

THE EXPERIENCE OF SEEKING HELP FOR POSTNATAL DEPRESSION

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ABSTRACT

This qualitative study sought to explore women's experiences of support and treatment for postnatal depression. In-depth interviews from seven women were analysed using the phenomenological method described by Creswell (1998). Findings indicate that partners provided women the most support. The women did not know where to seek professional help, often being identified and helped by the maternal health nurse who monitors and guides the progress of their babies' development. Hospital programs were criticised for not informing and involving family. The women were dissatisfied with hospital doctors and their GPs claiming they had limited time for counselling, preferring to prescribe medication that alleviated symptoms but reinforced feelings of inadequacy. Recommendations are made to involve families and to use the unique position of the maternal health nurse in assessing new mothers.

INTRODUCTION

Postnatal depression (PND) is a commonly occurring clinical depression that usually begins within weeks following birth (Spinelli 1997) and is considered a serious problem in terms of the consequences for a mother and her family. PND has been associated with marital, familial and relational conflict, child maltreatment, an increase risk of accidental injury to the child, neglect and at the extreme end, maternal suicide and infanticide (Spinelli 1997). Cooper et al (1996) postulate that PND can have a harmful impact on the mother-infant relationship, and this in turn, may endanger the subsequent cognitive and emotional development of the infant.

The incidence of PND ranges from 10-40% worldwide (Barnett 1991), but because of the complexity involved in identifying women with PND, it is thought to be frequently undetected and untreated (McIntosh 1993). Compounding this situation is the anger or shame women feel at having to consult a doctor or psychologist and the fear of being stigmatised as having a 'mental illness' (McIntosh 1993). Furthermore, women are often unaware of what they are suffering from and consequently fail to consult a professional (Sweet 1996). In support of this last point, Whitton et al (1996) found that while 90% of women recognized that something was wrong, only 30% believed they suffered from PND and 80% had not reported symptoms to health professionals.

PND has been associated with a lack of social support (Bebbington 1998). The risk of PND has been found to increase when the level of social support is low or absent (Morse et al 2000; Pederson 1999). This fact is not surprising when considering that parenting consumes enormous quantities of time, energy and effort on a daily basis (Morse et al 2000). The substantial work entailed in being a new parent comprises 4-10 feeds every 24 hours, with each feed lasting 5-90 minutes, and a total of 4000-5000 nappy changes across the period of infancy (Barry 1997). Social support not only provides practical help but can aid the mother emotionally by hindering the common experience of rumination (Beck 1992) as partners, friends and family can engage the mother's attention and allow her little time for rumination.

While husbands or partners may also be experiencing postnatal adjustment difficulties, Morse et al (2000) found they still provided the greatest emotional and instrumental support to new mothers. Partners can be indirectly supportive as they have also been found to influence the mother's coping responses (Barry 1997). After partners, Morse et al (2000) rated family and then friends as providing frequent and satisfying support of an instrumental and emotional nature. Terry et al (1996) suggest families are in the best position to offer non-threatening assistance and support, especially for the mother with a temperamentally difficult infant.

Outside the mother's immediate network of family and friends, sources of support are generally in the form of treatment by service providers such as doctors, psychiatrists and hospitals. The health care setting is an ideal venue for the intervention and treatment of PND (Sheppard 1997; Taylor 1997; Balcomb 1996) as the health centre nurse is usually the first port of call for new mothers to obtain advice and counsel (Whitton et al 1996).

Qualitative research on PND is scarce. Cheryl Beck (1992) completed the first phenomenological study to explore women's experience of PND. Beck (1992) focused on identifying the theme clusters that comprise the structure of PND and did not address the experience of seeking help. However, in a study by McIntosh (1993), the absence of help and support was found to be fundamental to women's experiences of PND. Although desperately wanting help, only 26% of women with PND actively sought it, preferring to remain silent. They dared not approach even family or friends for help, fearing shame and embarrassment at what they felt represented personal inadequacy and failure. The ten mothers who sought professional help saw this as a last resort, having reached a stage where they could not function properly. Nine of the mothers that sought professional assistance were not satisfied with the advice or help they received. They rejected the advice, especially the prescription of drugs, feeling this was an inappropriate solution to their problems (McIntosh 1993).

Consistent with this finding, Wood and Meigan (1997) found women with PND did not perceive health professionals to be beneficial as they failed to meet their need for understanding, and often did not take them seriously. The women reported being given antidepressants without alternative treatments being discussed. Furthermore, the possibility of their infant ingesting drugs via breast feeding, were not considered or discussed. Although ambivalent regarding drugs, the women felt their views were considered unimportant. One mother reported being prescribed medication over the telephone without a consultation or assessment, and another severely depressed mother had to wait six months to see a psychologist.

These findings are similar to the results of two qualitative studies that focused on the experiences of women undergoing treatment for depression (Hood et al 1999; Steen 1996). Although the clinical signs and symptoms of depression are not identical to those of PND, they are comparative (Terry et al 1996). As there are no studies that explore the avenues women with PND have sought for support, these studies help to highlight the experiences of women accessing and receiving treatment and support from service providers for a condition similar to PND. The studies above found that GPs had limited time and counselling expertise, rarely referred women on to specialist mental health services, and generally provided medication as treatment without adequate assessment. While the women felt medication was useful for managing symptoms, they perceived its use as a personal weakness in not being able to cope without it. Counselling was found useful when the women believed that the counsellor understood them and met their perceptions of what they needed. This finding supports Burns and Nolen-Hoeksema (1992) who found therapeutic empathy to be positively associated with clinical improvement in patients with depression, and highlights the importance of the therapeutic relationship as documented by Gelso and Fretz (1992).

To date, Beck (1992) is the only phenomenological study that explores the lived experiences of women with PND. However, she does not explore women's experience of seeking help and support. Thus, the aim of this research was to investigate (i) what avenues of support and treatment women with PND access and (ii) how the women experienced these avenues (that is, were they helpful or not). The phenomenological method is useful in producing rich descriptive data that can be used to enhance treatment and intervention for women with PND by nursing, medical and other health care professionals.

DESIGN AND METHODOLOGY

This study employed phenomenology where the purpose of research is to capture the essence and meaning of a phenomenon through descriptions of lived experience (Creswell 1998). The 'hermeneutic or interpretive method' was taken where presuppositions are not bracketed but are used to frame the search for meaning (Creswell 1998). Using the psychological approach as proposed by Creswell, the meaning of individual experiences rather than group experiences, were central. Being sensitive to the women's feelings, the interviewer established a confidential atmosphere in which the women felt safe enough to talk freely about their feelings and experiences (Kvale 1996). The women were interviewed individually in their own homes and asked a range of questions about their experiences with postnatal depression. The interviews were audiotaped and averaged 90 minutes in length.

Seven women participated. Mary, Emma, Karen, Mandy and Stacy (pseudonyms), were referred through a postnatal support group in a community health service, while Jill and Lee were referred through a specialist sexual assault centre. Both places are located within a suburb of a major Australian city. While Stacy was in a defacto relationship, the other women were married. However, Stacy and Mandy separated from their partners within months of delivery. The women had an average of 1.7 children each and were aged between 24 and 43. Eligibility in the study required the women to be currently suffering from or have a recent history of PND. The study was approved by the Victoria University Ethics Committee, and according to the ethical guidelines, the women signed consent forms before participation.

DATA ANALYSIS

The phenomenological method involved a number of steps in analysis as described by Creswell (1998, p.55). The entire interview transcripts were read to gain a sense of the whole experience, and then divided into statements. These units were transformed into ‘clusters of meanings’ or themes and then linked to make a general description of what was experienced and how it was experienced. These steps provided an ‘essential, invariant structure (or essence)’ of the perceived experiences of seeking help for PND.

To help ensure credibility of the data, a member check (Guba and Lincoln 1985) was done by five of the seven mothers who reviewed the description of the findings to validate that it captured their experiences.

FINDINGS

Four theme clusters were identified by the women’s experiences as they sought support for PND (see Figure 1). Figure 1 indicates these theme clusters of support networks are: interpersonal support; maternal health nurse; medical professionals such as general practitioners (GPs) and psychologists; and postnatal support groups.

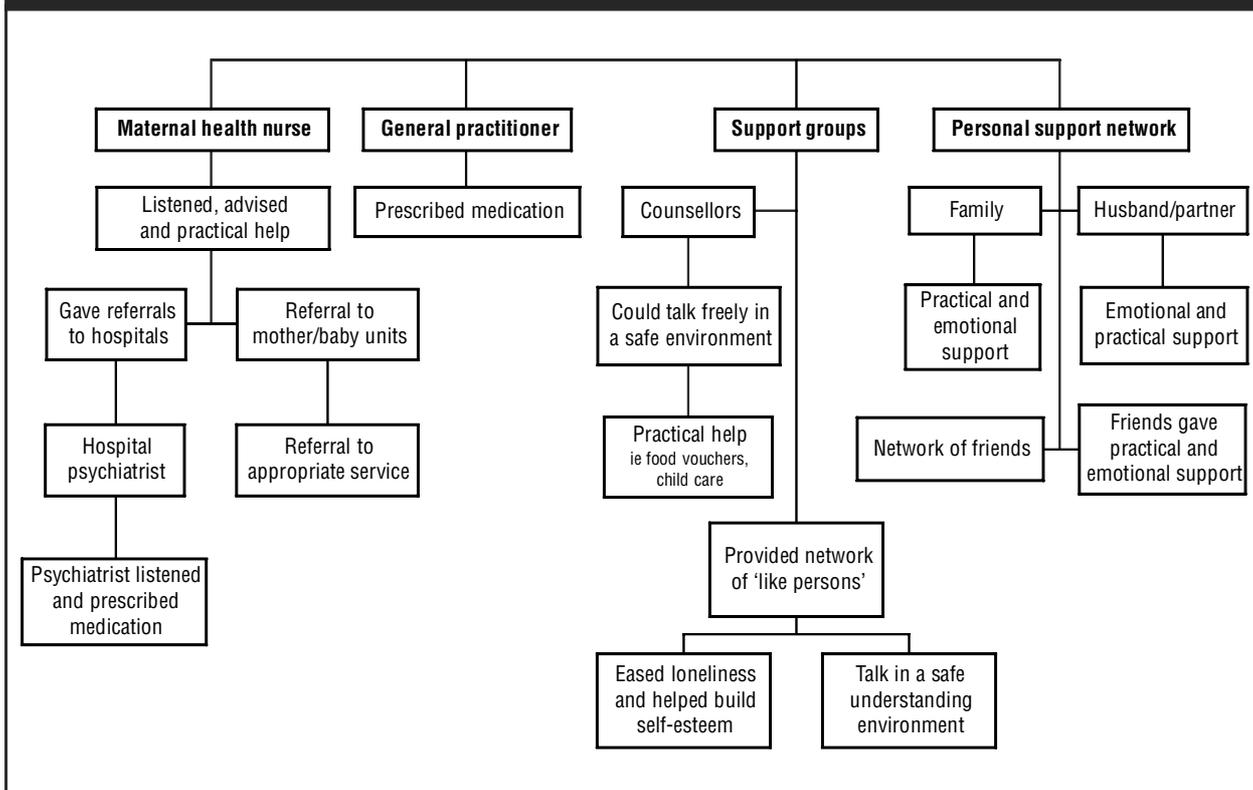
Referrals were made by these sources to hospitals, psychiatrists and mother-baby units. The women’s perception of these four support networks is the focus of the findings.

Interpersonal support

A support network of significant others included partner, family and friends. Consistent with Morse et al (2000), partners were a great support for four women who reported caring, loving husbands. Karen stated:

He’s (husband) always been very, very open and very supportive. I’m lucky, he’s a gentle, gentle man. But we’ve always been able to talk about anything.

Figure1: The avenues of support and treatment reported by women experiencing postnatal depression.



However, Mary, Mandy and Stacy complained about the lack of emotional and instrumental support once they went home from hospital. Mandy reflected on this lack of physical support in the home:

And then I went from the hospital home and the minute I walked in the door, I started doing washing ... I started cleaning!

Mary perceived her husband as unsupportive because of cultural practices:

He was of that era and thought these were women's problems. I never really talked to him.

In these non-supportive relationships, marital conflict was evident, directly giving weight to Brown's (1996) view that conflict is a factor in PND. Indeed, two relationships with 'unsupporting partners' ended within weeks or months of the baby's birth. However, it remains unclear if the lack of support from partners contributed to or maintained the depression, or if marital conflict was ongoing as a complication of depression.

With family (excluding husbands), the findings indicate mixed support. While Stacy, Mary, Jill and Lee reported having supportive families, Mandy, Emma and Karen's families were unaware of their PND until they were either hospitalised or broke down. These families were unable to be supportive until crisis hit. Consistent with Barnett (1991), the women feared the revelation of their PND would cause them shame and embarrassment at having a mental illness.

Lee and Jill's families were unsupportive as an artifact of sexual abuse. Jill talks about her mother:

She gave me no help like you think a mother would do for a daughter ... we had a big fight as she just wants me to forget about it [sexual abuse by father] completely.

Maternal health nurses

The women reported not knowing where to go for help as Mary explains:

I don't think I sought outside help because I didn't know what help to get.

The help they got was incidental as having a baby placed the women in touch with their maternal health nurse who checked the mother and baby's health regularly. The maternal health nurse usually identified that the women either had or were at risk of PND and were in need of support, and would make appropriate referrals. However, Stella's experience was not perceived as supportive. It undermined her self worth by adding to a sense of guilt for being unable to cope with the role of motherhood. Stella explained:

The health sister nurse was a bitch. I went there one day and she kept saying that 'she's like this because of you. She's picking up on how you're feeling, it's all your fault

basically!' I left there howling because it's all my fault, you know.

More generally and consistent with the findings of Whitton et al (1996), the maternal health nurse was considered helpful as she listened and gave advice. Often she had children so mothers felt she understood their experiences. She made referrals to hospitals, mother-baby units or PND support groups that could offer appropriate help. Mandy declared:

My maternal health nurse was the only person that was really really helpful ... she knew what was going on in my marriage and put me into Queen Elizabeth [hospital].

Some referrals led to hospitals and mother/baby units where mothers had helpful and unhelpful experiences. Experiences were perceived as unhelpful when family were uninformed or ostracised from the hospital setting. Emma stated:

They [family] had been excluded before, it was like this patient confidentiality thing, we're not going to tell you anything, it's up to Emma what you know. And basically, they just didn't know anything and I wasn't capable of telling them.

Karen reported a positive experience in a hospital:

The nursing staff there were just great. They were really good to me.

Medical professionals

Consistent with Rout and Rout (1996), all of the women received treatment by general practitioners (GPs). As found by Hood et al (1999), GPs did not make referrals to counsellors or psychiatrists. The bulk of referrals came from the maternal health nurse, hospital or community groups. Ultimately, the women were seeking support and understanding from medical professionals as stated by Mary:

You are looking for the human understanding, not the man or woman behind the seat that tells you what you have to do to feel better. And 'if you don't do it the way you should do it, well what are you coming here for.

Instead of understanding, the women reported occasional patronising attitudes from doctors towards their symptoms that exacerbated feelings of low self-worth and guilt at being unable to cope. These experiences are supported by Steen (1996) who found that women felt GPs and psychiatrists were often disinterested, and even GPs considered sympathetic were thought to be too busy to have the time to really listen. Jill stated:

(The Dr) was very concerned and understanding, but unfortunately, I know that GPs have 10 people waiting and they've only got their 10 minutes.

It remains unclear if the women were sensitive as a result of their depressed state, angry and shameful for

having to consult a practitioner as suggested by Barnett (1991) or if some practitioners fail to appreciate PND as a real illness. Mary stated:

I kept going to this doctor and he used to give me a pep talk and send me home. I am with three children and a walking distress ... because I had no car ... those years were horrible because virtually he said to me ... that I would just have to put up with it and shut up!

Furthermore, women complained that without private health cover, they had to wait lengthy periods to see a psychiatrist during which time they became vulnerable to self-medication. Stacy tells:

And then I had to wait two months to get into a psychiatrist, so I nuked [sic] on those Valium when I needed them.

Overall, as also noted by Hood et al (1999), the women found GPs and psychiatrists helpful because they prescribed medication that helped alleviate their symptoms. The women reached a time when they could not function and medication became a common way of coping. Supporting Steen's (1996) findings, the women felt medication helped them regain some level of control so they could work out how to deal with what was going on in their lives. Emma explained:

Once the medication started to kick in I started to get some functioning back and some level of control back.

Nonetheless, medication was a 'no-win situation' as the women felt shame at not being able to cope alone and stigmatised for taking medication. The use of medication reinforced their feelings of personal weakness in being unable to cope alone, a finding consistent with that of Hood et al (1999). Karen tells:

Faced with living on medication is very scary. It's just the stigma most of us have. We don't like being supported, we don't like to think we can't cope on our own.

Without medication, the women feared they might go insane, harm themselves or their baby, and were generally anxious about how they would survive. Jill explained:

I can't cope with day to day life. Without them, I yell and I scream at the kids ... I cry, I have panic attacks ... I think bad things all the time and then I have got to the stage where I have thought about suicide.

Furthermore, GPs and psychiatrists did not provide women with enough information to make their own informed choices about medication and treatment. Consistent with Steen (1996), lack of information often led to anger, frustration and fear of the unknown, feelings that served to exacerbate the women's fragile emotional states. The women did not understand how hospitals could help or what was expected from medication. Consequently, they became anxious and often desperate when medication caused side effects like weight gain or

the perception of 'living in a cloud'. Many women had to endure a process of trial and error to find the right medication and dosage compatible with their body chemistry. Lee stated:

I put on 20-something kilos. . . it was one of the side effects I wasn't told about.

Support groups

Support groups were predominately seen in a positive light. As proposed by Steen (1996), the women felt support groups provided them with a network of 'like women' and a safe environment to express whatever they wished without fear of condemnation. The friendships that developed helped to ease loneliness and provide understanding and acceptance as explained by Karen:

Finding people who were going through the same thing, having that support ... I knew someone was there.

Furthermore, Jill stated:

I never talked about anything, so just talking about it helped me to feel better after.

Mandy reported that while initially benefiting from the postnatal support group, she became overloaded with her own life and was unable to take anyone else's problems on board:

I'm just sick of hearing about it. I'm sick of going there and everyone just sitting around saying the same thing. I'm fed up with it ... I just feel like my head's ready to explode most of the time anyway.

These cases suggest that support groups are useful when women feel they meet their identified needs, but may not offer the total solution.

Jill and Lee identified a need to be part of a group focusing on the issue of sexual abuse rather than PND for while the birth of the baby was a trigger, sexual abuse was fundamental to their own experience of PND. While the support group provided the essential elements of listening and understanding, Lee wanted more than understanding, feeling she needed to play an active role in helping herself:

I needed feedback ... I needed something to work with, like practical method thing, I wanted to work in it, not just talk about how I feel today or how things are going.

CONCLUSION

An important issue that emerged from the data is that most women did not know how or where to seek support outside of their home. Consistent with Whitton et al's (1996) findings, all the women recognised something was wrong, but as most of them were first time mothers, they did not actively seek help for PND as they were unaware they were experiencing it. The help they received was

mostly incidental, being identified by the maternal health nurse when she checked the baby's health. This finding confirms the crucial role the maternal health nurse can play in identifying those mothers at risk and providing them with help and support. The maternal health nurse was generally perceived as being most helpful and supportive, providing information, practical help, referrals to other health professionals, empathy and understanding. Her close contact with new mothers places her in a strategic and responsible position that should be promoted to the advantage of women with PND.

Commonly, the women sought support from their GP. The therapeutic relationship with GPs was hindered by limited time and understanding as found in previous research. By increasing the time spent with patients, GPs could address the need to be understood by developing therapeutic empathy via discussion of women's concerns, treatment options and possible side effects of medication.

The issue of medication is important as the women were ambivalent about its use, for although they needed it to function, its use reinforced personal beliefs of being weak and unable to manage on their own. This stigma needs to be addressed by health professionals as it forced women to remain silent about their PND, cutting them off from their own families until their ordeal became unbearable. Ultimately, the help they desperately wanted was to simply be understood. Understanding was achieved when someone took the time to listen. Unfortunately, for many GPs, Medicare issues may limit time, and if so, this is a situation that needs to be addressed.

Partners were supportive in all respects, unless marital conflict was evident. Families were also supportive but were often unaware of the mother's condition. As the mother was frequently incapable of telling them, recommendations are made that health professionals consult and seek the mother's permission to inform her family. Families can then be included in the recovery process, providing appropriate support to the mother.

It is suggested that further study be undertaken describing women's perceptions of the efficacy of psychosocial interventions such as counselling, and medication in the management of the physiological and psychological symptoms of PND.

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