

# Exploring the Narratives of Women Who Identify with the Term “Postnatal Depression”

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

**Keywords:** postnatal depression, research and theories, disorders and diseases

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

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### **Labelling Perinatal Depression**

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

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

The debate on diagnostic labelling relies on the need to pathologize women’s experiences as either being MDD or PPD following childbirth. This is perpetuated by the medical profession which continues to pathologize women’s experiences as “abnormal.” This has, perhaps, stemmed from a socio-political context of the developing concept of “motherhood” which has caused it to be romanticized and mystified, to serve patriarchal interests (Nicholson, 1990).

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

### **Service Context**

In 2012, the Joint Commissioning Panel for Mental Health highlighted the need for a perinatal mental health integrated care pathway to be used by all services to ensure access for the right people at the right time. Extra training on perinatal mental health for practitioners working in community services such as IAPT (Improving Access to Psychological Therapies) was also raised as an important aspect of future services. Holistic assessments from primary care practitioners such as GPs and midwives were also called for. However, in an NSPCC report the following year, 42% of GPs surveyed said they lacked knowledge about specialist services for people with severe mental illnesses, 29% of midwives said they had received no content on mental health in their pre-

registration training, and 41% of mothers said that their health visitors had never asked them about depression (Hogg, 2013). The report described access to appropriate services as “a postcode lottery.”

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

In March 2015, following a scoping exercise by NHS Improving Quality (2015), it was announced by the Government that £75 million would be spent over five years, in order to provide the “right care to more women who experience mental ill health during the perinatal or antenatal period” (NHS Improving Quality, 2015, pg. 6).

### **The Present Research - Women in Perinatal Research**

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

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

Therefore, this study aims to:

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

## **Method**

### **Narrative research.**

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

### **Recruitment.**

#### Inclusion criteria

Mothers who:

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

#### Exclusion criteria

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

Participants were recruited via an advertisement placed on social media platforms by PND charities. Individual users of these platforms were then able to share the advertisement with their friends and

followers. As a result, there was a snowball element to the purposive sampling methodology.

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

### **Ethical Approval.**

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

### **Participants.**

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

Table 1

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

### **Procedure.**

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

### **Reflexive Position.**

The researcher is a trainee clinical psychologist with a professional interest in women’s health and both professional and personal experiences of mental health difficulties following childbirth.

### **Transcription and Analysis.**

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

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

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

## Findings

### Abstract

**Trauma.** Each abstract reflected trauma in some way. Three of the women explicitly said that they had found their labors "traumatic." For Connie, this was physical trauma of a difficult labor and subsequent injuries and surgeries that resulted:

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

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

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

*The birth I found quite traumatic. - Ellie*

The remaining women discussed previous losses in the form of miscarriages and the experience of anxiety in their subsequent pregnancies resulting from this trauma. Amy described a traumatic antenatal period but an "absolutely perfect labor [and] delivery; it was lovely." Interestingly, this participant later accessed a service aimed at

women who had experienced traumatic births. The service offered women a space and time to sit with a midwife and look through their notes in order to process any difficult experiences they may have had.

### Orientation

**Internal Confusion/ Something Isn't Right.** As the participants oriented the researcher to their stories, they all described a period of internal confusion that occurred soon after giving birth. This experience was often described as difficult to articulate but something that the women felt intuitively; an instinct that they felt and in many cases motivated them to seek help.

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

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

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

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

### Complicating action

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

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



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

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

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

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

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

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

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

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

Agnes' comments regarding the health visitor "paying lip service" suggest a lack of sincerity. Rather than speaking and not being heard, she suggests that the lack of rapport silenced her and she was unable to voice

her difficulties. Agnes is shocked that the health visitor was also unable to pick up on her nonverbal cues of distress.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## **Resolution**

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

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

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

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

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

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

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

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

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

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

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

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

## Evaluation

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

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

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

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

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

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

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

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



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

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

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

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

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

## Discussion

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

## Trauma

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

Connie's story was the only one to tell a positive journey through mental health community services. Interestingly, Connie was the only participant to be left with physical injury following birth. Even though her health visitor recognized that Connie's scores on the EPNDS suggested

she was somewhat at risk, they did not refer her to mental health services. It was the physical health staff she saw, who could see the physical trauma she had experienced, that encouraged her to seek support. She was subsequently treated for post-traumatic stress disorder (PTSD). Many of the other participants talked about having to fight or hunt for support and feeling unheard. This raises questions about how “trauma” is identified within mental health services and other healthcare professions, and by whom.

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

### **Feeling Unheard/Finding a Language**

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

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

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

### **Society's View of Motherhood**

A narrative about the expectations of others and the pressure this caused were heard throughout the women's stories. This pressure came as voiced expectations from members of some of the women's families as well as the women's perceptions of healthcare professionals and society's expectations of mothers. Willow discussed how she perceived offers of help from her family as "weird." Both she and Ellie talked about a feeling that they should be doing things alone, they should be stronger than they felt. It is important to think about where these perceptions come from and they have been considered in feminist research previously. In their 2012 paper, Held and Rutherford discuss the construction of motherhood from the 1950s to 2012. They evaluate the changing attitudes towards postnatal mental health problems through the decades regarding causes and interventions and also highlight the assumption that remains constant: that motherhood and distress should not mix. The authors suggest that this assumption is rarely challenged. From the postwar prosperity of the 1950s, in which the extended family and support networks were eroded as young couples began to live independently, to the sexual politics of more recent times, women are "expected to work, clean, and raise families, and smile about it." Held and Rutherford (2012, p.119) argue that "when the most important job in the world becomes one of the most distressing, perhaps we need to look seriously, not only at the mother, but at the job itself."

Choi, Henshaw, Baker, and Tree (2005) illustrated how myths of motherhood perpetuated by society create feelings of inadequacy and shame in mothers who cannot live up to the expectations placed on them. Nicolson (1999) noted that whilst the women that she interviewed were

happy to be mothers, they were unhappy at the losses they suffered as a result of motherhood. This paper argues that the transition to motherhood should be seen by families, professionals, and society as a healthy process towards psychological re-integration rather than a pathological response to a “happy event” (Nicolson, 1999). All of the women in the present study talked at some point about withholding information, denying themselves support in some form or feeling ashamed as a result of their perceived inability to conform to what a mother “should be.”

### **What is vulnerable?**

A narrative regarding the positioning of the women in society could also be heard throughout the stories. Several of the participants questioned services’ definition of “vulnerable.” Amy talked about receiving an “out of the ordinary referral,” usually reserved for women who professionals would define as more vulnerable, such as single parents or low income families. It is important to note that all of the women here were White British, in stable relationships with the fathers of their children, and employed. Some of the participants worried that the women they perceived as more vulnerable would not be able to access support; they felt that as they had needed to fight and struggle to get help, that women in a more vulnerable position would be missed. However, it could be argued that, as evidenced by Amy’s “unusual” referral, perhaps the inverse is true. Again, sexual politics needs to be considered here as Collins observed in 1980: “married or not, most women are single parents...motherhood can be even more difficult for women in intact families because they’re not seen as being alone in their tasks” (Collins, 1980, p. 115). Perhaps the fact that services and society viewed the women in this study as supported and secure meant that they were excluded from accessing help, whereas those women and families who are defined as “vulnerable” by services may access support more easily.

### **Clinical implications**

The way in which trauma is perceived seems to vary greatly between professionals and the women who experience it but also within these two groups. NICE (2014, p.14) defines traumatic births as those that are “physically traumatic...and those that are experienced as traumatic, even when the delivery is obstetrically straightforward.” This definition recognizes the subjective nature of the experience of trauma, although the findings here would suggest that physical trauma and psychological trauma are viewed very differently by services and professionals within them. This is a consideration that should be taken into account as training for primary caregivers and the assessments they use are developed.

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

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

### **Strengths and limitations**

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

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

A significant limitation of this study is that participants were recruited via charities' social media platforms and websites alone. Women who are not active online would not necessarily have been able to request

to participate; those that did choose to participate may belong to a particular group of women. However, in January 2017 there were 16.6 million female, UK users of Facebook registered between the ages of 18-54 (Statista, 2018) and the use of websites and social media will have given this project good geographical reach across the UK.

### **Conclusion**

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

### **References**

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5<sup>th</sup> ed.). Arlington, VA: American Psychiatric Publishing.
- Boals, A., & Schuettler, D. (2009). PTSD symptoms in response to traumatic and non-traumatic events: The role of respondent perception and A2 criterion. *Journal of Anxiety Disorders, 23*, 458-462.
- Centre for Mental Health; Bauer, A., Parsonage, M., Knapp, M., Lemmi, V., & Adelaja, B. (2014). *The costs of perinatal mental health problems*. London: Centre for Mental Health.
- Choi, P., Henshaw, C., Baker, S., & Tree, J. (2005). Supermum, superwife, supereverything: performing femininity in the transition to motherhood. *Journal of Reproductive and Infant Psychology, 23*(2), 167-180.
- Collins, J. E. (1980). Why new mothers get the blues and what they can do about it. *Glamour, 78*, 76-78. Reprinted in L. Held, L., & A. Rutherford, A. (2012), Can't a mother sing the blues? Postpartum depression and the construction of motherhood in late 20<sup>th</sup> century America. *History of Psychology, 15*(2), 107-123.
- Collins, S., & Long, A. (2003). Working with the psychological effects of trauma: consequences for mental health care workers - a literature review. *Journal of Psychiatric and Mental Health Nursing, 10*, 217-424.
- Department of Health (DOH) (2014). *The Mandate. A mandate from the Government to NHS England: April 2014 to March 2015*. London: Crown Copyright.

- Emden, C. (1998). Conducting narrative analysis. *Collegian Journal of the Royal College of Nursing Australia*, 5(3), 34-39
- Etherington, K. (2013). *Narrative approaches to case studies*. [online]. Available from: <https://www.keele.ac.uk/media/keeleuniversity/facnatsci/schpsych/documents/counselling/conference/5thannual/NarrativeApproaches toCaseStudies.pdf>
- Gold, S. D., Marx, B. P., Soler-Baillo, J. M., & Sloan, D. M. (2005). Is life stress more traumatic than traumatic stress? *Journal of Anxiety Disorders*, 19, 687–698.
- Held, L., & Rutherford, A. (2012). Can't a mother sing the blues? Postpartum depression and the construction of motherhood in late 20<sup>th</sup> century America. *History of Psychology*, 15(2), 107-123.
- Hogg, S. (2013). NSPCC, *Prevention in mind. All babies count: spotlight on perinatal mental health*. London: NSPCC.
- Joint Commissioning Panel for Mental Health (2012). *Guidance for commissioners of perinatal mental health services. Volume two: practical mental health commissioning*. London: Rafferty's.
- Jomeen, J. (2012). Women's psychological status in pregnancy and childbirth – measuring or understanding? *Journal of Reproductive and Infant Psychology*, 30(4), 337-340.
- Labov, W. (1972). The transformation of experience in narrative syntax. In W. Labov (Ed.), *Language in the inner city*, (354-396). Philadelphia: University of Pennsylvania Press.
- Masood, Y., Lovell, K., Lunat, F., Atif, N., Waheed, W., Rahman, A., Mossabir, R., Chaudhry, N., & Husain, N. (2015). Group psychological intervention for postnatal depression: a nested qualitative study with British South Asian women. *BMC Women's Health*, 15, 109.
- McCarthy, M., & McMahon, C. (2008). Acceptance and experience of treatment for postnatal depression in a community mental health setting. *Health Care for Women International*, 29, 618-637.
- McNally, R. J. (2009). Can we fix PTSD in DSM-V? *Depression and Anxiety*, 26(7), 597-600.
- Myors, K. A., Schmied, V., Johnson, M., & Cleary, M. (2014) 'My special time': Australian women's experiences of accessing a specialist perinatal and infant mental health service. *Health and Social Care in the Community*, 22(3), 268-277.
- NHS England (2014). Putting patients first. Business plan 2014-14 to 2016-17. Available from: <https://www.england.nhs.uk/wp-content/uploads/2015/11/nhse-bus-plan-1415-1617.pdf>
- NHS Improving Quality (2015). *Improving access to perinatal mental health services in England - A review*. NHS Improving Quality: publication date: August 2015.
- NICE (2014). *Antenatal and postnatal mental health: clinical management and service guidance*. Clinical Guidance [CG192].
- Nicholson, P. (1999). Loss, happiness and postpartum depression: the ultimate paradox. *Canadian Psychology*, 40(2), 162-178.
- Polkinghorne, D. E. (1988). *Narrative knowing and the human sciences*. Albany: State University of New York Press.
- Royal College of Psychiatrists (2014). CCQI: *Quality network for perinatal mental health services. Service standards* (2nd ed.). Publication number CCQI171.
- Rubin, D. C., & Feeling, N. (2013). Measuring the severity of negative and traumatic events. *Clinical Psychological Science*, 1, 375–389.

- Shaikh, A., & Kauppi, C. (2015). Postpartum depression: deconstructing the label through a social constructionist lens. *Social Work in Mental Health, 13*(5), 459-480.
- Shakespeare, J., Blake, F., & Garcia, J. (2006). How do women with postnatal depression experience listening visits in primary care? A qualitative interview study. *Journal of Reproductive and Infant Psychology, 24*(2), 149-162.
- Statista (2018). Total number of Facebook user in the United Kingdom (UK) in January 2017, by age group and gender (in millions). Available from <https://www.statista.com/statistics/507417/number-of-facebook-user-in-the-united-kingdom-uk-by-age-and-gender/>
- Turner, K. M., Chew-Graham, C., Folkes, L., & Sharp, D. (2010). Women's experiences of health visitor delivered listening visits as a treatment for postnatal depression: a qualitative study. *Patient Education and Counselling, 78*, 234-239.
- Templeton, L., Velleman, R., Persaud, A., & Milner, P. (2003). The experiences of postnatal depression in women from black and minority ethnic communities in Wiltshire, UK. *Ethnicity and Health, 8*(3), 207-221.
- Ussher, J. M. (2005). *Managing the monstrous feminine*. Florence, KY: Routeledge.
- Wittkowski, A., Zumla, A., Glendenning, S., & Fox, J. E. (2011). The experience of postnatal depression in South Asian mothers living in Great Britain: A qualitative study. *Journal of Reproductive And Infant Psychology, 29*(5), 480-492.
- Wood, D. (1991). *On Paul Ricoeur: Narrative and interpretation*. London: Routledge.