The concept of normality as a component of help seeking and adaptation in couples with experience of postnatal depression: A grounded theory study

By

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Volume 2 Chapter eight, appendices and references
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8.1 Introduction

This chapter examines the findings from the thesis and discusses them in relation to the literature on postnatal depression. It adds new material to that published since the earlier review and suggests new perspectives on the subject, which have emerged from this study. The study findings are discussed in relation to the literature on the experience of postnatal depression for women and some of the issues raised by the small amount of work on men. It expands on this area in particular and adds the dimension of the couple relationship to the body of work. A number of support issues are identified. These describe the factors, which the respondents considered when they assess the help available to them. These reflect recommendations for practice proposed in the professional literature but also highlight gaps in services. The core category 'normality' proposed by the study describes some of the key concerns, which contribute to the respondents' understanding of their experience. This chapter summarises the findings from the study and relates these to the delivery of clinical service for families with experience of postnatal depression. Recommendations for future research, which arise from this study, are made. The study provides an insight into the experience of postnatal depression for couples and their support needs. It further adds to our understanding of the meaning of parenting for the respondents and its influence on their decision to access help and chart their
recovery from the illness. The findings illustrate the complexity of the experience of postnatal depression and have implications for the delivery of clinical services. Recommendations for future research are made. Men need to be acknowledged as integral partners to the care of women with postnatal depression but also as participants with specific needs of their own.

8.2 The research question revisited

The two areas of interest for this study were the couples' experience of postnatal depression and the related support issues. A number of factors were of particular concern to the respondents: they speculated about the causality of the illness, considered various coping strategies to manage the illness and described how they aimed to achieve their 'normality'. The participants in this study explored these aspects based on a perception that the couple relationship is valuable and should be preserved. They all had considered ending their relationship at some point during the woman's illness, but had decided to remain with their respective partner. Their position reflected a particular perspective which may be specific to this group of respondents. In addition the format of support, the people providing it, their characteristics and the outcomes of this support were important considerations for the respondents to access potential help.

8.2.1 Experiencing postnatal depression

The findings reflect some of the factors identified in the literature, particularly in relation to the experience of postnatal depression for women. Mauthner (1999, 2002) and Nicolson (1988, 1990) highlight the effect of the illness on
women and question the representation of postnatal depression as a medical condition. Their work describes vividly how women experience postnatal depression. They understand it as a debilitating condition brought about by the demands of the care for the new baby and the need to maintain a functioning image of competent motherhood. Beck (2002) summarises the qualitative work undertaken in the field and proposes four perspectives. These reflect the sense of incongruity between the expectations and the reality of motherhood. Women experience a downward spiral towards isolation and loneliness, which is characterised by feelings of guilt, pervasive loss and contemplation of self harm. Gains are only made through a process of surrender, reintegration and change.

The respondents in this study also talked about a similar sense of incongruity. They felt that often their expectations did not fit with their actual experience of motherhood. They expressed a frequent desire to maintain an image of normality but found that this conflicted with their ability to access help from those around them. Their experience added a new perspective to that presented in Beck's model (2002). They acknowledged similar feelings of loss and guilt but also expressed their desire to actively strive to regain or adapt what they perceived to be their former 'normality'. While they experienced the feelings of guilt and loss described by Beck (2002) they appeared to engage more actively in the process of recovery. The women in this study presented themselves not so much as victims of their illness but as individuals with a desire to regain control over their lives. Social factors and the demands of the care of the new baby were a recurrent theme for these
women as Mauthner (1999, 2002) and Nicolson (1988, 1990) suggest. However they also appeared to see their response to these changes less in terms of passive acceptance and expressed a desire to play an active part in their recovery. They adopted a position of realism and adjusted their expectations accordingly. Whether this is necessarily desirable is questionable since it potentially implies an acceptance of the status quo. These women went through change towards recovery as indicated by Beck (2002) but saw this less in terms of surrender than as an opportunity to regain control over their lives. Although this process was challenging, it provided the women in the study with a sense of empowerment and control.

The above authors suggest that the experience of postnatal depression is gender specific and reflects the difficulties faced specifically by women. The influence of the woman's personality or her personal background is not considered. Such a gendered perspective was less obvious in the current study with differences in explanations less clearly delineated. The partners placed a different emphasis on some aspects of the experience but also shared similar concerns. For instance both partners speculated at length on the causes of the woman's illness to help them make sense of their experience. The women used a range of physical explanations such as a difficult birth experience, hormonal causes and the demands of a difficult child. They also considered the role changes brought about by motherhood and their effect on the women's mental health. These women utilised the same range of explanations of causality proposed by the literature but also reflected the tension between physiological and social explanations apparent
there (McIntosh 1993, Moore and Emanuel 2001, Nicolson 1990, Small et al. 1994). Edhborgh et al (2000) and Meredith and Noller (2003) specifically identify the difficult child as a contributory factor. The latter suggest that depressed mothers have a tendency to see their children as fussy and difficult to manage. As the respondents in this study commented on the potential impact of their difficult child, this may be a reflection of their depression rather than their child's objective problems. For other couples in the study difficulties of childcare were not necessarily an issue. On the contrary, they expressed puzzlement that they did feel depressed despite having a 'good baby'. They would have found it easier to understand, if their depression had been caused by a difficult child. This aspect contrasts with the literature since the respondents assessed their child's behaviour more favourably than some of the authors suggest. The women's judgement of their child's temperament may have been less distorted than anticipated.

The concept of motherhood and the notion of a good mother and wife are further key concerns for women with postnatal depression. Women judge their own performance as good women based on their understanding that they need to fulfil their domestic roles as carers. Prioritising their own needs is perceived to be unnatural placing women in conflict with their social world and creating tension in their personal identity (LaFrance and Stoppard 2006). The need to be seen to function effectively and to fulfil the role of a 'good mother' also informed the women's understanding of their experience in the current study. They compared their own experience with their peers, who were perceived to fulfil this aspect of their role more effectively. They made
these comparison based on their definition of 'normal' parenting. They also talked about the need to take time out from their childcare duties and their feelings of guilt when they expressed this desire. Like the women in LaFrance and Stoppard's study (2006), the women in the current study demonstrated a similar need to reject the concept of the 'good woman' before they were able to recover from their depression.

Some couples were more likely to attribute the causality of the illness to the influence of hormonal factors and traumatic birth events, while others stressed the social causes of their illness, the additional child care demands and changes in family roles. While the emphasis was slightly different, both partners commented on the same aspects of the experience with some couples focussing more on physiological explanations while others attributed the illness more to social causes. The literature on postnatal depression identifies similar conflicts of interpretation but is moving towards an interpretation which recognises both perspectives (Holden 1991, Huang and Mathers 2001, Tennant 2002). These are recognised in the importance which is placed on the need to consider both medical and psychological approaches to treatment (Scottish Intercollegiate Guidelines Network 2002).

The respondents in this study tried to make sense of their experience and used the explanations currently available to them. Contact with medical staff and the easy availability of drug treatment might have reinforced particularly the physiological explanations. In addition, the men favoured more tangible explanations for their partners' illness such as hormonal causes,
complications of childbirth and exhaustion. Since men often can feel frustration when they can not 'fix the problem' (Meighan et al. 1999), such an attitude might have made a physiological explanation for their partner's depression more accessible to the men in the study. It could also explain the men's more positive attitude towards medication as a treatment, although they expressed their concerns about the potential side effects of medication.

At the same time, these functional explanations were insufficient to explain all aspects of the experience. Leventhal et al. (2003) suggest that individuals develop their understanding of illness representations from a range of sources of information which include biological changes, the observation of others and information gathered from the wider social context. The respondents in this study were aware of the ranges of explanations available to them. Their selection appeared to be based less on gendered differences than on their need to make sense of their experience over time and within their social context.

In addition the respondents in this study engaged in significant emotion work to manage the disruption which postnatal depression had caused in their lifecourse. The women commented on their efforts to hide their feelings in an attempt to maintain normal social interaction with those around them and manage the perceived stigma of their diagnosis. The respondents saw their experience as contrary to their personal and social expectations of parenthood, a perception which challenged their self identity. Emotion work allows individuals to conform to given, dominant expectations. People
actively deal with their emotions to manage their experience for themselves and for others (Frith and Kitzinger 1998). This requires skill and effort since it involves handling not only personal emotions but also those of close others.

It is possible that this can create a potential tension between the needs of the patient and significant others (Duncome and Marsden 1998). The respondents in this study demonstrated such a conflict in their efforts to meet not only their own emotional needs but also those of their partner. The attempts of both the men and women in the study to protect the partner from distress illustrated such efforts to manage conflicting emotions. Their emotion work reflected their sense of care and protection towards the other partner. While it is suggested that such care work is gendered and the domain of the female (Frith and Kitzinger 1998), both partners displayed similar concerns. A significant life event can disrupt not only daily life but also the expected lifecourse. Emotion work can help the patient to feel better about the self but also make others feel better in order to maintain an authentic self within a perceived disrupted lifecourse (Exley and Letherby 2001).

Managing emotions in response to a significant life event, which is perceived to disrupt the expected course of personal or family life, requires emotion work from not only the patient but also the informal carer. Informal carers of cancer patients for instance undertake emotion work to help the patient while also trying to manage their own distress. The relationship can be strengthened by a sense of shared responsibility to manage the complex emotions generated by the diagnosis. At the same time a desire to provide
reassurance and maintain a positive image for the patient can make additional emotional demands on the carer (Thomas et al. 2002). The men in the current study engaged in similar emotion work when they commented on their efforts to provide reassurance to their partners, stressed the common responsibility for the management of their partner's depression but also described their hidden, personal distress. This suggests that the carers engaged in emotion work not only for themselves but also for their partner. The complexity of this process and the considerable emotional effort involved have been highlighted by other authors (Duncombe and Marsden 1998, Exley and Letherby 2001).

For both partners, the underlying strength of the couple relationship was of concern and a recurrent theme throughout the interviews. The feelings of isolation and confusion described in the literature were also significant for the respondents in this study. In addition they conveyed a sense of commonality and a desire to maintain the relationship. A number of authors focus on the negative impact of the illness on the relationship. They identify feelings of isolation, frustration and a fear of not being able to cope with the partner's depression (Aiken and Kingsley 2000, Beck 2002, Davey et al. 2006). Demands of childcare and sexual difficulties are additional stressors for the relationship (Edhborg et al. 2000). The couples in the current study also commented on their feelings of isolation from each other and their inability to share their feelings of distress. Both partners felt a sense of distance, often withholding important information in an attempt to protect the other partner from distress. The men often felt frustrated that they were unable to help their
partner effectively and could not always understand what was expected of them. They expressed a desire to obtain information about their partner’s illness to help them understand the conflicting demands made on them. These findings reiterate the points made by other authors (Aiken and Kingsley 2000, Davey et al. 2006), but add a further positive perspective to this presentation. The respondents commented that their relationship had also matured as a result of their experience. As they moved towards recovery, they felt that they had developed as people and gained in understanding.

The more the partners were able to communicate with each other, the more they had felt that their relationship had developed positively. This need to communicate with the partner to facilitate the relationship and to actively seek help from others has been identified previously (George 1996). Even if the women are supported effectively there is the possibility that they continue to feel troubled in their relationship. Often the marital relationship is portrayed as the primary source of support. Such a position can detract from the role other forms of support play particularly for women (Mauthner and Doucet 1998). The women in this study also valued additional sources of support such as family members, friends and professional helpers. While the men in the study often perceived themselves to be more emotionally self-sufficient, they also described their need for additional support to help them manage their partner’s illness. Both partners experienced postnatal depression in similar terms. Although they had considered leaving the relationship at some time during the course of the illness, they remained together based on the
value both partners placed on the relationship. It is possible that the men stayed in the relationship because they were more likely to draw emotional support from their partner and had fewer support networks. Since this study sought to explore the perspectives of parents who had negotiated postnatal depression as a couple it could be argued that this represents an inherent bias in the sample. While acknowledging this limitation to the study findings, it could be argued that their perspective is as relevant as that of couples who have separated. The experience of the respondents in this study has the potential to provide valuable insights which might be of benefit to couples at a crossroads in their relationship.

8.2.2 Supporting and being supported

The experience of postnatal depression described by the participants in this study highlighted more similarities between the partners than suggested by the literature. This was also the case for the support issues identified by the respondents in terms of the format of the help available and discussed in more detail below. In addition the study provided an insight into the various considerations, which influenced the respondents' help seeking decisions.

8.2.2.1 Format of support

Medication and physical exercise have been identified by users of mental health services as important elements of support (Faulkner and Layzell 2000). Other helpful strategies include the need to change personal attitudes and recognise the importance of relationships with others. The SIGN guidelines for postnatal depression (2002) further stress the need for
combined medical and psychosocial interventions. Of particular interest to the couples in this study was the social support available to them. Social support is defined in terms of instrumental, informational and emotional support by a number of authors (Dunbar et al. 1993, Kendall - Tackett and Kantor 1993, Reid et al. 2002, Wills 1985). The respondents in this study commented on the various aspects of support. Examples of practical support were given such as help with household chores, baby care and time out from childcare. Emotional support was valued in the form of listening, understanding and relationship advice. These examples contribute to our understanding of the issues which were of concern to the participants and help to contextualise the abstract concepts identified by others. The respondents were not passive recipients of this help but judged its effectiveness against their own expectations. For some couples unfulfilled expectations led to feelings of rejection, which affected future requests for help.

While the partner is often cited as the main source of instrumental and emotional support (Besser et al. 2002, Leathers et al. 1997), some of the men in this study expressed the need to be supported themselves. A number of the men gave examples of having tried to seek help from other members of the family network, friends and professionals. This suggested a tension in the expectations of the men. They stated that they were inclined to manage any difficulties independently but also described their efforts to seek out others for emotional support. Particularly the support provided by the partners for each other can contribute to a sense of satisfaction with the
relationship (Knauth 2000). Furthermore men are more likely to be affected by their partner's difficulties and the state of the marital relationship (Dudley et al. 2001). This suggests that it is important to address the emotional needs of both partners, but contrasts with the findings from this study. The maps of the couples' support networks consistently demonstrated an imbalance in the support available to the two partners. The men identified themselves and were seen by their partners as the women's main support but only some received support from their partner during her illness. They commented on this loss of a previously supportive relationship but felt able to manage this by treating the difficulties as a temporary problem. The men in this study had to manage an increased emotional burden at a time when their main source of help was unable to provide it. It has been suggested that it is important to consider the quality of the relationship and the mood of both partners during the transition to parenthood to reduce the development of depression (Morse et al. 2000). This, together with the recognition that men are more likely to be affected by their partner's problems (Dudley et al. 2001), has implications for the emotional health of both partners.

Men provide both emotional and practical support for their partners, managing their partner's negative emotions due to a more robust self esteem (Morgan et al. 1997). While the respondents in this study expressed a stoic acceptance of their partner's difficulties, they asked for information and suggestions to support their partner more effectively. The opportunity to explore these issues was welcomed by at least some of the men. As men are increasingly included in the provision of support programmes, their need for
information and desire to feel less isolated is gradually being recognised (Morgan et al. 1997, Riecher-Roessler and Hofecker Fallahpour 2003, Roberts and Kowalski 2000). However, most of these interventions relate to the provision of various forms of group support. In contrast, the respondents in this study expressed at least some reservations with this format of support. They preferred informal contact and informational support in order to 'fix' their partner's problems. This desire to manage the disruption caused by the illness and the need to 'fix' their partner has been identified previously by Meighan et al. (1999) but was also expressed by the women in this study.

8.2.2.2 Access

Access to support was a further issue of concern to the respondents. They indicated that help seeking was a complex process and subject to a number of considerations. For instance different individuals were likely to prefer different interventions. They based their choice on their prior knowledge of the helpers and their expected ability to deliver this support. This use of background information, which might lead to a decision to reject the help, suggested a new perspective on the provision of support. Both partners described instances, which led them to exclude particular helpers based on their prior experience in other situations of need.

This is an issue identified by Brugha et al. (1998), who suggest that the perceived level of support can act as an early indicator for depression. A perception that social support is poor is more significant than the actual size of the support network. Overall, a relationship is judged to be satisfactory if it
matches existing expectations. For women, in particular, this is more important than the tangible support received. For the fathers concrete support is more important than their expectations (Coffman et al. 1994). The respondents in the current study reported similar considerations but did not demonstrate the gender differences noted by the above authors. Both partners described a clear decision making process, which was informed by their previous experience of the potential helper. This in turn could lead to the exclusion of that person from their expectations and a revised support plan. This finding was unexpected. The literature focuses on the support activities rather than the expectations of the recipients of that help. This study highlighted the need for any helping activity to include a clear process of negotiation. It was important to the respondents that the help offered actually met their expectations and appeared to explain variations in the uptake of some provisions.

In addition, the men and women in this study preferred different forms of support activities. For instance the women commented favourably on the benefits of group support in various forms, but found timing to be crucial. This was in contrast to other studies, which note that women attend these groups erratically and do not necessarily benefit from this intervention (Reid et al. 2002, Stamp et al. 1995). These studies suggest that little economic or health benefits could be gained by attendance at such groups. Since attendance in particular can be variable, the viability of such groups has been called into question (Reid et al. 2002). Nevertheless the findings from this study suggested that the women did value group support but often were not
able to attend when they were unwell. At such times they felt vulnerable and exposed to unfavourable criticism from their peers. At other times they were able to benefit from attendance by gaining positive support from others outside their immediate family circle. They accessed groups as they felt well enough to attend but also valued individual contact with sympathetic helpers. For the men, group support was more contentious and appropriate only if it was available for both partners. They felt that they would attend a group to help their partner but had reservations about the potential benefits for themselves. The male participants in a study by Webster (2002) also expressed these attitudes. They had reservations about attendance at a men's group but were more receptive to a group in support of their female partners. In contrast, work done more recently by Davey et al. (2006) suggests that men do value support from their peers to reduce feelings of frustration and isolation. It is possible that this difference in perspectives could be attributed to the difference of context between these studies. For instance the Davey et al. study (2006) reported on the findings of a postnatal support group for fathers while Webster (2002) and the current study asked men about their perceived attitudes without an actual experience of such groups.

Most men in the current study expressed a need for more information about their partner's illness and strategies to support her. While they managed their partners' distress often unsupported, they provided practical as well as emotional support. While men are more likely to support their partners through practical tasks (Webster 2002), they do not necessarily need to
undertake traditional female tasks to be perceived as supportive (Mauthner 2002). However the men in the current study described both practical and emotional support activities. This suggests that they took a broader perspective to their partners' support needs than previously indicated.

8.2.2.3 Characteristics and conditions

An attitude of warmth and unconditional regard were important helper characteristics identified by the respondents. These attributes have been described at length in the large body of literature on counselling relationships (McLeod 1998) and specifically Rogers' (1961) work on the basic qualities of the effective helper. Effective counsellors should be able to demonstrate a range of interpersonal skills including the ability to listen with empathy, be aware of non-verbal communication and be sensitive to the expression of emotion from a position of concern for others (McLeod 1998). Rogers (1961) suggests that those who are being helped need to be able to trust the helper and feel understood. The helper should show a warm interest for the person without being too emotionally involved. The attitude of the helper is consistently more important than a specific theoretical orientation. In fact, there is little evidence that support from one type of individual is more effective than that from another (Ray and Hodnett 2001). The respondents in this study recognised and valued similar characteristics in the helper but went further by suggesting that these were more important to them than a recognised qualification. Both partners in this study appreciated an attitude of encouragement, shared decision making and acceptance. These are characteristic of the qualities of a close confidante described in the literature,
who provides active, consistent and sensitive support (Armstrong 1995, Davy 1998, Dickinson 1990). In addition the couples found it unhelpful, when a helper was dismissive and perceived to be too busy to listen. As expected, being able to listen sensitively to their needs and communicate effectively was appreciated as helpful.

A further significant aspect of support in this study was the outcome of the helping activity. It related to the goals of support and its impact on the recipients. Other studies, which have specifically focussed on women attending postnatal support groups, have identified the need to build self esteem (Gutteridge 2001, Hall et al. 1996). For instance increased self esteem can help women negotiate various social stressors more effectively and improve the quality of the marital relationship (Hall et al. 1996). These studies focussed specifically on the needs of women. At the same time men also comment on their need to manage their family and work responsibilities, often feeling unable to cope and left out (Aiken and Kingsley 2000). Interventions, which are aimed at women and their partners, challenge negative thinking patterns and are promoted to address this concern. These can provide opportunities for the partners to access their joint resources and move beyond feelings of rejection towards a reappraisal of the help available in preparation for a future pregnancy (Peden et al. 2005, Riecher- Roessler and Hofecker Fallahpour 2003). Both partners in the current study expressed similar concerns and talked about the negative emotions generated by their experience and unmet expectations. They found it difficult to express their need for help to each other and to others. A fear of the consequences, which
a diagnosis of mental illness would bring with it in terms of stigma, was a recurrent theme. How such a fear can act as a barrier to help seeking has been recognised by various authors (Riecher-Roessler and Hofecker Fallahpour 2003, Rogers and Pilgrim 1996). The fear of stigma for instance has been implicated as one of the reasons why women often delay their requests for help. This, together with a failure to accurately diagnose the condition, suggests the need for specific psychotherapeutic interventions for this client group (Riecher-Roessler and Hofecker Fallahpour 2003). In addition, Rogers and Pilgrim (1996) highlight the conflict generally experienced by individuals suffering from mental health problems. Their desire to share their difficulties with others can interfere with their need to present a positive image of themselves to others. This is a sentiment expressed by the women in the current study, who described the tension between their wish to meet other mothers and the feelings of failure, which such contact generated for them.

Finally, the respondents identified a number of conditions, which helped them access support. These related to their need for adequate information about postnatal depression and its management. Help giving was interpreted as a reciprocal obligation, based on an understanding that help received in the past should be returned. This aspect of the couple relationship contains elements of social exchange theory first proposed by Homans (1961) and Blau (1964). It suggests that individuals act towards others based on mutual rewards, which influence their relationships over time (Cropanzano and Mitchell 2005). While social exchange theory is often related to the intricacies
of economic exchanges, Widegren (1983) relates it specifically to intimate relationships. In this context, the interaction between individuals is guided not by economic considerations but concern for the other person's well being. Reciprocity becomes an indicator of the level of positive regard for the other person. It contributes to the creation of increasingly positive attitudes between the partners and nurtures the relationship (Widegren 1983). The men's perception of the reciprocity of support reflects Widegren's (1983) premise and an expression of their concern for the wellbeing of their partners.

The respondents suggested that postnatal depression should be managed as a joint problem to facilitate access to help and support. The men were often unaware of the level of severity of their partner's distress and could only offer effective support, once they had understood this better. In addition both the woman and her partner needed to be ready to accept the help on offer from lay and professional helpers. While the need for relevant information has been recognised by other writers (Roberts and Kowalski 2000, Davey et al. 2006), the other elements identified by the couples have not been described in this detail. Williams et al. (2004) stress the need to ensure that any definition of support is informed by, and explored within, the context of the specific situation of the individuals affected. Definitions derived from other contexts, which are then superimposed on that particular experience, are unsuitable. Although the respondents in this study shared aspects of their definition of support with others, their experience was also unique and highlighted their specific support needs.
8.3 The concept of 'normality'

Throughout the interviews the respondents utilised the term 'normal' and described their experience in these terms. They defined this 'normality' by comparing it with a number of factors. Some of these were internal to the couple while others were external. Although often aware of the idealised nature of the images, which informed their definition, the couples utilised them to assess their experience. Nicolson (1988, 1986) describes a similar approach to the construction of meaning through which her respondents attempt to understand postnatal depression. She suggests that this is a process both conscious and unconscious, which evolves from the reflexivity of the participants. Part of this process is unconscious and affects the understanding of the experience of the individual. Symbolic interactionism (Hewitt 1997, Klein and White 1996, Layder 1994, Meltzer et al. 1975) suggests that such a reflective process is integral to the daily activity of making sense of the social world. Language helps to understand the world and allocate meaning to objects. I was aware that the language used by the respondents in the current study, had a range of meaning not only to them but also to me. For instance the use of language in terms of 'nuts', 'off the rocker' and 'mad' had a range of possible interpretations, which differed between layperson and professional. The interviewees utilised these terms to compare 'normality' and 'abnormality', while I initially interpreted them in terms of mental illness and psychosis. Their definition of 'normality' was a constant theme for the respondents. It informed their decision making and the assessment of their experience and progress. Consequently their responses needed to be seen against this specific interpretative background.
Family system theory provided a framework to explore the couples' experience. The approach to families as systems is a useful concept to make sense of a life-changing event such as postnatal depression. The theory proposes that the various elements of the system interact with each other and are in a constant state of flux as they react to events. Any incident affects the individuals and the system as a whole (Allmond et al. 1979). However caution should be exercised, not to confuse the model with the reality of family interaction. This is an abstract model, which should be used as a guide to understanding family interaction rather than as a blueprint for family function (Broderick 1993). Klein (1996) suggests further that the underlying constructivist epistemology of the approach ensures the use of the model as an artificial construct to illustrate the interaction of the various family members with each other and their social world. Although family system theory adopts a constructivist perspective, Wright and Leahey (2000) also acknowledge that meaning is created through the different interpretations which both nurses and their clients bring to any interaction. They stress the need for practitioners to be open and explore these different perspectives in the therapeutic encounter. In this way their family assessment model combines an understanding that reality and meaning are constructed by the social actors with an implicit respect for the reality of the world of experience of the participants. Their model understands human participants as active agents in their world but also recognises that the world of each family member is constructed within a wider social setting.
The following definition of the family informs the work of family nurses: 'the family is a self identified group of two or more individuals whose association is characterised by special terms, who may or may not be related by bloodlines or law, but who function in such a way that they consider themselves to be a family' (Wegener and Alexander 1993, pg 4). In addition families are made up of individual members who relate to each other and form subsystems such as couple, sibling or parent-child groupings. The family contains individual subsystems but also relates, as a whole, to other systems outside the immediate family such as the wider community represented by various social and political organisations (Wright and Leahey 2000). The current study focussed particularly on the parent dyad as a subsystem of the family to explore the experience of the key partners in the parenting relationship. In addition it acknowledged that the respondents were embedded in the wider context of their family and its social and environmental background (Broderick 1993).

Changes in the system occur as a result of the influences of the environment or individual members on the family. The current study was based on the premise that postnatal depression triggered such a change in the family system. The couples' desire to achieve 'normality' was an example of the goal seeking behaviour proposed by the model. As an adaptive system, the family is in a constant state of flux, influenced by a range of interpersonal as well as external factors. The analogy of a mobile with interlinking, interdependent parts illustrates the interaction of the different members of the family system (Allmond et al. 1979). The family is able to respond to the
different forces, which impact on it, and achieve a balance between change and stability. The ‘process of adaptation to a new normality’ identified in the current study illustrated the respondents’ attempts to establish a balance in the system over time.

8.3.1 The process to seek help

Family systems nursing proposes that systems are able to regulate themselves through a reflective process of assessment, which informs a continuous feedback loop (Wright and Leahey 2000). This process was apparent in the couples’ response to the challenge of postnatal depression. They compared their experience against their definition of ‘normality’ and their personal goals. When their experience did not meet their expectations, this information was fed back to adjust their response. For instance the couples reassessed their need to seek help based on the realisation that their experience differs from that expected as part of the ‘normal’ transition to parenthood. Feedback resulted in a review of the earlier interpretation, an adjustment in response and disclosure.

The trajectory and time span of the ‘process to seek help’ proposed in this study depended on a number of factors, which influenced the couples’ decision to request treatment and care. From the number of maternal barriers to help seeking identified in the literature (Dennis and Chung-Lee 2006), of particular interest was the suggestion that women attributed their symptoms to causes other than postnatal depression. They also found it difficult to disclose their problems to their partners and family, fearing the stigma of
mental illness. It has been suggested that men and women have different perspectives in their attribution of the causes of postnatal depression: women focus on the social process of transition to motherhood; men see the physical demands of childcare as central (Everingham et al. 2005). These different perspectives hamper the process of communication between the partners but also the couples' ability to share their experience with others. Women need to be reassured that their experience is valid and that they are 'good mothers' while the men try to fix the problem for their partners. When this fails, they in turn become distressed and remove themselves from the relationship. They withdraw to other activities such as work and hobbies, which make them feel more comfortable (Everingham et al. 2005). However the respondents in the current study did not demonstrate such clear divisions in their interpretation and often expressed very similar concerns. Both partners considered various reasons for the woman's illness, attributing her symptoms to a range of causes both physical and social. During the early stages of the process to seek help, these different interpretations influenced the decision to disclose any difficulties to others outwith the couple relationship. In addition both partners talked about the stigma surrounding the diagnosis of mental illness and took this into consideration when they sought help particularly from external sources of support. Their responses contrasted with Goldstein's suggestion that only individuals, who attribute depression to psychological causes, are more likely to express a fear of stigma and delay their help seeking accordingly (Goldstein and Roselli 2003). Regardless of attribution, the respondents in this study shared a concern of the stigma of a diagnosis of depression.
8.3.2 Adaptation to a new normality

Families evolve continually in response to changes in the family members (Bateson 1979, Maturana and Valera 1992). Illness, as a major life event, can prompt a major transformation in the family system. This leads to changes in attitudes and behaviours. Change of the system is influenced by previous experience and the interaction of the family members with the external systems. The respondents in the current study described their progression from early parenthood and postnatal depression to a new understanding of the illness and their relationship. Systems theory describes the various components of the self-regulating feedback loop in broad terms.

In contrast, the Leventhal et al. (2003, 1997) self-regulation model of health and illness focuses specifically on four distinct elements of health behaviour. The model is informed by a problem solving approach. It suggests that individuals identify goals, consider various inputs and outputs and evaluate the effectiveness of interventions when they respond to an illness. Of particular interest to the current study are the five domains of illness representation proposed by the model: identity, cause, timeline, consequences and cure. Individuals act as common sense scientists when they attempt to assess a threat to their health (Leventhal et al. 2003). They then utilise these representations to set goals for the management of the illness, identify procedures to attain these goals and evaluate the effectiveness of the response. In addition the individual continues to strive to make sense of the illness experience as more information becomes available (Leventhal et al. 2003).
When the model was reviewed as part of a meta-analysis of relevant studies, its usefulness as an aid to our understanding of the response of individuals to various physical illnesses was confirmed (Hagger and Orbell 2003). In contrast, the current study focused on the experience of postnatal depression, a mental illness. The ‘process to seek help’ proposed by this work met the criteria for the five domains of the Leventhal et al. (2003) self regulation model. Respondents described how their experience deviated from their understanding of ‘normality’ (identity), speculated about the reasons for these symptoms (cause) and determined a time period (timeline) within which they assessed the symptoms to reflect the ‘normal’ early recovery from childbirth. They were further prompted to act by concerns of the potential consequences of poor parenting and the effect of the illness on the couple relationship (consequences) and the available treatment options (cure).

The Leventhal et al. (2003) model further suggests that an individual’s emotional response to a health threat affects their practical management of that threat. For instance a correlation exists between medication uptake and depression in patients receiving treatment for a physical illness (DiMatteo et al. 2000). When the illness is perceived to be time limited and controllable, individuals are more likely to seek solutions to the problem and adapt to the changes brought about by the illness (Hagger and Orbell 2003). The respondents in this study emphasised specifically the anticipated timeline of the woman’s depression. The men wanted to ‘fix’ their partner. The couples’
expectation that the illness was time limited and curable influenced their response and prompted their search for help.

The current study supports the Leventhal et al. (2003) model and relates it to mental illness. It identifies a specific additional element: the identification of an appropriate helper. The respondents based their decision to seek help on their previous experience. The personal characteristics and the relationship of the helper to the family were significant considerations in this process. Leventhal et al. (2003) formulate a number of rules to explain how individuals interpret their experience and seek to control illness. The current study proposed an additional rule: a ‘helper knowledge- support access’ rule. A potential helper was more likely to be approached if he or she was perceived to have positive attributes. In such a case, the helper’s characteristics were more important than their relationship to the family system or their qualifications.

The outcome of the process of adaptation took on different forms. Some couples noted a return of their relationship to pre-illness levels, adjusted to include the new baby. Others described a new type of relationship, strengthened by their experience of postnatal depression. Finally, a few couples adapted to respond to a more chronic depressive illness. When this adaptation was successful, the couples experienced a sense of developmental growth characterised by the reaffirmation of their relationship. Andresen et al (2003) propose a model of recovery for patients suffering from serious mental illness. The individual’s ability to re-establish previous goals
or formulate new ones is an important aspect of this process, which is characterised by personal growth and a positive sense of the self. The individual should feel ‘that the experience has made them a better person than they might otherwise have been’ (Andresen et al. 2003, pg 591). The respondents in the current study experienced such a sense of personal growth when they talked about achieving a ‘new normality’ at the end of their journey through postnatal depression.

8.4 Potential limitations

Methodological considerations have been discussed in chapter 3 which explored issues relating to the sample selection, access to respondents through gatekeepers and issues arising from joint interviewing. The following points should be considered as additional potential limitations for this study.

8.4.1 Retrospective accounts

The respondents talked about experiences and feelings, which they had had some time previously (see chapter 3, table 1). The average time, which had elapsed between the time of diagnosis and the first interview with the respondents, was approximately two years and three months. The professionals referring potential participants to the study were asked to approach only couples well enough to participate. As the exploration of difficult memories had the potential to challenge an already fragile situation, the need to protect the participants from additional distress was a key
concern. All respondents were therefore already somewhere on their path to recovery when they participated in the study.

While some respondents were still relatively close to the initial diagnosis, others recalled events from a number of years previously. Speaking to the couples and reading their accounts highlighted the ongoing immediacy of their experience for me. Evelyn, Frances, Rachel and their partners talked about their experience five to seven years previously. Despite this distance in time, they described their feelings and actions in great detail. In addition they had reflected on their experience and added new interpretations to their accounts. Other couples were closer in time to the illness. For some a new pregnancy potentially challenged the relationship and the woman's mental health. The interviews were often the first opportunity for the couple to explore their feelings together. All couples felt that helped them to revisit their experience and allowed them to move forward as a couple.

It is important to ensure that the boundary between research- and therapeutic interview is not overstepped. The research interview must not provide new interpretations for the respondents but focus on their understanding of themselves and their experience (Kvale 1996). As the participants in this study talked about their experience they also tried to make sense of their feelings and responses. It was often difficult to separate their accounts of their experience from their subsequent interpretation of events. In addition the partners often continued a conversation started during the interview after I had left. They then brought these thoughts to our subsequent conversation.
This posed a dilemma, which reflects the tension between Kvale’s (1996) position and Holstein and Gubrium’s (1995), which recognises this active process of interpretation constructed jointly by the interviewer and the respondents. The couples developed further personal interpretations during and after the interviews, over which I had little control and which illustrate the additional complexity of the joint interview. It remains important to guard against an infringement of the boundary between research interview and therapeutic intervention by building appropriate support mechanisms into the process (Dicicco-Bloom and Crabtree 2006). All couples were encouraged to utilise their existing healthcare contacts to explore any new perspectives further and ensure access to appropriate therapeutic interventions.

Silverman (2000) gives an example of a qualitative study, which reported the retrospective interpretations of the respondents and claims that these represent the subjects’ experience. He cautions that such a claim fails to understand the complexity of the interview encounter. He suggests a social constructionist approach to address this issue (Silverman 2001). The researcher needs to recognise that the respondents’ own perspective is informed by the wider social context of their experience. The participants in this study for instance often use the conjunctive in their narratives. They noted that they might have acted differently or that their interpretation did not reflect more commonly held beliefs. They often commented that they ‘should’ or ‘ought’ to have acted in a particular manner. The respondents differentiated between their reported actions and their desirable actions, their interpretation of their experience and its socially acceptable context. This
study reports the couples’ experience as it was informed by the social construction of their world, their subsequent reflection on the events and the specifics of the interview situation.

8.4.2 Chronic mental health problems

The majority of respondents had recovered or were on the path towards recovery by the end of the study. For three women the initial diagnosis of postnatal depression though had developed into a chronic depressive illness. In addition two of the men were receiving treatment for a depressive illness. This fact needs to be considered when assessing the findings of this study. As depression is associated with expressions of intense feelings of helplessness, hopelessness and worthlessness (American Psychiatric Association 2000), some of their responses may have reflected these emotions. Nevertheless their experience also illustrated one of many representations and levels of severity of postnatal depression.

8.5 Summary of findings

The study explored the experience of postnatal depression for couples and their support needs. Both partners shared significant aspects of this experience but also placed different emphases on some aspects of their experience. Respondents attributed postnatal depression to a range of causes. They expressed a need for more clarification and specific advice about the management of the illness. The couples conveyed a strong commitment to their relationship, which allowed them to manage the
challenges posed by the illness and recognise opportunities for personal growth. Support was understood to be an integral part of any reciprocal relationship and obliged the well partners to help the ill partner. Postnatal depression was perceived to be a temporary difficulty, which was likely to resolve within the foreseeable future.

The couples commented on various support activities including group activities. The men expressed some reservations in relation group support and highlighted the perceived mother-child focus of clinical services. Potential helpers were valued if they demonstrated an attitude of acceptance, strove to ensure that the expectations of the partners were explored and involved both partners in clinical decisions. The men tried to support their partner in practical and emotional terms. They did find it difficult to judge the extent and severity of their partner's illness though. The couples, and in particular the men, expressed a need for information on postnatal depression and specific strategies to respond to their personal experience. Effective support therefore needs to be individualised, non judgemental and inclusive of both partners.

Family system nursing (Wright and Leahey 2000) and the Leventhal et al. (2003) self regulation model of health and illness provided the theoretical background for the study. The core category 'normality' was the benchmark against which the respondents assessed their experience of the illness, sought help and charted their progress towards recovery. The respondents considered similar issues to those described by Leventhal et al. (2003): the
causality of the illness and its anticipated time line. The study provides additional confirmation of this model and extents it into the field of mental health. The respondents’ utilised their prior knowledge of the helper and previous helping activities to decide whether to access a potential source for help. This ‘helper knowledge- support access’ rule is proposed as an additional rule for the Leventhal et al. (2003) model but requires further exploration.

8.6 Service implications

The respondents identified a number of factors which are of interest to healthcare professionals providing services for this group of clients and for educators preparing clinical staff for work in this area. Considering the implications of this study’s findings for healthcare professionals from a range of backgrounds recognises the contribution of a multidisciplinary group of practitioners to the care of families experiencing postnatal depression. It is suggested that the findings might be of interest to medical personnel, nursing staff and workers in the non-statutory sector. The themes for service provision identified in this study reflect the current focus of care delivery which stresses the need to involve clients actively in the decision making process of their care (Faulkner and Layzell 2000). Self care is encouraged based on access to appropriate information and tailored to the client’s specific needs. Services should be flexible in response to identified client needs. The redesign of community nursing services in Scotland currently in progress emphasises the importance of a central contact person for clients to access (Scottish Executive Health Department 2006). This has significant
implications for mental health practitioners since it recognises the importance of client centred care which is responsive to need through negotiated care planning involving the whole family. Professionals should become allies in recovery to help clients become able to reach out for help, take control and become involved in their treatment (Mancini 2007). These issues should be considered by the range of professionals who support families with postnatal depression. It is important that these general principles also inform education in the field in order to develop practitioners who work with their clients from a perspective of inclusion and empowerment.

8.6.1 Empowerment

The need to be active participants in their recovery was identified clearly by the respondents. Both partners expressed a desire to have control and share in the decision making process. They wanted to be involved when decisions about treatment were made and valued treatment decisions which took account of their specific situation and the stage of the illness. Only when clients feel that they are actively involved in this process does empowerment become more than a rhetorical concept (Lloyd 2007). Service users have highlighted the values which should underpin a service based on a philosophy of empowerment. The keys for self help in this context are information, the active participation of service users, providing participants with the skills to be assertive and to express themselves. Services need to ensure that clients feel that their experience is valued and encourage clients to take control of the management of their condition (Lucock et al. 2007).
Since managing the demands of postnatal depression involved both partners in emotion work, this needs to be recognised by those providing services. Often communication between the partners had broken down and was recognised by the respondents as a contributory factor to mutual feelings of isolation. Screening early for relationship problems and devising subsequent interventions informed by the issues identified during this process as proposed by Simons et al. (2001) may be useful in raising awareness of the importance of the relationship and identify problems early. Providing care which is aimed at inclusion can facilitate a sense of empowerment not only of the person receiving care but also engage the carer in this process. Service providers working with families with postnatal depression may consider a couple counselling approach to work with families to provide more inclusive care. For instance Dennis and Ross (2006) stressed the importance of perceived social integration through encouraging the partners to communicate their expectations of parenthood and child care in the prenatal period. Such an approach recognises the potential contributory effect of the men towards the development of postnatal depression in their partners. As a result, service provider should facilitate discussions about the relationship as part of routine postpartum care and include the male partners in such conversations (Dennis and Ross 2006).

8.6.2 Information sharing

Information appropriate to the needs of clients is a recurrent theme in the literature which identifies a lack of relevant information for women with postnatal depression and their carers. For instance women can feel
unprepared for the impact which postnatal depression has on their lives and require detailed information about the causality of the illness and treatment options (Ugarriza 2002). Men particularly appreciate the opportunity to gain information about management strategies and practical information (Davey et al. 2006). Although such information needs have been identified, there would appear to be scope for service providers to review how information is made available to clients. The comments by respondents in this study would suggest that alternative approaches to information sharing may need to be explored further. The partners, but in particular the men in the current study, commented on the lack of relevant information regarding the condition. They needed to be able to apply general knowledge about postnatal depression to their specific situation and understand the severity of their partner's illness. Opportunities to discuss their personal experience with a trusted, knowledgeable helper were welcomed by both partners. It was suggested that these contacts should be available in various formats depending on the specific needs of the couple. These ranged from a single information session shortly after diagnosis to extended counselling interventions for one or both partners. Certainly carers need to be included in any information provided and not only 'tagged on' to the care of the main recipient of professional services (Morris and Thomas 2002). The need for information about service provision and treatment options identified in their study of carers of cancer sufferers were also relevant concerns for the partners of the postnatally depressed women in the current study. As a consequence service providers should seek out early opportunities to explore which specific information clients require and provide individualised support based on this assessment.
When the respondents speculated about the causality of the illness, they attempted to make sense of their experience and also understand the various treatment options available to them. This suggests the need for service providers to present information about the range of causes of postnatal depression, the treatments available and their side effects in various formats. The latter was of particular importance to the men in this study but was also a concern for the women when their treatment resulted in unexpected side effects. Information sharing has been recognised as an essential element in the effort to encourage self care. The respondents expressed a desire to be fully active in their care for which they needed to have relevant information. It is important for service providers to be aware of this need and provide information in a range of formats, specifically negotiated with all participants (Lloyd and Carson 2005). Although previously identified specifically as important for carers and patients with a severe and enduring mental illness, the expressed desire of couples in this study highlights the need for service providers to make similar information available to postnatally depressed women and their partners.

8.6.3 Client centred care planning

The various aspects of both the experience of postnatal depression and the support issues identified in the study reinforce the principles of current policy initiatives for inclusion and the empowerment of service users and their carers (Scottish Executive 1997, Scottish Executive 2003b, Scottish Executive 2006a, Scottish Executive 2007). The respondents' understanding
of the concept of 'normality' and its related processes provided an insight into the decision making of this group of clients, which can be used to review and focus service delivery. Service providers could use this concept to explore with their clients what they perceive to be the normal transitory process of parenthood and how their own experience differs from this. Including such a discussion in the assessment process can provide additional insights into the clients' experience and inform care planning. If care providers can facilitate a process of reflection on these beliefs, this may help clients to examine their expectations in the light of new information and make informed comparisons.

The process of adjustment to a new normality described in this study highlighted that such a readjustment of beliefs was part of the recovery for this client group. In addition, respondents based their search for help on their previous experience of the helpers available to them from their existing support network of family, friends and professionals. This information is relevant to care providers since it would allow them to clarify early the specific support needs of their clients and what systems would be potentially available to draw on for support. The recovery alliance theory proposed by Shanley and Jubb-Shanley (2007) proposes that an approach to care informed by the concept of recovery can facilitate the development of client centred services. It is important for health professionals to explore and understand their clients' perspective, their previous coping mechanisms and experiences. Using a problem solving approach the client is at the centre of care planning and accepted as able to cope (Shanley and Jubb-Shanley 2007). Some of the respondents in this study commented specifically that
they had excluded some family members and friends from their identified network of helpers due to a perceived lack of interest or understanding. An awareness of such existing issues would provide a useful background for service providers who would need to adjust their care planning in the light of the family's particular circumstances. For instance professionals can not assume that grandparents living locally will be available or acceptable to provide the support required by the woman and her partner. In such circumstances other sources of help would need to be explored and mobilised. Professionals should try to understand what the couples understand to be their concept of 'normal' parenting and what their support expectations are in the light of their previous experience, their specific situation and needs. Healthcare interventions for postnatally depressed women which focus on needs identification certainly would appear to be more effective than interventions based solely on education (Tezel and Gozum 2006). The findings from this study suggest that such an approach would be welcomed by clients and help professionals gain important information to provide support contextualised to the circumstances of each family.

8.6.4 Flexible care for different needs

The respondents’ experience highlighted that any decisions about the care available should consider further that treatments are specific to the client's situation and the stage of the women's illness. For instance, although the women often commented favourably on the benefits of support from other women accessed through mother and baby groups, they also had negative
experiences if either the groups were not welcoming or the women were not well enough to attend. In those circumstances attendance at a group was detrimental to the women's mental health and support on a more personal, on-to-one basis was appreciated. This suggests that service providers should negotiate the format of support with the woman and tailor it to her ability to participate in groups. Although the women commented favourably on the benefits of group support, they expressed a need that this should be available in conjunction with individual support. Encouraging individuals to share their experience with others can help to reduce the perceived stigma of a diagnosis of mental illness and positively influence efforts to seek help from others. This may lead to improvements in self esteem and a reduction in distress. However, service providers should also be aware of the potentially detrimental effects of social disapproval which disclosure may bring with it (Ruesch et al. 2005). The sentiments expressed by the respondents in this study highlighted this potential dilemma and the need to offer opportunities for disclosure within an appropriate setting. When group support is provided, this should be none threatening and available at the right time providing flexible and accessible care for women.

In addition, the men and women in the study favoured different types of support activities. The quality of the couple relationship, paternal-infant attachment and the father's emotional health should be recognised as significant influencing factors in the transition process to parenthood (Condon et al. 2004). Although the existence of postnatal depression in men has been questioned (Condon et al. 2004), any depressive illness in the father during
the early months of parenthood can be detrimental to the infant's development (Buist et al. 2003, Ramchandani et al. 2005). Since the father's attitude towards his partner's illness can affect its outcome, health professionals should be aware of the various stressors affecting the relationship and provide interventions aimed at reducing their impact (Condon 2006). One such intervention discussed in the current study was the provision of group support to both partners. This was viewed less favourably by the men than their partners and contrasted with the findings from previous studies (Roberts and Kowalski 2000, Morgan et al. 1997). The men in this study favoured individual support in preference to group support specifically for men. Although it has been demonstrated that men can benefit from peer support (Davey et al. 2006), the men in this study preferred to accompany their partner in preference to attending a 'men only' group event. Service providers should consider the different needs of men and women when planning services for this client group. Healthcare professionals providing support activities for men should take account that such services are likely to be more acceptable if they are offered on an individual basis or publicised for women accompanied by their partner.

8.6.5 Partners in care

The respondents valued a number of specific characteristics in the helper: time to listen, a caring attitude and an acceptance of the decisions made by the couple. Their desire to be involved in decision making and the importance of a trusting relationship with their clinician highlights the need for professionals to ensure that clients not only receive information but also feel
that they are heard. Patients can feel more engaged with services if they trust their clinician and have a choice of treatments (Laugharne and Priebe 2006). Additional considerations were important when the respondents accessed support. These included their need to feel in control over the support activity but also their readiness to accept the help available. They expressed a need to explore their support expectations with others to encourage active participation in care and develop self esteem. Although such sentiments are often expressed at organisational level, they are not always as apparent in daily clinical practice (Laugharne and Priebe 2006). The experience of the respondents in this study does suggest that there is scope for further improvements in this area. Since the men often perceived themselves to be positioned on the periphery of the care provided for their partners, their need for support was often ignored by them and the professionals providing services to the couples. As the men talked about the emotional and practical demands which their efforts to support their partner generated, they often had to manage the tension this created between their work and family commitments. The impact of stress on the carer can be reduced through social support (Gavois et al. 2006). In addition carers need to be recognised as a source of knowledge to inform the care of the client. Open communication and shared planning can support both the client and the carer and allow them to respond to the challenges of the illness more effectively. Within this context, the benefits of a therapeutic relationship between the professional and the whole family have been recognised (Gavois et al. 2006). Service providers need to continue to explore educational and staff development opportunities to ensure that clients have access to
professionals with relevant interpersonal skills to build mutually trusting relationships with both parents.

The perceived stigma of healthcare providers can act as a barrier to access to these services. The self stigmatising views by the woman and her fear that the child may be taken into care are additional factors, which influence service access (Edwards and Timmons 2005). Stigma was a recurrent theme for the participants, who stressed the need to actively work towards raising awareness of postnatal depression in order to facilitate early diagnosis and access to appropriate services. Throughout the process of recovery, the respondents valued ongoing contact with their helpers to monitor progress and readjust to a 'new normality'. The contribution of informal and professional helpers was seen to be an integral element to facilitate this developmental journey towards recovery. The respondents expressed a desire to be actively involved in their care but also highlighted the importance of access to relevant information from healthcare professionals. Individuals need to be able to take control over and make decisions about their own lives but should be supported in this by a public commitment to reduce stigma through legislation and public awareness raising (Masterton and Owen 2006). Service providers should take these issues into account when they seek to identify potential clients early and explore strategies to improve access to support. Early access to services can be encouraged if service providers support women in reducing the perceived stigma of a diagnosis of postnatal depression. It has been suggested previously that this process could be facilitated by contact between women newly diagnosed with
postnatal depression and those recovering from the illness (Edwards and Timmons 2005). It might be useful to consider the development of individual peer support in addition to self help groups to achieve this. For instance close contact with successfully breastfeeding peers can influence attitudes towards breastfeeding (Hoddinott and Pill 1999) and may be a useful model to adapt for the support of families experiencing postnatal depression. The complex nature of the interaction between the potential helper and the recipient of that help has been highlighted in this study. With this in mind healthcare professionals should ensure that they establish a reciprocal relationship with both partners and involve them in the decision making process as equal participants. In addition, they should be aware of the impact of stigma in terms of treatment and help seeking in their clients. They should further examine their own attitudes and exert a positive influence on public attitudes towards mental health (Pinto-Foltz and Logsdon 2008).

The study adds to the understanding of the underlying considerations and processes, which informed the participants' response to the illness. The concept of 'normality' for instance highlighted both the internal and external factors, which affected the participants' response to the illness. Clinicians might wish to explore this understanding to shape their support strategies and gain an insight into their clients' perspective. The 'process to seek' help demonstrated the interplay between internal and external systems. Practitioners can use this knowledge to explore opportunities for early interventions and strategies to reduce some of the barriers to service access. The respondents particularly highlighted the stigma of a diagnosis of mental
illness and the need to differentiate normal and abnormal responses to childbirth and parenting. The process ‘adaptation to a new normality’ outlined in the study, illustrated the potential for personal growth and development of the relationship as a positive outcome of postnatal depression, which service providers can discuss when they provide information to individuals and advise on suitable management strategies. This process can be facilitated by a clear identification of goals and an acknowledgement that each partner has specific support expectations. Overall, a range of support options should be available, which are responsive to the couples’ needs at different times of the illness and negotiated with all parties concerned.

8.7 Recommendations for future research

While these considerations should inform the delivery of care, it is important that future research tests changes in such approaches to care in terms of acceptability and efficiency. In particular approaches to involve male partners in care decisions, while seen as favourable by the respondents in this study, need to be explored more with a wider group of clients in diverse settings. As policy drivers promote the importance of client empowerment and involvement in decision making (Scottish Executive 2003b, Scottish Executive 2007), it is important that these are subjected to robust evaluation. For instance different approaches to information sharing with clients and how families can be involved in care decisions need to be explored further. The respondents in this study valued individualised information to help the men specifically to support their partners. Although suggestions about how this information could be conveyed were made by the respondents, the format
and its most effective dissemination still require further investigation in comparative studies with clients from different backgrounds. The use of family health assessments has been promoted as one way to involve all partners in client care (Scottish Executive 2006b) but this and other family models of care still require detailed testing with families experiencing postnatal depression.

Work undertaken in relation to peer support by lay helpers for breastfeeding women have been related to positive outcomes (Hoddinott and Pill 1999, Palda et al. 2003). Similar peer initiatives aimed at young people have also been proposed but require further examination specifically in relation to the most appropriate type of intervention (The Evidence for Policy and Practice Information and Co-ordinating Centre (EPPI-Centre) 2001). The use of people with similar experiences has been recommended as one possible strategy to support young parents in particular (The Evidence for Policy and Practice Information and Co-ordinating Centre (EPPI-Centre) 2006). Support for women with postnatal depression and to a lesser extend for their partners in peer groups has also been examined but with mixed results (Reid et al. 2002, Stamp et al. 1995). The value which the respondents in the current study placed on the specific personal characteristics of their helpers suggests that this is an area which would benefit from further study. Since it would appear that the characteristics of the helper rather than the professional qualifications of the helper were valued, exploring support initiatives which utilise peers with experience of postnatal depression might be of benefit. Such work should specifically examine issues of acceptability, empowerment
and stigma reduction through different models of care delivered by lay and professional helper.

8.8 Trustworthiness and authenticity

Considerable discussion surrounds the issue of trustworthiness of the findings of qualitative research. A number of likely interpretations of the findings are possible, which depend on the researcher’s philosophical perspective (Bryman 2001, Flick 2002). The main stances adopted range from those informed by a positivist perspective to those, which have moved to a post structural interpretation. The latter clearly define the criteria for interpretation but set them apart from those applied to quantitative enquiry (Denzin and Lincoln 2000). Positivism embraces the notion that all scientific research needs to be able to meet the same standards of rigour and address issues of validity, reliability and generalisability equally well. Post positivism also recognises the need for such criteria. It argues that the naturalistic context of qualitative research should be acknowledged and reflected in the findings. Issues of scientific credibility, a theory grounded in the data, which can be generalised to other settings and recognition of the impact of the researcher and the setting on the findings, need to be clearly addressed.

In contrast, the interpretivist writers argue that these concepts should be replaced by the two central dimensions of trustworthiness and authenticity (Denzin and Lincoln 2000). This reflects the reality of qualitative research, which does not claim to reflect a neutral, objective reality but present one of many possible interpretations of a social reality (Lincoln and Guba 1985).
Credibility is a key aim of the work. It needs to demonstrate that the given account has been reached through a rigorous process and is acceptable to the wider research community. Kvale (1996) in particular describes seven criteria for the evaluation of scientific rigour in qualitative work. This extends from the early design of the work through the actual process of interviewing respondents to the analysis and the reporting of the final results of the research. Finally, post-modern and poststructuralist approaches reject such positivist scientific concepts altogether. They argue that the nature of qualitative enquiry conflicts with this form of assessment and fails to acknowledge the subjective and emotional elements of the research process.

This debate reflects the wider concerns about the differences between qualitative and quantitative research. The positivist, quantitative researcher searches for an objective reality through a clearly defined, systematic process. Theory is tested to reach an objective, value free conclusion. This is in contrast to the interpretivist perspective, which strives to seek out the subjective meaning of any observed social action. Individuals differ from one another, attribute meaning to their experience and cannot be interpreted as inane objects of science. An understanding of the world is sought, which sees through the eyes of the participants and seeks to represent their interpretation of events. This approach is informed by the search for 'verstehen' (Weber 1947, Schwandt 1998) and symbolic interactionism (Schwandt 1997, Bryman 2001). Bryman (2001) argues that most qualitative researchers identify with a position in the middle between these two perspectives. Respondents' narratives may represent one of many possible
versions, but strategies need to be applied to ensure the trustworthiness and authenticity of the accounts presented.

The current work is informed by both the desire to seek a rich description of their experiences from respondents, but also to approach the process of analysis in a systematic manner and with scientific rigour. An analytical approach informed by grounded theory combined with a symbolic interactionist perspective meets both the above requirements. The work is positioned in a post positivist, interpretivist part of the spectrum of enquiry. It addresses issues of trustworthiness and authenticity through a systematic approach to enquiry, the constant comparison of the data and the search for deviant cases (Silverman 2000).

While the exploration of specific contexts and experiences of respondents provides a rich description and in depth analysis, the results of such an approach are often met with criticism that they are not transferable to the wider population due to the sample size and the specificity of the situation explored. The researcher therefore aims to transfer the findings of the work to the wider population through the application of criteria to relate the findings to contexts outside the immediate area of investigation. It is suggested that this process contains three distinctive steps: a decision of the degree of generalisation aimed for, the integration of different cases and context through careful sampling and finally the systematic comparison of the data (Flick 2002). Thus the procedures employed in the sampling and the analysis of the data becomes central to the degree of generalisation possible. It is the
researcher's responsibility to present the case as concisely and clearly for the reader to judge the degree of generalisability of the emerging theory (Bryman 2001, Kvale 1996). Kvale (1996) compares this approach to the judicial process, where the audience seeks out similar cases to that under investigation and applies the findings to the case under discussion.

To make a judgement about the transferability of the study's findings asks the reader to utilise the data and their contextual background presented by the researcher to assess whether they could be applicable to other settings. This thesis has presented not only detailed information about the study population and their characteristics but has also charted the various stages of the data analysis in detail to provide an audit trail of the analytical process. In addition, the findings have been related to the wider literature in the field. It is suggested that this will allow the reader to make a decision about the transferability of the findings and set the work within the broader context of healthcare.

8.9 Conclusion

Family systems theory and the Leventhal et al. (2003) model of health and illness provide the theoretical context of this study. The core category 'normality' is a central component of the feedback loop, which informs the couples' response to the illness. The self regulation model of health and illness (Leventhal et al. 2003) contributes the more specific components of this process. The current study adds an example of the mental health perspective to the existing work on illness representation. The proposed additional rule of “helper knowledge- support access” relates to the specific
experience of the respondents in this study, which requires further evaluation.

Methodological considerations have been highlighted which relate to the use of two datasets and joint interviewing. The data generated by the study were analysed in stages and utilised to confirm and refine the emerging findings. This approach provides an additional tool to strengthen confidence in the findings. The use of joint interviews has the potential to raise both organisational and ethical problems which were overcome by combining joint and individual interviews. This allowed each participant to be heard separately but also provided opportunities for the couples to present their joint narrative.

The reader of this study would wish to consider a number of issues when reviewing the findings. These relate to the retrospective nature of the responses, the use of respondent validation, the effect of chronic depressive illness on some of the participants and the recruitment of the respondents through gatekeepers. Participants constructed their responses during the interviews based on a retrospective reflection on their experience and as a result of the interview process itself. Respondent validation was utilised as a source of additional data rather than to seek a confirmation of the "truth" of the responses. The validity of the study's findings should be judged on the systematic approach to the analysis and rich description of the findings rather than on respondent validation.
Some respondents reflected on their experience not only from the perspective of postnatal depression but also that of chronic depressive illness. In this respect the study illustrates the range of experiences associated with postnatal depression and its continuing impact on the mental health of some individuals. Although some potential participants were excluded from the study sample, the overriding need to protect potential participants from harm and avoid exposure to distress was paramount. The respondents included in the study were able to participate over a considerable period of time and provide detailed insight into their experience.

This study has highlighted a number of areas of interest, which have provided useful insights into the experience of postnatal depression and the support needs of couples. The findings reflect a considerable amount of the literature on postnatal depression and support for women. It adds the perspective of the male partners to this knowledge but also some themes of common interest to both partners. The couples' definition of their 'normality' informed their decisions when they sought help and assessed their recovery. This illustrates the complex interaction between the internal and external forces, which affected the participants' response to the illness. The Leventhal et al. (2003) common sense model of health and illness provides a useful framework for our understanding of these processes. This model is utilised and extended to relate to people suffering from postnatal depression. The additional rule of 'helper knowledge- support expectation' reflects the couples' assessment and expectations of the potential helper. The proposed processes and their representation require further testing as do the
suggested links to the Leventhal et al. model (2003). The study adds the
dimension of the couple experience to our understanding of postnatal
depression. It recognises that men, as fathers and partners in the couple
relationship, make a significant contribution to their families' well being.
Research and clinical services have, in the past, focussed on the needs of
the women and children. It is important to recognise that men are active
participants in parenting work and that the successful outcome of postnatal
depression for the couples in this study is a joint achievement involving both
partners.
Appendices and list of references
### Appendix 1 Diagnostic criteria for postnatal depression

<table>
<thead>
<tr>
<th>Psychiatric classification</th>
<th>Criteria for postnatal depression</th>
</tr>
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<tbody>
<tr>
<td>International Classification of Diseases Version 10, World Health Organization</td>
<td>Depressed mood for most of the day</td>
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<td></td>
<td>Loss of interest or pleasure in normally pleasurable activities such as playing with the baby</td>
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<td></td>
<td>Tiredness, decreased energy and fatigue</td>
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<td>Additionally, any four of the following should be present:</td>
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<tr>
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<td>Loss of confidence and self esteem</td>
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<td>Feelings of guilt and blaming oneself</td>
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<td>Recurrent thoughts of suicide or death, including that of the child</td>
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<td></td>
<td>Difficulty in concentration</td>
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<td></td>
<td>Agitation or lethargy</td>
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<td></td>
<td>Sleep disturbance</td>
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<td></td>
<td>Appetite disturbance</td>
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<tr>
<td>DSM IV - Postpartum onset specifier</td>
<td>Onset of depressive episode must be within 4 weeks postpartum</td>
</tr>
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<td></td>
<td>Symptoms do not differ from symptoms in non-postpartum mood episodes and may include:</td>
</tr>
<tr>
<td></td>
<td>Fluctuations in mood</td>
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<td></td>
<td>Preoccupation with infant well being</td>
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<td></td>
<td>Severe anxiety</td>
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<td></td>
<td>Panic attacks</td>
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<td></td>
<td>Fearfulness of being alone with infant</td>
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Appendix 2 Couple summaries

The following short family summaries present background information about the couples and their circumstances. They are intended to give the reader an understanding of the couples' perspective, which informs their presentation of their experience of postnatal depression.

Aileen and Alan - couple 1
Aileen and Alan had been together for 6 years. Aileen had a daughter from a previous relationship to whom Alan had been a devoted father from early childhood. They lived in a small flat in a rural village setting, where they moved before the birth of their second daughter. At the time of the first interview, Aileen still felt that she was a stranger in the village, experiencing a sense of isolation and distance from her family a distance away. Alan worked in the village and knew a number of people due to his involvement with the local golf club. Aileen was a very chatty and gregarious person who was keen to share her experience during the interview. Alan was the more taciturn and quiet partner of the couple, who was used to being self reliant and keeping his own counsel.

The couple welcomed me and made every effort to allow space and privacy for the interviews to take place in their home. For the individual partner interviews each partner ensured that interruptions were kept to a minimum, although due to space restriction, the baby was in the room throughout each session. Both engaged actively in the interviews and were open about their feelings. Aileen often became quite emotional but insistent that she would continue the sessions commenting that it was useful to revisit her experiences. Alan engaged in the sessions but often need a little more prompting to share his deeper feelings.

Both reported a close relationship with each other, although Alan appeared at times to have been somewhat distanced from Aileen's emotional turmoil. Aileen commented that she preferred to talk to the professionals about her problems rather than burden Alan with her worries. He noted that he was always prepared to talk, but tended to protect Aileen from some of his own worries.

When I visited Aileen and Alan after 6 months for the return interview Aileen was well on the way to recovery, had started a new job locally and had made friends with a number of other women in the village.

Barbara and Bert - couple 2
At the time of the first interview Barbara and Bert had been together for 4 years. They had left their respective partners for each other. Having left the village for some time they had decided to return there shortly before the birth of their second child. Barbara's son from her previous marriage had been with the couple throughout. Initially the family had lived in a small cramped flat but had recently moved to a house located centrally in the village. Bert's
parents and extended family all lived in the village. Barbara's family stayed a
distance away but she felt that she could relate better to Bert's parents than
her own. The father of her older son also stayed in the village, which had
caused some embarrassment in the past when they had met. This seemed to
have been resolved prior to my involvement with the family.

Both were welcoming and participated fully in all interviews. Bert felt a little
apprehensive at first but quickly relaxed into the conversations, sharing his
experience freely. Both commented that this had been the first time they had
had a chance to review their situation consciously and hear each other's
perspective. I was very conscious that my role was that of interviewer and not
as a health professional, although Barbara and Bert were not the only couple
who commented that they had felt that participation in the interviews had
been beneficial to their relationship.

They had both been fully involved in the management of Barbara's illness,
with Bert regularly taking over childcare responsibilities on his return home
from work. He felt that he had tried hard to support Barbara under some
rather difficult circumstances. Both felt that early housing issues and
emotional strain had contributed to Barbara's illness. At the time of the
interviews they felt more settled in their own house, were in regular contact
with Bert's family and had been accepted again by the wider village
community. Bert's mother had played a key role in helping the couple
understand Barbara's illness utilising her connections with the local surgery
to obtain useful information on medication and treatment.

When I returned to visit the couple after a six months interval, Barbara had
discontinued her antidepressant medication. Over the Christmas period she
had felt a little low again but had not required further medication. Barbara had
started to work on a part time basis in a local shop and felt more confident
and positive since the initial set of interviews had been conducted.

Carla and Chris- couple 3
Carla and Chris had been together for 5 years following the break-up of their
respective previous relationships. Carla's daughter and Chris' son as well as
their son from their relationship were living together in a small house in a
rural village. Carla had had to take extended sick time from her work as a
teacher due to her postnatal depression. Carla had previously been in an
abusive relationship but felt happy and comfortable with Chris. Both were
very outgoing people who obviously enjoyed each other's company, sharing
light banter throughout the interview sessions. Both Chris' and Carla's family
lived in the village. Carla's relationship particularly with Chris' sister was
positive and open. Although Chris was initially reluctant to participate in the
interviews, he quickly became engaged and offered his views on Carla's
illness. Both had felt that their relationship had been put under significant
stress due to Carla's illness but felt it important to stay together to overcome
their difficulties.

There were sometimes mixed messages from this couple. They appeared to
be supportive of each other, while he seemed to be actively involved in the
care of the children. At the same time he made no secret of his impatience with the situation and his feelings of frustration. Both seemed to work together to manage the situation. Carla had supported Chris in the past through stressful work problem. This seemed to lead to an understanding between the partners that there was an obligation for Chris to return the favour. Their mutual affection appeared to have helped the couple to work through their difficulties.

When I returned to interview them after six months, they had moved house to be closer to their friends and family, Carla was contemplating her return to work and they had explored the possibility of a further pregnancy. They had decided against adding to their family, with Chris feeling that they had enough responsibilities already, while Carla was afraid of a possible recurrence of postnatal depression.

Dana and David - couple 4
When I first met Dana and David, Dana was heavily pregnant with their second child. They were alternately looking forward to the delivery and apprehensive in the light of their previous experience of postnatal depression. For most of their 7-year relationship they had been living away from their respective families. David's work had also meant that they had been moving around and had not stayed long in a number of places. They presented a close relationship to their families and friends but had felt very isolated from each during the early stages of her illness. They had only gradually been able to share their feelings and fears.

When I interviewed the couple they had been able to resolve these difficulties and were both very open about sharing their feelings with me. David, in particular seemed to welcome the contact. Both commented that the interviews had given them the opportunity to revisit their experience and also plan for how they would manage a possible recurrence of postnatal depression after the expected birth of their second child.

Both seemed to have found it difficult to cope with postnatal depression. Dana had experienced a traumatic birth and had suffered considerable medical complications. Initially David had found it difficult to understand how Dana had been feeling. He had also been newly promoted to his post; he felt pressured at work and had been working away from home. The early months seemed to have been spent in isolation from each other. Gradually David was able to understand Dana's feelings more as she was more able to ask for help, sharing her difficulties more and utilising medical treatment. David felt that his attitude changed as Dana started to feel better and he could see an improvement in her condition. David was mainly involved with the care of their young daughter, while Dana had found it difficult to relate to the child. Dana struggled with her feelings for the new baby, while David had been able to bond very quickly. This had been an additional strain to their relationship.

When I returned to interview the couple after six months, they were positive and felt able to enjoy their second daughter. The birth had been a much more positive experience, breastfeeding had been established and the new baby
seemed to be a calmer, more settled baby. Their attitude was positive and optimistic. Their fears of a recurrence of postnatal depression had not been realised. Both felt that they had been able to share their feelings more openly with related benefits to their relationship.

Evelyn and Edward - couple 5
Evelyn and Edward had been together for 9 years during which time they had experienced a number of significant challenges to their relationship such as financial difficulties, housing problems and job loss. Although Evelyn's diagnosis of postnatal depression went back to the birth of the couple's first son, 7 years previously, the couple recalled their feelings from that time vividly.

Both partners had suffered depressive illnesses since then, with Evelyn being treated for chronic depression to the present day. When I first met them, they were living in an upstairs flat on the outskirts of a small town. They had moved there from their home in another part of the country shortly after the birth of their son. Their three children were active and outgoing, frequently joining the interview sessions. Edward was working in the local hospital, while Evelyn looked after the children at home. Both were still in regular contact with local health professionals but felt that they had had difficulties accessing services after the birth of their son. Evelyn and Edward were able to explore their experience of postnatal depression but also to contrast this with their subsequent experience of chronic depression. Evelyn certainly felt that postnatal depression had been the more challenging illness due to the concurrent responsibilities for a new baby.

Edward appeared to have been Evelyn's main practical and emotional support, despite trying to work through his own considerable personal difficulties. He had found it difficult to share his feelings with Evelyn, who was heavily reliant on his support during her illness. Both talked about the importance of their religious faith to their lives and their relationship.

When I returned to interview them after six months, they felt they had made progress in the intervening months. Evelyn had returned to work part-time, they were making plans for the future and felt positive about being able to manage their mental health.

Frances and Freddy - couple 6
Frances and Freddy had been together for 13 years, when I first met them. The couple had been older when they started their family. Frances had given up a responsible job to stay at home and look after the couple's two boys. Freddy often worked long, unsociable hours away from home. He also was actively involved with a local sports club, playing at competitive level. Frances had discovered a talent for writing poetry and used this extensively to express her feelings about personal experiences and family problems.

The couple were welcoming when I arrived to interview them, although Freddy tended to sit apart from the interview group and frequently expressed his view, that the situation was mainly Frances' problem. Frances on her part
commented on her feelings of frustration and loss of role since she had given up work to stay at home full time.

The couple appeared to have a number of unresolved relationship issues relating to role adjustment, responsibility for postnatal depression and different expectations of the support to be expected from the other partner. Freddy felt that he was able to deal with any problems himself, while Frances utilised local support groups to share her feelings and seek help. Frances felt that there were parallels in experience between postnatal depression and other taboo subjects such as infertility and continence.

When I returned to interview the couple after six months, Freddy had been promoted in his post and was working more irregular hours. Frances seemed to have resigned herself to this. She had become more involved with work for a local charity and was going out more often to meetings. She also felt that her poetry had helped her to express her feelings but also gain recognition and build her self-esteem.

**Gina and George - couple 7**

Gina and George had been together for 9 years. Their two boys were active and outgoing, close to their mother and enjoying the company of their father. The couple had lost a baby four years previously, a loss still strongly felt by Gina in particular. They lived in a small village close to Gina's parents. George was estranged from his mother and had lived most of his life with his father. He felt that he had a good relationship with Gina's parents and encouraged her to have regular contact with them.

When I first met them, the couple were reticent to talk about their experience. Gina commented that she had felt uncomfortable talking about herself previously when health professionals had visited during her illness. George commented that talking was very much a part of his job, he felt inhibited when asked to talk about his own personal experiences. Both relaxed more as the interviews progressed, commenting that sharing their thoughts had been a new experience for both of them.

Gina and George seemed torn between a desire to be available for each other and feeling distant from the feelings of the other partner. At times they appeared to have withdrawn into their own private worlds, occasionally trying to reach out to the other partner. A sense of mutual isolation during Gina's illness seemed to be the main theme of the couple's experience. Both appeared to have stayed in the relationship for their own reasons. George in particular commented that he felt committed to his family and did not want his own children to experience the same difficulties he had had due to his own parents' break-up.

When I returned to interview them after six months, both were much more relaxed with each other and with me. They were easy in each other's company, exchanging light jokes and more able to talk about personal issues. Gina had felt more able to make social contact with other women in the village, had joined the local mother and toddler group, had supported
another mother through postnatal depression and had attended a keep fit class on a regular basis.

Hannah and Harold- couple 8
Hannah and Harold had been together for about 4 years. They had been living in the local village since the birth of their daughter, but Harold often had to be away from home for work commitments. Hannah’s parents had provided some practical child care help in his absence when Hannah had been unwell. Although useful, both partners had felt that this was intrusive and had made them feel that they were losing control. Harold had a difficult relationship with his parents and did not have any contact with them.

Both partners seemed to be supportive of each other. Harold had taken on the main burden of care for Hannah when she had been unwell. She expressed feelings of guilt that she had had to rely on him as much as she had needed. At the same time Harold’s support had been the most important to Hannah. Hannah and Harold appear to have relied mainly on each other throughout her illness. Harold’s frequent work absences made it difficult for Hannah to manage. This was a particular problem when she had not been well. Both try to keep in touch with each other when Harold is away but often need to encourage each other to share feelings of low mood.

On the return interview, the conversation centred mainly on Hannah’s pregnancy with her second child and how the couple were going to manage the possible recurrence of postnatal depression. Harold had re-established contact with his own family. Both felt that they would be able to ask them for help. Hannah had also decided that her expectations of help from her family would be more realistic. Both seemed to feel that their previous self-reliant approach had been the most effective. They had learned how to manage postnatal depression previously and felt more confident to do so should it recur.

Irene and Ian- couple 9
Both had been together for approximately 8 years. Their twins, a boy and a girl, had been born just over 2 years previously. Although Irene had suffered from depression before the birth of the children, she had become very unwell afterwards. She was still struggling with her illness and found the stress of childcare for two demanding toddlers almost unbearable. Ian was finding it difficult to understand Irene’s strong feelings, her recurrent tiredness and inability to tolerate the children. Both their families lived a significant distance away from the couple and had little contact with them. Both felt let down by their respective parents but also local professional services.

The relationship between the partners had been significantly affected since the birth of the children and Irene’s postnatal depression. Both commented how postnatal depression had affected their relationship and been causing stress for them individually and as a couple. Ian’s frequent work related moves and absences from home had added to these stresses. Both felt that Irene’s postnatal depression and chronic depression was a family problem and required both their input. They presented a number of mixed responses
to interview questions, which made an understanding of their needs, and how professional workers responded to them, somewhat unclear.

When I returned after six months, the relationship had continued to be stressed and tense. Particularly Irene had felt that she was becoming distant from Ian, while he seemed to have lost his desire to try to understand her feelings. Despite these problems they had continued to stay together and felt that they would be able overcome their difficulties together.

**Jane and Jason - couple 10**

Jane and Jason, the youngest of the couples, had only moved into their current home near Jane's family one month before I visited them for the first interview. They had been together for 19 months and had moved house 4 times since the birth of their little son. Jane was happy to have moved to live closer to her family, but Jason felt isolated and without any local friends. Jason was not working and was spending his time at home to support Jane and look after the baby.

The couple had had a traumatic time since their son's birth both socially and emotionally. They were trying to manage a number of financial and social problems but presented them as less significant than their concerns in relation to Jane's mental health. Jason appeared to be suffering from low mood, while at the same time trying to support Jane to the best of his abilities. Jane felt that the postnatal depression was directly related to traumatic birth experience and isolation from her family. Since their move to the local area, she felt more able to share her feelings with her extended family.

When I returned to interview them after six months, both seemed to have mixed feelings about progress in the interim. Although Jane felt more positive, Jason had commenced on anti depressant medication himself and was still unsure about his future life in the locality, living a considerable distance away from his own family. Jason in particular felt that he was unable to meet Jane's expectations of him, which appeared to add to his emotional stress.

**Karen and Kurt - couple 11**

Karen and Kurt had been together for 5 years when I first met them. Although they had been together for some time before the birth of their daughter, they had faced the challenge of marriage, childbirth, moving to a new house and starting a new business all within the previous year. Kurt was working from home, often away for long hours and visiting prospective clients in the evening, while Karen stayed at home with the baby. The location of their home in the countryside made it difficult for Karen to meet other mothers and friends. Both their families lived a considerable distance away from home. Kurt's father was unwell and required nursing care. These concerns appeared to add considerably to the couples' difficulties and had left them both feeling stressed.
They were open about their difficulties, which had affected their relationship in the early weeks after the birth of their daughter. Kurt commented that he had often used his work commitments as an excuse to escape the home situation. Only a conscious effort by him to bond with the baby eventually helped him to engage with his young family. There seemed to be a discrepancy in the needs of each partner. Kurt tended to stress the physical aspects of the relationship and his desire to avoid conflict. Karen for her part had felt left alone and isolated but had needed to be heard and share her feelings with somebody. Karen felt that she would have felt more able to do this with another woman like her mother rather than with a man since men: “don’t understand feelings and are more into action”.

When I returned to interview the couple six months later, they had made considerable progress and felt much more positive. Karen had passed her driving test, which had allowed her to be more independent and meet friends locally. She had stopped taking her anti depressant medication independently of her General Practitioner, which she had felt to have been a major step towards independence. Both had felt that they had adjusted to their new life but also been able to accept the limitations of their situation. They raised the issue of adjustment and acceptance of a new normality, which eventually developed into an analytical category.

Lena and Len - couple 12
Lena and Len had been together for 6 years. Both presented as a successful couple with a large home and a busy working life for Len. Lena had held a responsible job managing her own business prior to the birth of their older son. She was now at home to look after their two boys and retraining as a childminder. Len was away from home on frequent business trips. When Lena became ill with postnatal depression, Len had been between jobs and had been under considerable work related stress.

Throughout the interviews, Lena in particular felt that she continued to adjust to a changed lifestyle. She commented that Len was mostly uninvolved in the care of their children. He was helping with childcare when he was available but this occurred on his terms. Both portrayed a positive picture of having managed postnatal depression effectively. This was in contrast to their recurrent references to feelings of frustration and helplessness. Neither had been able to share their feelings with each other or their families. Len felt that he was close to his parents but had been reluctant to burden them with his personal problems. Lena had tried to reach out to her family but had found little support since she was perceived to be a “coper”, able to manage independently.

When I interviewed them after six months, they reported to feel more relaxed and positive about their situation. Lena, in particular, felt that she had moved on considerably to the extent that she attributed her problems to lack of sleep rather than postnatal depression. She felt more in control and to have adjusted to her role of ‘stay at home mother’. Len felt that Lena had needed time for this adjustment. Since postnatal depression was very much Lena’s problem, she had to be given time to take control over her life.
Maureen and Mike- couple 13
When I first met Maureen and Mike, they had been together for 3 years. They had moved into the area only very recently and were still trying to settle into their new home. Mike was off work with depression. Both felt that they were struggling to overcome their own illnesses, support each other and look after their little girl. Maureen found it difficult to talk at times and Mike often apologised for not being able to express himself more clearly.

Mike had a history of depression and had been supported in the past by Maureen. When Maureen herself became ill with postnatal depression, Mike felt that he should support her in return. Although he had tried to do so, this had caused him significant stress and a relapse into depression. Both appeared to have tried very hard to work together to overcome their difficulties, trying to support each other, as they were able. Both were determined to reduce the impact of their problems on their little girl. They were making significant efforts to spend time with her and to hide their unhappiness from her. Maureen's own background as an adopted child made her particularly sensitive to the need to be a "good mother". Although some of the professional services had been helpful, the couple commented negatively on the lack of counselling services in the area.

When I returned to interview them after a six months interval, both were still unwell and receiving treatment for depression. Mike had recently returned to work, which had brought its own problems with it. Maureen had started to attend regular counselling sessions and had been able to explore some difficult personal issues. Their relationship appeared to have undergone a period of significant disharmony, which they were still trying to resolve when I visited.

Nancy and Norman- couple 14
Nancy and Norman had been together for 6 years when I visited for the first interview. Nancy had been diagnosed with postnatal depression two months after the birth of their daughter. Although this had been two years previously, both were still clear in their recollection of events and the impact the illness had had on their relationship. Nancy had been diagnosed relatively quickly, but had been reluctant to accept treatment initially. She had eventually moved to stay with her parents a considerable distance away, received treatment there and returned eventually after an absence of a number of months. Norman had supported this move and visited his wife and young child regularly at weekends throughout this time. During this time Norman had experienced considerable work related problems, which he had only been able to share with Nancy long after her return to the family home.

Both partners had struggled with Nancy's illness. There had been a significant time when they had not been able to share their feelings and had felt isolated from each other. Although Norman had visited at weekends, neither partner had felt these to have been successful, even contributing to the feelings of isolation and distance in the relationship. Both felt that this had
been due to the medication Nancy was taking rather than due to an underlying problem in the relationship. Mutual friends appeared to have withdrawn from contact with the couple. Both stressed the lack of support available for Norman as the reason to participate in the study.

When I returned to interview the couple after an interval of six months, Nancy and Norma felt positive and announced that they were expecting their second child. They felt very positive about this event, having reflected on their previous experience. They had decided to be proactive in their approach, planning for the pregnancy and the possibility of a recurrence of Nancy's postnatal depression. Norman showed a particular interest in the dissemination of the study's finding, reiterating the need for men to be offered more support from professional services.

Olive and Oscar - couple 15
Olive and Oscar had been together for 20 years when I first interviewed them. They lived in a semi-detached house in an urban area in close proximity to both their families. Their older daughter attended the local primary school and had been very excited about the arrival of the new baby eight weeks previously.

Olive had experienced postnatal depression after the birth of both their children, and the partners were able to contrast these episodes clearly. Both commented that their attitudes and those of the professionals had changed, that the time to diagnose the condition and seek help had been shorter and that their family network had reacted very differently. Oscar admitted that he had found it difficult to accept Olive's first illness, escaping into work to manage the situation at home. Both commented that they had been able to use their first experience to prepare themselves for a possible recurrence after the birth of their second daughter. This had allowed them to seek help early and also to enrol the help of their extended families more effectively. Both had been able to draw on an inner circle of friends and family who were aware of their difficulties. An outer circle of acquaintances was not aware of the couple's problems.

When I returned after six months to interview them, Olive and Oscar reported positive progress. Olive had been able to negotiate an extension to her maternity leave to allow her more time to recover from her postnatal depression. Family support had been helpful, allowing Olive time to recover. Oscar had reduced his working hours and was able to spend more time with his family.

Pam and Paul - couple 16
Pam and Paul had been together for 15 years when I first visited. They lived in a terraced house in a small town with access to local facilities and transport. Their teenage son had welcomed the arrival of his little sister, 11 years his junior. Although Pam had been diagnosed with postnatal depression approximately two months after the birth, she was unwell and continued to need medication when I visited two years later. Both had
suffered considerable emotional difficulties during the previous two years. Paul was self employed and tried to support Pam, while worrying about his business.

Postnatal depression appeared to have had an impact on both the partners as well as their older son. Pam suffered from postnatal depression initially, which then became chronic depression after an episode of glandular fever. This made it difficult to distinguish between the impact of postnatal depression and the subsequent depression. Particularly Paul's levels of tolerance towards Pam's illness appeared to have changed as the condition became more chronic. Both partners appeared to have tried to protect each other from the more serious effects of their individual problems.

In the interval before my return after six months, Pam had been very unwell. She had had to be referred to the community psychiatric nursing service and was also attending the local psychiatric day hospital. The couple differed in their assessment of the benefits of this. Pam felt she had benefited from this contact, while Paul felt that Pam was becoming dependant on treatment.

Rachel and Richard- couple 17
Rachel and Richard had been together for 20 years when I first met them. They were living in a detached house in a large urban area, where they had moved to shortly after the birth of their son. Rachel's postnatal depression had been diagnosed and treated abroad, while Richard had been working for a large company.

They were able to contrast their experience of services there and in Britain. They commented in particular on the family focussed nature of services and the involvement of both partners in the Rachel's care. They felt that Richard had been involved in Rachel's care decisions at all stages of her illness, diagnosis, care and discharge. These included arrangements for childcare while Rachel was in hospital, time off work for Richard and joint as well as individual counselling sessions for both of them. They perceived the care provided to have been family focussed rather than individual focussed with a proactive approach to care, anticipating possibly problems and addressing them before they became an issue. Rachel's postnatal depression had eventually developed into bipolar disorder, for which she continued to receive treatment.

When I returned to interview them after six months, they had continued to work together to manage Rachel's illness, remained committed to their relationship and felt that they had been able to balance Rachel's need for ongoing care with a satisfying family life.
Appendix 3 Example of couple interview guide

Interview 1- Joint interview with couple

Thank you for making time today for the interview
I am interested in your views about the care of families with experience of postnatal depression and in particular your views on their support needs
The interview is fully confidential and will last about one hour

Introduction
Who am I?
Consent
Confidentiality
Honesty/ non-judgemental
Basic personal details and how interviews will happen

Today and over the next 2 interviews I would like to find out from you about your experience of postnatal depression and the support you have had from different people such as professionals, family, and friends
How would you define ‘support?’
What have you found helpful when trying to cope with postnatal depression?
What has been less useful when trying to cope as a family with postnatal depression?
What would have been an ideal solution to managing postnatal depression?

First of all could you tell me a little about you as a family who has experience of postnatal depression?
Can you tell me how you first found out about postnatal depression?
How were you referred?
How were you diagnosed?
What treatments were offered/ available?
What information was given/ did you request?
How often were you seen by professionals?
What treatments did you receive?

Often the woman will have most contact with professional services
What involvement did you as the partner have in your wife’s care?
What was your role?
What were your concerns as the male partner?
What contact did you have with professionals?
What were your information needs?
What was your response to the diagnosis?

Postnatal depression can cause stress in a relationship-
How did this affect you both?
Could I just summarise what you were telling me, just to check that I have understood.......

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Support is always quoted as one of the important factors to help women recover from postnatal depression. I am particularly interested in the kinds of support which have been helpful to you both. Who? Where? What? Differences between woman and partner's need. Support that has not been helpful.

How easily were you able to access these supports? What barriers were there to access? Can you think of anything that should be available but is not?

Is there anything that you can think of that we have not covered in this interview? Anything you would like to add? Many thanks. Could I return if I need further help?

**Interview 2- Individual interview with each partner- couple C7**

Thanks for seeing me today. This time I am particularly interested in your personal views and experiences. The last time we spoke together of postnatal depression and how this has been for you as a couple. Today I would like to look specifically at your own perspective. None of the information we'll discuss today will be passed on to your partner. It is confidential within this study.

Relationship effect of postnatal depression
Effect of postnatal depression on relationship- can you tell me a little bit about how postnatal depression has affected the relationship between the two of you? Men, whose partners suffer from postnatal depression, often feel quite helpless, never being able to do the right thing. How did you feel you were able to meet X's expectations? Men are often expected to take on the shared responsibilities of looking after the children. How do you divide the chores in the house now? How is this different from the time when your partner was ill?

Support issues-
Tell me about an example during postnatal depression when you felt supported. What was it about that situation that made all the difference? What kind of things made you feel less supported? What word or phrase would best describe the ideal kind of support that your partner could have given you?
How about the support which you were able to give to your partner?
Can you give me an example of a situation in which you felt that you supported your partner well?
How did it feel to give/ receive this support?
Where do you/ did you get support when it is not from your partner?
What help did you get from these people, which you did not get from your partner/ your relationship?
How are things for you now?

C7-PM-Specific Issues
Information needs— possible support group
Contrast of coping with emotional issues at work vs. at home— putting things into boxes?
Professional defence
What would have helped him/ would he have liked to have done—
With hindsight, would he have done anything different?
If HV had invited him to listening sessions— what would his reaction have been?
Own childhood experiences and need to keep the family together— could he have walked out?
Personal relationships— experience?
Feelings of rejection during postnatal depression from wife— difficulty to admit this
What is not helpful?

C7-PF-Specific Issues
Your views on others have commented on: postnatal depression as a weakness/ embarrassment re seeing community psychiatric nurse
Difficult to speak to people— what would have made it easier to do that?
What questions would have helped her to open up?
Hiding feelings/ didn’t talk in depth— how far was she able to open up/ what stopped her from going further?
What are the barriers to help— to speaking?
Is talking helpful? Are there other things also helpful?
Did the Edinburgh postnatal depression scale ever get done? How did that feel? How honest?
What is not helpful?

Is there anything which you would like to add, anything that is important and has not been covered?
Thank you for your time and help with this interview

One piece of advice for other couples

Interview 4- joint return interview with couple
Identify changes that have happened to the couple since the previous contact.
Have they had any further thoughts on postnatal depression and support issues?
Are there any relevant key points that they think are important when supporting families with postnatal depression?

Can you map your own support network for me?
Where are you individually and together?
Who is around you?
How close are they to you in terms of support when you were not well?
Use of different coloured post- its:
Those important in giving support to him– green
Those important in giving support to her– pink
Those important in giving support to both– yellow

Feedback from study– narrative
How does this compare to your own experience?
### Appendix 4 Table illustrating the stages of analysis

<table>
<thead>
<tr>
<th>Stage</th>
<th>Grounded Theory tool</th>
<th>Action</th>
<th>Content</th>
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</thead>
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<td>1- inductive</td>
<td>Open coding</td>
<td>Grouping concepts and early category development</td>
<td>Reduction of range of codes and formation into thematic groups</td>
</tr>
<tr>
<td>1- inductive</td>
<td>Early axial coding</td>
<td>Categories and subcategories</td>
<td>Networks of subcategories</td>
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<tr>
<td>1- inductive</td>
<td>Narratives</td>
<td>Hypothesis development to integrate concepts</td>
<td>Develop narrative story for respondents- mother/ father/ couple</td>
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<tr>
<td>2- deductive</td>
<td>Axial coding at category level</td>
<td>Categories arranged around: Relationship issues</td>
<td>Components of final processes described:</td>
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<tr>
<td>2- deductive</td>
<td>informed by research questions</td>
<td>Support issues</td>
<td>1. Adaptation to new normality</td>
</tr>
<tr>
<td>2- deductive</td>
<td></td>
<td>Mini frameworks to illustrate relationships between concepts</td>
<td>2. Process to seek help</td>
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<tr>
<td>3- inductive</td>
<td>Selective coding</td>
<td>Identification of core category 'parenting normality' and</td>
<td>Description of process theories and their component categories</td>
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<tr>
<td>3- inductive</td>
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<td>development of process theory</td>
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<td>THEMATIC CODE</td>
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<td>Believes</td>
<td>Happy families</td>
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<td>Include the partner</td>
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<td>Couple conflict</td>
<td>Love and affection</td>
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<td>Couple problem</td>
<td>Not a bad person</td>
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<td>Distancing</td>
<td>Outsider</td>
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<td>Family dynamics</td>
<td>Partner’s interest</td>
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<td>Protect</td>
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<td>Relationship stress</td>
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<td>Group dynamics</td>
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<td>Woman’s problem</td>
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<td>Gender issues</td>
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<td>Very young</td>
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<td>Voluntary groups</td>
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<td>Talk</td>
<td>What can I do to help?</td>
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<td>Professionals</td>
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<td>Good wife</td>
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<td>Medical vs. layman</td>
<td>Sick role</td>
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<td>Parenting responsibilities</td>
<td>Worker role</td>
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<td>Permission to support</td>
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Appendix 5 Thematic codes condensed under thematic headings

Relationships

Gender issues

Attitudes

Types of support

Roles
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<td>Partner’s needs</td>
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<td>Social issues</td>
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<td>Fears</td>
<td>Society factors</td>
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<td>Fix it</td>
<td>Transport</td>
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<td>Work commitments</td>
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<td>Fallen through the net</td>
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<td>Activate own resources</td>
<td>Hunch</td>
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<td>Assessment</td>
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<td>Push things aside</td>
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<td>Wavering off the truth</td>
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Appendix 6 Mind maps of the stages of the analysis

Stage 1 of the analysis

Network- causality

Chapter 5, Section 5.2.1

Network- emotional health

Chapter 5, Section 5.2.2

Network- access

Chapter 5, Section 5.2.3

Network- roles and gender

Chapter 5, Section 5.2.4

Network- professionals

Chapter 5, Section 5.2.5

Network- solutions

Chapter 5, Section 5.2.6

Network- help seeking

Chapter 5, Section 5.2.7
Stage 2 of the analysis

Experience of PND

- Communication intensity
  - Physical
  - Speculation about causality
- Social
  - Coping strategies
  - Competition with others
- Dress to achieve normally
- Not the same person

Sample Support Network

- Lena's mother and siblings: Reliance on Lena for support
- Lena's local friends: gradual development, sharing
- Lena's Practitioner: female, listening, time constraints
- Lena's friends: not for sharing personal problems
- Support group: variable involvement

Support Issues

- Individual
- People
- Groups
- Goal
- Outcome
- Impact

Sample Support Network

- Lena's mother and siblings: Reliance on Lena for support
- Lena's local friends: gradual development, sharing
- Lena's Practitioner: female, listening, time constraints
- Lena's friends: not for sharing personal problems
- Support group: variable involvement

Stage 3 of the analysis

Defining parenting normality

- Maintain image of normality
- What is normal abnormal?
- Stage 2
  - Stage 1
    - Dress to achieve normally
  - Not the same person
- Comparison with internal/external factors
- Stage 3
  - Parenting normally

Core category and related processes

- Core category: Parenting normally
- Process to seek help
- Process of adaptation to a new parenting normality

Process to seek help

- Treatment
  - Stages
    - Help gained
    - External systems
    - Internal systems
    - Grass
    - Don't admit
    - Unrelated
    - Check symptoms
    - Effect on relationship

Adaptation to a new normality

- Representation of Postnatal Depression
  - Feelings: coping mechanisms, timeframe
  - Considerations
  - Birth
  - Support
  - New normality

Chapter 6, Section 6.3

Chapter 6, Section 6.4

Chapter 6, Section 6.4.5

Chapter 7, Section 7.2

Chapter 7, Section 7.2.7

Chapter 7, Section 7.3

Chapter 7, Section 7.4

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### Appendix 7 Stage 1 categories and their link to stage 2 frameworks

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<th>Category from stage 1 analysis (1 of 7)</th>
<th>Stage 2 analysis Mini framework 2: support issues</th>
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<td>External factors</td>
<td>Outcomes People</td>
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<td>Internal factors</td>
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<td>Responsibility</td>
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<td>1. CAUSALITY</td>
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<td>Strive to return to lost normality</td>
<td>Influences</td>
<td>Outcomes People</td>
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<td>Response</td>
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<td>Background</td>
<td>Outcomes Format</td>
</tr>
<tr>
<td>Strength of relationship</td>
<td>Maintenance</td>
<td>Outcomes</td>
</tr>
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<td>2. EMOTIONAL HEALTH</td>
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<td>Coping strategies</td>
<td>Representation</td>
<td>Outcomes</td>
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<td>Strive to return to normality</td>
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<td>Characteristics</td>
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<tr>
<td>Coping strategies</td>
<td>Resources</td>
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384
<table>
<thead>
<tr>
<th>Mini framework 1 - experience of PND</th>
<th>Category from stage 1 analysis (1 of 7)</th>
<th>Mini framework 2 - support issues</th>
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<td><strong>4. ROLES AND GENDER</strong></td>
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<td>Emotional challenges of new baby</td>
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<td>Personal background</td>
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<td>Strength of relationship</td>
<td>Partner's response</td>
<td>People</td>
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<td></td>
<td></td>
<td>Characteristics</td>
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<tr>
<td><strong>5. PROFESSIONALS AND WORKERS</strong></td>
<td></td>
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</tr>
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<td>Activities</td>
<td>People</td>
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<td>Medication</td>
<td>People</td>
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<td>Influences on function</td>
<td>People</td>
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<td>Characteristics</td>
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<td><strong>6. SOLUTIONS</strong></td>
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<td>Personal resources</td>
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<td>Strength of the relationship</td>
<td>Helper's attitudes</td>
<td>Characteristics</td>
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<td>Coping strategies</td>
<td>Services</td>
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<td>Characteristics</td>
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<tr>
<td>Coping strategies</td>
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<td>Category from stage 1 analysis (1 of 7)</td>
<td>Mini framework 2 - support issues</td>
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<td>7. HELP SEEKING</td>
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<td>Relationships</td>
<td>Outcomes</td>
</tr>
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<td>Considerations</td>
<td>Access</td>
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<tr>
<td>Coping strategies</td>
<td>Services</td>
<td>Characteristics</td>
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### Appendix 8 The components of the category framework ‘support issues’

<table>
<thead>
<tr>
<th>Category</th>
<th>Subcategory</th>
<th>Components/ representations</th>
<th>Subcomponents</th>
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<tbody>
<tr>
<td>PEOPLE</td>
<td>Individuals</td>
<td>Family</td>
<td>Partner</td>
</tr>
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<td></td>
<td>Children/ baby</td>
</tr>
<tr>
<td></td>
<td></td>
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<td>Parents</td>
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<td>Siblings</td>
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<td></td>
<td></td>
<td>Extended relations</td>
</tr>
<tr>
<td></td>
<td>Friends</td>
<td></td>
<td>Close friends</td>
</tr>
<tr>
<td></td>
<td>Extended</td>
<td></td>
<td>circle of friends</td>
</tr>
<tr>
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<td>Professionals</td>
<td></td>
<td>Midwives</td>
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<td>Health visitor</td>
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<td>General Practitioner</td>
</tr>
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<td></td>
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<td></td>
<td>Community Psychiatric Nurse</td>
</tr>
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<td></td>
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<td></td>
<td>Counsellor</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Psychiatrist/ Psychologist</td>
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<tr>
<td>Groups</td>
<td>Formal</td>
<td></td>
<td>M&amp;T groups</td>
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<td></td>
<td></td>
<td></td>
<td>BF support groups</td>
</tr>
<tr>
<td></td>
<td>Informal</td>
<td></td>
<td>Other mothers</td>
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</table>


<table>
<thead>
<tr>
<th>FORMAT</th>
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<tr>
<td></td>
<td>Emotional</td>
<td></td>
</tr>
<tr>
<td>CHARACTERISTICS</td>
<td>Helpful/ Effective</td>
<td>Helper</td>
</tr>
<tr>
<td></td>
<td>Activity</td>
<td>Recipient</td>
</tr>
<tr>
<td></td>
<td>Unhelpful/ limitations/ barriers</td>
<td>Helper</td>
</tr>
<tr>
<td></td>
<td>Activity</td>
<td>Recipient</td>
</tr>
<tr>
<td>CONDITIONS</td>
<td>Under which help is given</td>
<td>Level of awareness of severity of illness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Perspective of problem &quot;us&quot; vs. &quot;me&quot;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Perceived reciprocity of obligation</td>
</tr>
<tr>
<td></td>
<td>Under which help is received</td>
<td>Level of readiness to accept help</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Perception that experience is internal to the individual and can not be alleviated by others</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Level of readiness to recovery</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Perceived need to protect the helper</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Perception that helper is too busy with own issues/ problems</td>
</tr>
<tr>
<td>OUTCOMES</td>
<td>Goal</td>
<td>Expectations of helper ability to provide</td>
</tr>
<tr>
<td></td>
<td>Impact</td>
<td></td>
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</table>
## Support activities

<table>
<thead>
<tr>
<th>Practical approaches for effective support</th>
<th>Emotional approaches for effective support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Undertake daily chores (house/ childcare)</td>
<td>Reassurance of recovery/ normality/ time limit of condition</td>
</tr>
<tr>
<td>Facilitate access to transport</td>
<td>Breastfeeding as a bonding activity with the baby (NB opposite for some women i.e. BF as more stressful to PND)</td>
</tr>
<tr>
<td>Have access to a network of family/ friends as a structured support framework</td>
<td>Utilisation of self discipline to persevere with daily tasks</td>
</tr>
<tr>
<td>Have structure to the day/ week</td>
<td>Desire to be independent as a driver to persevere</td>
</tr>
<tr>
<td>Provide financial security</td>
<td>Talk (personal/ telephone/ general or counselling)</td>
</tr>
<tr>
<td>Access to medication</td>
<td>Listen</td>
</tr>
<tr>
<td>Regular contact with helper/s</td>
<td>Share experience</td>
</tr>
<tr>
<td>Advice from helper/s</td>
<td>Understanding of condition</td>
</tr>
<tr>
<td>Joint/ individual listening sessions</td>
<td>Time to self - &quot;release&quot;</td>
</tr>
<tr>
<td>Information from reliable source</td>
<td>Openness</td>
</tr>
<tr>
<td>Facilitate access to medical appointments</td>
<td>Mutual protection (specifically between partners)</td>
</tr>
<tr>
<td>Consider work outside the home (part of process of recovery)</td>
<td>Encouragement</td>
</tr>
<tr>
<td>&quot;Buddies&quot; to facilitate attendance of groups and activities</td>
<td>Raise awareness of the impact of PND: issues/ effect on child/ consequences of untreated illness</td>
</tr>
<tr>
<td>Get out of the house/ arrange outings</td>
<td>Awareness of changes in the person</td>
</tr>
<tr>
<td>Review of birth records</td>
<td>CBT</td>
</tr>
<tr>
<td>Provide space for individual/ couple</td>
<td>Consultation to reach treatment decisions</td>
</tr>
<tr>
<td></td>
<td>Chart progress in diary</td>
</tr>
</tbody>
</table>
### Support characteristics

<table>
<thead>
<tr>
<th><strong>Helpful strategies/ mechanisms</strong></th>
<th><strong>RECIPIENT</strong></th>
<th><strong>Unhelpful strategies/ barriers to effective support</strong></th>
<th><strong>RECIPIENT</strong></th>
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</thead>
<tbody>
<tr>
<td><strong>HELPERS</strong></td>
<td><strong>ACTIVITIES</strong></td>
<td><strong>HELPERS</strong></td>
<td><strong>ACTIVITIES</strong></td>
</tr>
<tr>
<td><strong>Consistency/ Continuity</strong></td>
<td>Self generated</td>
<td>Level of readiness</td>
<td>Service constraints/ staff changes</td>
</tr>
<tr>
<td><strong>Understanding</strong></td>
<td>Recovery not forced</td>
<td>Level of readiness</td>
<td>Unrealistic demands</td>
</tr>
<tr>
<td><strong>Availability</strong></td>
<td>Focus on the individual</td>
<td>Comfortable with helper/ values the helper</td>
<td>Lack of understanding</td>
</tr>
<tr>
<td><strong>Shared experience</strong></td>
<td>Adopts a family perspective</td>
<td>Openness/ prepared to disclose</td>
<td>Lack of availability/ distance/ avoidance/ work commitments</td>
</tr>
<tr>
<td><strong>Familiarity</strong></td>
<td>Facilitates meeting other parents</td>
<td>Positive feelings</td>
<td>Inappropriate comments</td>
</tr>
<tr>
<td><strong>Commitment</strong></td>
<td>Diversity of option/ activities</td>
<td>Desire to recover</td>
<td>Conditional</td>
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<tr>
<td><strong>Honesty</strong></td>
<td>Comfortable to the recipient</td>
<td>Honesty</td>
<td>Geographic distance (telephone contact can be substituted for some couples)</td>
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<td>Perceived role obligations</td>
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<tr>
<td>Helpful strategies/ mechanisms</td>
<td>Unhelpful strategies/ barriers to effective support</td>
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<tr>
<td>HELPERS</td>
<td>ACTIVITIES</td>
<td>RECIPIENT</td>
<td>HELPERS</td>
</tr>
<tr>
<td>Quality of the relationship</td>
<td>Appropriate format</td>
<td>Trust in helper/others</td>
<td>Too busy with own concerns</td>
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<tr>
<td>Prepared to take the initiative</td>
<td>Unrelated to problem and childcare demands</td>
<td>Trust in helper</td>
<td>Awareness of level of severity of illness</td>
</tr>
<tr>
<td>Perceptiveness/sensitivity</td>
<td>Timely</td>
<td></td>
<td>Unhelpful/dismissive advice</td>
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<tr>
<td>Approachable</td>
<td>Links to the experience of others</td>
<td></td>
<td>“Her/she” perspective</td>
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<tr>
<td>Not judgmental</td>
<td>May take on different meaning than that perceived e.g. weighing clinics</td>
<td></td>
<td>Dismissive attitude</td>
</tr>
<tr>
<td>Not bearing a grudge</td>
<td>Anonymity</td>
<td>Lack of interest</td>
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</tr>
<tr>
<td>“Us” perspective</td>
<td>Confidentiality</td>
<td>Wants to help but does not understand</td>
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</tr>
<tr>
<td>Reciprocity of obligation</td>
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<td>Judgemental</td>
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<tr>
<td>Helpful strategies/ mechanisms</td>
<td>Unhelpful strategies/ barriers to effective support</td>
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<tr>
<td><strong>HELPERS</strong></td>
<td><strong>ACTIVITIES</strong></td>
<td><strong>HELPERS</strong></td>
<td><strong>ACTIVITIES</strong></td>
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<tr>
<td>Liked by the recipient of help</td>
<td>Diagnostic/ prescriptive</td>
<td>Deceptive outward appearance</td>
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<tr>
<td>Show non-invasive interest</td>
<td>Helplessness</td>
<td>Perceived derisory attitude of potential helper/ men</td>
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<tr>
<td>Informal contact</td>
<td>Distant</td>
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<tr>
<td>Prepared to spend time</td>
<td>Information given is out of date</td>
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<tr>
<td>Mutuality of relationship</td>
<td>Assumptions about knowledge due to familiarity</td>
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<tr>
<td>Leave recipient/ couple in control</td>
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<tr>
<td>Expertise</td>
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<tr>
<td>Accept variation in mood</td>
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<tr>
<td>Awareness for need for space for woman/ couple</td>
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<tr>
<td>Does not panic</td>
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<tr>
<td>Prepared to listen</td>
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<td>Impartial</td>
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<tr>
<td>Knowledgeable/ relevant information</td>
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<tr>
<td>Not emotionally involved</td>
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<tr>
<td>Helpful strategies/ mechanisms</td>
<td>Unhelpful strategies/ barriers to effective support</td>
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<tr>
<td>HELPER ACTIVITIES HELPER ACTIVITIES HELPER ACTIVITIES HELPER</td>
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<tr>
<td>Demonstrates an interest in the couple/ the problem</td>
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<tr>
<td>Inclusive of the partner</td>
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<td></td>
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<tr>
<td>&quot;Be themselves&quot;</td>
<td></td>
<td></td>
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<tr>
<td>Alleviate anxieties</td>
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<tr>
<td>Get to the point</td>
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<tr>
<td>Awareness of potential difficulties</td>
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<tr>
<td>Open to suggestions</td>
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<tr>
<td>No preconceptions</td>
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<td>Low profile</td>
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### Outcomes of support

<table>
<thead>
<tr>
<th>Goal</th>
<th>Impact</th>
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<tbody>
<tr>
<td>Achieve distance from problem</td>
<td>Increased understanding of condition/ helping strategies</td>
</tr>
<tr>
<td>Seek help (often outside the immediate family system)</td>
<td>Reduced guilt</td>
</tr>
<tr>
<td>Early access to help</td>
<td>Improved mobility</td>
</tr>
<tr>
<td>Time to self/ break from childcare</td>
<td>Perseverance/ keep going</td>
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<tr>
<td>Retain perspective/ proportionality</td>
<td>Mixed outcome- practical/ not so practical</td>
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<tr>
<td>Reduce pressure on PF vs. address underlying cause</td>
<td>Choice of action/ freedom to choose</td>
</tr>
<tr>
<td>Achieve enjoyment/ anticipation</td>
<td>Reassurance that partner is cared for</td>
</tr>
<tr>
<td>Enjoy positive aspects of parenting</td>
<td>Not feeling like a nuisance</td>
</tr>
<tr>
<td>Achieve a structure to the day/ week</td>
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</tr>
<tr>
<td>Adjustment to the situation/ illness</td>
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</tr>
<tr>
<td>Reduce isolation</td>
<td></td>
</tr>
<tr>
<td>Reduce chance of deterioration</td>
<td></td>
</tr>
<tr>
<td>Recovery</td>
<td></td>
</tr>
<tr>
<td>Increase confidence and self esteem</td>
<td></td>
</tr>
<tr>
<td>Increase mobility</td>
<td></td>
</tr>
<tr>
<td>Increase openness</td>
<td></td>
</tr>
<tr>
<td>Encourage disclosure</td>
<td></td>
</tr>
<tr>
<td>Improve understanding of PND and its causes</td>
<td></td>
</tr>
<tr>
<td><strong>Goal</strong></td>
<td><strong>Impact</strong></td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Increase coping strategies</td>
<td>WHEN SUPPORT IS NOT EFFECTIVE THE IMPACT CAN BE:</td>
</tr>
<tr>
<td>Gain reassurance</td>
<td>Disappointed expectations</td>
</tr>
<tr>
<td>Manage problem vs. find solution to the problem</td>
<td>Isolation</td>
</tr>
<tr>
<td>&quot;Offload&quot; on others</td>
<td>Dread of attendance becomes a barrier to support</td>
</tr>
<tr>
<td>Social contact</td>
<td>Varying levels of support for partners</td>
</tr>
<tr>
<td>Retain control</td>
<td>Reduced self esteem/ reduced self worth</td>
</tr>
<tr>
<td>Specific feedback vs. general insight</td>
<td>Informs the assessment of the degree of recovery</td>
</tr>
<tr>
<td>Reduce deterioration</td>
<td>Reassess potential approach to future support</td>
</tr>
<tr>
<td>Relaxation &quot;let hair down&quot;</td>
<td></td>
</tr>
<tr>
<td>Progression (to recovery)</td>
<td></td>
</tr>
<tr>
<td>Realistic advice</td>
<td>Feeling pushed away</td>
</tr>
</tbody>
</table>
Appendix 9 Examples of couple support networks

Support network: Aileen and Alan

Support network: Barbara and Bert

Support network: Carla and Chris

Support network: Frances and Freddy

Support network: Nancy and Norman

Support network: Hannah and Harold

Support network: Maureen and Mike

Support network: Pam and Paul
## Appendix 10 Descriptions of normality

Descriptions of normality extracted from data and grouped under the following categories:

1. Interaction with baby
2. As a parent
3. Interaction with partner/ in the relationship
4. Interaction with others- people/ family
5. Characteristics of what a normal person is/ does
6. Comparisons which inform the individuals definition of what is normal/ What was before

<table>
<thead>
<tr>
<th>1. Interaction with baby</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Baby becomes part of the family</td>
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</tr>
<tr>
<td>Routine is established for the child</td>
<td></td>
</tr>
<tr>
<td>No change to the regular routine in the household or very limited change</td>
<td></td>
</tr>
<tr>
<td>No adjustment to the household routine</td>
<td></td>
</tr>
<tr>
<td>Being able to leave the baby with others</td>
<td></td>
</tr>
<tr>
<td>Being able to adjust to the baby as another member of the family</td>
<td></td>
</tr>
<tr>
<td>Being able to enjoy and smile with the baby</td>
<td></td>
</tr>
</tbody>
</table>

NORMAl
Baby as part of the family
Routine for baby
Adjust to baby's presence
Able to leave baby with others
Smile with baby

Parenting/baby dimension

NOT NORMAl
No adjustment
Tired and weepy
Useless
No good with the baby

2. As a parent |  |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Childcare easier due to child's growing independence</td>
<td></td>
</tr>
<tr>
<td>Competence in childcare</td>
<td></td>
</tr>
<tr>
<td>Not doubting parenting abilities</td>
<td></td>
</tr>
<tr>
<td>Not blaming the child/children</td>
<td></td>
</tr>
<tr>
<td>Not feeling negative towards the child/children</td>
<td></td>
</tr>
<tr>
<td>Being a confident parent</td>
<td>Work at motherhood</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Having a natural birth</td>
<td>Doubting one's parenting abilities</td>
</tr>
<tr>
<td>Easy motherhood</td>
<td>Having negative feelings towards the child/children</td>
</tr>
<tr>
<td>Being tired as a new parent</td>
<td>Blame the child/children for the illness</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NORMAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Easy motherhood</td>
</tr>
<tr>
<td>Easy childcare</td>
</tr>
<tr>
<td>Competent in childcare</td>
</tr>
<tr>
<td>Confident as a parent</td>
</tr>
<tr>
<td>Natural birth</td>
</tr>
<tr>
<td>Tired as a new parent</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Parenting dimension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Give best to the relationship</td>
</tr>
<tr>
<td>Talk together</td>
</tr>
<tr>
<td>Being/feeling empathetic to partner</td>
</tr>
<tr>
<td>Give inspiration to partner</td>
</tr>
<tr>
<td>Accept ups and downs of relationship/life</td>
</tr>
<tr>
<td>Have fun together as a couple</td>
</tr>
<tr>
<td>Share events</td>
</tr>
<tr>
<td>Love/care for the partner</td>
</tr>
<tr>
<td>Have reasonable expectations</td>
</tr>
<tr>
<td>Maintain role distributions? Be accepting/understanding of each others role</td>
</tr>
<tr>
<td>Having a solid relationship</td>
</tr>
<tr>
<td>Being in sync with each other</td>
</tr>
<tr>
<td>Close relationship</td>
</tr>
<tr>
<td>Not keeping things to self</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NOT NORMAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work at motherhood</td>
</tr>
<tr>
<td>Doubting one's parenting abilities</td>
</tr>
<tr>
<td>Having negative feelings towards the child/children</td>
</tr>
<tr>
<td>Blame the child/children for the illness</td>
</tr>
</tbody>
</table>

3. Interaction with the partner/ the relationship
<table>
<thead>
<tr>
<th>NORMAL</th>
<th>Relationship dimension</th>
<th>NOT NORMAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care</td>
<td></td>
<td>Keep things to self</td>
</tr>
<tr>
<td>Fun</td>
<td></td>
<td>Isolation from partner</td>
</tr>
<tr>
<td>Empathy</td>
<td></td>
<td>Distance</td>
</tr>
<tr>
<td>Sharing</td>
<td></td>
<td>Out of sync with each other</td>
</tr>
<tr>
<td>Reasonable expectations</td>
<td></td>
<td>Unreasonable</td>
</tr>
<tr>
<td>Solid</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Interaction with others- family/ people</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td></td>
</tr>
<tr>
<td>Attentive to people</td>
<td></td>
</tr>
<tr>
<td>Being part of people’s lives</td>
<td></td>
</tr>
<tr>
<td>Have time for people</td>
<td></td>
</tr>
<tr>
<td>Speak to others, sit and chat</td>
<td></td>
</tr>
<tr>
<td>Make an effort with family</td>
<td></td>
</tr>
<tr>
<td>Tolerate crowded venues/ groups of people</td>
<td></td>
</tr>
<tr>
<td>Having family support</td>
<td></td>
</tr>
<tr>
<td>Help others</td>
<td></td>
</tr>
<tr>
<td>Have contact with close friends</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Characteristics of a normal person</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td></td>
</tr>
<tr>
<td>Attentive to others</td>
<td></td>
</tr>
<tr>
<td>Involved</td>
<td></td>
</tr>
<tr>
<td>Interact</td>
<td></td>
</tr>
<tr>
<td>Being tolerant</td>
<td></td>
</tr>
<tr>
<td>Closeness (short talks on the phone)</td>
<td></td>
</tr>
<tr>
<td>Social interaction dimension</td>
<td></td>
</tr>
<tr>
<td>NOT NORMAL</td>
<td></td>
</tr>
<tr>
<td>Tied to the house</td>
<td></td>
</tr>
<tr>
<td>Irrational</td>
<td></td>
</tr>
<tr>
<td>Isolation</td>
<td></td>
</tr>
<tr>
<td>Distance from friends</td>
<td></td>
</tr>
<tr>
<td>(too long on the phone)</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Emotions</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td></td>
</tr>
<tr>
<td>Strong</td>
<td></td>
</tr>
<tr>
<td>Moody: Grumpy/ have a temper</td>
<td></td>
</tr>
<tr>
<td>Logical</td>
<td></td>
</tr>
<tr>
<td>Positive</td>
<td></td>
</tr>
<tr>
<td>In control: plans activities/ feelings/ the environment/ simple</td>
<td></td>
</tr>
<tr>
<td>Characteristics</td>
<td></td>
</tr>
<tr>
<td>-------------------------</td>
<td></td>
</tr>
<tr>
<td>things and the bigger picture</td>
<td></td>
</tr>
<tr>
<td>Independent</td>
<td></td>
</tr>
<tr>
<td>In charge</td>
<td></td>
</tr>
<tr>
<td>Be strong</td>
<td></td>
</tr>
<tr>
<td>Be self</td>
<td></td>
</tr>
<tr>
<td>Caring</td>
<td></td>
</tr>
<tr>
<td>Motivated</td>
<td></td>
</tr>
<tr>
<td>Outgoing</td>
<td></td>
</tr>
<tr>
<td>Enjoy life</td>
<td></td>
</tr>
<tr>
<td>Happy/ full of the joys of living</td>
<td></td>
</tr>
<tr>
<td>Touchy/ feely</td>
<td></td>
</tr>
<tr>
<td>Fiery/ have a short fuse</td>
<td></td>
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<tr>
<td>Impulsive</td>
<td></td>
</tr>
<tr>
<td>Bubbly</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do simple chores/ keep up with the household chore</td>
</tr>
<tr>
<td>Have a good night out</td>
</tr>
<tr>
<td>Cope admit to limitations</td>
</tr>
<tr>
<td>Say what I want</td>
</tr>
<tr>
<td>Trust own judgement</td>
</tr>
<tr>
<td>Do anything</td>
</tr>
<tr>
<td>Socially active/ go out/ socialise/ enjoy holidays</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physiological</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular menstruation</td>
</tr>
<tr>
<td>DESIRABLE</td>
</tr>
<tr>
<td>---------------------------</td>
</tr>
<tr>
<td>In control/ coping</td>
</tr>
<tr>
<td>Independent</td>
</tr>
<tr>
<td>Strong</td>
</tr>
<tr>
<td>Happy/ bubbly</td>
</tr>
<tr>
<td>Sociable</td>
</tr>
<tr>
<td>Return to work</td>
</tr>
<tr>
<td>Have a range of moods</td>
</tr>
</tbody>
</table>

6. What was before: comparison to inform definition of normal

- Go back to before the illness
- Accept change
- Calm rather than storm
- Less stress
- Hope of recovery
- No more laughing
- Minor adjustments
- Get on and do things
- Planning activities rather than being spontaneous
<table>
<thead>
<tr>
<th>NO RECOVERY</th>
<th>Indicators of recovery or lack of recovery</th>
<th>RECOVERY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Storm</td>
<td>Accept change</td>
<td></td>
</tr>
<tr>
<td>Being spontaneous</td>
<td>Calmness</td>
<td></td>
</tr>
<tr>
<td>No more laughing</td>
<td>Get on and do things</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Plan activities (this can be an indicator of recovery or an acceptance that new coping mechanisms have had to be found)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Get on and do things</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hope of recovery</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Go back to what was before</td>
<td></td>
</tr>
<tr>
<td></td>
<td>New normality</td>
<td></td>
</tr>
</tbody>
</table>
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