure experiences on fear of disclosure and well-being. *Journal of Social Issues, 66*(3), 570-584.
- Chamberlain, K., Stephens, C., & Lyons, A. (1997). Encompassing experience: Meanings and methods in health psychology. *Psychology and Health, 12*, 691-709.
- Chew-Graham, C. A., Sharp, D., Chamberlain, E., Folkes, L., & Turner, K. M. (2009). Disclosure of symptoms of postnatal depression, the perspectives of health professionals and women: a qualitative study. *BMC Family Practice, 10*(7), 1-9.
- Cicchetti, D., Rogosch, F. A., & Toth, S. L. (2000). The efficacy of toddler-parent psychotherapy for fostering cognitive development in offspring of depressed mothers. *Journal of Abnormal Child Psychology, 28*, 135-148.
- Clark, H. J., Lindner, G., Armistead, L., & Austin, B. (2003). Stigma, disclosure, and psychological functioning among HIV-infected and non-infected African-American women. *Women & Health, 38*, 57-71.
- Clark, L. F. (1993). Stress and the cognitive-conversational benefits of social interaction. *Journal of Social and Clinical Psychology, 12*, 25-55.
- Clark, R., Anderson, N. B., Clark, V. R., & Williams, D. R. (1999). Racism as a stressor for African Americans: A biopsychosocial model. *American Psychologist, 54*, 805-816.
- Colbourne, L., & Sque, M. (2005). The culture of cancer and the therapeutic impact of qualitative research interviews. *Journal of Research in Nursing, 10*, 551-567.

- Cooklin, A. (2013). Promoting children's resilience to parental mental illness: engaging the child's thinking. *Advances in Psychiatric Treatment, 19*(3), 229-240.
- Cooper, P., & Murray, L. (1995). Course and recurrence of postnatal depression. Evidence for the specificity of the diagnostic concept. *British Journal of Psychiatry, 166*, 191-195.
- Cooper, P. J., Murray, L., Wilson, A., & Romaniuk, H. (2003). Controlled trial of the short- and long-term effect of psychological treatment of post-partum depression. 1. Impact on maternal mood. *British Journal of Psychiatry, 182*, 412-419.
- Corrigan, P. W. (2005). *On the stigma of mental illness: Practical strategies for research and social change*. Washington DC: American Psychological Association.
- Corrigan, P. W., Kosyluk, K. A., & Rusch, N. (2013). Reducing self-stigma by coming out proud. *American Journal of Public Health, 103*, 794-800.
- Corrigan, P. W., & Rao, D. (2012). On the Self-Stigma of Mental Illness: Stages, Disclosure, and Strategies for Change. *Canadian Journal of Psychiatry, 57*(8), 464-469.
- Corrigan, P. W., Watson, A., & Barr, L. (2006). The self-stigma of mental illness: Implications for self-esteem and self-efficacy. *Journal of Social & Clinical Psychology, 25*(9), 875-884.
- Cox, J. L. (1989). Postnatal depression: a serious and neglected postpartum complication. *Baillere's Clinical Obstetrics and Gynaecology, 3*, 839-855.
- Cox, J. L., & Holden, J. (1994). *Perinatal Psychiatry: Use and Misuse of the Edinburgh Postpartum Depression Scale*. London: Gaskell.
- Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry, 150*, 782-786.

- Cummings, E. M., & Cicchetti, D. (1990). Toward a transactional model of relations between attachment and depression. In: M. T. Greenberg, D. Cicchetti, & E. M. Cummings, (Eds.), *Attachment in the preschool years*, (pp.339-372). Chicago: University of Chicago Press.
- Dallos, R., & Draper, R. (2010). *An introduction to family therapy: Systemic theory and practice*. Milton Keynes: Open University Press.
- Dalton, K. (1989). *Depression after childbirth: How to recognize and treat postpartum depression*. Oxford: Oxford University Press.
- Darvill, R., Skirton, H., & Farrand, P. (2010). Psychological factors that impact on women's experiences of first-time motherhood: a qualitative study of the transition. *Midwifery*, 26, 357-366.
- Davey, S. J., Dziurawiec, S., & O'Brien-Malone, A. (2007). Men's voices: Postnatal depression from the perspective of male partners. *Qualitative Health Research*, 16(2), 206-220.
- Davies, R. (2011, October 3). The mothers abandoned to postnatal depression. The Guardian. Retrieved from: <http://www.theguardian.com/commentisfree/2011/oct/03/mothers-postnatal-depression>
- Day, E. H. (2007). Applying the *Listening to Mothers II* results in Lamaze class. *The Journal of Perinatal Education*, 16(4), 52-54.
- Dennis, C. L. (2003). The effect of peer support on postpartum depression: a pilot randomized controlled trial. *Canadian Journal of Psychiatry*, 48(2), 115-124,
- Dennis, C. L., & Chung-Lee, L. (2006). Postpartum depression help-seeking barriers and maternal treatment preferences: A qualitative systematic review. *Birth*, 33(4), 323-331.

- Dennis, C. L., & Hodnett, E. D. (2007). Psychosocial and psychological interventions for treating postpartum depression. *Cochrane Database of Systematic Reviews, Issue 4*, Art No: CD006166. DOI: 10.1002/14651858. CD006116pub2.
- Dennis, C. L., Hodnett, E., Kenton, L., Weston, J., Zupancic, J., Stewart, D. E., & Kiss, A. (2009). Effect of peer support on prevention of postnatal depression among high risk women: multisite randomised controlled trial. *BMJ*, 338: a3064.
- Dennis, C. L., & Letourneau, N. (2007). Global and relationship-specific perceptions of support and the development of postpartum depressive symptomatology. *Social Psychiatry and Psychiatric Epidemiology*, 42, 389-395.
- Dennis, C. L. & McQueen, K. (2007). Does maternal postpartum depressive symptomatology influence infant feeding outcomes? *Acta Paediatrica*, 96, 590-594.
- Department of Health (2004). The Expert Patient: A New Approach to Chronic Disease Management for the 21<sup>st</sup> Century. Retrieved from: <http://www.dh.gov.uk/>
- Derlega, V. J., Metts, S., Petronio, S., & Margulis, S. T. (1993). *Self-disclosure*. Thousand Oaks, CA: Sage Publications.
- Deutsch, H. (1944). *The psychology of women – A psychoanalytical interpretation*. New York, NY: Grune & Stratton.
- Dickson, J. M., & MacLeod, A. K. (2004). Anxiety, depression and approach and avoidance goals. *Cognition and Emotion*, 18(3), 423-430.
- Dinos, S., Stevens, S., Serfaty, M., Weich, S., & King, M. (2004). Stigma: the feelings and experiences of 46 people with mental illness. *British Journal of Psychiatry*, 184, 176-181.
- Douglas, S. J. & Michaels, M. W. (2004). *The mommy myth: The idealization of motherhood and how it has undermined women*. New York, NY: Free Press.

- Dumesnil, H., & Verger, P. (2009). Public awareness campaigns about depression and suicide: A review. *Psychiatric Services, 60*(9), 1203-1213.
- East London NHS Foundation Trust. (2013). *Recipe of Life: Vietnamese Community Combats Mental Health Issues Through Cooking*. Retrieved from East London NHS Foundation Trust website: <http://www.eastlondon.nhs.uk/News-Events/Press-Releases/2013/Vietnamese-Mental-Health-Food-Project-Recipe-of-Life.pdf>
- Eatough, V. & Smith, J. A. (2006). I feel like a scrambled egg in my head: An idiographic case study of meaning making and anger using interpretative phenomenological analysis. *Psychology and Psychotherapy: Theory, Research and Practice, 79*,115-135.
- Eatough, V., & Smith, J. A. (2008). Interpretative phenomenological analysis. In C. Willing, & W. Stainton-Rogers, (Eds). *The Sage handbook of qualitative research in psychology* (pp 179-194). Los Angeles: Sage.
- Edhborg, M. (2004). Postpartum depressive symptoms in family perspective: Some indicators, experiences and consequences (thesis). Karolinska Institutet, Sweden. Retrieved from: [http://www.researchgate.net/profile/Maigun\\_Edhborg/publication/254703021\\_POSTPARTUM\\_DEPRESSIVE\\_SYMPTOMS\\_IN\\_FAMILY\\_PERSPECTIVE\\_SOME\\_INDICATORS\\_EXPERIENCES\\_AND\\_CONSEQUENCES/links/5474ee850cf245eb436e729d.pdf](http://www.researchgate.net/profile/Maigun_Edhborg/publication/254703021_POSTPARTUM_DEPRESSIVE_SYMPTOMS_IN_FAMILY_PERSPECTIVE_SOME_INDICATORS_EXPERIENCES_AND_CONSEQUENCES/links/5474ee850cf245eb436e729d.pdf)
- Edhborg, M., Friberg, M., Lundh, W., & Widstrom, A. (2005). "Struggling with life": Narratives from women with signs of postpartum depression. *Scandinavian Journal of Public Health, 33*, 261-267.
- Edwards, E., & Timmons, S. (2005). A qualitative study of stigma among women suffering from postnatal illness. *Journal of Mental Health, 14*(5), 471-481.
- Ehrenreich, B., & English, D. (1978). *For her own good: 150 years of the experts' advice to women*. New York, NY: Doubleday.
- Elliott, A. J. (1999). Approach and avoidance motivation and achievement goals. *Educational Psychologist, 34*, 169-189.

- Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, 38, 215-229.
- Ellis, D., & Cromby, J. (2009). Inhibition and re-appraisal within emotional disclosure: the embodying of narration, *Counselling and Psychology Quarterly*, 22(3), 319-331.
- Ely, M., Anzul, M., Friedman, T., Garner, D., & Steinmetz, A.M. (1991). *Doing qualitative research: Circles within circles*. Philadelphia: Falmer.
- Erikson, E. H. (1968). *Identity: Youth and crisis*. New York, NY: Norton.
- Ertel, K. A., Koenen, K. C., Rich-Edwards, J. W., & Gillman, M. W. (2010). Antenatal and postpartum depressive symptoms are differentially associated with early childhood weight and adiposity. *Paediatric and Perinatal Epidemiology*, 24(2), 179-189.
- Evans-Lacko, S., Henderson, C., & Thornicroft, G. (2013). Public knowledge, attitudes and behaviour regarding people with mental illness in England 2009-2012. *The British Journal of Psychiatry*, 202, s51-57.
- Evans-Lacko, S., Henderson, C., Thornicroft, G., & McCrone, P. (2013). Economic evaluation of the anti-stigma social marketing campaign in England 2009-2011. *The British Journal of Psychiatry*, 202, s95-101.
- Ferguson, S. S., Jamieson, D.J., & Lindsay, M. (2002). Diagnosing postpartum depression: can we do better? *American Journal of Obstetrics and Gynecology*, 186, 899-902.
- Festinger, L. (1954a). A theory of social comparison processes. *Human Relations*, 7, 117-140.
- Festinger, L. (1954b). Motivation leading to social behaviour. In M.R. Jones (Ed.), *Nebraska Symposium on Motivation* (pp. 12-45). Lincoln: University of Nebraska Press.

- Field, T. (1996). Attachment and separation in young children. *Annual Review of Psychology*, 47, 541-562.
- Figes, K. (2012, November 3). Postnatal depression: the pressures new mothers face, now more than ever. *The Guardian*. Retrieved from:  
<http://www.theguardian.com/society/2012/nov/03/postnatal-depression-widespread-felicia-boots>
- Finkenauer, C., Engels, R. C. M. E., Branje, S. J. T., & Meeus, W. (2004). Disclosure and relationship satisfaction in families. *Journal of Marriage and Family*, 66, 195-209.
- Fisher, J., Hammarberg, K., & Baker, G. (2005). Assisted conception is a risk factor for postnatal mood disturbance and early parenting difficulties. *Fertility and Sterility*, 84(2), 426-430.
- Fitelson, E., Kim, S., Scott Baker, A., & Leight, K. (2011). Treatment of postpartum depression: clinical, psychological and pharmacological options. *International Journal of Women's Health*, 3, 1-14.
- Flanagan, T. J., White, H., & Carter, B. G. (2011). Differential impairments in emotion face recognition in postpartum and nonpostpartum depressed women. *Journal of Affective Disorders*, 128, 314-318.
- Flores, D. L., & Hendrick, V. C. (2002). Etiology and treatment of postpartum depression. *Current Psychiatry Reports*, 4, 461-466.
- Foa, E. B., & Rothbaum, B. O. (1998). *Treating the trauma of rape: cognitive-behavioral therapy for PTSD*. New York: Guildford.
- Frank, A. W. (1997). *The wounded storyteller: Body, illness, and ethics*. Chicago: The University of Chicago Press.
- Freedman, J., & Combs, G. (1996). *Narrative therapy: The social construction of preferred realities*. New York: WW Norton & Co.

- Gagliardi, L., Petrozzi, A., & Rusconi, F. (2012). Symptoms of maternal depression immediately after delivery predict unsuccessful breast feeding. *Archives of Disease in Childhood*, *97*, 355-357.
- Gallagher, R.W., Hobfall, S.E., Ritter, C., & Lavin, J. (1997). Marriage, intimate support and depression during pregnancy: A study of inner-city women. *Journal of Health Psychology*, *2*(4), 457-469.
- Garcia, J. A., & Crocker, J. (2008). Reasons for disclosing depression matter: The consequences of having egosystem and ecosystem goals. *Social Science and Medicine*, *67*, 453-462.
- Gattuso, S., Fullagar, S., & Young, I. (2005). Speaking of women's 'nameless misery': The everyday construction of depression in Australian women's magazines. *Social Science & Medicine*, *61*, 1640-1648.
- Gergen, K. J. (1985). The social constructionist movement in modern psychology. *American Psychologist*, *40*(3), 266-275.
- Gergen, K. J. (2009). *Relational being: Beyond self and community*. New York, NY: Oxford University Press.
- Gibbons, F. X. (1986). Social comparison and depression: Company's effect on misery. *Journal of Personality and Social Psychology*, *51*(1), 140-148.
- Gibson, J., McKenzie-McHarg, K., Shakespeare, J., Price, J., & Gray, R. (2009). A systematic review of studies validating the Edinburgh Postnatal Depression Scale in antepartum and postpartum women. *Acta Psychiatrica Scandinavica*, *119*, 350-364.
- Gilbert, P. (1992). *Depression: The Evolution of Powerlessness*. Hove: Lawrence Erlbaum Associates.
- Gilbert, P. (1997). The evolution of social attractiveness and its role in shame, humiliation, guilt and therapy. *British Journal of Medical Psychology*, *70*, 113-147.

- Gilbert, P. (2005). *Compassion: Conceptualisations, research and use in psychotherapy*. London: Routledge.
- Gilbert, P. (2010). *The Compassionate Mind*. London: Constable Robinson.
- Gilbert, P., & McGuire, M. (1998). Shame, social roles and status: The psychobiological continuum from monkey to human. In: P. Gilbert, & B. Andrews (Eds.), *Shame: Interpersonal Behavior, Psychopathology and Culture*, (pp.99-125). New York: Oxford University Press.
- Gittins, D. (1993). *The family in question*. Basingstoke: Macmillan.
- Goffman, E. (1963). *Stigma: Notes on the management of a spoiled identity*. Englewood Cliffs, NJ: Prentice Hall.
- Goldberg, D., & Huxley, P. (1980). *Mental Illness in the community: The pathway to psychiatric care*. London: Tavistock Publications.
- Goodman, J. H. (2009). Women's attitudes, preferences, and perceived barriers to treatment for perinatal depression. *Birth*, 36(1), 60-69.
- Goodyer, I. M., Tamplin, A., Herbert, J., & Altham, P. M. (2000). Recent life events, cortisol, dehydroepiandrosterone and the onset of major depression in high-risk adolescents. *British Journal of Psychiatry*, 177, 499-504.
- Gotlib, I. H., Whiffen, V. E., Wallace, P. M., & Mount, J. H. (1991). Prospective investigation of postpartum depression: Factors involved in onset and recovery. *Journal of Abnormal Psychology*, 100(2), 122-132.
- Gottman, J. M., Katz, L. F., & Hooven, C. (1997). *Meta emotion: How families communicate emotionally*. Mahwah, NJ: Erlbaum.

- Grace, S. L., Evindar, A., & Stewart, D. E. (2003). The effect of postpartum depression on child cognitive development and behaviour: A review and critical analysis of the literature. *Archives of Women's Mental Health, 6*(4), 263-274.
- Grant, J. (1998). *Raising baby by the book: The education of American mothers*. New Haven, CT: Yale University Press.
- Greene, K., Derlega, V. J., Yep, G.A., & Petronio, S. (2003). *Privacy and disclosure of HIV in interpersonal relationships: A sourcebook for researchers and practitioners*. Mahwah, NJ: Lawrence Erlbaum Associates.
- Gress-Smith, J., Luecken, L. J., Lemery-Chalfant, K., & Howe, R. (2012). Postpartum depression prevalence and impact on infant health, weight, and sleep in low-income and ethnic minority women and infants. *Maternal and Child Health Journal, 16*(4), 887-893.
- Gross, J. J. (2002). Emotion regulation: Affective, cognitive, and social consequences. *Psychophysiology, 39*, 281-291.
- Gross, J. J., & John, O. P. (2003). Individual differences in two emotion regulation processes: Implications for affect, relationships, and well-being. *Journal of Personality and Social Psychology, 85*, 348-362.
- Gump, B. B., Reihman, J., Stewart, P., Lonky, E., Darvill, T., Granger, D. A., & Matthews, K. A. (2009). Trajectories of maternal depressive symptoms over her child's lifespan: Relation to adrenocortical, cardiovascular, and emotional functioning in children. *Development and Psychopathology, 21*(1), 207-225.
- Halligan, S. L., Herbert, J., Goodyer, I. M., & Murray, L. (2004). Exposure to Postnatal Depression Predicts Elevated Cortisol in Adolescent Offspring. *Biological Psychiatry, 55*(4), 376-381.
- Harber, K. D., & Pennebaker, J. W. (1992). Overcoming traumatic memories. In: S. A. Christianson, (Ed.). *The handbook of emotion and memory*, (pp. 359-387). Hillsdale, NJ: Erlbaum.

- Harris, T. O., Borsanyi, S., Messari, S., Stanford, K., Cleary, S. E., Shiers, H. M., Brown, G. W., & Herbert, J. (2000). Morning cortisol as a risk factor for subsequent major depressive disorder in adult women. *British Journal of Psychiatry, 177*, 505-510.
- Hartmann, S. N. (1994). Women's employment and the domestic ideal in the early cold war years. In J. Meyerowitz (Ed.), *Not June Cleaver: Women and gender in postwar America, 1945-1960* (pp. 84-100). Philadelphia, PA: Temple University Press.
- Harvey, I., & McGrath, G. (1988). Psychiatric morbidity in spouses of women admitted to a mother and baby unit. *British Journal of Psychiatry, 152*, 506-510.
- Harwood, K., McLean, N., & Durkin, K. (2007). First-time mothers expectations of parenthood: What happens when optimistic expectations are not matched by later experiences? *Developmental Psychology, 43*(1), 1-12.
- Haslam, D. M., Pakenham, K. I., & Smith, A. (2006). Social support and postpartum depressive symptomatology: The mediating role of maternal self-efficacy. *Infant Mental Health Journal, 27*(3), 276-291.
- Hatz, J., & Rohm, A. (2007). Postpartum depression: worse than baby blues. *NCSL legisbrief, 15*(24), 1-2.
- Hay, D. F., Pawlby, S., Sharp, D., Asten, P., Mills, A., & Kumar, R. (2001). Intellectual problems shown by 11-year-old children whose mothers had postnatal depression. *Journal of Child Psychology and Psychiatry, 42*(7), 871-889.
- Hayes, N. (2000). *Doing psychological research: Gathering and analyzing data*. Buckingham, UK: Open University Press.
- Hayes, S. C., Strosahl, K., Wilson, K. G., Bissett, R. T., Pistorello, J., Toarmino, D., Polusny, M. A., Dykstra, T. A., Batten, S. V., Bergan, J., Stewart, S. H., Zvolensky, M. J., Eifert, G. H., Bond, F. W., Forsyth, J. P., Karekla, M., & McCurry, S. M. (2004). Measuring

- experiential avoidance: A preliminary tests of a working model. *The Psychological Record*, 54, 553-578.
- Hayes, S. C., Wilson, K. G., Gifford, E. V., Follette, V. M., & Strosahl, K. (1996). Experiential avoidance and behavioral disorders: A functional dimensional approach to diagnosis and treatment. *Journal of Consulting and Clinical Psychology*, 64, 1152-1168.
- Heidegger, M., Macquarrie, J., & Robinson, E. (1962). *Being and Time*. Oxford: Blackwell.
- Held, L., & Rutherford, A. (2012). Can't a mother sing the Blues? Postpartum depression and the construction of motherhood in late 20<sup>th</sup>-century America. *History of Psychology*, 15(2), 107-123.
- Henderson, C., & Thornicroft, G. (2013). Evaluation of the Time to Change programme in England 2008-2011. *The British Journal of Psychiatry*, 202, s45-48.
- Hendrick, V. (2003). Treatment of postnatal depression: Effective interventions are available but the condition remains under-diagnosed. *British Medical Journal*, 327(7422), 1003-1005.
- Hendrick, V., Altshuler, I., Strouse, T., & Grosser, S. (2000). Postpartum and non-postpartum depression: differences in presentation and response to pharmacologic treatment. *Depression and Anxiety*, 11, 66-72.
- Heneghan, A. M., Mercer, M., & DeLeone, N. S. (2004). Will mothers discuss parenting stress and depressive symptoms with their child's paediatrician? *Paediatrics*, 113, 460-467.
- Herek, G. M. (2009). Hate crimes and stigma-related experiences among sexual minority adults in the United States: Prevalence estimates from a national probability sample. *Journal of Interpersonal Violence*, 24, 54-74.
- Herrschaft, D., & Mills, K. I. (2002). *The state of the workplace for lesbian, gay, bisexual and transgender Americans*. Human Rights Campaign; Washington, D.C.

- Herzberg, D. (2009). *Happy Pills in America: From Miltown to Prozac*. Baltimore, MD: Johns Hopkins University Press.
- Hessl, D., Dawson, G., Frey, K., Panagiotides, H., Self, H., Yamada, E., & Osterling, J. (1998). A longitudinal study of children of depressed mothers: Psychobiological findings related to stress. In: D. M. Hann, L. C. Huffman, K. K. Lederhendler, & D. Minecke, (Eds.), *Advancing research on developmental plasticity: Integrating the behavioral sciences and the neurosciences of mental health*. (pp. 256) Bethesda, MD: National Institutes of Mental Health.
- Higgins, E. T. (1987). Self-Discrepancy: A theory relating self and affect. *Psychological Review*, *94*(3), 319-340.
- Higgins, E. T., Roney, C. J. R., Crowe, E., & Hymes, C. (1994). Ideal versus ought predilections for approach and avoidance: Distinct self-regulatory systems. *Journal of Personality and Social Psychology*, *66*(2), 276-286.
- Higgins, E. T., Strauman, T., & Klein, R. (1986). Standards and the process of self-evaluation: Multiple affects from multiple stages. In R. M. Sorrentino, & E. T. Higgins (Eds.), *Handbook of motivation and cognition: Foundation of social behaviour*. (pp. 23-63). New York: Guildford.
- Ho, I., & Holroyd, E. (2002). Chinese women's perceptions of the effectiveness of antenatal education in the preparation for motherhood. *Journal of Advanced Nursing*, *38*(1), 74-85.
- Hofmann, S. G., Sawyer, A. T., Witt, A. A., & Oh, D. (2010). The effect of mindfulness-based therapy on anxiety and depression: A meta-analytic review. *Journal of Consultant Clinical Psychology*, *78*(2), 169-183.
- Holden, J. (1996). The role of health visitors in postnatal depression. *International Review of Psychiatry*, *8*, 79-86.

- Holopainen, D. (2002). The experience of seeking help for postnatal depression. *Australian Journal of Advanced Nursing, 19*(3), 39-44.
- Hopkins, J., & Campbell, S. B. (2008). Development and validation of a scale to assess social support in the postpartum period. *Archives of women's mental health, 11*(1), 57-65.
- Horsburgh, D. (2003). Evaluation of qualitative research. *Journal of Clinical Nursing, 12*, 307-312.
- Hughes, A., Williams, M., Bardacke, N., Duncan, L. G., Dimidjian, S., & Goodman, S. H. (2009). Mindfulness approaches to childbirth and parenting. *British Journal of Midwifery, 17*(10), 630-635.
- Inglis, S. (2002). Accessing a debriefing service following birth. *British Journal of Midwifery, 10*(6), 368-371.
- Jagger, M., & Richards, K. (1965). Mother's Little Helper [Recorded by The Rolling Stones]. On *Aftermath* [CD]. London, England: London Records.
- Jardri, R., & Maron, M. (2006). Why and how to improve postnatal depression screening in the immediate post-partum? *Clinical Effectiveness in Nursing, 9*(2), e238-e241.
- John, O. P., & Gross, J. J. (2004). Healthy and unhealthy emotion regulation: Personality processes, individual differences, and life span development. *Journal of Personality, 72*, 1301-1333.
- Johnstone, S. J., Boyce, P. M., Hickey, A. R., Morris-Yates, A. D., & Harris, M. G. (2001). Obstetric risk factors for postnatal depression in urban and rural community samples. *Australian and New Zealand Journal of Psychiatry, 35*, 69-74.
- Jones, E. E., Farina, A., Hastorf, A. H., Markus, H., Miller, D. T., & Scott, A. S. (1984). *Social stigma: The psychology of marked relationships*. New York: Freeman.

- Jonzon, E., & Lindblad, F. (2005). Adult female victims of child sexual abuse: Multitype maltreatment and disclosure characteristics related to subjective health. *Journal of Interpersonal Violence, 20*, 651-666.
- Jordan, B. (1997). Gender Politics and Infant Mental Health. *The Signal: Newsletter of the World Association for Infant Mental Health, 5*(3), 1-5.
- Jorm, A. F., Korten, A. E., Jacomb, P. A., Christensen, H., Rodgers, B., & Pollitt, P. (1997). "Mental health literacy": a survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment. *Medical Journal of Australia, 166*(4), 182-186.
- Josefsson, A., Angelsioo, L., Berg, G., Ekstrom, C. M., Gunnervik, C., Nordin, C., & Sydsjo, G. (2002). Obstetric, somatic, and demographic risk factors for postpartum depressive symptoms. *Obstetrics and Gynecology, 99*, 223-228.
- Josefsson, A., & Sydsjo, G. (2007). A follow-up study of postpartum depressed women: recurrent maternal depressive symptoms and child behaviour after four years. *Archives of Women's Mental Health, 10*, 141-145.
- Jourard, S. M. (1971). *Self-disclosure: An experimental analysis of the transparent self*. Oxford, England: John Wiley.
- Kabat-Zinn, J. (1990). *Full catastrophe living*. New York: Bantam.
- Kahn, J. H., & Cantwell, K. E. (2012, August). *Social support and the disclosure of everyday unpleasant emotional events*. Poster presented at the 120th Annual Convention of the American Psychological Association, Orlando, FL.
- Kanner, A. D., Coyne, J. C., Schaefer, C., & Lazarus, R.S. (1981). Comparison of two modes of stress measurement: Daily hassles and uplifts versus major life events. *Journal of Behavioral Medicine, 4*, 1-39.

- Kanuha, V. K. (2000). "Being" native versus "going native": Conducting social work research as an insider. *Social Work, 45*(5), 439-447.
- Kashdan, T. B., Barrios, V., Forsyth, J. P., & Steger, M. F. (2006). Experiential avoidance as a generalized psychological vulnerability: Comparisons with coping and emotional regulation strategies. *Behaviour Research and Therapy, 44*, 1301-1320.
- Kashy, D. A., & Kenny, D. A. (2000). The analysis of data from dyads and groups. In: H. T. Reis, & C. M. Judd, (Eds.). *Handbook of research methods in social and personality psychology*. (pp. 451-477). Cambridge, UK: Cambridge University Press.
- Kelly, G. (1955). *The Psychology of Personal Constructs. Volume 2*. New York: Norton.
- Kennedy, H. P., Beck, C. T., & Driscoll, J. W. (2002). A light in the fog: Caring for women with postpartum depression. *Journal of Midwifery & Women's Health, 47*(5), 318-330.
- Kennedy-Moore, E., & Watson, J. C. (2001). How and when does emotional expression help? *Review of General Psychology, 5*, 187-212.
- Knox, S., & Hill, C. E. (2003). Therapist self-disclosure: Research-based suggestions for practitioners. *Journal of Clinical Psychology, 59*(5), 529-539.
- Knudson-Martin, C. & Silverstein, R. (2009). Suffering in silence: A qualitative meta-data-analysis of postpartum depression. *Journal of Marital and Family Therapy, 35*, 145-158.
- Kondel-Laws, T., Parkinson, A., Hensman, R., & Laws, K. (2012). The impact of attending a psycho-educational antenatal group on the observed parent-infant relationship: a randomised-controlled study. *Division of Clinical Psychology Annual Conference*.
- Koo, V., Lynch, J., & Cooper, S. (2003). Risk of postnatal depression after emergency delivery. *Journal of Obstetrics and Gynaecology Research, 29*(4), 246-250.

- Kruglanski, A. W., & Maysless, O. (1990). Classic and current social comparison research: Expanding the perspective. *Psychological Bulletin*, *108*(2), 195-208.
- Kubler-Ross, E. (1969). *On death and dying*. New York: The Macmillan Company.
- Kudielka, B. M., Broderick, J. E., & Kirschbaum, C. (2003). Compliance with saliva sampling protocols: Electronic monitoring reveals invalid cortisol daytime profiles in noncompliant subjects. *Psychosomatic Medicine*, *65*(2), 313-319.
- Kuipers, L. (1992). Needs of relatives of long-term psychiatric patients. In: G. Thornicroft, C. R. Brewin, & J. Wing, (Eds.), *Measuring Mental Health Needs*, (pp.291-307). London: Gaskell.
- Langdrige, D. (2007). *Phenomenological psychology: theory, research and method*. Harlow: Pearson Prentice Hall.
- Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology*, *3*, 102-120.
- Lauer-Williams, J. (2001). Postpartum depression: A phenomenological exploration of the woman's experience. *Dissertation Abstracts International*, *62*(4-B), 2064.
- Leahy-Warren, P., & McCarthy, G. (2007). Postnatal depression: Prevalence, mothers' perspectives, and treatments. *Archives of Psychiatric Nursing*, *21*(2), 91-100.
- Leonardou, A., Zervas, Y., & Papageorgiou, C. (2009). Validation of the Edinburgh Postnatal Depression Scale and prevalence of postnatal depression at two months postpartum in a sample of Greek mothers. *Journal of Reproductive and Infant Psychology*, *27*(1), 28-39.
- Lepore, S. J., Fernandez-Berrocal, P., Ragan, J., & Ramos, N. (2004). It's not that bad: Social challenges to emotional disclosure enhance adjustment to stress. *Anxiety, Stress, and Coping*, *17*(4), 341-361.

- Lepore, S. J., Ragan, J. D., & Jones, S. (2000). Talking facilitates cognitive-emotional processes of adaptation to an acute stressor. *Journal of Personality and Social Psychology, 78*, 499-508.
- Letourneau, N. L., Duffett-Leger, L., Stewart, M., Hegadoren, K., Dennis, C., Rinaldi, C., & Stoppard, J. (2007). Canadian mothers' perceived support needs during postpartum depression. *Journal of Obstetric, Gynecologic and Neonatal Nursing, 36*(5), 441-449.
- Liamputtong, P. (2006). Motherhood and "Moral Career": Discourses of good motherhood among Southeast Asian immigrant women in Australia. *Qualitative Sociology, 29*(1), 25-53.
- Liamputtong, P., & Naksook, C. (2003). Perceptions and experiences of motherhood, health and the husband's role among Thai women in Australia. *Midwifery, 19*, 27-36.
- Liamputtong, P., Yimyam, S., Parisunyakul, S., Baosoung, C., & Sansiriphun, N. (2004). When I become a mother!: Discourses of motherhood among Thai women in Northern Thailand. *Women's Studies International Forum, 27*, 589-601.
- Lock, A., & Strong, T. (2010). *Social constructionism: Sources and stirrings*. Oxford: Oxford University Press.
- Lovestone, S., & Kumar, R. (1993). Postnatal psychiatric illness: The impact of partners. *British Journal of Psychiatry, 163*, 210-216.
- Lucksted, A., Drapalski, A., Calmes, C., Forbes, C., DeForge, B., & Boyd, J. (2011). Ending self-stigma: pilot evaluation of a new intervention to reduce internalized stigma among people with mental illnesses. *Psychiatric Rehabilitation Journal, 35*(1), 51-54.
- Lupton, D. (2000). 'A love/hate relationship': the ideals and experiences of first-time mothers. *Journal of Sociology, 36*(1), 50-63.
- Major, B., & Gramzow, R. H. (1999). Abortion as stigma: Cognitive and emotional implications of concealment. *Journal of Personality and Social Psychology, 77*, 735-745.

- Margolis, M. L. (1984). *Mothers and such: Views of American women and why they changed*. Berkeley: University of California Press.
- Martinez, R., Johnston-Robledo, I., Ulsh, H. M., & Chrisler, J. C. (2000). Singing “the baby blues”: A content analysis of popular press articles about postpartum affective disturbances. *Women & Health, 31*, 37-56.
- Mauthner, N. S. (1998). It’s a woman’s cry for help: A relational perspective on postnatal depression. *Feminism & Psychology, 8*, 325-355.
- Mauthner, N. S. (1999). “Feeling low and feeling really bad about feeling low”: Women’s experiences of motherhood and postpartum depression. *Canadian Psychology, 40*(2), 143-161.
- McCarthy, M., & McMahon, C. (2008). Acceptance and Experience of Treatment for Postnatal Depression in a Community Mental Health Setting. *Health Care for Women International, 29*(6), 618-637.
- McGowan, F. J. (1957). The doctor talks about postnatal blues. *McCall's, 84*(4), 143.
- McIntosh, J. (1993). Postpartum depression: Women’s help-seeking behaviour and perceptions of cause. *Journal of Advanced Nursing, 18*(2), 178-184.
- McRobbie, A. (2006, March 2). Yummy Mummies leave a bad taste for young women. The Guardian. Retrieved from:  
<http://www.guardian.co.uk/comment/story/0,,1721450,00.html>
- Meadows, S. O., McLanahan, S. S., & Brooks-Gunn, J. (2008). Stability and change in family structure and maternal health trajectories. *American Sociological Review, 73*(2), 314-334.
- Meichenbaum, D., & Fitzpatrick, D. (1993). A constructivist narrative perspective on stress and coping: Stress inoculation applications. In: L. Goldberger, & S. Breznitz, (Eds.),

*Handbook of stress: Theoretical and clinical aspects*, 2<sup>nd</sup> ed, (pp.706-723). New York: Free Press.

Meighan, M., Davies, M. W., Thomas, S. P., & Droppleman, P. G. (1999). Living with postpartum depression: The father's experience. *MCN, American Journal of Maternal Child Nursing*, 24(4), 202-208.

Menaghann, E. G. (1990). Social stress and individual distress. *Research in Community and Mental Health*, 6, 107-141.

Mercer, R. T. (1986). *First-time Motherhood: Experiences from Teens to Forties*. New York: Springer.

Mercer, R. T. (2004). Becoming a mother versus role attainment. *Journal of Nursing Scholarship*, 36, 226-232.

Michaels, P.J., Lopez, M., Rusch, N., & Corrigan, P. W. (2012). Constructs and concepts comprising the stigma of mental illness. *Psychology, Society, & Education*, 4(2), 183-194.

Miles, M., & Huberman, A. (1994). *Qualitative data Analysis*. Sage, London.

Milgrom, J., & McCloud, P. (1996). Parenting stress and postnatal depression. *Stress Medicine*, 12(3), 177-186.

Miller, J. B. (1999). Attachment orientation and memory for attachment-related events. *Journal of Social and Personal Relationships*, 16, 773-801.

Mind & Rethink Mental Illness (2008). *Time To Change*. Retrieved from: <http://www.time-to-change.org.uk>

Misri, S., Sinclair, D., & Kuan, A. (1997). Breast-feeding and postpartum depression: is there a relationship? *Canadian Journal of Psychiatry*, 42(10), 1061-1065.

- Mitmansgruber, H., Beck, T. N., Hofer, S., & Schubler, G. (2009). When you don't like what you feel: Experiential avoidance, mindfulness and meta-emotion in emotion regulation. *Personality and Individual Differences, 46*, 448-453.
- Morse, C. A., Buist, A., & Durkin, S. (2000). First time parenthood: Influences on pre and postnatal adjustment in fathers and mothers. *Journal of Psychosomatic Obstetrics and Gynecology, 21*, 109-120.
- Morse, J. M. (1999). Qualitative generalizability. *Qualitative Health Research, 9(1)*, 5-6.
- Murray, B. L. (2003). Qualitative research interviews: therapeutic benefits for the participants. *Journal of Psychiatric and Mental Health Nursing, 10(2)*, 233-236.
- Murray, D., Cox, J. L., Chapman, G., & Jones, P. (1995). Childbirth: life event or start of a long-term difficulty? Further data from the Stoke-on-Trent controlled study of postnatal depression. *British Journal of Psychiatry, 166(5)*, 595-600.
- Murray, L., Arteche, A., Fearon, P., Halligan, S., Goodyer, I., & Cooper, P. (2011). Maternal postnatal depression and the development of depression in offspring up to 16 years of age. *Journal of the American Academy of Child and Adolescent Psychiatry, 50(5)*, 460-470.
- Murray, L., Cooper, P. J., Wilson, A., & Romaniuk, H. (2003). Controlled trial of the short- and long-term effect of psychological treatment of post-partum depression. *The British Journal of Psychiatry, 182(5)*, 420-427.
- Murray, L., Fiori-Cowley, A., Hooper, R., & Cooper, P. (1996). The impact of postnatal depression and associated adversity on early mother-infant interactions and later infant outcome. *Child Development, 67(5)*, 2512-2526.
- Murray, L., Halligan, S. L., Goodyer, I., & Herbert, J. (2010). Disturbances in early parenting of depressed mothers and cortisol secretion in offspring: A preliminary study. *Journal of Affective Disorders, 122*, 218-223.

- Neter, E., Collins, N. L., Lobel, M., & Dunkel-Schetter, C. (1995). Psychosocial predictors of postpartum depressed mood in socioeconomically disadvantaged women. *Women's Health: Research on Gender, Behavior, and Policy*, 1(1), 51-75.
- National Health Service (2014). *Cognitive behavioural therapy (CBT) – Considerations*. National Health Service website. Retrieved from: <http://www.nhs.uk/Conditions/Cognitive-behavioural-therapy/Pages/Advantages.aspx>
- NICE (2008). *Improving the nutrition of pregnant and breastfeeding mothers and children in low-income households*. London: National Institute for Health and Clinical Excellence.
- NICE (2014). *Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance*. NICE clinical guidance 192. London: National Institute for Health and Clinical Excellence. Retrieved from: <http://www.nice.org.uk/CG192>.
- Nicolson, P. (1998). *Postnatal depression; Psychology, science and the transition to motherhood*. Florence, KY US: Taylor and Frances/Routledge.
- Nicolson, P. (1999). Loss, happiness and postpartum depression: The ultimate paradox. *Canadian Psychology*, 40(2), 162-178.
- Nicolson, P. (2001). *Postnatal Depression: Facing the paradox of loss, happiness and motherhood*. Chichester: John Wiley & Sons Ltd.
- NHMRC (2000). *Postnatal Depression, not just the baby blues*. National Health and Medical Research Council, Canberra.
- Nylen, K. J., O'Hara, M. W., Brock, R., Moel, J., Gorman, L., & Stuart, S. (2010). Predictors of the longitudinal course of postpartum depression following interpersonal psychotherapy. *Journal of Consulting and Clinical Psychology*, 78, 757-763.
- Oates, M. R., Cox, J. L., Neema, S., Asten, P., Glangeaud-Freudenthal, N., Figueiredo, B., Gorman, L. L., Hacking, S., Hirst, E., Kammerer, M. H., Klier, C. M., Seneviratne, G.,

- Smith, M., Sutter-Dallay, A., Valoriani, V., Wickberg, B., & Yoshido, K. (2004). Postnatal depression across countries and cultures: a qualitative study. *British Journal of Psychiatry, 184*, 10-16.
- O'Hara, M. W. (2009). Postpartum depression: what we know. *Journal of Clinical Psychology, 65*(12), 1258-1269.
- O'Hara, M. W., & McCabe, J. E. (2013). Postpartum depression: Current status and future directions. *Annual Review of Clinical Psychology, 9*, 379-407.
- O'Hara, M. W., Rehm, L. P., & Campbell, S. B. (1983). Postpartum depression. A role for social network and life stress variables. *Journal of nervous and mental disease, 171*, 336-341.
- O'Hara, M. W., & Swain, A. M. (1996). Rates and risk of postpartum depression – a meta-analysis. *International Review of Psychiatry, 8*, 37-54.
- O'Hara, M. W., & Zekoski, E. M. (1988). Postpartum depression: A comprehensive review. In R. Kumar & I.F. Brockington (Eds.), *Motherhood and Mental Illness 2: Causes and Consequences*. London: Wright.
- O'Mahen, H., Fedock, G., Henshaw, E., Himle, J. A., Forman, J., & Flynn, H. A. (2012). Modifying CBT for perinatal depression: What do women want? A Qualitative Study. *Cognitive and Behavioral Practice, 19*, 359-371.
- Pachankis, J.E. (2007). The psychological implications of concealing a stigma: A cognitive-affective-behavioral model. *Psychological Bulletin, 133*, 328-345.
- Page, A. (2013, 22<sup>nd</sup> February). *A case of the baby blues: 14 celebrity moms who battled postpartum depression*. Retrieved from: <http://madamenoire.com/262864/a-case-of-the-baby-blues-14-celebrity-moms-who-battled-postpartum-depression/>
- Parker, I., & Shotter, J. (1990). *Deconstructing Social Psychology*. London: Routledge.

- Parvin, A., Jones, C.E., & Hull, S.A. (2004). Experiences and understandings of social and emotional distress in the postnatal period among Bangladeshi women living in Tower Hamlets. *Family Practice, 21*(3), 254-260.
- Patel, V., Rodrigues, M., & De Souza, N. (2002). Gender, poverty & post-natal depression: A cohort study from Goa, India. *American Journal of Psychiatry, 159*, 43-47.
- Patton, M. (1990). *Qualitative Evaluation and Research Methods*. London: Sage.
- Phoenix, A., Woollett, A., & Lloyd, E. (1991). *Motherhood: Meanings, practices, ideologies*. London, England: Sage.
- Pietkiewicz, I., & Smith, J. A. (2012). Praktyczny przewodnik interpretacyjnej analizy fenomenologicznej w badaniach jakościowych w psychologii. *Czasopismo Psychologiczne, 18*(2), 361-369.
- Pope, S., Watts, J., Evans, S., McDonald, S., & Henderson, J. (2000). *An information paper. Postnatal depression: A systematic review of published scientific literature to 1999*. NHMRC, Canberra: Commonwealth of Australia.
- Quinn, D. M., & Chaudoir, S. R. (2009). Living with a concealable stigmatized identity: The impact of anticipated stigma, centrality, salience, and cultural stigma on psychological distress and health. *Journal of Personality and Social Psychology, 97*, 634-651.
- Reissman, C.K. (2008). *Narrative Methods for the Human Sciences*. London: Sage.
- Rennie, D. L. (1999). Qualitative research: a matter of hermeneutics and the sociology of knowledge. In: M. Kopala, & L. A. Suzuki, (Eds.), *Using qualitative methods in psychology*, (pp 3-13). Thousand Oaks: Sage.
- Richards, H. M., & Schwartz, L. J. (2002). Ethics of qualitative research: are there special issues for health services research? *Family Practice, 19*(2), 135-139.

- Ridge, D., & Ziebland, S. (2006). "The Old Me Could Never Have Done That": How People Give Meaning to Recovery Following Depression. *Qualitative Health Research, 16*(8), 1038-1053.
- Righetti-Veltema, M., Conne-Perreard, E., Bousquet, A., & Manzano, J. (2002). Postpartum depression and mother-infant relationship at 3 months old. *Journal of Affective Disorders, 70*(3), 291-306.
- Rime, B. (1995). Mental rumination, social sharing, and the recovery from emotional exposure. In J.W. Pennebaker (Ed.), *Emotion, disclosure, and health* (pp.271-291). Washington DC: American Psychological Association.
- Robertson, E., Celason, N., & Stewart, D. E. (2003). Risk Factors for postpartum depression. In D.E. Stewart, E. Robertson, C. L. Dennis, S. L. Grace, & T. A. Wallington, (Eds.), *Postpartum depression: Literature review of risk factors and interventions*. (pp. 9-70). Toronto: University Health Network Women's Health Program and Toronto Public Health.
- Rodrigues, M., Patel, V., Jaswal, S., & de Souza, N. (2003). Listening to mothers: qualitative studies on motherhood and depression from Goa, India. *Social Science & Medicine, 57*, 1797-1806.
- Rodriguez, R. R., & Kelly, A. E. (2006). Health effects of disclosing secrets to imagined accepting versus nonaccepting confidants. *Journal of Social & Clinical Psychology, 25*, 1023-1047.
- Romito, P. (1989). Unhappiness after childbirth. In I. Chalmers, M. Enkin, & M. Keirse (Eds.), *Effective Care in Pregnancy and Childbirth. Volume 2*. (pp. 221-227). Oxford: Oxford University Press.
- Roux, G., Anderson, C., & Roan, C. (2002). Postpartum depression, marital dysfunction, and infant outcome: A longitudinal study. *The Journal of Perinatal Education, 11*(4), 25-36.
- Salmela-Aro, K., Nurmi, J., Saisto, T., & Halmesmaki, E. (2001). Goal reconstruction and depressive symptoms during the transition to motherhood: evidence from two cross-

- lagged longitudinal studies. *Journal of Personality and Social Psychology*, 81(6), 1144-1159.
- Salzer, M., & Shear, S. L. (2002). Identifying consumer-provider benefits in evaluations of consumer-delivered services. *Psychiatric Rehabilitation Journal*, 25(3), 281-288.
- Schulze, B. (2007). Stigma and mental health professionals: A review of the evidence on an intricate relationship. *International Review of Psychiatry*, 19(2), 137-155.
- Schumacher, K. L. & Meleis, A. L. (1994). Transitions: a central concept in nursing. *Journal of Nursing Scholarship*, 26(2), 119-127.
- Seguin, L., Potvin, L., St Denis, M., & Loiselle, J. (1999). Depressive symptoms in the late postpartum among low socioeconomic status women. *Birth*, 26, 157-163.
- Serovich, J. M., Oliver, D. G., Smith, S. A., & Mason, T. L. (2005). Methods of HIV disclosure by men who have sex with the men to casual sexual partners. *AIDS Patient Care and STDs*, 19, 823-832.
- Shakespeare, J., Blake, F., & Garcia, J. (2003). A qualitative study of the acceptability of routine screening of postnatal women using the Edinburgh Postnatal Depression Scale. *British Journal of General Practice*, 53, 614-619.
- Sharp, D. (1996). The Prevention of Postnatal Depression. In: D. Kendrick, P. Freeling, & A. Tyle (Eds). *The Prevention of Mental Illness in Primary Care*. (pp. 57-73). Cambridge, England: Cambridge University Press.
- Shields, B. (2005). *Down Came the Rain: My Journey Through Postpartum Depression*. New York, NY: Hyperion.
- Silverstein, L. B., Auerbach, C. F., & Silverstein, R. F. (2006). Using qualitative research to strengthen clinical practice. *Professional Psychology: Research and Practice*, 37(4), 351-358.

- Simpson, J. A., Rholes, W. S., Campbell, L., Tran, S. and Wilson, C. L. (2003). Adult Attachment, the Transition to Parenthood, and Depressive Symptoms. *Journal of Personality and Social Psychology*, *84*(6), 1172-1187.
- Sit, D. K., Perel, J. M., Helsel, J. C., & Wisner, K. L. (2008). Changes in antidepressant metabolism and dosing across pregnancy and early postpartum. *Journal of Clinical Psychiatry*, *69*(4), 652-658.
- Small, R., Brown, S., Lumley, J., & Astbury, J. (1994). Missing voices: What women say and do about depression after childbirth. *Journal of Reproductive and Infant Psychology*, *12*, 89-103.
- Smith, J. A. (1996). Beyond the divide between cognition and discourse: using interpretative phenomenological analysis in health psychology. *Psychology and Health*, *11*, 261-271.
- Smith, J. A. (2004). Reflecting on the development interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology*, *1*, 39-54.
- Smith, J. A. (2007). Hermeneutics, human sciences and health: linking theory and practice. *International Journal of Qualitative Studies on Health and Well-being*, *2*, 3-11.
- Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: theory, method and research*. Los Angeles: Sage.
- Smith, J., & Mitchell, S. (1996). Debriefing after childbirth: a tool for effective risk management. *British Journal of Midwifery*, *4*(11), 581-586.
- Smith, J. A., & Osborn, M. (2003). Interpretative Phenomenological Analysis. In J. A. Smith (Ed.), *Qualitative Psychology: A Practical Guide to Methods*. London: Sage.
- Smith, J. A., & Osborn, M. (2008). Interpretative Phenomenological Analysis. In J.A. Smith (Ed.), *Qualitative Psychology: A Practical Guide to Methods*. London: Sage. (2<sup>nd</sup> edition).

- Smith, R., Rossetto, K., & Peterson, B. L. (2008). A meta-analysis of disclosure of one's HIV-positive status, stigma and social support. *AIDS Care, 20*, 1266-1275.
- Sohr-Preston, S. L., & Scaramella, L. V. (2006). Implications of timing and maternal depressive symptoms for early cognitive and language development. *Clinical Child and Family Psychology Review, 9*, 65-83.
- Soliday, E., McClusky-Fawcett, K., & O'Brien, M. (1999). Postpartum affect and depressive symptoms in mothers and fathers. *American Journal of Orthopsychiatry, 69*, 30-38.
- Sroufe, L. A. (1988). The Role of Infant-Caregiver Attachment in Development. In: J. Belsky, & T. Nezworski (Eds.) *Clinical Implications of Attachment*. (pp 18-38). Hillsdale, NJ: Lawrence Erlbaum Associates.
- Stearns, P. N. (2002). *Anxious parents: A history of modern childrearing in America*. New York, NY: New York University Press.
- Stein, A., Malmberg, L. E., Sylva, K., Barnes, J., Leach, P., & FCCC Team (2008). The influence of maternal depression, caregiving, and socioeconomic status in the post-natal year on children's language development. *Child: Care, Health and Development, 38*(3), 420-424.
- Stein, G., Marsh, A., & Morton, J. (1981). Mental symptoms, weight changes, and electrolyte excretion in the first postpartum week. *Journal of psychosomatic Research, 25*, 395-408.
- Sterne, J. A., Egger, M., & Smith, G. D. (2001). Systematic reviews in health care: investigating and dealing with publication and other biases in meta-analysis. *British Medical Journal, 323*, 101-105.
- Stewart, D. E., Robertson, E., Dennis, C-L., Grace, S. L., & Wallington, T. (2003). Postpartum Depression: Literature Review of Risk Factors and Interventions. Toronto, Ont: University Health Network Women's Health Program and Toronto Public Health. Retrieved from: [www.city.toronto.on.ca/health/pp\\_depression.htm](http://www.city.toronto.on.ca/health/pp_depression.htm)

- Stiles, W. B. (1987). I have to talk to somebody: A fever model of disclosure. In: V.J. Derlega & J.H. Berg (Eds.), *Self-disclosure: Theory, research and therapy* (pp. 257-282). New York: Plenum Press.
- Stiles, W. B. (1993). Quality control in qualitative research. *Clinical Psychology Review, 13*, 593-618.
- Strahan, E. J., Wilson, A. E., Cressman, K. E., & Buote, V. M. (2006). Comparing to perfection: How cultural norms for appearance affect social comparisons and self-image. *Body Image, 3*(3), 211-227.
- Stuchbery, M., Matthey, S., & Barnett, B. (1998). Postnatal depression and social supports in Vietnamese, Arabic and Anglo-Celtic mothers. *Social Psychiatry and Psychiatric Epidemiology, 33*, 483-490.
- Sword, W., Landy, C. K., Thabane, L., Watt, S., Krueger, P., Farine, D., & Foster, G. (2011). Is mode of delivery associated with postpartum depression at 6 weeks: a prospective cohort study. *BJOG: an international journal of obstetrics and gynaecology, 118*(8), 966-977.
- Tait, L., & Heron, J. (2010). Management of postnatal depression in primary care: a window of opportunity. *British Journal of General Practice, 60* (580), 801-802.
- Tait, R., & Silver, R.C. (1989). Coming to terms with major negative life events. In: J. S. Uleman, & J. A. Barg (Eds.). *Unintended thoughts*, (pp. 351-382). New York: Guilford.
- Tangney, J.P., Niedenthal, P.M., Covert, M.V., & Barlow, D.H. (1998). Are shame and guilt related to distinct self-discrepancies? A test of Higgins's (1987) hypotheses. *Journal of Personality and Social Psychology, 75*(1), 256-268.
- Templeton, L., Velleman, R., Persaud, A., & Milner, P. (2003). The experiences of postnatal depression in women from black and minority ethnic communities in Wiltshire, UK. *Ethnicity and Health, 8*, 207-221.

- The British Psychological Society (2010). *Code of Human Research Ethics*. Leicester: The British Psychological Society.
- Thoits, P.A. (2011). Mechanisms linking social ties and support to physical and mental health. *Journal of Health and Social Behavior, 52*(2), 145-161.
- Thornicroft, G., Rose, D., Kassam, A., & Sartorius, N. (2007). Stigma: ignorance, prejudice or discrimination. *British Journal of Psychiatry, 190*, 192-193.
- Thurtle, V. (1995). Post-natal depression: the relevance of sociological approaches. *Journal of advanced nursing, 22*(3), 416.
- Tone, A. (2009). *The age of anxiety: A history of America's turbulent affair with tranquilizers*. New York, NY: Basic Books.
- Topping, A. (2012, October 30). Woman admits killing her two babies. *The Guardian*. Retrieved from: <http://www.theguardian.com/uk/2012/oct/30/woman-admits-killing-two-babies>
- Tronick, E. Z., & Weinberg, M. K. (1997). Depressed mothers and infants: Failure to form dyadic states of consciousness. In L. Murray & P. Cooper (Eds.), *Postpartum depression and child development* (p54). New York: Guildford Press.
- Tull, M. T., Gratz, K. L., Salters, K., & Roemer, L. (2004). The role of experiential avoidance in posttraumatic stress symptoms and symptoms of depression, anxiety and somatization. *Journal of Nervous and Mental Disease, 192*, 754-761.
- Turner, K.M., Sharp, D., Folkes, L., & Chew-Graham, C. (2008). Women's views and experiences of antidepressants as a treatment for postnatal depression: a qualitative study. *Family Practice, 25*(6), 450-455.

- Uchino, B. N. (2009). Understanding the links between social support and physical health: A life-span perspective with emphasis on the separability of perceived and received support. *Perspectives on Psychological Science, 4*, 236-255.
- Ugarriza, D. N. (2002). Postpartum depressed women's explanation of depression. *Journal of Nursing Scholarship, 34*(3), 227-233.
- Ullman, S. E. (2003). Social reactions to child sexual abuse disclosures: A critical review. *Journal of Child Sexual Abuse, 12*, 89-121.
- University of Hertfordshire (2004). *Guide to Good Practice in Research*. Hatfield: University of Hertfordshire.
- Vieten, C., & Astin, J. (2008). Effects of a mindfulness-based intervention during pregnancy on prenatal stress and mood: results of a pilot study. *Archives of Women's Mental Health, 11*, 67-74.
- Vik, K., & Hafting, M. (2012). "Smile through it!" Keeping up the Façade While Suffering from Postnatal Depressive Symptoms and Feelings of Loss: Findings of a Qualitative Study. *Psychology, 3*, 810-817.
- Walker, N. (2000). *Shaping our mother's world: American women's magazines*. Jackson: University Press of Mississippi.
- Wall, G. (2001). Moral Constructions of Motherhood in breastfeeding discourse. *Gender & Society, 15*, 592-610.
- Warner, R., Appleby, L., Whitton, A., & Faragher, B. (1996). Demographic and obstetric risk factors for postnatal psychiatric morbidity. *British Journal of Psychiatry, 168*, 607-611.
- Weaver, J., & Usher, J. (1997). How motherhood changes life – a discourse analytic study with mothers of young children. *Journal of Reproductive and Infant Psychology, 15*, 51-68.

- Webb, C. (1992). The use of the first person in academic writing: objectivity, language and gatekeeping. *Journal of Advanced Nursing*, 17(6), 745-752.
- Webster, J., Nicholas, C, Vellacott, C., Cridland, N., & Fawcett, L. (2011). Quality of Life and depression following childbirth: Impact of social support. *Midwifery*, 27, 245-749.
- Welberg, L. (2008). Affective disorders: Baby blues. *Nature Reviews Neuroscience*, 9(9), 657.
- WHO (2003). *United Nations Children's Fund: Global Strategy for Infant and Young Child Feeding*. Geneva: World Health Organisation.
- Wilkinson, S. (1996). *Feminist Social Psychologies: International Perspectives*. Buckingham: Open University Press.
- Williams, S., & Calnan, M. (1996). Modern medicine and the lay populace: Theoretical and methodological issues. In: S. Williams, & M. Calnan (Eds.), *Modern medicine: Lay perspectives and experiences*. (pp. 2-25). London: University College London: Press.
- Wills, T. A. (1981). Downward comparison principles in social psychology. *Psychological Bulletin*, 90(2), 245.
- Winnicott, D. W. (1953). Transitional objects and transitional phenomena. *International Journal of Psychoanalysis*, 34, 89-97.
- Winnicott, D. W. (1957). *The child and the family: First relationships*. London, England: Tavistock Publications.
- Woollett, A., & Parr, M. (1997). Psychological tasks for women and men in the postpartum. *Journal of Reproductive Infant Psychology*, 15, 159-183.
- Woollett, A., & Phoenix, A. (1991). Psychological views of mothering. In A. Phoenix, A. Woollett, & E. Lloyd (Eds.). *Motherhood: Meanings, Practices and Ideologies*. (pp. 28-46). London: Sage.

- World Health Organisation (1992). International Statistical Classification of Diseases and Related Health Problems, 10<sup>th</sup> Revision (ICD-10). Geneva: WHO.
- Wright, J. G., Swiontkowski, M. F., & Heckman, J. D. (2003). Editorial: Introducing levels of evidence to The Journal. *The Journal of Bone & Joint Surgery*, *85(1)*, 1-3.
- Yanos, P.T., Roe, D., & Lysaker, P.H. (2011). Narrative enhancement and cognitive therapy: A new group-based treatment for internalized stigma among persons with severe mental illness. *International Journal of Group Psychotherapy*, *61(4)*, 576-595.
- Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology & Health*, *15*, 215-228.
- Yardley, L. (2008). Demonstrating validity in qualitative psychology. In J.A. Smith (Ed.), *Qualitative Psychology: A Practical Guide to Methods* (2<sup>nd</sup> edn). London: Sage.
- Yehuda, R., Halligan, S. L., Yang, R. K., Guo, L. S., Makotkine, I., Singh, B., & Pickholtz, D. (2003). Relationship between 24-hour urinary-free cortisol excretion and salivary cortisol levels sampled from awakening to bedtime in healthy subjects. *Life Sciences*, *73(3)*, 349-358.
- Zauderer, C. (2009). Postpartum Depression: How Childbirth Educators Can Help Break the Silence. *The Journal of Perinatal Education*, *18(2)*, 23-31.
- Zelkowitz, P., & Milet, T. H. (1996). Postpartum psychiatric disorders: Their relationship to psychological adjustment and marital satisfaction in the spouses. *Journal of Abnormal Psychology*, *105(2)*, 281-285.
- Zelkowitz, P., & Milet, T. H. (1997). Stress and support as related to postpartum paternal mental health and perceptions of the infant. *Infant Mental Health Journal*, *18(4)*, 424-435.
- Zink, T., Levin, L., Wollan, P., & Putnam, F. (2006). Mother's Comfort with Screening Questions about Sensitive Issues, including domestic violence. *American Board of Family Medicine*, *19*, 358-367.



## 8.0 APPENDICES

### 8.1 Appendix 1: Summary of issues related to current definition of postnatal depression

#### *Period of onset*

In clinical practice and research, women with a depressive disorder within 12 months of birth are often classified as having “Major Depressive Disorder, with postpartum onset” (O’Hara & McCabe, 2013) and outside of the DSM-V and ICD-10 classifications, PND has been defined as any major or minor unipolar depressive episode occurring within the first postnatal year (NHMRC, 2000; NICE, 2014; Gibson, McKenzie-McHarg, Shakespeare, Price, & Gray, 2009). Recommendations for an extension of the onset of PND from 4 weeks to 6 months was considered by the workgroup for the DSM-V, but it was decided that the available epidemiological evidence to support such an extension was not yet compelling (O’Hara & McCabe, 2013).

#### *Defining features*

Certain features appear to distinguish PND from a ‘major depressive episode’ occurring at other times in women’s lives, including increased likelihood of comorbid anxiety, more severe depression, plus longer recovery due to a slower response to antidepressants (Flores & Hendrick, 2002; Hendrick, Altshuler, Strouse, & Grosser, 2000). Also, some researchers in this field suggest that additional symptoms for PND be added to formal definitions of depression to make it more in line with women’s experiences of the condition, e.g. fear for and sometimes of the infant; fear of death or harm to the partner; non-stop thoughts and fears of harming the baby; and extreme, possibly unreasonable, disappointment in labour, delivery, breastfeeding or other aspects of motherhood (Barnett & Fowler, 1995; Cox, 1989; Sharp, 1996). These experiences have been identified through qualitative research (e.g. Edhborg et al., 2005). However, the vast majority of research exploring PND is within a medical, psychiatric, or experimental psychology framework where PND is constructed as a ‘disease’ or ‘illness’ (Mauthner, 1999) and so less attention has been paid to the mother’s subjective experience of PND (Small et al., 1994).

### *Cut off between Postnatal Blues and PND*

Another difficulty in defining PND arises from disagreement about the line between 'postnatal blues' (or the 'baby blues') and PND (Hatz & Rohm, 2007; Welberg, 2008). Postnatal blues is a common condition, with a prevalence rate of up to 85% of new mothers (Stein, Marsh, & Morton, 1981), occurring a few days to a week after childbirth and is usually short-lived, lasting up to 14 days. Symptoms include emotional lability plus increased anxiety, irritability, and tearfulness. It is still unclear whether postnatal blues or PND are entirely different entities with differing groups of symptoms and etiologies, or whether they represent a continuum of the same disorder. However, PND is currently viewed as a separate and more severe illness from postnatal blues (Flores & Hendrick, 2002).

### *Inconsistent findings regarding convergent validity*

In support of the current diagnostic criteria for PND, epidemiological studies carried out in both Western and non-Western cultures have demonstrated convergent validity of PND as a construct (Patel, Rodrigues & De Souza, 2002; Rodrigues et al., 2003). However, other research contradicts this. For example, a study by Asten, Marks, Oates, & the Transcultural Study of Postnatal Depression Group (2004) highlighted the heterogeneity of definition across cultures and regions.

## 8.2 Appendix 2: List of proposed risk factors for postnatal depression

- Biological factors
  - Hormonal changes (Robertson, Celason, & Stewart, 2003)
- Obstetric factors
  - Obstetric complications (O'Hara and Swain, 1996)
  - Delivery method (e.g. Boyce & Todd, 1992; Koo, Lynch, & Cooper, 2003)
  - Unplanned or unwanted pregnancy (Beck, 1996; Warner, Appleby, Whitton, & Faragher, 1996)
  - Breastfeeding (Breese McCoy, Beal, Miller Shipman, Payton, & Watson, 2006; Ferguson, Jamieson, & Lindsay, 2002; Misri, Sinclair, & Kuan, 1997)
  - Maternal postnatal complications (Sword et al., 2011)
- Psychological factors
  - Previous history of depression (Beck, 2001; Johnstone, Boyce, Hickey, Morris-Yatees, & Harris, 2001; Josefsson, et al., 2002; O'Hara & Swain, 1996).
  - Family history of depression (Johnstone et al., 2001; O'Hara & Swain, 1996)
  - Antenatal depression (Beck, 1996; NHMRC, 2000; O'Hara & Swain, 1996)
  - Antenatal anxiety (Johnstone et al., 2001; Neter, Collins, Lobel, & Dunkel-Schetter, 1995; O'Hara & Swain, 1996).
  - Negative cognitive attributional style (O'Hara & Swain, 1996)
  - Neuroticism (O'Hara and Swain, 1996)
- Social factors
  - Life events (Beck, 2001)
  - Socioeconomic status (Beck, 2001; O'Hara & Swain, 1996)
  - Early relationships (Blum, 2007; Murray, Cox, Chapman, & Jones, 1995)
  - Maternal attachment style – (Carnelley, Pietromonaco, & Jaffe, 1994; Simpson, Rholes, Campbell, Tran, & Wilson, 2003)
  - Current relationships – (Zelkowitz & Milet, 1996; NHMRC, 2000)
  - Social support – see section 3.5.1

### **8.3 Appendix 3: Summary of the potential impact of postnatal depression on infant behavioural, cognitive, psychological, and physical health development**

#### *Behaviour*

Recent studies have found that maternal depressive symptoms experienced during the first six months postpartum are associated with behavioural problems from early childhood to adolescence (Avan, Richter, Ramchandani, Norris & Stein, 2010; Murray, Arteche, Fearon, Halligan, Goodyer & Cooper, 2011). Brennan and colleagues (2000) found that both severity and chronicity of maternal depressive symptoms predicted future child behavioural problems. Reviews of the literature suggest that chronicity of maternal depression (i.e. the amount of exposure the child has to depression) may play a more critical role in child behavioural outcomes than PND specifically (Brand & Brennan, 2009; Grace, Evindar, & Stewart, 2003).

#### *Cognitive Development*

There is a high level of convergence amongst reviews of the literature focusing on the adverse influence of chronic PND on language, IQ and attentional skills in children, across both childhood and adolescence (Brand & Brennan, 2009; Grace et al., 2003; Hay, Pawlby, Sharp, Asten, Mills, & Kumar, 2001; Sohr-Preston & Scaramella, 2006; O'Hara & McCabe, 2013). This may be due to the depressed mother's tendency to provide fewer learning opportunities (Stein, Malmberg, Sylva, Barnes, Leach & FCCC Team, 2008). As with child behavioural outcomes, research has found that chronicity of maternal depressive symptoms may have more of an influence on a child's vulnerabilities to developmental delay compared to PND per se (Sohr-Preston & Scaramella, 2006).

#### *Physical Health*

The benefits of breastfeeding for mothers and infants are widely acknowledged (NICE, 2008; WHO, 2003). These include more secure attachment in the infant due to factors such as the frequent close physical contact between infant and mother in breastfeeding, which in turn can make the mother more responsive to the infant's needs (Anisfeld, Casper, Nozyce & Cunningham, 1990; Brandt, Andrews & Kvale, 1998). A number of research studies have reported a negative effect of PND on breastfeeding outcomes (Dennis & McQueen, 2007;

Gagliardi, Petrozzi & Rusconi, 2012). However, it is important to note that a number of studies have found no association between PND and feeding outcomes (Dennis & McQueen, 2009).

Mothers with PND are less likely to engage in positive caretaking behaviours, such as attending regular child health checks (O'Hara & McCabe, 2013). This can have an adverse effect on the infant's physical health, including cardiovascular functioning (Gump et al., 2009), gastrointestinal infections and lower respiratory tract infections (Ban, Gibson, West & Tata, 2010), and child growth (Ertel, Koenen, Rich-Edwards & Gillman, 2010; Gress-Smith, Luecken, Lemery-Chalfant & Howe, 2012).

### *Mental Health*

Research has found that offspring of postnatally depressed mothers are at increased risk for clinical depression (major depressive episode and dysthymia) by the age of sixteen (Murray et al., 2011). Associations between exposure to maternal PND and higher salivary cortisol levels have been found in both infants (Ashman, Dawson, Panagiotides, Yamada & Wilkins, 2002; Hessel et al., 1998) and adolescents and adults (Goodyer, Tamplin, Herbert & Altham, 2000; Harris et al., 2000), even when factors such as experiences of life events are controlled for (Halligan, Herbert, Goodyer, & Murray, 2004). However, this association has not been consistently found (e.g. Hessel et al., 1998) and some researchers have highlighted methodological limitations of measuring salivary cortisol (Halligan et al., 2004; Kudielka, Broderick & Kirschbaum, 2003; Yehuda, et al., 2003).

#### 8.4 Appendix 4: Table illustrating how I met Yardley’s (2008) quality guidelines in the current study

Criteria for quality	How I met the criteria
<b>1. Sensitivity to context</b>	
Consideration of relevant theoretical and empirical literature	An in-depth search and review of the theoretical and empirical literature relevant to the current study was conducted and is presented in section 3.0. These processes aided the identification of gaps in the current literature and the formulation of a suitable research question. Results were reviewed in light of current theoretical and empirical literature. The contribution of the current findings to clinical practice was considered in section 6.4.
Sensitivity to perspective and socio-cultural context of participants	A pilot interview (see section 4.5.2) was conducted to review the relevance and sensitivity of the interview schedule (Appendix 10). The use of open-ended questions ensured that the interviews were sensitive to participants’ perspectives. In each interview I showed empathy towards the participants, particularly when they became tearful and discussed highly emotive experiences (see section 4.4.3). Attempts were made to make each participant feel at ease by considering the setting and timing of interviews (section 4.5.3), by implementing ethical procedures that emphasized their right to terminate or pause the interview, and by debriefing and offering support following the interviews (see section 4.4). Whilst I was in the position of ‘expert researcher’, I held in mind at all times that they were the experts on their own experiences. The IPA analysis process carried out and the use of numerous verbatim extracts to support findings ensured that the analytic claims are grounded in the data. All of this demonstrated sensitivity to context.
<b>2. Commitment and rigour</b>	
Thorough data collection	Questions within the semi-structured interviews (Appendix 10) were designed to be open and expansive so as the participants could be encouraged to talk at length about their lived experiences, with minimal verbal input

	from the researcher, to ensure flexibility and freedom for novel areas to be raised and explored. I attended closely to what each participant was saying during data collection and took steps to ensure they felt safe and comfortable by letting them choose the setting for the interview and overseeing ethical procedures (as above).
Depth / breadth of analysis	Guidelines for conducting IPA (Smith, Flowers & Larkin, 2009) were adhered to meaning that a rigorous and in-depth process of analysis was undertaken (see section 4.7). Discussion of emerging themes within supervision and with another qualified Clinical Psychologist ensured depth of analysis. A transcript and audit trail (Appendix 11) demonstrate the breadth of analysis. As this study had a small sample size of five, extracts were included from all participants for whom the theme was relevant.
Methodological competence / skill	As well as consulting a range of relevant IPA literature, I attended a conference, workshop and speciality lectures on IPA. Supervision and discussions around the analysis of a transcript (Appendix 11) with a qualified Clinical Psychologist provided the opportunity to discuss and enhance my knowledge and skills related to IPA.
In-depth engagement with the topic	My personal experiences, detailed in sections 2.1.1, initiated and maintained engagement with the topic. Keeping a reflective diary and having a bracketing interview (see section 4.5.2) prevented me from over identifying with the participants' experiences. A continuous commitment to updating the literature search and review, and keeping up-to-date with media reports of PND, all over a three year period also demonstrates an in-depth engagement with the topic.
<b>3. Coherence and transparency</b>	
<i>Coherence</i>	Coherence is demonstrated by the rationale for this study, based on the literature review (see section 3.6) and the theoretical background of IPA and rationale for choosing this methodology. The coherence and comprehensibility of my analyses, particularly with regards the emerging themes, was enhanced through triangulation, which occurred in two ways in the present study: convergence of themes across the sample; and through discussions in supervision. The interview transcript of one participant (Louise), and related audit

	documentation, (see Appendix 11) and sections of the other interviews were audited by the primary research supervisor (Smith, Flowers & Larkin, 2009). In addition, both research supervisors checked the Results section and were in general agreement with the emerging themes. Finally, a transcript was checked by a qualified Clinical Psychologist who has previously conducted IPA research and who is independent of the present research. The themes he elicited were comparable to my own.
<i>Transparency</i>	The detailed descriptions of the research process (e.g. literature review process, methodological procedures and analysis process) outlined above contribute to a transparent approach and the process of analysis in IPA enhances transparency. An audit trail of the analysis process is provided in Appendix 11. Themes are highlighted by verbatim extracts that are used frequently in the write up to illustrate and explain analytical interpretations. This allows the readers to see how the data fits with the interpretations. Transparency was also ensured through the use of a reflective diary and personal reflections in the analysis of data. I have also read several versions of this thesis very carefully, each time attempting to put myself in the shoes of the reader.
<b>4. Impact and importance</b>	
<i>Impact and importance</i>	The relevance and need for this research study were outlined following the literature review (section 3.0). Suggestions are made in section 6.0 regarding how this study can further our understanding of the experiences of mothers who disclose their symptoms of PND to other people in their support network. The findings can contribute to evidence-based clinical practice for Psychologists and other professionals working with mothers with PND.

## 8.5 Appendix 5: Participant recruitment advertisement



### WHAT ARE THE EXPERIENCES OF MOTHERS

### WHO DISCLOSE THEIR SYMPTOMS OF POSTNATAL DEPRESSION?

Recruitment Advert - Version 1 - Date: 05 / 11 / 2012

#### **Participants required for confidential postnatal depression study**

A researcher from the University of Hertfordshire would like to interview women who feel they suffered from postnatal depression (whether or not they were formally diagnosed with the condition) and talked about their difficulties to other people.

#### **The purpose of the study**

Previous research has tended to focus on mothers' experiences of disclosing to health professionals, with limited focus on experiences of disclosing to non-professionals (e.g. partners, family members, friends). As personal support networks form part of and impact on the whole process of speaking out, it would be interesting and important to understand this under-researched area.

#### **What the study will involve**

If you could spare some time (approx 60-90 mins) to be involved in this novel piece of research, you will be asked to take part in a (strictly confidential and anonymous) interview regarding your own experiences of postnatal depression and disclosure (speaking out to others).

#### **Benefits of participating in this research**

This study aims to voice the experiences of women who have suffered from postnatal depression and gone through the process of talking about their difficulties to other people. It is hoped that the findings of the present study will increase both health professionals' and society's understanding of the overall process through which women go to disclose their symptoms (not just to health professionals), which could identify further ways of helping mothers with postnatal depression feel able to disclose, to feel supported and thus enhance their help-seeking.

If you would like to be involved, please contact Kelly Abraham-Smith (Trainee Clinical Psychologist) on:

██████████ or ██████████

## 8.6 Appendix 6: Participant information sheet

University of  
Hertfordshire



### WHAT ARE THE EXPERIENCES OF MOTHERS WHO DISCLOSE THEIR SYMPTOMS OF POSTNATAL DEPRESSION?

Participant Information Sheet - Version 1 - Date: 05 / 11 / 2012

My name is Kelly Abraham-Smith and I am a third year Trainee Clinical Psychologist at the University of Hertfordshire. I am contacting you because I am interested in how mothers who have suffered from postnatal depression experienced disclosing their difficulties to other people. Current research predominantly focuses on mothers' experiences of disclosing their symptoms to health professionals. However, there is very limited research focusing on disclosure to partners, family, friends and other people in their lives. I hope that you might be willing to take part in my research which aims to address this knowledge gap.

#### WHAT ARE THE RISKS OF TAKING PART?

The risk involved in taking part in this study is that talking about your experiences may trigger some feelings of distress. In case this happened you would be able to stop the interview at any point and I would provide you with appropriate support. However, it may also be that talking about such experiences has a positive benefit for you. Either way, you will be given an opportunity at the end your interviews to discuss you experience of taking part in the research. The researcher is a Clinical Psychologist in training, and therefore has experience of supporting people in distress.

#### WHAT ARE THE BENEFITS OF TAKING PART?

It is hoped that this study can be used to voice the lived experiences of those who have suffered from postnatal depression and gone through the process of disclosing their difficulties to other people. It is hoped that the findings of the present study will increase both health professionals' and society's understanding of the overall process through which women go to disclose their symptoms (not just to health professionals), which could identify further ways of helping mothers with postnatal depression feel able to disclose thus enhancing their help-seeking.

#### WHAT IS INVOLVED?

If you consent to being involved in this research you will be asked to take part in an audio recorded interview that will take place in your home, or in a place of your choosing. The interview should take no longer than 1 ½ hours and will involve me asking you about your experiences of postnatal depression and of disclosing your symptoms of postnatal depression to other people. Each person who participates in this research will be asked similar questions, however, the aim is to hear about your individual thoughts, feelings and experiences.

#### CONFIDENTIALITY

If you choose to be interviewed for this study all information you provide will be kept confidential from the course team, trainees and other participants who take part in this study, in compliance with the Data Protection Act 1998. An audio recording of your interview will be given a code (e.g. Interview A) and stored on a password protected and encrypted USB drive and backed up on a password protected and

secure computer. I will pay a transcription service to transcribe my interviews, which involves typing up the interview verbatim. I will gain a signed non-disclosure / confidentiality agreement from the service prior to giving them my recordings. Further to this, all names and identifiable information will be removed from the transcripts by the researcher and kept securely and separately from the transcripts. The researcher's supervisors will therefore be kept blind as to the identity of participants when reviewing transcripts.

I will look for themes within the transcripts of yours and others' interviews. The results will be reported in a thesis for the purpose of gaining a qualification in Clinical Psychology. The thesis will be held at the University of Hertfordshire Learning Resource Centre and will be accessible to interested parties. A summary of the main research findings may be published in written work or articles that the researcher and / or her project supervisors write, as well as for the purpose of teaching / conference presentations. Information emanating from the study will only be made public in an unattributable format or at the aggregate level in order to ensure that no participant is identifiable.

Contact details of your general practitioner will be recorded by the researcher. As standard protocol, your general practitioner will only be contacted should any issues of risk to yourself or others be identified during the interviews, but this would be discussed and agreed with you at the time of the interview.

#### **HOW LONG WILL MY PERSONAL INFORMATION BE KEPT?**

Your personal information and recordings will be kept for up to five years after the research is submitted for examination (until approximately June 2017). The information will be stored securely according to the University of Hertfordshire's 'Good Practice in Research' guidelines.

#### **WHO HAS REVIEWED THIS STUDY?**

This study has been approved by the University of Hertfordshire's School of Psychology Ethics Committee (protocol number: **PSY/11/12/KAS**). The research design has also been formally peer-reviewed by the study's supervisors - Dr Saskia Keville and Wendy Solomons, as well as research staff from the University of Hertfordshire's Doctoral Clinical Psychology training programme.

#### **FURTHER INFORMATION**

Thank you for taking the time to read this information. If you are interested in taking part in this research please contact me. Alternatively, if you have any questions please contact me or the primary project supervisor via the contact details provided below:

*Kelly Abraham-Smith*

✦ e-mail: [REDACTED]

✦ telephone: [REDACTED]

✦ post: c/o Doctorate in Clinical Psychology, 1F424 Health Related Research Building, College Lane Campus, Hatfield, AL10 9AB

*Dr Saskia Keville*

[REDACTED]

telephone: [REDACTED]



## 8.8 Appendix 8: Transcription agreement

University of  
Hertfordshire



### TRANSCRIPTION AGREEMENT

Doctorate in Clinical Psychology

University of Hertfordshire

#### Transcription confidentiality / non-disclosure agreement

This non-disclosure agreement is in reference to the following parties:

KELLY ABRAHAM-SMITH ('the discloser')

and

REBECCA ADLINGTON ('the recipient')

The recipient agrees to not divulge any information to a third party with regards to the transcription of audio recordings, as recorded by the discloser. The information shared will therefore remain confidential.

The recipient also agrees to destroy the transcripts as soon as they have been provided to the discloser.

The recipient agrees to return and or destroy any copies of the recordings they were able to access provided by the discloser.

Signed:.....

Date:.....

## 8.9 Appendix 9: Resource sheet

### WHAT ARE THE EXPERIENCES OF MOTHERS

#### WHO DISCLOSE THEIR SYMPTOMS OF POSTNATAL DEPRESSION?

Resource Sheet - Version 1 - Date: 05 / 11 / 2012

Please find below the details of some registered organisations which can provide support and information to individuals suffering from postnatal depression.

- **Postnatal Illness** (A website and forum run by sufferers and past sufferers of Post Natal Illness)  
Website: <http://www.pni.org.uk/>  
Email: [enquiries@pni.org.uk](mailto:enquiries@pni.org.uk)
- **Mothers For Mothers** (Postnatal Depression support group)  
Website: <http://www.mothersformothers.co.uk/>  
Tel: 0117 975 6006  
Email: [support@mothersformothers.co.uk](mailto:support@mothersformothers.co.uk)
- **Pandas Foundation** (Pre and Post Natal Depression Advice and Support)  
Website: <http://www.pandasfoundation.org.uk/>  
Tel: 0843 2898401
- **House of Light** (Support, advice and information for women and their families affected by Postnatal Depression)  
Website: <http://www.pndsupport.co.uk/>  
Tel: 0800 043 2031  
Email: [help@pndsupport.co.uk](mailto:help@pndsupport.co.uk)
- **The Association for Postnatal Illness (APNI)** (A network of phone and postal volunteers who have had - and recovered from - postnatal depression)  
Website: [www.apni.org](http://www.apni.org)  
Tel: 020 7386 0868

## 8.10 Appendix 10: Interview schedule

### WHAT ARE THE EXPERIENCES OF MOTHERS WHO DISCLOSE THEIR SYMPTOMS OF POSTNATAL DEPRESSION?

*Interview schedule* - Version 1 - Date: 05 / 11 / 2012

#### A. *Postnatal Depression*

- 1) How would you define postnatal depression?  
*Prompt: What images / metaphors / words come to mind?*
- 2) What was your experience of postnatal depression?  
*Prompt: feelings, thoughts, experience of and towards others, impact on life*
- 3) How did you try to manage your emotional difficulties prior to disclosure?  
*Prompt: What was helpful; what was unhelpful?*

#### B. *Social Support*

- 4) Prior to becoming a mother, what was your experience of disclosing emotional difficulties and reaching out to others for help?  
*Prompt:*
  - o *Who were you about to turn to during difficult times? Why?*
  - o *Who were you unable to turn to? Why?*

#### C. *Disclosure*

- 5) Can you tell me about the time when you first disclosed your experiences of postnatal depression?  
*Prompt: Why then? Expectations? Fears?*
- 6) Who did you feel more able to disclose to?  
*Prompt: Was this similar to before? If not, why do you think it changed? What was it about them or your relationship with them? Who did you not feel able to disclose to?*
- 7) *Can you describe any positive experiences of disclosure you had?*
- 8) *Can you describe any negative experiences of disclosure you had?*
- 9) *What was helpful/unhelpful about disclosing to other people?*  
*Prompt:*
  - o *consequences, impact on symptoms, relationships e.g. with child, partner, family members, friends?*
  - o *Your views on postnatal depression and disclosure?*

#### D. *Identity*

- 10) How did you experience yourself before and after disclosing postnatal depression?  
*Prompt:*
  - o *As a woman / mother / partner / friend / family member / member of society?*
- 11) How do you think those you have disclosed to see you now compared to before?

- *As a woman / mother / partner / friend / family member / member of society?*

**E. *Experience of this interview***

- 12) What was it like being interviewed by another woman who is a mother?

DEBRIEF PARTICIPANT

## 8.11 Appendix 11: Audit Trail for 'Louise'

### 8.11.1 Appendix 11a: Anonymised interview transcript with my initial reactions and analysis of emergent themes for Louise

Exploratory Comments	LOUISE	Emergent Themes
<p>Emphasizing the enormity of the experience with repetition of 'very'. Overwhelmed by new motherhood once the baby arrives. Seems to separate motherhood and "the whole baby thing". Use of 'down' and upset' - emphasis on mood disturbance as a significant part of her experience. Affected by change from pre-motherhood routine – feeling out of control?</p> <p>The use of the phrases 'some woman' and 'just a person' (below) may indicate a detachment from PND now.</p> <p>As she says she is no longer suffering from PND, she may have detached herself from the woman she imagines</p> <p>Emphasizing with the repetition of "No" that the woman she imagines has no known identity to her. Also, is Louise emphasising the disconnect between her current self and PND self? Why does Louise struggle to be more specific?</p>	<p>R: ok so erm the first question I want to ask is how would you define postnatal depression? So what images, metaphors or words come to mind?</p> <p>LOUISE: Feeling very [small pause] down, very bewildered, thinking oh my god I can't do this, as in motherhood and the whole baby thing once you've got your baby, (R: Mm) erm, and just generally being upset and completely out of kilter</p> <p>R: Ok, (pause) what, what images come to mind when you think of postnatal depression?</p> <p>LOUISE: Erm, some woman who's just sitting there crying</p> <p>R: And is that woman yourself, when you think of that image?</p> <p>LOUISE: No, (R: Right) it's not</p> <p>R: So it's, so is there a particular person that you're thinking of?</p> <p>LOUISE: No just no</p> <p>R: Just a ..</p> <p>LOUISE: Just a person (said over R)</p> <p>R: Person</p>	<p>Feeling very down and tearful</p> <p>I can't do this: Struggling with transition to motherhood</p> <p>Feeling completely out of kilter</p> <p>A possible disconnection from suffering</p>

<p>Louise had short hair – is this another way in which she now detaches herself from being a woman with PND? Is Louise describing a stereotypical woman – where does this image come from?</p> <p>Laughter – why did Louise find this humorous? Maybe nervous laughter? Difficult feelings coming to the fore?</p> <p>Louise’s only experience of a peer seeking help for PND from GP involved prescription of antidepressants.</p> <p>PND is a not really spoken about Use and repetition of the word ‘really’ implies that from her experience there were some but minimal opportunities for disclosure, but that disclosure is only safe with very close friends</p> <p>Reference to British cultural ways of coping with emotionally challenging experiences</p>	<p>LOUISE: Yes</p> <p>R: That’s a woman, ok</p> <p>LOUISE: And she’s got long hair for some reason</p> <p>R: Ok</p> <p>LOUISE: (laughs)</p> <p>R: (pause) Have you ever known anybody else before that’s suffered from postnatal depression?</p> <p>LOUISE: No not that, oh actually, one girlfriend she got, she went to her GPs and got some antidepressants but I don’t know if they actually said you’ve (R: Mm) got postnatal depression</p> <p>R: Right ok, ok, so there, there’s other people in your life you’re aware of who have suffered in the same way as, as you</p> <p>LOUISE: Yes</p> <p>R: Ok, erm,</p> <p>LOUISE: It’s still not really spoken about even amongst friends unless you’re very close, it’s not even (R: Mm) really mentioned</p> <p>R: Yeah, and, and why do you think that is?</p> <p>LOUISE: Erm, I think it’s the whole, (small pause) stiff upper lip you should cope, (R: Mm)</p>	<p>It’s not really spoken about</p> <p>Disclosure influenced by emotional and physical closeness versus distance</p>
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<p>Internalised rules ('You should cope', 'you manage') about how mothers should cope come from? Where do they come from?          Appeared to prevent her from disclosing and seeking help          Challenging perceived expectations of new mothers internally at that time          Two routes to go down, both undesirable to her – In my mind, this brings up a sense of Louise feeling trapped. Maybe part of the experience of PND may involve feeling trapped by the condition, with few known options and lack of clarity about the future?</p> <p>Physical help improves quality of life and provides the opportunity for the woman to work and regain parts of her previous identity</p> <p>Louise does not feel she could be a full time mum – she wants and needs to hold on to parts of her pre-motherhood identity ("me before I had a baby") including work</p> <p>Individualised strategies to help mothers feel happy are important</p>	<p>erm even amongst my NCT class and things like that it's still oh you've had a baby you cope you manage, (R: Yeah) and it's sort of well hold on, do I just have to cope? (R: Mm) you know isn't there something else I can do to, to, you know apart from pills or something or is this the rest of my life where it is just about coping and not enjoying it?</p> <p>R: Mm, so you feel erm, that it's, that it's kind of either coping erm with how it is, or you go, or the other choice would be to go and get some pills from, from your GP would be the other option?</p> <p>LOUISE: Yeah</p> <p>R: Ok, erm</p> <p>LOUISE: Or you get physical help like we've got an aupair, (R: Oh right ok) so that also helps me have a quality of life (R: Ok) also helps me work (R: Mm) but I sort of can get back to erm me before I had a baby, (R: Ok) which is lovely whereas if I had to be a mum the whole time, I don't think I could, I could do it</p> <p>R: So it's kind of coping, which would then entail...</p> <p>LOUISE: Having a strategy in place to make you happy</p>	<p>Do I just have to cope?: Internal versus external expectations and assumptions of motherhood</p> <p>Isn't there something else I can do?</p> <p>Importance of practical support and independence</p> <p>Getting back to me: Connecting with multiple identities</p>
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<p>Needing life to continue as 'normal', a continuous flow from pre- to post-natal stages. Motherhood may be introducing a new role and this may bring uncertainty and anxiety with it. For example, on a much lower level moving from being an assistant to a trainee. In times of uncertainty we may try and create certainty, which for Louise may be remaining connected with her pre-motherhood self.</p> <p>Difficulty adapting to strict routine every day of the week. Function of strict routine? A way of controlling when feeling "out of kilter"? Losses include lie-ins at weekend and ability to 'pop' to shop or see close friends (freedom to control own life?). Reference to friends who don't have children.</p> <p>Repeated reference to the process of realisation</p> <p>"So that's a bit of normal gone"</p> <p>Began describing a sequence of events that could cause her to be late leaving the house but changed line of discussion before she had begun to describe how she managed those challenges (perhaps overwhelming or exhausting for her to describe even now?)</p>	<p>R: Right, yep</p> <p>LOUISE: It's having the strategy and knowing that the, <b>life can continue as normal</b></p> <p>R: Mm, err what erm is interesting erm, is, kind of what parts of, of normal you wanted to hold onto, what, what was that for you?</p> <p>LOUISE: It would be the, oh gosh, the, the, <b>the first thing that really hit me</b> because we've had a strict routine with [child's name] since she was, we came home from hospital so it's a case of getting up every day at 7, (R: Mm) and <b>the first weekend erm, it was just like i can't do this every day</b> and there's, there's no lay in there's no nothing there's up at 7 every day, (R: Mm) and it was a realisation so i'd say to start with it was realising there are actually gonna be no lie ins, (R: Mm) erm <b>so that bit of normal's gone</b>, erm, <b>being able to pop out to the shops</b> without having to, take a child with you, erm, so then you spend half an hour getting them ready, and then they do a poo so you've then got to, then it's, (R: Mm) erm you know, just being able to pop out and see friends, who don't have children, and you don't have to take your child with you <b>so it was that trying to get back to normal as well</b></p> <p>R: Right, so those are very precious things to you</p>	<p><b>Getting back to me: attempting to stay connected with pre-motherhood 'normality'</b></p> <p><b>Being "hit" by losses and changes: Adjusting to the new role and uncertainty of motherhood</b></p> <p><b>i can't do this: Struggling with transition to motherhood</b></p> <p><b>Getting back to me: attempting to stay connected with pre-motherhood 'normality'</b></p>
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<p>Considers being an older mother as an explanation for her not 'slipping into' the mother role as easily – origins of these ideas? What were her prenatal expectations?</p> <p>Assumption that for younger mothers motherhood is a priority whereas for older mothers a career or finding the right man is a priority As you get older you gain more control over your life and how you want things to be</p> <p>Hesitant repetitions ('is, is'). Might be unsure whether to continue following a description of herself as being more 'selfish' as an older mother</p> <p>Researcher summarised and then changed the subject</p>	<p>LOUISE: Yes</p> <p>R: Those aspects of your life (LOUISE: Yes) kind of some sleep, and some soc- socialising with, with other people particularly friends</p> <p>LOUISE: Yes</p> <p>R: Yeah</p> <p>LOUISE: I don't know if that's because I'm older and because I've spent obviously more time on my own, (R: Mm) or more time erm doing exactly what I want to do, whereas if I'd had a baby when I was 23 I'd probably slip into the role, a lot easier.</p> <p>R: Ok, and why do you think that would be, about slipping into the role easier at, at that age?</p> <p>LOUISE: Because you don't know any different, (R: Ok) erm, because you sort of think well obviously at 23 you're probably want to have had a baby for quite a few years, (R: Mm) instead of thinking actually I'm gonna work, erm then thinking I haven't met the right man so I'm not going to have a baby, erm, and you know it's, and I think being older you're then more selfish, (R: Ok) is, is how I feel about it</p> <p>R: Yeah, ok, erm, kind of thinking about your experience then, of postnatal depression, when did it start, would you say?</p>	<p>Comparison to other mothers</p> <p>Exploring explanations for suffering</p> <p>Internal versus external expectations and assumptions of motherhood</p> <p>Internal versus external expectations and assumptions of motherhood</p> <p>Exploring explanations for suffering</p> <p>Comparison to other mothers</p>
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<p>"Disappear" - implies a sense of permanent loss.</p> <p>"Coming to terms with it" – this implies the importance of processing and mourning losses that come with motherhood, in order to be able to feel better. An adjustment process.</p> <p>"That's it" implies a perception of the early days as a new mother as being permanent, as how life will now be – unable to see beyond it. Sense of permanent loss at that point in time.</p> <p>Repetition of "too much" implies as sense of feeling overwhelmed.</p> <p>Overwhelmed by having to juggle different aspects of her life including motherhood.</p> <p>Importance of support and presence of partner.</p> <p>Fears feeling overwhelmed by being left alone with the baby and responsible for her, which may lead to PND returning. Fear of experiencing PND again – avoidance of it.</p> <p>Importance of practical support.</p>	<p>that's now going to disappear and it's coming to terms with it, (R: Right) and once you've come to terms with it I then felt better but it's to start with it's like oh my god that's it (R: Mhmmm)</p> <p><i>Clock can be heard chiming loudly in the background</i></p> <p>R: Erm, and, err, would it, would you say that you're still, still suffering from postnatal depression symptoms of?</p> <p>LOUISE: I would say not</p> <p>R: Ok</p> <p>LOUISE: Err but then I don't know how fine that line is balanced because if we didn't (R: Mm) have an aupair then I would find it very, difficult doing anything well I wouldn't be able to work for a start, (R: Mm) because trying to juggle everything is, is just, (R: Yes) is too much, erm, erm, and my husband travels a lot so I'm then left with, [Child's Name] the whole time which, (R: Mm) I think might be, too much and I might then start, having postnatal depression again yes</p> <p>R: If he travels again?</p> <p>LOUISE: Erm no if we didn't have an aupair</p>	<p>Coming to terms with loss / grieving lead to feeling better</p> <p>Importance of practical support</p> <p>Looking after the baby is "down to me": Adjusting to the new role of motherhood</p> <p>Exploring explanations for suffering</p>
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<p>Importance of social / practical support.</p> <p>Desire to have a support network nearby, like other mothers she knows (social comparisons), especially when she feels overwhelmed and when she needs to “pop out”. Implies that the inability to escape the challenges of motherhood plus the loss of freedom and control of her life are things she finds difficult. Perhaps Louise is looking towards social support as a way of managing distress or it giving her a temporary relief from understandable stresses of motherhood?</p> <p>Other mothers she knows (social comparisons) can have time out from children / motherhood. What’s the function of this?</p> <p>Inhalation (Overwhelmed? Angry?) “a bit too much”</p> <p>Researcher inhales (Projection?). Maybe both of us felt overwhelmed by the emotion in the room at that time?</p> <p>Participant pauses twice and does not answer my question. She focuses on her behaviour, not thought processes – is she avoiding thinking about the thoughts she had at that time? Was her internal world at that time unpleasant? Alternatively, maybe for Louise the emotions are the first thing she associates with PND. Also, given the emotion in the last exchange, this may explain why she went to emotions first.</p>	<p>R: Oh I see</p> <p>LOUISE: Yes</p> <p>R: I see what you mean so if it was just yeah</p> <p>LOUISE: If I didn't have the help, (R: Yeah) you know again because we've got no family (R: Yeah) who lives close by so I've got no-one to call up like my sister does to my mum and say, "the boys are being a nightmare can you come and put them to bed please" (R: Mm) or "I'm going to pop out to the supermarket can you come round and look after them", or you know, have them for the afternoon, erm, so she's got all of that help and erm, a lot of my friends down here have got family close by, a lot of relatives live here in [affluent town], (R: Mm) so they, you know, their, their children spend a bit of time away from them, and I just, (inhales) yeah without having somebody else here I find it a bit too much</p> <p>R: Right, (inhales) erm, what erm, would you say, when you started to suffer from postnatal depression, erm, how did you experience it in terms of perhaps your, thinking, the way you thought about things?</p> <p>LOUISE: (pause) I, (pause) would cry, and I could quite happily sit and cry, (R: Mm) all afternoon I found the weekends the worst</p> <p>R: And that was when you had your husband here or?</p>	<p>Importance of social support</p> <p>Comparison to other mothers</p> <p>Importance of practical support and independence</p> <p>Being “hit” by losses and changes: Adjusting to the new role and uncertainty of motherhood</p>
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<p>The meanings of weekends (i.e. "time off") has changed with motherhood. Adapting to this loss and change involves changing expectations and perceptions of what weekends involve.</p> <p>Gender inequality / unfairness in parenthood. She acknowledged her husband's need for a break, perhaps because she hoped he would acknowledge her need for one? Then when these needs were not met it led to arguments? Why did she offer to look after the baby when she was struggling to cope with a loss of "time off"? Was there a conflict between the idealised mother she wanted to be and the mother she could be? Was she trying to portray herself a certain way to her husband or to herself? Was she agreeing to childcare to avoid arguments?</p> <p>Repetition of "yes" emphasizes the importance of having a break from motherhood.</p> <p>Only those people closest to you would know you still loved your child if you wanted to take a break from them.</p>	<p>LOUISE: Yes</p> <p>R: Right</p> <p>LOUISE: Because I would, I was very happy with the weeks and you think ah the weekend, excellent, bit of time off for me as well, and it's like no that doesn't happen, (R: Mm) so, you're still doing your job, he's having a lie-in or he's out playing golf or he's out doing this and that, and you say to him "no don't worry" because he works hard during the week, "don't worry I'll look after the baby" so I found the weekends harder, (R: Ok, yeah) than during the weeks, 'cause I knew I was on my own I was quite happy with that, you get self-sufficient, you do everything you need to do, and then at the weekends yes, it's then sort of arguments, not arguments but sort of well, "can you take care of her while I want to get dressed" well, you know just</p> <p>R: So would erm, just thinking about what, what you're saying, and saying overall erm, is there something about needing a break, erm at, either on a regular basis erm</p> <p>LOUISE: Yes, yes (R: Yeah) yes, I, definitely</p> <p>R: Erm, I'm also wondering whether, in relation to having a break, was it something about being, feeling able to say you need a break?</p> <p>LOUISE: But to anybody apart from those closest to you you sound like you don't love your child, (R: Mm) if you admitted that to</p>	<p>Importance of social support and independence</p> <p>Being "hit" by losses and changes: Adjusting to the new role and uncertainty of motherhood</p> <p>Negotiating parental responsibilities</p> <p>Harder when support is available but not given / received</p> <p>Trying to be the coping mother</p> <p>Importance of having a break</p> <p>Disclosure influenced by emotional and physical closeness versus distance</p> <p>Fear of judgement / responses from others</p>
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<p>Powerful message about motherhood. Louise is potentially communicating internalised values of motherhood and her perceived societal expectations of motherhood.</p> <p>Relating herself to other people. She does not see her needs as unusual, but still feels others would judge her negatively - perhaps see her as an 'unusual' mother? Internalised critical judgemental voices dominate over supportive voices – where do her critical voices come from?</p> <p>Need for independence from child / motherhood.</p> <p>Her fear of judgement is predominantly from other mothers, but can be generalised to everybody in her life. This places pressure on her to not disclose and be honest. Alternatively, perhaps Louise isn't necessarily generalising the fear to others, more that the criticism from other mothers is feared the most.</p> <p>Pressure and judgement comes from people with and without their own experience of parenthood.</p> <p>Pressure and judgement comes from all women with and without their own experience of motherhood, for Louise.</p>	<p>anybody that would be the, but yes, I think everybody needs a break, even if it's just to go out and, and, be able to go and have a coffee on your own or just go and buy a pint of milk on your own, just to be able to have some time</p> <p>R: Mm, where do you feel the, the pressure comes from to, to not be able to say these things and, you know because you worry that, erm, people might think a certain way about you?</p> <p>LOUISE: I'd say it's other mums, (R: Ok) and even people who aren't mums, I'd say it's everybody, like the way you bring up a child everybody thinks they have a, they're able to tell you what to do, (R: Mmhm) even if they've got no experience, (R: Right) erm, it's like it's, it's, it's everybody judging, (R: Mm) everybody else</p> <p>R: Ok, and erm, so you feel like it particular comes from other mothers?</p> <p>LOUISE: Erm, yes and friends you know,</p> <p>R: Friends you know? (said quietly)</p> <p>LOUISE: yes, it, it, who are mums and who, aren't mum's yes</p> <p>R: Ok</p>	<p>Needing a break but struggling to ask for one</p> <p>Importance of having a break</p> <p>Importance of social support and independence</p> <p>Other mothers as a source of support but also comparison / judgement</p> <p>Fear of judgement / responses from others</p> <p>Internal versus external expectations and assumptions of motherhood</p> <p>Fear of judgement / responses from others</p> <p>Other mothers as a source of support but also comparison / judgement</p>
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<p>More perceived judgement from those close to Louise. Is this because they felt they had the right or perhaps the role to pass judgements on her mothering? Contradiction to other comments about disclosure to close friends being preferable – ‘slot rattling’? Bearing in mind the rest of the interview, this also feels like other mothers being a resource but also competition. Therefore those closer to you in age are easier to both compare and identify with perhaps? Theory – downward social comparisons increasing one’s self-worth / self-esteem / sense of self.</p> <p>Older women are less judgemental and believe mothers should do whatever they need to do to cope, compared to younger mothers. Is this because in their 50’s motherhood becomes less important as a role to women, particularly if children have become more independent from them, and a long time has passed since their own struggles associated with motherhood, enabling them to support younger women who may now be struggling – i.e. time provides distance from struggles? Or are mothers judgements of other mothers aimed at women in their own cohort?</p> <p>Hesitancy and lack of fluency. A clear sense of her struggling to answer the question. It feels that she is struggling to make sense of how mothers interact with each other here. She is making meaning with me in the moment, hence why things are muddled up, complicated and don’t have a logic.</p> <p>For Louise, women under 35 years of age are more judgemental and less honest, making it more difficult to feel able to disclose to them.</p>	<p>LOUISE: So I’d say the people who are closest to you in age are probably more judgemental, the older ladies who I know here in [affluent town] have been great, (R: Mm) erm but they’re in their 50s and their children are now off at University, (R: Right) erm and it, it’s just like you know, “you do whatever you need to do”, (R: Right) erm whereas the younger ones are just like, “oh that’s not very good is it” you know or</p> <p>R: Right, yeah, so what do you think it is about them, what do you think it is about the age of the woman that might make them more or less judgemental?</p> <p>LOUISE: (Sighs) I would say ...</p> <p><i>Banging and voices can be heard in the background</i></p> <p>LOUISE: ...(pause) I don’t know that’s a very, a difficult question actually, (R: Mm) it’s, it’s, (pause) I’d, I’d sa-, I’d say probably most mums are younger mums erm, (R: Mm) but anything under the sort of, anything under the thirty-five mark, (R: Ok) erm, the more judgemental, erm the ones who are slightly older, you know, or have had their babies, (R: Mm) erm closer to my age we’re probably more open and honest with each other and will say “actually I’m finding it really difficult”, (R: Right) whereas the</p>	<p>Preferred characteristics of the confidant – age, children are older</p> <p>Other mothers as a source of support but also comparison / judgement</p> <p>Older age &amp; distance from new motherhood increases compassion and openness</p> <p>Do I just have to cope?: Internal versus external expectations and assumptions of motherhood</p> <p>Preferred characteristics of the confidant – age, children are older</p> <p>Fear of judgement / responses from others</p> <p>Older age &amp; distance from new motherhood increases compassion and openness</p> <p>Disclosure facilitated through shared experience</p>
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<p>Two factors, age (&gt;35 years) and children no longer 'babies', appear to lead to greater openness and honesty amongst mothers about their postnatal difficulties for Louise.</p> <p>Whilst age is an important factor, closeness of the relationship she has with another mother has a greater influence over her felt ability to disclose her postnatal difficulties to other mothers than the age of the mother.</p> <p>Dedicated time and energy to being on a committee of an organisation related to becoming a mother. What was she hoping to gain from this in terms of her identity as a mother and her relationship with motherhood?</p> <p>Importance of building social networks with other mothers, especially when she did not feel close to her NCT group.</p> <p>Thoughts of infanticide – the worst of her experiences of PND. "I wouldn't, and obviously haven't" – a need to clarify this to the Researcher.</p>	<p>other ones that are younger you, you wouldn't even, (R: Mm) say anything to</p> <p>R: And you talked about your NCT group before, erm, did you find that that age, erm, that age situation occurred in that group where there was you know the younger ones were in, in, different to perhaps the older, older mothers?</p> <p>LOUISE: Erm, I mean there's only 5 people in our, 6 people in our group anyway, (R: Right) so it's a very small group, (R: Mm) erm, there's one mum my age, and the others were actually not too far behind but we never really, got close as a group, (R: Oh right ok) erm, I've become closer to other NCT mums, erm, erm, 'cause I'm on the events committee (R: Ah right) so I've sort of got closer to, to some of them we met at bumps and babies and there's baby signing, (R: Mm) erm, and you feel you can be a bit more open with them and again they're the same sort of, erm, similar age, (R: Mm) erm, I've got yeah</p> <p>R: Ok, erm, so you, just thinking about your experience of postnatal depression so you sort of talked about kind of, crying quite a lot, (LOUISE: Mm) what other things were, were going on for you that indicated you might have been suffering from postnatal depression?</p> <p>LOUISE: The worst was when I actually thought I could, drown [Child's Name], (R: Ok) that was the worst when I was bathing her I wouldn't, and obviously haven't done, but bathing her</p>	<p>Disclosure influenced by emotional and physical closeness versus distance</p> <p>Disclosure facilitated through shared experience</p> <p>Preferred characteristics of the confidant - age</p> <p>Thoughts of infanticide experienced as worst part of PND</p>
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<p>Perhaps still related to her feeling overwhelmed by a sense of responsibility for someone else's life?</p> <p>Perhaps she had previously felt her daughter and / or motherhood had power over her, making her feel out of control? "power over her" – perhaps this was a realisation of the power and control she had.</p> <p>Her infanticidal thoughts were the worst experience of PND for her.</p> <p>I move away from the emotional intensity of that experience for Louise, asking questions requiring factual unemotive responses, perhaps because I felt uncomfortable with the idea that a mother could have such thoughts?</p>	<p>and just thinking I could so easily take my arm away, (R: Mm) and she'd drown</p> <p>R: And what was happening in that moment where it kind of made you feel like that?</p> <p>LOUISE: Because I was in complete control of her life, (R: Mmhm) even more so than if I was, if she was laying in bed because, well she'd be on her own, or if she was, in her pushchair it was that if I took my hand away she would, literally drown I, I had that much power over her, (R: Ok) only lasted I would say for 48 hours, (R: Mmhm) but that was, that was the worst</p> <p>R: Ok</p> <p>LOUISE: And it was only bathing her because it was not doing anything else it was just (R: Mm) bathing her</p> <p>R: And so it's just the one incident but the feelings around that and thoughts around that lasted for 48 hours?</p> <p>LOUISE: Yes</p> <p>R: Yeah</p> <p>LOUISE: Well it was twice because it was obviously over two days</p> <p>R: Oh so you'd bathed her twice</p> <p>LOUISE: But yes</p>	<p>Overwhelmed by responsibility and control over the baby's life</p> <p>Looking after the baby is "down to me": Adjusting to the new role of motherhood</p> <p>Overwhelmed by responsibility and control over the baby's life</p>
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<p>Repetition of the phrase “that was the worst”, emphasising the intensity of that experience for her.</p> <p>Here I explore other experiences of PND that Louise had, rather than exploring the experience that she has labelled “the worst”. Does this represent discomfort with talking about this aspect of her experience?</p> <p>“Ok I think I am a bit... postnatally depressed” – minimising?</p> <p>Avoidance of seeking professional help No mention of turning to personal support network before professional help for this symptom. Perhaps because infanticide is more of a social taboo than other symptoms of PND? Apparent relief from infanticidal thoughts meant she did not seek help. Did she feel that as the infanticidal thoughts had stopped, there was no need for her to seek help?</p> <p>Repetition of “not having a lie-in”, emphasises the significance of this loss to her. Her symptoms reduced as a significant loss was mourned.</p> <p>Around 4 months postnatally she appeared to be coming to terms with some losses and had put in place strategies (e.g. cleaner) to make things easier for her, but she still seemed to be struggling with weekends.</p>	<p>R: Ok</p> <p>LOUISE: Yes erm, and that, that was the worst</p> <p>R: Ok, would you say that all your other experiences of, any other so, f-feelings or thoughts you might have been having, all your other symptoms at postnatal depression, were they at their worst at that point as well?</p> <p>LOUISE: Erm I didn't even necessarily think of those, or even sort of, at the time relate the two together, (R: Mm) I think it was only, afterwards or during that 48 hour period that it was ok I think I am a bit, (R: Mm) postnatally depressed, and, and, and I was thinking well if it doesn't, well if I don't feel any better I'm going to have to go to the doctors, (R: Ok) erm and then I, I just, I started to feel better (R: Mm) so then I've obviously had these feelings of, of killing [Child's Name] and, and, (R: Mm) it just sort of went away, erm</p> <p>R: How about your other symptoms, what else were you experiencing?</p> <p>LOUISE: Erm, I don't think I was having many other symptoms 'cause I'd come to terms with not having a lie-in, (R: Mm) erm we were having help, we had a cleaner that came in a couple of times a week, erm, I was still finding the weekends, the hardest and I, I think I was still feeling, down and up-set, again it, it's a question of, time, (R: Mm) and I was, I'd</p>	<p>Thoughts of infanticide experienced as worst part of PND</p> <p>Minimising difficulties associated with PND</p> <p>Diagnosing self</p> <p>Self-reliance versus seeking help from others</p> <p>Coming to terms with loss / grieving lead to feeling better</p> <p>Importance of practical support</p> <p>Being “hit” by losses and changes: Adjusting to the new role and uncertainty of motherhood</p>
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<p>Returned to work when baby was 4 months old – was this a way of her taking back some control over her life? Regaining some of her old life back? But she still could not regain weekends – these had changed beyond her control.</p> <p>Feeling helplessness – difficult to find a clear way to get better.</p> <p>In a "black hole" changed to "Teetering on the edge of it" – perhaps she altered her description to appear or believe she was more in control of her condition?</p> <p>"I can't get out of my own accord" – realisation that reliance on her own resources may not be enough for her to recover from PND, may need support from others.</p> <p>Reluctance to seek professional help – what would professional help mean to her?</p> <p>(Maternal) PND is a female issue - gender perceived as a barrier?</p> <p>How did it help to be heard by someone she felt was incapable of empathising and understanding PND? Was just being able to externalise and be heard helpful?</p> <p>Confidant not being "judgemental" is important.</p> <p>"take on board what I am saying" - the person you disclose to needs to have the capacity to 'hold' some of what you externalise.</p> <p>Husband now gives her some time out at the weekend – is this due to her externalising, which would have allowed her to seek help from him? Disclosure opens up the possibility for solutions?</p>	<p>been working since August so since [Child's Name] was 4 months old, erm, yes it's just sometimes a feeling of, helplessness, (R: Yep) that you can't, or there's, it's very difficult to get out of the black hole that you're ... in and you're sort of teetering on the edge of it, (R: Right) erm, and it, y- yes I was still feeling that in August when I was working so yes [Child's Name] was 4 months old, and I just had these occasional, bouts of just thinking if, you know, things don't change and I'm going to fall in to this, (R: Mm) hole and I can't get out on my own, of my own accord, (R: Right) erm, my husband's quite good because I was talking to him about it, (R: Mm) instead of sort of, going to, to a doctor so it was a case of having somebody to listen and to understand, (R: Right) not that men really can but not to be judgemental, (R: Right) and to, to take on board what I was saying, (R: Mmhm) erm, and, he, (pause) he does makes sure that I do have, time as in at the weekend he will get [Child's Name] up so it's trying to take everything off me</p> <p>R: Right, so that's, that's interesting erm, and i think we'll, we'll come back to (LOUISE: Mm) how your husband helps you and your relationship with him, erm, you talked about the black hole, (LOUISE: Yeah) and teetering on the edge of it, erm, I was just trying to kind of, imagining this black hole, (LOUISE: Yeah) and what you were saying erm, do you feel you were ever in the black hole but that you were</p>	<p>Isn't there something else I can do?</p> <p>On the edge versus falling in</p> <p>Self-reliance versus seeking help from others</p> <p>Avoidance of professional support</p> <p>Importance of social support and independence</p> <p>Gender as a potential barrier to shared understanding: Men may not understand but women may be judgemental</p> <p>Disclosure facilitates opportunities for solutions</p>
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<p>What would falling in have looked like, in comparison to “teetering on the edge”?</p> <p>Reliance on “own reserves” – these may have stopped her from falling in to the “Black hole” but not from “teetering on the edge”? Support from others appears to have been needed for this. Previous ways of overcoming emotional problems not fully successful when suffering from PND. Something about the metaphor represents LOUISE switching between self-reliance / denial of need of support versus desire for social support. Maybe because social support was not always available for her e.g. husband at weekends, family living elsewhere etc.</p>	<p>trying to get out, or do you think that you were always on the edge of slipping into this black hole?</p> <p>LOUISE: I felt I was on the edge, (R: Ok, yeah) I didn't feel that I'd ever completely fallen in</p> <p>R: Ok, hmm, erm, and what, what do you think stopped you from falling in?</p> <p>LOUISE: I, think my own, reserves, (R: Mmhmm) erm, I've always been able to, if I've had a problem, be able to, sort out what it, what it is, or been upset or angry or cross, and then once you work through and you realise what the problem is then (R: Mm) you feel a bit better</p> <p>R: So you'll work though it, but talking to yourself like internally</p> <p>LOUISE: Yes, yes</p> <p>R: Or talking to others?</p> <p>LOUISE: Erm, n- talking to myself</p> <p>R: Talking to yourself</p> <p>LOUISE: Yes</p> <p>R: Yeah, erm, before you ever became a mother, was reaching out to people and talking to them about emotional difficulties something you would have done?</p>	<p>On the edge versus falling in</p> <p>Self-reliance versus seeking help from others</p> <p>Defining the problem makes you feel better</p> <p>Self-reliance versus seeking help from others</p>
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<p>Before she became a mother she would prefer to manage emotional difficulties internally rather than disclosing to others. If she did disclose to others, alcohol was probably consumed. Was it important for both her and her friends to have had alcohol? May simply be lowered boundaries around self-disclosure or becoming more connected with emotions when consuming alcohol.</p> <p>Alcohol consumption not classed by her as a "crucial" prerequisite for disclosure of emotional difficulties but is often involved.</p> <p>Louise moves away from question and describes another significant loss associated with new motherhood for her.</p> <p>Loss of daily social contact with a specific group of people. Social contact was a natural part of her job, but it's something she had to create herself as a new mother.</p> <p>Importance of regular social contact.</p> <p>Perhaps Louise feels a responsibility in having to create social contact, in contrast to the naturally occurring contact when working. Contrast between working life and new motherhood.</p> <p>Louise returns to the original question.</p>	<p>LOUISE: No, <b>only girl- girlfriends</b> when you've probably had a couple of drinkies, (R: Right) erm, (R laughs) but otherwise no not really</p> <p>R: Right, and so, just thinking of, about kind of, having drinks, (LOUISE: Mm) erm would that be quite crucial in you being able to, un, unload?</p> <p>LOUISE: No not really</p> <p>R: Right, no so you could do it without</p> <p>LOUISE: Yes, yeah</p> <p>R: Yeah, ok, erm, and who, you talk about girlfriends, who in particular did you used to talk to, before you became a mum?</p> <p>LOUISE: There was erm, one of [Child's Name]'s god-mums my friend I used to work with, (R: Right) erm, and, again <b>it's a case of going from work where you've got lots of people to talk to,</b> (R: Mm) where you see people every day to then sort of being a mum, and, working from home, and then you don't see, as many people so y-, I didn't miss it as much as I thought 'cause I spent a year working part-time anyway, (R: Mm) but you still sort of miss the everyday interaction unless you get out of the house, (R: Mm) you sometime-, you don't, see anybody, (R: Right, yeah) so I think it's seeing people in general as well as, <b>but no yes there's definitely</b></p>	<p><b>Disclosure influenced by emotional and physical closeness versus distance</b></p> <p><b>Being "hit" by losses and changes: Adjusting to the new role and uncertainty of motherhood</b></p> <p><b>Importance of social support</b></p>
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<p>importance of closeness. What is 'closeness' to her? How does she define it?  importance of empathy / shared experiences.  Does she tend to idolise people who appear to not have emotional difficulties?  PND is a "weakness".  it's important for the person to whom you are disclosing to have "weaknesses" and be willing to disclose them – perhaps this is why alcohol was involved in disclosing to friends, as it can allow people consuming to feel more able to show their vulnerabilities? Shared experiences (socially constructed "weaknesses") provide an opportunity for disclosure.  People placed at different "levels" according to their "weaknesses" by Louise.</p> <p>It's not important for the other person to have the same problem or "weakness" (does not have to be a mental health problem), but it is important for them to have visible "weaknesses"</p>	<p>[two friends] who I'm seeing, erm, tonight erm, so, yeah, I'd probably say, those two</p> <p>R: Mhmm and what was it about them, that meant you could turn to them, before you became a mum you were able to turn to these people?</p> <p>LOUISE: Erm, probably 'cause we're quite close, (R: Mm) and they've had problems as well so it's not like talking to somebody who you've sort of, put up on a pedestal who you idolising, you then don't want to show your weaknesses to, (R: Mm)they're happy to show their weaknesses to you as well, (R: Right) so it's sort of, (R: Yeah) reciprocating because you say "oh god yeah I've got this wrong" then you know, (R: Mm)but it, it's just being able to talk to somebody on your level</p> <p>R: Right, if those particular women erm hadn't had any problems themselves, would you have then been able to talk to them?</p> <p>LOUISE: No probably not</p> <p>R: Right, so it's something about the, them having a similar or the, similar sort of experience to you?</p> <p>LOUISE: Erm, w- they're, not similar 'cause I mean the, neither of them are mothers but at the time yes problems with work problems with boyfriends, (R: Yeah) you know that kind of thing</p>	<p>Disclosure influenced by emotional and physical closeness versus distance</p> <p>Shared experience of 'weaknesses' promoting disclosure</p> <p>Social comparison</p> <p>Reciprocal nature of disclosure</p> <p>Disclosing to people on your level</p> <p>Shared experience of 'weaknesses' promoting disclosure</p> <p>Shared experience of 'weaknesses' promoting disclosure</p>
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<p>No change to personal relationships when suffering PND noticed by Louise.</p> <p>Sigh, pause and exhalation – was this period in time so difficult for her that it's draining for her to recollect? Louise repeats that weekends were a difficult time for her.</p> <p>Behavioural changes, particularly at weekends: quieter, get more upset, get cross with people close to her, particularly her husband. Laughter – a defence against a difficult emotions related to the memories she is recalling?</p>	<p>R: Before you, yeah</p> <p>LOUISE: Yeah</p> <p>R: Yeah, ok, erm, then err I've just sort of going back to your experiences of postnatal depression, I wondered how, erm, you might have felt others changed towards you, erm, during that period or, and how you might have changed towards other people, erm, so kind of your interactions with other people relationships with other people, how did they change in that period where, before you disclosed you were suffering from these postnatal depression symptoms and, how would you say things changed?</p> <p>LOUISE: I'd say they didn't, (R: Right) I'd say they just yeah carried on as, as the people I knew beforehand, err the people I'd met, (R: Mm) erm, NCT classes and things like that, I'd say they didn't change at all</p> <p>R: Erm, err did you notice any err behaviours in you that had changed, once, in this period where you were suffering, before you disclosed?</p> <p>LOUISE: Err (sighs, pause) again I'm (exhales) I might have been a bit quieter at weekends or I'd get more upset, at weekends than I would do during the week or just, probably you get cross with the people closest to you so probably I was more cross with my husband (said with a slight laugh) (R: Right) erm, and then other people it, it's, you know you don't</p>	<p>Getting cross with people close to you</p>
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<p>Initial reliance on own resources and ways of coping with emotional disturbances - processing it internally which involved trying to understand her experience to reach a conclusion that it would either improve or other options were available. Optimism.</p> <p>A need to understand her experience, to know it was not permanent, and to know other options for managing it.</p> <p>Reluctance to seek professional help. Were there other routes she had considered which she has not mentioned in this interview, and why did she wish to avoid them?</p>	<p>sort of tend to get, cross with your friends so yeah it, yeah I'd get more cross with my husband</p> <p>R: Right, and was he before you, before you had your child, (LOUISE: Mm) was he someone you would disclose any emotional difficulties to, talk, talk about things</p> <p>LOUISE: Yes, yeah</p> <p><i>Clock starts chiming again</i></p> <p>R: So him and your, your closest friends</p> <p>LOUISE: Yeah</p> <p>R: Ok, erm, so, just sort of, sort of going back to when you had [Child's Name], erm, and these, emotional difficulties started, (LOUISE: Mm) so this is before you disclosed anything, (LOUISE: Mm) how were you, you may have touched on this already, in, in some ways but how were you trying to manage those emotional difficulties?</p> <p>LOUISE: I was trying to manage by talking them through with myself, (R: Mm) understanding what was wrong and knowing that, it wouldn't go on forever, (R: Mm) and that if it got too bad there were options but those were routes I didn't want to go down so I was going to try and overcome it myself</p>	<p>Consistency in confidant</p> <p>Disclosure influenced by emotional and physical closeness versus distance</p> <p>Self-reliance versus seeking help from others</p>
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<p>Managing her PND involved reflecting on and changing pre-existing tendencies, lifestyle and expectations of self. Self-compassion? "rigidly structured" days before becoming a mother.</p> <p>Pacing and realistic expectations of self as a new mother seem to have been important ways of her coping with PND.</p> <p>Laughter may be a defence against how hard this was for her.</p> <p>What did she want to gain from fitting lots in? A sense of achievement and success? Emotional avoidance? Strong sense of identity? Connection with other people in a variety of social contexts? A way of creating certainty / control when so much had changed? Where did this pressure on herself come from? Practical support and rest are important.</p>	<p>R: Right, and what did that involve?</p> <p>LOUISE: (smacks lips) Just, (pause) me listening to myself not pushing myself too hard, because that's what I do tend to do, (R: Mm) instead of doing one chore I like to do 5 or 6 (R gives small laugh) and then I have my day very rigidly structured so I can fit 10 things in, (R gives small laugh) you know like going to [affluent town] for a coffee coming back here meeting somebody else, and going to evening prayers doing this that and the other, you know, and then coming back and you know cleaning the bathroom or something so I like to do as much as I can in a day, and it was actually realising that no I don't have to do this, (R: Mm) when [Child's Name]'s asleep I can actually go upstairs and go to bed myself, so it was doing things like taking the pressure off me, and re-knowing that I didn't have to do anything, my husband took over doing all the cooking, so I, I didn't have to worry about doing any of that</p> <p>R: Was there, it sounds like you were, you were, have found some very positive, helpful strategies, was there anything that you were trying to do that perhaps wasn't helping?</p> <p>LOUISE: Erm, no I'd say everything I was doing was (R: Mm) helping</p> <p>R: Ok, erm, and, (pause) when you used to disclose, we've talked about you disclosing to, your sort of couple of close friends, (LOUISE: Mm) erm, and also erm, to your husband before you became a mother, and those were</p>	<p>Self-reliance versus seeking help from others</p> <p>Being "hit" by losses and changes: Adjusting to the new role and uncertainty of motherhood</p> <p>Importance of social support</p> <p>Self-reliance versus seeking help from others</p>
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<p>Sympathy – was this important to her?</p> <p>Other people shutting down conversations of PND.</p> <p>Louise was left wondering why other people shut her down when she attempted to disclose to them. Was closeness in the relationships in this context missing?</p> <p>Being shut down after attempting to disclose made her feel more alone and increased her reluctance to disclose to professionals. This seemed to strengthen her belief that she needed to manage her PND herself, by drawing on her own resources. Repetition of “really” emphasizes her reluctance. She perceives pills as the outcome of disclosing to doctors.</p> <p>What would sorting it out look like?</p>	<p>yeah) that was erm made you realise that things perhaps weren't as bad, erm, was that true when it came to postnatal depression?</p> <p>LOUISE: I would say apart from speaking to my husband I would say, (pause) I mentioned it vaguely to a couple of other people but th-, they were sort of very, erm, there was only one girl I know who erm, not the one who had it herself who sort of said “oh god poor you I hope you're alright” whereas a couple of other people I tried to start talking to about it didn't even want to begin the conversation</p> <p>R: They didn't want to begin the conversation?</p> <p>LOUISE: Yeah</p> <p>R: And what do you think that was about?</p> <p>LOUISE: Whether they were having it, as well, or didn't want to say anything, 'cause I did try a few times and it just, then didn't feel right so I then just didn't, (R: Mm)carry on</p> <p>R: How did it leave you feeling, having tried to disclose?</p> <p>LOUISE: A bit, left me feeling I, oh, in some ways I don't know more alone more on my own, (R: Yeah) then I was thinking gosh well, you know I really really don't want to go down the road of going to the doctors and pills and you know I've got to try and, again sort this out</p>	<p>Cautious, trial and error approach to disclosure</p> <p>Shared experience of 'weaknesses' promoting disclosure</p> <p>It's not really spoken about</p> <p>Cautious, trial and error approach to disclosure</p> <p>Avoidance of professional support</p> <p>Self-reliance versus seeking help from others</p>
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<p>Pills = failure – where does this construct come from?          Taking pills did not fit with her pre-motherhood identity? For someone who feels and wants to be self-reliant, quite a challenge to think about seeking professional support. Maybe thinking of pills as the outcome is functional / safety behaviour for her i.e. stopping her from thinking professional support is an option and forces herself to rely upon herself          “visions” – where did her fantasies and expectations come from?          “throw” – seems uncaring and impersonal. Not listening to distress?          Simply viewing as label?          There seems to be an expectation that a GP would not listen to her experience.          Use of the description “last resort” and repetition of “really” emphasizes her reluctance.</p>	<p>myself so it's probably more of a challenge for me then to, (R: Mm) sort it out</p> <p>R: Mm, which sounds like quite a lot of pressure on you, erm, but I wonder, you said you didn't want to go down that road of (LOUISE: Mm) going to the doctors and, and getting pills, erm, what would that have meant for you if you, if you, if you did go down that route? At that point in time what would it have meant for you?</p> <p>LOUISE: That I'd have failed, (R: Ok) erm, I've never taken any pills or anything like that before and I don't know what the route is I mean my visions were you just went to the doctors and said “oh I've got postnatal depression” they just throw some pills at you, (R: Mm) and, and I, I didn't want to, do that, (R: Ok) I mean as a last resort I would have done but that's something I really really didn't want to do</p> <p><i>A child can be heard crying in the background</i></p> <p>R: Right, ok, so the, there were, there were times when erm, you were c- perhaps closed down by other women when you told them, erm, (pause) the, the women that you, or, or the people that you did tell, did you have any</p>	<p>I'd have failed: Seeking professional support as last resort</p> <p>Assumptions about professional care hindering help seeking</p>
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<p>Physical distance from person disclosing to – does distance feel safer? Shared experience. "wild life" – why is this important in this context? Does she perceive it as meaning she is more "open" minded and so less judgemental? Perhaps that her behaviour does not fit with social expectations of her, which the participant might be feeling in her role as a mother? Social ranking – weaknesses (e.g. "she's been on and off pills her entire life). Downward social comparisons supporting her sense of self? Normalisation – but through shared experience? Repetition of this emphasizes its importance to her. She also quotes her friend twice regarding normalisation – she appears to have internalised these comments from her friend as part of a process of self-acceptance. Realising her thoughts of infanticide were less of a "taboo secret" than she had previously perceived them to be following disclosure seemed to make her feel better but it did not seem to allow her to disclose this experience beyond her friend and her husband.</p> <p>Importance of normalisation.</p>	<p>positive memories of, of, of telling people you know, that it was actually quite helpful?</p> <p>LOUISE: Erm yes my girlfriend, she lives in Amsterdam so I didn't see her a huge amount but we speak (R: Mm) quite a lot she's (R: Right) she's got a little boy and she's the only one I've actually admitted to erm, I really actually felt the urge to kill [Child's Name], (R: Ok) she's the only one I've told apart from my husband, (R: Right) erm, (R: Yeah) but she's been on and off pills her entire life, she's led quite a wild life, she's more, erm, open about things like that, (R: Mm) so for me sort of saying something like that she's so ea- "no I felt the same, it's normal" (R: Right) and as soon as you hear somebody say "don't worry it's normal" you're thinking well ok I actually feel a bit better, but you know these are the sort of things that happen and, (R: Mm) it's not some great taboo secret that I just thought, you know I could quite happily kill my (R: yeah) child</p> <p>R: Right, so it's something about normalising</p> <p>LOUISE: Yes</p> <p>R: That's quite important</p> <p>P2: Yeah</p> <p>R: And also someone else again coming back to someone having a similar experience to you (R: Mm) obviously in a different context (LOUISE: Yes) but a, or you know, as you say someone that's had medication in a different way or, you</p>	<p>Disclosure influenced by emotional and physical closeness versus distance</p> <p>it's not really spoken about</p> <p>Disclosure facilitated through shared experience</p> <p>Shared experience of 'weaknesses' promoting disclosure</p> <p>Preferred characteristics of the confidant</p> <p>Normalisation through shared experience</p> <p>Voicing it and being heard as reflective and transformative process</p> <p>Normalisation through shared experience</p>
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<p>Age of confidant. Social ranking / social comparison based on difficulties and use of medication.</p> <p>Normalisation. Helpful to hear someone tell you to not worry about internal experiences.</p> <p>Fear that disclosure would cause her to be perceived differently by other people she knew who do not have the aforementioned 'weaknesses' – the power of perceived / feared social judgement.</p> <p>Social discourses around PND and medication as treatment for PND are perceived by her as more powerful than those related to sexual health. For Louise, PND and medication for it = you can't cope as a mother. Is coping more important to her than being 'healthy'?</p> <p>Her expectation is that other people would have perceived her as not being able to cope</p>	<p>know that they, they've experienced something similar to you with a child (LOUISE: Yes) as well, erm</p> <p>LOUISE: And speaking to much older mums like the other ladies I know from [affluent town] they're in their 50s, (R: Mm) erm speaking to, them there's a couple who're on antidepressants now, erm so I feel I can speak to them about it and they're sort of like "oh yes, no, it, it, it's normal" (R: Mm) "you don't worry about it" you know</p> <p>R: So what would your fear have been of telling somebody who has never been on antidepressants or experienced a form of depression or, has never had a child, what would your fear be, of telling somebody like that?</p> <p>LOUISE: That they would look at you in a completely different way and I probably would find it easier to tell them I had an STD or something like that (both laugh) than admitting that, you know I was having postnatal depression and on antidepressants because the whole thing is you obviously then can't cope</p> <p>R: Mm, so it's, it's perhaps what ....</p> <p>LOUISE: it's a perception that you can't cope</p>	<p>Preferred characteristics of the confidant – age &amp; history of taking anti-depressants</p> <p>Shared experience of 'weaknesses' promoting disclosure</p> <p>Normalisation through shared experience</p> <p>Fear of judgement / responses from others</p> <p>Expecting to be seen differently by others following disclosure</p> <p>It's not really spoken about</p> <p>Do I just have to cope?: Internal versus external expectations and assumptions of motherhood</p> <p>Do I just have to cope?: Internal versus external expectations and assumptions of motherhood</p> <p>Fear of judgement / responses from others</p>
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<p>The description "the whole thing" plus the emphasis on "is".  The "big smile" – façade that mothers adopt to hide their suffering.  Was it part of her façade?  "Oh no, it's all fine, don't worry" – is this something she used to say to people? Was this part of her façade?  Making PND invisible (denial reaction) does not make it go away.  PND can affect all women independent of occupation and social class.  Embedded within her language are messages of social ranking and social comparisons – perhaps human beings naturally order and rank?</p> <p>Why would she not have had any expectations of her husband's reaction? "work through it together" – surely this is an expectation?</p>	<p>R: (said quietly at same time as LOUISE) a perception yeah, mm</p> <p>LOUISE: Rather than, I would say anything, else but, th- th- the whole thing about postnatal depression is that it's not talked about enough, not enough is done about it, too many people hide it, and you then get to the stage of that erm lady, recently who what killed her two children then herself or something, erm, because everybody's trying to put this big smile on "oh no it's all fine, don't worry" (R: Mm) erm and then this whole thing of just trying to push it under the carpet when actually it's real and it's not going to go away (R: Yeah) and it doesn't matter who you are whether you're, you know, a, a, the cleaner or the banker or anybody in between it, it effects you, the same</p> <p>R: And you, you mentioned at well from what you've said i, i am picking up that your husband was the first person you told?</p> <p>LOUISE: Yes</p> <p>R: Right, and so then when you told him, what expectations and fears did you have?</p> <p>LOUISE: Erm, i felt there weren't any expectations and we'd work through it together, (R: Right, ok) erm</p> <p>R: So you didn't have any worries about telling him?</p>	<p>It's not really spoken about</p> <p>Disclosure facilitates opportunities for solutions</p> <p>It's like putting a coat of armour on: Façades as internally and externally protective</p> <p>The unprejudiced impact of PND</p> <p>Husband as first confidant about low mood</p> <p>Importance of social support</p> <p>Disclosure facilitates opportunities for solutions</p>
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<p>What was it about their relationship that meant she had no worries or fears about disclosing to her husband? Was it past experience of them working through problems together?</p> <p>Husband gave her an alternative to going to the doctors.</p> <p>"try" implies this was a challenge – what was making it so hard, considering she had no expectations other than him working through it with her?</p> <p>Disclosure, especially about her most difficult experiences of PND, was easier when her suffering has ended / reduced. Did she need to establish that she was not a 'danger' to her daughter in order to believe others did not think she was?</p> <p>Impact / burden on others.</p> <p>Interview making her think about new ideas.</p> <p>Negative perceptions of other people's perceptions of her – prevents / delays disclosure. <i>Projection?</i></p> <p><i>Symptoms of PND = can't cope.</i></p> <p><i>"I couldn't cope" and "seriously losing it" – very extreme (black and white) judgements – no scope for grey area in other people's perceptions.</i></p> <p>Tails off "and then he..." – what did she think would then result from her husband having those thoughts about her?</p>	<p>LOUISE: No</p> <p>R: Ok, erm and why, oh sorry, erm, what point did you tell him?</p> <p>LOUISE: Erm, (pause) oh he knew something was up the first weekend or the first couple of weekends when I was, in tears and he said "look you know if you need to go to the doctors, do go, but otherwise just talk to me" so I would then try when I wasn't feeling great to, (R: Mm) say something but I only told him about wanting to kill [Child's Name] about 5 months after I felt it, (R: Oh right ok) when it was way in the past and there was no danger of me, 'cause I didn't want him to then start panicking, then coming home from work early (R: Mm) so he could bath [Child's Name] so</p> <p>R: Mm, would that have then fed into your worry about other peop- people perceiving you can't cope?</p> <p>LOUISE: Erm, (pause) I, I hadn't really thought about it but I suppose yes it must have been, (R: Mm) because I was worried that he would then think I couldn't cope, or I was then seriously losing it, erm, and then he... yes, so then that's, that's why I didn't tell him until, (R: Mm) many months afterwards</p> <p>R: And erm, it, it sounds like from what you've said you, you often have to process stuff yourself first, erm, and err, it sounded like you did that then that you (LOUISE: Mm) had before you could tell your husband you had to</p>	<p>Disclosure facilitates opportunities for solutions</p> <p>It's not really spoken about</p> <p>Conquering PND: Easier to disclose following recovery</p> <p>Concern about impact of disclosure on others</p> <p>Trying to be the coping mother</p> <p>Do I just have to cope?: Internal versus external expectations and assumptions of motherhood</p> <p>Fear of judgement / responses from others</p> <p>Making sense of one's experience before disclosure can occur</p>
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<p>Things need to get better before disclosure can occur?</p> <p>Husband was supportive, understanding and happy she could disclose to him. "quite" and "severe" contradict each other in terms of describing the severity of what she was disclosing. Perhaps using the word "quite" softens the impact for other people (and perhaps herself) when they hear the experience she had.</p> <p>Contradiction – he did do something (hug, supportive comments) – what did she expect or want him to do? Did she hope disclosure would end PND?</p> <p>Change from first few weeks as a new mother. She seems more assertive and able to express her needs.</p> <p>Social comparisons.</p> <p>Importance of partner support.</p>	<p>process it yourself what went on and, and know perhaps things had got better?</p> <p>LOUISE: Yes</p> <p>R: Erm, and, yeah, and then yeah, and then when you did tell him, what, what did, how did he react?</p> <p>LOUISE: He was, erm, (smacks her lips, short pause) very understanding, and he was, very happy that I could actually, or felt that I could tell him something, quite, severe, shocking, (R: Ok) erm but he was very supportive</p> <p>R: Mm, and so what is it he did following erm, the, disclosure?</p> <p>LOUISE: Erm, (pause) he probably gave me a hug but I don't think he necessarily did anything, but he does always tend to, say to me "oh you're the best mum" (R: Mm) you know "you're doing really well" so there's that amount of praise I'm getting which makes me feel, (R: Mm) better and he, he tries to do, what he can, and, and erm, occasionally I do get cross and just say, "look you are taking the piss now you've got to" (R: Mm) you know "come home or help out or do this that and the other" erm, but he is actually quite good he does a lot more than other peoples' husbands, erm, a huge amount more than other peoples' husbands</p> <p>R: Right erm, so erm, sort of thinking about your, that first experience of disclosure then,</p>	<p>Making sense of one's experience before disclosure can occur</p> <p>Importance of social support</p> <p>Impact of disclosure on marital relationships</p> <p>Disclosure facilitates opportunities for solutions</p> <p>Voicing it and being heard as reflective and transformative process</p> <p>Negotiating parental responsibilities</p> <p>Comparison to other mothers</p>
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<p>She disclosed to a friend living in [Foreign country] before her husband who she lived with. Does physical distance make it feel safer to disclose? If so, why? Fear of being a burden to those nearby? The person you have disclosed to is not simultaneously seeing you in your role as a new mother, thus less potential for judgement following disclosure? A way of leaving difficult emotions with friend abroad?</p> <p>Enough time spent with a person to be able to disclose to them.</p> <p>The need to feel close to the person to whom you are disclosing.</p> <p>Importance of normalising and reassurance.</p>	<p>erm, who did you then go on to tell after your husband?</p> <p>LOUISE: Erm, (pause) well I told my girlfriend in [Foreign country] first, (R: Right) this about killing [Child's Name] well erm, and then I told my husband I think that Christmas when I told her, (R: Right) I was out there in September, (R: Right ok) so I told her in September and I told him at Christmas</p> <p>R: Right, and, and, and err just, out of curiosity wondered why you told that friend before your husband, just, do, do you have a, any meaning to that?</p> <p>LOUISE: (starts talking over R) Erm, erm no we spent a few days together, because she obviously lives in [Foreign country] and we'd met up and gone away for a few days in [holiday destination], (R: Right) so I felt actually quite close to her at the time, and spending a few days with her, at that, you know it sort of feels right to say this</p> <p>R: Right ok, erm, and then how did she, so she responded by saying, no- normalising (LOUISE: Yes) and by drawing on (LOUISE: Yes) her own experiences is there anything else that she did that you, err found a positive?</p> <p>LOUISE: Erm, no just normalising it and saying (R: Mm) "no, it, it is fine to, (R: Yeah) feel like that".</p>	<p>Disclosure influenced by emotional and physical closeness versus distance</p> <p>Friend as first confidant about thoughts of infanticide</p> <p>Needing the right social context for disclosure to occur</p> <p>Disclosure influenced by emotional and physical closeness versus distance</p> <p>Normalisation through shared experience</p>
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<p>Disclosing in small amounts initially – being tentative Importance of the person being “open”</p> <p>Email provides distance from those you are disclosing to – does it then feel safer?</p> <p>The girl’s honesty allowed Louise to be honest – does it need to be reciprocal? What allowed the girl to be honest – with self and others? What response did she get from the recipients? Relational risk taking? Laughter – does it hide frustration at other women’s lack of honesty, as she perceives it? Discomfort with difficult feelings?</p> <p>How does she know other mothers feel like this? What did she sense in other women which was not verbalised?</p> <p>Other mothers’ honesty about their postnatal emotional difficulties provides mothers with opportunities to disclose themselves. Reciprocal nature of disclosure.</p>	<p>R: Any other experiences you’ve had of disclosing and it’s been really positive?</p> <p>LOUISE: Erm, only one other girl and I didn’t really sort of say a huge amount but erm, she is quite, open, erm, and one day- ‘cause we’re a-all organising some events thing and she actually sent an email round just saying “girls I feel really down at the moment” (R: Right) erm which is very honest, erm, because no one else I know (said with a slight laugh) has ever done or said anything that- and even in conversations or when you meet people no-one ever says (R: Mm) “I’m knackered I feel shit, I don’t wanna do this”</p> <p>R: Mhmm, erm, and so that, that, that, was that a positive, you recall that as a positive experience of...</p> <p>LOUISE: Yes</p> <p>R: ...of, of you disclosing as well or erm, she just disclosed to you?</p> <p>LOUISE: Erm she disclosed to me but then I sort of felt well if I did want to talk to anybody about it I could always, talk to her</p> <p>R: So it was knowing that she was there?</p> <p>LOUISE: Yes</p> <p>R: And, and did you ever go to her?</p>	<p>Cautious, trial and error approach to disclosure</p> <p>Preferred characteristics of the confidant</p> <p>It’s not really spoken about</p> <p>Reciprocal nature of disclosure</p>
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<p>Does confidence to disclose increase with time since experiencing PND?</p> <p>Reciprocal nature of disclosure. Did the older mothers also disclose to her because she had made herself vulnerable and disclosed first?</p> <p>Does Louise's view that some of the other new mothers around her are suffering but not speaking out come from discussions with older mothers who can reflect on their own struggles and reference other mothers who had had similar experiences?</p> <p>A stepped approach to disclosure. It's like a tentative search process. Start by "hedging round" the topic and then assessing the feedback. It seems like a process of trial-and-error.</p>	<p>R: Erm and why do you think it might be more acceptable to an older generation, erm, or mum's that have, that their children are older?</p> <p>LOUISE: Because they've been there and done that, they've experienced it, they've also got the confidence to say, "yeah no you're right" you know "I suffered from postnatal depression" "so did I and so did so-and-so" much more open about it as well, (R: Right) I think 'cause they're old and they've got the confidence</p> <p>R: Ok, so it's about the confidence to say it or</p> <p>LOUISE: Yes</p> <p>R: Yeah</p> <p>LOUISE: Yep</p> <p>R: Ok, erm, so we talked about some kind of positive experiences erm but how about some negative experiences, you have touched on telling people and then they've kind of closed you down ...</p> <p><i>Clock can be heard chiming in the background</i></p> <p>R: ...was there any other, negative experiences you had of, of disclosing?</p> <p>LOUISE: Erm, (pause) I think those were the, (pause) only ones you know again it was sort of a few people, 'cause you sort of start hedging round the conversations by saying "gosh I'm</p>	<p>Disclosure facilitated through shared experience</p> <p>Reciprocal nature of disclosure</p> <p>Distance from new motherhood increases compassion and openness</p> <p>Cautious, trial and error approach to disclosure</p> <p>Fear of judgement / responses from others</p>
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<p>"won't take this any further" – initial responses can shut down a conversation</p> <p>Finding people she could develop a conversation about PND beyond the initial comment with was hard.</p> <p>"rebuffed right at the very beginning" – an abrupt refusal by the other person to take the conversation any further</p> <p>Abrupt change of topic – why? Does she feel that because her daughter slept well that she did not deserve or was not entitled to have PND?</p> <p>Repetition of how "lucky" she is – a lowered sense of entitlement to have PND when she compares herself to other women whose children do not sleep as well? She describes sleep as very important to her (she described sleep deprivation as a significant loss in the first few weeks following childbirth, earlier in the interview) whereas it may not be as important to other women. Thus, differing variables may be compared in the process of mothers comparing themselves to other mothers in establishing their entitlement to have PND – thus the comparison process is itself not comparable between mothers. Feeling less / not entitled may have shut Louise down - "I don't want to talk about it a huge amount because I'm far luckier than, a lot of people...".</p> <p>"well your child's sleeping you're still not coping, what's wrong with you?"</p> <p>Where does this quote come from? Did someone say that to her or was it a thought she had? If the latter, what is that thought based on and from what social discourses did it develop? It implies that if certain risk factors for PND are not present then the problem is internal to the woman, that she cannot cope. Did she and other women need their suffering to make sense to other people?</p> <p>Baby sleeping well and help from husband – two factors that may make her feel less entitled to have PND.</p> <p>"it says you can't cope at all" – where did this message come from?</p>	<p>finding this really hard" (R: Mm) and then depending on what people say or if they come back and say "yeah w- it is hard but we all get on with it" and you're like ooh ok (R: Mm) won't take this any further, and erm you know and, yeah trying to find people who you could sort of go, speak a bit further with was hard, 'cause then you're rebuffed right at the, very beginning, (R: Right) and I'm lucky that, that [Child's Name] sleeps through the night and she has done since she was sort of 10 weeks old, (R: Mm) erm I stopped the dream feed when she was 4 months so from 4 months she's been sleeping, you know 12 hours a night, so, I'm very lucky, whereas a lot of women don't even have that, so again I don't want to talk about it a huge amount because I'm far luckier than, (R: Mm) a lot of people so then there's this added thing like the "well your child's sleeping you're still not coping, what's wrong with you?" (R: Right, ok) you know plus my husband helps an awful lot, so again it's you know, (laughs) it, it says you can't cope at all, (R: So) and it's just like, so you'd feel even worse</p>	<p>Reciprocal nature of disclosure</p> <p>Do I just have to cope?: Internal versus external expectations and assumptions of motherhood</p> <p>"I'm far luckier": Questioning entitlement to have PND</p> <p>Comparisons to other mothers</p> <p>It's not really spoken about</p> <p>Trying to be the coping mother</p> <p>Do I just have to cope?: Internal versus external expectations and assumptions of motherhood</p> <p>Fear of judgement / responses from others</p>
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<p>"so you feel even worse" – hearing other mothers' stories about their struggles made her feel lucky and so less entitled to feel low, which then made her feel even worse – <b>perpetuating factor in PND?</b></p> <p>"it's your thinking" – she is able to see that our automatic thoughts are not necessarily valid.</p> <p>"if you suffer from postnatal depression you really should be..." – socially constructed conditions/criteria for being at risk of (thus entitled to?) PND.</p> <p>Louise lists conditions then summarises "life should be <i>really, really hard</i>" – what other conditions was she going to mention?</p> <p>Repetition of and emphasis on "really" implies that she sees PND as a risk to mothers in extreme personal situations only.</p> <p>"you've got a reason not to cope" – mothers need to have a (socially acceptable) reason to not cope.</p> <p>Repetition of the two factors (baby sleeping well and help from husband) in relation to her reduced sense of entitlement to suffer from PND – clearly these are her criteria – does she judge other women by them, as well as herself?</p>	<p>R: (said over LOUISE) so you feel, so in your head is there a kind of erm, perception of what might, of what should be going on in a, in a mother's life, in order for her to suffer from postnatal depression?</p> <p>LOUISE: (sighs) Yes it's like, a, a, a child having nits you think that child comes from a dirty home, (R: Right) whereas they don't actually.</p> <p>(R: Mm) you know, and it, it's your thinking so if you suffer from postnatal depression you really should be quite on the edge as in single parent, having to work, you know and it sh- life should be <i>really really hard for you to then suffer from postnatal depression 'cause you, you've got a reason not to cope, instead of, having a husband who helps, having a child who sleeps through the night</i></p> <p>R: Right (inhales) erm, the people that you did turn to, erm, were these the people that you, used to turn to before you became a mother, I know obviously you mentioned your husband, (LOUISE: Mm) and there was your 2 friends that you mentioned (LOUISE: Mm), erm, that you used to turn to, before you became a mother, were these two of the friends that you did turn to ...</p> <p>LOUISE: Yes</p>	<p>Fear of judgement / responses from others</p> <p>Internal versus external expectations and assumptions of motherhood</p> <p>"I'm far luckier": Questioning entitlement to have PND</p> <p>Do I just have to cope?: Internal versus external expectations and assumptions of motherhood</p>
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<p>She turned to the same friends she used to turn to before she became a mother. Is this because she could predict their responses would be helpful? Also, could Louise be reconnecting with the friends as a way of reconnecting with her 'old' life and thus creating certainty in the face of uncertainty of new motherhood?</p> <p>She needed to see them in order to disclose.</p> <p>"she says she can't cope either" – descriptions of lived experiences amongst non-mothers as well as mothers about coping – what is 'coping' versus 'not coping'? It seems dichotomous. Do people assume having PND = not coping?</p> <p>Earlier in interview she said she could cope. Why the contradiction?</p> <p>Normalising Externalising Being able to voice your suffering.</p>	<p>R: ...after you</p> <p>LOUISE: Yeah</p> <p>R: ...suffered from postnatal depression, or whilst you were suffering from postnatal depression?</p> <p>LOUISE: Yes 'cause you could sort of, erm, I wouldn't see either of them a huge amount because then you've gotta babysit it's not as easy to get into [city] and see people, but, erm, yes you would or, or, especially [friend] would come over here, so you would be able just to s- to say "look, you know I can't, cope you know", or, "I'm finding this really hard" and again, she'd say, "don't worry about it babe, you know my sister's just had a baby, she says she can't cope either, I'm sure it's all normal" (R: Right) so again it's normalising, (R: Normalising) and voicing and</p> <p>R: Yeah, and wh-, wh-, do you feel that there are, I mean obviously you, you talked about other mums (LOUISE: Mm) you met, erm, sort of a few other mums that you tried to, to talk to, was there, a big change in kind of who you went to disclose to, or who you didn't end up disclosing to who you used to disclose to, so basically was there a change in who you felt comfortable talking to?</p> <p>LOUISE: Erm, I suppose so yes 'cause err, err, it's also when you're a new mum you then try and meet as many people as you can and the people you obviously don't like or you feel you</p>	<p>Disclosure influenced by emotional and physical closeness versus distance</p> <p>Do I just have to cope?: Internal versus external expectations and assumptions of motherhood</p> <p>Trying to be the coping mother</p> <p>Normalisation through shared experience</p> <p>Reciprocal nature of disclosure</p> <p>Voicing it and being heard as reflective and transformative process</p> <p>Importance of social support</p> <p>Disclosure influenced by emotional and physical closeness versus distance</p>
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<p>Perceived ability to disclose or not disclose to certain people altered her relationships and contact with people in her support network. Does this involve a process of loss of change for Louise?</p> <p>Sigh. Might represent sadness about the loss or exhaustion from it being a big decision?</p> <p>Hesitation and lack of fluency. She might be struggling to articulate a response because she has not processed and therefore made sense of her 'not fitting in' and taking the action she took. Was it something she knew she had to do in order to cope, despite not fully understanding why?</p> <p>Powerful message about how Louise experienced others' expectations of how new mothers should behave The word "just" implies 'getting on with it' is easy.</p> <p>Repetition of "no" – is she emphasizing that discussing PND was far from what the women would do?</p> <p>Staged approach to disclosure – starts with a tentative search.</p>	<p>can't talk to you then don't bother seeing anymore. (R: Mm) so erm, yes 'cause I used to belong to an NCT group in, oh gosh over towards, [affluent town] and that way, and I've stopped doing that, (R: Right) erm I think be- for some reason I really didn't feel like I fitted in with the group, (R: Ok) erm, and I just thought actually I've (sighs), I'm going to stop going</p> <p>R: And, the fitting in, was that something to do with having postnatal depression?</p> <p>LOUISE: Erm, I, I don't think it was I just felt I didn't fit in in general, (R: Ok) I don't know why, (R: Mm) but I, I, felt I didn't, you know or again yes trying to talk to the lady who organised one time about postnatal depression, her comment was "oh you just get on with it"</p> <p>R: And that was the, the woman who, who, sorry can you tell me who that was?</p> <p>LOUISE: Erm yeah she was organising the kind of groups and coffee mornings</p> <p>R: Mm, and she, she talked to, to every- everybody about postnatal depression?</p> <p>LOUISE: No no no, not at all sh- no I, I just sort of mentioned it (R: Right) 'cause she came over here one time for a coffee morning and I just sort of mentioned it going out to the car and saying "oh my god" you know "I don't know</p>	<p>Comparison to other mothers</p> <p>Withdrawal when don't feel like I fit in</p> <p>Do I just have to cope?: Internal versus external expectations and assumptions of motherhood</p> <p>Cautious, trial and error approach to disclosure</p> <p>Reciprocal nature of disclosure</p> <p>Other mothers as a source of support but also comparison / judgement</p>
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<p>Importance of sleep. Social comparison. Lucky. The second of two comments from the woman implying that mothers should just cope when things are hard – where does this idea about motherhood and coping come from for her?</p> <p>Lack of fluency – what is she trying to articulate? Why does she change the subject abruptly? Repetition of “normal” in relation to her physical appearance – why is it so important to her? Was her desire to return to her pre-motherhood size a reflection of her desire to feel more in control of her life? Was she struggling to fully ‘engage’ with parts of motherhood which then hindered the secondary process of ‘growth and transformation’ (Nelson, 2003) of her identity? Is this in contrast to “women who are quite happy to, keep their baby weight” and “look like they’ve been dragged through a hedge backwards”.</p> <p>Mascara – part of her ‘mask’ / facade? “Presentable” – to who? Others, or herself? Importance of external appearance. Repetition of the phrase “dragged through a hedge backwards”. Her descriptions are quite extreme. Did she unconsciously think the other mothers in her NCT group were not suffering from PND because they did not need the ‘mask’ that she did, and so she disengaged from the group because they would be unable to empathise with her?</p>	<p>how I’d cope if my child was up all night or if I wasn’t very well” and she said “well you just do don’t you” (R: Mm) and it’s just like, ok, alright so it’s, and I went to a few more after that and it’s just like, mm, (R: Right) not again, and, and, and again I just wanted to, I don’t know, after I had a baby to, (pause) get back down to my normal size as quickly as possible, erm, to erm, you know always wear a bit of make-up even if it is just some mascara or just to, look a bit normal, (R: Mhmm) erm, whereas a lot of people I’ve met are quite happy to, keep their baby weight, look like they’ve just been dragged through a hedge backwards (R: Right) and it’s like even if I’ve just got 2 minutes just to make myself look a bit presentable, so I felt in some ways a bit, not, I could say, alienated from this [affluent town] group, ‘cause most mothers just, yeah look like they’ve been dragged through a hedge backwards</p> <p>R: Right, so what did it mean for you to look well presented?</p> <p>LOUISE: A lot</p> <p>R: Ok</p> <p>LOUISE: Erm, oh god years and years ago I was dating some chap and I said, it was a new year’s</p>	<p>Fear of judgement / responses from others</p> <p>Do I just have to cope?: Internal versus external expectations and assumptions of motherhood</p> <p>Getting back to me: Connecting with multiple identities</p> <p>Being “hit” by losses and changes: Adjusting to the new role and uncertainty of motherhood</p> <p>It’s like putting a coat of armour on: Façades as internally and externally protective</p> <p>Comparison to other mothers</p> <p>Withdrawal when don’t feel like I fit in</p>
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<p>Importance of appearance for her seems to stem from social interactions and relationships.</p> <p>A need to stay in control? Seems as though she made a rigid rule for herself that she was determined to stick to, even as a new mother.</p> <p>“pretty” versus “haggard” – quite black and white descriptions of appearances – no ‘grey’ area for her?</p> <p>Importance of appearance for her also seems to stem from her previous occupation and area of London she worked in.</p>	<p>resolution it must have been like 2001, 2002, that, I was always going to try and look pretty, even if I was sitting at home in my pyjamas, I always want to try and sort of look pretty so it, I think it’s something going back to that, (R: Mm) that there’s, unless you’re being really ill there’s no need to look, haggard, (R: Right) erm, and for many years I worked in [affluent part of London] so again it’s seeing everybody that’s properly turned out, (R: Mm) that looks exquisite, erm, and again there’s no reason not to, (R: Mm) put a dab of make up on, you know, and so, yeah I’ve always tried to do that</p> <p>R: How did you notice your, desire to be presented a certain way change, or did it stay the same when you were suffering from postnatal depression?</p>	<p>It’s like putting a coat of armour on: Façades as internally and externally protective</p>
<p>Internal personal world strongly connected to external presentation of the self.</p> <p>Phrases “bump into” and “caught unawares” suggest that ‘being seen’ by other people without a ‘mask’ to hide her true self was something she could not tolerate – both pre and post motherhood.</p> <p>Repetition of the phrase “caught unawares” emphasizing link between looking and feeling presentable for her.</p>	<p>LOUISE: It stayed, the same, (R: Mm) because if I looked presentable then I felt more presentable inside, (R: Mm, yep) whereas I think it’s only once or twice when I’ve actually been out without mascara on, even here in [affluent town] because you don’t know who you might bump into, (R: Right) you know, and again, working [affluent part of London] I used to live in [affluent part of London] and I was an Estate Agent so I’d occasionally bump into clients or something and if you popped out in your pyjamas, you know with a coat on, no makeup on it’s just like, “oh my god”, (R: Mm) so again it’s always sort of, you know being caught unawares, so if you look presentable on the outside then you feel a bit more,</p>	<p>It’s like putting a coat of armour on: Façades as internally and externally protective</p> <p>Fear of judgement / responses from others</p>

<p>I had asked her about what other people might think of her but she responded with what she would think of other people. Projection of her own views on mothers, or on herself at that time, into other people?</p> <p>When being true to herself, she can see nothing wrong with the above descriptions of a mother. Does the pressure we place on ourselves and standards we set ourselves prevent us from being honest? Do these completely come from ourselves? Do they come from societal ideas or rules we turn in on ourselves?</p> <p>Also, Louise appears to challenge her own beliefs during the course of the interview. Perhaps this reflects how disclosing and discussing lived experiences can help challenge / transform beliefs about them?</p> <p>Importance of shared experience and therefore being understood.</p>	<p>presentable- it's like buying, putting a coat of armour on or something</p> <p>R: Mm, if, if you was, someone was to see you with no makeup, (LOUISE: Mm) erm, as a mum walking down the street, (LOUISE: Mm) erm, baby in a pushchair, what do you think they might be thinking?</p> <p>LOUISE: I'd think "god she can't be arsed", (R: Mm) or "she's knackered" or, erm, you know "she's had a bad night" or yeah, "she just can't be bothered"</p> <p>R: And what would, what do you think would be so bad about that?</p> <p>LOUISE: Erm to be honest nothing, so again it's high standards that, we have over ourselves, (R: Mm) that we then put pressure on our-, (R: Mm) -selves</p> <p>R: Ok, erm, (pause) just thinking about so you, but you disclosed to obviously, a, a, select few in your (LOUISE: Mm) life, erm, (inhales, pause) who erm, who did you not feel able to disclose to that you would have previously discussed anything with?</p> <p>LOUISE: (Pause) Erm, (pause) I would say only probably, one or two people and actually they haven't got children so you sort of think, I</p>	<p>Fear of judgement / responses from others</p> <p>Comparisons to other mothers</p> <p>Voicing it and being heard as reflective and transformative process</p> <p>Internal versus external expectations and assumptions of motherhood</p> <p>Preferred characteristics of the confidant</p> <p>Disclosure facilitated through shared experience</p>
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<p>Concern about how other people, particularly professionals, perceive mothers who have a history of PND and how it can alter / bias their perception of a child's well-being. Her concern clearly prevented her from disclosing to her GP and seeking professional help. "aha" indicates view that professionals will make a reflex assumption once they see PND as part of mother's history Social stigma.</p> <p>Judgement from others.</p> <p>A struggle for me to articulate a question to Louise at this point. I wanted to remain as neutral as possible, yet was very keen to hear about any possible changes following disclosure. Perhaps my verbal struggle was representative of an internal struggle in obtaining bias-free information?</p> <p>Louise appears to contradict herself in this sentence. Perhaps she is trying to communicate that the strength of her relationships facilitated disclosure i.e. strength was the cause rather than result of disclosure. Improvement in her relationships with those people with whom she had a positive experience of disclosure.</p> <p>Positive impact on mother's mood from voicing her struggles</p>	<p>R: Ok, right, erm, because what would that have meant for you?</p> <p>LOUISE: (pause) that, it's always there and if you've got mental issues to start with, then if anything happened to your child, or you, I, you know they broke a limb or something or you then, you know then it, it's just like "aha" flagged up and, (R: Mm) so you think if it's not there in the first place, (R: Ok) then</p> <p>R: So, I guess that links maybe to further, or your perception of how people might judge you?</p> <p>LOUISE: Yeah</p> <p>R: Erm, and wh- a, like I say you disclosed to, people in your private life, erm, what were the consequences of disclosing, in terms of erm, how was it helpful erm, in terms of how you felt, erm, relationships with people, erm, what, what changes did you notice after disclosing, to yourself and relationships?</p> <p>LOUISE: Erm, I'd say not a huge amount of difference, I felt better and I also felt our relationship was stronger, erm</p> <p>R: Your husband?</p> <p>LOUISE: Yes and also with girlfriends as well, (R: Right, yep) erm, but it's just feeling, better and</p>	<p>It's always there: The stigma of mental health issues</p> <p>Fear of judgement / responses from others</p> <p>Voicing it and being heard as reflective and transformative process</p> <p>Impact of disclosure on marital relationships</p> <p>Voicing it and being heard as reflective and transformative process</p>
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<p>She only disclosed PND after the symptoms had subsided.</p> <p>Minimising. Her description of her suffering afterwards contrasts her description of her experience of PND. Admitting to who? Other people? Herself? It would have felt too much for her to disclose to other people other than her husband whilst suffering from PND. 'Conquering' PND gave her the courage to disclose / talk about it, but this involved minimising it, perhaps because she was 'victorious' over it – perhaps she felt 'bigger' than PND now she had recovered from it, so PND seemed 'smaller' to her now compared to when she was suffering from it?</p> <p>Fear of it returning after telling people – she could only disclose to a wider audience when she felt safe it was over. Why was this? Fear of being seen by others as having 'failed'? A need to stay in control of it and not let others see you out of control again?</p> <p>Likened to smoking – something that is socially perceived as difficult to overcome and has attached stigma?</p>	<p>happier yourself, that you've actually voiced something</p> <p>R: Mhmm, erm, but did you notice err, a particular symptoms improve, so, erm, the way that you felt, the way you thought, err about things, the way you behaved?</p> <p>LOUISE: Erm, no 'cause I think I sort of only told people about it after I, it had finished having the symptoms, I didn't really discuss it with anybody (R: Mm) apart from my husband and close friends while I was having, (R: Mm) the symptoms, so it was only afterwards and I could look back and say "yeah, I think I had a bit of postnatal depression" that (R: Right, mm) 'cause to actually admit that you're, having it at the time would probably have been too, much, (R: Right) whereas it's easier to admit something after it's been over and done with and you've conquered it</p> <p>R: Right, and what is it about conquering it that allows you to then feel more able to disclose?</p> <p>LOUISE: Because you've, it's over and done with, and it's something that isn't going to come back, (R: Mhmm) erm, that's why you feel that, erm, you can do it, it's like giving up smoking there's no point in telling everybody on the first day and the first minute saying "oh I've given up smoking" you know until you've actually passed a week or a month or, to then be able to say "yes, I've done this, it's now been a week or a month or a year"</p>	<p>Importance of social support and independence</p> <p>Conquering PND: Easier to disclose following recovery</p> <p>Weak PND self vs. the empowered recovered self</p> <p>Conquering PND: Easier to disclose following recovery</p> <p>It's like putting a coat of armour on: Façades as internally and externally protective</p> <p>Fear of judgement / responses from others</p>
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<p>Confidence to disclose increases as time since suffering increases. Safer for Louise to discuss now as she can say all over – reduces the chances of perceived criticism / judgement as overcome it?</p> <p>Disclosure had no impact on behaviour towards or relationship with child. Louise appears potentially defensive here. Perhaps she fears judgement from me as another mother? Maybe she inferred from my question PND did have an impact on her child?</p> <p>Uncertainty about how to seek help and who to disclose to.</p> <p>“they’re all new mums so that’s not happening” – she found that “new mums” were not a source of support, in general, perhaps because of direct comparisons of mothers at same stage as her. Why was this a topic of conversation that felt ‘shut down’ by these mothers?</p> <p>Realising she could not disclose to / seek help from other new mums made her feel worse.</p> <p>Self-talk helped her feel better again following ‘set-backs’.</p>	<p>R: Mmhmm, ok, (inhales) erm, and, d- err you say you become closer to people, (LOUISE: Mm) relationships stronger erm, how about erm with your child as well, erm did you notice any change in behaviour or your relationship with your child, anything, going on there, once you had disclosed how you felt?</p> <p>LOUISE: No I'd have said (R: Mm) not</p> <p>R: Right, erm, n- and also the, I'm thinking was it w-, did disclosing have any negative impact on you, because I know you mentioned before that when you felt shut down by some people, (LOUISE: Mm) you felt more alone, erm, so was there any, was there ever a time when you disclosed and it actually made you feel worse or your symptoms, erm, worsened, or relationships worsened?</p> <p>LOUISE: Erm, (pause) there probably was straight afterwards 'cause you sort of think ok now where do I turn to to try and talk to somebody they're all new mums so that's not happening, erm, so, for a while whether that was a few minutes or a couple of hours, I would or did feel worse, but then sort of, started to feel better again 'cause you sort of think ok well, if I can't talk to them then I will just talk to myself, or talk to my husband when he comes home</p>	<p>Isn't there something else I can do?</p> <p>Cautious, trial and error approach to disclosure</p> <p>Preferred characteristics of the confidant</p> <p>Self-reliance versus seeking help from others</p> <p>Importance of partner support</p>
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<p>Reliance on own resources and her husband. What goes through a mother's mind whilst she is waiting for support after 'set-backs'? Very small network of support at this stage, meaning she had limited exposure to alternative perspectives, especially female / maternal ones.</p> <p>Strategies.</p> <p>"sort it out" – a need to resolve / conquer.</p> <p>What she feels she should have done (tell more people and disclose to doctor) is not what she did whilst suffering – is this because she has now "conquered" PND? Disclosure seems and feels more possible with hindsight compared to when suffering? Can see the value in disclosing and wants others to feel more able to?</p> <p>(Participant speaks to her Nanny)</p>	<p>R: Right so you had other strategies in place</p> <p>LOUISE: Yes</p> <p>R: To com-</p> <p>LOUISE: Yes to try and sort it out</p> <p>R: Ok</p> <p>LOUISE: Yeah</p> <p>R: Erm, once you had disclosed to people, (LOUISE: Mm) erm, how did that affect your views of, of postnatal depression, as a condition?</p> <p>LOUISE: It, (pause) made me think that people who do have postnatal depression should tell more people or tell the doctor so at least they're aware of what's (small pause) going on. (R: Right) and saying that I'm as guilty because I did nothing about it, (R: Right, ok)</p> <p><i>LOUISE shouts "has she gone down for a nap?" Another woman can be heard entering the room and she and R say hello, LOUISE says "thanks [Nanny]" R resumes interview</i></p> <p>R: Erm, ok and erm, and what, how did it change your views on disclosure, as well as postnatal depression, I know you sort of said</p>	<p>Conquering PND: Easier to disclose following recovery</p> <p>Importance of social support and independence</p> <p>Guilt at not speaking out</p>
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<p>She needed a reduction in her symptoms and to feel 'stronger' to be able to disclose. Intrapersonal conditions for disclosure. <i>What interaction between interpersonal and intrapersonal conditions aids disclosure?</i></p> <p>Influence of celebrities and people in the public eye on her perception of when to disclose. Disclosure is modelled as something you do when you are "better".</p> <p>Difficulty defining her experience at the time of suffering. Lack of knowledge about the definitions.</p> <p>Louise quotes the Health Visitor – implies the significance of the Health Visitors comment to her.</p> <p>Health Visitor did not provide a realistic expectation of how the course of postpartum emotional difficulties could progress. "you'll get over it" - she created a perception of it as something that ends and women get over it. Alternatively, was the health visitor intending to normalise Louise's difficulties but she may have experienced it as</p>	<p>then about erm, people should talk and, should open up about it?</p> <p><i>Someone can be heard moving around in the background</i></p> <p>LOUISE: (speaking over R) Yeah again it's after-afterwards and you feeling better and stronger (R: Mm) that you feel you can then disclose it, (R: Right) like all these celebrity mums that have had it like was it erm, Jamie Oliver's wife, yeah it's after it's happened that you then feel more able to, to say "yes I've had it and I now feel better"</p> <p>R: Right so you, after you disclosed you were able to recognise that it's something you c-erm, it was easier for you to do once you had got through it</p> <p>LOUISE: Mm, I th-</p> <p>R: And that would be the same for other women?</p> <p>LOUISE: I think one of the hardest things is trying to differentiate between the baby blues, and postnatal depression I think that the health visitors erm, and people who visit you to start with, don't really help, (R: Mm) 'cause like "oh it's just the baby blues don't worry about it, you'll get over it" erm, whereas yeah I probably would have if I felt I could have spoken to them, (R: Mm) I might have then felt, erm, or I if, if I'd have felt able to talk to them, I probably would have done, 'cause I think I was</p>	<p>Conquering PND: Easier to disclose following recovery</p> <p>Weak PND self vs. the empowered recovered self</p> <p>Comparison to other mothers</p> <p>Trying to understand and define experience</p> <p>Others' responses as normalising versus minimising</p> <p>Do I just have to cope?: Internal versus external expectations and assumptions of motherhood</p> <p>Dying to talk to somebody in a professional role</p> <p>Self-reliance versus seeking help from others</p>
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<p>minimising? e.g. "oh it's just the baby blues" "don't worry about it". These two factors may have shut Louise down.</p> <p>"I was dying to talk to somebody" – her language illustrates how strong her need to disclose and discuss her suffering to the Health Visitor (or someone in a "significant role") was, yet she did not feel able to.</p> <p>Counselling for PND offered by / through NHS Sure Start Service - would all women have noticed a telephone number at the bottom of a leaflet?</p> <p>Why did the process of seeking help stop at "thinking" about it for her? What was the blockage? What would have helped her moved to the next stage of disclosure and help seeking? Does this reflect her ambivalent relationship to seeking help from health professionals?</p> <p>A very short answer with no follow-up explanation offered. Why?</p> <p>Reliance on internal resources – what happens to women who do not have effective internal coping mechanisms and thinking patterns?</p> <p>Fixed ideas about what different sources of professional help offer.</p>	<p>dying to talk to somebody, erm, in, in a significant role, (R: Mm) that I, that I was feeling like this, (R: Mm) erm and I noticed on the erm, sure start leaflet because I go to all the clubs and the baby weigh-ins and things there was a number at the bottom that you could actually call that said if you're suffering from postnatal depression or you want some counselling...</p> <p><i>Clock can be heard chiming in the background</i></p> <p>LOUISE: ...(R: Mm) erm and that's another route I was thinking of going down is counselling</p> <p>R: And erm, is that something you're still considering?</p> <p>LOUISE: No</p> <p>R: Ok, erm, what were your thoughts on counselling?</p> <p>LOUISE: Erm, that if I didn't feel better myself then I'd try that before I went to the doctor</p> <p>R: Right, ok, and why would that be?</p> <p>LOUISE: Erm, because counselling is about talking whereas going to the doctor would be about pills</p> <p>R: Ok, ok, erm, you mentioned that you said some- or it sounded from what you said that</p>	<p>Self-reliance versus seeking help from others</p> <p>I'd have failed: Seeking professional support as last resort</p> <p>Assumptions about professional care hindering help seeking</p>
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<p>Older health visitor – did age / cohort of the professional affect her attitude to PND? Did her age influence Louise's felt ability to disclose / discuss her suffering further with her?</p> <p>Health Visitors are in women's "arms reach to talk". Importance of close proximity to / access to other mothers for support.</p> <p>She wants professionals to ask women how they are feeling, rather than responsibility for disclosure being the mother's. Assistance with disclosure. Disclosure is a two-way interpersonal process rather than one-way? Does a professional approaching the subject first make it seem more acceptable to the mother? Perhaps because it might imply an expectation of emotional difficulties in new mothers? Disclosure may be experienced as a risk, and so due to her ambivalence with help-seeking at that time she may have wanted the professional to take the risk for her?</p> <p>Louise feels that even within a group of other mothers, being asked if anyone is suffering from PND would help mothers to disclose – contradicts what she says later in the paragraph about not wanting to disclose to a room of mothers. Does this reflect her ambivalence with help seeking within professional contexts?</p> <p>Louise states ideal questions from Health Visitors to new mothers and responses mothers might then be able to give. Are these 'quotes' from conversations she fantasized about when suffering from PND? What stopped her from just saying "I think I'm suffering from postnatal depression", without being asked? Is it the desire to be self-reliant and fear of being judged?</p>	<p>you have said <i>something</i> to your health visitor, but had you-, what had you said?</p> <p>LOUISE: I hadn't really said anything. I, oh, it was, no we had an older health visitor who came, erm, when I'd just come out of hospital and I, can't remember what I said but I think she just said "oh it's the baby blues you'll be fine", (R: Mm) erm, but it's all the health visitors that when you do see them they're there they're in your arms reach to talk (R: Mm) to them about and I think if they came up to you and, and said "are you feeling alright?" or "do you think you're suffering from postnatal depression or is there anybody here who does?" (R: Mm) then you could've put your hand up, or something like that, instead of having to go to them and say, "I think I'm suffering from postnatal depression" there was never, quite the right time you then (R: Mm) couldn't get them on their own, or, (R: Right) you didn't really want to sort of, admit to the entire room, (R: Mm) you know but it was, I think if, yes if there was some way of individually doing it, (R: Mm) erm, or when you get your baby weighed then they then spoke to you like that as well</p> <p>R: Mhmm, so that, that's erm, err, is that something that, doesn't really happen, you don't see a health visitor on their own after the first few weeks?</p>	<p>Cautious, trial and error approach to disclosure</p> <p>Others' responses as normalising versus minimising</p> <p>Trying to understand and define experience</p> <p>They're within your arms' reach: Desire for professionals to simply ask</p> <p>Disclosure as a two-way interpersonal process</p> <p>Needing the right social context for disclosure to occur</p> <p>Fear of judgement / responses from others</p>
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<p>Mismatch of antenatal expectations of postnatal care and the actual care received.</p> <p>Two visits from Health Visitor at home (individual basis) then remaining contact was in a group setting – importance of continuation of individual contact with Health Visitor beyond the first two visits.</p> <p>'baby weigh in' – this phrase suggests the focus is on the baby.</p> <p>Strict boundaries set by Health Visitors about their role and responsibilities. What is driving these boundaries (e.g. time restraints)? Do these boundaries put women off from disclosing and discussing their own needs? Does the health professional system around new mothers have a need (e.g. financial) to put boundaries in place?</p> <p>Change in behaviour of Health Visitors when form of contact changes</p> <p>First disclosure in the home setting.</p> <p>Normalising "in the wrong way". What would normalising "in the right way" look like?</p>	<p>LOUISE: Yeah you don't you don't at all, I was surprised at how little care you get, (R: Ok) erm, I think I only had the health visitor here (small pause) twice, erm when we came home from hospital and then you see them at baby weigh in, (R: Mm) erm but that's it, I mean they don't even measure the height of your baby they just take the baby's weight, (R: Right) and that's it when I did ask them to measure [Child's Name]'s height they said "oh we can't do that" and I said "I've got a tape measure can you help me?" (R: Mm) and they said "no we can't do that" (R: Oh right what was...) so you, and it was an old lady in her fifties who'd been quite good to start with and it was just like well, I just wanted to measure her, (R: Yeah) height</p> <p>R: So when you had mentioned about, err I know that the, the memory might be a bit sketchy (LOUISE: Mm) for you but was it at home that you (LOUISE: Yes) had said something</p> <p>LOUISE: Yes</p> <p>R: Yeah, and when she had said "oh, it might be baby blues" (LOUISE: Mm) did that feel like she was normalising it?</p> <p>LOUISE: Erm it did but in the wrong way, (R: Ok) because you've only just come out of hospital so actually it probably could have been the baby (R: Mm) blues because you've had all the visitors in you've, you know you have all the presents, and then it's just like, (R: Mm) you</p>	<p>Surprised at how little care you get - Reality of postnatal care not matching expectations</p> <p>Oh we can't do that: The impact of boundaries of health professionals' roles</p> <p>Others' responses as normalising versus minimising</p> <p>Trying to understand and define experience</p> <p>The importance of support and independence</p>
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<p>Lack of follow up at the point in the postnatal period when husbands return to work, fewer visits are received by the mother and all the presents from people have been opened. Is this a crucial point when a mother's emotional well-being should be re-assessed?</p> <p>Louise now discusses how she had a responsibility to follow-up contact with Health Visitor following initial disclosure. Why is her perceived responsibility in the disclosure process discussed so much later in the interview than her perception of the responsibility of professionals? Does this represent a belief that professionals have most / initial responsibility to aid disclosure? What is it about the professional "following up" her emotional well-being that makes it "easier" for mothers to continue the process of disclosure? If their experience of suffering is seemingly forgotten by health professionals, does this make a mother feel like her ongoing experience is invalidated and people do not want to hear about it anymore, closing down her felt ability to disclose?</p> <p>Quoting from fantasized conversations?</p> <p>"it was never mentioned again, and I, I, didn't mention it either" – if one party 'pulls out' of the disclosure process the whole process collapses? Does this become a vicious cycle?</p>	<p>and your baby, husband's back at work) (R: Mm) you know that's it so yes, it could have been, but then, they never sort of followed it up</p> <p>R: Right, so you kind of, did you feel that you'd made a disclosure but it, nothing was (LOUISE: Yep) it was normalised perhaps in a negative way?</p> <p>LOUISE: Yes, (R: Right) but then again I could have followed it up myself and I didn't, (R: Mm) but I would have probably found it easier if they'd have followed it up</p> <p>R: Mhmm, right, erm so you, once you had disclosed at that stage, (LOUISE: Mm) you felt that, that you needed someone to guide you, going on further with it to follow it up</p> <p>LOUISE: (Speaking over R) Yes I would just saying "are you still having problems? Is this alright? Would you want somebody to talk to?" (R: Mhmm) or, whereas, it was never mentioned again, and I, I, didn't mention it either</p>	<p>Surprised at how little care you get - Reality of postnatal care not matching expectations</p> <p>They're within your arms' reach: Desire for professionals to simply ask</p> <p>Disclosure as a two-way interpersonal process</p> <p>They're within your arms' reach: Desire for professionals to simply ask</p> <p>Disclosure as a two-way interpersonal process</p> <p>They're within your arms' reach: Desire for professionals to simply ask</p> <p>It's not really spoken about</p>
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<p>Sighs – does this represent a sense of hopelessness she felt at that time?  “try and catch one of the ladies on their own” – seeking opportunity for disclosure - She tried several times to catch other mothers on their own after group situations in order to disclose / feel able to disclose.  Sighs again – representing her sense of hopelessness?  Quoting from a fantasized conversation?</p> <p>Do mothers look for reasons not to persist with disclosure after initial attempts failed?</p> <p>Pauses may indicate that this is something she has not reflected on before.</p> <p>PND made her feel “weak” at the time of suffering but “empowered” after she overcame it. Links to her previous comments on ‘conquering’ PND.</p>	<p>R: And how did that make you feel <i>about</i> having emotional difficulties?</p> <p>LOUISE: Erm, (sighs) probab-, well not great because then there's no-one, to talk to and I know several times I went to, like baby massage and I wanted then to try and catch one of the ladies on their own afterwards, (R: Mm) but they were never, (sighs) on their own just to say “look, I think I’m suffering from postnatal depression, what can I do?” (R: Mm) erm, but I never managed to get them on their own and by then I sort of thought well I’m feeling a bit better so I’ll leave it</p> <p>R: Mm, ok, erm, just interested then in how, you experienced yourself, before and after disclosing, postnatal depression (LOUISE: Mm) so how your identity, how, how your identity and how you saw yourself might have changed?</p> <p>LOUISE: (small pause) I think I felt quite, (pause) weak while I was, or I would look at myself and think “gosh you must be quite weak” whilst I was having it, (R: Mm) and then after I’d overcome it I felt better and more empowered</p> <p>R: More empowered, erm, so you felt, you felt stronger before you got postnatal depression, (LOUISE: Mm) weak whilst you were having it and (LOUISE: Yeah) then erm, stronger and (LOUISE: Stronger again) more empowered afterwards. Erm, was that as a woman, or a</p>	<p>Cautious, trial and error approach to disclosure</p> <p>Disclosure as a two-way interpersonal process</p> <p>Needing the right social context for disclosure to occur</p> <p>Self-reliance versus seeking help from others</p> <p>Weak PND self vs. the empowered recovered self</p>
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<p>Sense of empowerment is not specific to her identity as a mother but to her overall identity.</p> <p>Smacking her lips and pausing – is the impact of PND on this part of her identity more difficult to talk about? This part of her identity was affected in a number of ways. The influence on her desire to be intimate with her husband is particularly dominant for her.</p> <p>In addition to, and perhaps because of, suffering from PND, she felt unable to meet her husband's needs for intimacy – did this contribute to her PND (e.g. sense of failure)?</p> <p>Laughter – defence against pain?</p> <p>"I'm actually finding you very unattractive" – projection?</p> <p>Why does it seem easier for her to have disclosed her needs and desires regarding intimacy and sex but not emotional difficulties? Links to her earlier comments about finding it easier to disclose about issues related to sex (having an STD) than mental health. Social discourses around PND are perceived by her as more powerful than those related to sexual activity and sexual health. Also, sex and intimacy are relational – perhaps PND is perceived / experienced by Louise as internal?</p> <p>"It's being open and honest with the people that really matter, who can then understand it, and who can then work with you..." Her idealised sequence of events?: Identify the people that "matter", disclose your lived experience, they can then understand your lived experience, and can then help you.</p>	<p>mother, or a person in society, or, what was erm?</p> <p>LOUISE: I would say, as a mother and a person</p> <p>R: Ok, erm, and how, how did you see yourself as a, as a woman?</p> <p>LOUISE: (smacks her lips) (pause) Not great while I was suffering with it because I think it gets you down in, all sorts of ways and you don't really want to be, close to your husband, (R: Mm) you just sort of think actually don't even touch me, erm, so there's all of that as well, (R: Mm) so it's not just a case of you're feeling crap, you know they want some affection you, it's the last thing you want, (R: Mm) so there's, (R: Mm) and then having to say to your husband or explaining why you don't want to have sex because actually (starts laughing as she talks) "at the moment I'm actually finding you very unattractive, and I feel shit" (R: Mm) and again once I'd said that to him, then I felt better 'cause I knew that he could give me a cuddle without me worrying it's going to lead to anything, so again it's being open and honest with the people that really matter, (R: Mm) who can then understand it, and who can then work with you, (R: Mm) instead of no-one knowing apart from yourself and then them getting upset as to why you don't wanna have sex, or you're crying the entire time, (R: Mm) or, all of that</p>	<p>Don't even touch me: Having to manage reduced desire for intimacy with partner</p> <p>Voicing it and being heard as reflective and transformative process</p> <p>Importance of partner support</p> <p>Disclosure enabling the possibility for solutions</p> <p>Impact of disclosure on marital relationships</p>
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<p>Other people knowing her lived experience benefits them as well as her.</p> <p>Disclosure to family members not mentioned so far in interview.</p> <p>Geographical distance and family members experiencing their own life events at that time may have influenced why she did not turn to them, including her sister who had children?</p> <p>Does physical health get prioritised over mental health? Did this influence her felt ability to reach out for help for this clinical disorder? "they weren't really around" – physically or emotionally?</p> <p>Sighs – sadness about absence of family support?</p> <p>"North-South divide". British regional stereotypes – what influence do these have on British people's perspectives about how 'easy' motherhood is for women in other parts of the country, and on a mother's sense of entitlement to PND? These societal pressures may prevent opportunity for disclosure and sharing of experiences.</p> <p>Conditions for PND.</p> <p>Silly voice – does she feel 'silly' for having PND because she has "loads of money" and "loads of help"? Assumption that money and practical support reduce or prevent emotional difficulties.</p> <p>Comparing herself to other mothers.</p>	<p>R: Mm, ok, erm, I notice as well, erm, that you've spoken a lot about your husband and your family and friends, (LOUISE: Mm) but I just erm, sorry your, your friends, but I notice you haven't spoken much about your family and whether there's a particular reason you haven't mentioned them in terms of, disclosing and talking to them?</p> <p>LOUISE: Erm, they're all up in [Northern County], (R: Right) erm my sister's little boy's just recovering from cancer, (R: Aw) erm and he was in hospital having loads of chemo whilst I was pregnant and then having [Child's Name], (R: Mm) so they weren't really around, (R: Mm) and (sighs) without sounding really rude there seems to be this sort of north south divide that we're down here we're Southern, you know we've got loads of money and everything else and I've got loads of help, (said in a silly voice) whereas my poor sister's up there and her husband won't even let her have a cleaner, (R: Mm) you know she's got a boy in hospital, one at you know he's young, so there's this huge sort of thing that you know we seem to live a gilded life and if I said "oh god I was suffering from postnatal depression" or anything it would just sort of be "oh pull yourself together" (R: Right) you know, it's, it's, "[sister]'s got it hard you haven't, stop</p>	<p>Disclosure influenced by emotional and physical closeness versus distance</p> <p>Social comparisons</p> <p>Comparison to other mothers</p> <p>"I'm far luckier": Questioning entitlement to have PND</p> <p>Other mothers as a source of support but also comparison / judgement</p> <p>Fear of judgement / responses from others</p> <p>Do I just have to cope?: Internal versus external expectations and assumptions of motherhood</p>
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<p>Living a "gilded life". Your social class and lifestyle influence people's sympathy for and interest in your suffering. Is this particularly so when there is a significant difference in these factors within a family, in which the siblings were originally of the same class and way of life?</p> <p>"oh pull yourself together" – what does this mean? How does a mother do that? This statement may compare her to other mothers in a way that minimises and devalues her experience and implies she does not qualify for PND. Maybe this feared response caused her to not disclose her suffering anymore?</p> <p>Louise compares her own situations to her sister's situation. Do we rank situations of suffering in terms of perceived severity?</p> <p>Her parent's moved from south of England to the North of England to be closer to Grandchildren as Louise and her husband were not planning on having children.</p> <p>What is "this huge thing" she feels? Sadness? Loneliness? Abandonment? Loss?</p> <p>Feels isolated from family – did the fact her sister had her parents close by for support make it harder for her to hear their comments implying her situation does not qualify for suffering?</p> <p>"feeding off their own ideas" – Did she feel that the distance means they don't fully understand her?</p>	<p>worrying" so there would be, I haven't even bothered talking to them about it</p> <p>R: And, err, wh- when you sort of erm, err, talk about them in that way is that, is that the voice of a particular parent or both parents or everybody in the family or particular people?</p> <p>LOUISE: I'd say everybody in the family, (R: Right) erm my parents used to live down here as well in [Southern County], (R: Right) and a couple of years ago or 3 years ago they retired up to my sister's in [Northern County] she's got 2 children and we weren't going to have any children, erm, so yeah you feel this huge thing that instead of my parents would have been down here with us, (R: Mm) they're now sort of all, clumped together up there, so they're all feeding off their...</p> <p>Mobile phone bleeps</p> <p>LOUISE: ...own ideas and whatever, and I feel...</p>	<p>Cautious, trial and error approach to disclosure</p> <p>Importance of social support and independence</p> <p>Fear of judgement / responses from others</p>
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<p>Feels isolated from family.</p> <p>Expectation that a disclosure of PND would be laughed at by her sister, despite her sister working as a Social Worker (caring profession).</p> <p>Would her expectation have matched up to reality? Did initial comments made by family members lead to her assuming that disclosure of PND at any point in time and to anybody in the family would leave her feeling "silly" / "isolated" / not entitled to PND?</p> <p>Comparison to another mother.</p> <p>Why is it not worth saying anything? Is disclosure only worth it if you get the 'right' response / support from people? Disclosure is a two-way process?</p> <p>Louise had not previously turned to family members for emotional support – is this representative of her internal dilemma of Self-reliance versus seeking help from others?</p> <p>Repetition of one-word answer "No" – is this expression how difficult it is for her to talk about the difficult feeling she has towards her family?</p> <p>She only became close to her sister when her sister moved away to university, but the distance this created reduced their contact, which led to them talking just about "the nice bits" of their lives when they</p>	<p><i>Mobile phone bleeps</i></p> <p>LOUISE: ...in somewhat quite isolated being down here from them now</p> <p>R: Yep, erm, and how would, do you think they would react if you were to tell them now, that you erm, had suffered with postnatal depression?</p> <p>LOUISE: But I think my sister would just laugh at me, (R :Right) to be honest, erm, and she, she's a social worker, but she deals with erm, old people, (R: Right) erm, and even though she does that I think she'd probably, just laugh at me and just say "well look what I've had to cope with for the last 18 months with her little boy", (R: Mm) and it's just not even worth saying anything</p> <p>R: Ok, erm, (slight pause) did you used to turn to those people though in the past?</p> <p>LOUISE: No</p> <p>R: For any other emotional difficulties?</p> <p>LOUISE: No</p> <p>R: No, ok, so nothing changed then necessarily?</p> <p>LOUISE: No</p> <p>R: Ok</p> <p>LOUISE: No I mean I've been close to my sister but, she erm, erm, we never got on until she</p>	<p>Importance of social support and independence</p> <p>Fear of judgement / responses from others</p> <p>Other mothers as a source of support but also comparison / judgement</p> <p>Comparison to other mothers</p> <p>Cautious, trial and error approach to disclosure – weighing up whether it's worth it</p> <p>Consistency of confidant</p> <p>Disclosure influenced by emotional and physical closeness versus distance</p>
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<p>spoke. This may have set up a pattern / way of communicating which removed / reduced space for discussion about difficulties and suffering. This may also be representative of how difficulties are managed and talked about within the family, or more specifically Louise's cautious approach to disclosure.</p> <p>Louise's sister felt Louise did not understand her experience. Louise also felt this about sister. Does this have something to do with sibling rivalry? Comparison of who was suffering the most. Neither sister could be there for the other due to own suffering. Also strikes a chord with her earlier description of feeling unable to speak out or ask for help, as well as wanting to be asked.</p> <p>Laughter – defence against difficult feelings?</p> <p>Absence of support from family-in-law as well as her own family.</p> <p>Laughter – defence against difficult feelings?</p> <p>Louise and her husband both have strained relationships with their siblings.</p> <p>Isolated from sources of support.</p>	<p>left university she is 3 years younger than me, (R: Mm) and when she went to university erm up north and then she never came back down, (R: Right) so we're quite close but we don't get a huge amount of time to, talk or anything like that so you just sort of talk about the nice bits.</p> <p>(R: Mm) erm she did have a go at me over Christmas actually that I didn't understand what she was going through and she was quite shocked, (R: Right) erm, you know that I hadn't been more supportive or anything else, and it's just like "hold on I've had a baby" (R: Mm) you know and I wasn't really quite sure what I could have done, erm, but it's just, oh you sort of think ok fine yeah, (R: Mm) you know, I'm trying (gives a small laugh)</p> <p>R: Yeah, erm, (pause) and, so it had, it'd, it...</p> <p>LOUISE: Oh and my husband's family his mum's well, she's now dead she was 87 (R: Right) so there was no (laughs) way any, any of them were going to sort of come down and help (R: Mm) they're in [Northern County], (R: Right) erm, and his sister they don't get on terribly well so (R: Mm) yeah, we're sort of quite isolated down here</p> <p>R: Do you think h- erm, if you had been able to disclose to your family, either side of the family or both, that that made a, may have made things easier?</p>	<p>Disclosure as a two-way interpersonal process</p> <p>Other mothers as a source of support but also comparison / judgement</p> <p>Do I just have to cope?: Internal versus external expectations and assumptions of motherhood</p> <p>Importance of social support</p>
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<p>Geographical distance from family members influenced her ability to disclose to them and seek emotional as well as practical support.</p>	<p>LOUISE: Erm, if they lived around here and I had the (drags out word), I had them closer probably yes</p> <p>R: Right, and would that be for the practical help, erm?</p> <p>LOUISE: Erm practical and emotional</p> <p>R: And emotional</p> <p>LOUISE: Yep</p> <p>R: Yeah, (inhales) and erm when you're on the phone to your sister at Christmas, erm, what would you have like to have said to her about perhaps your experience or being a, a, a mum and maybe some of the difficulties you'd have had?</p>	<p>Disclosure influenced by emotional and physical closeness versus distance</p>
<p>What would have made it worthwhile?</p>	<p>LOUISE: Err it, it wouldn't have even been worth going there</p> <p>R: Really yeah?</p>	<p>Cautious, trial and error approach to disclosure – weighing up whether it's worth it</p>
<p>Comparison between sisters of the severity of their situations. A continuation of sibling rivalry? Would equity unite them?</p>	<p>LOUISE: Yeah, (R: Ok) erm, and you know and, and erm I, [Child's Name] was in erm, Great Ormond street for a week after she was born, (R: Mm) so my sister sort of given me a bit of a dig about that as well, and it's sort of, well you know it, it's again well what does she want me to do? (R: Right) you know or, I think her thing was that my son could die, yet I just want to talk to someone openly about it, 'cause I think everybody is just like, always trying to say the positive, (R: Mm) "oh don't worry [Sister]</p>	<p>Other mothers as a source of support but also comparison / judgement</p> <p>Comparison to other mothers</p> <p>Others' responses as normalising versus minimising</p>

<p>Louise's sister wanted to be listened to, feel validated, not minimised – similar to Louise herself.</p> <p>Comparison and entitlement.</p> <p>"Lucky" – comparing her situation to that of other mothers</p> <p>Hesitant repetitions "erm" and "err" – Does this section of her journey into motherhood still require some processing? Or just difficult emotionally?</p> <p>Contradiction regarding choice in birth – does this represent her struggle with her inability to "push a baby out" or her lack of choice in the birth method make her feel before she had already become a mother? How was her identity as a mother affected?</p> <p>Unable to recall how long she was in hospital following a c-section. What does this suggest about how unprocessed this time was? Why is that?</p> <p>How did a week at [specialist hospital] affect her, her baby, and her bonding with her baby?</p>	<p>there's only a 40% chance he might live but, you know, don't worry about it I'm sure it'll all work out", whereas I think she, all she wanted was somebody to listen to her, (R: Mm) and say "yes he could die you're right" (R: Mm) you know, or have a big hug about it, I think that's what she wanted, erm, (sighs) but I don't know, I'm, there was nothing wrong with [Child's Name], someone panicked at [hospital] when she was born, erm, so again we were quite lucky that, there was nothing wrong with her</p> <p>R: Right, erm, n- and on just thinking 'cause you did say that when she was born (LOUISE: Mm) it was by a C-section, (LOUISE: Yeah) erm, and, did you, looking back, do you find the birth experience, erm, h- might have contributed to, to emotional difficulties?</p> <p>LOUISE: No</p> <p>R: Or anything that happened after the birth and the hospitalisation?</p> <p>LOUISE: Erm, (sighs) I would have said not, (R: Right) err the birth was err the C-section was my choice, erm I'd had a prolapsed operation err the year before, (R: Mm) so I knew I couldn't physically push a baby out, (R: Right) so I really had no choice in the C-section, (R: Ok) erm and that was brilliant the care at [hospital] was shocking. (R: Mm) but you're only there for 24 hours or 48 hours, erm, and then at [specialist hospital] for a week but I wouldn't say that was...</p>	<p>Exploring explanations for suffering</p> <p>"I'm far luckier": Questioning entitlement to have PND</p> <p>I really had no choice: Powerlessness within the birthing process</p> <p>Surprised at postnatal care - Reality of postnatal care not matching expectations</p>
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<p>"Everybody" – were there any exceptions?          "you've actually done nothing" – did she feel her needs were ignored and her experience minimised? How did this affect her identity as a mother?          How was it that people treated her to make her think this?          Repetition of "stomach slit/cut open" – is she trying to emphasize what having a caesarean operation involves to counteract her sense of having her needs ignored following the birth?</p> <p>Double edge sword of being in hospital following her c-section.</p> <p>Reassurance.          Unsure.          "comforting". Is this a time when mothers need to be comforted by others?          What does she mean by "It's like Oh my god"? Were her expectations of the birth and initial postnatal period not met?          The majority of this response focuses on the positive aspects of her being in hospital following her birth experience, particularly in terms of the support and care she received. This was clearly of importance to her. Did she not expect to receive this care at home due to absence of family support?          She recalled a "lady" (nurse) helping her to change her baby in the night when she did not know what to do. Was there an absence of maternal figures in her life outside of the hospital?</p>	<p>R: What was that like though going to [specialist hospital] having sort of just given birth?</p> <p>LOUISE: That was, (sighs) erm, in some ways quite strange because everybody treats you as though, you've actually done nothing. (R: Mm) as in, you know I'd had my stomach slit open and, I then ended up having to, apart from the first night, sleep on a sofa bed, (R: Right) next to my daughter and then trying to get up and get down, (R: Mm) when you've had your stomach cut open was quite, hard, but in some ways it was reassuring because you had so much care and, and, and you know during the night if I was unsure of anything there'd always be a nurse there, (R: Mm) erm, so that side of it was really nice, (R: Yeah) and comforting. (R: Right) erm and she was sick on herself one time and a lady oh a nurse came and changed her for me and, (R: Mm) 'cause I'm like oh my god I don't know what to do, A. I'm a new mum and B. It's like Oh my god. (R: Mm) erm so in some ways that was actually really quite, positive, (R: Ok) erm, and they just kept her in because I think they just wanted to be sure that there was nothing wrong</p> <p>R: Right, yeah, and erm, so you talked about yourself as being, kind of, quite a strong person, and then became, felt weaker (LOUISE: Mm) when you were suffering from postnatal</p>	<p>Normalisation versus minimising from others          A mother's needs are ignored</p> <p>Hospitals as reassuring versus invalidating</p> <p>Importance of practical support          Looking after the baby is "down to me":          Adjusting to the new role of motherhood</p>
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<p>Hesitant repetition – I struggled to formulate this question, perhaps trying to focus on too much rather than breaking down question into stages of identity change. Influence of my own change in identity?</p> <p>Hesitant repetitions and pause. What is she struggling to articulate? Maybe a struggle with understanding the question?</p> <p>Change from talking about self to collective. The answer minimises her own strength or does she gain strength from viewing herself as part of a collective?. Comparison to others.</p> <p>Contradiction to earlier description of feeling stronger after “conquering” PND. Instead, she recalls feeling strong when she gave up smoking and coordinated a bathroom refitting whilst pregnant – influence of societal ideas of what makes a strong woman?</p> <p>“you cope with that and you get over it” – where does that message come from for Louise (e.g. family? Society?)? She appears to have internalised messages about coping from other mothers, mentioned earlier in the interview. Her sister’s child was not “fine” medically so was she ‘entitled’ to the sympathy and support as a mother from her family - which Louise felt she would not receive?</p> <p>Silent / invisible suffering.</p>	<p>depression and became stronger again, erm, did the w- erm, did the strength change did it, did you feel stronger in different ways erm, did you see yourself actually different even though you might still be a strong person, after the postnatal depression, as you were before hand, did you see yourself in a different way?</p> <p>LOUISE: No, No, I, I would say (small pause) not, (R: Mhmm) erm, ‘cause I, I know that we are all far more capable of doing things than, than we give ourselves credit for, (R: Mm) erm, and, I, no so I would say I wouldn’t, I didn’t feel any stronger, because I’d overcome it because it’s, I gave up smoking I, while I was pregnant actually refitted a bathroom at my flat, I didn’t physically but I got everything there and coordinated all of that and, beforehand you sort of think oh my god I could never have done that, so, we can all do things that we, need to do and you know again you, you know you’ve got a baby they suddenly think is very sick and could die, you know you cope with that and you get over it, you know and, baby’s fine, so again it’s, you know that you can deal with things</p> <p>R: Mhmm, (inhales) erm, do you think other people saw you differently?</p> <p>LOUISE: No, ‘cause no-one really knew I was suffering from anything (R: Mm) so they wouldn’t have even</p> <p>R: Those who you disclosed to would they have erm, would they have seen you, oh sorry do, do</p>	<p>You know you can deal with things: Strength both cause and result of overcoming difficulties</p> <p>Do I just have to cope?: Internal versus external expectations and assumptions of motherhood</p> <p>Trying to be the coping mother</p> <p>It’s not really spoken about</p>
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<p>I did not let Louise finish answer – Was I wanting to hear that her identity did change in the eyes of others?</p> <p>Why did Louise become aware of /speak of her need to pause the interview to use the toilet at this point? Did she feel a need to punctuate the interview here? Or simply need “a wee”?  “yes no...” contradictory answer – did I feel dissatisfied with previous answers? Or frustrated at the break in the interview?</p> <p>Doing this interview was experienced as insightful and helpful by Louise. Link between these two qualities. Emphasises the role of disclosing and discussing suffering in processing and gaining insight into experience.</p> <p>Participant sees the benefit to others of disclosure and sharing of experiences, i.e. greater understanding and subsequent action. Participating in a research study involves disclosure and publishing data which includes accounts of their lived experiences. Why is it that the participant can share their lived experiences on such a wide scale after they have recovered from PND but struggle to do so whilst suffering? Is it because they are aware they are anonymous?</p>	<p>you know that they saw you in a different way, in terms of something they might have said or the way they behave towards you?</p> <p>LOUISE: No, not at all</p> <p>R: No, erm</p> <p>LOUISE: I’m just going to have to go and have a wee</p> <p>R: Yes no that’s fine I’ll pause the interview, ooh</p> <p><i>Can hear movement before the recording is paused at 1:06:19</i></p> <p>R: Erm, so, I guess one of the, my final sort of few questions is erm, how did you find the interview today?</p> <p>LOUISE: Erm, insightful, helpful, erm, good to, well I hope I can be help, help in your study that I suppose, eventually will be able to I don’t know help other people or get a truer understanding of postnatal depression so that actually something can be (R: Mm) properly done about it.</p>	<p>Voicing it and being heard as reflective and transformative process</p> <p>Disclosure facilitates opportunities for solutions</p>
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<p>Joint roles of both a mother and health professional in the disclosure process acknowledged. Louise suggests greater responsibility of health professional compared to mother in facilitating disclosure. "done at source" – disclosure at the point where mothers and health professionals are in contact with each other.</p> <p>She appears surprised by the clarity of her answers and descriptions / accounts. Did her lived experience seem chaotic in her head but through discussing it seemed clearer? Avoidance of this interview – avoidant of the content or of the emotion? Interview has helped her to 1. Get in touch with, 2. Voice, 3. Understand, and 4. Process her true emotional experience</p> <p>"consistent run" – the interview provided her with enough space to continuously process her lived experience - perhaps conversations with people don't fully provide this?</p>	<p>R: And what would you hope would come, would be done about it and come from this interview?</p> <p>LOUISE: That more people feel able to talk about it, or to, I don't know have their health visitors raise it so if something's done at source, erm instead of perhaps the person who needs the help actually having to seek the help out the help can come directly to them, (R: Right) without them having to do anything.</p> <p>R: Right, ok, erm, and you said you found it insightful and helpful, erm, in what way did you find it insightful and helpful?</p> <p>LOUISE: Erm, I, would, say, (pause) that, I've been able to, say things quite clearly, I haven't really thought about this interview at all and was (R: Mm) just sort of thinking oh gosh you know how do I really feel or anything like that so I, it, it's helped me to voice what I was actually feeling, (R: Mm) erm, and to then understand those feelings so, you've then got a sort of, consistent run or you can understand so you got a, you can then process everything yourself</p> <p>R: Mhmm, and what was it like being interviewed by another woman?</p> <p>LOUISE: Fine</p> <p>R: Was that not something you'd thought, you thought about?</p>	<p>Disclosure facilitates opportunities for solutions</p> <p>They're within your arms' reach: Desire for professionals to simply ask</p> <p>Disclosure as a two-way interpersonal process</p> <p>Voicing it and being heard as reflective and transformative process</p>
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<p>Importance of shared experience for disclosure.</p> <p>Less importance placed on shared experience if a health professional?</p> <p>Contradicts earlier statements about importance of shared experience for disclosure – but perhaps not in professional contexts? Is it professional position / status / manner that becomes the important factor?</p> <p>How “good” the professional is judged to be is important.</p> <p>Gender (and therefore shared experience) viewed as a less important factor if professionally “good”.</p> <p>Repetition of single word “No” – is she starting to think about the interviewer as a mother, which she hadn’t previously done?</p> <p>Shared experience (mother to mother) not as important as personal characteristics of the person you are disclosing too – e.g. judgemental? A doctor should not judge her.</p>	<p>LOUISE: Erm, I’ve hadn’t really thought about, that I suppose, a man wouldn’t really have the understanding, but then I don’t mind seeing a male doctor or, or, anything like that</p> <p>R: Would you see a male doctor about postnatal depression?</p> <p>LOUISE: Probably yes because my doctor’s male and I would have spoken to him about it</p> <p>R: Ok</p> <p>LOUISE: ‘Cause he’s a good doctor</p> <p>R: Right</p> <p>LOUISE: So I don’t think sex matters (R: Mmhmm) in that case</p> <p>R: Erm, did it have any impact on the fact that you knew I was a mother or on perhaps your answers or?</p> <p>LOUISE: No, no</p> <p>R: You weren’t aware of it ...</p> <p>LOUISE: No</p> <p>R: ...yourself as you were going along? Ok...</p> <p>LOUISE: And in some ways it might be easier to talk to a man about it, because women I feel can be very judgemental even though a doctor probably shouldn’t, (R: Mmhmm) erm, you sh-</p>	<p>Gender as a potential barrier to shared understanding: Men may not understand but women may be judgemental</p> <p>Deciding to disclose: Preferred characteristics of the confidant across contexts</p> <p>Gender as a potential barrier to shared understanding: Men may not understand but women may be judgemental</p>
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<p>Why did she feel a man would not judge her? Or why would she be less affected by male judgement?</p> <p>She was not worried about judgement by female interviewer. Does the context of an interview reduce worry about being judged?</p> <p>Hesitation. Was I trying to decide whether to explore any further points before final question of interview?</p> <p>For Louise, seeking emotional and practical help are ways to overcome PND. Is it easier to accept that disclosure and seeking support is the right path to take when you are no longer suffering from PND, compared to when suffering?</p> <p>Practical support is needed to help a woman overcome PND.</p>	<p>I, yes probably to be honest probably would rather talk to a man about it</p> <p>R: Mm, erm, and, obviously we've talked about judgement today and you mentioned it then, did you feel any point that doing this, that I might have judged you or that you were aware of any particular points that you were saying something I might judge?</p> <p>LOUISE: No</p> <p>R: Right</p> <p>LOUISE: I didn't worry about that</p> <p>R: Yeah, erm, and I err just finally then, I just wondered, erm, if there's anything that you would like erm, to add erm, or think might be helpful for me to know? Anything, anything else that we haven't covered today?</p> <p>LOUISE: Erm, (pause) no, I don't think there is I would just say that erm, a way to overcome it though is to get, help of, of (R: Mm) any sort, (R: Ok) whether that's, I mean preferably not pills for a lot of people but emotional help, and physical help</p> <p>R: When you say physical help do you mean help do you mean for erm, in terms of the woman's health or in terms of erm, practical help?</p> <p>LOUISE: Practical</p>	<p>Deciding to disclose: Preferred characteristics of the confidant across contexts</p> <p>Importance of social support</p> <p>Avoidance of professional support</p> <p>Importance of practical support</p>
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<p>She needed independence and separation from the child. Emphasis on "need". What function does this serve? Did it help this mother get back in touch with her pre-motherhood identity? Is identity divided into separate parts (e.g. identity as a mother, as a career woman, as a wife, as a family member, as a friend, as a woman) and we need to get in touch with each part at different times? Or is it a whole, which evolves and is updated with new life experiences? So is part of the struggle in PND the need to get away from the baby / motherhood and reconnect with parts of identity, or a resistance to identity as a mother which means it cannot merge with overall whole identity.</p> <p>Conditions to accepting practical support.</p> <p>Mutual confidence and therefore trust is required.</p> <p>Louise could have accepted help but struggled to ask for it at the time.</p>	<p>R: Practical help, so yeah</p> <p>LOUISE: Even just you know coming in and, somebody looking after your child so you can just pop out to the shops on your own (R: Mm) sometimes that's just all you need, (R: Mm) is a little bit of space then you can regroup yourself, (R: Mm) and you come back feeling much better</p> <p>R: And had someone offered you that help, would it have depended who offered you the help, for you to be able to take it?</p> <p>LOUISE: I (sighs) I'd say that you've probably got to get to know that person to then trust them with your child but you can also get an instinct of to no I think this person's going to be fine, (R: Mmhm) also it comes, it, I would say it depends on how confident they are, (R: Mmhm) and if they're confident they can look after your baby even if the baby cries, (R: Mmhm) then you're quite likely to trust them</p> <p>R: And if you think back to when you were suffering with postnatal depression, and someone would have offered you (LOUISE: Mm) help in terms of looking after the baby, erm, do you think you would have accepted it?</p> <p>LOUISE: Yes</p> <p>R: Yeah, so it is about some practical support and getting that break...</p>	<p>Importance of social support and independence</p> <p>Getting back to me: Connecting with multiple identities</p> <p>Confidence and trust as requisite for practical support</p>
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<p>Repetition of "yes" – emphasizing the importance of practical support having a break for her</p> <p>Time alone, not just away from child.</p> <p>Asking for childcare support from people she knew felt like she was relying on others, but not when she left her baby with someone she did not have a personal relationship with. What made her feel better about this? Why did it make her feel more in control? Was it because she was making a decision about time away from her child without judgement from someone she had a personal relationship with? Perhaps it was because she was obtaining a paid independent carer and so remained in control / autonomous? Or possibly about the stigma / fear of judgement around asking for help?</p> <p>"I was quite good" – why did she feel she was "good" for leaving her baby and having some time to herself? Was it something she struggled with but was able to do to meet her need for independence? Where does the idea this is "good" come from for her? Maybe she wanted her child to be independent too - like her?</p> <p>She needed to start being able to leave her baby.</p> <p>Independence from her baby was very important to her but she appreciates others feeling differently about leaving their child.</p> <p>"chained to their, child" – imprisonment, inability to escape. Removes element of choice other mothers have to be independent from their child.</p>	<p>LOUISE: (speaking over R) Yes, yes</p> <p>R: ...you mentioned earlier</p> <p>LOUISE: And it's probably, it's not even a case of going to friends, 'cause I've got lots of friends here who, who you know all I need to do is pick up the phone and say (R: Mm) "can you look after [Child's Name]?" or you know, they would have done it but it was, again you are, you're then having to rely on somebody else, (R: Mmhm) whereas if you've got somebody who you're doing it independently of, (R: Mm) then you feel much better and more in control</p> <p>R: Right, ok, that's really interesting</p> <p>LOUISE: But I was, I was quite good and I left [Child's Name] for the first time when she was 3 weeks old, (R: Ok) erm, with our cleaner, 'cause I knew I needed to start being able to leave her, erm, and I did I just went out and had a coffee for an hour and came back, (R: Mmhm) erm and that was something that I started straight away, whereas I've got friends now whose babies are 9 months and they haven't left them with anybody, (R: Right) you know they haven't had a, an evening out you know with their partners or girlfriends they're sort of, completely chained to their, child they they've, happy to do it, (R: Mm) but they haven't had any time for themselves</p> <p>R: But for you that was important?</p>	<p>Importance of social support and independence</p> <p>Self-reliance versus seeking help from others</p> <p>Importance of social support and independence</p> <p>Social comparisons</p>
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<p>Time to herself.</p> <p>The interview was experienced as "concise" and the questions as "very thought through". The interviewer was judged as being good at moving from point-to-point and linking parts of the interview up.  <i>Why is she praising me at this point – unsolicited? Wants to show me that she isn't judgemental, but actually is making a judgment of me? Or was she grateful for me helping to bring this new understanding / insight?</i>  <i>Laughter – does this represent my relief and happiness at Louise's experience of interview?</i>  <i>Reciprocated laughter. A light way to end an interview regarding emotional struggle.</i></p>	<p>LOUISE: Yes</p> <p>R: Time for yourself</p> <p>LOUISE: Yeah</p> <p>R: Yeah, ok, that's really good to know, erm, and is there anything else you would like to add or, anything you think I've missed?</p> <p>LOUISE: I don't, think so it seems very concise and all the questions that you have asked seem very thought through, (R: Mm) and you seem very good at going from one point and then coming back to another and sort of linking everything up</p> <p>R: Good, yeah, I'm pleased you experienced me that way (laughs)</p> <p>LOUISE: (laughs)</p> <p>R: Ok, thank you very much <i>(Recording ends 6:19)</i></p>	<p>Voicing it and being heard as reflective and transformative process</p>
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### 8.11.2 Appendix 11b: Preliminary list of emerging themes for Louise

#### PRELIMINARY LIST OF EMERGING THEMES, PRESENTED IN ALPHABETICAL ORDER

- A mother's needs are ignored
- A possible disconnection from suffering
- Assumptions about professional care hindering help seeking
- Avoidance of professional support
- Being "hit" by losses and changes: Adjusting to the new role and uncertainty of motherhood
- Cautious, trial and error approach to disclosure
- Coming to terms with loss / grieving lead to feeling better
- Comparison to other mothers
- Concern about impact of disclosure on others
- Confidence and trust as requisite for practical support
- Conquering PND: Easier to disclose following recovery
- Consistency in confidant
- Deciding to disclose: Preferred factors about the confidant across contexts
- Defining the problem makes you feel better
- Diagnosing self
- Disclosing to people on your level
- Disclosure as a two-way interpersonal process
- Disclosure enabling the possibility for solutions
- Disclosure facilitated through shared experience
- Disclosure facilitates opportunities for solutions
- Disclosure influenced by emotional and physical closeness versus distance
- Distance from new motherhood increases compassion and openness
- Do I just have to cope?: Internal versus external expectations and assumptions of motherhood
- Don't even touch me: Having to manage reduced desire for intimacy with partner
- Dying to talk to somebody in a professional role
- Expecting to be seen differently by others following disclosure It's not really spoken about
- Exploring explanations for suffering Fear of judgement / responses from others
- Feeling completely out of kilter
- Feeling very down and tearful
- Friend as first confidant about thoughts of infanticide
- Gender as a potential barrier to shared understanding: Men may not understand but women may be judgemental
- Getting back to me: attempting to stay connected with pre-motherhood 'normality'
- Getting back to me: Connecting with multiple identities
- Getting cross with people close to you
- Guilt at not speaking out
- Harder when support is available but not given / received
- Hospitals as reassuring versus invalidating
- Husband as first confidant about low mood
- I can't do this: Struggling with transition to motherhood
- I really had no choice: Powerlessness within the birthing process
- I'd have failed: Seeking professional support as last resort
- "I'm far luckier": Questioning entitlement to have PND
- Impact of disclosure on marital relationships
- Needing the right social context for disclosure to occur
- Negotiating parental responsibilities
- Normalisation through shared experience
- Normalisation versus minimising from others
- Oh we can't do that: The impact of boundaries of health professionals' roles
- Older age & distance from new motherhood increases compassion and openness
- On the edge versus falling in
- Other mothers as a source of support but also comparison / judgement
- Others' responses as normalising versus minimising

- Importance of having a break
- Importance of partner support
- Importance of practical support
- Importance of practical support and independence
- Importance of social support
- Importance of social support and independence
- Internal versus external expectations and assumptions of motherhood
- Isn't there something else I can do?
- It's always there: The stigma of mental health issues
- It's like putting a coat of armour on: Façades as internally and externally protective
- Looking after the baby is "down to me": Adjusting to the new role of motherhood
- Making sense of one's experience before disclosure can occur
- Minimising difficulties associated with PND
- Needing a break but struggling to ask for one
- Trying to be the coping mother
- Trying to understand and define experience
- Voicing it and being heard as reflective and transformative process
- Weak PND self vs. the empowered recovered self
- Withdrawal when don't feel like I fit in
- You know you can deal with things: Strength both cause and result of overcoming difficulties
- Overwhelmed by responsibility and control over the baby's life
- Preferred characteristics of the confidant
- Reciprocal nature of disclosure
- Self-reliance versus seeking help from others
- Shared experience of 'weaknesses' promoting disclosure
- Social comparison
- Surprised at how little care you get - Reality of postnatal care not matching expectations
- Surprised at postnatal care - Reality of postnatal care not matching expectations
- The importance of support and independence
- The unprejudiced impact of PND
- They're within your arms' reach: Desire for professionals to simply ask
- Thoughts of infanticide experienced as worst part of PND

8.11.3 Appendix 11c: Final list of emerging themes for Louise

<b>FINAL LIST OF EMERGING THEMES</b>	
<b>Assumptions about care pathway hindering help seeking</b>	<b>On the edge versus falling in</b>
<b>Cautious, trial and error approach to disclosure</b>	<b>Preferred factors about the confidant</b>
<b>Concern about impact of disclosure on others</b>	<b>Self-reliance versus seeking help from others</b>
<b>Disclosure facilitates opportunities for solutions</b>	<b>Shared experience of 'weaknesses' promoting disclosure</b>
<b>Disclosure influenced by emotional and physical closeness versus distance</b>	<b>They're within your arms' reach: Desire for professionals to simply ask</b>
<b>Do I just have to cope?: Internal versus external expectations and assumptions of motherhood</b>	<b>Trying to be the coping mother</b>
<b>Dying to talk to somebody in a professional role</b>	<b>Voicing it and being heard as reflective and transformative process</b>
<b>Fear of judgement / responses from others</b>	<b>Weak PND self vs. the empowered recovered self</b>
<b>I'd have failed: Seeking professional support as last resort</b>	
<b>"I'm far luckier": Questioning entitlement to have PND</b>	
<b>Impact of disclosure on marital relationships</b>	
<b>It's like putting a coat of armour on: Façades as internally and externally protective</b>	
<b>It's not really spoken about</b>	
<b>Needing a break but struggling to ask for one</b>	
<b>Needing the right social context for disclosure</b>	
<b>Normalisation through shared experience</b>	

8.11.4 Appendix 11d: Clustering of themes for Louise

THEMES CLUSTERED TOGETHER			
Trying to just cope	Deciding whether to disclose: Facilitative and inhibiting factors	Disclosure as a two-way interpersonal process	Disclosure as part of a reflective and transformative process
<ul style="list-style-type: none"> <li>• On the edge versus falling in</li> <li>• Dying to talk to somebody in a professional role</li> <li>• Needing a break but struggling to ask for one</li> <li>• Do I just have to cope?: Internal versus external expectations and assumptions of motherhood</li> <li>• I'd have failed: Seeking professional support as last resort</li> <li>• Self-reliance versus seeking help from others</li> <li>• It's like putting a coat of armour on: Façades as internally and externally protective</li> <li>• Trying to be the coping mother</li> </ul>	<ul style="list-style-type: none"> <li>• Assumptions about care pathway hindering help seeking</li> <li>• "I'm far luckier": Questioning entitlement to have PND</li> <li>• It's not really spoken about</li> <li>• Fear of judgement / responses from others</li> <li>• Shared experience of 'weaknesses' promoting disclosure</li> <li>• Preferred factors about the confidant</li> <li>• Concern about impact of disclosure on others</li> </ul>	<ul style="list-style-type: none"> <li>• Cautious, trial and error approach to disclosure</li> <li>• They're within your arms' reach: Desire for professionals to simply ask</li> <li>• Needing the right social context for disclosure</li> <li>• Disclosure influenced by emotional and physical closeness versus distance</li> </ul>	<ul style="list-style-type: none"> <li>• Voicing it and being heard as a reflective and transformative process</li> <li>• Normalisation through shared experience</li> <li>• Disclosure facilitates opportunities for solutions</li> <li>• Impact of disclosure on marital relationships</li> <li>• Weak PND self vs. the empowered recovered self</li> </ul>

8.11.5 Appendix 11e: Superordinate themes for Louise

Superordinate Theme	Subordinate Theme	Page: Line	Quote
Trying to just cope	On the edge versus falling in	15: 2-6	...it's just sometimes a feeling of, helplessness, that you can't, or there's, it's very difficult to get out of the black hole that you're... in and you're sort of teetering on the edge of it...
		16: 4-5	I felt I was on the edge, I didn't feel that I'd ever completely fallen in
	Dying to talk to somebody in a professional role	46: 26 47: 3	...whereas yeah I probably would have if I felt I could have spoken to them (Health Visitors) I might have then felt, or I if I'd have felt able to talk to them, I probably would have done, 'cause I think I was dying to talk to somebody in a significant role, that I was feeling like this...
	Needing a break but struggling to ask for one	9: 28 – 10: 5	But to anybody apart from those closest to you you sound like you don't love your child, if you admitted that to, anybody that would be the, but yes, I think everybody needs a break, even if it's just to go out and, and, be able to go and have a coffee on your own or just go and buy a pint of milk on your own, just to be able to have some time
	Do I just have to cope?: Internal versus external expectations and assumptions of motherhood	2: 24 - 3: 8	Erm, I think it's the whole, (small pause) stiff upper lip you should cope, even amongst my NCT class and things like that it's still oh you've had a baby you cope you manage, and it's sort of well hold on, do I just have to cope? you know isn't there something else I can do to, to, you know apart from pills or something or is this the rest of my life where it is <i>just</i> about coping and not enjoying it?
		37: 15-17	...trying to talk to the lady who organised one time about postnatal depression, her comment was "oh you just get on with it"
		46: 22-26	...I think that the, health visitors, and people who visit you to start with, don't really help, 'cause like "oh it's just the baby blues don't worry about it, you'll get over it"...

	I'd have failed: Seeking professional support as last resort	24: 11-20	That I'd have failed, I've never taken any pills or anything like that before and I don't know what the route is I mean my visions were you just went to the doctors and said "oh I've got postnatal depression" they just throw some pills at you, and I didn't want to, do that, I mean as a last resort I would have done but that's something I really really didn't want to do
		23: 22 – 24: 2	...I was thinking gosh well, you know I really really don't want to go down the road of going to the doctors and pills and you know I've got to try and, again sort this out myself so it's probably more of a challenge for me then to sort it out
	Self-reliance versus seeking help from others	16: 8-14	I, think my own, reserves, I've always been able to, if I've had a problem, be able to, sort out what it, what it is, or been upset or angry or cross, and then once you work through and you realise what the problem is then you feel a bit better
		20: 20-26	I was trying to manage by talking them through with myself, understanding what was wrong and knowing that, it wouldn't go on forever, and that if it got too bad there were options but those were routes I didn't want to go down so I was going to try and overcome it myself
		66: 4-13	...I've got lots of friends here who, who you know all I need to do is pick up the phone and say "can you look after [Child's Name]?" or you know, they would have done it but it was, again you are, you're then having to rely on somebody else, whereas if you've got somebody who you're doing it independently of, then you feel much better and more in control
	It's like putting a coat of armour on: Façades as internally and externally protective	27: 10-14	...everybody's trying to put this big smile on "oh no it's all fine, don't worry" and then this whole thing of just trying to push it under the carpet when actually it's real and it's not going to go away...
		39: 18-22	...if I looked presentable then I felt more presentable inside, whereas I think it's only once or twice when I've actually been out without mascara on,...

		39: 32 – 40: 4	...so if you look presentable on the outside then you feel a bit more, presentable- it's like buying, putting a coat of armour on or something
	Trying to be the coping mother	6: 24-30	Erm I felt I could cope (small pause) I felt I could cope very well, it was just the thought of, there's no-one now to look after [Child's Name], as in to get her up, and to do the other things so that's now down to me, it's not that I couldn't cope with it...
		9: 11-15	...I found the weekends harder, than during the weeks, 'cause I knew I was on my own I was quite happy with that, you get self-sufficient, you do everything you need to do...
		36: 10-13	[friend] would come over here, so you would be able just to s-, to say "look, you know I can't, cope you know", or, "I'm finding this really hard"
Deciding whether to disclose: Facilitative and inhibiting factors	Assumptions about professional care hindering help seeking	24: 11-16	I've never taken any pills or anything like that before and I don't know what the route is I mean my visions were you just went to the doctors and said "oh I've got postnatal depression" they just throw some pills at you
		41: 18-22	Because I thought that, whether it's wrong in thinking but I just thought he'd give pills to me straight away, and I probably actually didn't want that on my medical records either
		47: 22-24	...because counselling is about talking whereas going to the doctor would be about pills
	"I'm far luckier": Questioning entitlement to have PND	34: 9-25	...and I'm lucky that, that [Child's Name] sleeps through the night and she has done since she was sort of 10 weeks old, I stopped the dream feed when she was 4 months so from 4 months she's been sleeping, you know 12 hours a night, so, I'm very lucky, whereas a lot of women don't even have that, so again I don't want to talk about it a huge amount because I'm far luckier than, a lot of people so then there's this added thing like the "well your child's sleeping you're still not coping, what's wrong with you?" you know plus my husband helps an awful lot, so again it's you know, (laughs) it, it says you can't cope at all, and it's just like, so you'd feel even worse

		35: 10-18	...so if you suffer from postnatal depression you really should be quite on the edge as in single parent, having to work, you know and life should be <i>really really</i> hard for you to then suffer from postnatal depression 'cause you, you've got a reason not to cope, instead of, having a husband who helps, having a child who sleeps through the night
		53: 19 – 54: 2	... we're down here we're Southern, you know we've got loads of money and everything else and I've got loads of help, (said in a silly voice) whereas my poor sister's up there and her husband won't even let her have a cleaner, you know she's got a boy in hospital, one at you know he's young, so there's this huge sort of thing that you know we seem to live a gilded life and if I said "oh god I was suffering from postnatal depression" or anything it would just sort of be "oh pull yourself together" you know, it's, it's, "[sister]'s got it hard you haven't, stop worrying" so there would be, I haven't even bothered talking to them about it
		55: 12 - 16	I think she'd (sister) probably, just laugh at me and just say "well look what I've had to cope with for the last 18 months with her little boy", and it's just not even worth saying anything
	It's not really spoken about	2: 20-22	It's still not really spoken about even amongst friends unless you're very close, it's not even really mentioned
		26: 19-23	...I probably would find it easier to tell them I had an STD or something like that (both laugh) than admitting that, you know I was having postnatal depression and on antidepressants...
		27: 4-5	...the whole thing about postnatal depression <i>is</i> that it's not talked about enough,...
		31: 6-14	...she (a girl Louise was organising an event with) actually sent an email round just saying "girls I feel really down at the moment"... which is very honest, because no one else I know (said with a slight laugh) has ever done or said anything that- and even in conversations or when you meet people no-one ever says "I'm knackered I feel [swear word], I don't wanna do this"

		32: 27-28	Because again saying the words postnatal depression is, not acceptable
	Fear of judgement / responses from others	10: 12-19	I'd say it's other mums, and even people who aren't mums, I'd say it's everybody, like the way you bring up a child everybody thinks they have a, they're able to tell you what to do, even if they've got no experience, it's like it's everybody judging, everybody else
		26: 18-24	That they (people who have never had depression, taken antidepressants, had children...) would look at you in a completely different way and I probably would find it easier to tell them I had an STD or something like that (both laugh) than admitting that, you know I was having postnatal depression and on antidepressants because the whole thing is you obviously then can't cope
		28: 22-26	I was worried that <i>he</i> (husband) would then think I couldn't cope, or I was then seriously <i>losing</i> it and then he... yes, so then that's, that's why I didn't tell him until many months afterwards
		42: 3-9	...it's always there (antidepressant prescription on medical records) and if you've got mental issues to start with, then if anything happened to your child, or you, I, you know they broke a limb or something or you then, you know then it, it's just like "aha" flagged up and, so you think if it's not there in the first place, then
		55: 8-15	But I think my sister would just laugh at me, to be honest, and she, she's a social worker, but she deals with old people, and even though she does that I think she'd probably, just laugh at me and just say "well look what I've had to cope with for the last 18 months with her little boy"
	Shared experience of 'weaknesses' promoting disclosure	18: 8-17	they've had problems as well so it's not like talking to somebody who you've sort of, put up on a pedestal who you idolising, you then don't want to show your weaknesses to, they're happy to show their weaknesses to you as well, so it's sort of, reciprocating because you say "oh god yeah I've got this wrong" then you know, but it, it's just being able to talk to somebody on your level

		25: 9-13	she's (friend) the only one I've told apart from my husband, but she's been on and off pills her entire life, she's led quite a wild life, she's more open about things like that
		26: 4-9	And speaking to much older mums like the other ladies I know from [affluent town] they're in their 50s, speaking to, them there's a couple who're on antidepressants now, so I feel I can speak to them about it
	Preferred characteristics of the confidant	11: 1-10	So I'd say the people who are closest to you in age are probably more judgemental, the older ladies who I know here in [affluent town] have been great, but they're in their 50s and their children are now off at University, and it, it's just like you know, "you do whatever you need to do", whereas the younger ones are just like, "oh that's not very good is it" you know or
		11: 23 – 12: 2	...anything under the sort of, anything under the thirty-five mark, the more judgemental, the ones who are slightly older, you know, or have had their babies, closer to my age we're probably more open and honest with each other and will say "actually I'm finding it really difficult", whereas the other ones that are younger you, you wouldn't even, say anything to
		40: 26 - 41: 3	...I would say only probably, one or two people and actually they haven't got children so you sort of think, I won't bother going there because you haven't got children so you'd never even begin to, understand
		63: 2-4	...a man wouldn't really have the understanding, but then I don't mind seeing a male doctor or, or, anything like that
		63: 21 - 64: 2	And in some ways it might be easier to talk to a man about it, because women I feel can be very judgemental even though a doctor probably shouldn't, you sh- I, yes probably to be honest probably would rather talk to a man about it
	Concern about impact of disclosure on others	28: 10-16	...I only told him (husband) about wanting to kill [Child's Name] about 5 months after I felt it, when it was way in the past and there was no danger of me, 'cause I didn't want

			him to then start panicking, then coming home from work early so he could bath [Child's Name] so
Two-way interpersonal nature of disclosure	Cautious, trial and error approach to disclosure	23: 4-12	I would say apart from speaking to my husband I would say, (pause) I mentioned it vaguely to a couple of other people but th-, they were sort of very, there was only one girl I know who, not the one who had it herself who sort of said "oh god poor you I hope you're alright", whereas a couple of other people I tried to start talking to about it didn't even want to begin the conversation
		23: 16-19	Whether they were having it (PND), as well, or didn't want to say anything, 'cause I did try a few times and it just, then didn't feel right so I then just didn't, carry on
		33: 25 - 34: 9	...it was sort of a few people, 'cause you sort of start hedging round the conversations by saying "gosh I'm finding this really hard" and then depending on what people say or if they come back and say "yeah w- it is hard but we all get on with it" and you're like ooh ok won't take this any further, and you know and, yeah trying to find people who you could sort of go, speak a bit further with was hard, 'cause then you're rebuffed right at the, very beginning,...
		37: 25 - 38: 5	...I just sort of mentioned it (PND) 'cause she (another mother) came over here one time for a coffee morning and I just sort of mentioned it going out to the car and saying "oh my god" you know "I don't know how I'd cope if my child was up all night or if I wasn't very well" and she said "well you just do don't you" and it's just like, ok, alright so it's, and I went to a few more after that and it's just like, mm, not again...
	They're within your arms' reach: Desire for professionals to simply ask	48: 8-18	...but it's all the health visitors that when you do see them they're there they're in your arms reach to talk to them about and I think if they came up to you and, and said "are you feeling alright?" or "do you think you're suffering from postnatal depression or is there anybody here who does?" then you could've put your hand up, or something like that, instead of having to go to them and say, "I think I'm suffering from postnatal depression" ...

		50: 9-12	Yes, but then again I could have followed it up myself and I didn't, but I would have probably found it easier if <i>they'd</i> have followed it up
		50: 21 -26	Yes I (Louise thinking of herself in the position of a Health Visitor) would just saying "are you still having problems? Is this alright? Would you want somebody to talk to?" or, whereas, it was never mentioned again, and I, I didn't mention it either
		62: 5-10	...I don't know have their health visitors raise it so if something's done at source, instead of perhaps the person who needs the help actually having to seek the help out the help can come directly to them, without them having to do anything.
	Needing the right social context for disclosure	48: 18-25	...there was never, quite the right time you then couldn't get them on their own, or, you didn't really want to sort of, admit to the entire room, you know but it was, I think if, yes if there was some way of individually doing it, or when you get your baby weighed then they then spoke to you like that as well
		51: 5-13	several times I went to, like baby massage and I wanted then to try and catch one of the ladies on their own afterwards, but they were never, (sighs) on their own just to say "look, I think I'm suffering from postnatal depression, what can I do?", but I never managed to get them on their own and by then I sort of thought well I'm feeling a bit better so I'll leave it
		30: 14-21	we (Louise and the friend she disclosed her thoughts of infanticide to) spent a few days together, because she obviously lives in [Foreign country] and we'd met up and gone away for a few days in [holiday destination], so I felt actually quite close to her at the time, and spending a few days with her, at that, you know it sort of feels right to say this
	Disclosure influenced by emotional and physical closeness versus distance	2: 20-21	It's still not really spoken about even amongst friends unless you're very close
		12: 13-20	we never really, got close as a group, I've become closer to other NCT mums, 'cause I'm on the events committee so I've sort of got closer to, to some of them we met at

			bumps and babies and there's baby signing, and you feel you can be a bit more open with them
		36: 6-13	I wouldn't see either of them (two closest friends) a huge amount because then you've gotta babysit it's not as easy to get into [city] and see people, but, yes you would or, or, especially [friend] would come over here, so you would be able just to s-, to say "look, you know I can't, cope you know", or, "I'm finding this really hard"
		53: 11-16	(When asked about disclosure to family) ...they're all up in [Northern County], my sister's little boy's just recovering from cancer, and he was in hospital having loads of chemo whilst I was pregnant and then having [Child's Name], so they weren't really around,
		55: 25 - 56: 6	No I mean I've been close to my sister but, she, we never got on until she left university she is 3 years younger than me, and when she went to university up north and then she never came back down, so we're quite close but we don't get a huge amount of time to, talk or anything like that so you just sort of talk about the nice bits
		57: 1-3	Erm, if they (parents-in-law) lived around here and I had the (drags out word), I had them closer probably yes (would have disclosed PND to them)
Disclosure as part of a reflective and transformative process	Voicing it and being heard as reflective and transformative process	22: 6-19	...I'd say they just listened, and it's also as soon as you voice something out in the open it's never as bad, as you're internalising it, so once you voice it it's out in the open and you've had a bit of a laugh about it or you, or you know they've given you a couple of ideas as to "oh don't be so bloody stupid" you know, "pull yourself together" or "actually there isn't a problem there at all you're just blowing it out of all proportions" once they've given their input then you're thinking actually, that's probably not as bad as I think and I've just got myself in a complete tizzy over nothing
		25: 17-21	...you're thinking well ok I actually feel a bit better, but you know these are the sort of things that happen and, it's not some great taboo secret that I just thought, you know I could quite happily kill my child

		42: 26- 43: 2	...Yes and also with girlfriends as well, but it's just feeling, better and happier yourself, that you've actually voiced something
		62: 14-24	I, would, say, (pause) that, I've been able to, say things quite clearly, I haven't really thought about this interview at all and was just sort of thinking oh gosh you know how do I really feel or anything like that so I, it, it's helped me to voice what I was actually feeling, and to then understand those feelings so, you've then got a sort of, consistent run or you can understand so you got a, you can then process everything yourself
	Normalisation through shared experience	25: 13-18	...so for me sort of saying something like that she's so ea- "no I felt the same, it's normal" and as soon as you hear somebody say "don't worry it's normal" you're thinking well ok I actually feel a bit better,...
		26: 9-11	they're (two older mums she knows who are on antidepressants) sort of like "oh yes, no, it, it, it's normal", "you don't worry about it" you know
		30: 27-29	no just normalising it and saying "no, it, it is fine to, feel like that".
		36: 12-18	"look, you know I can't, cope you know", or, "I'm finding this really hard" and again, she'd say, "don't worry about it babe, you know my sister's just had a baby, she says she can't cope either, I'm sure it's all normal" so again it's normalising and voicing
	Disclosure facilitates opportunities for solutions	15: 13-23	...my husband's quite good because I was talking to him about it, instead of sort of, going to, to a doctor so it was a case of having somebody to listen and to understand, not that men really can but not to be judgemental, and to, to take on board what I was saying, and, he, (pause) he does makes sure that I do have, time as in at the weekend he will get [Child's Name] up so it's trying to take everything off me
		29: 14-28	(after disclosing to husband)...he probably gave me a hug but I don't think he necessarily did anything, but he does always tend to, say to me "oh you're the best mum" you know "you're doing really well" so there's that amount of praise I'm getting which makes me feel, better and he, he tries to do, what he can, and, occasionally I do get cross and just say, "look you are taking the piss now you've got to" you know

			“come home or help out or do this that and the other” but he is actually quite good he does a lot more than other peoples’ husbands, a huge amount more than other peoples’ husbands
		52: 20-26	...again once I’d said that to him, then I felt better ‘cause I knew that he could give me a cuddle without me worrying it’s going to lead to anything, so again it’s being open and honest with the people that really matter, who can then understand it, and who can then work with you,...
		61: 16-21	...well I hope I can be help, help in your study that I suppose, eventually will be able to I don’t know help other people or get a truer understanding of postnatal depression so that actually something can be properly done about it
	Impact of disclosure on marital relationships	29: 8-11	he was, very happy that I could actually, or felt that I could tell him something, quite, severe, shocking, but he was very supportive
		42: 21-23	... I felt better (after disclosure of PND to husband) and I also felt our relationship was stronger
		52: 27-30	...instead of no-one knowing apart from yourself and then them getting upset as to why you don’t wanna have sex, or you’re crying the entire time, or, all of that
	Weak PND self vs. the empowered recovered self	43: 7-19	I think I sort of only told people about it after I, it had finished having the symptoms, I didn’t really discuss it with anybody apart from my husband and close friends while I was having, the symptoms, so it was only afterwards and I could look back and say “yeah, I think I had a bit of postnatal depression” that ‘cause to actually admit that you’re, having it at the time would probably have been too, much, whereas it’s easier to admit something after it’s been over and done with and you’ve conquered it
		43: 22-31	Because you’ve, it’s over and done with, and it’s something that isn’t going to come back, that’s why you feel that, you can do it, it’s like giving up smoking there’s no point in telling everybody on the first day and the first minute saying “oh I’ve given up

			smoking" you know until you've actually passed a week or a month or, to then be able to say "yes, I've done this, it's now been a week or a month or a year"
		46: 5-12	... Yeah again it's after- afterwards and you feeling better and stronger that you feel you can then disclose it, like all these celebrity mums that have had it like was it, Jamie Oliver's wife, yeah it's after it's happened that you then feel more able to, to say "yes I've had it and I now feel better"
		51: 20-25	I think I felt quite, (pause) weak while I was, or I would look at myself and think "gosh you must be quite weak" whilst I was having it, and then after I'd overcome it I felt better and more empowered
		33: 4-11	Because they've (older mothers where Louise lives) been there and done that, they've experienced it, they've also got the confidence to say, "yeah no you're right" you know "I suffered from postnatal depression" "so did I and so did so-and-so", much more open about it as well, I think 'cause they're old and they've got the confidence

8.12 Appendix 12: Table of recurrence of themes for all participants

		PARTICIPANTS				
		ANNE	LOUISE	VICTORIA	MARIE	JOANNE
SUPER-ORDINATE AND SUB-ORDINATE THEMES	<b>THEME 1: TRYING TO COPE WHILST MAKING SENSE OF EXPERIENCES</b>					
	● HOLDING THE THREADS OF MY LIFE TOGETHER: TRYING TO BE THE COPING MOTHER	<input checked="" type="checkbox"/>				
	● NEEDING TO COPE: HOW PERCEPTIONS OF EXTERNAL EXPECTATIONS OF MOTHERHOOD INFLUENCE MOTHERS' INTERNAL EXPECTATIONS OF SELF	<input checked="" type="checkbox"/>				
	● "PUTTING ON A FACE": EXTERNAL FAÇADES AS INTERNALLY PROTECTIVE	<input checked="" type="checkbox"/>				
	● TRYING TO DEFINE AND UNDERSTAND EXPERIENCE	<input checked="" type="checkbox"/>				
	<b>THEME 2: DECIDING WHETHER TO DISCLOSE: FACILITATIVE AND INHIBITING FACTORS</b>					
	● "I'M FAR LUCKIER": FACTORS THAT INFLUENCE PERCEIVED ENTITLEMENT TO HAVE POSTNATAL DEPRESSION AND RECEIVE SUPPORT	<input checked="" type="checkbox"/>				
	● "YOU DO HAVE THE WORRIES ABOUT WHAT PEOPLE THINK OF YOU": THE STIGMA ATTACHED TO POSTNATAL DEPRESSION	<input checked="" type="checkbox"/>				
	● "THAT FAITH THAT SHE WOULDN'T JUDGE": FACTORS THAT INFLUENCE THE SELECTION OF CONFIDANTS	<input checked="" type="checkbox"/>				
	<b>THEME 3: THE TWO-WAY INTERPERSONAL NATURE OF DISCLOSURE</b>					
	● "HEDGING ROUND THE CONVERSATIONS": A CAUTIOUS APPROACH TO DISCLOSURE	<input checked="" type="checkbox"/>				
	● "YOU'RE REBUFFED RIGHT AT THE VERY BEGINNING": DEALING WITH SET-BACKS	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	X	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	● PERCEIVED IMPACT OF DISCLOSURE AND SUPPORT-SEEKING ON RELATIONSHIPS	<input checked="" type="checkbox"/>				
	<b>THEME 4: DISCLOSURE AS PART OF A TRANSFORMATIVE PROCESS</b>					
	● "I OBVIOUSLY WASN'T GOING MAD": DISCLOSURE TRANSFORMING PERCEPTION AND EXPERIENCE OF THE PROBLEM	<input checked="" type="checkbox"/>				
	● DISCLOSURE FACILITATES OPPORTUNITIES FOR SUPPORT	<input checked="" type="checkbox"/>				
● CONQUERING POSTNATAL DEPRESSION: "IT'S EVER SO MUCH EASIER TO TALK ABOUT SOMETHING IN THE PAST"	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	

8.13 Appendix 13: Affect regulation system (source: adapted from Gilbert, 2005, p. 26)

