Older mothers' experiences of postnatal depression. An
interpretative phenomenological analysis.

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Acknowledgments

To my kids, with all my love. Thanks for your patience.

Abstract

This study uses Interpretative Phenomenology Analysis to explore the lived experience of postnatal depression. The four participants, all aged 30 years or above at the birth of their first child, had never suffered from depression prior to the birth. Each was interviewed on two separate occasions, with a period of 4 to 6 months between interviews. The inductive approach of IPA sought to capture the richness and complexity of participants' lived emotional world.

Six superordinate themes emerged from the interviews: striving to be a perfect mother; feeling a failure; being sucked dry; shame of the others gaze; feeling stuck and overwhelmed and becoming lost. Participants sacrificed themselves in the hopeless pursuit of their own expectations of being the perfect mother and fulfilling all their child's needs. Not wanting to appear inadequate to others, and desperate to make sense of what was happening to them, they continued to suffer in silence in a context of depleting resources and the loss of their former life, wellbeing and sense of self.

The findings suggest that particular themes of postnatal depression exist within older mothers' experiences. While such themes may be less relevant to younger mothers, their presence suggests a tailored treatment approach for older first-time mothers with PND.

Aspects of these findings can be found in previous postnatal depression research with primigravida and multigravida women of varying ages. In a situation where postnatal depression is the most common complication of childbearing in the UK, affecting between ten and fifteen percent of new mothers (Royal College of Psychiatrists, 2014) and where the birth rate for women aged 30+ is growing faster than for any other age group in the UK, research that furthers understanding of the experience of postnatal depression for mothers in this age group can help guide interventions and support.

(The words 'postnatal depression' and 'postpartum depression' are used interchangeably in this text)

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Chapter 1 Introduction

The aim of this study is to provide a qualitative, phenomenological exploration of how first-time mothers, aged 30 years and above and with no prior history of depression, experience postnatal depression (PND).

I begin this introductory chapter with an overview of postnatal depression, including its symptoms and how it is assessed, together with a review of key trends in birth rates and why women may be delaying motherhood. I then present the need for the current study and the specific problem it seeks to address. On this basis, I introduce the study's primary research questions, the research design used, and the theoretical framework within which the research is conducted. I conclude by placing myself in relation to the topic and the current study, before adding my own personal reflections.

1.1 Postnatal Depression: medical definitions and current context

The transition to motherhood is recognised as a pivotal time of change in a woman's life, psychologically, developmentally and biologically (Deutsch, Ruble, Feming, Brook-Gunn, & Stangor, 1988; Devinen Bove & Olson, 2000; Jennings & Edmundson, 1980; Zabielski, 1994). Adult developmental theory suggests that older primiparous mothers, because of their place in the life span, are particularly disposed to a unique type of maternal transitional crisis (Levinson, 1996), which is related to the simultaneous maternal and age-related transitions which older mothers experience.

Estimates of the scope and prevalence of PND vary. Postpartum mood and anxiety disorders are estimated to impair 10-20 per cent of new mothers, and postpartum psychosis strikes one in 1,000 new mothers (Knopps 1993; O'Hara et al., 1990). In 2014, the Royal College of Psychiatrists published findings suggesting that between 10 and 15 per cent of post-partum women become depressed. (Royal College of Psychiatrists, 2014).

The 2013 Diagnostic and statistical manual of mental disorders, fifth edition (DSM-5) does not recognise postnatal depression as a separate diagnosis; rather, patients must meet the criteria for a major depressive episode and the criteria for the perinatal-onset specifier. The definition is therefore a major depressive episode with

an onset in pregnancy or within 4 weeks of delivery. (The DSM-5 criteria for a major depressive episode can be found in Appendix 1.) Identification and treatment of PND is vital, given that infant development is particularly sensitive to the quality of the mother-child interaction in the first postpartum year (Logsdon et al., 2006). The absence of a close and sustained relationship with their mother (or mother figure) has been found to have irreversible mental health consequences for babies (Bowlby, 1951). Postnatal depression also places women at increased risk of suffering from depressive episodes in the future, and increases the likelihood of their children experiencing emotional, cognitive and social problems (Murray & Cooper, 1997; O'Hara, 1987). Such findings highlight the importance of identifying women with PND and treating them.

1.1.2 PND and delayed motherhood

In 2013 a report by the Office for National Statistics (ONS) entitled *Births in England and Wales, 2013* (ONS, 2014) reported that the number of live births in England and Wales stood at 698,512. Though this figure shows a fall of 4.3% from 2012's figures, between 2001 and 2012 live births in England and Wales rose by 23%. (ONS, 2014).

A further report by the ONS entitled *Live Births in England and Wales by Characteristics of Mother 1, 2013* found that over half (51%) of all live births in England and Wales were to mothers aged 30 and over. With women within the age range of 30-34 years producing the largest amount of babies born in England and Wales (ONS 2014). The average age of all mothers increased to 30 years in 2013, compared with 29.8 years in 2012, and the average age of first time mothers was 28.3 years in 2013, compared with 28.1 years in 2012.

Such figures reflect the postponement of childbearing in the UK, with an increasing number of women becoming mothers for the first time, or having further children, at or after the age of 30. At present the birth rate for women aged over 30 is growing faster than for any other age group in the UK. This trend reflects the trend in most developed countries of the increasing number of women delaying both partnership formation and childbearing to later in life (ONS, 2014).

Possible factors contributing to delayed motherhood include increased female participation in the labour force; the increasing importance of a career; the rising opportunity costs of childbearing; labour market uncertainty; housing factors and

instability of partnerships (Bhrolcháin & Beaujouan, 2012; Jefferies, 2008).In developed countries, older mothers tend to be better educated and engaged in paid employment (Berkowitz et al, 1993; Windridge & Berryman, 1999;). Granrose & Kaplan (1996) found that women who had spent a significant amount of years building up their career were also more likely to be included in the figures for those who started childbearing later on. Bhrolchàin et al (2012) found that changing patterns of educational enrolment also contributed to the postponement of childbearing, suggesting that the "root causes of fertility tempo change are to be found in fundamental macro-economic and structural factors rather than in the cultural domain." Bhrolchàin et al (2012, p. 323).

Further understanding of why women may be delaying childbirth can be gained from social and occupational psychological research which shows that, partly as a result of increased career aspirations, many women are waiting longer before having children and that a growing population of women expect to remain childless (Van Dusen and Sheldon, 1976).

1.2 Statement of the problem

Research studies of postnatal depression have included women (both primiparous and multiparous) from across the fertility spectrum (17-48 years), with assisted or non-assisted reproduction technologies. However, few studies to date have concentrated solely on older mothers' experiences of PND. In England and Wales where the birth rate for women aged 30 years and above is growing faster than for any other age group, it appears likely that an increasing number of women aged 30 years and over will experience PND in the future. It remains unclear if the support needed by a single teenage mother of an unplanned/unwanted baby and suffering from PND is the same as that required by a 35-year-old professional woman in a stable, loving relationship who develops postnatal depression after the arrival of a longed for baby. This highlights the need for further research to guide tailored, age-appropriate treatment and care.

In addition, to date the field has not been systematically informed by a theoretical model that integrates both the lived experience of postnatal depression and the understanding of older first-time motherhood as a critical developmental transition. The current study attempts to begin to address this lacuna.

1.3 Primary research questions

The current study seeks to shed light on the lived experience of older first-time mothers with PND. The central question addressed is: How is postnatal depression experienced by first-time mothers who are aged 30 years and above and have never suffered with depression in the past? On the basis of the results, the question is then posed: What are the implications of the results of this study on the appropriateness of clinical interventions and support currently offered to older mothers suffering from PND?

1.4 Significance of the study

Over the last few years an increasing number of groups and organisations have been set up in the UK to support women with PND, along their families and spouses. Yet the experience of postnatal depression for women aged 30 and above, who now form the largest group of mothers in the UK, has not been researched in depth, and it remains unclear whether older women experience PND differently from younger mothers. Whilst this research project was open to all women who fitted the criteria and were aged over 30 years when they had their first child, three of the participants in the study were aged between 30-34 years when they had their first child, with the fourth participant being 35 years old when she had her first child. The research for first-time mothers within the age group of 30-34 years, who in 2013 had more babies than any other age group in England and Wales (ONS, 2014) is far more limited than for new mothers of advanced maternal age (AMA), that is 35 years plus. Within this study the terms 'older mother' is used to refer to women who have a child over the age of 30, unless specifically referenced otherwise.

The current study, which seeks to bring together insights from lifespan psychology and phenomenological psychology, aims to contribute to an improved understanding of the nature of PND, especially as it is experienced by older mothers. It also seeks to guide the development and investigation of promising PND interventions for the growing number of women who are delaying motherhood.

1.5 Research design

This qualitative, phenomenological study uses Interpretative Phenomenological Analysis to provide an in-depth description of four older women's experiences of PND following the birth of their first child. The approach has an idiographic focus which does not attempt to test hypotheses.

While recognising that not all first-time mothers over the age of 30 and suffering from PND will have experiences identical or similar to those of my four participants, I offer my findings in the hope that they will add to our understanding of the phenomenon. I look forward to further research which, acknowledging the uniqueness of the individual, seeks to explore how PND may be experienced differently by different women at different times of their lives.

1.6 Researcher's position in relation to the project

In this section I consider how my experience as a trainee counselling psychologist influences the way in which I work with clients and the methodological choices I have made within this research study.

My way of being with clients is influenced by the humanistic existential philosophy which underpins my work. This philosophy embraces the uniqueness of the individual, their autonomy and the human potential for growth, wellbeing and change, whilst acknowledging the contextual nature of all relationships.

I value a client's subjective experience, recognising it as a valid source of knowledge and their own truth. I prioritise a phenomenological method of enquiry with clients, believing that human behaviour is shaped by the phenomena of experience rather than by an external objective reality (Cohen and Manion, 1994). As a trainee counselling psychologist, I place great emphasis on my own responsibility to be aware of, and to question, my own subjectivity, which might surface within the therapeutic relationship.

One of the key philosophical principles that underpins my work with clients is the uniqueness of each person's experience of relating with others in the world and the meaning they construe from their experiences. I understand relational needs as being present throughout the entire life cycle, from early infancy through to old age, and that these needs can shift from moment to moment.

My beliefs and philosophy about subjective meaning-making, the uniqueness of the person, an individual's changing needs throughout life and my own personal experience of being an older mother with postnatal depression symptoms have led me not only to the research topic of this study but also to my choice of research methodology. I chose interpretative phenomenological analysis (IPA) as the methodology for this study because it attempts to offer an in-depth description of the experience of the individual and the meaning attached to those experiences.

In my work, I am often guided by Paul's (1967, p.111) question: "What treatment, by whom, is most effective for this individual with that specific problem, under which set of circumstances?" For the present study, it seems to me that unless we know *how* older mothers such as my four participants actually experience PND, how can we offer effective and appropriate help? With the help of IPA, I feel I have begun the journey to answer this question.

1.7 Personal reflections

My own experience of becoming a mother has fuelled my desire to carry out this research into the meanings women make of their PND experiences.

I became a mother for the first time at the age of 29. Thirteen months later, I had my second child. Before their arrival, I had worked as a director at an international financial services organisation. My family history contains both a strong work ethic, instilled by my father's side of the family, and a 'stay at home with the children' ethic admired on my mother's side. As I value both approaches, I believe my own struggle to balance them while creating an environment that worked for me and my family put a lot of pressure on me. Although I was never formally diagnosed with PND, I now realise that I experienced many of its symptoms. I found not working outside the home for a period of time very difficult and my experience was accompanied by a sense of loss.

My sense of isolation, following the arrival of two children in quick succession, was increased by two close family bereavements within weeks of the birth of my second child and the subsequent sadness I experienced following these bereavements. The belief that I 'should' be able to cope, having been a very capable senior executive

before childbirth, inhibited my recovery period and increased my reluctance to ask others for help. Little support was volunteered by family or friends, who perhaps expected me to be able to cope; my difficulties went unseen behind the capable person that people knew me to be. Not recognising my own symptoms as those of PND, I just thought that motherhood was 'bloody hard work'.

On reflection, I was unprepared for the change in lifestyle that came from giving up work and being a full-time mother. This has made me eager to understand how other 'older' mums experience this time, and to seek ways of breaking barriers so that mothers can ask for and receive the help they may need without fear of judgment or shame. In my own case, I was helped by finding a local mother and baby group that included older, professional mothers. As we talked over coffee about our previous lives before the children came along and what we missed from those lives, I began to normalise my situation. I was also helped by continuing with my Open University degree, which enabled me to retain a sense of the woman I used to be and gave me a sense of having a professional future.

All the same, I found it hard to understand why I felt so low and 'bereft' when on the surface I had a healthy baby that my husband and I had keenly wanted and our financial situation allowed me to choose to stay at home and look after that child. I just hadn't anticipated this happening to me, to us: it wasn't part of the 'plan'. It was this unseen, unanticipated 'shock', so much part of PND and its impact, that I also wanted to explore, which explains why I sought participants without a history of mental health problems.

A few years ago I ran a training session about understanding PND for midwives. After the training when I was chatting with some of the delegates I told a midwife how I was interested in carrying out my Doctoral research on older mothers with PND. Her casual reply about older mothers was 'you can spot the ones who will go on to suffer with postnatal depression a mile off.' Not having the opportunity to explore this midwife's comment further at that time and my own personal experience of being a mother made me want to facilitate an appropriate outlet for the thoughts and experiences of other older mothers, and to understand better their individual values, assumptions and ideals. The idea of doing this struck me as important, imperative and a privilege.

I view current treatment approaches to PND as tending towards a 'one size fits all' strategy which undervalues the individual and takes little account of the intricacies of their specific PND experience. I see PND as a cruel and unjust illness which strikes a woman when she is physically and emotionally drained, plunging her into a vortex of self-doubt, failure and despair at a time when all her resourcefulness is needed. To be stuck in the vortex, unable to ask for help because she expects to cope, or 'should' be able to cope, strikes me as wrong on so many levels.

Chapter 2 Literature Review

In the first section of this chapter I offer an overview of postnatal depression, including difficulties in diagnosis and current available treatment methods. This is followed by a summary of the challenges women may experience during their transition to motherhood. I then consider the contribution and limitations of both quantitative and qualitative research to the current understanding of postnatal depression. The next section concentrates on the available literature relating to older mothers who experience PND. In the final section of this chapter I offer my rationale for the current study by identifying the research gap this study hopes to fill, and what it hopes to contribute to the field of PND and counselling psychology. I conclude the chapter with my personal reflections on the project.

2.1 Overview of postnatal depression

Postnatal depression is a depressive illness which affects 10 to 15 in every 100 women having a baby (Royal College of Psychiatrists, 2014). One in 4 adult women is estimated to experience some form of emotional distress in the postpartum period (Alexander & Higgins, 1993; Hopkins, Marcus, & Campbell, 1984; Pierce, Strauman, & Vandell, 1999).

2.1.1 Diagnosis of postnatal depression

Postnatal depression is under-diagnosed worldwide, with fewer than 40% of depressed mothers seeking help (Haynes, 2007). In the UK the most commonly used assessment tool for PND is the Edinburgh Postnatal Depression Scale (EPDS) a questionnaire-based quantitative tool.

PND can be difficult to detect not only because new mothers can be reluctant to report depressive symptoms to health care professionals (Beck & Gable, 2000) but also because mood disorders may appear postnatally as differential diagnoses of postnatal depression, including postnatal blues and the more serious condition of puerperal psychosis.

Up to 80% of women, worldwide, who have given birth experience some mild depressive symptoms such as tearfulness and sleep disturbances (Robertson,

Grace, Wallington & Stewart, 2004). Commonly known as the 'baby blues' (Bennett & Indman, 2003), these symptoms appear 3-5 days after birth, are transitory in nature and do not require treatment.

In contrast, puerperal psychosis is a severe episode of mental illness which begins suddenly in the days or weeks after having a baby. Puerperal psychosis is a rare condition and much less common than baby blues or postnatal depression, occurring in about 1 in every 1000 women (0.1%) who have a baby (Royal College of Psychiatrists, 2014). Symptoms of puerperal psychosis may include high mood (mania), depression, confusion, hallucinations and delusions. They are more commonly found in women with a family history of schizophrenia or manic depression, especially if such women have a non-supportive partner (Gregoire, 1995).

Postnatal depression usually occurs within 6 months of delivery. According to the DSM-5, which uses the criteria for a major depressive episode to diagnose the condition, PND can have its onset during pregnancy or within 4 weeks of delivery (see Appendix 1). Its symptoms include depressed mood, loss of interest or pleasure, worthlessness and impaired concentration.

In practice it is often much longer than 4 weeks postpartum before women are diagnosed with PND. Studies have also shown that reported symptoms can differ from those described by DSM-5, and may include tearfulness, despondency, feelings of inadequacy, mood swings, increasing guilt about the birth, inability to cope with the care of the baby and guilt about performance as a mother (Berggren-Clive, 1998; Nalepka & Coblentz, 1995; O'Hara & Swain, 1996). These varying symptoms can add to existing difficulties in diagnosing PND.

Identification and treatment of PND is vital as infant development is particularly sensitive to the quality of the mother-child interaction in the first postpartum year (Logsdon et al., 2006). The absence of a close, sustained relationship with the mother (or mother figure) can have irreversible mental health consequences for the child (Bowlby, 1951).

To date the causes of postnatal depression remain unknown. However, research has shown that protective factors include optimism, robust self-esteem, a good marital relationship, increased availability of social support, and adequate preparation for the

physical and psychosocial changes of parenthood (Beck, 1996; Lennon, 1996; Morgan et al, 1997; Pope, 2002; Romans, 1998).

2.1.2 Treatment of PND

For a variety of reasons many women with postnatal depression still remain undetected. Those diagnosed with the condition are offered varying treatments, dependent on personal preferences and the severity of the depression. A significant factor contributing to the duration of PND is the length of delay until adequate treatment is received (Beck & Indman, 2005).

Antidepressant medication is frequently used in the care and treatment of women suffering with PND (Misri et al, 2004). While in theory the full range of antidepressant medication is available, SSRIs such as fluoxetine and sertraline are the most commonly prescribed drugs (Wisner et al, 2006).

Other evidence-based treatments include Cognitive Behavioural Therapy (Chabrol et al, 2002); psychodynamic therapy (Cooper et al, 2003); and counselling, whether home, group or telephone supportive (Holden et al, 1989).

PND is an increasing problem for women and health care professionals throughout the world. With some women apparently reluctant to disclose symptoms of PND and with differing and often fluctuating symptoms reported at differing times postnatally, the recognition, diagnosis and appropriate treatment of PND can be difficult.

2.2 PND and the transition to motherhood

Becoming a mother can be described as a natural process which is biologically the same throughout the world. The very process of becoming a mother is a life event marked by a major transition. As with any life event, it can have a huge impact on the individual. The first year of new motherhood is recognised as a potentially difficult transitional period for many women (Cowan & Cowan, 1995; Lee, 1997).

Research supports the assumption that culturally and personally in Western societies, women are or want to be mothers (Letherby, 1994; Nicolson, 1998). Motherhood is constructed as a positive experience, with any negative feelings about

it being portrayed as unnatural (Marshall, 1991). The 'perfect mother' is seen as one who is completely committed to her children and to her role as mother (Forna, 1999). An Australian study by Buultjens & Liamputtong (2007) found that stigma was frequently attached to women who were unhappy after the birth of their child, because they were judged to be not coping with the demands of motherhood or had failed to instantly bond with their baby.

Psychodynamic research suggests that few experiences in a woman's life have more transformative power than pregnancy and motherhood (Cohen & Slade, 2000). This transition emerges as an important and complex developmental period in the life of a woman (Blum, 2007; Cowan & Cowan, 1992; Raphael-Leff, 2001; Stern, 1995). Research by Hopkins, Marcus & Campbell (1984) suggests that the transition to motherhood requires a redefinition of self and other, heralding the beginning of a dramatic reorganisation across a number of spheres in a woman's life, including the transformation of her relationship with her body, significant others, culture, and concept of self (Cohen & Slade, 2000).

Childbirth and the need to reorganise conscious and unconscious aspects of representations of self and others may reactivate unprocessed experiences, such as loss and mourning (Raphael-Leff, 2001). Stern (1995) notes that with the birth of a baby the mother passes into a new and unique psychic organisation: the 'motherhood constellation'. This involves openness, or a close connection with unconscious representations and processes, with feelings and experiences that at other moments in life are often ignored.

Adult development theory suggests that older primiparous mothers are particularly disposed to a unique type of maternal transitional crisis (Levinson, 1996), which is related to the simultaneous maternal and age-related transitions that older mothers experience. A study by Windridge & Berryman (1999) found that older mothers exhibit personality traits, such as increased autonomy, which negatively affect their transition to motherhood.

It is important to note that the experience of difficulties in the transition to motherhood does not constitute a descriptive profile of the symptoms of PND. The meaning that women attach to their experiences of motherhood has been explored in various studies (Lewis & Nicolson, 1998; Nicolson, 1998; Stoppard, 1998; Ussher,

1989). Such research suggests that while many women experience difficulty in the transition to motherhood, they experience less severe symptoms that do not reach clinical levels, and do not go on to develop PND.

2.3 Research contributions to the understanding of PND

In this section I consider both quantitative and qualitative research contributions to the understanding of PND, and explore the advantages and limitations of these different types of methodology.

The aetiology of PND remains unclear. While research suggests that women can undergo many psychological, biological and physiological experiences after giving birth, not every woman becomes depressed after having a baby. Although hormonal fluctuations may help to explain women's predisposition to emotional instability after childbirth, they do not provide a complete explanation (Harvard Medical School, 2011). It is also unclear why, among women with the same risk factors, some go on to suffer with postnatal depression while others do not (Cooper & Murray, 1997).

2.3.1 Quantitative research

A large volume of quantitative research has contributed to our understanding of PND. Studies have shown that known predictive factors can help to identify women who may be at a higher risk of developing PND. Beck (2001) carried out a quantitative meta-analysis on PND predictors, with the purpose of updating a previous meta-analysis study with the same focus, conducted in the 1980s. Beck (2001) conducted a meta-analysis of 84 studies published in the decade of the 1990s to determine the magnitude of the relationship between postpartum depression and various risk factors. Beck's results revealed thirteen significant predictors that put mothers at risk for PND: prenatal depression; self-esteem; childcare stress; prenatal anxiety; life stress; social support; marital relationship; history of previous depression; infant temperament; maternity blues; marital status; socio-economic status; and unplanned/unwanted pregnancy.

By synthesising these findings from her updated meta-analysis, Beck was able to offer the following profile of a woman at the highest risk of developing PND:

She is single, or if married, is dissatisfied with her marital relationship. She has low socio-economic status, low self-esteem and a history of depression. Over the past year, she has experienced a number of life stressors, with the addition now of child care stress. This pregnancy was neither planned nor wanted. During her pregnancy she experienced anxiety and depression. After delivery, she experienced maternity blues, for the 1st week postpartum. She describes her infant as being a difficult baby who is irritable and hard to console. Last, she does not feel that her partner, family, and friends have provided her with adequate emotional or instrumental support (Beck, 2001, p.401).

Noting that such risk factors "can repeatedly weaken a mother's fault line, placing her in a dangerous position for an emotional earthquake" (p. 283), Beck argued that these predictors could be used by clinicians as 'red flags' indicating that a woman might be at risk of developing this mood disorder.

Other quantitative studies have also helped identify potential risk factors for PND. They have found PND to be correlated with: previous psychiatric history (O'Hara, Schlechte, Lewis & Varber, 1991); the occurrence of stressful life events other than childbirth, such as death in the family, illness, moving house, or childcare related stresses (O'Hara et al, 1991; Paykel, Emms, Fletcher, & Rassaby, 1980); postpartum cognitive difficulties (Messinis et al, 2010); multiple births (Choi et al, 2009); individual personality traits (Gelabert et al, 2011); traditional sex role expectations (Steinberg & Bellavance, 1999); and first-time motherhood with low levels of social support (Leahy-Warren et al, 2011). A meta-analysis by O'Hara and Swain (1996) of 59 studies involving a total of 12, 810 participants led the authors to conclude that depressed mood or anxiety during pregnancy were significant predictors of postnatal depression.

In a later study entitled 'The many faces of postpartum depression', Beck (2005) aimed to provide a profile of women suffering from major postpartum depression as assessed by the Postpartum Depression Screening Scale (PDSS) developed by Beck & Gable in 2003. The PDSS is a 35-item scale consisting of seven dimensions of postpartum depression: sleeping/eating disturbances; anxiety/insecurity;

emotional lability; mental confusion; loss of self; guilt/shame; and suicidal thoughts. Beck found that the scores of women with PND had elevated positions on all seven dimensions of the PDSS; the three dimensions which scored highest were emotional lability, mental confusion and anxiety/insecurity.

Quantitative studies have clearly made an important contribution to an understanding of PND. The nature of quantitative methodology enables it to be particularly useful for testing and validating already constructed theories about how and why phenomena occur, including theories based on the findings of smaller scale, in-depth qualitative studies. Quantitative methodology also allows for the generalisation of research findings when such findings have been replicated in many different populations and subpopulations on the basis of random samples of sufficient size. Other advantages of this methodology include the swiftness of data collection (typically through questionnaires and/or telephone interviews), the provision of precise and numerical data which is relatively independent of the researcher, and the large pool of potential participants available to research based on questionnaires and similar assessment tools.

However, such quantitative studies raise a number of problematic questions. In relation to PND, the large numbers of participants required for quantitative studies means that often both primiparous and multiparous women of differing ages with differing severity of symptoms participate. This may reduce the ability of such research to further understanding of how specific groups of women experience PND: for example, first-time mothers in their 30s, or adolescent single mothers.

Given that the symptoms of PND occur across cultures (Oates et al, 2004), with different cultural contexts and beliefs affecting the severity of symptoms (Bina, 2008) as well as the meanings applied to them and how they are expressed (Posmontier & Horowitz, 2004), quantitative studies may struggle to deal with this complexity. The large participant numbers often found in quantitative research limit the ability to provide much detail on such factors as participants' socio-economic background, culture and ethnicity. This can limit comparisons of postpartum depressive symptomatology across various groups of women.

A further problem is that by its very nature questionnaire-based research may not use categories which reflect participants' own understandings. Phenomena may be missed through the focus on hypothesis-testing rather than on theory or hypothesis generation. This focus may also produce knowledge too abstract and general for direct application to specific local situations, contexts, and individuals. For example, if participants, when identifying their PND symptoms, fail to fit into a 'box' or specific category defined in a questionnaire, they may find themselves limited in their ability to describe their experience of PND. This in turn may limit the results of the research and its contribution to understanding the illness.

The scale of quantitative research can also involve practical problems. For example, the EPDS scale, often used in quantitative PND studies, is supposed to be answered in the presence of a midwife or health visitor, but this may often be ruled out or become impractical due to the large numbers of people taking part in quantitative research

Beck and Indman's (2005) recognised the limitations of some assessment scales which potentially impacted the results of previous studies. For example, the Beck Depression Inventory–II (Beck, Steer, & Brown, 1996) did not contain any items relating to anxiety, while the Edinburgh Postnatal Depression Scale (Cox et al, 1987) lacked items measuring mental confusion, despite the fact that anxiety and mental confusion constituted symptoms of PND that had been recognised by earlier studies (Dion, 2002; Matthey et al, 2003). However it is unlikely that every woman with PND will present with the same symptoms. Beck (2005) acknowledged that an effective screening scale needed to cast a wide enough net for all possible symptoms to be accounted for. This would help ensure that no mothers suffering from postpartum depression were missed or incorrectly screened as not being depressed.

To summarise: while quantitative research has been very helpful in expanding knowledge and testing theories generated from smaller qualitative studies, it often involves large numbers of participants, making it difficult to take into account participants' personal and cultural specificity. The assessment-based nature of quantitative studies provides only a limited opportunity for women to elaborate on their experiences of PND, especially if these differ from the options or dimensions provided on an assessment scale. This aspect of quantitative research may limit the

value of findings, in turn negatively impacting the relevance and appropriateness of treatment and care offered to women with PND.

2.3.2 Qualitative Research

Qualitative research tends to work with smaller numbers of participants and at greater depth. Qualitative studies of PND can often extend the depth of findings from quantitative research while offering a fuller understanding of the difficulties and conflicts experienced by mothers.

Qualitative research into PND has uncovered a number of more abstract themes not easily accessible through quantitative research methods. These include conflict, loss, autonomy, shame, fear of being judged by others, societal expectations of mothers, and contextual and cultural influences.

Beck (1992) used Colaizzi's (1978) descriptive phenomenological method to describe the essential structure of the lived experience of PND. Seven mothers who had suffered from postpartum depression were interviewed about their subjective experiences. Forty-five significant statements were extracted from the mothers and clustered into 11 themes, which described PND as a living nightmare filled with uncontrollable anxiety attacks and obsessive thinking. Mothers contemplated harming not only themselves but also their infants; they felt enveloped in loneliness with an all-encompassing fear that their normal lives would never return. Beck (1992) then compared the theme clusters with symptoms of depression as identified on the Beck Depression Inventory (BDI) (Beck, Ward, & Mendelson, 1961) and the Edinburgh Postnatal Depression Scale (Cox et al, 1987). Beck noted that only three of the themes in her study were present in the BDI: contemplating death; loss of interests; and guilt. Other themes which emerged from her study were not represented in the BDI. These included unbearable loneliness; thoughts of being a bad mother; loss of self; inability to concentrate; feeling like a robot; uncontrollable anxiety; loss of control; and the need to be mothered. Beck concluded there was a need to develop a screening instrument that identified PND more accurately. Her research suggested that women might not be best served by research instruments that screen for depression in the general population.

However, given the large number of themes emerging from the data Beck (1992) analysed, it is difficult to get a good 'feel' for the women's experience. The purpose of Beck's study was to describe the essential structure of the lived experience of PND. It was based on the assumption that there existed an essential form of PND which could be abstracted from the data, and that this structure was independent of context. Beck's findings are used primarily as an aid to refining the measurement of the construct of postpartum depression. However, had the data been viewed through a different phenomenological lens, such as thematic analysis, patterns could have been identified that allowed for meanings to be identified from the themes and related back to the research. For example, an IPA idiographic lens would offer findings which contextualise the women within their experiences, thereby giving a more in-depth picture of the lived experience of PND.

In 2002, Beck conducted a metasynthesis consisting of 18 qualitative PND studies published between 1990 and 1999. The studies had been conducted in various countries throughout the world, with women of varying ethnicity. In total these studies included 309 participants. Whilst three of the studies did not specify the age of the participants, in the remaining studies the age of participants ranged from 18 to 44 years, with most studies including both primiparous and multiparous women.

Beck's (2002) metasynthesis identified four overarching themes or perspectives involved in postpartum depression: (a) incongruity between expectations and the reality of motherhood; (b) 'spiralling downward' and 'sinking deeper and deeper': themes which describe mothers' distress and feelings of being overwhelmed by the demands of their baby; (c) pervasive loss; and (d) making gains. These themes offer a much fuller and descriptive sense of participant experiences of PND than did the findings of Beck's 2001 quantitative study. However, given the wide range of participants involved in the 18 studies drawn on, it could be argued that findings become less helpful when an in-depth experience of PND is sought for a particular category of participant, such as older first-time mothers. As Sandelowski et al (1997) note,

> to summarize qualitative findings is to destroy the integrity of the individual projects on which such summaries are based, to thin out the desired thickness of particulars…and ultimately to lose the vitality, viscerality and

vicariism of the human experiences represented in the original studies (p.366).

Beck's (2002) finding of the discrepancy between women's expectations of motherhood and reality has been frequently noted in women's narratives (Buultjens & Liamputtong, 2007) and PND (Nicolson, 1998; Oakley, 1980). This recurring identified overarching theme of the discrepancy between expectations and reality identified in women's experiences of PND suggests an emotional conflict or tension between participants' lived, embodied experience of being a mother and cultural constructions of being a mother (for example, as something that is 'natural'). A general finding from such qualitative studies is that women are often surprised by the extent of their difficulties on becoming a mother. Their finding the situation difficult leads to feel they are 'failing', which is anxiety-provoking and damaging to their sense of self-worth.

The results from Beck's (2002) metasynthesis and the other studies cited in the previous paragraph are extremely important and informative in relation to PND treatment. They offer a better understanding of the ways in which PND can impact a woman and they provide insights into what might be appropriate support for women whose experience might not be easily captured or explained via a box-ticking questionnaire. For example, they offer greater insight into why women might tick the EPDS tick box question asking if they have been 'sad or miserable' since their baby was born.

The problematic idea of the 'perfect mother' has been well documented in women's subjective accounts of postnatal depression. Certain attitudes to mothering and the 'right' kind of parenting are pervasive in the British media (Hadfield et al, 2007), with much media discourse centred on the 'good' mother: heterosexual, selfless, fertile (Gillespie, 2000), middle class, and aged between 25 and 35.

Social constructionism may be defined as a perspective which believes that a great deal of human life exists as it does due to social and interpersonal influences (Gergen 1985) with its roots seen as emerging within existential-phenomenological psychology, social history, hermeneutics and social psychology (Holstein & Miller 1993, Watzlawick 1984). In 1996, Sharon Hays first named a central, defining topic

embedded in these public conversations about ideal motherhood as "intensive mothering." Intensive mothering demands that women continue to be the primary caregivers of children, selfishly devoted to lavishing large amounts of time and energy on their children as they raise them. The mother portrayed in this ideology is devoted to the care of others and is self-sacrificing (Arendell, 2000: 1194). It seems the ideology of intense mothering has become the standard against which a mother's performance is measured with even those mothers who disagree with and/or who do not conform to the ideology of intensive mothering being affected by it and being judged by others according to how closely their practices fit with it and position themselves against it (Arendell, 2000; Gailey, 2000; Landsman, 1998). But as Hays (1996) reports, inevitably women fail to live up to this impossible standard. There appears to be a 'no win' situation for mothers as Hays (1996) suggests that that the ideology of intensive mothering dominates the experience of professional, middle-class mothers, regardless of whether they stay at home with their children or go to work. It seems that the social construction of motherhood which permeates contemporary society sets mothers up for a fall and the development of a sense of failure and guilt as they become overwhelmed by the reality of their new life which fails to meet expectations. This in turn can adversely impact a woman's sense of worth as she is now measured against a socially constructed ideal based on an ideology which defines women's existence. This suggests that an understanding of PND experiences can benefit from an understanding of the social and cultural climate in which they occur and are constructed.

In most cultures, postpartum depression carries with it a specific stigma and guilt apart from the regular stigma of mental illness (Knudson-Martin & Silverstein, 2009). Despite the fact that more and more women are choosing to remain childless, motherhood still defines the social construct of a feminine identity for cultures around the world. Within different societies there exists ideas and ideals about what a mother should be and societies can be critical of how, and stigmatizing of how well, a woman can perform her duties to her children (Medina & Magnuson, 2009). This social stigma may contribute to delayed detection of PPD and a reluctance for women coming forward with PND seeking treatment.

In an article entitled 'It's a Woman's Cry for Help: A Relational Perspective on Postnatal Depression', Mauthner (1998) discussed 18 women's experiences of PND

taken from her previous qualitative study (1994). The experiences were gathered from in-depth interviews and the data analysed using Brown and Gilligan's (1992) 'voice-centred relational method' (VCR). In the article, Mauthner identified three kinds of conflict within 18 postpartum-depressed mothers' narratives, all of them centred on being the 'perfect mother'. One area of conflict centred on how to care for the child. The second centred on women's depression and unhappiness, and how this conflicted with how they had expected to be around their baby. The third conflict revolved around the women's expectations that they would be able to cope with motherhood versus the reality of their needing help. For each individual mother, it seemed that the conflict experienced depended on their personal notion of what makes a 'good mother' and the value they placed on this, which affected what they were striving for. It is important therefore to consider the importance of images of mothers in formulating society's view of the mother, intense mothering (Hays, 1996) pressures and their impact on women. This might involve exploring PND from a relational perspective which examines women's feelings in terms of their relationship with themselves, their interpersonal relationships, and how they are impacted by cultural and structural opportunities and constraints.

VCR places relationships at the centre of research, valuing and recognising human interdependence rather than human independence. The in-depth interviews of 18 mothers of young children included in Mauthner's (1994) study yielded an enormous amount of data. The method focused on the analysis of narrative accounts told within an interview, with detailed attention paid to the voice of the 'I' in an attempt to raise the volume of the respondents' voice. However, while VCR offers an effective means to explore emotions and relationships, its ability to produce large quantities of data raises the risk that data may not be sufficiently reduced, leading to a certain lack of depth in relation to findings.

In the case of the current study, my aim was to explore women's lived experience of PND by waiting to see what emerged from the data rather than selecting which narrative to concentrate on. By choosing IPA as my research methodology I hoped to idiographically explore PND not only in terms of participants' relationships with others but also in terms of embodiment, temporality, spatiality and other lifeworld dimensions. My goal was to explore the wholeness and uniqueness of the individual (Malim et al, 1992) through a more holistic lens.

Blum (2007) draws on the few available psychoanalytically informed articles, reports and books about PND and on his own clinical experience as a private practitioner. He explored emotional conflicts in three areas typical of the experience of postpartum depression: dependency; aggression; and motherhood. From this he concluded that if the new mother "can accept her dependent needs and ensure that she is in fact taken care of, and if she can tolerate her baby's dependency and her reactions to it, she is unlikely to develop a postpartum depression" (Blum, 2007, p.53).

Blum argues that many women with PND have difficulty handling anger, feeling as if they have no right to be angry, or afraid to express it. The arrival of the baby, Blum acknowledges, has "turned the woman's life topsy-turvy, deprived her of sleep and numerous other customary satisfactions, been fed and cared for while the mother hasn't, and done little, so far, but drain her" (Blum, 2007,p.54). Blum says that feeling the anger, tolerating it and judiciously putting it into words is the difficult yet essential task for the mother.

Other psychodynamic research suggests that a mother's own early attachment experiences, and her perceptions of how she herself was cared for, influence her attachment to her child and that this association is mediated by the mother's representations of early caring relationships, especially with her own mother (Fonagy, Gergely, & Target, 2007).

Psychodynamically inspired studies, which to date have played a comparatively minor role in PND theory, research and treatment, have taken a more dimensional approach; for example, studying the transition to motherhood, attachment, normal outcomes, and more unusual outcomes in the postpartum period, including depressive symptoms and non-depressive ones.

A phenomenological approach to PND offers a different perspective. The current study, for example, offers participants the opportunity to talk about their experiences of PND while allowing space for significant relationships, both past and present, to be talked about if desired. There is the potential for findings to contribute to knowledge about attachment and the difficulties encountered in the transition to motherhood.

Qualitative research, with its more in-depth approach, has the capacity to consider context and relational influences more fully than does quantitative research. This is illustrated by Mauthner's (1999) qualitative study of the impact of cultural and contextual factors on PND. This research drew on 18 women's experiences of PND, collecting data through semi-structured in-depth interviews lasting on average three and a half hours. A range of methods was used to analyse the data. Individual transcripts were analysed using Brown and Gilligan's (1992) VCR method and then a thematic analysis of the data set as a whole was carried out. At the time the interviews were conducted, eight mothers said they had recovered from the depression, four said they were still in the process of recovering, and six said they were still struggling with quite severe feelings of depression.

Mauthner (1999) concluded that as not all women became depressed following childbirth, women's varying responses to motherhood needed to be recognized. She put forwards a relational re-framing of PND whereby it occurs when women are "unable to experience, express, and validate their feelings and needs within supportive, accepting, and non-judgmental interpersonal relationships and cultural contexts" (p.148). The socially constructed idea of motherhood as a happy and fulfilling experience (Ussher, 1990; Nicolson, 1993) means that women are socialised to anticipate gains, advantages and positive aspects of becoming a mother and having a child will bring, the anticipation of these gains can mask thoughts about the losses that this change of life and lifestyle may ensue though research shows us that loss, for many women can often be a part of motherhood (Oakley, 1980; Vik & Hafting, 2013). However when selecting the participants for the study, Mauthner did not consider such variables as socio-economic, educational and occupational background as 'useful' in relation to participants' experiences of PND. This was despite the findings of other research which suggested that loss of occupational identity had a place within PND (Nicolson, 1999); that higher levels of education contributed negatively to maternal adjustment (Rutledge et al, 1991); and that concern about ability to be a 'good' mother was even more pronounced in educated women (Leifer, 1980). Past research has also suggested that middle class, employed mothers may experience the most guilt resulting from intensive mothering as they are they are the individuals who are most targeted by the ideology. Such findings are relevant in view of the fact that childbearing women aged 30 or above

are likely to be better educated and of higher socioeconomic status than they were in the past. There is scope therefore for research within the area of PND that compares experiences of women with differing socioeconomic status.

Despite the disadvantages of the VCR method (already discussed), overall the results of Mauthner's (1999) research are very useful, since they explore motherhood and PND from different women's point of view. Thematic analysis studies allow for a wide range of analytic options, which means that the potential range of things that can be said about data collected is broad. While this can be an advantage it can also be a disadvantage as it makes developing specific guidelines for higher-phase analysis difficult. This can make it difficult for researchers to decide which aspects of the data to concentrate on. Thematic analysis also has limited inter-relatable power beyond description, especially if it is not used within an existing theoretical framework that anchors the analytic claims that are made.

By its very nature, IPA is often the interpretation of a single researcher. This can create doubts about claims it may make regarding the significance of findings. The small number of participants typically involved in IPA research also impacts the transferability of findings and their ability to provide an understanding of the complex, changing and variable circumstances, relationships and social contexts within which women became depressed.

In the case of the current study, however, my research aim was not to derive meaningful patterns from the data collected through analysis of the themes. Rather it was to apply an IPA lens to the data and discover more about the participants' lived experience: how it was for these women to be in this environment whilst depressed, and what it was like to be in relation to others.

Knudson-Martin & Silverstein (2009) applied a relational lens to a grounded theory metadata analysis of nine qualitative studies on PND conducted between 1999 and 2005 from a broad range of countries and cultures, with participants of diverse ethnicity and socioeconomic status. All nine studies were qualitative in character but used different methods to analyse data, including phenomenology, grounded theory, thematic analysis and relational cultural theory. Participants came from eleven different countries, were of different ages, and were at varying points on the

motherhood spectrum: primiparous, multiparous and pregnant women were included.

Knudson-Martin & Silverstein (2009) found that in every setting women described PND in similar terms. As in Beck's 2002 study, the women described feeling deeply shamed, anxious and distressed at not living up to what they believed were the societal standards for a good mother. This study however highlights an important contextual issue for these mothers: it was not the feelings themselves that maintained the depression but rather the inability to "express these emotions in a validating context and the resultant experience of isolation from others" (Knudson-Martin & Silverstein, 2009, p.155).

It should be noted, however, that the different studies within this metadata analysis will have varied in the amount of transparency regarding their methods and inclusion of actual quotes from participants. The use of multiple perspectives within individual studies raises questions about the rigorousness of the findings of a metadata analysis and the depth of those findings.

By studying women' accounts of their experience of PND, qualitative studies are able to consider and offer possible explanations of how contextual, interpersonal and cultural influences impact and maintain postnatal depression. Studies by Mauthner (1999) and Knudson-Martin & Silverstein (2009) are part of an increasing number of qualitative research studies which suggest that, rather than being simply an individual problem for women, PND is part of the larger societal issue of the socially constructed nature of ideal motherhood. Such research places depression in women squarely in the context of interpersonal and cultural processes that limit self-expression. This view is also considered in a study by Medina and Magnuson (2009), which found that society can be critical about how well a woman performs her duty as a mother to her children. This may account for the delay, often experienced, in the recognition and detection of PND, since women may be reluctant to speak up about any difficulties they may be having postnatally.

Hall (2006) interviewed ten new mothers about their experiences of PND, and then applied IPA to the data collected. The themes uncovered included the difficulties mothers experienced telling people about their thoughts and feelings; participants' expectations of motherhood; their beliefs around being a bad mother; and issues around attachment. Mothers' fears about inflicting psychological damage on their infants, and their sense that they were unjustified in being depressed as they now had a beautiful, healthy baby, also contributed to and compounded feelings of guilt and low mood. This study also highlighted women's reluctance to disclose their feelings of depression for fear of negative consequences. This finding was in line with previous research suggesting that some depressed mothers only reluctantly sought professional help (McIntosh, 1993; Small et al, 1994). Other mothers, despite being identified by professionals as depressed, denied that they were feeling low in mood (Briscoe, 1986), while the social stigma attached to PND influenced other mothers in their choice not to seek help (Beck, 2001).

All Hall's participants met IPA criteria for homogeneity in that all had "experienced postnatal depression with impaired daily functioning, such as difficulty carrying out their usual household tasks, or requiring additional help from friends and family to look after their baby" (Hall, 2006 p.259). In other respects, however, participants were quite varied: five of them were primiparous, three had one other child, and two had four children each. One of the participants had a multiple birth. While nine of the women were of Northern European ethnic origin, one was of Greek origin. This lack of homogeneity results in an absence of focus on the experience of PND by specific 'types' of women, such as new mothers or older first-time mothers.

Hall's (2006) analysis identified four main themes. However, many other thoughts and feelings were expressed by participants, on the basis of which six further specific themes were selected for further analysis. It could be argued that the number of themes generated from this study dilutes the overall sense of the lived experience of PND and creates an overlap between themes, to the detriment of the overall depth of the findings.

Although IPA attempts to privilege the individual, in the case of Hall (2006) the lack of homogeneity among participants compromises the overall richness of the findings. A further problem is that each participant was interviewed only once, using an

unstructured approach where participants were simply asked to talk about their experience of PND. The amount of data collected and the number of themes and experiences identified appear to have compromised the depth of understanding achieved and confused the underlying structure. This undermines the ability of the reader to come away with the feeling "I understand better what it is like for someone to experience that" (Polkinghorne, 1989, p.46).

The current study also fulfils IPA criteria of homogeneity, since all its participants have suffered with PND. Where it differs from Hall (2006) is in the greater homogeneity of its participants, all of whom are of similar age and background, with one child each, and all of whom have experienced PND after giving birth to that child. The current study considers how PND is experienced within this tighter group of homogenous participants.

Despite the increasing number of women suffering with postnatal depression, it is still generally assumed that motherhood will be a 'happy time'. Against this, various qualitative studies have associated the postnatal period with a sense of loss: loss of identity and of a sense of separate, autonomous and individuated self (Oakley, 1980); loss of former identity; and loss of self-reliance and capacity for self-care in the early postpartum period (Vik & Hafting, 2013).

Nicolson (1999) carried out a UK-based longitudinal qualitative study of postpartum depression, interviewing 24 women during their pregnancy and then one, three and six months after the birth. Participants were aged between 21 and 41 years and included both primiparous and multiparous women. The resulting data were analysed from a symbolic interactionist perspective in order to identify themes surrounding the meaning of motherhood and experience of depression during this time.

The symbolic interactionist perspective has been criticised for overlooking macro-social structures (e.g., norms, culture) by focusing on micro-level interactions. Some symbolic interactionists, however, would counter this by arguing that the incorporation of role theory into symbolic interactionism addresses this issue.

I regard Nicolson's (1999) study as really useful. It was carried out over a period of more than 6 months, following participants' experiences from pregnancy to giving

birth and on into the first months of motherhood. This allowed time for the full impact of having a baby and living life as a mother to kick in, in contrast to the shorter timeframes of other studies, with their focus on the immediate post-birth period, a time when the full extent of a life change may not be apparent. The data were analysed within a broadly symbolic interactionist framework in which transcripts were studied to examine the ways in which reported experiences were given meaning by the respondents. Words which referred to emotion and mood were identified by Nicolson, along with behaviours typically associated with negative affect, such as crying. Surrounding paragraphs were examined to make sense of how depression was talked about and how far it was related to meaning, experience and the biographical content of the woman's life.

Although rooted in phenomenological thought, symbolic interactionism contends that the objective world has no reality for humans, and that only subjectively defined objects have meaning. Symbolic interactionism understands the world by interpreting human interaction, which occurs through the use of symbols such as language.

However, talking about an experience is not always the same as *describing* that experience. Symbolic interactionism may neglect or overlook phrases or sentences where experiences are described. The availability of language for a participant means language precedes an experience and thus shapes the experience itself. The current study seeks to explore older mothers' experiences of PND by focusing not simply on participants' *language* but also on their phenomenological *experiences* .

Nicolson (1999) found that while all participants were happy to be mothers to their children, some struggled with a sense of loss of autonomy, were often exhausted, and found it hard to allocate time for self-care. On the basis of the research, Nicolson (1999, 2002) conceptualised motherhood in terms of loss and depression, likened it to bereavement, and concluded that some degree of postpartum depression "should be considered the rule rather than the exception. It is also potentially a healthy, grieving reaction to loss" (Nicolson, 1999, p.176).

Qualitative research into PND has also found that some women experience a changed sense of self. Edhborg et al (2005) carried out a grounded theory study aimed at exploring and describing how Swedish women with signs of PND experienced the first months with their child. Of the 224 women who completed the

EPDS, 22 were interviewed. Their ages ranged from 20 to 42 years, with the average age 32.2 years; both primiparous and multiparous women were included. Of the 22 women interviewed, twelve had suffered with depression previously, with one having suffered with PND previously.

The results were analysed using grounded theory based on Glaser & Strauss (1967). Analysis highlighted how women's struggles with life during this period related to the self, the child and the partner. Grounded theory is a particularly useful exploratory method and is well suited for investigating social processes that have attracted little prior research, such as the current research study. It is also a good method to determine what actually happens, producing thick description that acknowledges areas of conflict and contradiction. As a method, however, it can generate a large amount of data which can often be difficult to manage. IPA can often contribute to existing theories and findings by offering a more in-depth account that privileges the individual and a perspective different from that of grounded theory, which tends to use larger sample numbers to substantiate theory (Barbour, 2007).

A hermeneutic phenomenological enquiry by Lawler et al (2003) found that several participants experienced a loss of their former self, a process described by Rubin (1984) as a shift from being a known person in a known world to an unknown person in an unknown world. Lawler et al (2003) interviewed seven women aged between 21 and 40 years, each through a single in-depth, unstructured interview. Participants included five first-time mothers and two multiparous ones. Data processing was done using the hermeneutic circle and findings were presented under the four existential lifeworlds (Van Manen, 1990).

Lawler et al's (2003) study is helpful in uncovering in-depth experiences of PND. Participants vividly describe their brokenness and sorrow as they come to terms with their new role as a mother. They portray the cycle of grief they experience as they adjust to motherhood, accepting their new self and the death of their former self. Valuable insights are provided in respect of all four lifeworlds. However, the considerable age span of the participants, and the inclusion of both primiparous and multiparous mothers, reduced the element of homogeneity. It is hoped that the current study, with its greater focus on age-related experiences through interviewing

only first-time mothers over 30 years who had never suffered with depression previously, will complement and add to Lawler's findings.

A number of qualitative studies have revealed mothers' sense of entrapment within PND (Roseth, 2013; Wood et al 1997). This is also the case with Chan et al's (2002) study of the experience of a group of Hong Kong Chinese women diagnosed with PND. On the basis of a large purposive sample (for a qualitative study) of 35 women of different ages, the researchers collected data through semi-structured interviews and analysed it according to Colaizzi's (1978) phenomenological methodology. The results found mothers feeling trapped in their situation, experiencing a sense of hopelessness, helplessness and loss of control, and with ambivalent feelings towards their babies. The majority of participants perceived their husbands as uncaring and controlling, with many participants relating their depression to conflicts with their parents-in-law. Certain aspects of these results emphasise not only how different cultural practices and beliefs may affect the severity of PND, as mentioned previously in this chapter but also the need for appropriate treatment plans.

In summary, qualitative research, with its exploratory focus, is useful for gaining an understanding of underlying reasons, meanings, relationship patterns, opinions, emotions and motivations. It provides insights which can help develop ideas or hypotheses for further research, including quantitative studies. Qualitative research can prove particularly useful if exploratory work is required before a quantitative study is carried out, or if a quantitative study has been carried out and exploration is required to validate particular measures or clarify meanings. The results it offers differ from those of quantitative research through the insights they provide into a particular experience. This is achieved through well-grounded, rich descriptions and explanations of processes in identifiable local contexts, enabling the uncovering of new dimensions (for example, the cultural and socio-economic positioning that may impact women's experience of PND).

Research methodologies such as IPA offer in-depth explications helpful to uncovering previously unrecognised aspects of phenomena. In the case of under-researched topics such as that of the current study, IPA offers specific insights by its use of small numbers of participants whose experiences are explored in depth. It is also useful for a study which focuses on the meaning particular phenomena have for

participants. The findings of IPA research can challenge assumptions about specific phenomena, as well as reflect areas of inconsistency, variation and contradiction.

As with quantitative research, qualitative studies have their own particular strengths and weaknesses. Qualitative research can be time-consuming. Richards and Richards (1994) identify four other perceived constraints militating against its use: volume of data; complexity of analysis; details of classification record; and flexibility and momentum of analysis. The use of comparatively large numbers of participants by some qualitative studies may compromise the depth of explication of the phenomena. The value and quality of data and analysis rely upon the skills of the researcher, with some methodologies requiring more skill and ability than others.

Both quantitative and qualitative research can contribute to our understanding of PND; each has its own strengths and limitations, which need to be considered in relation to the particular research question under investigation. However, qualitative research into PND suggests that different women have different experiences of PND, and that these experiences do not easily fit into diagnostic categories, nor are they readily recognisable via the assessment instruments and diagnostic tools of quantitative research.

2.4 The literature on older mothers and postnatal depression

Understanding how older mothers experience the transition to motherhood and PND remains limited, despite an increase in both quantitative and qualitative research on older mothering in recent years (Carolan, 2005; Nelson, 2003, 2004; Shelton & Johnson, 2006). The increase in qualitative research has been particularly marked, perhaps because of the difficulty in capturing the complexity of the experience with quantifiable data. Whilst there are a handful of studies exploring older mothers' experiences of birth and motherhood, I have been unable to find a qualitative study whose specific focus is on first-time older mothers' experiences of PND.

Published quantitative and qualitative literature on delayed motherhood have produced conflicting results. Often, delayed motherhood is associated with positive aspects such as feeling psychologically prepared (Dion 1995); more resilient

(McMahon et al, 2011); and being better prepared for parenthood than younger mothers (Carolan, 2005; Shelton & Johnson, 2006). Older mothers have been found to have increased confidence owing to their successful careers (Welch, 1992) and (in the case of those aged 30 years and older) to have greater flexibility and personality integration than younger mothers (Mercer, 1986). According to several studies, the majority of older first-time mothers report a readiness for motherhood as a self and in the perspective of a lifetime (Formanek, 1989; Joseph, 1982; Robrecht, 1991; Winslow, 1987).

Ruzza's (2008) phenomenological inquiry into the experience of first-time motherhood after the age of forty found that the majority of mothers interviewed believed that their age and experiences made them better mothers than if they had had their children at a younger age. Older women have been found to be more likely to follow a healthy lifestyle, attend antenatal care sessions regularly and have a positive perception of their pregnancy, factors that are strongly associated with lower rates of poor outcome (Mills et al, 2012). Meisenhelder & Meservey (1987), in a quantitative study using the Miller maternal attitude questionnaire, found that previous experience in solving other problems potentially gave older mothers confidence in their ability to handle whatever might arise during pregnancy and parenting. Older mothers have been found to exert more control in planning their pregnancies and pregnancy care (Winslow, 1987). Stark (1997) found that neither age nor previous experience with pregnancy and birth diminished or accentuated the conflicts an older mother might experience regarding her maternal role: conflicts in the process of adapting to pregnancy were found to be no greater for older women than for younger ones.

Despite these positive findings, other research paints a rather different picture of older motherhood. Several qualitative accounts describe older first-time mothers as feeling that they have more at stake with respect to lifestyle changes, career, and long-term relationships than do younger mothers (Enter, 1993; Gander, 1992; Nelson, 2003, 2004; Sanderson, 1989).

Windridge and Berryman(1999) postulated a link between older primiparity (among women aged over 35) and higher than usual levels of anxiety, based on the results of a longitudinal study comparing experiences of pregnancy, birth, and the first year

of motherhood among women aged 35 years and over with the experiences of women aged 20 to 29 years. Data from 107 women were collected from medical records of labour and delivery, and women themselves evaluated control and pain management in labour, satisfaction with support from professionals, labour problems, and postnatal depression. Associations were calculated between maternal age and parity and (1) obstetric outcomes, (2) women's perceptions of labour and delivery, and (3) PND. The study found that older and younger women's experiences of labour differed in ways that were not mirrored by obstetric differences. Women over 35 years, even if healthy, tended to believe that their age might make their infants particularly vulnerable during labour. However the researchers concluded that such women's higher levels of concern did not necessarily have negative consequences for their experience of childbirth or their postnatal emotional well-being.

Muraca & Joseph's (2014) Canada-based quantitative study found that women of advanced maternal age (AMA) (that is, aged 35 years and over) had significantly higher rates of depression than younger women. Data on the prevalence of depression for women aged 20 to 44 years who had given birth within the five years prior to 2007/ 2008 were obtained from the Canadian Community Health Survey. Data collection was made via a short-form scale of items from the Composite International Diagnostic Interview, a structured diagnostic instrument designed to produce diagnoses according to the definitions and criteria of the DSM IV and ICD-10. The study found that women who gave birth between 35 and 44 years of age showed significantly higher rates of depression than women who gave birth at a younger age.

The results of Murca & Joseph's (2014) study are consistent with a growing body of literature which suggests an increased risk of depression in AMA (Aasheim et al, 2012; Spence 2008). However, the quantitative nature of Murca & Joseph's (2014) study limits its ability to shed light on which aspects of the experience of having a child when older are associated with depression. This suggests an opportunity for further qualitative research.

In the UK, where the number of births involving women of AMA is on the rise, some research studies have begun separating the experience of AMA into 'older' mothers (aged 30-34) and 'older' older mothers (35 years plus). Studies of older mothers previously have included women between the ages of 30 and 48 years old. Such a large age span can contribute to inconsistency in studies, making findings difficult to synthesize. The experience of motherhood for 'older' older mothers may potentially be very different to that for 'younger' older mothers, but such differences may not be captured. Nelson (2004), for example, found a 48-year-old participant adopting a 'grandparent type', laidback approach to motherhood: perhaps an approach less likely to be taken by a 30-year-old new mother. Of the limited literature on older mothers, studies such as that of Carolan & Nelson (2007) concentrate on anxiety-provoking aspects of 'risk' that mothers may experience due to maternal age.

While unclear as to whether the transition to motherhood is qualitatively different for older mothers than for younger ones, existing research suggests that older women have a different approach to motherhood than do their younger counterparts. Adopting a phenomenological/hermeneutic approach to place the reader in contact with the lived experience of the older first-time mother, Nelson (2004) interviewed seven older first-time mothers, aged between 36 and 48, during their first maternal transitional year. The qualitative phenomenological hermeneutic method used in this study derived from Van Manen's (1990) Human Science research approach, and the data was subjected to thematic analysis. Although the participants did not necessarily suffer from PND during this period, Nelson found that a major theme emerging from their experiences was what she called a 'planned intensity' to motherhood. This approach to pregnancy among older mothers was characterised by such expressions as 'I've waited so long' and 'I'm going to do this thing right'. Nelson noted that this intense approach contributed not only to the high demands older mothers often placed on themselves but also to greater demands on health care professionals. A common characteristic of these older women was that they were seldom satisfied with 'standard' procedures or instructions, either before or after their baby was born. This planned approach finding is supported by previous research by Formanek (1989) and Winslow (1987).

Carolan's (2003) longitudinal qualitative study adds weight to the suggestion that older mothers' experience of, and approach to, motherhood differs from that of other mothers. Titled 'Late motherhood: the experience of parturition for first-time mother aged 35 years', this study describes how some participants experienced the 'awesome responsibility' of caring for the baby, and how this appeared to promote a 'No-one could do it like me' phenomenon. Carolan interviewed women aged 35 and over at three points in time: when they were at 35-38 weeks gestation; at 7-10 days postpartum; and at 6-8 months postpartum. Thematic analysis was applied to the data from the interviews conducted at 7-10 days postpartum, which identified the following sub themes: intellectualising the experience; pregnancy and work; lack of connectedness; helplessness; seeking more information/the expert phenomenon; identity; and putting up a front/judgements. The study found that participants identified adjustment to motherhood as a particularly challenging event, fraught with anxieties and initial struggles.

The findings of Carolan's (2003) study, while useful, rest on data collected very soon after birth. As it is well established that PND can take longer to emerge (and be diagnosed) than during the 4 weeks postpartum quoted in the DSM, analysis of women's interviews after the first month or more would enrich these findings. Such analysis would also potentially capture the experience of PND for some of those participants, which could be compared with the non-PND experiences of other participants.

While the results from both Carolan's and Nelson's studies increase understanding of older first-time mothering, the differences between difficult and normal maternal adjustment remain unclear, as do the origins of the downwards spiral to PND. The results also emphasise the urgency for further research. If Carolan (2003) and Nelson (2004) plot the path to a 'normal' experience for older first-time mothers not diagnosed with PND, how does the presence of PND impact on this already intense and pressurised experience? Research projects which attempt to answer these questions will provide health professionals, midwives and treatment programmes with invaluable insights.

Carolan's (2005) study, entitled 'Doing it properly: The experience of first time mothering over 35 years', contributes fresh insights to our understanding of late

motherhood experiences. Carolan (2005) found that maternal adaptation for first-time mothers over the age of 35 occurred approximately 4-6 months postpartum. This contrasts with the findings of other studies which suggest that most mothers were considered to have adapted by 3 months postpartum (Mercer, 1986; Pridham & Chang, 1992). Unlike previous studies on older mothering, Carolan (2005) found no association between advanced maternal age and poorer adjustment, despite her acknowledgement that "undeniably, first mothering over 35 years is fraught with anxiety and initial struggle" (p.782). Carolan also found that by 6-8 months post-partum, mothers were "overwhelmingly positive about their mothering roles and did not display the high rates of postpartum depression frequently associated with older mothering" (p.782). Focus group data used in this study clearly indicated that this older group of mothers had concerns and needs that differed from those of younger mothers, particularly in regard to confidence building in the first three months post-partum. The mothers in this study, while not diagnosed with PND, identified their adjustment to motherhood as a particularly challenging process. Further research into older mothers' experiences of PND, and the development of PND, may help clarify the differences between difficult maternal adjustment and the experience of PND among older women.

 Carolan (2005) describes a postpartum stage, experienced by her participants, between 4 and 6 months after giving birth. The themes experienced during this stage are titled 'Giving in'; 'Realising'; and 'Finding my own way'. Throughout this stage, participants appear to start coming terms with being mother: they have increased confidence and a greater sense of enjoyment. By 6-8 months postpartum they report 'Feeling like a mother' and the majority are 'overwhelmingly positive'. These stages appear useful when considering the stages of PND within older mothering and identifying changes which could support women during these challenging months.

Carolan (2007) used in-depth qualitative interviews and a thematic analysis methodology in a more recent study called 'The Project: Having a baby over 35 years'. In-depth qualitative interviewing with a total of 22 women was carried out at three points of time during late pregnancy and the early postpartum period. Interviews conducted soon after participants had given birth, at 10-14 days postpartum, provided insights into women's experiences of birth and early mothering. In similar vein to Nelson's (2004) 'planned intensity', Carolan (2007) found a

significant number of mothers in this age group approaching childbearing as a major project in their lives. Data analysis revealed that for women who had chosen to delay pregnancy, the 'project' approach was particularly common. The 'project' itself progressed through clearly defined stages: information gathering; planning and preparing; and finishing up tasks prior to the birth. Carolan's (2007) research suggests that older women want to be 'ready' for childbirth and to 'get it right'. It sheds some light on the experience of older primiparous, especially those who had a significant career investment. Carolan was also struck by certain inherent contradictions. While participants appeared to be very much in control of their pregnancies and expended vast quantities of time intellectualising their experiences and formulating plans, it seemed particularly if their baby was unsettled, the mothers felt helpless and inadequate when faced with the reality of looking after him/her. (Carolan, 2007).

Carolan's findings provide ample evidence of the fact that the transition to motherhood is a particularly challenging event, one 'fraught with difficulty' for many older mothers. Their experience includes increased incidence of PND and high levels of attendance at mother and baby units and clinics. It seems that older mothers place significant demands on health care professionals, which suggests that their requirements may differ from those of younger mothers. Like Dobrzykowski (1998), who found that nursing staff viewed older mothers as "difficult to work with, hysterical and psychologically challenging"' (p.4), Carolan (2005) found nursing staff perceiving older mothers as 'difficult' and 'needy' in terms of taking up nursing time and resources.

While Carolan's research is useful for understanding older women's experience of early motherhood, it has less to offer in relation to PND since interviews were carried out very early postpartum, a time when perhaps the full impact of PND was yet to be felt. The current study seeks to address this lacuna by interviewing older mothers about their experienced of PND but with interviews conducted after their recovery. The focus of the current study is on experiences of motherhood which have led to PND, as opposed to difficult maternal adjustment which did not reach clinical levels.

The idea that PND may have a significant impact on women and their identities as mothers is suggested by the way in which 'good' mothering has become inexorably

linked with not feeling 'down' at the birth of one's baby: in other words, the dominance of the 'perfect mother' discourse within ideologies of motherhood. Media images of older mothers can contribute to how older mothers are perceived more generally in society, potentially adding to their anxiety. Shaw & Giles (2009) collected news items from the week 23-27 October 2006, identifying 23 articles relevant to the broad topic of older mothering. The researchers then applied a media framing analysis to the data, focusing on the negative framing of older motherhood and the media's potential contribution to anxiety in expectant older mothers through the circulation of negative discourses around the topic. They found that notions of 'normative' development and the 'perfect mother' continued to structure cultural constructions of motherhood. It appeared that although feminist research on motherhood had raised awareness among women that mothering is not always idyllic, such research had yet to address the issue of the unconventional mother (Letherby, 1999). Shaw and Giles (2009) concluded that

> our communications systems –our popular culture – are not always successful in capturing the diversity of contemporary society. Or perhaps, our analysis reveals nostalgia for old-fashioned ideas, which contradict the advances of science (Shaw and Giles, 2009, p. 232).

Choi et al (2005), who used a material-discursive approach to interpret data from semi-structured interviews with 24 primiparous and multiparous women, also recognised that a potential source of anxiety for older mothers could be the 'idealised' representation of older mothers in the media.

The limited research into older mothering, while producing sometimes conflicting results, suggests that adaptation to motherhood is different, and more intense, for older first-time mothers. It seems that older mothers have a different approach to motherhood, different personal expectations, and higher levels of anxiety. They tend to be more demanding of health professionals and to be viewed by health professionals and wider society in a somewhat negative light.

Many instruments have been used to measure various aspects of PND and maternal adaptation. However, not all of these may be relevant to all women's experiences,

and this may have added to the contradictory nature of some findings. The wide range of ages of participants in many studies, the lack of clarity around the effects of age-related differences, and the inclusion of both primiparous and multiparous women may also have contributed to conflicting results.

Research focused on the experiences of older mothering is in its infancy and it seems research into the experience of PND for older mothers has barely begun. The existing literature suggests that if expectations of, and approaches to, motherhood vary according to age, the nature and quality of older mothers' postnatal depression may also be different. Their experience of PND may embrace different conflicts, disappointments and expectations, in turn requiring different professional treatment and care.

The limited available research in this area, and the differing, sometimes conflicting results, point to a lack of clarity when it comes to understanding PND among older mothers. How do we expect to care for these mothers, and offer them appropriate treatment services, if the nature of their suffering is not understood? Qualitative research offers a good starting point to better understand this under-researched phenomenon.

2.5 Rationale for the current study

Research informs us that the first year of new motherhood is recognised as a potentially difficult transitional period for many women (Cowan & Cowan, 1995; Lee, 1997), with older primiparous mothers particularly disposed to a unique type of maternal transitional crisis (Levinson, 1996).

Postnatal depression remains a complex phenomenon. To date there is no clear indication why postpartum depression strikes some women and not others, but it is known that 10-15 in every 100 women become depressed after having a baby and that the prevalence of PND is significant for first-time mothers.

In England and Wales, the average age of first-time mothers, steadily increasing for years, is currently estimated at over 30 years old (ONS). If current trends continue, an increasing number of first-time (and multiparous) mothers over the age of 30 in

England and Wales will suffer with PND. This emphasises the need to explore and more fully understand their depression so that appropriate treatment programmes and clinical interventions can be made available. The growing number of older mothers with PND is also likely to increase demands on health care professionals, doctors and midwives. Research which improves understanding of the nature of those needs can benefit health services and improve the relevance and cost-effectiveness of the support offered to older mothers.

This study recognises that there are major gaps in the existing evidence base in relation to research on the transition to motherhood and the PND experiences of older mothers. There is no clear theory relating to PND among older mothers and only limited research exploring older mothers' experiences of postnatal depression, despite over 51% of live births in England and Wales in 2013 being to mothers aged 30 and over, a percentage which is increasing annually.

Knudson (2009) and Mauthner (1994) highlight the importance of interpersonal factors that limit self-expression and maintain depression, and stress the need to contextualise women's experiences. IPA allows for this, and offers a good research methodology option to consider how women experience themselves, their relationships, and the world around them in the midst of their PND.

What is known from the small amount of research which has been carried out with older mothers is that they approach motherhood with a 'planned intensity' and more autonomy than younger women, confront challenging media and societal representations of older mothers, and demand something other than 'standard' care from health professionals. It seems likely that if their approach to motherhood differs from that of women of other ages, then their experience of PND may too.

This study sought women who were first-time mothers, over the age of 30 when they had their first child, had suffered with PND after having that child, but had never suffered with depression previously. History of depression is identified as a major risk factor for PND, so women without a previous history of depression were chosen to rule out any comparisons of previous depressive episodes. I chose primiparous mothers as I wanted to capture a woman's first experience of PND rather than a second or third experience, whose impact might have been lessened by knowledge and practice of coping strategies learned from previous PND experiences. By

choosing women over the age of 30 I specifically targeted the fast growing category of UK mothers in this age group. I hoped to target the women described by the midwife as the ones 'you can spot...a mile off' as likely to suffer from PND.

The existing literature suggests that the best way to research women's experiences of PND and motherhood is to ask them directly: to invite them to share their own account of their experiences. This appears more relevant and appropriate than using quantitative approaches which apply predefined scales and ratings to women's perceptions and do not allow women to talk about their experiences outside pre-set frameworks.

Existing quantitative and qualitative PND studies have used differing numbers of primiparous and multiparous participants from a wide age range, with differing life experiences, culture and socio-economic backgrounds. They have included women who have self-identified as suffering with PND along with others who have been admitted to a psychiatric unit following the birth of their baby and others still who have been clinically diagnosed via instruments such as the EPDS. Interviews have taken place at varying times, pre- and postnatally; some interviews have been carried out with the mother alone, while others have involved partners. This variety of variables can make it difficult to capture a highly personal lived experience of PND, identify the differences between women's experiences, and recognise differences which are truly age-related. Whilst the current writer considers neither quantitative nor qualitative research to be superior to the other, qualitative research lends itself to the purposes of the current study appears, which involve the exploration of participants' subjective experiences rather than the collection of quantifiable information.

IPA is concerned with the detailed examination of human lived experience via in-depth interviews with a small number of participants. This methodology enables the experience of PND to be expressed in its own terms, rather than in pre-defined category systems. Smith and Osborn (2003) describe IPA as "especially useful when one is concerned with complexity, process or novelty" (p. 53). The use of IPA in under-researched topics such as the experience of PND among older mothers suggests that IPA might provide insights into, and a reappraisal of, the experience of PND among mothers of varying ages.

Findings from IPA research, often highly nuanced, can offer an understanding of a phenomenon which can then be used to contextualise existing quantitative research. IPA studies can enhance understanding, enlarge insight and contribute to existing theories and the generation of new hypotheses (Johnson, 1997; Kearney 2001; Yardley, 2008). When little is known about an identified group, such as older mothers with PND, IPA offers an opportunity to explore a phenomenon in depth. Results can then be expanded to larger numbers, creating opportunities for theory generation and testing through quantitative methods.

By prioritising women's subjective accounts, this study follows in the footsteps of a long tradition of feminist research which seeks to listen to women, understand their lives 'in and on their own terms,' and create theory that is grounded in women's experiences, language and concepts (Edwards & Ribbens, 1991; Gilligan, 1982).

Despite an increase in postnatal depression figures and the demographic trend in developed countries of an increasing proportion of women postponing first-time parenthood; there is little research exploring the experiences of older first-time motherhood and even less exploring the experience of what it is like to be an older first-time mother with PND. No studies have specifically concentrated on the PND experiences of older first-time mothers who have never suffered from depression previously.

Research suggests that the older mother's transition to motherhood has a different quality to that of younger mothers. The question remains unanswered as to whether the quality of the experience of PND is different for these mothers, too. While there is evidence of growing research into mothers of AMA, the current study is focused on women aged between 30 and 34: the age group which accounts for more births in England and Wales currently than any other (ONS, 2014).

Some research has suggested that PND is less likely to affect older mothers due to their positioning in society, stable relationships, life experience, and autonomy. Even were this to be the case, the needs of mothers over the age of 30 (who make up an increasing percentage of mothers in the UK) require exploration in order to be addressed, and the factors contributing to the development of PND among older mothers demand clarification so that health professionals can better support such women.

The provision of effective, sensitive care and treatment which meets the needs of older mothers with PND relies on a clear understanding of the special challenges PND presents to this demographic group. Such information is currently very limited. Health professionals and maternity service providers need to understand the impact of maternal age on the experience of PND so that effective strategies can be introduced to support women and reduce the impact of PND on them, their children and their wider families. It is hoped that this study will be able to go some way towards capturing the essence of the experience of being a first-time older mother with PND and towards bridging the gap between the treatment currently available and what might be more appropriate.

2.6   Summary

This literature review has uncovered a limited yet growing number of published studies exploring the experience of motherhood for older mothers. By focusing on the PND experiences of a specific group of women (first-time mothers in their 30s with no prior history of depression), the current IPA study aims to extend understanding of the potential impact of PND by focusing on a group identified by previous research as experiencing considerable difficulties in the transition to motherhood and in the early postpartum period. The results of this study may encourage further research into other specific groups of mothers to discover the extent to which age and other circumstances may affect the experience of PND.

The current study aims to build on previous research and fill a gap by providing a deeper phenomenological exploration of the lived experience of PND for older first-time mothers. I believe this study will contribute to the field of counselling psychology and psychotherapy by shedding light on the most challenging aspects of PND for older mothers. In turn it is hoped this study will inform treatment programmes and provide health professionals with an increased awareness of how PND is experienced by women of differing ages, enabling care for these women to be tailored accordingly.

2.7 Reflections

During this literature review I found myself getting quite frustrated at the 'assumption' that the experience of PND is the same for a 17-year-old unemployed, unmarried mother with an unplanned pregnancy and little social support as it is for a 35-year-old professional woman, happily married with a longed for baby and enjoying good social support. When I have run this comparison idea past midwives and health care practitioners I know, their immediate response is always 'It's got to be different!' My frustration comes from the fact that if it is different why aren't more treatment options being offered to mothers, options which are tailored to their needs? If we don't understand the nature of PND how can it possibly be treated appropriately?

I realise this study concentrates on the experience of only a small group of post-natally depressed women. Yet the age-related group of mothers to which they belong makes up a large percentage of women worldwide. I'm conscious of hoping that my study will encourage further investigation involving mothers of different ages and life experiences who happen to suffer from PND. Prevention of postpartum depression remains an important but elusive goal and may never be fully achieved. Research studies like the present one, which address a specific vulnerability to postpartum depression, will advance these efforts.

Before beginning this project I recognised the importance of finding out more about the experience of PND for older mothers in order to treat them medically and therapeutically with appropriate care and support. I also recognised my own reluctance to talk about how difficult I found life after having a baby. Only after 10 years was I prepared to reflect back on my own experiences, aware that my children were no longer babies, were happy and achieving, and did not seem to have suffered as a result of my lowness of mood in those few months after their birth. I wanted to ensure that the participants in this research felt safe and comfortable talking about their experiences and that the interview didn't impact them in an adverse way: for example, by increasing their concerns about their children or encouraging them to punish themselves for a time when they perceived themselves as 'failing'.

I saw that within the PND field much of the research involved interviewing mothers in the midst of their depression when it often might be hard to focus and there might be some cognitive and coping difficulties. I remembered how tiring my own first few weeks of motherhood had been, as I sought to adjust to being a mother despite my own clarity of thought being clouded and difficult. I felt therefore that interviewing women once they were safely out of the PND 'danger zone' and the experience had been processed would not only generate less pain or self-criticism but also enable them to employ hindsight to clarify their experiences. Free of shame, they would be able to look back from a stronger vantage point, one from which they could speak frankly about their experiences and consider what had helped them rise up and pull themselves free of the downward spiral of PND.

Chapter 3 Methodology and Method

This study explores women's lived experience of postnatal depression by engaging a qualitative phenomenological paradigm which adheres to constructivist epistemology and utilises hermeneutically-orientated Interpretative Phenomenological Analysis (IPA). In this chapter I begin by outlining my personal philosophical perspective and the nature of the qualitative paradigm that is central to this study. The chapter then engages a more specific focus on the epistemological and methodological concerns of hermeneutic phenomenology in general and IPA specifically. Attention next turns to the methods used in the study, including those relating to participant recruitment, data collection and analysis, and ethics and quality assurance. The final section of the chapter explores the use of reflexivity, both personal and methodological, throughout the study.

3.1 Personal philosophical perspective

In the introductory chapter I clarified how I work as a counselling psychologist and how this has influenced the way in which this research project has been carried out.

I believe the assumptions made about the nature of reality, knowledge and meaning within a phenomenological approach to research (in particular that of IPA) are consistent with my theoretical stance as an integrative therapist and researcher. My desire within this research study to explore each person's meaning and their lived experience of PND is linked to a collaborative stance, one which I seek to uphold and value as a therapist and which I find possible to achieve by using IPA as my research methodology.

My epistemological interest is embedded in the phenomenal reality of how a person's experience is constructed, subjectively experienced and socially contextualised. I conceptualise the framework of this project as coming from a constructivist perspective that leans towards a contextual social constructionist one. This perspective does not assume the presence of one reality and maintains a belief in the existence of many possible 'truths'.

Constructivism can be defined as a process by which reality is constructed by the observer, who creates reality by giving meaning to what is observed (von

Glasersfeld, 1984). Thus we are conscious, interpreting intentional relational beings who exist-in-the- social/cultural world and who co-create meanings through relating (Madill et al., 2000). Individuals are seen as being actively involved in the construction of knowledge and within this process the researcher is also viewed as an active participant (Jaeger and Rosnow, 1988). The position acknowledges that all knowledge is dependent on the situation and that meaning can be altered by its context (Jaeger and Rosnow, 1988). It follows that research results will vary according to the context within which data collection and analysis occurred (Madill et al., 2000).

In this constructivist context, the challenge is to develop a therapeutic understanding and interventions which are specific and appropriate to an individual's personal and social/cultural situation. Here the therapist needs to be aware of the broader cultural context and recognise the impact of discursive positioning of women and mothers. Therapy is then seen as a co-constructive process where the therapist might aim to engage in "transformative dialogue" (Gergen, 1994) through the hermeneutic process (Gadamer, 1975).

These beliefs and the integrative model developed over the course of my training have all contributed to the methodological choice made for this project.

3.2 Methodology

3.2.1 Rationale for a qualitative approach

The intention of the research question in this study is to explore the participants' lived experience of PND and the meaning attached to those experiences. Meaning is therefore central to this study, which strives to obtain a better understanding of how the participants derived meaning from their surroundings, environment and relationships during their experience of PND.

Qualitative research is aimed at gaining a deeper understanding of a specific event by first-hand experience, in-depth enquiry or quotations from actual narratives, with the intention of understanding how participants derive meaning from their surroundings, and how their meaning influences their behaviour. This is in contrast to quantitative research, which is often used to quantify data, generalise results from a

sample to a wider population, or measure the incidence of various views and opinions in a chosen sample, in the process gaining a surface description of a large sample of a population.

A qualitative research approach was decided upon as the best way of answering my research question and because of its usefulness in gaining understanding of underlying reasons and motivations, providing insights into the setting of a problem, generating ideas and/or hypotheses that could be used for further quantitative or qualitative research and to uncover prevalent trends in thought and opinion.

3.2.2 Rationale for a phenomenological approach

Once qualitative research was selected as offering the 'best personal fit' for this study, the next stage was to consider which qualitative research paradigm would best assist in answering the research question.

There is no single accepted way of doing qualitative research. Often the chosen methodology of the researcher depends on a range of factors, such as the researcher's beliefs about ontology and epistemology and the purpose of the research.

Phenomenology is a philosophical approach to the study of experience with an interest in what the experience of being human is like. Phenomenology is an umbrella term which encompasses a philosophical movement and a range of research approaches which "are informed by phenomenology but with different emphases, depending on the specific strand of phenomenological philosophy that most informs the methodology" (Langdridge, 2007. p.4).

The philosophy underlying phenomenological research developed in opposition to the positivist paradigm, with its emphasis on the existence of an objective reality that is ordered, rational, and logical. The positivist assumption is that objectivity exists independent of human interaction and that human subjectivity can be negated through strictly controlled data collection and analysis methods.

Phenomenology originated with Edmund Husserl (1859-938) and his extensive writings on phenomenological philosophy. Husserl's work emphasised a search for the central underlying meaning of a person's experience, on the basis of a perspective free from hypotheses or preconceptions. As he saw it, the essential aim was to *describe* rather than explain (Husserl 1970).

Husserl claimed that in order to consider and examine every-day experience, it is necessary to step outside our *natural attitude* (Smith et al., 2009). This concept refers to the idea that within everyday life we take things for granted and do not challenge the existence of objects and events (Giorgi, 1997). Husserl argued for the use of *bracketing* in order to look at things in a different way. Bracketing, or *epoché* (Husserl, 1936/1970), can be defined as a process which requires "the suspension of presuppositions and assumptions, judgements and interpretations to allow ourselves to become fully aware of what is actually before us" (Willig, 2008, p.53). Bracketing is part of the process of the *phenomenological reduction*; a method by which a different way of thinking can be achieved (Smith et al., 2009). This phenomenological reduction Husserl saw as a radical self-meditative process whereby the philosopher brackets the natural world and any interpretations in order to allow the phenomena to show itself in its essence (Husserl, 1936/1970, 1962/1977). By employing this eidetic reduction method Husserl believed that existential assumptions about a particular phenomenon could be entirely set aside and that this involved a shift from existential affirmation or negation to description.

Martin Heidegger (1889-1976), Husserl's student, rejected the theory of knowledge known as epistemology in favour of ontology, the science of being. Heidegger's approach to phenomenology diverged from Husserl's approach in its more hermeneutic and existential emphasis. In his book *Being and Time* (1927) Heidegger unfurled his rendition of phenomenology, which was a more contextualised phenomenology than had been considered previously. He broadened hermeneutics by studying the concept of being in the world rather than that of knowing the world. Heidegger saw human beings as being 'thrown into' a world, arguing that the individual and their activities were always "in the world", since our being is one of 'being-in-the-world'. As we are always 'in-relation-to' something, our activities cannot be studied by bracketing the world. Rather we interpret our activities

and the meaning things have for us by exploring our contextual relations to things in the world. From this Heidegger deduced that any attempt to suspend every empirical and metaphysical presupposition through a process of bracketing was effectively impossible.

For Heidegger, all description was already interpretation. Through the use of hermeneutics he sought to move beyond the description of experience to uncover meanings embedded in everyday occurrences. Phenomenology thus becomes hermeneutical when its method is taken to be interpretative rather than purely descriptive. According to hermeneutics, one needs to comprehend the mind-set of a person, and the language which mediates their experiences of the world, in order to access their message (Freeman, 2008).

Given Heidegger's view that understanding is a circular process (Packer & Addison, 1989), the hermeneutical study of a given phenomenon begins with a certain preliminary understanding of it, formed out of our presumptions, expectations, and cultural background. As information is gathered about this particular phenomenon through the process of inquiry, the knowledge that is gain is structured in terms of those preliminary understandings. This interpretative process, a central element of hermeneutics developed by Heidegger known as the 'hermeneutic circle', provides a 'method' of understanding a text and thereby interpreting its meaning. Heidegger developed the concept of the hermeneutic circle to envision a whole in terms of a reality that was situated in the detailed experience of everyday existence by an individual (the parts).

Heidegger's notion of being in the world, his idea of the hermeneutic circle and his rejection of the Cartesian tradition of subject-object dualism struck me as being well suited to my integrative model and to the goals of my research question.I therefore chose a hermeneutic phenomenological approach to theoretically underpin the current research. I opted for this because of its interpretative (rather than descriptive) nature. It also recognised the role that I, as researcher, would play in accessing and understanding Others' experience (whilst at all times acknowledging that such access would be affected by my own beliefs and thoughts). Smith and Osborn (2003, p.51) point out that the process by which "the participants are trying to make

sense of their world [while]; the researcher is trying to make sense of the participants trying to make sense of their world" is in essence a double hermeneutic.

I concur with Eatough and Smith's (2006) view that it is impossible to access a person's 'lifeworld' directly or to understand a phenomenon without making an interpretation. I also agree with researchers such as Finlay (2008), who argues that researcher influence is inevitable and must be explicitly acknowledged and worked with reflexively (i.e. with critical awareness). Finlay (2008, p.3) describes the "tension as the researcher moves between striving for reductive focus and being reflexively aware; dancing between bracketing pre-understandings and exploiting then as a source of insight; between naïve openness and sophisticated criticality.'"

By applying the reduction to psychological research I entered the 'dance'. I needed to critically and reflexively evaluate how my pre-understandings might be influencing my research at every stage of the process, from data collection to analysis. At the same time, I needed to hold them aside in order to be open to the phenomenon. I was called upon to appreciate the dialectical movement between being immersed in the phenomenon and reflexively working with my own perspective in order to distinguish what belonged to the phenomenon.

Phenomenologists assume that knowledge is achieved through interactions between researchers and participants and consider phenomenological research as subjective, inductive, and dynamic. A phenomenological approach, when applied to research, involves the study of phenomena, their nature and meanings. The focus is on the way things appear to us through experience or in our consciousness, towards the goal of providing a rich, textured description of lived experience. Researchers using phenomenological methods aim to uncover the meaning of an individual's experience of a specified phenomenon by focusing on a concrete experiential account grounded in everyday life (Langdridge, 2007).

Qualitative methodologies such as grounded theory and discourse analysis, were considered before IPA was finally selected as the methodology for this study. Grounded theory (Glaser & Strauss, 1967) is a qualitative research approach that develops theory relating to the phenomenon of interest. However, given my focus on

women who had experienced PND under similar conditions (with the aim of seeing if there were shared meanings within their experiences), I was not seeking to develop an explanatory theory of basic social processes surrounding PND. I was also aware of a plethora of existing research involving participants who had experienced PND under differing conditions. I also discounted discourse analysis, finding myself felt less interested in the specific language people use to interpret their own experience than in their sense of embodiment and sense of self and their lived experience.

3.2.3 Rationale for choice of Interpretative Phenomenological Analysis (IPA)

A number of distinct methodologies have evolved within phenomenology, including descriptive phenomenology, hermeneutic phenomenology, the lifeworld approach and interpretative phenomenological analysis (IPA) (Finlay, 2011). Given my aim of discovering more about participants' lived experience of PND, I wanted to focus on "an individual's personal perception of an event or experience as opposed to an attempt to produce an objective statement of the event itself" (Smith, 1996 p.263). I therefore chose a phenomenological interpretative approach (IPA), which I saw as in keeping with the aim of the project and its focus on describing participants' experiences rather than explaining behaviour or theorising about their experiences.

IPA, a systematic, flexible, multidirectional analytic process, offers a suitable approach for investigating how individuals make sense of their personal and social worlds (Smith and Osborne, 2003). In relation to my way of being as a counselling psychologist, IPA offers considerable congruency in terms of its assumptions, its perspective on the nature of reality and its understanding of how individuals strive to make meaning of their life experiences.

IPA is underpinned and informed by concepts and debates from three key areas of the philosophy of knowledge: phenomenology, hermeneutics and idiography. Its aim is to seek out idiographic meanings in an attempt to understand the individual and their lived experience, an exercise which may or may not offer general insights. IPA is one of a number of methodologies which have been developed to capture a person's experience of a specific phenomenon (Smith, 2004) via an approach that

involves the detailed examination of participants' 'lifeworld': their experiences of a particular phenomenon, how they have made sense of these experiences, and the meanings they attach to them (Smith, 2004). I consider this existential hermeneutic methodology useful for research into about how new mothers in their 30s, who have never been depressed before, before experience PND.

Idiography is concerned with the particular, in contrast to most psychology, which is nomothetic and concerned with making claims at a group or population level. IPA employs an idiographic level of analysis concerned with making statements about specific individuals, rather than a nomothetic approach of making probabilistic claims about groups (Smith, Harré & Van Langenhove, 1995b). This approach tends to use in-depth analysis of single cases as a means to examine individual participant perspectives in their unique context.

The idiographic nature of IPA means that the 'lived experience' of the participant is coupled with a subjective and reflective process of interpretation, in which the researcher/analyst explicitly enters into the research process (Reid, Flowers & Larkin, 2005).

In this research project the methodological aim was to capture the experiences of first-time mothers with PND, aged thirty years and over, and transparently demonstrate the interpreted meaning that those mothers ascribe to their experiences. In the process, the research sought to address the shortcomings of the current research base by providing a more comprehensive understanding of the experiences of this group of women. These experiences would provide an underlying 'structure', allowing the reader to go away with the feeling that "I understand better what it is like for someone to experience that" (Polkinghorne, 1989, p.46).

IPA acknowledges how the role of the researcher and the dynamics of the research process are implicated in the construction of meaning. It understands that all questioning and interpretation carry assumptions based on prior experience, and that these shape the limits of what can be disclosed. Consequently the phenomenon can never disclose itself in its entirety, and interpretative work is required to understand the meaning of the (partial) disclosure (Moran, 2000). What is captured of another's

experience using IPA will always be indicative and provisional rather than absolute and definitive, since researchers cannot completely escape the contextual basis of their own experience (Larkin, Watts and Clifton 2006).

IPA has been criticised at both the epistemological and methodological level. Firstly there remains some confusion concerning the ontological and epistemological status of IPA. Smith et al (1995, 1997, 1999) assert a critical realist position while claiming an interpretative, hermeneutic base which might be seen in more relativist terms. Furthermore, many hermeneutic phenomenologists, from Gadamer to van Manen, argue against 'method', and IPA's structured approach could be seen as standing in contradiction to this. Such considerations highlighted the need for me to use IPA fluidly rather than prescriptively.

In terms of methodology, Willig (2008) argues that IPA relies on an ability to use language. According to social constructionist theory, language is seen as constructing reality, rather than describing it. It could therefore be said that IPA analysis reveals more about the way individuals *talk* about their experience than about the experience itself. Against this, hermeneutic phenomenologists highlight the expressive function of language. Furthermore the interpretative analysis engaged in IPA to explore explicit meaning demonstrates that language is not always taken literally.

As in most qualitative studies, IPA-based research is limited by participants' capacity for self-expression. In the case of the current study, this was less of a concern, as all my participants proved reasonably articulate. That some aspects of their experience were out of awareness justifies my use of IPA, with its interpretative element.

3.3 Method

In this section I begin by presenting the research design of the study, followed by the criteria used to select participants and the recruitment process. I then clarify the collection and procedures used and the process of analysing the data. Finally I provide details of how the study addressed a range of ethical and evaluation considerations.

3.3.1 Research design and format

The study makes use of a qualitative research design based on Interpretative Phenomenological Analysis (IPA). This design values the relationship dynamic between researcher and participant and views the data collected from each participant as emerging out of the intersubjective space between researcher and participant (Finlay and Evans, 2009).

At the point of beginning the research process I was (and continue to be) a student enrolled on a Doctorate in Counselling Psychology & Psychotherapy.

Before interviewing participants I requested a colleague to interview me on my own experience of first-time motherhood at the age of 30. This was intended to draw out my own personal assumptions about this project and what I expected to find. A pilot study was then carried out with a participant, whose selection is outlined below. The information and knowledge gained from both personal interview and pilot study were used to inform a semi-structured interview schedule. This was used to guide in-depth interviews with four further participants, each of whom was interviewed on two occasions about their experiences of PND. The content of the four in-depth interviews was then subjected to IPA.

3.3.2 Selection and recruitment of participants

I planned to interview five female participants, one of whom would participate in the pilot interview but not in the subsequent in-depth interviews. The inclusion criteria specified that all participants would be women who had had their first child when they were aged 30 years or older. This child would have been born within the last 5 years and the mother would have to identify with feeling '*down, with little interest or pleasure in doing things'* for a period of at least two weeks within 4 weeks of giving birth to their child. Originally I had planned to interview first time mothers within 2 years of the birth of their first child, but no-body came forward for interview. The period after the birth of the first child was extended to 5 years and it was agreed with the Metanoia ethics committee that the criteria for 'first-time mothers' would also include women who had gone on to have further children (as long as the experience

of PND followed their first child) in the hope that some participants would come forward with the widening of the criteria –though appreciating that the experience of motherhood with a second child might have been different to the experience of a first child and may or may not have involved PND.

Each woman would not have a prior history of depression before childbirth and each would be recovered at the time of being interviewed. Hall's 2006 study had highlighted women's reluctance to disclose their feelings of depression for fear of negative consequences, so the criteria did not specify that participants had to be formally diagnosed with PND but to be able to identify with feeling *'down, with little interest or pleasure in doing things'* after the birth of their first child. I chose primiparous mothers because I wanted women to talk about the impact of PND from the shared viewpoint of having their first child and I wanted to capture a woman's first experience of PND rather than a second or third experience, whose impact might have been lessened by knowledge and practice of coping strategies learned from previous PND experiences. This was based on the assumption that experiences of PND after having second or subsequent children might be different, whether more or less impactful.

Mothers in the 30-39 year age range were chosen originally because the average age of mothers in England and Wales in 2013 was 30 years (ONS, 2014) and also due to the growing proportion of babies born in England and Wales born to women aged 30 years and above. However three of the participants in this study were within the 30-34 year old age range and one participant was aged 35 years when they had their first child and suffered with PND.

The process of recruitment began through an existing connection I had with an organisation referred to throughout this project at Company1, an organisation which offers local support services to mothers and their families affected by the symptoms of Pre- and Postnatal Depression in Central England.

Only one prospective participant came forward from Company1, and she took part in the pilot study. I then contacted two other postnatal depression support organisations about the research project and within a few days two women from each organisation came forward. These four women were each interviewed twice over a six-month period.

Of the women chosen to participate in the study, two had been formally diagnosed with PND and two had identified and experienced the symptoms of PND but without a formal diagnosis. Two participants had gone on to have a second child at the time of interview.

All four women were white, middle-class, English-speaking, highly educated and married. Three were from the UK, where their first child was born, while the fourth was from outside of the UK and had given birth to her first child there. While one woman had returned to full-time employment, the others were either working part-time or still fulltime mothers. All had been married when they had their first child and all were still married to the same partner when the interviews were carried out. No potential participants were excluded from the research as only 5 women in total came forward to volunteer to take part in the study.

The selection of four participants for individual interviews was in line with the recommendation by Smith, Flowers & Larkin (2009) that IPA studies consist of between 4 and 10 interviews.

3.3.3 Data collection

Before the search for participants began, I invited a colleague to interview me on my own experience of having a child when aged 30 years old and 'feeling down'. This was to facilitate reflection on my part by summoning my own memories. The interview aimed to help me gain further clarity about my own beliefs and assumptions around this work in order to "acknowledge how [one's] own experiences, and contexts inform the process and outcomes of inquiry" (Etherington, 2004, pp. 31-32).

A transcribed copy of the personal interview was sent to my colleague (the interviewer) for us to discuss. A copy of the interview was also sent to my supervisor for consideration, discussion and feedback. As a result of those discussions I was able to write up my own personal assumptions with the aim of bracketing them during the research process (see Appendix 2). As Gadamer (1975) notes, "the important thing is to be aware of one's own biases, so that text can present itself in

all its otherness and thus assert its own truth against one's own fore-meanings (Gadamer 1975, pp. 268-69).

In discussion with my supervisor it was noticed that most of my experiences of that period in my life had been negative and that it was important for me to bear in mind that not all people's experiences of PND might be quite so negative. Finlay (2013) points out that when a researcher has gone through an experience similar to that of a participant, it is necessary for her "to try to bracket her own experience in the first instance and not assume any commonality of experience. Instead, the researcher would need to be genuinely curious about the other and be open to the very real possibility of being surprised by what the participant brings" (Finlay, 2013, p.7).

The next stage of the project involved conducting a pilot study, to enable further reflection as well as fine-tuning to improve the overall strength of the research design and augment its validity. It was hoped that the findings of the pilot study would guide and refine interview questions, identify unhelpful aspects of interviewing such as leading questions and amend the interviewing approach for the in-depth interviews to follow. In short, the pilot study was to help ensure that the data collection process would achieve the desired results as set out in the research question. In relation to qualitative and ethnographic studies, Sampson (2004) considers pilot work prior to researcher immersion in the field and suggests that 'while pilots can be used to refine research instruments such as questionnaires and interview schedules they have greater use still in ethnographic approaches to data collection in foreshadowing research problems and questions, in highlighting gaps and wastage in data collection, and in considering broader and highly significant issues such as research validity, ethics, representation and researcher health and safety " (Sampson, 2004, p. 383).

I discussed the purpose of the study and practical aspects of it (including the interviewing process and the amount of time that would be required of each participant) with the directors of Company1, who signed a consent form (Appendix 3) allowing me access to their clients through any of the Company1 support branches.

The directors agreed to display information about the research project in the form of an A4 research poster (see Appendix 4) at all Company1 sites hosting mother and baby groups. The poster encouraged women who fitted the research criteria to

contact the directors, who would in turn gain permission from each potential participant for me to contact them to talk about the project in greater detail.

Before the posters were displayed, one of the directors outlined the project to 'Claire', a Company1 client who fitted the participant criteria, and she agreed to be contacted by me. I contacted Claire initially via telephone to validate that she had agreed to take part in the research and check that she fitted the criteria. Once this had been established Claire was then emailed an information sheet and consent form. The information sheet included contact numbers for me and my supervisor, so that Claire could get in touch should she have any additional questions or clarifications (Appendix 5).

After considering this information Claire agreed to take part in the pilot study and completed and signed the consent form. This was given to the researcher at the start of the interview, which was carried out at her home. The interview, which lasted 65 minutes, was then transcribed and, whilst not subjected to IPA, was dwelt upon in great detail.

As a result of my personal interview and this pilot interview, semi-structured interview questions were put together to guide future in-depth interviews (see Appendix 6).

After the pilot interview, several weeks elapsed where no further participants came forward from Company1. I therefore contacted two other PND organisations, referred to within this project as Company2 and Company3, initially via telephone. In each case I was able to speak to a director and explain the purpose of the research project, along with the inclusion criteria. Both organisations agreed to display a research poster (Appendix 7) on their Facebook web pages. Within a week two women from each organisation contacted me to tell me that they met the inclusion criteria. I spoke with each potential participant to further explain the project and check that each of them fitted the participant criteria, which they did.

With the participants' agreement, I then emailed each of them the information sheet and consent form as previously described. All four participants agreed to be interviewed either in their home or via internet (Skype), if more convenient, on two separate occasions separated by between three and six months. For the two participants who were to be interviewed face-to-face, I followed the same procedure

as that applied to the pilot study, above. The two internet interviewees posted me their signed consent forms prior to their interviews. (Skype was more convenient for two of the participants owing to family commitments. The impact of interviewing participants via Skype rather than face to face is considered in the Discussion chapter of this project.)

The data for this IPA study therefore emerged from eight in-depth interviews with four participants. Each interview lasted approximately 60 minutes. Each was recorded on a digital tape recorder, transcribed afterwards, and a copy sent to each participant for consideration and verification of accuracy. The same process was followed for the second round of interviews, arranged with participants several months later. I made notes of any points of interests arising from the first interviews that participants might usefully to expand upon during the second interviews, if they felt able to do so.

3.3.4 Data analysis

After transcription, each interview was subjected to IPA (Smith, 1996). After all interviews were completed, for two weeks I listened to each interview again, making sure to read and re-read each of the eight interview transcripts without making notes. By doing so I immersed myself in the data, allowing myself to 'dwell' with the data in accordance with Finlay's (2013) observation that "'as we dwell, new understandings emerge; data are transformed into meaning" (Finlay, 2013, p.10). I aimed to become as familiar as possible with each text and develop further the process of entering into the participant's world. On this basis I began to get an idea of the experience of the participants as a whole.

After this initial period, I began to make notes on each transcript. I sought to identify anything of special interest, focussing on the nature of the phenomenon as a human experience and not the individual per se. I chose to manually analyse the data and not use computer software at all, for the reason that I wanted the phenomenological process to be solely between me and the participant. I saw computer software as giving the appearance of interference in the phenomenological process and I felt that would distance me from the interviews and ultimately the participants.

Gradually I began to identify and focus on 'meaning units' of data. These included not only passages of text but also pauses, sighs and other non-verbal communication which seemed to stand out from the preceding text. I began to write in pen at the side of the meaning units any notes of interest resulting from each interview, along with emerging themes and how PND was experienced by the individuals. In accordance with IPA, I gradually began to engage in the double hermeneutic process described previously, exploring the semantic content and language descriptively, linguistically and conceptually.

During this phase it became apparent that the interviews with one participant (participant 3) were providing a fuller explanation of her experience of PND than those of the other three participants. On completion of this phase, the transcripts relating to participant 3 was therefore used to produce a list of potential sub-themes (Appendix 8).

The in-depth analysis of this participant's interviews allowed sub-themes to be refined and developed. The other six transcripts were then analysed to identify, refine, contradict or add to these sub-themes. Each sub-theme from the participant 3 transcripts was written up on a separate piece of paper and the researcher studied the remaining transcripts to see if a sub-theme was supported and developed further by these transcripts, or contradicted. An effort was made to see if any additional sub-themes could be identified. Verbatim quotes from all transcripts were used to support the sub-themes.

At the end of this part of the process, connections between emerging sub-themes were sought and they were grouped together according to conceptual similarities. Each grouping was then given a descriptive label. At this stage some of the sub-themes were discarded due to lack of support or of connection across transcripts, indicating a weak evidential base. Others were dropped because they did not tie in with the emerging structure. Out of this developed a final list, which provided the basis of a table of six superordinate themes, which are explored in the next chapter.

Appendix 9 illustrates the progression towards the development of final superordinate themes through the process described above. Although typed

versions of the themes are presented in the appendices, all the analysis involved was carried out by pen and paper.

3.3.5 Ethical considerations

Attention was paid throughout the research to key ethical principles relating to duty of care, informed consent and confidentiality. All participants were informed that they could withdraw from the research process at any time up to the writing up of this thesis.

Given the significant existential issues being discussed I was aware of the potential to distress or re-traumatise participants. I drew on my sensitivity, empathy and therapist skills as I monitored how each interview was affecting the participant. I often checked in with them to ensure they were not unduly upset or moved by the content of the interview. Time was always left at the end for the participant to review any difficulties she may have had during the interview. I ascertained that after the interview the participant would have the support of a friend or partner so that they would not be on their own in the house. Participants were also offered a further meeting or Skype interview with me in which they could discuss any matters or problems arising from the interview. In addition, they were told they could access the Company1 team, either in person or via telephone.

The proposal for this research was granted full ethical approval by the Metanoia Ethical Committee and guided by the ethical codes of the British Psychological Society (BPS). I understand ethical research practice as a dynamic process which requires monitoring and reflection throughout the research process. As mentioned previously, all participants were provided with a 'Participant Information Sheet' and completed a 'Research Consent Form' which reiterated their right to withdraw from the research project at any point.

All audio tapes and transcripts were kept in a locked compartment. Typed transcripts were kept in secure computer files and the names of each participant and any family members that they mentioned in the transcripts were changed to adhere to anonymity considerations (this study uses the changed names throughout). After each interview, individual participants were sent a transcribed copy of their interview

to check that they were satisfied that the typed version was accurate. I telephoned or emailed each participant to check that they were satisfied with their interview transcripts and received confirmation before any analysis began.

3.3.6 Validity and trustworthiness

Differing perspectives exist regarding the importance of validation, reliability and generalisability in qualitative research, how these can best be defined, the use of procedures to establish them and the terms used to describe them.

Within the qualitative research field the concept of validity is not seen as a single, fixed concept but more as "a contingent construct, inescapably grounded in the processed and intentions of particular research methodologies and projects" (Winter, 2000, p.1).

Within qualitative research, there are differing strategies for 'testing' validity. Creswell and Miller (2000) identify eight validation strategies often used by qualitative researchers, including those of the researcher spending a prolonged engagement in the field, rich and thick detailed descriptions, and clarification of reader bias.

With small sample sizes, the concept of generalisation is inappropriate. However, qualitative researchers' use of the concept of transferability is relevant. This refers to the degree to which the results of qualitative research can be generalised or transferred to other contexts or settings. Readers need to know as much as possible about the original research situation in order to determine whether it is similar to their own and therefore whether results can be transferred to a different context. In order to do this, researchers must supply a highly detailed description of their research situation, along with the assumptions and methods that were central to the research.

Criteria related to reliability (in terms of providing standard, consistent measurement) are also less relevant to qualitative research. However, perspectives vary. Researchers such as Stenbacka (2001) believe reliability issues concerning measurement have no relevance in qualitative research. Others consider reliability and validity as being appropriately replaced within qualitative research by an examination of trustworthiness (Mishler, 2000), which can establish confidence in

findings (Lincoln & Guba, 1985). Patton (2001) sees reliability as a consequence of the validity within a study regarding the researcher's ability and skill.

Within qualitative research discussions of reliability and validity, the term 'rigour' is often mentioned. Davies and Dodd (2002) see a place within qualitative research for rigour, even if its application may differ from that in quantitative research. They argue that by "accepting there is a quantitative bias in the concept of rigour, we now move on to develop our reconception of rigour by exploring subjectivity, reflexivity, and the social interaction of interviewing" (Davies and Dodd, 2002, p.281).

While there is no general agreement on how qualitative research can be considered valid, reliable and generalisable, I view traditional positivist conceptions of validity, reliability and generalisability as inappropriate to qualitative approaches. I would argue that such terms need to be redefined in a way which is sensitive to the project in hand. However, I agree with Madill et al's (2000) view that "it seems entirely appropriate that qualitative research be open to scrutiny and that the credibility of findings rest on more than the authority of the researcher" (Madill et al, 2000, p.2).

There is no specific evaluation method applicable to IPA. However, Smith and colleagues (2009) favour the 'four principles' approach of Yardley (2000; 2008), where qualitative research is open to scrutiny in terms of sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance. I now apply these criteria to the current research.

Sensitivity to context is attended to through my choice of IPA as a method. IPA prizes the idiographic and the particular while also appreciating the interactional nature of data collection. Claims arising from IPA studies are emergent and tentative and interpretations are presented only as possible readings.

Commitment and rigour are shown in IPA research by the quality of analysis and by the provision of illustrations from the transcripts for each sub-theme and superordinate theme. My commitment is shown by my use of reflexivity, a necessary component of any interpretative study, at every stage of the project.

Transparency and coherence are demonstrated through my attention to accounting for each step of the research process: for example, as shown in the use of appendices to demonstrate the logic of the iterative stages followed in the research.

Impact and importance criteria are met though a commitment to connect with the wider literature in the psychology and therapy fields. The research findings also need to tell a good story such that participants' worlds are revealed and findings resonate for the reader. For Finlay (2011), good phenomenological research

> evokes the lived world. It challenges or deepens our understanding of the lives experience being studies. It helps us grow and enriches our work as practitioners. Good phenomenological research is also likely to be rigorous and transparently trustworthy (Finlay, 2011, p.261).

As Yardley notes in relation to the evaluation criteria,

> the framework does not prescribe exactly what you should do in order to show that your study is valid, since every study is different and can be validated in different ways, Nonetheless, if you wish to claim that your research is valid, you may find it helpful to show that, in its own way, your study meets each of the key criteria in the framework (Yardley, cited in Smith, 2007, p.235).

3.4 Personal and Methodological Reflexivity

This chapter has already considered a number of epistemological issues, such as assumptions about the type of knowledge this research seeks to generate and ontological assumptions about the world and how these may impact the research. In this final section I engage in personal and methodological reflexivity as a way of processing the influences on my research study (Finlay, 2009).

Reflexivity is an active process which is crucial to becoming self-aware. It enables the researcher to see, as far as is possible, the extent to which their experience,

biases and beliefs might be implicated in the collection and analysis of data and how their interpretation of a participant's account may be impacted by this. By stating my reflexive awareness, I hope to demonstrate the effort taken throughout this research to adhere to a rigorous approach.

My own experience of motherhood has forged a 'strong relation' (van Manen, 1990, p.33) for me with this topic. Throughout this research process I was aware of my own experiences of being an older mother who experienced PND symptoms after the birth of my first child. I agree with Finlay (2013), who highlights the necessity for the researcher to take time to reflect on both prior and evolving understandings and for them to know what it is they are striving to bracket in order to be open. Throughout this study I aimed to adopt a phenomenological attitude to my research, one in which I could slide between "striving for reductive focus and reflexive self-awareness; between bracketing pre-understandings and exploiting them as a source of insight" (Finlay, 2008, p.1).

As I interviewed the participants in this study, I maintained the hermeneutic epistemological and ontological viewpoint that the researcher cannot remain detached from the phenomenon she is studying, nor can she prevent any personal values from influencing it as she attempts to bracket personal feelings and attitudes.

3.4.1 The impact of my personal interview

In order to "stay open to receiving what is given" (Finlay, 2013, p.9) by my participants and to be both empathic and compassionate (Churchill 2012), I began by being interviewed myself. This personal interview, and subsequent discussions with a critical friend and with my supervisor, made me acutely aware of the very negative terms in which I viewed PND. It hadn't occurred to me that there would be any positive experiences that my participants would be able to speak about, and if there were, then perhaps they were making them up. As Finlay notes, "past knowledge is both restricted and used to interrogate the meanings that come to be, in order for the researcher to be more fully open to the research encounter" (Finlay, 2008, p.29).

I knew that I would need to be aware of these beliefs and biases when analysing my data. I aimed to hold in mind the personal assumptions drawn from my own personal interview in order to maintain a critical self-awareness of my own "vested interests, predilections and assumptions" (Finlay, 2008, p.17) and how these might impact on the research process and findings. I thus placed my own subjectivity in the foreground as I began the process of separating out what belonged to me and what belonged to the participants.

The revelations from my personal interview enabled me to be hear more clearly not only the bad but also the more positive aspects of participants' experiences: for example, their unfaltering love for their child and their desire to be responsible for its care. I worked hard at holding these tensions between my own past experiences and those of the study in order to determine differences and be "open and fully attentive and not objective and disengaged" (Finlay, 2013, p.6).

As I listened to participants' accounts of their struggles, I was very aware that in my opinion their experiences had been far worse than mine. I felt relieved that I had not gone through that and to a certain extent felt I had 'got off lightly'. This enabled me to an extent to separate my experiences from theirs and to achieve a good balance: I felt 'open' to their good experiences and at the same time shocked when hearing of the extent of their suffering.

3.4.2 My positioning as a therapist

Before I underwent my personal interview I was aware of my own reluctance to undergo it. I had never really reflected in depth on this experience and was slightly afraid of 'reliving' those bad times and reopening old wounds. I believe my reluctance to 'go there' myself affected the depth of questioning in my subsequent interviews with participants, all of them mothers of young children. Aware that the past could never be changed, I was conscious of taking them back to a difficult time. Time itself had now passed, and their lives had moved on.

I therefore believe my own personal experience may have held me back somewhat when questioning participants. In addition, my experience as a psychotherapist perhaps made me cautious regarding the depth of my questioning and encouraged me to monitor my participants' responses and wellbeing during interviews more

acutely. Whilst I believe my experience as a therapist also enabled me to be empathic during the interviews, I also think it held me back to an extent. As a therapist I was conscious of the short time we had together. In addition, my experience of working with clients in the medium- to long-term also made me aware of not opening up emotional boxes which could not be closed in the short time we spent together.

However, my skills as a therapist and my genuine interest in this project I think contributed to the rich quality of the interviews. Although I may not have pushed participants to search deeply for answers, I think my 'insider' status as a mother and my presence as a therapist enabled me to actually receive more from the participants than I had to ask for. I think it created a space for them to fill comfortably with information, if they chose to. I myself was comfortable with this, for it gave the power to them, allowing them to disclose according to their own choice and not be pushed by me into 'going somewhere' they didn't want to venture.

By the same token, I was relieved that these women were no longer in a depressed state. Had it been otherwise, my questioning would have to have proceeded far more gingerly, and it might well have felt unsafe for me to question them. As it was, I felt protective towards them.

3.4.3 My presence in the interview process

It is necessary to consider the extent to which participants' accounts may have been influenced by my presence during interviews. Along with knowing that I was a mother who worked in a voluntary capacity for a PND organisation, they could also tell by looking at me that I was older than them and that I had probably started a family about the same age as they had.

I believe that within this process I was considered an 'insider' as opposed to an 'outsider'. I was seen as someone with an understanding of how it is to struggle with a situation yet remain a competent woman: after all I was training for a doctorate and was a mother, too. My own experiences as mother also I believe enabled the interview process and added to the quality of the data that was collected.

The interviews themselves were quite fast moving. It was as if friends were chatting, with occasional pauses along with moments of laughter which, I think, acknowledged our shared understanding of motherhood and challenging times. I think the humour may also have acted as an antidote to shame, making the space between us a non-threatening one.

As I consider more deeply the relational process emerging between myself and my participants (Finlay and Evans, 2009), I wonder if the fact of my being a little older than the participants while having a shared experience with them may have created a positive transference: perhaps a 'mother' transference. Certainly, the interviews seemed very honest and searching; participants did not hold back, and information was very forthcoming without my having to push. The fact that we had so much common ground -- in terms of educational level, cultural background and life experience -- seemed to contribute to this positive transference and to the richness of the data collected' It seemed to strengthen the alliance we forged and, to an extent, to counteract the 'experimenter' effect, which may limit participants' ability to be completely open and honest about their experiences.

3.4.4 Methodological Reflexivity

Typically IPA researchers aim for a fairly homogenous sample of participants. I was aware that all five women (including the pilot study participant) who put themselves as participants were highly educated, successful professional women who were ethnically White. I wondered whether they might be the kind of women who typically stepped forward to help others and whether there was something about this aspect of their personality which may have made them more susceptible to depression in the postnatal period. I also was aware that I was interviewing a particular 'kind' of person: determined, articulate, brave, altruistic in their desire to help others by talking about their own experience, and ultimately capable.

I would have liked to have been able to interview a more diverse range of women for this study. It would have been interesting to see if there were shared PND experiences among women from a variety of socio-economic and cultural

backgrounds. Such a diversity of participants had been initially expected, both by myself and by the directors of Company1, a large postnatal depression support organisation in Central England. A fuller exploration of why so few women came forward to participate in this study, while not helpful for this project, might provide further insights into why certain women come forward while others remain reluctant. As I reflected on this reluctance on the part of mothers to come forward, I recalled my own reluctance to go through that initial personal interview.

Reflecting back on the process of analysing the data, I am glad that I used pen and paper rather than a computer. I think this way of analysing kept me immersed in transcripts and very connected to the participants during my efforts to be open and mindfully aware of my biases and assumptions.

However, using traditional tools for the analysis may have made the process longer, and I feel slightly uncomfortable at the length of time (18 months from the time of the initial interviews) taken to complete this project. While, for me, the intensity of the interviews was not lost, I was conscious of not wanting the participants to feel they were not my priority.

At times I found this project, and the data it had yielded, overwhelming. This was particularly the case if there were family or emotional difficulties going on in my life, at which times I put the research aside. I found it initially quite daunting to consider the data I had collected. As I began identifying patterns across cases to seek to build a thematic structure (Smith et al, 2009), the quantum of data reduced. I knew I had to let certain experiences go, but it felt almost as if I were betraying my participants, because I knew how much they wanted their experiences to be 'out there'. I wanted to try to include everything but knew that I couldn't. At times like this I began to feel quite 'stuck'. However, I would put off speaking to my supervisor or asking for help until (I told myself) I had worked through the 'stuckness' myself. Eventually the point was reached when I considered stopping the research altogether. I contacted my supervisor, who helped me move forward. Together we recognised the possibility of a parallel process between me as a researcher struggling to ask for help and the

participants within their PND, wanting to resolve their own difficulties yet suffering in silence.

Overall, I believe my commitment to personal, methodological and epistemological reflexivity throughout this project has added to its transparency, validity and trustworthiness.

Chapter 4 Findings

I begin this chapter by offering a short narrative summary of each participant's experience of postnatal depression. In the second section, I outline the six superordinate themes and eighteen sub-themes which emerged from the interviews with participants, further supporting quotes for each superordinate theme can be found in Appendix 9. The final section comprises my own reflections on the findings and analytic process.

4.1 Individual Narratives

4.1.1 Judy's story

Judy experienced her postnatal depression as a 'manic panic'. She found herself in a world full of risks requiring constant 'risk assessment' to keep her baby safe and alive. Her manic hyper-vigilance involved constantly scanning the environment and managing her fears about making a mistake which could scar her child for life. This resulted in internal pressure to ensure every aspect of child care was 'right' and 'perfect', placing her in a state of constant anxiety. She had a sense of shame about not being good enough to have her child because of her perceived poor mothering skills and belief that her daughter was being 'short-changed' because of this. Judy was stuck in a loop of internal criticism. She felt guilty and strove to improve her performance; this left her exhausted and anxious, which in turn led to feelings of being out of control. She then used self-harm as a way of punishing herself for her perceived underperformance and failure. Try as she might to improve her performance, it never seemed 'good enough' to her.

Her tried and tested coping strategies of hard work and sheer determination in her work life proved futile when applied to her new 'job' as a mother, leaving her sad and feeling cheated of the 'joyful' experience of motherhood. Unable to ask for help from others because of her fear of being judged, and with her decision-making process and determination to sort out her own difficulties both in a state of collapse, Judy felt completely trapped. Her only escape route was to run away, which she did on one

occasion. Counselling and returning to work eventually gave her the understanding and ability to move forward and regain the identity she felt she had lost.

4.1.2 Sophie's story

Believing herself to be full of 'black blood' and 'poison', Sophie was a mother overwhelmed by emotions. She felt she had 'lost' the person she used to be before having a child. While wanting to take responsibility for her child, she found this exhausting (her baby rarely slept) and missed the joy, simplicity and freedom of her old life. Feeling profoundly alone, she tried to cope with the endless demands of motherhood by giving everything of herself in order to keep some control over her life. She found herself sinking into an emotional 'vortex', with no chance of escape. As she sank lower and lower she contemplated being hit by a tram – not to die but just to lie down quietly for a while and find some peace. While aware that she was depressed, Sophie was afraid to admit it, keeping up the façade with friends, family and old work colleagues that all was well.   Feeling responsible and not wanting to 'burden' others made her feelings of isolation worse. She was unable to see a way out of her situation until sleep school rescued her, giving her 'hope' that her child would sleep and life could resume.

4.1.3 Mary's story

Mary had been looking forward to her new baby. She was expecting to enjoy motherhood and be naturally good at it. Disillusion quickly set in, and she found herself overwhelmed by the challenge of meeting the child's demands while desperately needing to be cared for herself. Feeling cheated of an enjoyable motherhood experience and unable to live up to her own expectations, she attempted to deny all that was happening to her. This worked initially and she was able to carry on, but gradually her body began to shut down and she felt disconnected from her surroundings and from others. Scared and aware that something significant was going wrong, she felt an urgent need to understand what it was rather than block it out with medication. Fearing that no-one would understand, and that she would lose the person she used to be if she alerted people to her changed state, she tried to cope with everything by herself. She felt she had to protect others from her worries and torment. Overwhelmed by the sense that the

help she needed was unreachable, she felt trapped and unable to see a way out of the situation. She would eventually be rescued through counselling.

4.1.4 Rachael's story

Rachael had always wanted a child but, unsure if she could have one, had said she would never moan if she ever had a baby. After looking forward to motherhood with certain expectations about how it would be, Rachael found the reality "distinctly underwhelming". A capable, skilled professional woman before motherhood, she hardly recognised the person she had become: someone with no control over her body or her world, and apparently incapable of being her version of the 'perfect mother'. Wanting the responsibility of caring for her child yet finding all her previous life skills seemingly useless, she spiralled out of control; she felt totally lost in this new 'job'. Her feelings of isolation worsened as she withdrew not only from her group of new mothers (which she didn't feel a part of) but also from her family. She did this to avoid the shame of having to 'confess' how she felt and also to protect them from worrying about her. As Rachael followed the socially constructed 'rules' of ideal motherhood (breastfeeding, educationally stimulating the child), she strove to do everything 'right' but found herself going through the motions in a robotic, functional, emotionless way. She sank deeper and deeper into misery, feeling increasingly disconnected from herself. Unwilling to ask for help or even give herself a break by passing the baby to someone else, Rachael sacrificed her own self-care and wellbeing in her pursuit of being a good mother. A breakdown finally made her distress impossible to deny and she was forced to recognise her situation. Her husband's insistence on intervention by a health professional steered Rachael into counselling, where she was helped to regain control of herself and her life.

4.2 Themes

There are several common elements in the narrative summaries above. All four participants had looked forward to motherhood without anticipating any difficulties. For each, the reality of becoming a mother had little in common with their expectations. PND acted to curtail their enjoyment of their new responsibilities,

making them feel they were failing to reach the standards they had set for themselves. This in turn fuelled feelings of shame that silenced them and damaged their sense of self to the point where they could hardly recognise the person they had become. Not wanting to burden others, and seeking to overcome their difficulties by themselves, they ended up exhausted and entrapped in a situation where nothing they did seemed good enough.

By analysing the data from the eight interviews a number of sub themes emerged which were then grouped together into six superordinate themes that appeared to resonate strongly with participants' experience: (1) Striving to be the perfect mother; (2) Feeling a failure;(3) Being sucked dry; (4) Shame of the other's gaze; (5) Feeling stuck and overwhelmed; and (6) Becoming lost.

4.2.1 Striving to be a perfect mother

This superordinate theme with its two sub-themes highlight the participants' project to be the best mother they could possibly be. All of them had been looking forward to becoming mothers and were excited at the prospect of having a baby. It seems that all participants held expectations, not only about the kind of mother they wanted (and were going) to be but also about how the experience of motherhood should be for them.

For Rachael, her pre-delivery expectations of motherhood were clear:

> I thought I wanted this (baby) for so long, I've been given this chance and it must be perfect, it must be amazing and I'll never be able to do this again [Rachael].

Mary "expected it would all just happen naturally and I would be really good" [Mary]. This expectation of being a 'natural' mother was also present for Sophie:

> He (the baby) was mine…he was my job, my responsibility…surely I could get this right. And I'm a mum! Doesn't that gene just turn up and…make women know what we're doing? [Sophie].

Judy, too, had high expectations:

> You kind of think, well the hospital will know what they're doing with the birth, beyond that I just thought, well it's a baby to look after and it can't be that difficult [Judy].

While all four participants expected to adapt easily to motherhood and find it an enjoyable time, over time they found the lived experience of being a mother to be very different from their expectations.

However, the qualities contributing to being the 'perfect' mother varied between participants. For some, being the 'perfect' mother was about giving the baby the 'perfect' start, while for others it was about enjoying motherhood in an effortless way, projecting a perfect mother image to others, or having a baby that slept well or was soothed quickly.

When the mothers found themselves falling well short of their own expectations, a number of different feelings were aroused within them. Rachael, for example, experienced a powerful sense of disillusion:

> I think because it wasn't the perfect image that I had envisaged or seen on the TV or whatever…I just thought no, it's not good enough. Yeah…it's not right up there…so it's bad…there's no middle ground…I kept thinking I'm off on maternity leave, I've got a year off, I should be enjoying it, everyone's telling me I should and I'm not! [Rachael].

Sophie found herself thoroughly perplexed:

> I'm actually allowed to be a stay-at-home mum. I'm choosing this, I'm not being forced to go back to work. I should be enjoying it more. I don't want to go back to work – I know I don't want to go back to work. I want to raise my children, but why aren't I doing a better job raising my children? [Sophie].

This failure to live up to their own expectations filled the mothers with disappointment, anger and frustration. These expectations of the self, present for all the participants is a sub-theme within this superordinate theme. All were used to coping, to working successfully through any difficulties they encountered during their lives before motherhood. Not being able to reach the standards set for themselves was really difficult to comprehend. Judy was frankly mystified:

> I've gone through the options and she's (the daughter) still not happy or she's still doing the opposite of what I want her to do [Judy].

Rachael, too, could not get her head round what was happening:

> I wasn't producing the results I'd expected, I thought this isn't right, I'm doing everything I'm supposed to…I'd always done well in exams and so had grown up with

the message yes study hard through books and everything will fall into place and then of course it didn't so felt a bit of a failure on that part…[Rachael].

A conflict arose between participants' expectations of the mother they wanted to be and their actual experience as mothers. This led them to believe they were somehow at fault or doing something wrong. Ultimately, all of them felt deskilled, with a deep sense of failure.

Rachael described her experience of conflict thus:

I think I just felt, very out of place with all of it, I didn't feel like a natural mother, it didn't come easily to me at all. I didn't know what to do, I know everyone has that, but I really didn't know my place as a mum and so he was…although bizarrely he was the reason for my being a mum he was preventing me from finding out about 'mummy' things by getting in my way of mum conversations and I just thought a real sort of conflict, like no no be quiet and then I can listen to this conversation about babies crying, without thinking actually he's just here. So yes, it was just conflict all the time [Rachael].

Sophie sought reassurance by summoning images of her old, capable self:

But I'm really stubborn and independent, so I kind of thought well I can get through this, I can fix this. I can read the books, I can do Gina Ford sleeping, oh that didn't work, shit, right, what does the next one say? Yes I was constantly …it'll come right, I can fix this, I will cope, it'll get better, it'll get better [Sophie].

Internal expectations remained high. As Judy put it, "I don't think it was what will the neighbours think, it was me putting the pressure on myself [Judy].

For some participants, societal expectations were also important. Wanting everything to be (and appear) perfect, these mothers found it difficult to let others know about their vulnerability, or give them any insight into their new world. Sophie, for example, worried about the image she was projecting to others, including her new peers and her old work colleagues:

You would tell some people in your mother's group but you're not completely honest with them, because you're still trying to give the impression of 'I've got the perfect life'…You want people…to kind of go, 'She's got it all' [Sophie].

In their professional lives, participants had been able to deal successfully with any situation, however difficult; they had worked their way methodically through problems, drawing on resources within themselves or from others. Now, despite their best efforts, old processes and ways of overcoming difficulties were failing them. They did not feel 'on top of' their new situation. Feeling far from perfect, they were unable to enjoy this new experience 'naturally' and their old fail-safe processes and problem-solving skills did not appear to work in this new 'role'. The mothers begin to feel deskilled, doubtful of themselves, and increasingly despondent and overwhelmed.

Overall, the experience of PND left the mothers with a sense that they were not providing the environment and start they wanted for their child. Their inability to live up to their own expectations and standards left them confused. For all of them, this was an unanticipated situation and one they tried hard to overcome or 'fix'.

Drawing on their professional life and experiences before motherhood offers them little help now. All of them know that something is wrong, although only Sophie identifies herself as suffering from PND.

Differing standards and ideals amongst the participants contribute to their sense of underperformance. All of them see themselves as being at fault, rather than the standards they are trying to attain. None of the mothers question the appropriateness or relevance of the standards, only themselves and are prepared to sacrifice everything of themselves to achieve these standards –a further sub-theme within this superordinate theme. No matter how hard all of them strive to be the perfect mother by reaching these personal standards, none ever feels their attempts are good enough.

4.2.2 Feeling a failure

This superordinate theme with its four sub-themes show how failing to live up to their expectation of being the perfect mother is a scary 'new' experience for the mothers and one they feel ill-equipped for. The sense of failure has a self-punishing element to it: the mothers feel responsible for their poor performance and angry with themselves. They appear to turn on themselves for their perceived inadequacy which is a sub-theme within this superordinate theme. Despite their active struggle to enjoy

motherhood, they experience anger not only at themselves but also at being 'cheated' out of the enjoyable experience of motherhood they feel entitled to.

Mary described her sense of failure thus:

> I'm not very good when I can't do something, when most things come to me quite easily. And I always kind of expected that I would end up as this mum with a big table in the kitchen cooking and baking with loads of kids round…So I think part of me was that I had failed and that I had failed Max and that I felt I was cheated out of what I thought motherhood would be like for me [Mary].

Judy was surprised by the absence of fun:

> It wasn't fun. And I think it took the excitement and the fun out of everything and being a mum…none of that time was fun, it was surviving…Feel kind of cheated. [Judy].

It was as if a new world had opened up, a scary place full of failure which seemed to throw into doubt almost everything that they had known to be true about themselves before motherhood. This new world challenged their self-identity and unsettled them. Unable to recognise themselves and gripped by this new feeling of failure, the mothers sailed into unchartered waters.

Rachael sense of failure left her feeling out of control:

> I was used to being very good at my job and then suddenly things were going wrong and it was my fault and I didn't like that at all, it was a real change in my identity so maybe, I think probably scared me a little bit 'Oh, I can't…I'm out of control' [Rachael].

The feelings of failure carry with them a sense of personal unworthiness. Participants spoke of feeling undeserving of the child, whom they saw as having been short-changed by the mother they had been given. As Sophie put it, "Sometimes you think would they be better off if I did put them up for adoption" [Sophie].

Judy's sense of failure led to her actually walking out of the situation:

> I walked out one morning…I sneaked out…and left my husband a note and said I can't do this, you're better off without me. I really did think I'm not doing this well enough. I really can't be a mum. Not to the point of I wish I hadn't had

her, it was never that, it was maybe I wasn't good enough to have had her [Judy].

Punishment for failing is never directed outwards towards the baby or others but is internalised and sometimes directed towards participants' own bodies. While one mother resorts to self-harm, others consider it in an attempt to cope with the feelings they are experiencing.

Judy described her attempts at self-harm:

Never was there a thought of breaking anything or harming anything, just…me…I was always thinking I was failing…I didn't know what to do at all and once I was on a complete downwards, I would try and hurt myself. If it was one thing that kicked it off then I would start punishing myself with all the other things I hadn't done, which of course would just make me worse and worse and then it was almost like if I could bite myself and get the pain out that way, it was like a trigger of a release [Judy].

Rachael found herself seriously tempted to self-harm:

...I don't think I seriously would ever have done it, but I do remember…I have a knife block in the kitchen, thinking about taking the knives from the block and what I could do…to myself…I wanted to punish myself in some way – which is horrible, isn't it! [Rachael].

In their new environment, barely able to recognise themselves and aware of having left behind the competent, professional woman they had once known, participants spoke of their concern that others, too, would not be able to recognise them. Their unspoken worry about how different and inadequate they feel generates shame and concerns about not being understood by others. As Rachel put it,

I've never really failed at anything so people just don't expect me to struggle with things or find things difficult, and I think when, when I did tell them they thought I was partly joking [Rachael].

Participants felt their relationships with peers to be threatened by their growing sense of isolation and failure. Such feelings were accompanied by the perception that only *their* own world had changed: that every other new mother was flourishing

and they were the only people who were failing. As Rachael saw it, the rest of the world were

> at work. Doing their own thing. Happy in their happy little families. Enjoying it. Managing to do shopping and clean the house from top to bottom and have a beautifully behaved baby as well [Rachael].

Such thoughts increased participants' sense of isolation and separateness, and made them feel 'different' with no sense of belonging, a further sub-theme within this superordinate theme. Theirs was a lonely existence, all-encompassing, overwhelming and inescapable. When finding herself with other new mothers, Rachael felt "very lonely amongst a group of people who are in all the same boat as me but they just felt worlds apart really" [Rachael]. When Judy was asked where the rest of the world was for her in moments of PND-induced panic, she replied "Nowhere...I kind of forgot there was a world outside" [Judy].

The sense of failure at being a mother led to participants feeling bad about themselves. This was reinforced when they were diagnosed with depression, a further sub-theme within this superordinate theme. The diagnosis made them question still further their identity and the person they had become; it seemed to increase their sense of failure rather than help clarify or explain it.

For Mary, her diagnosis came as a shock:

> I never wanted to be a depressed person. I never wanted to be that person…I think the thought of having anti-depressants to treat me, meant that I had failed as a mum…I want to be a mum who's happy and enjoying it [Mary].

When Rachael was diagnosed with PND, she found the situation unreal:

> I didn't really know what it was and I suppose part of me thought I can't suffer with that, there's nothing wrong with me, I'm fine. It doesn't affect people like me [Rachael].

Mary felt herself wanting to 'shake off' what being diagnosed with PND meant to her:

> To me I think I feel very disappointed with myself…I didn't want to identify with it because it felt like…and I don't know whether this is true, but I see postnatal depression as something different from someone who's just depressed, there is

a particular reason for it and therefore it's not me…not being able to cope with the world, it's like I couldn't necessarily control, that's not very fair really that's why I wanted to keep it as different to a general one [Mary].

The diagnosis of PND, then, adds to participants' feelings of failure. It feels strange and threatening to the mothers. It angers them: they see it as cruel and unjust and as cheating them out of an enjoyable experience of motherhood. Ultimately, it makes all of them feel they are failing as mothers.

Mary was failing because she wasn't having the 'enjoyable' experience of motherhood she longed for. Rachael was failing by feeling out of control of the situation, when she was normally able to cope so well. Sophie's experience of failure was so intense that she believed her children might be better off being up for adoption, whilst Judy's feelings of failure led her to punish herself by self-harming and feeling undeserving of her child.

In summary, all four participants were capable, professional women who had rarely failed at anything in life. They were therefore ill-equipped for failure, which for them represented an unknown, alien, and unplanned for experience. Failure challenged their self-identity and blinkered them to the positive things that were happening for their children. For in reality all the babies were thriving: they were reaching all their developmental milestones and no concerns about their progress were ever raised at the health clinics their mothers were attending. It was the mothers, not the babies, who were in danger. Their endless attempts to make the situation 'better' by providing baby with what they felt it deserved were being made at the expense of their own self-care.

4.2.3 Being sucked dry

This superordinate theme with its three sub-themes show how putting their own needs aside, participants gave everything of themselves in pursuit of being the perfect mother for their child. In the process, they drained themselves both physically and emotionally. Their priorities were clear: baby comes first. There seemed no cut-off point to the amount of attention the child could claim – and receive. An endless cycle of needs to be fulfilled was thus created.

For these mothers, their lived experience involved drawing from the well, never from the bucket. They neglected themselves and their own needs to fulfil their ceaseless role and never-ending responsibilities. They experienced constant pressure to provide more, and to do so by tapping resources within rather than seeking help from outside. They felt responsibility to lie exclusively at their door, a sub-theme within this superordinate theme.

The participants found they had insufficient energy to attend to their own needs along with those of the child. There seemed never enough time to eat, let alone find moments for relaxation and self-renewal; all energy was focused on the child. The importance of the self seemed to shrink; the self seemed to exist only to attend to the needs of the child. They themselves had seemed to become invisible, a further sub-theme. The world was itself becoming smaller as participants engaged in this all-encompassing task.

Sophie found it difficult to put into words her endless fatigue:

> I was tired to my bones…Exhausted is not a strong enough word. I need a new word. A bigger word…I can just…exhausted, to the bones. I'm just a sack. A floppy sack…there's nothing…but I've got to find the energy to give you more…I can't even sleep because I have to sit up so he can sleep on me [Sophie].

Judy found herself forgetting to eat and no longer taking care of her appearance:

> I didn't really make any time for me. I probably didn't care what I looked like (...) You'd just think well, it's not about me, it's about looking after…that's my job now, I have to look after her. Everything else for me comes second so long as she's ok…I probably didn't eat as much and as often as I should do because everything was…not wrongly but everything was focused on Angela (daughter). And I would eat when somebody reminded me to eat [Judy].

Caught in this unrelenting daily cycle, the mothers had problems eating and sleeping. They began losing their appetites, their attention to self-care, their personality, their energy, their desire for anything.

Rachael spoke of spending

a lot of time like slapping about, like huffing and puffing like getting lunch ready, for me it would be a half-hearted slice of toast as I couldn't be bothered to do anything else there was a real lack of difference to anything.

Gone now was the previous professional self; the mothers' sole purpose seemed to be to attend to the child at the sacrifice of their own needs and desires. Their identity and sense of success seemed dependent on the extent to which the child could be satisfied and provided for. As Sophie put it,

> I lost all sense of who I was…Me, was…a feeding machine…there is no time for anyone but this child who just demands everything and sucks the life out of me because he just wanted to feed all the time [Sophie].

For Rachael, one way of coping with motherhood was to become 'robotic': carrying out an endless list of repetitive tasks in a disengaged way:

> I knew what I should be doing and I was able to do it for the most part, there was just a real lack of feeling or connection with any of it. I just felt like I was going through out the motions a lot of the time and ticking a box…[Rachael].

There is a palpable sense here of needing to keep on giving when there is nothing left to give is. There is a 'no way out' element to this experience, a sense of hopelessness in the face of the child's needs, which are perceived as never going to cease. Resigned to the fact that this is now their 'job', participants feel they have no option but to 'up' their personal game: they must improve, become more proficient. This can only have a negative impact on their well-being.

Determined to persevere with breastfeeding, Mary struggled with night after night of broken sleep:

> I kind of carried on and did the best that I could. I started having real sleep problems…He was quite a demanding feeder…I remember one of the record times was eight times in a night [Mary].

Rachael described 'going through the motions':

> I think I was making that decision, no, no, keep plodding through it, it will get better… just existing I suppose, going through the motions…I found it all distinctly underwhelming really…But again just thought; no this is probably how

it's meant to…just thought…I don't even think I thought other people feel this, by that point I just thought this is how it is, I just carry on [Rachael].

For Rachael , the 'job' of looking after her baby was so draining, overwhelming, and exhausting that even speaking became too much effort: "I had a sort of breakdown…where I just didn't speak for about 4 days or get out of bed, I just couldn't" [Rachael].

The participants fantasised about rest and replenishment, which they saw as somehow 'wrong' to ask for. The experience of a depleted self is a sub-theme within this superordinate theme. Mary found herself craving the attention and care of someone – anyone – who would also take on the responsibility of looking after the child and herself:

> I just wanted…somebody else to look after me and they can bring Max to me when he needs feeding…I think what I wanted was rather than people trying to sympathise; someone to look after me [Mary].

Sophie's desperate need for rest drove her to dangerous thoughts:

> One day I was walking along…I'd thought well if I just jump in front of a tram, and I didn't want to die I just wanted to be hurt enough to go in a coma and sleep in hospital for a long time. That was all I wanted…peace…rest [Sophie].

As the mothers give everything of themselves to the all-encompassing project of prioritising the needs of the child, their self-care takes a backseat. Their lived experience of PND is one in which self-sacrifice is deemed essential for providing for the child and its limitless needs. Life is focused on survival, performing the endless demands of motherhood, and consciousness of the need to 'up one's game'. Still the women make no requests for help, feeling the responsibility is theirs and theirs alone.

4.2.4 Shame of the other's gaze

This superordinate theme along with its two sub-themes show how part of the experience of motherhood with PND involved shame: shame at being seen as deficient by others and also shame at feeling unable to ask for help. This led the

mothers to withdraw from family, friends, other mothers, and health professionals. Fear of being judged as deficient led them to hide themselves in their shame while wanting to appear 'perfect' to the outside world.

Participants were aware of the stigma attached to mothers with postnatal depression and had mixed feelings about letting other people know of their difficulties. Not knowing how others might respond to them if the truth were revealed, they strove to portray the image of the perfect mother. Their inner world experience conflicting with the outer image that others see is a sub-theme of this superordinate theme. Over time, this demanding role caused them to retreat from social interaction.

Sophie took pains to disguise her inner turmoil when she ventured outside:

> If I took Jonny into (his father's) work, I had to make sure I put make-up on and done my hair and was looking like we were a happy family and be jealous of us because we've got it all going on…because I was so controlled and good at my job before I had him, I can't seem that I'm failing…it was like I had to live this materialistic, false impression of I'm still me! I'm loving this! I've got it all under control…the myth, the image, you've got to keep that up! [Sophie].

Describing her relationships with friends and family, Rachael spoke of the immense effort it took to uphold the image she wanted them to see, and the devastating shame she felt in certain situations:

> I didn't see them as much, because I didn't want them to (a) see me that way I suppose because I knew it wasn't right but also to not have to pretend and act in front of them because that was quite tiring as well…I avoided seeing people. I was part of an NCT group and we met every week…but it was quite useless to me as Daniel always liked to be rocked, held, was wriggly, their girls slept the entire coffee afternoon. So…although I was there with them, I was pacing around Costa or slightly separate from them, so that was alright then, I had all these excuses all the time…I've got to go now, I've got to do this or he's not feeding well here I'm going to leave, sorry I'm a bit off today I was up all night, I just found myself apologising a lot, making a lot of excuses and umm…not enjoying any of it [Rachael].

Rachael also found it became increasingly difficult to maintain longstanding friendships:

> All my old friends were at work, going to the cinema, going to the theatre going to everything that I used to. And they still invited me along and I'd say 'yeah get me a ticket', my friend was going to a dance performance when Daniel was going to be 2 ½ months old and I said yes get me a ticket because I assumed I'd be able to go, and of course it got to it and he was feeding every hour and I rang her up and said I'm not going to be able to go, you're going to have to give the ticket to someone else, and she was like, really, can you not just leave him with Tim (husband)? He wasn't taking bottles or anything, I said I actually can't. I physically can't do it, it's not that I'd not wanted to but there is no way that I'm able to…we lost a lot of common ground really [Rachael].

The stigma of mental ill-health, and the fear and risk of being judged by others because of it, acts to silence the mothers in their distress and is another sub-theme of this superordinate theme. It seems they can't entrust how they feel to anyone. Nobody will understand, whether they are other new mothers (who are not perceived as experiencing the same problems) or friends without children. Others might judge. Unable to find a 'safe' outlet for their true feelings and needing to hide themselves in their shame, the mothers begin to withdraw.

Mary worried that if she told anyone how difficult she was finding motherhood their response would be "Really? What, really? Is it really not making you sleep?'" She added, "It's really hard with mental illness to actually feel that you are justified to get that sympathy" [Mary].

Judy kept her vulnerabilities close to her chest:

> My mum and dad knew, my in-laws don't know even now, because I didn't want my mother-in-law to judge me. So my parents knew, John (husband) obviously and other than that my friends, the only friends I told at the time were my NCT group, who were shocked because one of the other girls later admitted she had PND and two of the girls said 'we'd had guessed it with Cath, but never realised you had it, you seemed fine.' So, that was it…One or two other people I've since told but most people don't know. There's the stigma of it and I think that was why I was so keen to do this (interview). It's like well why should I be

embarrassed and why should I not tell people, it's so difficult to tell people [Judy].

Not only was it difficult for the mothers to cope, but also the lack of understanding and empathy they perceived from others silenced them further, preventing them from asking for help to ease their situation.

When Rachael told her parents about her PND diagnosis, she found herself battling their incomprehension and prejudices:

> Mum was very upset and was very concerned that it was something she'd done and then Dad didn't want to talk about it at all. I'd been put on anti-depressants…Dad was kind of saying well we won't tell anyone about this…because this is private and your business…Mental health just was never an issue in our sort of family…and so I suppose…I didn't really know what their reaction would be and I didn't know what a lot of people's reaction to me would be if I put my hand up and say 'yes, this is me'. I've always been quite a private-ish person anyway [Rachael].

Participants' accounts also made it clear that sometimes health services also failed to provide them with a safe haven. Some health professionals did not seem to understand how disempowering and unfamiliar it was for new mothers to think they were being seen as deficient. The delicacy of the participants' situation -- their need for reassurance, their fear of judgement and their own fragility -- was also reflected in their interactions with health professionals.

Sophie strove her best to keep up appearances, "particularly to the health nurse, because she was there to judge me – that was her job! Really her job is to make sure that we're ok and that our babes are ok, but I thought 'she's judging me…'" [Sophie].

Rachael found one encounter with an unsympathetic health professional particularly damaging:

> I would often go to the health visitor, I was a weekly visitor there and I would try and time it because there was one nice one and a couple of not very nice ones, and I would try and get her and she was great and she often gave me…she told me the right answers, really, which is like don't worry about it, and I think I knew

that, I just needed to be told by someone in authority. So these other two ladies would be quite militant…One horrible thing, Daniel had always been a real porker and putting on weight loads, which they were delighted with, but he had this horrible cold that lasted about two weeks, and he would often, just when he was sort of weaning, throw up a lot of his food and I knew it was all related, and of course I went to have him weighed and the weight had gone down and this really harsh lady said, 'what have you been doing?' And I tried to explain and then I was crying and I was in this clinic with loads of other people. Anyway, the nice health visitor then came over and she was great and kind of said, 'he looks active' and I said 'he's just rolling', you know and she was fine, but the damage had been done by that first lady really [Rachael].

The PND thus swathes the mothers in shame, silencing them and leading them to withdraw from family, friends and other mothers. The shame is silencing and becomes entrapping for all the participants. To speak out means to risk being judged, misunderstood or met with a non-empathic response. This is too much for the mothers, who are fragile enough already.

4.2.5 Feeling stuck and overwhelmed

This superordinate theme along with its four sub-themes show how central to this aspect of their experience of PND was the mothers' inability to ask for help: they felt they 'should' be able to sort out things for themselves. Conscious of doing a poor 'job' despite their best efforts and afraid of being judged, they isolated themselves from friends, family, peers and health professionals. Although anxious to understand what was going wrong, they could see only one 'solution': to try harder and 'push on' with their efforts while 'pushing down' their sense that all was not well. The cycle is one of hopelessness and entrapment; life becomes scary, lonely, and endlessly distressing. Participants' distress carries with it an embodied element which they try to deny as long as they can in order to cope.

Sophie described the nightmarish quality of this experience, which she likened to a 'vortex' that was sucking her in:

 It wasn't living. I wanted to get out of it. It wasn't me…I couldn't get a firm grasp on anything like I was just…drowning. Every day was…do I have to do this again?...how do I run away, how do I escape this? I've just got to get

through today, sort of thing and then you go why do I get through today because tomorrow it has to happen all over again…People say to you don't worry it will all get better they will be able to show you that they love you. I can't see tomorrow…so right now…I'm getting nothing…I can't see it ever getting better…So it was just kind of a downwards spiral and I would feel myself spinning and trying to climb the walls of this vortex that was kind of sucking me in. But I couldn't get out of it. I just felt like I was looking up all the time…I just felt scared and there was no-one that could help me. That was pretty lonely [Sophie].

This sense of entrapment is a sub-theme within this superordinate theme. Judy evoked a similar sense of imprisonment:

You can't see beyond the next day or the day after; it's like I'll just get through today and I'll start again tomorrow and that's not great…when you're in that situation you can't see beyond it, and you think you're going to feel like that forever…Trapped and frightened are two words that keep springing to mind when you dig into it [Judy].

For the participants, the inescapability of their situation is terrifying: the child's needs are unrelenting and they have to find the capacity to meet those needs, not just today but also tomorrow and ever onwards. The mothers feel trapped and unable to see a way out. Rescue seems impossible, for the quantity of help needed to effect an escape feels unbounded. The mothers reach a point within their postnatal depression where they feel stuck, overwhelmed and powerless.

Their distress is intensified by the belief that they must satisfy their child's needs themselves, like other mothers do, for it is wrong to 'burden' others. "I just felt like I need to be able to stick at this really," was how Mary put it. "So I just persevered with it" [Mary].

Rachael had similar thoughts:

I think subconsciously…I don't know I felt like I had to battle on – no, no, everyone else does it…you can't admit defeat…you have to just get on and do it [Rachael].

The mothers, who felt that they 'should' be able to sort out their own problems, found it difficult to ask for help. They sought to hide their difficulties rather than 'burden' others with them, a further sub-theme and they also wanted to protect their loved ones from worrying about them. This led them to disguise the full extent of their distress, so that the pain travelled inwards rather than outwards, creating another cycle of 'stuckness'.

Rachael said of her relationship with her husband:

> So he'd come back and say 'what have you done today?' and I'd say, 'well we went to the park, we went to the music group,' and he'd go 'oh I'd love to do that'. I think I thought I felt guilty then: I'm not enjoying this and I know you would and I don't really want to tell you about any of it because you'll think it just awful and (a) you want to be where I am (b) I'm not enjoying the things you want to do. It's like rubbing salt in a wound so maybe I was trying to protect him in some way, I think [Rachael].

While this failure to tell the family deepens participants' feelings of entrapment, their need to be helped becomes ever more urgent. As Mary put it, "It almost seems unreachable, the help that's needed…so it feels like a Catch-22 situation of 'what the hell can I do, then, because I'm stuck'" [Mary].

Their inability to ask for help prompts the mothers to look for other escape routes. Mary remembered searching her baby son for clues promising an end to the cycle:

> I was very interested in his kind of development, signs and thinking that's a sign and now that means that he's moving towards that point when it would get easier. When actually it wasn't about him getting easier it was about me getting better so I could cope with it [Mary].

Complete lack of hope about the possibility of being rescued encouraged some participants to develop ideas of escape with fantasy elements. Sophie, for example,

> wished I had a mum here so she could come and make me some casseroles and take the baby for a while, but that wasn't going to happen…I just wanted someone to come in and cook me a meal and do the ironing…I just dreamed of that person to come [Sophie].

The downward spiral of emotional turmoil contained an embodied element: a splitting-off or dissociation which Rachael described as "just like an out of body experience" [Rachael]. In order to manage their emotional distress, the mothers not only had to disconnect physically from others but also experienced an internal emotional disconnect, as if to prevent them having to acknowledge the change in themselves and their circumstances. This experience of shutting down is a further sub-theme within this superordinate theme. At first this bodily reaction is ignored or 'pushed down', but over time the impact on the body of the women's radically changed situation becomes undeniable.

Mary described the sense of disconnection thus:

> I think I did know probably all along that something wasn't right and I should do something about it, but I know there was a part of me that knew in a sense what was going on and wanting the other part of me to realise as well [Mary].

Rachael described a similar experience:

> There was part of me, a very tiny part that was aware that it was slightly out of perspective and slightly distorted (…) but I disregarded that, I didn't want to listen to that (…) It took a long time to realise something was properly wrong [Rachael].

Initially, this state of denial seemed to work as a means of self-preservation. But eventually participants' experiences became overwhelming and impossible to ignore. As Mary said,

> I know that something's going wrong or going on but I'm quite able to push that down and not think about it…and then I start to feel it in a bodily kind of way and I know I can't deny it anymore….The only thing I can remember, I don't live in that area any more, but I can really remember the shop, and everything seemed really bright, the lights seemed really bright, people all around me seemed really loud and it felt like an alien environment. And I just thought I can't actually physically be in here any longer…I think it made me feel...feeling like frozen almost to the spot…and I just think it freaked me, freaked me out almost kind of like a real sign that suddenly as much as I had wanted to pretend

it was ok, it wasn't ok because I knew a normal person wouldn't be finding this situation difficult…I suppose I just didn't want it to be true, really [Mary].'

For Rachael, too, her "whole body just felt so heavy, like slow motion, it was really odd, disconnected from everything, it was really horrible, not nice" [Rachael].

For some participants, their circumstances were such that eventually they had to acknowledge that something was wrong. All four participants were frightened by the extent of the 'damage' to themselves. Their narratives reveal their felt need to understand what was happening to them, as well as a reluctance to 'mask' the problem by simply resorting to medication.

Mary spoke about the limits of medication, given the scale of her ordeal:

> For some people…they'll take the tablets and get through it. But you kind of knew there was a gap between what the tablets could provide and that you needed…I really wanted to understand it and I really wanted to process it as well, because it was such a significant thing to experience that if I'd just left it and said well that was that and hadn't processed it then I'd just be….it probably would have come back at some stage because it was such a momentous thing [Mary].

Two months after having her baby, Judy, along with her husband, knew she "wasn't quite right"' but didn't want to go to her GP:

> I knew she would just write a prescription and send me away…that wasn't what I wanted, so I dealt with the health visitor [Judy].

As the mothers struggled desperately to understand what was going on, they were conscious that something big and important was happening, something that needed to be understood so it would not happen again. None of them saw medication as offering that explanation. This experience of needing more help than medication could provide is a sub-theme within this superordinate theme.

Running through all four participants' accounts is the idea of PND as a sense of entrapment. They look for escape, or signs that indicate a possible end to the agony: a way out of the vortex. These are capable women, used to taking responsibility and

to sorting out difficulties without 'burdening' others. But nothing they do in this new situation seems sufficient. They have depleted their resources. They are lost.

4.2.6 Becoming lost

This superordinate theme along with its three sub-themes show how for the participants, new motherhood with PND involved strong measures of giving, loss and personal sacrifice. As they battled to carry out their new role by loving and caring for their child and carrying out their responsibilities – their 'duty' as mothers -- they sacrificed their own needs and were left feeling drained. It seemed the living, breathing professional women who had existed before motherhood had vanished, and this triggered identity issues; a sub-theme within this superordinate theme. 'Who am I now?' the mothers asked themselves. 'How do I "be" a mother?' Feeling lost yet resistant to the idea of becoming a 'depressed' mother, they desperately sought answers to these questions.

Having sacrificed their 'old' professional self, participants experienced themselves differently. A familiar part of their lives -- doing a 'job' well – had disappeared, and with it a part of their identify they found reassuring, well-functioning and constant. They now found themselves venturing into unfamiliar territory where they felt in control neither of their performance nor of themselves. Despite their best attempts they were failing to reach their own internalised standards, and this left them frightened and full of self-doubt and a sense that going back to their old self was not possible, a further sub-theme within this superordinate theme.

Sophie recognised the difference between her new self and her old one:

> Old me was professional in my job, my job was timelines and process and controlling…and when the day finished, you took stress home but I could go to the movies, I could go out for dinner…but all of a sudden I was responsible for someone else who didn't fit my order and their demands were so instant and they would just cry and you didn't know what was wrong and there was no break…there was no turning off… I lost all sense of who I was. I lost me completely, because me didn't exist…I just didn't understand how I could completely lose my personality and there was no hope of that ever coming back [Sophie].

Rachael, too, spoke of her career experience before motherhood:

> I could manage -- give me a class of thirty 15-year-olds, no problem. One baby and I couldn't cope and I think I suddenly thought my God, I've lost…I've lost everything, I can't do it, you know. That sense of helplessness and out of control after being in an environment where you're used to discipline, having control and having everything ordered and routine and then that was all just up in the air…an awful, awful change for me…It wasn't the 'me' I was used to, and one I was ill prepared for…I kind of had this horrible feeling that maybe the me from before (having a child) wasn't the real me, now this was the real me…and that I'd been, that the whole thing before had been a pretence of something and this was how I was supposed to be [Rachael].

However, being responsible and caring for the child strengthened the mothers' sense of themselves, even if they felt they were not doing it well. It was the 'job' they had chosen for themselves, the one they had desired and fiercely fought for, even if it 'sucked them dry'. They couldn't go back and reclaim their old life and they struggled to successfully move forward. Giving up responsibility for the child was not an option, however, for this could potentially further damage their already fragile sense of self. As Judy said:

> It never crossed my mind to leave her with anybody else…that's the last thing I wanted…I wanted to keep looking after her even though I couldn't really cope with it very well [Judy].

Rachael was aware of using tactics to ensure responsibility for her child was not taken away from her:

> I think that's probably why I breastfed for so long as well. It was a genuine excuse no, no, you can't have him overnight because he won't take a bottle and he's still feeding and that's my job. That's a real barrier, self-imposed barrier, I think, partly to make it still my position [Rachael].

The mothers want to continue carrying out their role; they never give up their responsibility despite their reduced capacity. Help isn't sought in case it takes away or diminishes their responsibility, their sense of self, their identity and ownership of

the role they are so desperately clinging to. They feel a need to establish themselves in this changed state in order to learn who they have become.

Their perseverance as carers is not done reluctantly but on the basis of love. It involves a personal cost to the mothers, one which seems to almost threaten their own existence. But there seems never to be a cut-off point; the mothers just keep giving and giving.

As they struggled to exist as a separate entity from their helpless, ever-demanding child, participants spoke of how easy it seemed to lose their identity, individuality and 'footing in society'. For Judy,

> I think as me I didn't exist. I was there purely to look after Angela. To the point that it was silly, that it didn't matter what happened to me…she was ok [Judy].

When asked where her old self went, she replied: "I don't know, completely disappeared. You felt that was taken away from you, your previous identity" [Judy].

It seems the women become objectified as mothers and lose their own personhood and identity. There is no place for their former selves and their needs in this new world; their old self disappears and as individuals they become invisible. The prioritising of the child overshadows the needs of the mother, who becomes lost in the process.

This invisibility is reinforced by the attitudes of health professionals. Rachael recalls that

> They (health visitors) never asked about me, they only ever asked about breastfeeding and they seemed quite pleased that I was doing that, not for me though, but for the baby. They never asked me questions about how are you coping with that or that night feeding or anything, it was just about the practical implications for the baby, umm, but very little about me [Rachael].

Mary remembers that "it made me think maybe I'd have been much better if I'd had more severe postnatal depression, then they'd have to take notice" [Mary].

What emerges from the mothers' narratives is their yearning to be seen and acknowledged as a person, not just as a mother. As Judy puts it, "I'm not just Angela's mum, I'm more than that" [Judy].

To be 'found' a final sub-theme within this superordinate theme, appears to be connected to acceptance that the experience of motherhood has led to a changed existence. This is a frightening prospect. Mary describes this process of acknowledging and incorporating a changed self thus:

> I guess maybe by accepting (a new me) it I guess you had to acknowledge that the experience had happened, really happened and it wasn't something that was actually going to go away and it was something that was actually going to be part of me [Mary].

The more of themselves they give to the child the more 'lost' the mothers become. The process of being 'found' is however aided by counselling. Participants mention various reasons why counselling proves helpful. Firstly, it gives them the opportunity to speak to an independent person, someone unconnected to them who won't be burdened by their worries. Secondly, it seems connected with feelings of not being judged. Thirdly, counselling is seen as removing the threat of someone stepping in and taking the child away by its promise of emotional support, help and understanding.

Mary describes her experience of counselling thus:

> I think it's also speaking to someone who has no experience of what I went through or vested interest in me or anything like that which makes it easier to have that conversation I think…not kind of worrying if I describe what's happening you're not going to feel, 'Oh God, I could have been more supportive'...I think that's what I've found helped with the counselling at the time; being able to have a conversation and not having to worry about the impact of what I was saying [Mary].

Judy says of her counselling:

> It was just nice to open up and just tell somebody all the panics that I had got into…somebody who understood why you were saying it and somebody who was reminding you that it was an illness and not to feel guilty about it [Judy].

Participants' sense of not really recognising themselves seemed linked to their lack of belonging with their new peers (other new mothers) while not fitting in with their old friends, either. It was as if they were straddling two worlds. This seemed to create considerable instability for them.

All participants had been employed prior to having their babies, and that meant that certain aspects of their life had disappeared on leaving the workforce and workplace. There was some recognition that getting back to work would help them recover. As Judy put it, "I suppose I only really began to get better once I did get back to work and got that part of my identity back" [Judy].

Mary spoke of her hopes of regaining her old identity, and her realisation that this might not be the case:

> For a long time I was thinking when I'm better I'll be like I was before and it will be the Mary that was before, and I can't really tell you when, but at least a couple of years before accepting actually I was a changed person and I wasn't going to be the person I was before [Mary].

Now able to accept their experiences and their new self, participants came to realise that there was 'no going back': the tough, frightening, and exhausting journey of new motherhood had changed them as individuals.

For all the mothers, the sense that they have changed as a person seems undeniable. Questioning, and more questioning, saturates this experience. 'Who am I?' they ask. 'Where is the old me? Who am I now? Will I ever be my old self again?'

The participants describe losing their old identity and, for a while, not having a new identity into which they could step comfortably and confidently. Already profoundly lost, they attempt to stave off further loss of self by holding on tightly to their responsibility for their child. By this they seem to gain some semblance of control over a situation which is spiralling out of their control. Being found and being seen eventually comes about by their entering counselling, where they are heard and accepted in a 'safe' environment, on in which they can express themselves freely.

The six superordinate themes described and illustrated in this chapter seem to capture the experience of postnatal depression for these four participants, even if the findings are inevitably incomplete and emergent. Although the superordinate themes

have been presented separately, they merge into each other and there is a large amount of overlap. Whilst some of these superordinate and sub-themes have already been identified by the literature on postnatal depression, the current study has revealed a number of new dimensions and experiences. The ways in which these add to and enrich existing research in this field are discussed more fully in the next chapter.

4.3 Reflections

Whilst conducting this research, I was struck by the way the participants approached their interviews. All wanted to tell their stories with accuracy and to give examples to help clarify their experiences; all had a sense of urgency that this information should be accessible to women everywhere. Two participants spoke of their interviews offering an opportunity to 'give back': to help women everywhere who might be suffering as they did.

I was left with a sense of respect for their bravery in telling their stories, and a strong personal responsibility to share these experiences clearly and accurately with others. I felt privileged to be the recipient of this information, given that so many people in these women's lives had been (and perhaps remained) unaware of the pain they had suffered.

I was also struck by how deeply the participants reflected as they sought to find the words they needed or were comfortable with. It was clear that they wanted to 'do it properly'.   I did my best to ensure that I listened carefully to each narrative and avoided the temptation to group experiences together in a premature way.

I wanted passionately to honour their experiences and write accurately and clearly about them. During the interviews a couple of participants began making further sense of their experience, as if helped by the opportunity to talk it through. They seemed glad of this opportunity, even if on occasion they found it painful to recall the past. I was glad that I had waited to interview the participants when they were safely through their postnatal depression and able to reflect back on it.

I was also aware of entering some of the interviews with trepidation. I knew I would have to work a bit to put my own pain aside in order to hear their stories, for I did not want to tap into my own painful memories. I feel the project has helped me make

better sense of PND experiences. By witnessing the stories of the four mothers, I gained insights of transformative power in the process of being deeply moved by what these survivors of PND were generous enough to share with me.

Chapter 5 Discussion

I begin this chapter by exploring the findings from this study and considering them in the light of existing PND research. In the second section, I consider the strengths and weaknesses of this study. I then explore some ideas for possible future directions. Finally I outline the implications for practice suggested by this study, the value of my research and its professional relevance before concluding with reflections about the project and its analytic process.

5.1 Reconsidering the literature

In this section I outline five major themes which emerged from the findings of the current study and consider how they relate to the existing literature on PND.

5.1.1 Conflicting expectations of motherhood

The participants in this study all looked forward to motherhood. Their babies had been planned or hoped for, and all four had approached motherhood in a confident, informed way. Used to being successful and doing things well, they expected to experience motherhood in the same way.

It was apparent that all the participants had their own individual set ideas about the kind of mother they wanted to be and how motherhood 'should' be. Their disappointment at not having 'fun' as a mother and at being 'cheated' out of the experience of motherhood was notable in their interviews. All wanted to attend to the needs of their child, but when they failed to live up to their own individual expectations and idealised standards this 'failing' contributed to the development of their depression. Striving to be the perfect mother meant that the child's need were met, but at the expense of maternal self-care. It seems the demands of intensive mothering (Hays, 1996) came at a cost.

The participants never seemed to question the ideals and standards they had set for themselves, or wonder about their origins, sustainability or feasibility. They concentrated solely on their felt failure to reach them.

The gap between women's expectations of motherhood and the reality they experience has been frequently noted in research containing women's narratives (Antonis, 1981; Blum 2007). The findings of the current study are consistent with

Beck's (2002) metasynthesis, which found that conflicting expectations and experiences of motherhood were present in the development of postnatal depression, and with Berggren-Clive (1998), whose study revealed disillusionment among new mothers to be linked with their perceived failure to fulfil their expectation of being the perfect mother.

Among the participants in the current study, the ideals and standards to be reached were personal and varied, but all participants had expected to achieve them. There is considerable scope for future research into how ideals of being the 'perfect, natural mother' are formed. It seems that the questions asked by Mauthner (1999) to an extent remain unanswered:

> Where did these high expectations and ideals of the 'good' or 'perfect' mother come from and why did the women feel do compelled to live up to these ideals, and in doing so deny their needs, to such an extent that they were harming themselves? Why did women just question themselves rather than challenge or question the ideals that were socially constructed and keeping them stuck in their under-performance? (Mauthner,1998), p.341

Mauthner's (1998) response to these questions was to suggest a conflict between mothers' experience and needs on one hand and their expectations and ideals on the other. This created a moral dilemma for them which threatened their own sense of moral worth: for them, denying their own needs in order to be a 'good' mother was the now the 'right' thing to do.

The current study challenges Mauthner's (1998) findings in so far as it highlights the natural desire of each mother to provide for their child. This appears to spring not from a sense of duty but rather from a position of love for the child and a desire to take responsibility for the care of the child. Those participating in the current study did not seem to consciously deny their own needs; rather, their own needs just never seemed to enter the frame or occur to them, so all-consuming was the nature of their care for the child.

The findings of this study highlight how myths surrounding motherhood remain prevalent in contemporary society. The image projected is of women feeling fulfilled (Nicolson, 1990) in their new role as mother, happily attending to the needs of their child and adapting seamlessly to the tasks of motherhood (Sears, 1985).

It seems the ideology surrounding motherhood as a happy and fulfilling experience (Ussher, 1990; Nicholson, 1993) continues to permeates contemporary society setting women up to develop a sense of failure when reality does not match expectations. The role played by the media in forming people's ideals and reinforcing myths has recently been investigated to some degree (Choi et al, 2005; Gillespie, 2000; Hadfield et al, 2007). However, there would appear to be scope for further research into socially constructed, 'idealistic' media representations of perfect mothers and motherhood and the impact these may have on new mothers. Despite the recognition of the commonality of the problem that the ideology of motherhood raises for women, it still does not seem to empower them, leaving them trapped within social and structural constraints, feeling that they are failing and inhibiting them from reconstruct new roles for themselves as mothers. Rachael's comment "I think because it wasn't the perfect image that I had envisaged or seen on the TV or whatever…I just thought no, it's not good enough" (Rachael, ...) raises important questions about media portrayals of motherhood and the role they may play in limiting self-expression and projecting unrealistic visions of maternal perfection.

It was important to the participants to seem as if they were coping as far as the outside world was concerned. Very few family members knew the extent to which the women in this study were suffering. In nearly all the participants' experiences, those close to them were shocked when they learned that the women had postnatal depression, so convincing was their outward appearance. The shame of not feeling they were providing a perfect start for their child may have contributed to participants' need to outwardly appear confident. I liken this to Carolan's (2003) sub-theme of older mothers who are putting on a front. The current study also highlights the desire of participants to appear 'normal' by not wanting to burden others when they felt they 'should' be able to cope. They were also concerned that if their inability to cope was seen, this would somehow change how other people saw them. This false outward appearance served to keep their external identity intact, reduce their shame and prevent other people from taking over the role of responsibility for their child, which was precious to them.

Carolan's (2007) study of older mothers revealed how they wanted to get childbirth 'right' and how they approached childbearing as a major project in their lives. This was certainly true for the women in this study. All the participants were independent,

professional women with a significant career investment; they were used to sorting out difficulties and problems and achieving results. For such women, the failure of the 'project' to go according to plan appears to contribute to PND. Whether this is an aspect of mothering specific to older women requires further consideration and study.

All the participants in this study were delighted at becoming mothers; what they hadn't planned for was PND. Previous research has suggested that the taking on of maternal identity is complex and challenging, with older mothers exhibiting personality traits which negatively affect their transition to motherhood (Windridge & Berryman, 1999). Despite the existence of research recognising the difficulties in adjustment to motherhood that women may experience, and the pressure often felt by women to confirm to societal 'motherhood' norms, the extent to which such knowledge is available in the public domain seems questionable. Perhaps if such research findings were made available to women, both before and after the birth of their child, such knowledge would become normalised, with greater awareness among women of the possible challenges of motherhood. New mothers might then feel more able to speak about the difficulties they experience, thereby lessening their feelings of being cheated out of the 'perfect' experience.

5.1.2 Being lost and being found again

For the participants in this study, the antidote to being lost was being found again. They embarked on a recovery journey of personal understanding and increased self-awareness, made possible through counselling which may have enhanced the quality of the personal interviews given.

Antidepressant medication is frequently used in the care and treatment of women suffering with postnatal depression. What is clear from the current study is that even though at times the participants weren't fully aware of what was wrong with them, they instinctively knew that medication alone would not be sufficient to make them well, release them from their emotional 'vortex' and ultimately satisfy their desperate need to understand what was happening to them.

Their inability to fully understand what was happening to them frightened the participants, trapping them in their situation without the necessary tools or defences to get out of it. They also lacked understanding of how to fight a possible recurrence

of these difficulties in the future. All four interviewees found counselling helpful; the process of being able to talk through and understand their difficulties with an independent, non-judgmental, non-family member meant that they could lower their coping 'mask' and begin their road to recovery. However, a troubling aspect of the findings of the current study is that some participants had to fight for NHS counselling, while others paid for private counselling at a time when their financial resources were reduced. Participants' need to talk about their experiences with a person for whose feelings and reactions they did not feel responsible is a prominent and unambiguous finding of the current study. This finding adds a fresh dimension to previous research. In the current research, most of the participants had social support and accessible family around them but felt that they couldn't 'burden' their families with their problems, the more so because they were so used to dealing with their own problems successfully.

It seems that the women's prior success in dealing with problems, and worries about burdening others with a problem for which they feel responsible, can be factors that work against their wellness. The mothers in the current study wanted to sort things out themselves; they tried desperately to help themselves, reading mother-and-baby books and researching the internet for solutions, but nothing seemed to work. Impacted potentially by not reaching the societal standard of ideal motherhood may have made it more difficult for these women to ask for help and admitting 'failure', it seems the problems they were dealing with were both internally and externally (society) based.

These findings support Knudson-Martin and Silverstein's 2009 research which recognised that "women survive depression through support that validates their experience and promotes eventual reconnection with others" (p.145). They are also in line with Mauthner (1999), who found PND occurring when women were "unable to experience, express, and validate their feelings and needs within supportive, accepting, and non-judgmental interpersonal relationships and cultural contexts" (p.143). In addition, the current study found that concerns about 'burdening' others meant that participants did not view approaching their family for help as an option. This reduced their outlets and opportunities for support, and made it impossible for their needs and experiences to be validated.

The reluctance of the participants in the current study to rely solely on medication as the means to overcome their PND, and their determination to get to the root of the problem, raises the possibility that such attitudes may be part of the PND experience of older, capable women used to overcoming problems and achieving success in their lives. This study also highlights that even though they had social and family support, the participants felt unable to access it. This, too, could be a feature of older mothers' experience of PND. If such is the case, it emphasises the need for these women to be given the opportunity to explore and/or express feelings in a 'safe', non-judgmental environment, away from family and friends. Further research into both these findings could contribute usefully to future treatment programmes.

5.1.3 Risk and symptom recognition

All the participants in this study were white, of similar socio-economic background, could be considered middle-class, successful in their careers, and educated to a high level. All were aged between 30 and 35 at the birth of their first child. None of them had experienced depression or low self-esteem issues earlier in their lives, and none had suffered prenatal depression or prenatal anxiety. Their babies were not born pre-term or with a very low birth rate. All four participants were in marital relationships they wanted to be a part of. They had wanted their babies and planned their pregnancies. They had also chosen to leave work to take on the traditional sex role expectation (Steinberg & Bellavance, 1999) of being the primary care giver.

Beck (2001) lists some of the significant predictors that have been recognised as putting mothers at risk from PND. These include low self-esteem, childcare stress, prenatal anxiety, weak social support, poor marital relationships, history of previous depression, infant temperament, maternity blues, marital status, socio-economic status and unplanned/unwanted pregnancy. On the basis of this list, the participants in this study do not emerge as 'obvious' candidates for postnatal depression, given that they did not have many of the risk factors quoted.

The participants themselves seemed to know at varying points after giving birth that they felt 'different' or that something was 'wrong'. Yet only one participant actually labelled her symptoms as PND, despite all participants being well read in mother-and-baby literature and aware of the existence of PND.

A significant factor contributing to the duration of PND is the length of delay until adequate treatment is received (Beck & Indman, 2005). Rachael had PND for a year before, at her husband's insistence, she saw her GP. As she put it, "It took a long time to realise something was properly wrong" [Rachael]. When she was diagnosed with PND by her GP, her reaction was interesting: "I suppose part of me thought I can't suffer with that, there's nothing wrong with me, I'm fine. It doesn't affect people like me. It doesn't happen to people like me" [Rachael]. The prospect of being postnatally depressed perhaps challenged Rachael's socially constructed view of the 'type' of women who developed PND.

Such findings suggest that women, even highly educated and advantaged ones, may fail to recognise their symptoms as those of PND, and that this may prevent them from coming forward and seeking help. Whilst acknowledging that among such women there may be a resistance to being labelled, these findings do question the accuracy of symptoms listed in the DSM and support other findings which challenge the appropriateness of the DSM diagnosis (O'Hara & Swain, 1996). For example, within the DSM diagnosis there is no mention of certain experiences described by the participants in this study: the gap between their expectations of motherhood and the reality; feeling a failure; not wanting to burden others; feeling too ashamed to ask for help; and putting up a front. The absence of these important dimensions could well contribute to confusion in diagnosis.

Such results suggest that a more appropriate assessment tool would be useful for older mothers. The Edinburgh Postnatal Depression Scale (EPDS), the most commonly used assessment tool for PND in the UK, is used for new mothers across the age spectrum. The EPDS has not been updated since 1987, despite the major changes in the demographic of mothers (in the UK and throughout the world) that have occurred since then and for which the statistical evidence is compelling. As more research into older mothers' experiences of PND becomes available, there is scope for a more age-related assessment tool capable of providing a more accurate way of ascertaining whether PND is present.

It is also known that higher levels of education contribute negatively to the process of maternal adjustment (Rutledge, 1991). However, this is not reflected in any of the assessment tools. Should we be identifying women in this category in the prenatal

period? Would this assessment method help identify those women to whom the midwife (whom I had met a few years previously) was referring to in her off-hand comment about older mothers: "You can spot the ones who will go on to suffer with postnatal depression a mile off"?

Nelson (2004) reports a theme of older women having a planned intensity to their approach to motherhood. All the participants in my study had felt in control of their pregnancies and had "formulated plans" (Carolan, 2003, p.18) about how they wanted to look after their baby. They were well informed about motherhood; indeed, some had spent a lot of time around babies before having a baby themselves. Aware of their baby's need to be stimulated, they prioritised their baby's needs over their own, attended mother and baby groups, breast-fed and generally did all the things they believed were intellectually, socially and emotionally good for the baby. Such findings support research which links older maternal age with more nurturing behaviour and more optimal interaction with the child (Feldman & Nash, 1986; Gottesman, 1992; Grossman et al, 1980). They also support studies which have found that women can manage to provide good infant care regardless of the presence of depressive symptomology (Hall, 2006; Tammentie et al, 2004).

The findings of this study raise another question: if older mothers are well informed on motherhood and child development, why then do they fail to recognise that they may be suffering from PND? Could it be that current assessment and diagnosis tools require updating to address the needs of this growing proportion of new mothers?

5.1.4 Unexpected failure, punishment and shame

None of the participants in the current study approached motherhood with negative expectations: all were looking forward to becoming mothers. Not anticipating any difficulty coping with a baby, they were unprepared for an adverse outcome. When things began to become difficult and the mothers couldn't put it 'right' (a situation unfamiliar to them), they were unable to comprehend what was happening and insufficiently equipped to deal with the downward emotional spiral they experienced.

All the participants had been successful, whether in the workplace or in life more generally; they were used to dealing quickly and effectively with problems. Like the mothers in Nelson's (2004) study, they had approached motherhood   confident that they would prove better at it in their 30s than they would have done at an earlier age.

They would cope well, overcoming any problems they encountered, as in the past. Planning for success, they had not even contemplated failure, and did not seem to question if unattainable motherhood expectations set women up to fail and then condemned them for doing so.

The previous success enjoyed by the participants thus contributed to their expectations about being able to cope as a mother. When their previous strategies failed to work, despite their best attempts to live up to their own internalised ideals regarding motherhood, they perceived themselves to be failures. Judy, for example, felt her performance as a mother wasn't good enough for her child; she felt 'unworthy' of having a child. However, she reported never having any desire to give up the child or pass responsibility for it to someone else.

Unlike the participants in Carolan's (2003) study, whose accounts were suggestive of a 'no-one could do it like me' phenomenon, the mothers in the current research did not think they were better than anyone else at looking after their child. It was more that they just did not want to give up their role as mother. They wanted to continue looking after the child even when they knew they weren't coping.

None of the women had experience of mental health problems or overcoming them. What they did have were successful work and life strategies which they tried to implement within their new situation as a mother. These strategies had in the past involved working harder, finding out more about the problem in order to 'fix' it, and calling in support if needed.

The findings of earlier research are significant here. Randell (1993) found older mothers tending to exhibit endurance in the face of obstacles, while Meisenhelder & Meservey (1987) found that older mothers' previous experience in solving other problems potentially gave them enhanced confidence in their ability to handle whatever might arise during pregnancy and parenting.

In contrast, the findings of the current study suggest that older mothers may struggle to understand what is happening to them and experience shame about their perceived failure to cope. Eager to take responsibility for the child and not let others know they weren't coping for fear of burdening them or for fear of judgement, they find their previous work strategies rendered futile and their coping abilities severely limited.

The difficulties the participants found in transferring competency skills from their previous work life to their motherhood life is also reflected in Carolan's research (2003). Describing older mothers' experiences of parturition, she notes that the women seemed "unconsciously to import their working strategies into their new domestic and maternal lives, with limited success" (p.19). In relation to motherhood, the tried and tested coping capabilities of these women appeared to hinder rather than help them. While they were determined to try to overcome their difficulties, their inability or reluctance to reach out for help worsened their situation still further. That this may be something experienced more generally by older mothers merits further investigation.

Feeling a failure was a new experience for the women interviewed in this study. It appeared to lead to fragmentation, to loss of the person they knew themselves to be, sending them "spiralling downwards" (Beck, 2002, p.453) into a vortex. Here they felt trapped, hardly recognising or being able to identify the person they had become.

The punishment for failing was directed inwards, with one of the four participants going as far as to self-harm. Self-criticism was the order of the day; none of the mothers reported being openly criticised by anyone else. However, in contrast to the findings of Beck(1992), who found mothers contemplating harming not only themselves but also their infants, none of the participants in the current study ever contemplated harming their children, just themselves.

Together with their sense of failure, the participants experienced a profound loss of optimism. They seemed to have no expectation that things might get better. Rachael's search for developmental signs that might mean an end to her sense of 'stuckness' was conducted in quiet desperation. Sophie's negative, closed thinking kept her securely in the dark vortex of PND: "If sleep school didn't work, I saw there was no other option, my son was never going to sleep and I was never going to get another good night's sleep in my life" [Sophie].

Beck (1992), too, found new mothers suffering from an all-encompassing fear that their normal lives would never return. Pope (2002) identified the survival of optimism as offering some measure of protection against PND. However, there would seem to be scope for further investigation of the role played by optimism in the postnatal period and how it might be stimulated and sustained. Kurth et al (2013) recommend

that inexperienced mothers be shown how to manage their own stress and that they should receive postnatal care from experienced role models. There seems obvious value to a novice mother receiving acknowledgement from an experienced professional that while things may be hard at the moment, the situation *will* get better. Such a message can be very soothing, hopeful and normalising; it creates a positive expectation for someone stuck in a vortex of despair, especially when combined with providing mothers with the skills to handle their own stress.

In the current study, Rachael reported gaining confidence the more proficient she became at mothering; gradually she began to enjoy the experience more. Judy relaxed more in her mothering role as she became more adept and prepared: for example, in knowing what to take with her on a day out with her child. Kurth et al's (2013) suggestion that novice mothers learn from experienced role models appears to offer a practical route to enabling older mothers to support themselves, both personally and socially.

The profound impact of the shame experienced by new mothers has been well documented in the existing literature (Beck, 2002; Knudson-Martin & Silverstein, 2009). However, there appears to be room for a more psychotherapeutic perspective on this powerful aspect of PND. This would enrich the maternity literature available to healthcare professionals, as well as antenatal and postnatal information provided to their clients.

5.1.5 Self-silencing

The participants in the current study attended meticulously to their babies' needs; if anything, they 'over-loved' their offspring, to the detriment of their own wellbeing. Never in any danger, the babies were stimulated emotionally, socially and educationally by their postnatally depressed mothers. As they tended their new arrivals, the participants kept their suffering locked away from family members, other mothers, health professionals and close friends. They seemed imprisoned in the practice of self-silencing. The shame they experienced at not enjoying motherhood was thus kept hidden until they found the safety of the counselling room.

One aspect of this self-silencing, which does not feature in previous research studies and which may be of particular relevance to older mothers, is that many older mothers may have been trying for some time to have a baby, or may even have

been told they were unlikely to have children. In the current study, Rachael was a case in point:

> We'd gone through tests and check-ups and we were just about to start injections and IVF and I fell pregnant naturally…So in all of that build up, I think I'd also told myself if ever I have a child of my own, I'll never complain about sleepless nights. I'll love them and I'll never complain about nappies and exploding poo or anything. And so it came along and it was really grim and so I thought I really do want to complain now but I can't because I've got this precious little gift miracle and he's still hard work [Rachael].

Rachael's promise to herself, made before she became pregnant, seems to have contributed to her silent suffering. She felt unable to tell anyone how unhappy she was, keeping up her façade even with her husband.

The current study suggests that the notion that an older mother should count her blessings and be grateful can manifest in other ways. Sophie, for example, described wanting people to look at her and her lifestyle and say 'she's got it all'. Being an older mother aware that other women would like to be in her position contributed to Sophie's self-silencing; she maintained the façade of being the perfect mother in the best of circumstances. 'Grateful' for being in her situation, she felt unjustified in complaining or revealing that all was not well.

Perhaps the socially constructed view that older mothers 'have it all' -- a strong long-term relationship, a high educational level, a professional background, sufficient financial resources to be a fulltime mother, and success in pushing biological boundaries to have a healthy baby – merits further investigation as a possible contributory factor to their experience of PND. Expectations around such women feeling 'grateful' for their situation may contribute to their inability to speak out. For such women, a conflict may be created between 'allowing' their experiences of motherhood to be perceived as less than perfect when they have been 'lucky' enough to have a baby and are able to stay at home as fulltime mothers. In fact, all the participants in the current study acknowledged missing aspects of their previous, pre-baby life, including the freedom they had enjoyed, their sense of competency, and being seen as an individual rather than 'just' a mother. Clearly the losses they experienced were substantial.

The identification of loss as a theme in motherhood and postnatal depression is well documented in the literature. All-pervasive loss is explored by Beck (2002); Vik and Hafting (2012) discuss loss of former identity, self-reliance and capacity for self-care; and Nicolson (2004) explores loss of occupational identity. While none of the participants in the current study directly described becoming a mother as a loss, I concur with Nelson (2004) that the established lifestyles of older mothers mean that they have "more to lose upon having a child" (p.288) than do younger mothers. Similar conclusions are reached in the research of Enter (1993); Gander (1992); and Sanderson (1989).

The findings of the current research fit with Beck's (2002) metasynthesis, which showed that asking for help was a tremendous hurdle for mothers. Further investigation may extend those findings to see if older mother's positioning in society and situation as perceived by others contributes to their ability or willingness to seek help.

Another significant finding from the current study is the lack of empathy some participants encountered from health professionals. "They (health visitors) never asked about me," recalled Judy, "they only ever asked about breastfeeding and they seemed quite pleased that I was doing that, not for me, though, but for the baby" [Judy].

Mothers' difficulties in speaking out are not helped by attitudes such as those revealed by Dobrzykowski (1998), who found that nursing staff viewed older mothers as "difficult to work with, hysterical and psychologically challenging" (p.4). Carolan (2005), too, came across nursing perceptions of older mothers as "difficult" and "needy" (in terms of taking up nursing time and resources). This suggests the need for a fuller understanding among health professionals of the scale of the crisis experienced by some older mothers. If this were the case, perhaps such women would feel safer in expressing their feelings, and not feel judged.

5.1.6 The current study in relation to existing research: conclusions

In her work with older mothers, Carolan (2003) was struck by the inherent contradictions that emerged from her interviews. Women who appeared to have been very much in control of their pregnancies, expending vast quantities of time

intellectualising their experiences and formulating plans, underwent transformation following the arrival of their babies. They initially felt helpless, with an inability to make decisions about their own self-care.

In overall terms, Carolan's (2003) findings are echoed and reinforced by those of the current study. The five major themes outlined above provide insights into the factors that may contribute to older mothers' sense of crisis, shame and loss: potent, media-reinforced societal ideals about motherhood; mothers' self-judgement and perceived underperformance; their determination to take full responsibility for their child; their reluctance to burden others or even ask for help; the lack of empathy received from some health professionals; and mothers' inadequate preparation for the difficulties of motherhood and lack of access to appropriate coping skills. The current study also emphasises older mothers' need for a 'safe', non-judgmental environment in which to express their loss and unhappiness.

The findings of this study, while lending support to the existing literature on PND, therefore provide new insights into the experiences of older first-time mothers. They also raise questions about the appropriateness of existing diagnostic and assessment tools as applied to this rapidly growing category of mothers.

5.2 Strengths and limitations of the current study

In this section, I seek to evaluate the current study in terms of the methodology and method chosen and the evaluation criteria applied. On this basis, I present what I view as the strengths and weaknesses of this research.

5.2.1 Strengths

As explained in an earlier chapter, IPA was the methodology chosen for this research because of its closeness with my own background in existential psychotherapy (which is grounded in a phenomenological approach and encourages clients to explore their own meanings and experiences in the context of their own lives). IPA also allowed me to combine ideas of phenomenology and existential philosophy and focus on both subjective experience and interpretative possibilities in a way which is congruent with my worldview. I enjoyed working with an idiographic

perspective not only because it gave voice to each participant's experiences but also because it allowed an opportunity to explore commonalities across cases.

An important strength of this study is its focus on a particular section of new mothers. The inclusion criteria specified that all participants would be women who had had their first child when they were aged 30 years or older, with the child born no more than five years prior to the interview. Each mother would have to identify with feeling "down, with little interest or pleasure in doing things" (DSM V) for a period of at least two weeks within four weeks of giving birth to their child. Each would have had no prior history of depression before childbirth and each would have recovered from their PND at the time of being interviewed.

I chose new mothers in this age range because of the growing proportion of babies born in the UK to mothers aged 30 years and over (data suggests this was as high as 51 per cent in (ONS, 2014). Primiparous women were selected because I wanted women to talk about the impact of PND from the shared viewpoint of having their first child. This was based on the assumption that experiences of PND after having second or subsequent children might be different, whether more or less impactful.

Interviewing mothers who were no longer in the grip of depression allowed them to reflect on a time that had now passed, enabling them to tell their stories from a safe place rather than from one where their cognitive ability might be reduced. I was also hopeful that interviews taking place well after an experience of PND would give insights into what had helped participants overcome their depression, with a view to informing treatment programmes. Some of the participants commented on how the interview process had allowed them to reflect on their experience and provide further understanding of how it had been for them 'back then' and why it had happened.

In contrast with the current research, many previous studies of women with PND have explored the experiences of primiparous and multiparous women of differing ages. Such an approach has tended to yield 'blanket' treatment solutions rather than tailored support.

The in-depth, experiential analysis of participants' own meaning-making of their experience of PND, which is a central strength of the current study, has offered valuable insights into how it feels to be an older mother with PND. This 'insider's perspective' (Conrad, 1987) enables us as counselling psychologists to develop an

informed process for dealing with the ethics of PND research and practice: one able to address the needs of those with PND because it has been derived from the first-hand, experiential accounts of women in a similar situation.

A further strength of this study comes from my own standing as a mother with both personal and professional experience of PND. All the participants knew that I was mother who had been working for a PND organisation in a voluntary capacity for a number of years. I believe the participants may have picked up on some of my own vulnerability as a mother and my awareness of some of the challenges involved in being a mother. Such factors may have made me appear more human, perhaps helping participants feel sufficiently relaxed in my company to speak openly and thus build our relationship in the short time we had together.

Overall I felt my link to the research topic was an advantage. It reinforced my skills as a therapist and helped me foster a facilitating, caring, empathetic presence which encouraged participants to share their experiences. My awareness of PND meant that my interviewing style was respectful; I aimed at being effective without being intrusive. Had my own experience of motherhood been less painful, this might have influenced my interviewing style, but then I don't believe the relationship would have been there.

Regarding the validity of the findings of this study, I would argue that the research complies with each of Yardley's (2000; 2008) four principles: sensitivity to context, commitment and rigour, transparency; and coherence.

From the very early stages of the research process, I sought to be sensitive to context. I began by reading as much literature as I could about postnatal depression. I also drew on the time I have spent with Company1 Family Support, an organisation that offers pre- and post-natal depression support to families across the Birmingham area. From the befrienders who are an important aspect of Company1's outreach work I was able to find out more about their work with mothers, the kind of difficulties their clients were faced with, and the support they needed. I have also provided training to Company1 befrienders on the subject of postnatal depression. In my own private practice over the past six years, I have worked with a number of postnatally depressed mothers and learned about their experiences.

While conducting my research, I aimed to be aware of, and sensitive to, the inevitable imbalance of power between participants and researcher. I was conscious that I might appear to be an 'expert', differently placed by virtue of my role as an academic who stood to benefit materially from the research process. I therefore spent time with all participants before the interviews. I set aside time to chat with them in the hope of getting to know them a little better and also to let them know about my work with Company1 and how I had struggled with aspects of PND after the birth of my own two children. I felt that this self-disclosure encouraged rapport and trust and hopefully made them more comfortable during their interviews.

During the interview process, I sought to be show sensitivity to the data at every stage. The questions I asked were carefully considered, flexible and aimed at allowing participants to feel free to discuss what they felt was particularly important or relevant. I attempted to show empathy with the information participants were giving me and did my best to put them at ease. Throughout each interview, I checked regularly on participants' wellbeing, and made a further check at the end.

Before the start of each interview, the participant and I agreed that we would allow for time together after the interview for a debriefing. We also agreed to meet again to discuss any matters arising from the interview, should this be necessary. Participants were also told how to access support via Company1, if needed.

Throughout the analytic process, I attempted to pay the closest possible attention to the participants' experiences by tuning into my experience of being with them during our interviews.

When discussing her second evaluation criterion of 'commitment and rigour', Yardley (2000; 2008) defines this as "prolonged engagement with the topic…the development of competence and skills in the methods used, and immersion in the relevant data" (Yardley, 2008, p.221). Throughout the current research process, I endeavoured to meet this criterion via various means. Firstly, I strove to maintain a high level of commitment to the research process by working alongside Company1 and being fully engaged with the participants' narratives. My efforts here were strengthened by guidance from my supervisor, who was familiar with the processes of IPA. Helped by her knowledge and skills I slowed down and took my time

immersing myself in the data. Throughout the research process my supervisor and I corresponded regularly, and her support and guidance helped me at times when I was struggling to achieve the depth and quality required for an IPA study.

Yardley (2008, p.222) defines rigour as "prolonged contemplative and empathic exploration of the topic together with sophisticated theorising." I believe I have achieved such rigour within this IPA study through the depth of the research, my commitment to producing as complete as possible an interpretation of participants' narratives, and my own personal interview considerations. I have made a point of not rushing through this project, which has taken more than two years to complete, because of my wish to allow myself time to embrace IPA. By allowing this time, I have felt respectful towards the participants and their interviews. The slowed down pace has also allowed the emergence of dimensions of the experience of PND which perhaps had not been considered previously.

Yardley's third principle is that of 'transparency and coherence'. I have aimed to achieve transparency by detailing every aspect of the data collection process and showing them in the appendices. I have also presented excerpts from the textual data in the findings section to enable readers to discern for themselves the patterns and themes I developed. Regular contact with my research supervisor also aided the process of transparency. For example, it helped ensure that relevant aspects of the research process were disclosed, including my own biases and their potential impact on the findings (Finlay, 2009).

Given that the aim of the research was to explore the experience of PND in older mothers, I believe the phenomenological analysis of participants' interviews has provided a description of their experiences which is transparent and open to scrutiny. I have also provided evidence of a coherent fit between the research question and the philosophical perspective adopted.

The current study also meets Yardley's final broad principle: that of impact and importance. Here, Yardley (2008) suggests that the test of any project's real validity lies in its ability to tell the reader something interesting, important and/or useful. It has been my intention throughout this research to achieve this goal. While I feel satisfied with the results, and discuss the relevance and contribution of my study

later in this chapter, the extent to which this principle has been achieved ultimately is best judged by the reader.

5.2.2 Limitations

It bears emphasis that this research study rests upon a small, self-selected and somewhat homogeneous sample. Despite the fact that my request for research participants was advertised by important PND organisations throughout the UK, only five women came forward for interview. I therefore never had to turn any possible participants away. Against my expectation, when setting out on this research, that all participants would situated locally to me and would come from different ethnic, educational and cultural backgrounds, all five interviewees were white, middle-class, highly educated career women from different parts of the UK. Although they had been supported by several different postnatal depression organisations, there was still considerable overlap in terms of their experience of PND.

To counter questions arising from this homogeneity of participants, future research should perhaps attempt to base itself on a broader cross-selection comprising different socio-economic groups. One suggestion would be to make research participation mandatory for women attending programmes run by different health authorities.

There may also be a self-selection bias within this study, given that all the participants were volunteers who self-selected. This raises questions about pre-existing attitudes towards postnatal depression and the possibility that the participants were all a certain 'type' of individual: one prepared to come forward and share their personal experiences with the world. However, such bias is difficult to avoid in a study like this, where participants volunteer. Further investigation might reveal the extent to which the women in this study might be 'typical' of women who develop PND.

As an IPA study, the current research was necessarily non-randomised and did not have a control group for comparison and verification. Its findings, which are based on the researcher's personal interpretation of interviews with a small sample of respondents, are therefore not transferable across the entire population. The transferability of the findings is further limited by lack of clarity surrounding the extent

to which PND was responsible for the women's negative experiences. While some participants were clinically diagnosed with PND, others self-diagnosed. Despite exclusion criteria being in place, it cannot be said for certain that postnatal depression was responsible for the changes experienced by participants. Other factors may have intervened or have had some impact. For example, around the same time as giving birth, one participant had a family crisis while another was going through financial difficulties. Both situations may have contributed to the depression experienced.

However, given that the purpose of this study was to explore the lived experience of a specific category of women (older mothers who had postnatal depression after the birth of their first child, having never suffered from depression before), its focus was not on the transferability and generalisability of its findings. Instead, it sought to understand the lived experience of a specific group of women in a particular context.

A further possible limitation of this study derives from my skills as an interviewer working within a hermeneutic methodology. Here I believe there is scope for improvement.

Throughout the interviews, which I found quite an emotional undertaking, I was very much aware of being with women who had young babies. I felt in need of reassurance that their functionality would not be affected by my questions, and was watchful of their emotional state during the course of the interviews. Whilst I don't think this prevented me from asking questions, I purposely allowed the participants space within the interview questions to express themselves as fully as they wanted to. The whole interview process I believe was aided by the dogged determination and enthusiasm of all the participants to get their story heard in order to help other women who might find themselves in similar circumstances.

It should be noted that interviews with two of the participants (Mary and Rachael) were conducted online, via Skype. This was the interviewing option they chose which best suited their family and time commitments. While their interviews yielded fascinating and relevant data, it appears likely some elements of our discussion were affected by the use of this medium of communication. For example, during an initial online interview with one participant, the camera failed to work and the interview was conducted against a blank screen. The fact that the two of us could not see each

other may have affected the quality and depth of this first interview. I found my questioning somewhat guarded, as I was less able to monitor her wellbeing because of my inability to see her facial emotional responses. However, I checked several times verbally with her as to how she was doing during the course of the interview. When it came to interviewing this participant the second time, the camera was working perfectly, enabling us to 'introduce' ourselves in person, share a smile, and continue smoothly.

As I sat in close proximity to the participants I interviewed face-to-face, there were times when I gained a real sense of the presence of their PND. I felt particularly impacted when Sophie described feeling 'like a sack' when she was in the midst of her PND. I experienced a flatness and deadness in her being, and a heaviness in mine.

The two participants I interviewed via Skype also conveyed their experiences quite freely and I found their words very impactful. At the same time, I was aware that I was not 'alongside' them physically, making it more difficult to connect with the ebb and flow of their energy and movement.

The ability of participants to communicate successfully the rich texture of their experience is an aspect of IPA that has attracted criticism. Many people struggle to find the words to accurately convey the subtleties and nuances of their experience (Willig, 2001). In the case of the current research, this aspect surfaced as a potential problem during the online interviews, rather than those conducted face-to-face.

Both participants who were interviewed via Skype were eloquent and self-aware, having done a lot of personal work through counselling. However I found myself asking more questions during my interviews with them than during face-to-face interviews. I was conscious of being more verbal in expressing my empathy and understanding and I also asked more exploratory questions (for example, to try to ascertain what was not being said). The inevitable time lags associated with internet communication sometimes led to me to ask participants to repeat their last sentence, making conversation a little stilted at times.

Overall, however, these two participants were well able to describe their experiences and stay with that process; there seemed to be a freeness within their speech. It struck me that they might have experienced a greater sense of freedom by not

having their interviewer physically next to them. Given the fear of judgement and the shame attached to the experience of PND, the women may have felt able to express themselves more fully. There was also perhaps less of a power imbalance during an interview which they could end at any point by the flick of a switch.

There is little research to date which considers Skype as a data collection tool, most studies have been focused on Skype as the object of study. There is also little research into the differences between using varying interviews methods with participants within the same research project (Opdenakker, 2006). Skype offers an alternative interview method to face-to-face interviews allowing people to communicate, see each other and hear each other in real time all over the world, opening up the geographical landscape of participants.

The use of Skype as an interview tool for qualitative research studies has increased over the last few years and brings with it advantages and disadvantages. While Skype is free to download, geographically flexible with an instant messaging function it does present challenges such as parts of dialogue being lost or interrupted due to time lags in conversations, and disconnection problems which means interviews can't take place at all. Overall there appears to be growing interest in using online interviewing whether by email or videoconferencing or Skype. These debates have been ongoing since the 1990s (Dubrovsky et al, 1991; Walther, 1996).

The question of whether an individual is presenting an authentic self is often raised by qualitative researchers with internet interactions. Sullivan (2012) argues that using Skype 'mimics face-to-face interactions including the presentation of self in an authentic way, almost as well as those face-to-face exchanges' though she acknowledges that there is no way to know for definite that a person being interviewed is speaking the truth whichever medium of data collection is chosen. I think that during the interviews some of my skype participants were visibly upset as they recalled certain experiences and also took their time to try to accurately and coherently answer questions; for me at times, it felt as if we were sat together face-to-face.

My findings agree with Deakin and Wakefield (2014) that difficulties with rapport with Skype interviewees only tends to be an issue with a reserved or less responsive individual. I believe I was fortunately within this project that both of my Skype

interviewees were very responsive and very motivated to contribute to their interviews and prepared to consider difficult situations they have experienced within their PND and converse about them.

I think my findings match with those of Walther (1996) who found that online exchanges can be both liberating and limiting. All the participants within this study, irrespective of whether they were interviewed via Skype or face-to-face, showed determination to get their story heard. Overall I certainly think it was better to conduct interviews via Skype rather than to have missed out on the experiences of two participants.

5.3 Possible future directions

This study adds to existing research by suggesting, on the basis of its findings, that older women's experience of PND may contain elements of suffering not found in that of younger women. It bears emphasis, however, that there is considerable scope for further research into this question, towards the goal of guiding and tailoring PND support services and treatment programmes.

Such future research projects might include women from specific age categories, with differing numbers of children. For example, further research into the experience of 'older' motherhood may need to take into account the fact that the term 'older' mother denotes not only women in their 30s but also an increasing number of women in their 40s. Such women, some of whom may have benefited from assisted reproductive technology, may have their own particular experiences and expectations of motherhood.

It might also be beneficial to conduct a longitudinal study of mothers who meet the criteria chosen for this study and who have gone on to have further children. Such a study might reveal whether postnatal depression was experienced again, and if so, whether there were differences in how it was experienced following the arrival of subsequent offspring. Such information could be very useful in terms of lessons learned from first experiences and the impact of counselling, in particular how self-awareness from counselling may have modified a later postnatal experience.

Regarding the factors which enable and support women to overcome PND, the findings of the current study point to the central role played by counselling, which enabled all the participants to express their feelings in a non-judgemental, empathetic environment. Further research might explore other possible factors that could contribute to women successfully overcoming their PND. There is much scope for further research into the role played by the media in shaping expectations of motherhood.

In summary, while the current study adds weight to the possibility that the age of a primiparous woman may influence her experience of new motherhood and PND, there is much scope for future research into older mothers' experience of PND, and the treatment programmes that might best address this.

5.4 Value of the research and its implications for practice

Older childbearing is becoming increasingly common in developed countries, where PND is estimated to affect a significant proportion of new mothers. The better understanding of older first-time mothers' experiences of postnatal depression provided by qualitative phenomenological research has important implications for practice, whether that of health professionals, psychologists or those working in counselling.

Nicolson (1999) suggests that some degree of postpartum depression "should be considered the rule rather than the exception" (p.176) and that it is also "potentially a healthy, grieving reaction to loss" (176). While inclined to agree, I remain unclear about the extent to which this reality is being addressed in antenatal workshops and teaching. The findings from the current study suggest that women enter into motherhood without having considered the possibility of not being able to cope; they have not 'allowed' themselves to see the loss that is intrinsic to motherhood. If such issues were made more generally available and were discussed more frankly with prospective mothers, women's expectations of motherhood might become more realistic. The experience of loss and identity readjustment need to be accepted as a natural part of motherhood. Women need to be made aware that often the transition to motherhood is a complex process. This would help them accept their feelings

more readily, rather than feel like a failure. Aided by midwives, well-attuned antenatal classes and sensitive childbirth educators, women would then be in a position to overcome the self-silencing characteristic of the PND experience of the participants in this study.

This research has highlighted how self-silencing can be bought about by the desire to protect, or not burden, others. It has also revealed how a woman's desire to protect her autonomy potentially can hinder her recovery from PND. Such factors do not appear among the symptoms listed by the DSM V or the categories listed by the EPDS. This suggests the need for a fresh look at how women potentially suffering from PND are assessed.

The stigma attached to postnatal depression, still evident in society today, is another factor contributing to women's self-silencing. Realistic portrayals of postnatal depression, such as those included in this study, need to be more widely disseminated as part of an effort to challenge this stigma. For example the participants in this study experienced PND partly from feeling they were providing their child with less than the child deserved and not as is often believed about PND because they rejected or did not bond with their child.

The participants in this study all made loud and clear their desire to *understand* their PND, rather than just be medicated through it. They saw this as a way not only of overcoming their PND but also of preventing relapse. The implications for this may be that older mothers place less emphasis on medication and more on the effectiveness of counselling, personal understanding and self-awareness in their recovery process.

Being able to express their difficulties in a non-judgmental environment was invaluable to the participants in this study; it was this that set them on the road to recovery. This is finding is of clear relevance to health services. For example, there may be a need to step up the provision of telephone help-lines and chat rooms as a means to provide women with anonymity until longer term change (for example, provision of better information featuring more realistic portrayals of motherhood) can be effected

The interviews at the centre of this study raise important questions about the availability of counselling and ease of access to it. In some instances, counselling

had to be fought for: a difficult undertaking for a woman in the depths of depression with a young baby to care for. Some counselling was undertaken privately which suggests possible inadequate NHS provision.

This research emphasises that women without the typical risk factors associated with PND need to be monitored, too. It suggests that capable, well educated women who are used to being autonomous and are in relatively comfortable economical circumstances may also be at risk of PND.

There now appears to be a growing body of evidence from research studies that suggests that postnatal depression experiences are different for older mothers and those women of AMA. This study recognises three areas that would benefit from attention to ensure that adequate and appropriate support is being provided for these women; (1) Antenatal care and education which addresses damaging ideological portrayals of motherhood within society and the media. (2) The identification of women postnatally with PND symptoms who perhaps haven't recognised those symptoms as being PND. (3) The provision of relevant adequate support and treatment programmes appropriate to the difficulties older mothers experience. These three areas are considered further below.

With regards to antenatal care, the identification antenatally of women who may go on to suffer PND postnatally feels significant, particularly in light of the midwife's comment 'you can spot them a mile off'. The need for appropriate, age-sensitive antenatal education emerges clearly from the current study and the role for psychology and psychologists in the design of these workshops is essential. For example, workshops might be offered on the less positive aspects of motherhood, including its ability to feel like a conflicted space in which women's expectations are not met and where they can feel disillusioned and cheated. These workshops may highlight the difficulties women have transferring competency skills from their work life to their new motherhood life as found in Carolan's research (2003) and the feelings of failure and underperformance which may be associated with this. It is important that women are warned that, along with the excitement of having a wonderful new baby, they may also experience elements of loss relating to their role and life before motherhood. The difficulties highlighted in these workshops that many

women experience in their transition to motherhood need to be reframed as part of an adjustment process, rather than as evidence of personal inadequacy and offer opportunities to recognise and challenge socially constructed images of happy, contented, perfect mothering. Recognising that 'intense mothering' is targeted to middle-class women and that Rutledge's (1991) research suggests that higher levels of education contribute negatively to the process of maternal adjustment, this is an area where midwives and other health professionals can be mindful of some of the challenges older pregnant women fitting that description face when attending clinics. The challenge of socially constructed images of the 'type' of woman who might suffer postnatally can also be addressed, particularly as this current research project dispels Beck's (2001) 'typical' postnatally depressed woman, which might also limit feelings of shame. Asking for help should be encouraged at this stage antenatally; women need to know that feeling overwhelmed can lead to feelings of detachment and that, despite this, their babies are safe and well cared for. In common with other research, this study highlights the importance of optimism, self-soothing, and stress management for mothers seeking a way out of the emotional vortex of postnatal depression. However, women cannot be taught the value of hope if they are encouraged to approach motherhood with unrealistic expectations and remain ignorant of the challenges which lie ahead. Such a situation leaves them ill-prepared for difficulties and can add to their sense of being 'cheated' out of an enjoyable transition to motherhood.

The identification of women postnatally with PND symptoms who perhaps have not recognised those symptoms as being PND also appears to be an issue within postnatal care. According to Glavin, Smith, Sorum and Ellefsen (2010), one problem with detecting postpartum depression is the lack of knowledge that women have about the condition. It has already been stated that In the UK the most commonly used assessment tool for PND is the Edinburgh Postnatal Depression Scale (EPDS) a questionnaire-based quantitative tool. Yet in this study the majority of participants failed to recognise their symptoms as PND. There appears to be something in the identification of PND that plays out here alongside the non-recognition of symptoms. This is an area I believe there is scope for change which may help identification of women suffering with PND early on so they can access treatment programmes.

I believe there is an opportunity for a new assessment tool for PND to be developed for older mothers and those of AMA that is more relevant, suitable and better able to capture the PND experience of these women. This assessment could be run alongside or be incorporated into the EPDS which is currently used as a tool for identifying and capturing the experience of PND in women of all ages within the UK. The EPDS was developed in 1987, when the diagnostic and landscape of motherhood was very different to today. A new up to date assessment tool which reflects and acknowledges womens differing age categories and life experiences upon entering motherhood based on the growing body of evidence which supports the differing postnatal depression experiences of women at different points of their lives, could be a great help to identify women with PND.

The findings of the current study suggests that older mothers, particularly those within the 30-34 year old category may identify less with the current EPDS statement 'I have been anxious and worried for no good reason' and more with statements such as 'I feel it is my responsibility to provide solely for my child' or 'I feel I can't complain about motherhood because I chose to be a mother and should be grateful that I have a baby' or 'I'm upset that I'm not enjoying motherhood more'.

The gap between expectations of motherhood and reality which has been raised in numerous studies, and acknowledges and challenges social constructed ideas of motherhood and being the 'perfect' mother could also form part of a PND assessment tool which statements such as 'I feel I should be doing a better job at being a mother' 'I'm finding motherhood not as enjoyable as I expected' requiring an answer. A relevant, appropriate tool that helps identify this new cohort of women who are entering motherhood for the first (or subsequent) time can only be of help. It is important that if these women are identified, that appropriate treatment and care programme is then provided based upon the growing body of research which captures older mothers experiences of postnatal depression.

The need for treatment programmes for older mothers with PND will potentially be increasing in numbers in years to come if the trend for delayed motherhood continues and PND treatment providers may need to take into account that often older mothers are reluctant to rely solely on medication as a means of overcoming

their pnd. This study has highlighted participants need for understanding the difficulties they are experiencing and the value they placed on an 'independent' person for them to share their difficulties, whose feelings they did not feel responsible for. This difficulty is highlighted within the superordinate theme of being stuck and overwhelmed, with its sub-themes of needing to 'protect the other' and not burden others particularly family members with their problems. Perhaps support groups of mothers, and befriending services such as those offered within Company1 should be encouraged on a national scale. Further research into the positive aspects encouraging recovery from PND would help support this. A poignant finding within this project for health professionals and midwives is that despite the mothers in this project having social and family support, their feelings of responsibility, shame and inadequacy prevented them from accessing that support. There should not be an assumption that women who have access to their families and a network of friends will be adequately provided for emotionally.

Mothers with PND require increased opportunities to create their own cultural practices and to alter the way they are conceptualised by others, whether health professionals, family and friends, or other mothers. Given the difficulties this researcher encountered in locating just five women who fitted the criteria for this study and were prepared to take part, there appears to be a reluctance on the part of women to come forward. Perhaps this reflects a more general reluctance to 'speak up' about PND. If such is the case, I hope that this study contributes to an opening up of discussion and stimulates further research into women's lived experience of postnatal depression which encourages the provision of relevant treatment containing practical parenting skills, educational workshops and emotional support from informed health professionals, both ante- and postnatal for older mothers to help boost their confidence and generate optimism.

5.5 Personal reflections on this project

When I began interviewing the participants in this study, ten years had elapsed since the birth of my first child. Despite the length of time, I sensed some reluctance about

revisiting my own postnatal challenges. Dragging it all up again indeed proved painful, and this made me admire the bravery and determination of my participants. I began to gain a better understanding of why potential participants had been reluctant to come forward.

Looking back, I suppose I felt quite protective of the participants. As their interviews unfolded and the lack of care many of them had received from unhelpful health professionals came to light, I was glad that my approach had been encouraging and respectful, not pushy. There were times, however, when I was concerned that the research topic might be getting too close for comfort. I feared I would find myself heading downhill after empathising with the women and recognising aspects of my own experience.

Rising above such pain, however, was our mutual determination – theirs and mine -- to tell the story. The passion with which they spoke was both compelling and rejuvenating.

There were a couple of occasions during this project when I experienced a sense of being trapped in the work. Feeling overloaded, and overwhelmed by the amount of information and research on PND, I seemed to direct my own anger and frustration outwards. I felt angry that the women I interviewed had had to undergo so much pain and feel such failures; the transition to motherhood was obviously very complex, yet this was something that somehow these women didn't know.

This experience may have impacted the length of this research project. Whenever my life was beset by day-to-day troubles -- child care worries, for example -- I found myself withdrawing from the research, unable to dwell in the land of PND until I had surfaced emotionally again. However, it may be that the quality of this project benefited from such a stop/start approach. It was rather like taking mini-breaks from therapeutic practice when loss or emotion gets in the way of the therapist's emotional capabilities and presence. Having a balanced state of mind was beneficial to this project, enabling me to stand back, be objective, and reduce my emotional involvement.

As the project progressed, I found myself unable to send a draft to my supervisor until I felt it was 'good enough'. Two years had elapsed since I had finished my course and I felt I should be performing better. Instead I ground to a halt. I felt as if I

were drowning in a sea of hopelessness (rather like the mothers I had interviewed), and wanted to jack the whole thing in. It was at this point that I contacted my supervisor. We talked about my 'stuckness' and together managed to find a way through it. My motivation to continue the research mirrored that of my participants when describing their reasons for taking part: the need for women to know about postnatal depression and its devastating character. Along with my participants, I sensed the necessity of disseminating information and knowledge to prevent women from becoming 'stuck' and to break the silence which can be so damaging. It was as if I were engaged in a parallel process.

This got me thinking about the type of women I had interviewed. As I thought about them, I experienced a powerful realisation that they reminded me of close friends of mine: they were individuals with whom I would want to engage with on a social basis. I liked them; I could be friends with them!

As I reflected on my own experiences of PND, I was worried to discover how unable I had been to speak out. I'm not generally someone who is backwards in coming forwards, but as I completed the interviews I recognised and identified with the participants' inability to speak up and ask for help. This is as aspect of myself that I continue to consider in my day-to-day life. Traipsing from hockey field to rugby pitch, I note how comfortable I am taking other people's kids to events yet how reluctant I am to ask for help in return.

Conducting this research has also encouraged me to reflect on personality and personality types. Why had these particular women stepped forward for the research project? What was it about them, out of all the women in the UK who have suffered with PND, that made them want to be included? Was it their desire to help others in a similar situation? Was it to do with the fact that that they had been successful career women? Was this research undermined by the common personality type of the women who wanted to be included in it? Or was this 'type' of older woman the one most affected by PND?

If anything, this experience has helped me normalise my own experiences. I now feel connected, part of a much bigger picture, no longer alone. I am less inclined to blame myself for my own inability to speak up when in the grip of PND. I have come to realise that this research had been driven by my own unanswered questions,

which have now taken crystallised form. Why didn't I speak up? Why did I find that period of my life so difficult? Why wasn't I given more help and support? Or had I been offered help which I had rejected, afraid of giving in and feeling a failure? To what extent might this past experience still have relevance for my life now? To what extent is it part of me and my personality?

I sensed that I was on to something here, something that would benefit from further investigation. Perhaps the midwife's off-hand comment about older mothers -- "you can spot the ones who will go on to suffer with postnatal depression a mile off" -- contained a grain or two of truth, after all.

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Appendix 1

The DSM-5 criteria for a major depressive episode are as follows:

a) Five or more out of 9 symptoms (including at least one of depressed mood and loss of interest or pleasure) in the same 2-week period. Each of these symptoms represents a change from previous functioning, and needs to be present nearly every day:

- Depressed mood (subjective or observed); can be irritable mood in children and adolescents, most of the day;
- Loss of interest or pleasure, most of the day;
- Change in weight or appetite. Weight: 5 percent change over 1 month;
- Insomnia or hypersomnia;
- Psychomotor retardation or agitation (observed);
- Loss of energy or fatigue;
- Worthlessness or guilt;
- Impaired concentration or indecisiveness; or
- Recurrent thoughts of death or suicidal ideation or attempt.

b) Symptoms cause significant distress or impairment.

c) Episode is not attributable to a substance or medical condition.

d) Episode is not better explained by a psychotic disorder.

e) There has never been a manic or hypomanic episode. Exclusion e) does not apply if a (hypo)manic episode was substance-induced or attributable to a medical condition.

Appendix 2

Personal Interview

I was interviewed by a colleague with the aim of expanding and clarifying the assumptions I hold about why older mums experience postnatal depression, and I summarise these assumptions as follows:

- <u>Loss of freedom and independence</u>. My assumption here is that loss is experienced in many different forms when a woman becomes a mother for the first time. Before children come along into a person's life that person has flexibility and freedom to pursue their personal, social, economic and career goals however they choose, independent of a needful other. The arrival of a newborn baby heralds the arrival of another human being who is unable to provide for himself/herself and ultimately dependent on the mother (or caring other) for survival. This huge responsibility can weigh heavily on a woman, requiring her to sacrifice herself and her needs to ensure the survival of that child and in doing so curtailing her own freedom and independence –at least temporarily.

- <u>Loss of a professional self</u> . This loss I believe can be particularly damaging for older mums who have spent many years developing their careers. Those who make a decision to stay at home with the baby and adapt/delay professional goals, may experience this change in lifestyle as a loss. This loss of professional status may affect confidence and purposefulness as it closes down one aspect of a person's life.

- <u>Expectation of motherhood.</u> Many older mums may have waited a long time to have a child due to situations such as finding an appropriate partner, attaining specific career goals firstly or difficulties in becoming pregnant. I think a long awaited baby can be accompanied with many expectations about how joyful motherhood will be (when finally reached) and I believe there is a gap between this expectation and the reality of the situation – hard, draining work. I think this gap can fuelled by the media where celebrities appear to have a

child and regain their figure and lifestyle almost overnight. This experience is not always the case for non-celebrity mums.

- <u>Isolation and Loneliness</u>. The environment of being at home alone with a child can induce feelings of isolation and loneliness when contrasted with a busy working life full of interactions with work colleagues. Monotonous essential tasks, feeding, changing, sleeping can increase these feelings.

- <u>Expectations of others and of the self</u>. I think there may be an expectation attached to older mums that they will be able to cope with having a baby – more so than a young teenage mum with perhaps an unplanned pregnancy. I wonder if this expectation extends to the mother herself who just expected to cope with this change in her life and is too ashamed or never thinks to ask others for help. I also think other people are less likely to look for or spot depression symptoms in older mums because they just expect them to cope.

Appendix 3

To whom it may concern

This is this is to confirm that Company1 have been in contact with Julie Hannan over the last 12 months regarding her research on postnatal depression in older mums.

The title of her research is ' **Older mothers' experiences of postnatal depression – An Interpretative Phenomenological Analysis** and we consent to Julie accessing our clients for the study through any of the Company1 support branches.

We understand that her research will be reviewed by Metanoia and Middlesex University Research Ethics Committee and as a result it will not be necessary for her to undergo any more research applications from Company1 as the approval obtained by you is sufficient.
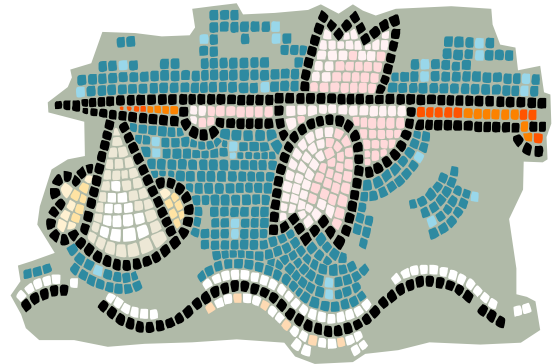
Yours sincerely,

Named Director   Named Director

Founder of Company1   Founder of Company1

Are you a mum who:

- ❖ Has had your **first** baby in the last **5 years**?
- ❖ Was **aged 30+ at the time of the birth?**
- ❖ Felt '***down, with little interest or pleasure in doing things'*** for a period of at least two weeks within 4 weeks of giving birth to your child -and are now recovered?
- ❖ Had no prior history of depression before childbirth?

If yes to all these questions, would you be interested in talking to me, Julie Hannan, a psychologist and therapist about your personal experiences?

I would like to interview you on two occasions, with each interview lasting for 1 to 1 ½ hours each – with a break of 3-6 months in between interviews.

It is hoped the findings from this study will be helpful in guiding future treatment for mums in similar situations suffering with symptoms of postnatal depression.

If you are interested or would like to know more then please contact Named Director on ***** ****** or Named Director **** ****** at Company1 for further information.

The research forms part of the requirements towards a Doctorate in Counselling Psychology and Psychotherapy at the Metanoia Institute, 13 Ealing Common, in conjunction with Middlesex University. The research is being supervised by Dr Linda Finlay.

METANOIA INSTITUTE & MIDDLESEX UNIVERSITY

PARTICIPANT INFORMATION SHEET (PIS) AND CONSENT FORM

1.   Study title: Older mothers experiences of postnatal depression – An Interpretative Phenomenological Analysis.

Simplified Title: An exploration of how older mums experience symptoms of postnatal depression.

2.   Invitation paragraph

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

3.   What is the purpose of the study?

The birth of a child can be a joyous occasion within the life of a family. Many women will enjoy the experience and the changes in life and dynamics of the family that a baby brings. Some women however struggle with these changes and experience postnatal depression.

It is estimated that postnatal depression (pnd) affects 1 in 7 new mothers (NICE Guidelines 2007). In 2009, 47 % of all births were to women aged 30 or over. To date no studies have

been carried out solely examining the experience of pnd for this particular age group of women.

Using information gathered from personal and group interviews, the aim of this study is to discover more about the experience of and provide a deeper understanding of what it is like to be postnatally depressed and aged 30 and over.

4. Why have I been chosen?

For the purpose of this study I wish to interview 1 woman for a pilot study and 6 women on an individual basis all of whom have experienced symptoms typical of postnatal depression after the birth of their first child, having never been depressed previously.

5. Do I have to take part?

Taking part in this research is entirely voluntary. It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

6. What will happen to me if I take part?

If you take part in the pilot study you will be interviewed about your experience of pnd. This interview should last between 1 -1½ hours and take place at Company1 (2 or 3), in your own home or via Skype

If you are a participant who has agreed to be personally interviewed, you will be interviewed on 2 occasions, two to three months apart for approximately 1 to 1 ½ hours each time to allow for reflection time in-between. These interviews will either take place at Company1,(2 or 3), in your own home if more convenient for you or via Skype.

Both sets of interviews will use semi-structured questions to guide the work.

7.   What are the possible disadvantages and risks of taking part?

Sometimes recalling past emotional events can be upsetting, therefore time will be set aside after personal interviews to recognise any distress you may be experiencing. If required, you will be able to access Company1's telephone support line and befriending service for further support.

8.   What are the possible benefits of taking part?

It is hoped that by participating in the study your contribution will help inform treatment and understanding of mums aged over 30 who have postnatal depression.

9.   Will my taking part in this study be kept confidential?

All information that is collected about you during the course of the research will be kept strictly confidential. Any information about you which is used will have your name and address removed so that you cannot be recognised from it. All data will be stored, analysed and reported in compliance with the UK Data Protection legislation.

10.   What will happen to the results of the research study?

The results of the research will be written up and presented to the doctoral assessment team, compromising both Metanoia Institute and Middlesex University members. I also aim to communicate the findings to the wider psychological and psychotherapeutic community by means of various publications distributed both in and outside of the UK and over the virtual media. Participant confidentiality will be respected at all times so you will not be identified in any report/publication.

11.   Who has reviewed the study?

The study has been reviewed by the Metanoia Research Ethics Committee.

12.   Contact for further information

The contact point for further information is:

Julie Hannan. DCPsych Candidate,

Project Supervisor Contact details; Dr Linda Finlay.

Thank you for taking part in this study. As a participant you will be given a copy of this information sheet and a signed consent form to keep.

Date: September 2012   Version: 1

<div align="center">

CONSENT FORM

</div>

Participant Identification Number:

Title of Project: Older mothers experiences of postnatal depression – An Interpretative Phenomenological Analysis.

Name of Researcher: Julie Hannan

<div align="right">

Please initial box

</div>

1. I confirm that I have read and understand the information sheet
    dated ....……………………for the above study and have had the
    opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw
    at any time, without giving any reason. If I choose to withdraw, I can decide
    what happens to any data I have provided.

3. I understand that my interview will be taped and subsequently transcribed ☐

4. I agree to take part in the above study ☐

5. I agree that this form that bears my name and signature may be seen by a designated auditor

☐

_____   _____   _____

Name of participant   Date   Signature

_____   _____   _____

Name of person taking consent   Date   Signature

(if different from researcher)

Julie Hannan   _____   _____

Researcher   Date   Signature

1 copy for participant; 1 copy for researcher

Appendix 6

Semi-structured interview questions devised after personal interview and pilot study.

The experience of pnd

1. Back then, can you describe a typical day for me?

2. Perhaps you can tell me about your experience of postnatal depression?

3. How did your life feel back then? What were your days like? (Temporality)

4. How do you make sense of that?

The experience of self and others

1. How were your relationships back then? How would you describe your relationships back there. (Spatiality)

2. How did you view yourself? What sense do you have of yourself at that time?

3. What was it like for you to be a mother?

Life and expectations

1. How did you expect motherhood to be? What was the source of those expectations?

2. To what extent was motherhood what you expected?

<u>OLDER MUMS EXPERIENCES OF POSTNATAL DEPRESSION</u>
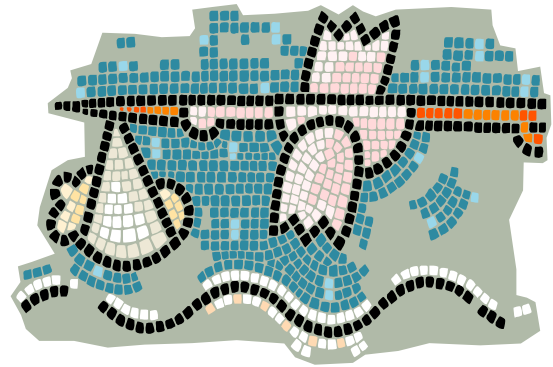
Are you a mum who:

- ❖ Has had your **first** baby in the last **5 years**?
- ❖ Was **aged 30+ at the time of the birth?**
- ❖ Felt '***down, with little interest or pleasure in doing things'*** for a period of at least two weeks within 4 weeks of giving birth to your child -and are now recovered?
- ❖ Had no prior history of depression before childbirth?

If yes to all these questions, would you be interested in talking to me, Julie Hannan, a psychologist and therapist from Birmingham, about your personal experiences?

I would like to interview you on two occasions, with each interview lasting for 1 to 1 ½ hours each – with a break of 3-6 months in between interviews.

It is hoped the findings from this study will be helpful in guiding future treatment for mums in similar situations suffering with symptoms of postnatal depression.

If you are interested or would like to know more, then please contact me on **** ****** for further information.

The research forms part of the requirements towards a Doctorate in Counselling Psychology and Psychotherapy at the Metanoia Institute, 13 Ealing Common, in conjunction with Middlesex University. The research is being supervised by Dr Linda Finlay.

Appendix 8 Participant 3 sub-themes

Original Transcript	Emergent sub-themes (in bold) and commentary
Researcher: So you were diagnosed with postnatal depression after Daniel.	
Rachael: I was, but only when he was about 15 months old. And I had the full year off on maternity leave and was miserable as hell but thought that's just how it should be and then went back to work full-time (and)…I suppose had a breakdown really.	**PND Diagnosis**; This is a late diagnosis outside of the DSM 1 year guidelines; were symptoms not recognised as PND? **Expectations of motherhood**: Rachael seems to just accept that being a mother means to be as 'miserable as hell'. **A sacrifice of the self** – her enjoyment of life for the needs of the baby.
My husband was great and suggested I go and see the doctor and I suppose mental health is not something that's ever been discussed in my family or with any of my friends…	**Shame**: The idea that mental health problems happen to other people –not people like Rachael or her family. What constructs surround mentally unwell people? Does this delay diagnosis or is there a reluctance to accept unhappiness and be a 'bad' mother? **Needing help/rescuing:** It is the husband who insisted on GP appointment not Rachael.
so I had a stupid doctors' appointment of going along and him saying what's wrong, and me saying; well there's nothing wrong of course, I think I'm just going mad.	**Outer portrayal and Inner conflict**: 'nothing wrong….I'm just going mad'. 'Mad' because perhaps she's not enjoying motherhood as she 'should' be – highlights the ideology of perfect mothering.
…It took a long time to diagnose and me to realise that there was something properly wrong once it was acknowledged it all went quite quickly from there	**PND Diagnosis**: 'took a long time …to realise'. Lack of recognition of symptoms as PND. Difficulties seen as lacking in the self rather than as an illness/situation.
Researcher: Oh that's brilliant. So you fought on for quite a long time before the diagnosis, 15 months or so.	
Rachael; Absolutely, sleeping was rubbish, I was crying all the time, just miserable, didn't answer my phone, didn't want to talk to anyone, avoided lots of situations, but at the same time,	**Self-silencing;** withdrawal from others. Hiding away through **shame** or **judgement**. **Belonging**: doesn't fit in the 'ideal' mother category and no solace in being with others.

when I started confessing to people that I had got this illness they had no idea, I'd covered it up brilliantly well apparently.	**Shame**; having to 'confess' to PND **Mask** : 'covered it up brilliantly' even though inside Rachael was suffering -**Inner/Outer conflict.**
In my mind although I'd been really crying and shut off and everything else, to their mind I performed as I always had really.	**Inner/Outer conflict:** Inner experience is 'shut off' from others which contrasts with outward **performance**. **Wearing a mask** and the **invisibility** of the person suffering underneath.
So, yeah it was a bit of an odd situation for them because my sister was devastated because she hadn't seen it, my mum was very upset,	**Protecting the other**: Concern for others: once truth is out, it is others who are upset. **Entrapment**: Hide difficulties to not upset others.
my dad didn't want to know about it – still doesn't want to know about it, I think that's a generation thing and a dad thing as well. So quite a long time unnoticed and just thinking everyone's like this and not realising that they weren't	**Shame;** Bringing shame and judgement on the family with her illness **Trapped**: everyone's like this. **Belonging and Feeling a failure**: Realising not everyone is like this. **The invisible Woman**: 'a long time unnoticed'.

Appendix 9. Superordinate themes and sub-themes.

This table illustrates the progression towards the development of final superordinate themes

Superordinate Theme 1 –Striving to be a perfect mother.		
Sub-themes	**Concepts**	**Quotations**
1.1 Sacrifice of the self	Prioritising the needs of the child to the detriment of the mother's wellbeing	'I was there purely to look after (the child)…it didn't matter what happened to me.'
1.2 Expectations of the self	Expecting to cope 'naturally' with motherhood and do a good 'job'. Not living up to own expectations.	'I'm choosing this…why aren't I doing a better job' 'I should be enjoying it more'.

Superordinate Theme 2 – Feeling a failure.		
Sub-themes	**Concepts**	**Quotations**
2.1 Turning on the self	Self-punishment. Self-harm. Personal unworthiness.	'I would try and hurt myself' "Sometimes you think they would they be better off if I did put them up for adoption"
2.2 Underperformance	Unanticipated shock of not performing well. Failure to transfer work competency skills to mother role.	I really did think I'm not doing this well enough. 'I've never really failed at anything'.
2.3 Belonging	All other mums are coping and happy. Feeling unable to fit in.	'Lonely amongst a group of people…in the same boat as me….felt worlds apart.'
2.4 Diagnosis of PND	Reluctance to accept diagnosis. Symptoms not recognised as PND. Diagnosis Implies failure as a mother. PND happens to other people.	'Having anti-depressants…meant...I had failed as a mum.' 'I didn't want to identify with it.' 'I just persevered with it'

Superordinate Theme 3. Being sucked dry.		
Sub-themes	**Concepts**	**Quotations**
3.1 Responsibility	Taking and wanting full responsibility for child and its needs	He (the baby) was mine…he was my job, my responsibility…surely I could get this right.
3.2 The invisible woman	Disappearance behind needs of child Wanting to be seen	They (health visitors) never asked about me…only…breastfeeding
3.3 The depleted self	Nothing left to give. Feeling empty. Hopelessness.	I'm just a sack.' 'Me…a feeding machine…I lost all sense of who I was'

Superordinate Theme 4. Shame of the others gaze.		
Sub-themes	**Concepts**	**Quotations**
4.1 Inner/outer conflict	Wearing a mask. Outside image belies inner turmoil. Fear of being seen as deficient	We…never realised you had it, you seemed fine' 'When I did tell them they thought I was partly joking'
4.2 Risk of judgement	Self-silencing, Unsafe health professionals. Be grateful that you have a child.	'I thought I really do want to complain now but I can't because I've got this precious little gift miracle'

Superordinate Theme 5. Being Stuck and Overwhelmed		
Sub-themes	**Concepts**	**Quotations**
5.1 Protecting the other	Not wanting to burden others with own problems.	I always felt like I was putting them in an awkward situation talking about it.
5.3 Entrapment	Needing rescuing and to be cared for. No escape. Unrelenting needs of the child.	I just wanted…somebody else to look after me' 'I would feel myself spinning and trying to climb the walls of this vortex that was kind of sucking me in
5.3 Shut down	Giving up on the self. Automatic functioning	'It wasn't living' 'I had to battle on' 'like slow motion…disconnected'
5.4. Needing help to break the cycle	Medication alone is insufficient for recovery.	'You kind of knew there was a gap between what the tablets would provide and what you needed'

Superordinate Theme 6. Becoming Lost		
Sub-themes	**Concepts**	**Quotations**
6.1 Identity	Loss of old capable professional self; New unrecognisable self.	I never wanted to be a depressed person 'Old me was professional in my job'.
6.2 No going back	The self as changed.	I wasn't going to be the person I was before.
6.3 Being found	Counselling. Accepting motherhood experience. Return	What I found helpful with the counselling…being able to have a conversation and not having to worry about the impact of what I was saying.

Supporting quotes for each superordinate theme:

1. Striving to be the perfect mother

'I've always had that determination to prove myself…There are some people who don't look like they have a clue what they're doing but they're good mums, so I'll be a good mum…I've got to give her the perfect start to life….I've got to make everything perfect for her [Judy].

'I think I hadn't realised it but before then (motherhood) although there had been tough times, everything had been quite easy…I'd been able to manage, whatever had come along and it had never been anything bad, I'd always been able to cope with…with Daniel coming along…I couldn't fix all the problems, sometimes he'd cry and I'd look in the books and I'd changed him, he was warm enough, I'd fed him, he was still crying and he's not bored, I'd tried to entertain him…I'd tried to find the answers and I wasn't used to that, so that was quite scary and unnerving really [Rachael].

2. Feeling a failure

I probably missed out on a lot of the fun things when she was little because I was too obsessed with keeping her safe…'I don't feel guilty, just probably a bit cheated that the first few months weren't as much fun as maybe other people had [Judy].

I just kind of broke down…and said I can't, I can't do this anymore. And also, at that point, I'd also had...I don't think I seriously would ever have done it, but I do remember, and it freaked me out thinking about it. I have a knife block in the kitchen, thinking about taking the knives from the block and what I could do…to myself…I think I always knew I had high standards and so on the odd occasion - give yourself a break or whatever but that would quickly go…I almost felt that I wanted to wallow in the negative and tell myself I'm doing a crap job, I wanted to punish myself in some way – which is horrible, isn't it! [Rachael].

I never wanted to be a depressed person. I never wanted to be that person…I think the thought of having anti-depressants to treat me, meant that I had failed as a mum…In my head I was thinking well I shouldn't be feeling like this…I was kinda mentally trying to work my way out of it…I want to be a mum who's happy and enjoying it [Mary].

To me I think I feel very disappointed with myself…there had been a lot of depression in my family and it did give me an experience of that and what that's like for somebody…at the same time I did try to identify with that a bit but at the same time I didn't want to identify with it because it felt like…and I don't know whether this is true, but I see postnatal depression as something different from someone who's just depressed, there is a particular reason for it and therefore it's not me…not being able to cope with the world, it's like I couldn't necessarily control, that's not very fair really that's why I wanted to keep it as different to a general one [Mary].

3. Being sucked dry

I didn't really make any time for me. I probably didn't care what I looked like (...) You'd just think well, it's not about me, it's about looking after…that's my job now, I have to look after her. Everything else for me comes second so long as she's ok…I probably didn't eat as much and as often as I should do because everything was…not wrongly but everything was focused on Angela (daughter). And I would eat when somebody reminded me to eat [Judy].

I lost all sense of who I was…Me, was…a feeding machine…there is no time for anyone but this child who just demands everything and sucks the life out of me because he just wanted to feed all the time. And then you have the midwife saying: make sure you eat, nutrition's really important for you…When? And newborns, nappies, all the time, all the time, all the time [Sophie].

I knew what I should be doing and I was able to do it for the most part, there was just a real lack of feeling or connection with any of it. I just felt like I was going through out the motions a lot of the time and ticking a box…at 5 o'clock on the dot I would be starting the baby massage routine ready for the next step of the bath. Yes I think that's one way how I knew I was getting through the day almost because I was counting down the hours and ticking off the things, feed, snack, feed, sleep, walk here [Rachael].

I think I was making that decision, no, no, keep plodding through it, it will get better, and the people who I did try to open up to a bit, all admitted that they'd had a rough time but then it gets so much better, and so I was always waiting for that to kind of kick in and just existing I suppose, going through the motions…I found it all distinctly underwhelming really…But again just thought; no this is probably how it's meant

to…just thought…I don't even think I thought other people feel this, by that point I just thought this is how it is, I just carry on [Rachael].

4. Shame of the others gaze

I didn't see them as much, because I didn't want them to (a) see me that way I suppose because I knew it wasn't right but also to not have to pretend and act in front of them because that was quite tiring as well…I avoided seeing people. I was part of an NCT group and we met every week, which I maintained, but it was quite useless to me as Daniel always liked to be rocked, held, was wriggly, their girls slept the entire coffee afternoon. So…although I was there with them, I was pacing around Costa or slightly separate from them, so that was alright then, I had all these excuses all the time…I've got to go now, I've got to do this or he's not feeding well here I'm going to leave, sorry I'm a bit off today I was up all night, I just found myself apologising a lot, making a lot of excuses and umm…not enjoying any of it [Rachael].

Mum was very upset and was very concerned that it was something she'd done and then Dad didn't want to talk about it at all. I'd been put on anti-depressants and he doesn't believe in them at all, doesn't really believe in any mental health issues he thinks it just pulling yourself together and snapping out of it. I tried to tell him I can't and that's why I'm ill, because I can't snap out of it that's the whole problem dad. Dad was kind of saying well we won't tell anyone about this…because this is private and your business…Mental health just was never an issue in our sort of family…and so I suppose…I didn't really know what their reaction would be and I didn't know what a lot of people's reaction to me would be if I put my hand up and say 'yes, this is me'. I've always been quite a private-ish person anyway [Rachael].

5. Being stuck and Overwhelmed

It wasn't living. I wanted to get out of it. It wasn't me…I couldn't get a firm grasp on anything like I was just…drowning. Every day was…do I have to do this again? This is not living. I don't want to be here…I don't…how do I run away, how do I escape this? I've just got to get through today, sort of thing and then you go why do I get through today because tomorrow it has to happen all over again…People say to you don't worry it will all get better they will be able to show you that they love you. I can't see tomorrow…so right now…I'm getting nothing…I can't see it ever getting better…So it was just kind of a downwards spiral and I would feel myself spinning and trying to

climb the walls of this vortex that was kind of sucking me in. But I couldn't get out of it. I just felt like I was looking up all the time…That's really scary to think how did I get to this place? And I can't see a way out of it. I just felt scared and there was no-one that could help me. That was pretty lonely [Sophie].

6. Becoming lost

Old me was professional in my job, my job was timelines and process and controlling…and when the day finished, you took stress home but I could go to the movies, I could go out for dinner…but all of a sudden I was responsible for someone else who didn't fit my order and their demands were so instant and they would just cry and you didn't know what was wrong and there was no break…there was no turning off… Never ending…you have everything of me…there is nothing left to give and so there's no way old me could even exist because everyone else got a bit of it…I lost all sense of who I was. I lost me completely, because me didn't exist (...) I felt I had completely lost me, lost my personality…I just felt alone….I just didn't understand how I could completely lose my personality and there was no hope of that ever coming back [Sophie].

It never crossed my mind to leave her with anybody else…that's the last thing I wanted…The first few months were not fun so it wasn't that I wanted to be with her because this is great fun, it was more I want to be with her because I love her and I want to look after her – not because I could do a better job or 'cos this is great and it's what I've always wanted, it was none of that it was….my responsibility, it was mine – she's mine…I wanted to keep looking after her even though I couldn't really cope with it very well [Judy].