

**Understanding the Role of Stigma in Women's
Help-Seeking Behaviours for Postpartum Emotional
Difficulties: A Grounded Theory Study**

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ABSTRACT

Rationale:

The reported incidence of postpartum depression and anxiety for women in the first year after birth in the UK ranges from 15 to 20 per cent. Research suggests that as many as 58 per cent of women with symptoms of postpartum depression do not seek professional help, indicating that the incidence of postpartum emotional difficulties may be much higher. Attempts to understand the help-seeking behaviours of women with symptoms of postnatal depression have identified stigma as one of the reasons for avoiding treatment. Although the relationship between stigma and help-seeking has been explored in the context of mental health in general, at the time of writing it does not appear to have been a primary research question for the specific population of women in the postpartum period.

Aim:

This thesis seeks to examine how women understand the role of stigma in the context of seeking help for postpartum emotional difficulties.

Method:

Constructivist grounded theory was selected due to its ability to accommodate a heterogeneous sample of women, representing a spectrum of emotional well-being and help-seeking behaviours. Initially, four first-time mothers were interviewed. Purposive sampling followed, recruiting two additional participants as well as conducting a follow-up interview with one of the original interviewees as part of data validation. In total, seven interviews were conducted with six women.

Findings:

Analysis highlighted five emergent themes: experiencing a difference between expectations and reality; re-evaluating a sense of self; seeking and trusting the help available; "saying it how it is" and the role of breastfeeding in stigma and help-seeking. A Grounded Theory Model was created to demonstrate the relationship between these themes. It appears that the absence and avoidance of 'open and honest' conversations about the difficult elements of mothering at a public, inter- and intra-personal level might perpetuate the stigmatisation of postpartum emotional difficulties. In addition, aspects of the way that professional support services are designed, which may indirectly amplify stigma and inhibit help-seeking, are explored. Implications for further research and the role that Counselling Psychologists can play in advancing multi-disciplinary practice to reduce stigma related to postpartum emotional difficulties are proposed.

Key words: *postnatal depression, stigma, help-seeking*

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LIST OF ABBREVIATIONS

BACE-3	Barriers to Access to Care Evaluation (Clement, Brohan, Henderson, Hatch and Thornicroft, 2012)
EPDS	Edinburgh Postnatal Depression Scale (Cox, Holden and Sagovsky, 1987)
NICE	National Institute of Clinical Excellence
SSOSH	Self-Stigma of Seeking Help questionnaire (Vogel, Wade and Haake, 2006)

GLOSSARY OF KEY TERMS

Postpartum/Postnatal Depression

“Postnatal Depression is a depressive illness which affects between 10 to 15 in every 100 women having a baby. The symptoms are similar to those in depression at other times. These include low mood and other symptoms lasting at least two weeks.”¹ The terms postpartum and postnatal are often used interchangeably. “While **postpartum** narrowly refers to a mother after giving birth, the similar term **postnatal** maybe be used either to contrast, referring to the baby after being born, or may be used synonymously, also referring to the mother.”²

Puerperal/Postpartum Psychosis

“Postpartum psychosis (or puerperal psychosis) affects thousands of women in the UK each year. It is a severe episode of mental illness which begins suddenly in the days or weeks after having a baby. Symptoms vary and can change rapidly. They can include high mood (mania), depression, confusion, hallucinations and delusions. Postpartum psychosis is a psychiatric emergency.”³

Stigma

“Social stigma is the extreme disapproval of (or discontent with) a person or group on socially characteristic grounds that are perceived, and serve to distinguish them, from other members of a society. Stigma may then be affixed to such a person, by the *greater* society, who differs from their cultural norms.”⁴

¹ ² From Royal College of Psychiatry: <http://the-difference-between.com/postnatal/postpartum>
<http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/postnataldepression.aspx>

³ <http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/postnataldepression.aspx>

⁴ https://en.wikipedia.org/wiki/Social_stigma

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PROLOGUE - REFLEXIVE STATEMENT

Before having children, one of my life-mottos was, “How hard can it be?”. I’d have a go at most things and be relatively successful. Becoming a mother, I was faced with challenges I struggled to overcome. My baby battled to feed and we were readmitted to hospital in the first week. Thereafter, I attempted to tell a Health Visitor how difficult I was finding things, how my baby cried whenever I put it down and how difficult this was to bear. She advised me to put my baby beside me as we talked and, as predicted, my baby started to cry. I looked at her for encouragement, but she laughed and said I would just have to get used to it. Retrospectively, I can understand her point – all babies cry; that’s just what they do. At the time, though, it reinforced my perception that I was not a capable mother and felt shamed for admitting I was not coping. I concluded I was doing something wrong. The possibility that I might be experiencing mild postpartum depression did not cross my mind at that stage. This period awakened a core belief of not being good enough laid down years earlier, so it is not surprising that finding things so difficult surfaced this schema. Aside from the Health Visitor, my husband was the only person who knew the extent of my unhappiness. To everyone else, I attempted to look on top of things, attending mother and baby groups and baking biscuits and cakes for those who gave us gifts. A few weeks after this incident, a sleep consultant gave me advice on settling my baby. What followed was months of endlessly bouncing and shushing my baby to sleep with dubious efficacy, but I felt more in control and the feelings of inadequacy passed.

Reflecting on this experience over nine years on, after the welcome arrival of two more children, I know that what I felt that first time was a lot to do with adjusting to the new identity of being a mother. But I also believe that these personal difficulties were exacerbated by the messages about motherhood I took from my external world, from a Health Visitor who seemed to trivialise my difficulties, to baby manuals that did not seem to work for me and the fact that none of the other mothers I met seemed to talk about how hard they were finding things.

Thankfully, my emotional adjustment was short-lived, but for many women postpartum difficulties are persistent. As the following critical literature review highlights, many women do not seek help for symptoms of postpartum depression. I am curious about why this is, especially when help is available.

Counselling Psychology recognises that I, as a reflexive researcher, will have a profound effect on the way I research, analyse and critique the literature and my own findings due to my personal status as a mother of three who experienced symptoms of postpartum depression. Therefore, in embarking on this journey, I will need to use epoche (Willig, 2008) to attempt to limit the effect that my own experiences and unconscious biases might otherwise have on the literature review (Kasket, 2012). Even though it was an isolated incident, I suspect on some level, I have a need to work through the experience of feeling shamed by the Health Visitor. Subsequent experience of Health Visitors has taught me that most of them are empathetic and supportive. However, I will need to ensure that the review does not seek out literature that exposes health professionals as inadequate. I will also need to be true to the Counselling Psychology philosophy of valuing idiosyncratic experiences. Not all women will experience what I did, and even if they did, they might construct a different meaning of it. This might include my historical tendency to believe that problems are there to be solved. Indeed, an alternative approach is that difficulties are there to be compassionately accepted. Therefore I will need to be mindful that my impatience to 'solve the problem of postpartum depression' does not obliterate pluralistic possibilities that might emerge from the review.

CHAPTER ONE

INTRODUCTION

The reported incidence of postpartum depression and anxiety in the first year after childbirth ranges from 15 to 20 per cent (NICE, 2014) in the UK. A recent survey undertaken by the charity 4Children (2011) reported that 58 per cent of mothers with postpartum depression do not seek professional help, meaning that the NICE guidelines for Antenatal and Postnatal Mental Health (NICE, 2007 and 2014) are not reaching many of the women they might help. Research suggests that stigma is one of the reasons that prevents women from seeking help, yet the reasons for this have, to date, not been explicitly explored. This research aims to understand the role that stigma plays in the help-seeking behaviours of women with symptoms of postpartum depression.

1.1 A Medical Model of Postpartum Depression: Definition, Causes, Diagnosis and Typical Treatment

1.1.1 Definition and causes.

Both the ICD-10 and DSM-v (World Health Organisation, 1992; American Psychiatric Association, 2013) assimilate postpartum depression within the broader definition of a major depressive episode (British Medical Journal Best Practice, 2016). To receive a diagnosis of postpartum depression, the DSM-v states that a woman should display the symptoms of a major depressive episode starting within four weeks of delivery and lasting for at least two weeks. Such symptoms include predominant feelings of sadness, minimal pleasure in day-to-day activities, as well as feelings of worthlessness or excessive guilt (Williamson and McCutcheon, 2004). It is important to distinguish postpartum depression from other postpartum experiences, such as 'The Baby Blues', a common experience in the first few days of motherhood characterised by short-term mood changes (Beck, 2006) and puerperal psychosis, a serious mental health complication affecting a minority of women (Valdimarsdóttir, Hultman, Harlow, Cnattingius and Sparén, 2009). In as many as 50 per cent of cases, postpartum depression is accompanied by comorbid anxiety (Ross, Gilbert-Evans, Sellers and Romach, 2003). Bennett and Indman (2003, cited in Zauderer, 2009) define postpartum adjustment as part of the expected biological and psychosocial consequences of the transition to motherhood. They also assert that maternal adjustment is characterised by similar symptoms to postpartum depression, such as sadness and anxiety but that the difference in the overlap is that these

do not have a significant negative impact on daily-functioning. Where symptoms last beyond 6 weeks, they state that a woman needs further assessment for postpartum depression. More recently, attention has evolved to consider the broader experience of postpartum mental health to include post-traumatic stress disorder (PTSD) and anxiety (Coates, Ayers and de Visser, 2014) as well as obsessional compulsive disorder (OCD; Russell, Fawcett and Mazmanian, 2013) which results in some researchers adopting the use of comprehensive terms of mental health such as “emotional distress” and “emotional difficulties” (Coates et al, 2014). Much of the research exploring postpartum maternal mental health has historically focused on depression (Coates et al, 2014) and the term has often “been used as a catchall phrase for many disorders” (Beck, 2006, p40). With this in mind, the current thesis reviews the literature on postpartum emotional difficulties acknowledging that there could be a disproportionate focus on literature relating to postpartum depression.

There are several different theories about what causes postpartum depression. These include biological causes (McCoy, 2011) such as endocrine changes (Bloch, Daly and Rubinow, 2003; Meltzer-Brody, 2011) and obstetric factors such as pregnancy-induced hypertension (Dennis, Janssen and Singer, 2004) and traumatic birth (Coates et al, 2014). Previous miscarriage is also a predictor of perinatal depression following the birth of a healthy infant (Blackmore, Côté-Arsenault, Tang, Glover, Evans, Golding and O'Connor, 2011).

In terms of social causes, poor social support and a poor marital relationship have been identified as strong predictors of postpartum depression (Dennis et al, 2004; Beck, 2006), with lower socio-economic status having a smaller but still significant effect on risk (O'Hara and Swain, 1996; Beck, 2006). McIntosh (1993) explored women's own views on the cause of their depressive symptoms, which included a sense of lost freedom, financial constraints and housing. Lack of social support has been identified as a particular risk factor for refugee and immigrant women living in their host country (Collins, Zimmerman and Howard, 2011) especially where immigration is recent (Dennis et al, 2004). Issues of isolation may also be more pertinent for refugee and immigrant women (Tobin, Napoli and Beck, 2017; Husain et al, 2012). In their research with low-income ethnic minority women in the United States, Abrams and colleagues (2009) have suggested that financial hardship may have a bigger impact on the risk of postpartum depression than ethnicity.

It is important to note that there are discrepancies within research findings related to social risk factors, for instance, Josefsson and Berg (2002) found no association between socio-demographic data and postpartum depression in their study of potential independent risk factors. Some research has suggested an association between primiparity and recurrent major depression (Di Florio et al, 2014), whilst other research claims that the evidence for the effect of parity on depressive symptoms is mixed (Forman, Videbech, Hedegaard, Salvig and Secher, 2000; Staehelin, Kurth, Schindler, Schmid and Zemp-Stutz, 2013; both cited in Coates et al, 2014). The literature recognises the need for further research in order to better understand the experience of women from “diverse, ethnic and socioeconomic backgrounds” (Beck, 2006, p44).

In terms of psychological factors, research suggests that women with a history of depression, independent of childbirth, are at greatest risk of developing postpartum depression (Beck, 1996; Dennis et al, 2004). Other psychological risk factors include depression and anxiety during the antenatal period and postpartum blues (O'Hara, 2009; Mallikarjun and Oyebo, 2005; Beck, 2006).

Taking a deeper look at the individual psychological processes which may underpin perinatal mental health, Beck (2006) refers to postpartum depression as the “dying of the self” where “a woman feels as though her “normal self” disappears” (p44). Staneva, Morawska, Bogossian and Wittkowski (2015) explored the role of maternal sense of coherence and mothering orientations (Raphael-Leff, 1986) in pregnancy-specific distress. These constructs were selected to reflect the psychological transition of a woman's “self-in-relation” to themselves and to others” (Staneva et al, 2015, p2) during the perinatal period. Their research highlighted how low social coherence, which describes an individual's “adaptive capacities to change and stress” (Staneva et al, 2015, p4), showed a significant association with pregnancy-specific distress. This aligns with research that identifies a strong association between stress experienced in pregnancy and symptoms of postpartum depression (Lanes, Kuk and Tamim, 2011). In addition, a regulator mothering orientation, where the baby's needs are expected to fit in with those of the mother (as opposed to a facilitator orientation where a mother adjusts her needs in line with those of her baby) was identified as a factor in Staneva et al's research (2015) for consideration in influencing pregnancy-specific distress even though its' correlation with distress was not statistically significant in the researchers' final model.

The roles of distancing and avoidance have also been identified as influencing the development of symptoms of postpartum depression (Coates et al, 2014; Razurel, Kaier,

Sellenet and Epiney, 2013). Sockol, Epperson and Barber (2014) found that maternal attitudes, which they defined as “beliefs about others’ judgement, beliefs about maternal responsibility and maternal role idealisation” (p199) predicted symptoms of postpartum depression and anxiety in first-time mothers. Maternal beliefs such as holding unrealistic expectations about motherhood have also been identified as a factor in difficult adjustment “irrespective of parity” (Staneva and Wittkowski, 2013, p265). In a study about factors influencing postpartum depression in a population of Chinese women, attachment styles were also found to correlate with depressive symptoms (Chi, Zhang, Wu and Wang, 2016). Overall, there appear to be several potential psychological factors which may increase a woman’s risk of developing postpartum emotional difficulties. Beck (2002) constructed the Postpartum Depression Predictors Inventory-Revised ([PDPI-R] in Beck, 2002) based on risk factors to be used by healthcare providers to help identify women vulnerable to depression, but as yet, there appears to be no consensus about a clear psychological model.

1.1.2 Diagnosis and treatment.

NICE guidelines (2007) state that indicators of postpartum depression can be detected by a healthcare professional, such as a Health Visitor, Midwife or GP, the latter being the coordinator of a woman’s postpartum care in the UK. At the first point of contact following birth, NICE guidelines advocate that Health Visitors use the Whooley questions to ask women whether they have been “bothered by feeling down, depressed or hopeless” or “having little interest or pleasure in doing things” (NICE, 2007). If answers to these two questions raise concern, the Health Visitor is expected to use the Edinburgh Postnatal Depression Scale ([EPDS]; Cox, Holden and Sagovsky, 1987) for further assessment of indicators (NICE, 2014). This is a commonly used tool to identify women with symptoms of postpartum depression and is identified within NICE guidelines as a tool for monitoring symptoms alongside the Patient Health Questionnaire (PHQ-9) and Generalised Anxiety Disorder (GAD-7) questionnaires. It also incorporates questions which can be used to screen for probable anxiety as well as depression (Matthey, 2008). The EPDS is a self-report scale, scored by a health professional (or researcher) and was not designed as a formal diagnostic instrument of postpartum depression (Mallikurjan et al, 2005).

In the UK, there are a number of typical treatment options for postpartum depression (Boath and Henshaw, 2001). NICE (2007; 2014) advocates the use of guided self-help, Interpersonal Psychotherapy (IPT), Cognitive Behaviour Therapy (CBT) and/or anti-depressants to treat women with symptoms of postpartum depression. Recently,

Gilbert and Cree have designed a Compassionate Mind Approach for postpartum depression available free online to mothers using online magazine, Netmums (Gilbert and Cree, <http://www.netmums.com/parenting-support/depression-and-anxiety/the-compassionate-mind-approach>). Kelman et al (2016) are in the process of undertaking a randomised controlled trial about the effectiveness of such approaches. Following their systematic review of the clinical and cost-effectiveness of preventative interventions for postpartum depression, Morrell et al (2016) advocate randomised controlled trials in order to determine more certainty about the suitability of interventions.

1.1.3 An alternative view of postpartum depression.

Despite recognition in the DSM-v and the NICE guidelines, the definition of postpartum depression is complex. The Confidential Enquiry into Maternal and Child Health (Lewis and Drife, 2004 as cited in the British Psychological Society's (BPS) report on Antenatal and Postnatal Mental Health, 2007 p.58) cautions against using the term postpartum depression, claiming it has been overused and led to misunderstandings. Furthering this view, Mallikarjun and Oyeboode (2005) critique the term 'postnatal depression' for being a "useful lay term" (p221) but less useful in a medical sense, due to the variety of diagnoses associated with it, such as anxiety and obsessional or post-traumatic disorders.

An alternative view of the symptoms of postpartum depression suggests that they are a normal response to the transition to childbirth rather than an illness. Research by Hall and Wittkowski (2006, p.321) showed that "negative cognitions usually associated with postpartum depression are also experienced by mothers who are not considered depressed", which might explain why many women do not present for treatment as they perceive their symptoms to be a normal part of the motherhood experience. Nicholson (1989) found little similarity in the way the 24 women in her study defined postpartum depression and none of the participants labelled their symptoms as postpartum depression. Whitton, Warner and Appleby (1996) studied the attitudes of 78 women whose EPDS scores indicated depression. They found that although 90 per cent of the women in their study sensed something was not right with their mental health, only a third described their symptoms as postpartum depression, a finding reinforced by several other studies (Holopainen, 2002; Shakespeare, Blake and Garcia, 2006; Dennis and Chung-Lee, 2006; McCarthy and McMahan, 2008). Furthermore, Oates et al (2004, as cited in Edwards and Timmons, 2005), who undertook research in maternal settings across 11 countries, found that whilst

recognising a period of disequilibrium typically following childbirth, not all cultures or languages had a name for postpartum depression or believed the experience required clinical intervention. Even within the UK, there are differences apparent in how diverse cultural groups experience postpartum depression. For instance, Gardner, Bunton, Edge and Wittkowski (2014) highlighted the importance of services being sensitive to culturally appropriate language within the West African community in the UK in order to increase identification of women with symptoms. Within the Chinese community, issues such as the way cultural norms influence emotional distress have been identified (Lam and Wittkowski, 2012). This emphasises the significance of a view that postpartum depression is, at least in part, socially constructed and that “it is through the daily interactions between people in the course of social life that our versions of knowledge become fabricated” (Burr, 2003, p4).

The spectrum of difference in how women experience difficulties in the postpartum period emphasises the need for a pluralistic understanding of the experience of postpartum emotional difficulties which may include a spectrum of postpartum depression, anxiety, PTSD, OCD and adjustment difficulties. It suggests that women form an idiosyncratic understanding of their difficulties rather than subscribe purely to a medical ‘truth’ that they are ‘ill’. How an individual “makes narrative sense of the classification [...] is an oft-forgotten variable in the separation of scientific discourse from narrative understanding” (Douglas, 2010, p.29). The philosophy of Counselling Psychology recognises this tension between the social constructionist and medical views and, rather than strive for resolution, seeks to understand how these pluralistic perspectives interact and influence the individual experience (Orlin, 2012). The epistemological positioning of this review explores the possibility that women’s subjective understanding of postpartum mental health is influenced by the cultural context, rather than merely the positivist medical view of depressive symptoms in the postpartum period. To reflect the evidence that not all women label their symptoms of postpartum depression in the same way and that women experience a broad range of emotional difficulties including but not limited to depressive symptoms, phrases such as ‘postpartum emotional difficulties’ and ‘emotional distress’ will be used in addition to the dominant medical term used in the literature, ‘postpartum depression’.

1.1.4 Consequences of not treating postpartum depression.

The consequences of not treating symptoms of postpartum depression are potentially serious. Putting the extreme cases of suicide and infanticide outlined in the media aside (e.g. Figes, 2012), the potential effects of postpartum depression include difficulties in maternal attachment which can lead to developmental difficulties for the child (Gerhardt, 2004; Flykt et al, 2010) as well as long-term episodes of depression for the mother (Goodman, 2004; Goodman, 2009; Wilkinson and Mulcahy, 2010). As a result of these potentially serious and enduring consequences, it is vital that the decision not to seek help is understood more fully, so that more women, who want it, receive the support to cope with emotional difficulties during the transition to motherhood. Furthermore, the financial imperative for action is clear, with perinatal mental health problems estimated to cost the NHS £1.2 billion per year for each “cohort of births” (Bauer, Parsonage, Knapp, Lemmi and Adelaja, 2014, p3).

1.2 The Structure of the Literature Review

At the start of the following literature review, the help-seeking behaviours of women in the postpartum period will be explored with a particular focus on the barriers that have been identified. The review will then examine the literature about stigma in seeking help for general mental health concerns. Finally, the chapter will critically evaluate the extent to which the link between stigma and help-seeking has been previously understood for women with postpartum emotional difficulties. Through a discussion of the limitations of existing research, a clear rationale for the current research study will be presented.

CHAPTER TWO

LITERATURE REVIEW

2.1 Seeking Help for Symptoms of Postpartum Depression

Several research studies have set out to understand the help-seeking behaviours of women with postpartum depression (McIntosh, 1993; Currie and Devlin, 2002; Holopainen, 2002; Dennis and Chung-Lee, 2006; Goodman, 2009; Abrams, Dornig and Curran, 2009; Chew-Graham, Sharp, Chamberlain, Folkes and Turner, 2009; Bilstza, Eriksen, Buist and Milgrom, 2010). Goodman (2009) conducted a quantitative study with 509 American women about the “preferences and attitudes about treatment for depression and perceived potential barriers to accessing treatment” (p.60) in the perinatal period. Data were collected using a self-administered questionnaire which included preferences about treatment options and sources of support, as well as completion of the EPDS, to ascertain level of depressive symptoms. Participants were invited to rank the top three perceived barriers to seeking professional help. A mix of practical, social and psychological barriers emerged.

2.1.1. Practical barriers.

Time was listed as the most frequent barrier (64.7 per cent) to help-seeking. Time as a barrier to seeking help was not reflected upon within Goodman's discussion, other than to suggest that locations for services should be convenient for women. Equally, time does not emerge as a significant factor in other literature on barriers to seeking treatment for symptoms of postpartum depression (McIntosh, 1993; Holopainen, 2003; Bilstza et al, 2010). Where practical barriers are mentioned, they focus on factors such as location of the service for ease of access (McCarthy and McMahon, 2008) and knowledge of where to seek help (Dennis and Chung-Lee, 2006). A possible explanation for why time featured in Goodman's research but not others might be because 57 per cent of the participating women in the study were in full-time employment, making it understandable that time emerged as a factor influencing barriers to help-seeking. Knowledge of how healthcare systems work in a host country and language barriers have been cited as particular practical barriers for immigrant women (Templeton, Velleman, Persaud and Milner, 2003).

2.1.2 Social and psychological barriers.

As described earlier, not all women with clinically indicated symptoms describe their experience as postpartum depression. There may be a number of explanations for this. It may be attributed to a lack of education about what postpartum depression is (McCarthy and McMahon, 2008) in addition to the broad spectrum of postpartum experiences described in section 1.1, such as maternal adjustment. Other women consider their experience to be a normal part of motherhood or not severe enough to merit treatment (4Children charity, 2011). The medical model of postpartum depression appears to be a barrier in itself, where women fear that asking for help will result in a prescription of antidepressants (Holopainen, 2002; Chew-Graham et al, 2009). Some women worry that seeking professional help will label them as mentally ill (Dennis and Chung-Lee, 2006; Chew-Graham et al, 2009) and lead to their baby being taken away, a fear also described in other studies (McCarthy and McMahon, 2008; Bilstza et al, 2010). In the previously cited study by Goodman (2009), 43 per cent of the participating women experienced stigma of help-seeking as a barrier to treatment.

2.2 Stigma and Help-seeking

2.2.1 Definition, types and causes of stigma.

In his seminal work, "Stigma: Notes on the Management of Spoiled Identity" (1990), Goffman described stigma in terms of how people use categorisation to help anticipate the behaviour of others. This can lead to the condemnation of a person or group based on a characteristic seen to deviate from social norms. He describes three different types of stigma, one of which focuses on "blemishes of character" (p.14), which might include some form of weakness or a mental disorder. He uses the term "normal deviant" (p.157) to describe people whose apparent difference is slight, where the "shamed person is ashamed to be ashamed" (p.155). Shame is considered to be a component of stigma that "does not relate to specific attitudes but encompasses general feelings of embarrassment and wishing to hide oneself" (Tucker et al, 2013, p529). Lewis (1998) comments on how shame and stigma share the process of attributing failure to the self. He describes the distinction between shame and stigma by highlighting stigma's reliance on a "social appearance factor" (Lewis, 1998, p128). In a paper exploring the relationship between mothering, guilt and shame, Sutherland (2010) defined guilt as a "negative self-evaluation that (...) stems from some specific act or behaviour", whereas shame is a "negative evaluation of (...) the entirety of the self" (p311).

More current writing on stigma attempts to classify different aspects of stigma. Corrigan (2004) further defines the distinction between the external and internal 'shaming' of a person using the terms public and self-stigma. Public stigma is about the prejudices and assumptions held about people with a particular set of symptoms. This form of stigma might lead to discriminating against someone with a diagnosed mental health condition. Self-stigma is the internalisation of externally held beliefs about a condition, such as postpartum depression, and can result in reduced perceptions of self-esteem and self-efficacy. Corrigan identifies four "social-cognitive processes" associated with stigma: "cues, stereotypes, prejudice and discrimination" (Corrigan, 2004, p.615). Corrigan et al (2010, p259) identify "strategies of shame", such as withdrawal, as an approach to coping with self-stigma. Clement et al (2014, p.1) offer further classifications of stigma, including anticipated and experienced stigma, stigma endorsement (how a person subscribes to stigmatising ideas) and treatment stigma (beliefs about help-seeking and being treated).

Self-stigma is typically associated with shame at being a failure (Corrigan, 2004). Recent writing on shaming locates it as an interpersonal phenomenon, grounded in relations with self and others (DeYoung, 2015). Wider psychological literature suggests that shame forms as a result of thinking that one is perceived by others as unacceptable or inferior. This potentially blurs the boundary of the psychological condition of being depressed with the social evaluation of what it means to be depressed (Beck, Rush, Shaw and Emery, 1979). There is evidence to suggest that people experiencing shame or self-stigma resulting from mental illness or their family's perception of their mental illness are significantly less likely to seek treatment (Sirey et al, as cited 2001 in Corrigan 2004; Vogel, Wade and Haake, 2006).

2.2.2 Stigma and help-seeking in mental health literature.

There is an abundance of UK literature on stigma of mental health, which emerged from the SAPPHIRE Project at Kings College London and the Institute of Psychiatry (SAPPHIRE Project, 2008-2013). This project researched stigma and discrimination in mental health. In relation to help-seeking, Clement et al (2014) undertook a systematic review of 144 quantitative and qualitative studies undertaken between 1980 and 2011 which had attempted to explore the relationship between help-seeking for mental health difficulties and the stigma of mental ill health. Within the quantitative studies, they standardized the number of barriers to help-seeking to ten and found that stigma was the fourth highest barrier. Quantitative studies have identified wanting to handle difficulties

oneself as one of the strongest barriers to seeking treatment (Mojtabai, 2011 in Clement et al, 2014). However, without knowing the reason for the desire to be self-sufficient, one cannot rule out that this may also be stigma-related. Clement et al's analysis suggested that specific stigma related barriers in mixed gender studies were "shame/embarrassment and negative social judgement" (p7). In research that just looked at women's attitudes, disclosure and concerns about confidentiality were found to be the most common stigma-related barrier to seeking help. Overall, the synthesis of the data suggested that the more self-stigma an individual experienced, the less likely they were to seek help, a finding also corroborated in other literature reviews (Vogel et al, 2006).

When synthesising the 51 *qualitative* studies, Clement et al (2014, p10) were able to develop a conceptual model to illustrate the relationship between stigma and help-seeking. This started with 'structural stigma' such as negative media stories and laws or policies that stigmatise people with mental ill health. This influenced individuals, creating distance between the ideal self and the extent to which one sees oneself conforming to social stereotypes of mental illness. This played a role in the extent to which an individual anticipated or experienced stigma, which in turn influenced their decision about whether or not to disclose their mental health concerns, which ultimately governed help-seeking behaviour. The study also identified a number of behaviours that facilitated rather than hindered help-seeking behaviour, such as selective disclosure, focusing on somatic aspects of the difficulty and ignoring stigma concerns. These results are enlightening and helpful due to the systematic approach the authors have taken. However, the findings are based on the analysis of a wide range of mental health difficulties, not just on the postpartum period, so it is not clear whether this conceptual model would explain the experience of women experiencing postpartum emotional difficulties.

Evans-Lacko, Brohan, Mojtabai and Thornicroft (2012) examined two European datasets to explore the association between public stigma and self-stigma. They found that individuals living in countries with less stigmatising attitudes had lower rates of self-stigma. This is perhaps an 'obvious' result, but the interest of the findings is in the detail. When exploring public stigma, it was found that the more comfortable people in a country felt about talking to someone with a mental illness, the less self-stigma individuals in that country tended to experience. The paper concludes by suggesting that effective anti-stigma campaigns should seek to encourage social inclusion and "dispel myths or stigmatizing attitudes about people with mental health problems" (Evans-Lacko et al, 2012, p.1748). They argue that anti-stigma campaigns must use targeted messages aimed at specific

populations which are “sensitive to the needs of the community context” (p.1749). Ultimately, the authors suggest that reducing public stigma will contribute to a reduction in the experience of self-stigma.

2.3 Stigma of Seeking Help for Symptoms of Postpartum Depression

To date, although several studies researching help-seeking behaviours of women with symptoms of postpartum depression have identified stigma as a reason for not disclosing or seeking help (McIntosh, 1993; Currie and Devlin, 2002; McCarthy and McMahan, 2008; Goodman, 2009; Bilstza et al, 2010), there appear to be no studies which explore the specific relationship between the two in detail. Seven perinatal studies were included in the sample of 144 research papers reviewed by Clement et al (2014). All of these were undertaken outside the UK (Abrams et al, 2009; Ahmed et al, 2008; Bilstza et al, 2010; Flynn et al, 2010; Goodman, 2009; Jesse et al, 2008; McCarthy and McMahan, 2008). Although they were included in Clement's meta-synthesis, none of the studies had the association between stigma and help-seeking as an explicit or primary research question. Instead, stigma was identified as an outcome of their own research questions. As such, it is not clear whether the factors driving stigma are a result of public or self-stigma or a combination of both. Nonetheless, although not overt, the concepts of public and self-stigma can be detected in the literature of seeking help for emotional difficulties in the postpartum period.

2.3.1 Women's experience of public stigma of postpartum depression.

McIntosh (1993) wrote up the results of a nested study of the help-seeking behaviour of 60 women with postpartum depression conducted within a wider study of the experiences of first-time mothers. Over the course of six interviews spanning from seven months pregnant to nine months postpartum, the women were asked whether they had felt depressed since the last session. In all, 63 per cent of the sample were classified as depressed (n=38). Only 47 per cent of these women (n=18) asked for help with their symptoms. The most likely source of support was their GP (21 per cent), followed by partners, friends and Health Visitors (13 per cent). Those that did seek help from friends and family experienced a mix of responses ranging from supportive warmth to being told to stop “making a fuss” or a lack of understanding and incapacity to help. This study demonstrates how fears that disclosing symptoms will be met with unhelpful remarks from others might be justified, reinforcing fears and stigma.

McIntosh's study (1993) is useful because it highlights some of the reasons for women's reluctance to seek help from professionals in their own words, namely that they will be labelled as mentally ill, shamed for being inadequate or even that their child might be taken away, as well as examples of experienced stigma from family and friends. Since this was a nested study and stigma was not the target for investigation, it did not explain how stigma and depth of depression influenced the women's decisions to seek help. The study did not explore the differences between depressed women who did seek help for their symptoms and those who did not seek help. Equally, it did not explain why only some women perceived stigma in seeking help. Overall, this study provides some promising leads, but is limited by the depth of analysis. In its defence, the link between stigma and help-seeking for postpartum depression was not the main focus of the research.

Edwards and Timmons (2005) explored the role that stigma plays in postpartum depression (but not specifically help-seeking). Participants were six women who had been discharged from in-patient treatment for severe postpartum depression up to 19 months earlier. Participants described how they anticipated and feared stigmatisation by other people. All had experienced at least one negative response from others but reported predominantly supportive comments from people once they felt able to disclose. While they felt stigma towards themselves, they also endorsed this stigma, by reporting initial feelings of stigma towards other women in their hospital. This later subsided as they began to accept the similarities between them. They also reported mixed feelings about the diagnosis and label of depression. Some found it comforting to have a name by which to understand their difficulties. Others were concerned about the legacy that this label would have on things such as life assurance applications, a reality which might understandably contribute to the construction of a structural barrier to help-seeking.

Edwards and Timmons (2005) identified limiting factors within their study, including the fact that women were interviewed retrospectively about their experiences and suggested further research to explore women's experiences at "different stages of the illness process" (p.478). Their study is important because, at the time of writing, it is the only study that attempts to explore the specific role that stigma plays in postpartum depression. It explores the experiences of a small minority whose symptoms were so severe that they needed in-patient care. It is not clear how these experiences might compare with those of the majority of women with symptoms of postpartum depression who do not require hospitalisation. It also alludes to the dual nature of stigma – stigma that women direct towards themselves about being a bad mother and the stigma of being

labelled as depressed by others. However, as with other studies, despite looking at the presence of stigma in relation to postpartum depression, it does not deconstruct the concept of stigma to the level of detail undertaken by Clement et al (2014) to consider how the stigma has formed.

As described earlier, the women in - Edwards and Timmons' research (2005) endorsed stigma by applying it to other women in their ward. In a study of how postpartum pram walking groups can improve well-being of mothers, Currie and Develin (2002) found that women would not want to attend such a group if it was marketed as something that could help people with postpartum depression. The implicit message is that they did not want to be labelled as experiencing postpartum depression. This suggests that women may communicate messages to each other that needing to seek help for postpartum depression is shameful or embarrassing, but it is not clear how such messages have formed.

A number of research papers have alluded to the negative influence of the media on women's experience of postpartum depression (Currie and Develin, 2002; Bilstza, 2010), but the extent to which this contributes to the construction of the stigma of help-seeking remains unclear. Women (n=15) in a study by McCarthy and McMahan in New Zealand (2008) admitted to knowing very little about postpartum depression and that what little they knew came from the media leading to a desire to distance themselves from being categorised with the same term as someone in a media story about infanticide. This suggests how influential the media might be in shaping women's ideas about postpartum depression. In contrast, the media can also offer support to women experiencing postpartum difficulties, with research suggesting that the use of online media such as social support groups and social networking sites can help women to feel connected to others, increasing their well-being (Evans, Donelle and Hume-Loveland, 2012; McDaniel, Coyne and Homes, 2012).

Cultural beliefs may influence help-seeking behaviours (Dennis and Chung-Lee, 2006) through the expectations of behaviour that are perceived as the norm. For instance, Abrams et al (2009) suggested that the need to be perceived as strong and resilient inhibited help-seeking amongst African American women. They also noted that talking about difficulties outside of the family was associated with shame within some cultural groups, such as Latina women. Gardner, Bunton, Edge and Wittkowski (2014) have also identified how cultural sensitivities about disclosing depression may inhibit help-seeking within West African women residing in the UK.

2.3.2 Healthcare professionals' perceptions of stigma of postpartum depression.

To form a deeper understanding of a phenomenon, it is critical to take a pluralistic view (McAteer, 2010). It is therefore important to consider whether others perceive a stigma attached to seeking help for symptoms of postpartum depression as well as women themselves. Research suggests that health professionals may inadvertently stigmatise childbearing women with depression (Gawley, 2011; Chew-Graham, Chamberlain, Folkes and Turner, 2008; Chew-Graham, Chamberlain, Folkes, Caulfield and Sharp, 2009). For instance, some healthcare professionals report acting in ways that can deliberately help or hinder the process of disclosure of symptoms of postpartum depression (Chew-Graham et al, 2009). Furthermore, healthcare students have been found to demonstrate stigma towards women with antenatal depression (Gawley, 2011).

Chew-Graham et al (2008) looked at GP and Health Visitor attitudes about postpartum depression. Some GPs interviewed felt the need to normalise the experience for women, believing that the symptoms would pass and deliberately choosing not to use a medical model. Others reported choosing not to facilitate a woman's disclosure of symptoms, because of the "lack of resources to which they could refer the women" (p.172).

Some Health Visitors reported feeling they could not offer much to women with postpartum depression and therefore saw identifying them as potentially depressed as having little benefit. They also had the view that a referral to GPs would result in a prescription for antidepressants, which concurs with women's fears that they will be prescribed medication but which seems to contrast with the GP view of seeking to normalise experiences rather than prescribe (Chew-Graham et al, 2008). The study found some evidence of GPs and Health Visitors having a negative view of each other's role. Counselling Psychologists, taking a systemic view of postpartum depression might speculate about the impact that healthcare professionals operating with these assumptions, of each other and about women, might have on the way women consider disclosing difficulties and seeking help. They might also ask what function, if any, this might serve in the experience of stigma and its association with help-seeking.

2.3.3 Women's experience of self-stigma.

As well as evidence of public stigma associated with postpartum depression, the literature contains examples of self-stigma associated with postpartum emotional

difficulties. It appears women feel they should be able to cope by themselves. Some of the women in the McIntosh study (1993) reported being “too embarrassed and ashamed to approach family and friends with what they regarded as a sign of personal inadequacy and an admission of failure on their part” (McIntosh, 1993, p.181).

2.3.3.1 Stereotypes.

The women interviewed in McCarthy and McMahon's study (2008) described how they compared themselves to what they saw as the social norm of new mothers who “always look sensational and have it all together” (p.625). As a result, they found themselves failing and isolated themselves from others, a typical response to shame (Gilbert and Irons, 2005). This had the consequence of cutting off an opportunity to normalise their experiences with those of other mothers. The women in the study reported reaching crisis point, such as suicidal thoughts, before actually seeking help.

Bilstza and his colleagues (2010) undertook a qualitative phenomenological study conducting focus groups with Australian women who had sought treatment for postpartum depression, looking at barriers and facilitators for accessing care. They identified eight recurrent themes in their analysis, which included expectations of motherhood, not coping and fear of failure, stigma and denial, help-seeking and treatment experiences and relationship with healthcare professionals. They highlighted the discrepancy between the realities of motherhood and the expectations prior to birth that mothering would be natural and joyful. As with the women in McCarthy and McMahon's study (2008), many of the women in Bilstza's research reported feeling the need to conform to idealised media portrayals of motherhood and show they were coping in order to avoid being “seen as a failure” (p.48) and feeling ashamed when they could not live up to these expectations. This led to the women concealing their experiences from those around them.

2.3.3.2 Diagnosis and labelling.

Being diagnosed with postpartum depression by a professional had various effects on the women. It reduced stigma “regarding an inability to cope as mothers” (McCarthy and McMahon, 2008, p.627) in some women, because it normalised their experiences of motherhood. This finding is helpful, because it highlights that if people can get over their initial reluctance to seek treatment, they might be able to formulate more realistic constructions of motherhood. However, other women found the label ‘postpartum depression’ stigmatising, which underlines the importance of considering idiosyncratic

experiences in determining approaches to discussing treatment. Indeed, several studies have highlighted women's belief that disclosing symptoms would result in being labelled as mentally ill and unfit to be a parent (McIntosh, 1993; Bilszta et al, 2010; McCarthy and McMahan, 2008). The women in Bilszta et al's research (2010) also described feeling fearful of being labelled as a bad mother or as depressed, with the former carrying more stigma than the latter. This is important, because it highlights that perhaps it is not so much postpartum depression that carries the stigma but the perception of not coping or the anticipated stigma of being labelled as a 'bad mother'.

In their qualitative study exploring women's perceptions of the acceptability of treatments for postpartum depression, McCarthy and McMahan (2008) identified fear of being perceived as a "bad mother" and "unable to cope" (p.618) as the main barrier to seeking help, which might be described as 'anticipated stigma' (Clement et al, 2014). The results highlighted that many women are reluctant to seek help despite having the opportunity to do so at "frequent contacts with primary care givers" (McCarthy and McMahan, 2008, p.619). While this study is important for the way it reinforces the idea of stigma as a barrier to help-seeking, all of the 15 women in the study had sought or accepted help for their symptoms. As the authors note, this means that the study cannot explain the experiences of women who choose not to seek or accept treatment.

The outcomes of these studies illustrate elements of Clement et al's (2014) study of stigma and general health. Firstly, it highlights the relevance of mismatched expectations (of being an ideal mother vs the reality) and secondly, it highlights the behaviour of negative self-labelling (e.g. bad mother).

2.3.3.3 Anticipated stigma.

In Goodman's research (2009) stigma was assessed by answers to "being embarrassed to talk about personal matters with others", "being afraid of what others might think" and "family members might not approve" (p.63), all statements signifying what Clement et al (2014) refer to as 'anticipated stigma'. As a result of the questionnaire-based method of data-collection, Goodman's research was unable to explore in depth what these fantasies about others were and how they were formed. Only 22 per cent of the participants "reported significant levels of depressive symptoms (EPDS > 10)" (p.65). The study did not explore whether those with significant symptoms of postpartum depression held different attitudes about treatment barriers than those who did not have depressive symptoms. Using logistic regression analyses, the study found that women with higher

scores on the EPDS were less likely to perceive individual therapy and pharmacological interventions as acceptable. This suggests that there may be a difference in the way that depressed mothers perceive help. However, the authors did not explore this further by looking at the relationship between depressive symptoms and potential barriers to accessing care, including stigma.

2.4 Assessing Stigma and Help-Seeking

The National Institute for Health Research recently funded the Sapphire Research Programme about Stigma and Discrimination in Mental Health at the Institute of Psychiatry and Kings College London (SAPPHIRE Project, 2008-2013). As part of this, a number of scales were devised to investigate stigma including barriers to accessing care (Barriers to Access to Care Evaluation scale (BACE), Clement, Brohan, Henderson, Hatch and Thornicroft, 2012). This builds on other stigma related scales such as the Self-Stigma of Seeking Help Scale (SSOSH, Vogel et al, 2006). Vogel et al (2006) successfully demonstrated how answers to the SSOSH differentiated people who later referred themselves for psychological help. This is an exciting finding, because it suggests a link between stigma and help-seeking. Clearly, stigma is a potentially valuable variable in predicting which women will and importantly those who do not present for treatment and deserves further investigation. However, Vogel et al (2006) state, “the research in this area is just beginning” (p.335).

2.5 Why More Needs to Be Done

Counselling Psychology places great importance on individuals being “experts” on how their own difficulties might best be resolved (Orlin, 2012). If women are choosing not to seek help, it is important that this is an empowered choice based on knowledge, rather than a disempowered one driven by public and self-stigma. Recommendations to overcome barriers to help-seeking in the literature on postpartum depression include training professionals and educating women more about the symptoms of postpartum depression (Whitton et al, 1996; Goodman, 2009; Dennis and Chung-Lee, 2006; Bilszta et al, 2010; Holopainen, 2002) as well as undertaking community/media campaigns to overcome stigma (Currie and Develin, 2002; Bilstza et al, 2010). Bilstza et al (2010, p.51) advocate a media campaign to overcome the “myths of motherhood”.

As part of the Sapphire project investigating how stigma can be overcome, Thornicroft, Brohan, Kassam and Lewis-Holmes (2008) undertook a literature review on

overcoming the stigma of mental health and signposted the importance of individual contact as possibly the most effective intervention for doing so, followed by social marketing aimed at the general population. What seems evident is that whilst the experience of stigma of postpartum depression is documented in the literature, a conceptual understanding of the way it forms and informs help-seeking in this context is under-researched. In the absence of such information, the basis for individual contact, social marketing and media interventions will be based on assumptions of what messages will be helpful, rather than informed by a theoretical understanding of the way stigmas influence the help-seeking process that women with postpartum emotional difficulties experience. Without a better understanding of the process which is preventing women from seeking treatment, significant numbers of women will continue to miss out on receiving the help that would help them and their children's development.

2.5.1 Limitations of existing research.

The Sapphire Research Programme has ascertained evidence that demonstrates an association between stigma and help-seeking (Clement et al, 2014). Clement's meta-synthesis of the 144 papers that fulfilled criteria for establishing a link between stigma and help-seeking included seven studies focused on postpartum issues (Goodman, 2009; Abrams et al, 2009; Ahmed et al, 2008; Bilstza et al, 2010; Flynn et al, 2010; Jesse et al, 2008; McCarthy and McMahan, 2008). Reading these papers, it is possible to discern how they have contributed to Clement's process model of stigma and help-seeking. However, there are several opportunities to build on this work.

Clement et al (2014) have helpfully constructed a conceptual model of stigma's association with help-seeking for mental health concerns in general. The authors conclude that further research is required to understand better the specific experience of groups "particularly likely to be deterred from help-seeking by stigma" (Clement et al, 2014, p.15). The statistic that over half of women with postpartum depression do not seek help (4Children, 2011) illuminates the imperative to better understand the association between stigma and help-seeking for this specific population. Furthermore, none of the seven postpartum papers included by Clement et al in their meta-synthesis were undertaken within the UK and therefore these findings are not necessarily generalisable to a British population.

In the papers examined in this review of literature, it is apparent that although several included a discussion of stigma and its association with help-seeking in their

discussions, none of them had made this the specific target of investigation. Their aims have included understanding acceptance and experience of treatment (McCarthy and McMahon, 2008; Goodman, 2009), help-seeking and perceptions of what causes symptoms (McIntosh, 1993) and the experience of stigma of being hospitalised with postpartum depression (Edwards and Timmons, 2005). At the time of writing, there is no research which specifically focuses on stigma's association with help-seeking for postpartum emotional difficulties as a target for investigation.

Most of the research undertaken to date has focused on the retrospective reflections of women who have received treatment. Although it may have included descriptions of the elements of stigma which made it difficult to seek and accept treatment, none of the research specifically focuses on how the experience of those who do seek help differs from the experience of those who do not seek help. The need to understand the experience of those who are not treated has been highlighted as an area for further research (McCarthy and McMahon, 2008).

The only reference to stigma in the most recent NICE guidelines on postpartum mental health is that healthcare professionals should be aware that women may be reluctant to disclose due to fears of stigma (NICE, CG192, 2014), with no practical guidance on how to address this. Several researchers (e.g. Clement et al, 2014; Vogel et al, 2006) also emphasise the importance of shaping services and campaigns that minimise stigma, yet to do this, the factors which contribute to a particular stigmatised group need to be understood. Recommendations for reducing stigma highlight the need for community and media campaigns, but the literature suggests that the media may be part of the problem (McCarthy and McMahon, 2008). Therefore, the messages that women are currently paying attention to and how they influence decisions about help-seeking need to be understood. Equally, by focusing attention on the media, it is possible that other sources of public and self-stigma may be unintentionally overlooked.

2.6 Current Research Aims

To address these limitations, the current research proposes to build a theoretical understanding of the factors and processes related to stigma that may play a role in a woman's decision to seek help for emotional difficulties in the postpartum period. The specific research questions are:

- How do women understand stigma in the context of postpartum emotional difficulties?

- What role does stigma play in decisions to seek help for postpartum emotional difficulties?

The aim of the proposed research is to enhance our theoretical understanding of whether and how stigma influences a woman's postpartum help-seeking behaviour. The specific objectives are to:

- Understand how women experience stigma related to postpartum emotional difficulties
- Understand how this stigma, where it exists, is constructed in terms of self and public stigma
- Understand how women experience help-seeking to relieve symptoms of postpartum emotional difficulties
- Understand how women see the relationship between stigma and help-seeking for postpartum emotional difficulties

In exploring these questions, the research will investigate the concepts of public stigma and self-stigma, thus providing greater granularity of what is meant by 'stigma' in relation to help-seeking for this population of women living in the UK.

2.7 Counselling Psychology's Contribution

There is a limited profile of Counselling Psychology in the literature on stigma and help-seeking. Of the articles reviewed in this literature review, only two appeared in Counselling Psychology journals (Vogel et al, 2006; Nicholson, 1989). This is a missed opportunity, because Counselling Psychologists are well-placed to research this topic. Firstly, it respects that each individual woman will have her own idiosyncratic experience of the postpartum period, yet firmly places her experience within the cultural context in which she lives. Secondly, it can negotiate the tensions between the medical view of postpartum depression articulated within the NICE guidelines and a view that postpartum depression is (at least in part) socially constructed by women. This is helpful, because currently NICE treatment takes a medical view. Indeed, much of the literature resides in medically based nursing journals. Yet if women do not present for treatment, the guidelines lose their practical value. Thirdly, Counselling Psychologists seek "to improve

the psychological functioning and well-being” of individuals including those who “life has challenged and who are struggling to adapt to these changes” (BPS, http://dcop.bps.org.uk/dcop/home/about/about_home.cfm) and therefore can legitimately focus on a population who might not require clinical intervention but whose symptoms may still have a significantly negative impact on their well-being and that of their child. The literature indicates that the phenomenon of seeking help for postpartum distress is multi-faceted. Counselling Psychology's discipline of taking a pluralistic view of the psychosocial aspects of a phenomenon is therefore highly appropriate for the proposed research.

2.8 Summary

The thematic approach of this review has highlighted that despite many studies referring to stigma as a reported treatment barrier, little is known about the detail of the relationship between stigma and help-seeking in women with symptoms of postpartum emotional difficulties, including depression. The benefit of this research is that it will generate recommendations, grounded in theory, for how stigma can be overcome in order to encourage more women to seek help with their symptoms.

CHAPTER THREE

METHODOLOGY

3.1 Epistemological and Ontological Position

The research questions of this thesis were explored using a qualitative methodology, because this enabled exploration and understanding of the lived experience of women in the postpartum period. A qualitative approach was selected for the way it embraces the researcher's relationship with the topic, which a quantitative approach is less able to consider. The epistemological position embodies the "subjective interrelationship" between the researcher, participant, subject matter and analytical process (Mills, Bonner and Francis, 2006, p. 26). This is consistent with a Counselling Psychology view favouring pluralistic perspectives (McAteer, 2010) in parallel with emphasising idiosyncratic experiences. The ontological stance reflects the relativist belief of the researcher that there are many different interpretations of an event, and therefore, there is no single positivist 'truth' awaiting discovery (Strauss and Corbin, 1994). In the case of this research, it means that the experience of seeking help for postpartum emotional difficulties has been considered within the wider context of societal and cultural considerations.

3.2 Selection of Method

To date, both quantitative and qualitative methods have been used to look at help-seeking for postpartum depression. Quantitative studies have focused on questionnaire based exploratory studies to assess the scale of difficulties and categorise the type of help-seeking used (e.g. Goodman, 2009; 4Children, 2011). Qualitative studies have used a variety of methods to describe the experience of individuals with or treating those with symptoms of postpartum depression, including Interpretative Phenomenological Analysis (Hall, 2006; Bilstza et al, 2010), Thematic Analysis (Chew-Graham et al. 2009; Moore, Ayers and Drey, 2016), Modified Analytic Induction (McCarthy and McMahan, 2008) and Grounded Theory (Beck, 1993; Abrams and Curran, 2009; Patel, Wittkowski, Fox and Wieck, 2013).

Three methods have been considered for researching how women experience stigma in relation to seeking help for postpartum depression: Interpretative Phenomenological Analysis, Discourse Analysis and Grounded Theory. Statistics

demonstrate that some women with postpartum emotional distress seek help and others do not. This highlights that despite sharing some characteristics (e.g. emotional distress), mothers are not a homogenous group in their help-seeking behaviours. To only consider the perspective of either the group that does seek help or the group that does not seek help would limit our understanding of help-seeking. This factor ruled out Interpretative Phenomenological Analysis as a method, due to its reliance on the homogeneity of the sample (Willig, 2008). Discourse analysis would provide an interesting perspective on how women experience the tension between the medical and social-constructionist perspectives on postpartum distress and what resources they use to inform the actions (such as help-seeking) they feel able to take (Willig, 2008). One of the criticisms of discursive approaches is that they fail to recognise the individual voice (Butt and Langdridge, 2003 as cited in Langdridge and Hagger-Johnson, 2009) and, given that the literature highlights the idiosyncratic nature of women's decision making, a discursive approach which overlooked this fact seemed unhelpful.

Grounded theory has its roots in sociology and was first developed by Glaser and Strauss (1967) as an inductive approach for systematically understanding social processes in order to build theory. It was conceived as an alternative to the deductive hypothesis-driven approach of other qualitative methods (Charmaz, 2006). There are several benefits to using Grounded theory as a method for understanding how women experience stigma in relation to seeking help for postpartum emotional difficulties. Grounded theory embraces a heterogeneous approach to sampling, which would suit the desire in this research to understand the difference in the way women experience and respond to stigma and help-seeking. Due to the dynamic nature of data collection and analysis, it proactively works to minimise the possible bias of the researcher in at least two ways. As no hypotheses are identified prior to initial data collection, *apriori* assumptions on what may be found are limited. Secondly, purposive sampling and negative case analysis deliberately seek cases that do not fit with emerging themes in order to make conclusions as general and robust as possible and ensure assumptions are rigorously challenged. Retrospective reflections on the appropriateness of grounded theory for this research are reviewed in the limitations section in 5.6.

3.2.1 Selecting the specific Grounded Theory approach.

There is a spectrum of approaches to grounded theory which includes three key approaches: traditional (Glaser, 1978), evolved (Strauss and Corbin, 1998) and

constructivist (Charmaz, 2006). Traditional Grounded Theory was immediately ruled out, as it requires data to be collected before a literature review is undertaken, which therefore discounts it as an approach for this doctoral thesis. Evolved grounded theory was considered, but discounted, because of the emphasis on axial coding. In theory, axial coding helps to explore “relationships between categories and their properties and dimensions” (Mills, Bonner and Francis, 2006, p.30). In practice, this approach has been criticized for the way it constrains the construction of theory (Charmaz, 2000 in Mills, Bonner and Francis, 2006). In particular, Charmaz (2006, p.181) argues that imposing codes might have “explanatory value” but that doing so would distance the theory from the real experience of the participants providing the data.

Charmaz's social constructionist approach to grounded theory (2006) has therefore been adopted for this research. In addition to the way this approach can accommodate a literature review in advance of data collection and a less stringent approach to coding, Charmaz's method aligns itself well with the reflective and reflexive principles of Counselling Psychology's core philosophy (Milton, 2010) and approach to research (Kasket and Gil-Rodriguez, 2011). Another debate within grounded theory is about whether the focus on investigation is on the impact of social process or on the individual experience (Willig, 2008). Willig (2008) asserts that to consider both allows a deeper understanding of the psychosocial dynamics and this is consistent with the literature's identification of public and self-stigma (Corrigan, 2004). The different experiences of postpartum emotional difficulties explored in the literature emphasise just how many ‘realities’ there are. This aligns itself well with the ontological position of a social constructionist approach that there is no objective reality. In taking a constructionist approach, Charmaz explicitly considers the placement of the data within the current explicit and implicit cultural norms and power hierarchies. Again, this approach is consistent with a Counselling Psychology desire to take a systemic view of experience (Manafi, 2010). For these reasons, I decided that constructionist grounded theory was appropriate for this research.

3.3 Theoretical Sample

Participants were adult women (over 18 years old) who gave birth within the last twelve months. The NICE guidelines define the postnatal period as up to one year after childbirth (NICE, 2014). This is a period of time used in the sampling strategy of other qualitative studies of postnatal emotional difficulties (Coates et al, 2014; Abrams et al,

2009). Furthermore, one of the limitations outlined within Edwards and Timmons' study (2005) highlighted how much of the stigmatizing experience recounted by women was retrospective and that further studies should explore attitudes at different stages of illness. Sampling women within the first year therefore aimed to privilege the views of women who were immersed within the immediate postpartum experience.

As depressive symptoms can take up to four weeks from delivery to emerge and to ensure that women who were experiencing significant symptoms of depression would have had an opportunity to disclose their symptoms to a GP or Health Visitor, at least ten weeks needed to have elapsed since birth before women could participate. Women attend a routine mother and baby check up with a GP that takes place between six and eight weeks postpartum (Public Health England, 2016/17). A decision was taken to focus on first-time mothers and exclude multiparous women who would be more likely "to compare how they feel with a previous experience of childbirth" (Whitton et al, 1996, p427), which may have confused current 'here and now' experience of stigma (the focus of this research) with previous, retrospective recollections. For ease of communication and transcription, participants needed to be able to converse fluently in English.

Given that many women with symptoms of postpartum depression do not recognize their symptoms (Whitton, Warner and Appleby, 1996) or come forward for treatment (4Children, 2011), targeting these women directly was expected to be difficult. A recognised recruitment strategy for targeting hard-to-reach populations, snowballing (Atkinson and Flint, 2001), was employed. Women attending local mother and baby groups were also targeted and organisations supporting women with postnatal emotional difficulties were approached. On-line forums were considered as potential recruitment pools, but were excluded due to concerns that, despite guidance not to, women might post personal information related to the study which the researcher would be unable to control. The pursuit of NHS Ethics Approval was considered, in order to be allowed to approach GPs and Health Visitors, but rejected as a result of general advice to avoid this lengthy process by the researcher's university.

The literature emphasises how women with depressive symptoms attach different meanings to their symptoms, with some thinking they are normal and not needing help, others who believe they need help and seek it, and others who do not seek help and remain distressed. Therefore, because the phenomenon being investigated was how women experience stigma in relation to seeking help for postpartum emotional distress, it was perceived as necessary to understand a broad sample of women's postpartum experiences.

Charmaz (2006, p100) explains how in grounded theory, you establish sampling criteria for people, cases, situations, and/or settings before you enter the field". The intended purposive participant sample therefore aimed to include a range of women with a broad spectrum of experiences of help-seeking and emotional difficulties, rather than a homogenous experience. The study aimed to include the experiences of:

- A woman with symptoms of postnatal depression (EPDS>10, <20) who had sought help for her symptoms
- A woman with symptoms of postnatal depression (EPDS>10, <20) who had not sought help for her symptoms and who reported stigma as one of the reasons for not doing so
- A woman with symptoms of postnatal depression (EPDS>10, <20) who believed her symptoms were normal and therefore did not seek help
- A woman with no symptoms of postnatal emotional distress (EPDS<10)

In hindsight, targeting the sample in this way may have been problematic. This is explored within the research limitations in section 5.6.

3.3.1 Specific exclusion criteria.

As new mothers are a potentially vulnerable population, a number of exclusion criteria were put in place to minimise the risk of extremely vulnerable women entering the study. Women who had received treatment for a mental health problem other than postnatal depression prior to the delivery of their baby were excluded⁵. Women who disclosed that they thought of harming themselves sometimes or often on the Edinburgh Postnatal Depression Scale were also excluded from the study⁶.

3.3.2 Actual sample.

The initial data collection interviewed four women and was supplemented by a further three interviews as part of the constant comparative procedure within Grounded

⁵ Given that women with a prior history of depression are at greatest risk of developing postpartum depression (Beck, 1996), early supervision requested the researcher to exclude women with a history of depression from the sample as there was a fear that they would be too vulnerable. The limitations of this approach are outlined in the discussion.

⁶ Please see 3.5 Ethical Considerations for more detail

Theory. Two of these were new interviewees and the third was one of the original participants interviewed as part of data validation. In total six women were interviewed.

3.4 Recruitment Materials and Procedure

To identify a suitable pool of potential participants, a poster (see Appendix A) was emailed to women known to the researcher to initiate the snowballing technique. In addition, paper copies of the poster were given to mothers attending local mother-and-baby groups and email copies were sent to organisations supporting women with postpartum emotional difficulties. Women who expressed an interest in participating in the research were provided with an information sheet detailing the study as well as a consent form (see Appendix B). If consent was given, they were asked to complete a screening pack on Survey Monkey to identify candidates who fulfilled the criteria of the preferred theoretical sample and collect demographic information about respondents. The rationale for using a poster, a recognised recruitment technique (Krusche, von Rohr, Muse, Duggan, Crane and Williams, 2014; Abrams et al, 2009), was to advertise the study and the purpose of the screening pack was to help identify a broad spectrum of experiences as described in 3.3 and build a heterogeneous sample.

The pack consisted of four sections (see Appendix C):

- *Consent form* – Reiterating aims and objectives of the study and confirming the participant's desire to take part.
- *Measure of depressive symptoms* - The Edinburgh Postnatal Depression Scale (EPDS, Cox et al.1987)⁷. This was used to provide contextual information about the level of depressive symptoms indicated by each participant. It was selected above other measurement tools used to assess perinatal distress, such as the Postpartum Depression Screening Scale (Beck and Gable, 2000) and Center for Epidemiologic Studies of Depression instrument (CES-D; Beeghly et al, 2002, cited in Sit and Wisner, 2009) because EPDS, which has been extensively validated (Sit and Wisner, 2009), is the recognised tool for assessing mental health in the perinatal period reflected within the NICE guidelines (NICE, 2007, 2014). Other qualitative studies have used the EPDS to “verify” depressive symptoms (Gardner, Bunton, Edge and Wittkowski, 2014, p757). The EPDS

⁷ The EPDS is available for use without further permission provided that copyright is respected by quoting the names of the authors, the title and the source of the paper.

contains questions related to both depression and anxiety (Matthey, 2013). It was also selected due to the inclusion of a question about self-harm ideation. Within this research, answers to this question were used to identify women perceived as too vulnerable to participate in the study, based on how often the thought of harming themselves had occurred to them in the past two weeks. Cox et al (1987; 1993) indicate that a score of 13 or more on the EPDS is indicative of major depression that needs further clinical assessment and that a threshold score of 10 is appropriate for routine use by healthcare professionals in the community to identify possible cases. For the purposes of this thesis a score of 10 was used as an indicator of potential depressive symptoms and a score of 20 or more considered as too severe to be included within the study. No clinical assessments were undertaken of participants so no formal diagnoses of postpartum depression were made. A critique of the inclusion/exclusion scores of this thesis are outlined within the limitations in section 5.6.

- *Measure of beliefs about seeking help* - Self-Stigma of Seeking Help (SSOSH, Vogel et al, 2006) and Barriers to Access to Care Evaluation (BACE-3, Clement et al, 2012) to provide contextual information about the women's depressive symptoms and their experience of self and public stigma in relation to help-seeking⁹. As a result, no cut-off scores were used.
- *Other participant information* - The screening pack also collected personal contact details so the researcher could follow up with participants and invite them to an interview. GP details were collected as a precaution, in the unlikely event that the researcher should need to contact them at any point in the process. Demographic details were requested to contextualise the sample. Mothers were also asked to indicate whether they had sought help for any symptoms of postpartum emotional difficulties. A question about previous treatment for mental health conditions was also included to identify women who needed to be excluded in line with the study's exclusion criteria.

Women who met the sampling criteria were invited to attend a face-to-face interview with the researcher. An initial interview schedule was prepared for this purpose

⁹ The wording of the SSOSH scale, designed for a US audience, has been altered slightly to reflect that women in the UK might speak to either a GP or Health Visitor before accessing psychological help, rather than going straight to a therapist. The proposed alternative wording was approved by the scale's author, David Vogel. Sarah Clement, author of the BACE-3, agreed to the use of this scale.

(Appendix D). Interviews lasted up to 60 minutes in a location convenient to participants, normally their own home, to assist with ease of childcare and privacy. Interviews were digitally recorded and transcribed verbatim (though anonymised where appropriate), subject to participant consent. The interview schedule consisted of key questions to initiate the discussion with a series of optional follow-up prompts. The interview was semi-structured, starting with a general question about the experience of motherhood in order to build rapport before focusing on questions designed to elicit understanding of how women experience the role of stigma in relation to seeking help for postpartum emotional difficulties. The key questions were based on the issues surfaced within the literature review and designed to stimulate discussion about stigma (public and self-stigma) and their potential relationship with help-seeking for emotional difficulties. This schedule was piloted with a course peer, who was also a mother, and language was adjusted according to feedback in order to make the questionnaires more appropriate for a lay-audience. Consistent with the principles of grounded theory, the interview schedule evolved. After the first four interviews (see Appendix D) the interview schedule was amended to follow up on emergent themes and to seek negative case examples.

All women who completed the interview and/or questionnaire phase were provided with a debrief letter (see Appendix E). This thanked them for their participation and provided them with a comprehensive list of organisations that provide support to women with symptoms of postpartum depression.

3.5 Ethical Considerations

The subject of postpartum depression is a potentially sensitive topic. According to the BPS Code of Human Research Ethics (BPS, 2010), the research involved risk because the content of the discussion could have led participants to become upset and label themselves (e.g. 'I'm a poor mother' or 'I'm useless because I can't cope').

The following steps were designed to mitigate the risk of vulnerable women entering the study or upsetting women who participated in the study:

1. *Inclusion of women who were > 10 weeks postpartum* – this was to ensure that the pool of potential participants had already had the opportunity to be referred for professional support for postpartum depression. All postpartum women are seen by Health Professionals several times in the weeks immediately following delivery. Women are asked about their emotional well-being and cases of concern

are then referred to their GP. In addition, all women are required to attend a six to eight week mother and baby check with their GP. Therefore, by 10 weeks postpartum, vulnerable women should have been identified and be receiving appropriate professional support, although given the previously cited research about women who choose not to disclose difficulty, the current research could not guarantee this. Indeed, the research hoped to understand the experiences of vulnerable women who chose not to disclose.

2. *Criteria to exclude vulnerable participants* – participants scoring 20 or more on the Edinburgh Postnatal Depression Scale, a valid measure indicating symptoms of postpartum depression (Cox et al, 1987) and/or any participant responding that they thought of harming themselves ‘sometimes’ or ‘yes, quite often’ were excluded. Any potential participant who indicated having received professional support for a mental health condition other than postpartum depression was excluded for being too vulnerable¹¹. In the event it was required, participants who indicated they ‘sometimes’ or ‘yes, quite often’ thought about self-harm on Question 10 of the EPDS would be followed up by telephone and subsequently by email/letter (see Appendix E). The researcher would provide them with information about appropriate support services, such as the Samaritans and the NHS Crisis Line which were also detailed in the debrief letter that all questionnaire participants received. These participants would be advised to contact their GP to ensure they were referred for appropriate support. Participants scoring 20 or more on the EPDS, and who were therefore excluded from the study, were also to be contacted in this way.
3. *Participant information sheet* – all participants were provided with a detailed participant information sheet describing the content of the research so that they could choose whether or not to participate. It was made clear that there was a possibility that they might find the content of the research emotive and that they were free to withdraw participation if this was of concern to them.
4. *Informed consent* – at the start of the interview, the researcher provided participants with another consent form to read and sign. This included information about the potentially emotive content of the interview and reinforced that they could choose to pause or terminate the interview at any point. Had a

¹¹ This was required by the researcher's first supervisor.

participant terminated the interview, consent would have been considered to have been removed and participants would have been informed that data would be destroyed and therefore not used within the research process. The form made it clear that if the researcher became concerned about the participant's well-being that she might wish to notify their GP so that they could be referred for appropriate professional care. GP details were collected as part of the questionnaire phase so that the researcher had them available in the unlikely event that they were needed.

5. *Clinical judgement in managing the interview process* – the researcher reinforced verbally to participants that they were free to pause or end the interview at any time. The researcher used her counselling skills to observe the participant for signs of distress throughout the interview. In the unlikely event that this occurred, the researcher planned to use her clinical judgement to intervene with grounding techniques, where necessary, to help the participant return to a stable mood before leaving the interview.
6. *Content and tone of interview questions* – the main focus of the interview questions was on the experience or perceptions of stigma in relation to seeking help for postpartum emotional difficulties. Whilst it came up in participants' narratives, the degree to which they were coping with motherhood and a detailed description of their emotional difficulties was not the principle focus of the interview. Whilst the researcher was using counselling skills to build rapport with her participants, the interview was designed as research rather than a therapeutic encounter.
7. *Provision of sources of support* – at the end of the questionnaire and interview phases, written information was provided to participants detailing organisations providing support for women with postpartum emotional difficulties. The information recommended that participants should speak to their GP if they were having emotional difficulties.
8. *Participant follow-up* – a follow-up phone call was made to all participants to thank them for their time and to offer to talk through the additional sources of support available if necessary.
9. *Distress protocol* – a distress protocol was designed to assess and manage suicidal risk (see Appendix F).

A potential risk of the researcher being moved by the material provided by participants was identified. However, given the researcher's clinical experience of managing client material without compromising her professional credibility, this was not considered to be a serious risk. Ideally, interviews would have been conducted in a neutral location. Unfortunately, due to financial constraints, interviews were undertaken in either the participant's or researcher's home. To ensure safe practice when interviewing in a participant's home, the researcher gave the address to a partner and arranged to call them within 15 minutes of the expected end of the interview. Upon safe completion of the interview, the partner destroyed details of the address. When interviews were undertaken in the researcher's own home, another household member was always present in a different part of the house. A copy of the Certificate of Ethics Approval obtained from London Metropolitan University's Research Ethics Review Panel appears in Appendix M.

3.6 Method of Analysis

A number of grounded theory techniques were used in the data analysis. The interviews were transcribed. As an example, extracts from two interviews appear in Appendix H.

3.6.1 Coding.

Initial coding was used to begin immersion in the data. As recommended by Glaser (1978, as cited in Charmaz, 2006), the researcher attempted to experience the data without making assumptions about what would be revealed. To achieve this, transcripts were coded line-by-line. Initial codes were constructed following the recommendations by Charmaz (2006), to be short and concise, close to the data and produced rapidly to avoid applying too much interpretation on the data. As part of this process, data were compared and contrasted to identify similarities and differences, known as the constant comparative technique (Glaser and Strauss, 1967). Where possible, *in vivo* codes were used to identify terms or metaphors used by participants to embody a particular meaning. Appendix I presents an extract of a coded transcript.

Focused coding was used once an initial formulation of the data was established. This technique was used to identify the significant categories that best explained the meaning communicated within the data. Focused codes were labelled with direct quotes from participants, where feasible, to ensure codes were 'grounded' in the data. To do this, transcripts were colour-coded by participant and then each code was cut out and sorted into

plastic wallets according to the focused codes (see Appendix J for an illustration). Once focused codes or categories were identified, these were also subjected to the constant comparative method in order to identify a deeper understanding of the data. Categories that best accounted for the meaning within the data were classified as theoretical concepts. These were considered in relation to existing theory and alternative narratives about how experience can be understood in terms of “specific conditions (...), conceptual relationships (...) and forecast consequences” (Charmaz, 2006, p.148). Where possible, codes were described as actions to help with subsequent theory formation (Charmaz, 2006). Coding tables for the identified theoretical concepts appear in Appendix K.

3.6.2 Theoretical sampling.

After the initial data had been analysed, areas requiring further information were identified, such as clarifying points of uncertainty, exploring links between categories, testing assumptions and deliberately seeking negative case examples to test emerging ideas (Charmaz, 2006; Willig, 2008). A copy of the evolved interview schedule appears in Appendix D. Further interviews were identified to follow up these areas to add “depth and density” to the theory (Willig, 2008, p.36). In theory, this iterative sampling should have continued until saturation was reached, where no new variations surfaced. Given the time and word count constraints of this doctoral research, this was not possible and therefore, the theory developed is presented as tentative (Strauss and Corbin, 1998).

To further enhance data collection, three additional interviews were scheduled (two for theoretical sampling and one for data validation). There were two ideal follow up participant profiles. Firstly, a woman who had symptoms of emotional difficulties, but who believed her symptoms were normal and therefore did not seek help was sought, because this profile had not been filled in the first round. Secondly, finding a woman with *no* experience of postpartum emotional difficulties was prioritised in order to balance the validation of emerging themes undertaken by Dana, who *had* experienced emotional difficulties. This was important in order to check for potential researcher bias within the interpretation of the data.

Finding women to participate in the study was challenging (and this is described in detail in the Discussion Chapter). Therefore, only two further women (Eleanor and Fiona) were identified, both of whom, at screening, appeared to have no emotional difficulties. A decision was taken to interview both, in case one of them was able to lend an alternative

perspective to the previous participants. Subsequently, when interviewed, Eleanor described a number of scenarios where she experienced extreme anxiety and described feeling 'miserable all the time', even though her EPDS fell below the threshold for potential postpartum emotional difficulties. She attributed her difficulties to somatic symptoms (e.g., tiredness) and therefore did not perceive herself to have emotional difficulties requiring treatment. Retrospectively, it might therefore be possible to allocate her to the outstanding participant profile. The final two women interviewed, Fiona and Eleanor, had slightly different experiences to the first four participants and the nuances of the themes were adjusted accordingly, in line with the constant comparative philosophy of grounded theory.

3.6.3 Memo writing.

Memos were used throughout the data collection and analysis to develop ideas about the patterns emerging from the data. Initially, memos were used to understand individual codes and categories in more detail and the way they interacted with each other. Thereafter, 'advanced memos' (Charmaz, 2006) were used to interrogate the emerging categories in terms of implicit and explicit beliefs, assumptions and contexts. Memos included a record of the researcher's reflexive response to the data. A sample memo can be found in Appendix L.

3.6.4 Construction of theory.

For the purposes of this research, theory was defined as building an "understanding rather than explanation" of the data (Charmaz, 2006, p.126) in order to emphasise that the analysis was a co-construction between the researcher and the data provided by the participant. Identified categories were integrated with memos to develop a theoretical understanding of the data. A diagram was used to demonstrate the inter-relationship between theoretical concepts.

3.6.5 Validation of data.

One participant (Dana) was approached to validate the data. The rationale for inviting Dana to expand on the themes was because she had experienced depressive symptoms and had been able to offer articulate answers in response to the questions about stigma and help-seeking during the first interview. Although, as a researcher, I attempted to bracket my personal experiences and how these impacted the research process, it is

possible that I was attracted to the passion that Dana communicated in the tone of her answers and interest in my topic and that this, at some level, influenced my choice of her as a validator. The theoretical sampling, described in 3.7.2 will hopefully have helped to balance any unintended bias towards Dana's world view. As a further method of validation, the researcher's supervisor was invited to read a transcript to validate the coding tables. Upon doing this, she concurred with the appropriateness of the themes identified.

CHAPTER FOUR

ANALYSIS

4.1 Summary of Participants

In response to the recruitment poster, 15 women completed the screening questionnaire. One woman, whose Edinburgh Postnatal Depression Scale (EPDS) score indicated symptoms of postpartum depression dropped out when it came to arranging an interview. Most of the initial responders did not score above 10 on the EPDS and as the intended focus was on interviewing both women who presented with emotional difficulties and those who did not, the majority of these women were not interviewed. The sampling approach is critiqued within the research limitations in section 5.6. In total, six women were interviewed as part of the research. A second interview was conducted with one of these women as part of data validation, bringing the total number of interviews to seven. Three of the women were recruited through mother and baby groups and three were recruited using the snowballing technique.

4.1.1 Participant characteristics.

All participants were White British first-time mothers aged between 36 and 40 years old. They were all married and lived in households where the annual income was more than £32,000. The women were educated to degree-level and were all currently on maternity leave. Five of the six women were intending to return to their professional careers where they had previously worked full-time. Chloe¹³ and Dana scored 11 and 10 on the EPDS respectively, whilst the other respondents scored 5 or less. Although not indicated by their EPDS scores, all mothers, with the exception of Belinda, disclosed to me that they had experienced emotional difficulties at some point since giving birth. Only Dana had sought professional help from her GP and had received a course of Cognitive Behaviour, but had not been given a formal diagnosis of depression. Ava had received support from her Health Visitor to build her social support network. None of the women interviewed had been prescribed anti-depressants. A Table providing more detail on the participant characteristics is provided in Appendix G.

¹³ All names are pseudonyms.

4.2 Summary of Theoretical Codes

The analysis highlighted five theoretical codes, as summarised in Table 1.

TABLE 1

Summary of Theoretical Codes

<p>Theoretical Concept 1: <i>Experiencing a difference between expectations and reality (and how this influences perception of self-concept)</i></p> <p>Illustrates how the participants constructed their ideas of motherhood and of 'self-as-mother' based on myriad sources of information, including cultural representations of motherhood and how they then compared these expectations with the reality they faced postpartum.</p>	
Focused codes	Initial codes
Anticipating the role of motherhood	What expected of motherhood
	What expected of them self
Constructing meaning from the gap between expectations and reality	Recognising the magnitude of change
	Making sense of the reality
<p>Theoretical Concept 2: <i>Re-evaluating a sense of self</i></p> <p>Explores the meaning that the participants made from the comparison between expectations and reality and how this sense-making sometimes led to difficulties being attributed to the self, resulting in self-stigma.</p>	
Focused codes	Initial codes
Pre-natal self as capable	Problem-solver
	In control
	A social being
Internalising postpartum self-stigmatising view of self	Guilt and shame
	Self-labelling
	Motherhood as an innate skill
Reinforcing loss of self through design of perinatal care	Focus on care of baby

Theoretical Concept 3: <i>Seeking and trusting the help available</i>	
Describes how participants evaluated the sources of help available to them (professional and non-professional) for all postpartum needs and constructed ideas about who they could turn to for emotional support.	
Focused codes	Initial codes
Availability of information	Freely available information
	Disregarding information
Constructing views about healthcare professionals capacity to provide help	Using own personal experiences (+/-)
	Influence of "others" experiences (+/-)
	Quality and consistency of advice
Making decisions about <i>who</i> to seek healthcare information from	Using non-NHS professionals (e.g. friends, family, non-NHS professionals)
	Timing of routine help not available when needed
Willingness to disclose difficulties	Anticipating stigma from Professionals
	Anticipating stigma from friends
Theoretical Concept 4: <i>"Saying it how it is"</i>	
Highlights a perceived absence and avoidance of 'open and honest' conversations about the difficult elements of mothering at a public, inter- and intra-personal level and how this appeared to perpetuate the stigmatisation of postpartum emotional difficulties.	
Focused codes	Initial codes
Dominant media portrayal of postpartum depression perceived as binary	Binary portrayal of motherhood
	Stories hold power
Withholding disclosure of 'real' experience to others	Desire to avoid a judgement
	Desire to protect others

	Labelling self or others
Endorsing a stigma of postpartum emotional difficulties	Avoiding asking others who appear to be experiencing difficulty
<p>Theoretical Concept 5: <i>Experiencing pressure to breastfeed as a stigma which inhibits desire to seek help</i></p> <p>Articulates how the women noticed intense pressure from healthcare professionals to breastfeed, and how decisions not to breastfeed or to give up were sometimes perceived as stigmatising and experienced as shaming. Pressure was perceived even when this was having a negative impact on the mother's emotional well-being, which influenced willingness to seek help from professionals for emotional concerns.</p>	
Focused codes	Initial codes
Perceiving judgement about not breastfeeding	From antenatal and hospital staff
	Influence from Health Visitors and GPs.
Experiencing emotional distress as a result of not breastfeeding.	Embarrassment in public about bottle feeding.
	Causal relationship between difficulties with breastfeeding and emotional difficulties .
Withholding disclosure of emotional difficulties as a result of (lack of support with) breastfeeding experience.	Assumptions made about how professionals would respond to emotional difficulties, based on experience of perceived stigma about not breastfeeding.

A model describing the relationship between the themes in the context of stigma and help-seeking for postpartum emotional difficulties follows. Thereafter, each theoretical concept will be described in detail and illustrated with verbatim extracts from participant interviews. Coding tables appear in Appendix K.

4.3 A Grounded Theory Model of Stigma and Help-Seeking for Postpartum Emotional Difficulties

A model to illustrate the inter-relationship of the emergent themes has been constructed (see Figure 1). This model is deliberately designed with the theoretical concepts displayed as concentric circles to emphasise the systemic rather than linear nature of how women prepare for, evaluate options and take decisions about help-seeking. This means that women might be engaging in all the processes concurrently rather than consecutively and may be constantly revisiting and evolving their stance as they absorb further information. The data have suggested that women tend to engage in these processes whether or not they have emotional experiences or seek help. The arrows on the diagram, which connect each of the circles with the others, represent the inter-relationships between themes.

4.3.1 The inter-relationship of the identified themes.

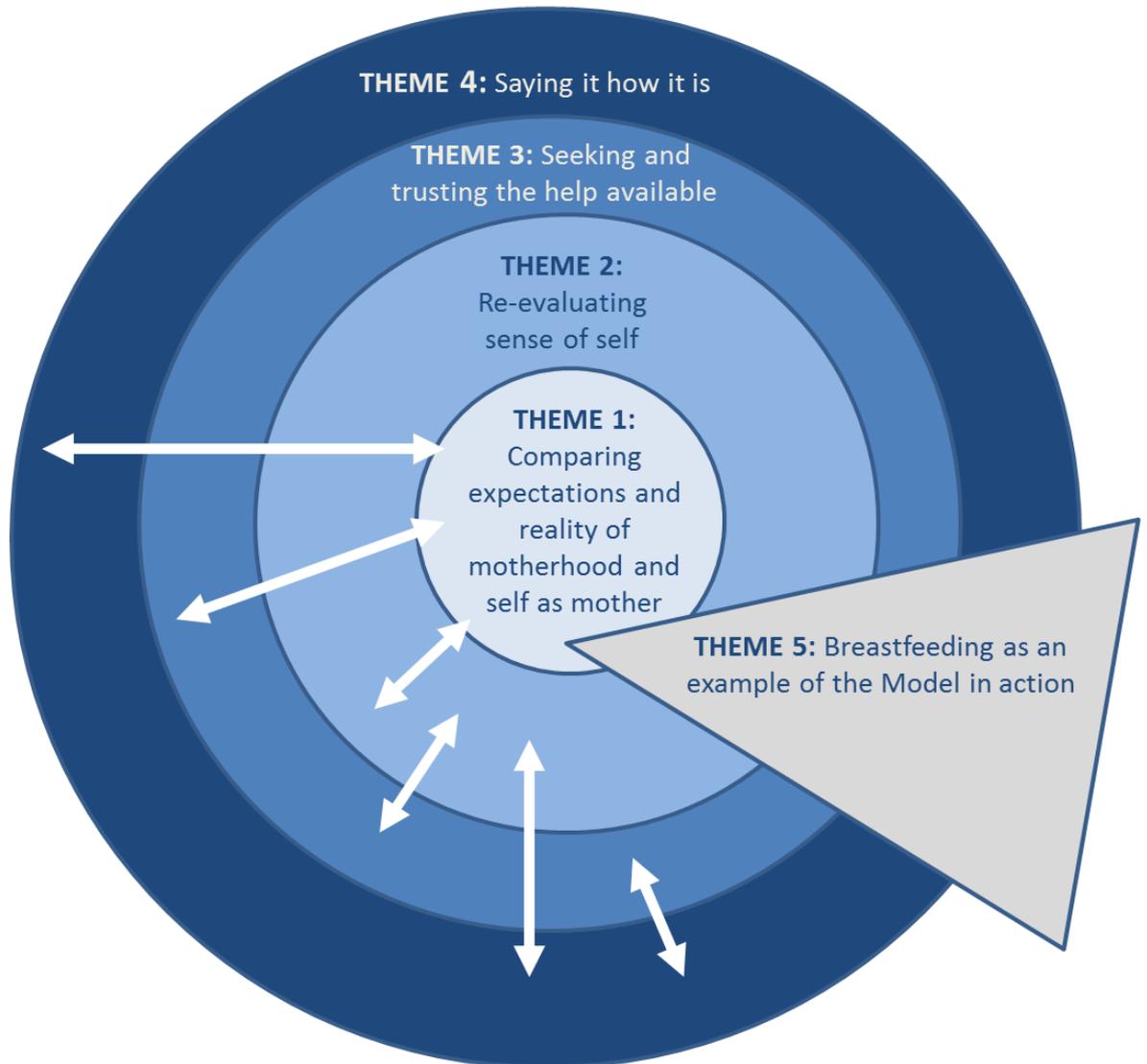
At the heart of the model, is Theme 1, “comparing expectations and reality of motherhood and self as mother”. It highlights how women look for myriad sources of information to help construct ideas about what motherhood will be like in the antenatal period. This might include sources personally known to the woman, for instance friends and family, as well as more remote sources like culturally dominant vehicles such as television programmes, baby manuals, newspapers and paper and on-line magazines. Forming ideas about how they would be as a mother was also something that women tended to engage with in the antenatal period. Women based their constructions on the skills and strengths that they had used in their life so far and believed that these would continue to work well for them in their new role as mothers.

There was a general perception that public portrayals of motherhood were dominated by the extremes of motherhood experiences, such as glamorous celebrity mothers or tragic cases of postpartum depression or postpartum psychosis. Notable by their absence were messages about the routine, everyday aspects of mothering, with hypotheses that these were not interesting or newsworthy enough to be reported. One consequence of

this absence was that women were susceptible to forming unrealistic constructions of what motherhood would be like.

In the postpartum period, mothers tended to compare their actual experience with expectations they had constructed in the antenatal period. Although all mothers commented on the scale of change, only those reporting emotional difficulties focused on the size of the gap between expectations and reality, potentially signifying a desire to attribute difficulties to external causes. There were differences in how women with and without emotional difficulties explained the difficult aspects of their experience, leading to Theme 2, "re-evaluating a sense of self". In reference to Beck's cognitive triad (Beck, Rush, Shaw and Emery, 1979), those with emotional difficulties seemed to make sense of the meaning by thinking "the world is unpredictable", "others have lied to me" and "I cannot cope". However those without difficulties saw 'the world as expected', others as unreliable (for instance advertisers, having an invested interest in portraying a certain image of motherhood) and as a consequence, saw themselves in a compassionate light performing as well as they could in a challenging and new role. The positive stories of motherhood set a benchmark of what motherhood would be like and not all women were able to be discerning about how reliable these messages were. The comparisons between their constructions of motherhood and of themselves as mother led the women with emotional difficulties to assume that other women cope and they concluded that they were incapable as mothers, which led to self-stigmatising ideas of themselves as failing and their identity as an efficacious individual was spoiled. The self-stigma appeared to focus on not coping as a mother, rather than on having a mental health issue. In contrast, women with no emotional difficulties emerged from the sense-making with their self-concept intact, as they tended to see themselves as coping as well as could be expected when faced with a new role. It is important to note that the change to self-concept and self-stigma is also likely to be influenced by other factors unexplained by the model, such as the individual's childhood schemata and factors relevant to shame (DeYoung, 2015).

Figure 1: A grounded theory model of stigma and help seeking for postpartum emotional difficulties: Demonstrating the systemic inter-relationships between the identified themes



Note: Theme 5 is included as it provides an example of the model being applied to understand the specific situation of how expectations of breastfeeding can lead to the re-evaluation of self-concept which in turn can influence the degree to which women feel able to “say it how it is”. This is also influenced by experiences of help which may diminish levels of trust.

The structural stigma created by media (Clement et al, 2014) of not “Saying it how it is”, represented by Theme 4, seems to impact women's beliefs about what they can and cannot talk about their mothering experience, as if public examples set the tone for permissible conversations about motherhood. This appeared to be true for both women who experienced emotional difficulties and those who did not. For example, one cannot complain about mild challenges of mothering, when they are not as bad as people who really struggle. Equally, one cannot talk about the really positive joys of motherhood, in case it makes someone who is struggling feel bad. So there seems to be a constant process of impression management, evaluating what one can and cannot say for fear of being judged.

Women appear to collude in reinforcing stigma by evading normalising conversations about the trials and tribulations of motherhood with their peers. This includes avoiding conversations with women perceived as not coping in order to prevent potential embarrassment. This implies that women make assumptions that women who struggle will feel embarrassed, and in doing so there is an implicit endorsement of the stigma of not coping.

Theme 3, “seeking and trusting the help available” focuses on how people construct ideas about what sources of help are available to them. Whilst the focus of this research was on help in respect of emotional difficulties, the data have suggested that women seem to consider help previously received for medical factors when deciding whether to seek help for emotional difficulties. Women evaluated their own experiences of help and considered aspects such as the quality and timeliness of advice as well as the nature of relationship they had with the options of help. Given the general lack of continuity of care provided, forming a trusting relationship with the professionals was seen as constrained.

Importantly, in addition to their personal experiences, women seemed to be strongly influenced by the experiences of others either known to them or appearing in the media. Some women commented on the power of these stories, for instance, tales of Health Visitors taking babies away, noticing the fear that they lodged within them, even though they recognised that these stories were extreme. This process of evaluating the provision of help from healthcare professionals was adopted by both women with emotional difficulties and by those without.

There is also an indication that the design of services may reinforce negative evaluations of self-concept, in particular, self-worth. In the eyes of some mothers, names such as ‘Baby Clinic’ creates the impression that the needs of mother are secondary to the

needs of baby in the eyes of the healthcare profession, which may further inhibit conceptions of self-worth and a trusting relationship. There is little engagement with professionals upfront about emotional difficulties, which was partly because many women expected not to have difficulties and therefore ignored the information in the antenatal period. But there is also a sense that when postpartum depression is discussed in antenatal classes, it is in practical terms, such as “Run Mum a bath”, rather than on how to validate emotional difficulties. Again, this seems to highlight an evasion of the awkwardness of “Saying it how it is”.

As a result of evaluating the sources of potential help, women decide whether to disclose difficulty, who they may disclose to, and whether they choose to seek professional help. Self-concept and self-stigma appear to play a role in deciding to disclose difficulty, regardless of who the disclosure is to. Concerns about being perceived as not coping and not performing in a mothering role which is seen as natural and innate appear to inhibit the desire to disclose difficulty more than the fear of being labelled as having a mental health difficulty. That label is something that, although many women said they did not believe there was a stigma about, they still did not want to be associated with, for instance, attending a group that might be titled ‘postpartum depression support group’. As such, there was evidence of endorsed stigma through behaviour and discourse, even if women did not overtly accept that they held a stigma. Strategies for evading disclosure included managing the impression given on the EPDS, which, again, highlights the significance of Theme 4, “Saying it how it is”.

The decision of who to disclose to was influenced by relational issues. Fears that speaking to a GP might result in mental health information being logged on one's medical record created a preference to speak to private practitioners about postpartum emotional difficulties. There was also, in some cases, a reluctance to disclose to Health Visitors, as being discharged from their care was seen as an ‘achievement’, and therefore prolonged involvement was associated with being a ‘failure’ because it appeared that one was not capable of coping. However, this was not a universal experience, and it appeared that women with a more positive self-concept were content to disclose difficulties to professionals as that was what they were there for.

Reticence to disclose difficulties also involved close family and friends, for instance, the desire to protect loved ones from hearing that you were in distress. Again, this drew on the theme of “Saying it how it is”, in that people developed ideas about what it was acceptable to share with others, including partners. Generally, it appeared that

disclosing concerns of a medical nature was admissible, whereas disclosing concerns of an emotional nature was not. This was evident between partners and within friendship groups. It is possible that these ideas of what is and is not admissible to disclose were formed based on the constructions of motherhood, outlined in Themes 1 and 2, potentially due to the absence of 'normal' mothering experiences appearing in public spaces.

4.3.2 An illustration of the model in practice: the case of breastfeeding.

The model can be illustrated using the final theme that emerged from the data: "experiencing pressure to breastfeed as a stigma that inhibits the desire to seek help". Women reported intense pressure from healthcare professionals in the perinatal period to breastfeed, leading to constructions that breastfeeding was normal and a view of the self as intending to breastfeed to conform to this norm. An analysis of the actual predominance of breastfeeding reveals that whilst 74.3 per cent initiate breastfeeding, by 6-8 weeks, only 29.3 per cent are exclusively breastfeeding and 43.3 per cent are not breastfeeding at all (NHS England, 2015)¹⁴. This is important, because the weight of pressure on women by healthcare professionals seems to influence women's constructions that breastfeeding is expected with the implication that not doing so may disadvantage their baby. Yet the prevalence of breastfeeding evident in the statistics does not support it as the norm. So although there is not a deliberate deception, again public messages are not conveying the full picture of "Saying it how it is". Furthermore, there is an impression that expectations of breastfeeding as the norm extends beyond healthcare, to the extent that women can anticipate stigma for bottle-feeding their baby in public. Perhaps this might be compounded by the public discourse and campaigns to increase the 'norm' of breastfeeding in public, although this did not come up in the data.

When breastfeeding proves to be more difficult than expected, there can be a tendency for some women to make sense of the difficulty by blaming themselves for 'failing' their baby, leading in turn to shame and self-stigma. This self-stigma is compounded when healthcare professionals continue to emphasise the relative merits of breastfeeding once a woman has decided to switch to bottle-feeding. Such interventions appear to be experienced as a threat to self-determination and may be taken as a devaluing of self-worth, which has already been threatened by the perceived prioritisation of the

¹⁴ Figures based on Q4 2014/25.

baby's needs over the mother's. Low self-esteem, self-worth and a revised self-concept lead to low mood.

Due to the perceived pressure imposed on women by healthcare professionals, some women can become distrustful of the relationship with healthcare professionals and the lack of respect and compassion demonstrated. As a result they may construct this avenue for help as unable to provide help in general, including for issues relating to emotional difficulty.

4.3.3 Summary.

The model is able to indicate processes that may be involved when individuals develop self-stigma and how implicit public stigma may be formed both through what information is publicly communicated (e.g., breastfeeding) as well as what information is notable by its absence (e.g., every-day humdrum nature of motherhood). Each theme will now be described in detail, supported by verbatim quotes from the participants.

4.4 Theoretical Code 1: Comparing Expectations and Reality.

This theme highlights the way that women tend to form expectations of motherhood ahead of birth and how women then compare the reality of their mothering experience with their predictions. Its significance for stigma and help-seeking is that it helps to demonstrate the processes of public and self-stigma that may be contributing to the experience of postpartum emotional difficulties due to the existence of assumptions, stereotypes and the process of social comparison.

4.4.1 Anticipating the role of motherhood and how they expected to handle it.

Most of the women formed expectations about what motherhood would be like and how they expected or hoped to be as a mother before they gave birth. Although some women seemed to find it difficult to think how they had formed their expectations, most cited numerous sources of information which helped them to construct these ideas, such as their own mother, friends with children, books, television programmes, lifestyle magazines, the internet and newspapers. The awareness of forming expectations appeared to be subtle and often unconscious.

4.4.1.1 Expectations of motherhood.

Forecasting that motherhood would be a positive experience, participants used words such as “perfect” and “amazing”, tempered with a certain degree of apprehension to describe how they had predicted motherhood to be. Ideas of how their time as mothers would be spent were recounted, with one woman imagining that she would spend the summer gardening while her babies sat in their bouncy chairs.

Chloe: (L¹⁵201) I think a lot of people have that kind of, you're a bit, of course you're a bit scared of it all. It's just kind of this 'rosy-glow' thinking: “It's all going to be perfect!”

For the participants who had spent several years attempting to become pregnant or carry a baby to full-term, there was an added element of excitement about reaching a long, awaited destination. However, the positive expectations were not universal, with one participant describing how she had been able to imagine all the potential negatives about having a child but struggled to find any positives, which she said was typical of her thinking style.

4.4.1.2 Expectations of self.

Alongside the positive predictions of what motherhood would be like, the women also tended to have an optimistic view of how they would cope. They expected to draw on the skills they employed as successful career women. In particular, they cited examples of how they were in control at work, that people complied with requests and how they were adept at solving problems.

Ava: (L34) So I'll literally feed them, change them and then they'll fall asleep.
(L278) I'm very pragmatic and very logical and there's a process to everything.

Only one participant reported having concerns in the antenatal period about how she would cope with a baby, describing intense anxiety about the weight of impending responsibility of looking after a child.

¹⁵ L - Line

4.4.2 Constructing meaning from the comparison between expectations and reality.

Although this was not a quantitative study, it was observed that the women who admitted to having had postpartum emotional difficulties described experiencing the variation between the reality of their early mothering experiences and how they expected things to be as more problematic than the women who did not express emotional difficulties.

4.4.2.1 Recognising the magnitude of change.

United in their view that life had changed significantly since delivering their babies, participants agreed that the experience could sometimes be overwhelming. Some women commented on just how different the reality was from what they had expected.

Dana: (L12) It was not at all what I expected. Umm, I did expect that it would be hard. And that I might find it a tricky new skill, but not that it would be such a huge, ummm (...) change of, of everything. Absolutely everything.

Dana, in particular, expressed a view that she had been 'sold' one image of motherhood which the reality did not match and this had made her angry. In contrast, other women, whilst recognising how their lives had transformed beyond recognition, experienced this change in line with their expectations.

Dana: (L17) There wasn't, there wasn't any of this joy, there wasn't any joy, this "it's amazing". None of that. And also, I was a bit sort of angry about that as well.

Eleanor: (L150) People say it's about sleepless nights, changing nappies and feeding and endless laundry, and that's basically what it is!

So whilst all women experienced a change, it seems that the women who disclosed emotional difficulties experienced the change more acutely than their peers and described a bigger difference between expectations and reality.

4.4.2.2 Making sense of the reality

As indicated above, there was a general sense that mothering was in stark contrast to the women's previous lives and also, that it was challenging and at times, quite hard work.

The women who did not disclose emotional difficulties tended to explain the change as expectedly hard and therefore, by taking a more compassionate and forgiving appraisal of unyielding demands, were not distressed by the difficulties that they experienced. Furthermore, they did not appear to be fixated by the scale or nature of the change, instead demonstrating acceptance and a degree of flexibility in their approach to dealing with the current situation.

Eleanor: (L54) It's too late now, he's here. I have to, I have to get used to that.

Eleanor described herself as having been quite stressed in a career and concluded that she was exactly the kind of mother she expected to be, so her anxiety was familiar to her and therefore, perhaps, not something that caused her concern. In contrast, the women who disclosed emotional difficulties seemed to dwell on trying to explain the problem. Dana queried whether everyone had lied to her about motherhood and wondered why no one had prepared her better. It is possible that this way of thinking might have led to her forming a slight distrust of other people and contributed to her feelings of isolation and loneliness. Her anger was evident in the energetic manner in which she talked about her experience and ruminating about these stories appeared to perpetuate her mood. When interviewed a second time, Dana was keen to emphasise her perception that the public messages about motherhood and postpartum depression had changed and that public portrayals were more open and honest. It is not the purpose of this research to determine whether her beliefs were objectively true, but one might hypothesise that as her emotional well-being had improved, she might have been more able to notice other stories, compared with a potential attributional bias that she held whilst depressed.

Typically, the greater the disparity between expectations and reality experienced, the more inclined the women appeared to be to talk about having experienced emotional difficulties. It appeared that experiencing motherhood as different to what was expected and the process of social comparison to perceived norms contributed to negative cognitive appraisal of the change and assaults on one's self-concept.

4.5. Theoretical Code 2: Reviewing a Sense of Self

Prior to birth, several women perceived themselves to be highly competent individuals. Often, this identity was entwined with successful, professional careers. These women also described a perception that their self-concept was confirmed by how others saw them. Following the birth of their babies, these women found the ambiguous challenges of motherhood difficult to find solutions for and this led some of them to review their self-concept. This is important for understanding the emergence of self-stigma.

4.5.1 Seeing pre-natal self as capable.

The data highlight that the women in this study tended to see themselves as efficacious individuals prior to having their babies. The self-concept of many of the participants appeared to include a view that they were good problem solvers, defined as being proficient performers in their place of work, where people came to them for advice on how to address difficulties. They also talked about being adept at resolving difficulties within the home, taking pride in their role of being able to, for instance, take charge of the car maintenance. They valued being seen by colleagues and partners as being able to fulfil these roles.

Dana: (L68) I can fix things. Like if something's wrong in the house, like if something breaks, I can take it apart and put it back together. I'm the one that does the car maintenance. Do you know what I mean?

Many of the individuals also described valuing being in control in the period prior to having a baby, for instance choosing how to use 'free time' at home. Furthermore, it encompassed career dynamics where people might be responsible for a team and they could rely on the team members to perform the duties as expected in a particular way. This predictability and control acted as a source of comfort and reinforced a sense of the self being in control.

Chloe: (L220) You've got a team of people [at work] who do the things you tell them to do, or give you good feedback and tell you another way to go, and they articulate what's wrong.

Some women commented on how, prior to motherhood, they had seen themselves as a popular, social being and that this fuelled their self-esteem. They highlighted how others also remarked on their sociability and that their identity was wrapped up within this. Overall, there seemed to be an implicit expectation amongst participants that their positive self-concept would help to equip them for motherhood.

4.5.2 Internalising self-stigmatising views of postpartum self.

When faced with challenges in the postpartum period, some of the women were surprised at how arduous they found the experience. The belief that they would be able to cope with problems as they surfaced was challenged, leading many of the women to question their self-concept.

Dana: (L70) I was just, I was completely taken aback that I would have a problem that I couldn't, I, I, I couldn't find a way to take it apart and put it back together. I didn't know what to do and how to do it. Feelings that I couldn't rationalise was just terrifying as well.

Ava: (L1050) It's just horrible having no, no mates. And, and, I've been for my whole life, the person who everyone wants at the party (...) and now I'm not the first person. I'm not even invited to the party because no one knows me. (...) I'm just a, you know, I'm just a bit of a no one with no friends.

It was evident that many women labelled themselves in a negative way. The realisation of a change to their self-concept turned into deeply self-critical views of themselves. Compounding their sense of helplessness, some women held a belief that motherhood was an innate skill that one should just be able to do.

Dana: (L355) I felt that I was an absolutely massive failure at this.

Eleanor: (L669) Yeah, because as a woman, you're supposed to be able to be a mother. You're supposed to be able to reproduce, you're supposed to be able to raise your child. And if you have postpartum depression then, there's something in the, there's some part of you that's not coping with that.

Dana_2: (L186) There's people giving birth to babies in , you know, the Amazon in a hut and getting on with it. It's ridiculous that I'm a first world person in a house with everything. "Why can't I do it?"

On occasion, women began to stigmatise themselves either for the practical difficulties or the thoughts about their difficulties that they had. Words, such as stigma and shame were not typically used, indeed, some of the women were eager to say that they did not endorse stigmatisation of emotional difficulties, but it was possible to discern shame in the way that women talked.

Dana: (L421) I had this dream that I had a baby and I woke up and thought, "Oh thank God it was a dream". And then I realised it wasn't a dream and then I was distraught. And then distraught that I felt like that, to even have that little feeling.

Ava also described shame about her behaviour, about counting down the hours until her partner came home or the weekend when there would be more support and said she did not believe she should be doing that. The women appeared to want to protect their pre-birth self-concept in the eyes of others, even if they could not hide it from themselves, as if they implicitly endorsed a shame of their actual experience.

Dana: (L581) I certainly would not have told any of my friends at work. Because I want to go back to work and I wouldn't want them to think that I had struggled with a problem.

It was evident that the women with emotional difficulties sought to distance themselves publicly from their perceived difficulties so as not to be seen by others in that situation, again highlighting a sense of shame.

Ava: (L189) I want to get out of here so no one sees me here in this situation.

However, although all women felt overwhelmed by their situation at times, some were able to cognitively restructure the experience of being out of control and unable to solve their own problems by taking a rational view and by normalising their experience.

Fiona: (L462) I absolutely knew that I was doing something that I hadn't done before. And I'm doing something that there actually isn't a definitive answer for.

Fiona: (L465) Knowing that everyone feels that way as well, was helpful.

4.5.3 Reinforcing the loss of self through the design of perinatal care.

There was a view that in some ways, the design of perinatal care reinforced a loss of self-concept, in particular, the worth of the mother.

4.5.3.1 Focus on the care of the baby.

Throughout perinatal care, some women experienced their baby as being the focus of the healthcare professionals' interest and that they, as mothers, were, by comparison, less or not significant. Of course, this could have been the result of cognitive distortion associated with their emotional state. Perhaps more objectively, the discourse used within the healthcare provision was seen as potentially reinforcing the loss of self. Indeed, there seemed to be a view that the well-being of the women was secondary to that of the babies.

Dana: (L509) I find all the classes (...) or you read any books, it's all about the practicalities. (...) The focus is entirely on your care of the baby. And they do a tiny bit on NCT which is, "If Mum's feeling a bit blue, Dad, perhaps you could run her a bath!" You know, this kind of bollocks. When in fact it should be totally equal, "You're not even going to be able to go to the toilet on your own for three weeks at least. You're going to be sleep deprived. Here's what sleep deprivation does to you." (...) The onus is on the care of the baby and not on the mum.

Dana_2: (L487) You know, surgeries have like a baby clinic? (...) I don't know why they don't have a Mum clinic as well. Umm. Coz the focus is so very much when you've had a baby, on the baby.

This had a potentially negative impact on self-worth. This is important, because it impacts the impression women form of the extent to which healthcare professionals care about their well-being and may influence subsequent attitudes to seeking help from these people. This is discussed further in Theme 4. Fiona had a different experience, and felt that because her baby was fine, the focus was on her.

4.6 Theoretical Code 3: Seeking and Trusting the Help Available

There were mixed experiences of the Midwives, Health Visitors and GPs that the participants had encountered in the perinatal period. Some experienced them as proactive in talking about emotional difficulties, whilst others expressed reservations about trusting professionals for reasons which included lack of confidence in quality of professional knowledge, lack of relationship, and lack of trust. In some cases there was a reluctance to seek professional help, preferring to seek assistance elsewhere, but the reasons were not always related to anticipating stigma.

4.6.1 Seeking information about emotional difficulties in the antenatal period.

Participants articulated a view that there was ample information about postpartum depression available, although there was a perception that it required some effort to access it. There were several comments about the usefulness of antenatal classes for raising the profile of postpartum depression. However, some women admitted to not anticipating postpartum emotional difficulties and therefore not paying attention to this information. This attitude presents a challenge for healthcare professionals who seek to promote messages in terms of raising awareness of symptoms, normalising difficulties and opening up the opportunity for dialogue in the postpartum period where help might be needed.

In contrast, following several miscarriages, one woman became concerned that she might be susceptible to postpartum depression. In addition to reading up about the symptoms, she proactively flagged this to both her Midwife and her family, asking them to keep an eye on her.

4.6.2 Constructing views about the provision of professional help.

The data indicated that women formed different views of the quality of the postpartum help that Health Professionals provided, whether for physical or emotional difficulties, based on their own personal experiences as well as stories they heard about others' experiences.

Ava experienced a Health Visitor who proactively identified symptoms of postpartum depression and helped her to take actions to improve her mood, through exercise and attending organised parent and baby groups. However, Dana had asked her GP for help for postpartum depression and was referred for psychological help. She

received a letter denying her treatment on the grounds that she was 'not sad enough' and this exacerbated Dana's mood and self-worth.

Dana: (L187) I got this appalling letter (...) which was essentially a letter that said (...) "she's not sad enough to qualify". They hadn't even talked to me. They hadn't done anything, they hadn't called me. (...) They had literally written me off. (...) And *that* actually serves to make me feel even more bad about it and even worse. Which is totally counter-productive. (...) If someone has really plucked up the courage to go to the doctor thinking you know, this is "I'm weak" or "I'm bonkers" or "I'm selfish" or whatever those things and gone and asked for help and that was the response, that is a dreadful, dreadful thing.

Even Belinda, who had no apparent emotional difficulties, appeared to feel unheard when she expressed concerns about her baby's weight to a Health Visitor. She was told her baby's weight was fine and therefore, she should just continue what she was doing. Her anxiety was neither named nor validated. This prioritisation of the practical content of discussions with health professionals over the unspoken emotional content appeared to be a common experience.

Many participants also relayed stories about their peers' experiences of healthcare professionals. Even if their own experience was different, the negative stories seemed to linger in their mind. Furthermore, stories or urban myths about, in particular, Health Visitors, which appeared in the media seemed to imprint a sense of caution in some of the women, lodging a fear that assessments by the Health Visitor could result in the removal of a child.

Chloe: (L558) But it's just that horror story that you hear that seemingly a nice couple had a knock on the door from social services and they got involved. And that, and that sounds horrible (...) And it's in the, it, it only takes one or two of those stories.

However, not all participants constructed their views of Health Visitors based on cautionary tales.

Eleanor: (L553) Health Visitors don't want to take children away from parents.

Belinda and Chloe also had concerns about the quality of advice they were given by their GPs, experiencing it as 'a bit hit and miss'. For example, when her milk stopped, Chloe's GP advised her to go home and Google remedies. Although the nature of their queries was medical, the advice given inhibited their confidence in the professionals' general ability to help them.

Belinda: (L291) I just think the Doctor is seen as useless, so it's more of a, I don't know that I would find the help that I would need or want there.

This conveys a possibility that women attach meaning to the advice they are given over and above just the objective content, which in turn impacts their trust in the quality of advice they can expect from professionals in future situations.

4.6.3 Making decisions about who to seek healthcare help from.

The women in this study implied that *who* they asked for help was influenced by the way they constructed their ideas about healthcare professionals based on their own experiences and those of others. Chloe described how she experienced the GP-based postpartum care as impersonal, believing that there was a tick-box mentality to assess emotional state. She and others recounted how they rarely saw the same professional twice and felt that not knowing the professional inhibited the formation of a trusting relationship. This impacted their willingness to disclose difficulty.

Belinda: (L333) I've actually learned more from my peer group (...) and my parents, you know, (...) and my mum, than any of the, you know, the professionals that are out there that I'm supposed to be able to access if I need support.

Chloe: (L70) I have never seen the same doctor twice (...) There's no kind of continuity (...) why would you talk to someone you didn't know?

In addition, there was a common view amongst the second round of participants, when duration of routine care was probed, that the timing of routine visits was misaligned to when help was most needed. In her second interview, Dana stated:

Dana_2: (L157) I feel like the care after you've had a baby is a very short window when literally, you're in such a blur trying to learn everything. You don't really come down to earth to discover how you feel about everything, about it, until that care is gone.

Overall, there appear to be myriad sources of potential support that women might draw on, which sometimes included NHS healthcare professionals. However, there is evidence in the data that some women do not feel they will get the help they need from these professionals based on their own experiences or those of others.

4.6.4 Willingness to disclose difficulties.

There were mixed views about whether or not to disclose difficulties and seek help from either professionals or friends. Eleanor had faith in the healthcare professionals' knowledge and had no reservations about asking for help, as she saw the provision of help as the purpose of their role.

Eleanor: (L540) Why would I be worried about going to see someone? That's what they're there for.

Dana stated she would not disclose her postpartum depression treatment to her colleagues for fear that it would change their perception of her work capabilities. Chloe voiced concerns over sharing emotional difficulties with her GP, as she feared this might result in a mental health difficulty being recorded on her medical record. When probed, she could not really explain this anticipated stigma, as, objectively, she did not think an employer would ever ask to access her records. However, she decided that if she did want to seek help, she would find it privately, just to be 'on the safe side'.

Chloe: (L539) I can't even properly articulate it. Maybe it's the, when you see things in the news. This feeling that social services are quick to take children into care. I mean you'd have to be an extreme case and things would have to be very bad. But you almost feel well, kind of, to be on the safe side, why would, it's very easy to kind of Google through therapists to help you, if you, if you wanted to do that.

Despite being able to discuss difficulties with her Health Visitor, Ava was reluctant to disclose her emotional difficulties to friends. She was concerned that asking for help

would be a burden to others and yet she could recognise her friends might be upset if they discovered she was withholding her need for help. This conveys a concern for the way she saw herself through the eyes of others and indicates a self-stigmatisation of her postpartum self-concept, discussed in more detail in the theme: "Reviewing a sense of self" (see Section 4.3).

Fiona also described feeling more comfortable sharing concerns with first-time mothers than with established friends, as then she would not feel so "stupid". The data indicates that even women who do not experience emotional difficulties are wary of disclosing their concerns to others for fear that they will be judged and make choices about who to disclose difficulties to accordingly. None of the participants had attended a postpartum depression support group. However, Ava expressed an interest in attending a group with other mothers who were experiencing difficulty. However, she stated that the first time she went, she would go in secret.

Ava: (L1109) I probably would, because if there was six of you then it's not abnormal.

Chloe: (L665) If it was just, you know, genuinely a support group type but don't, you can't call it that, it would have some of the stigma.

It seems that although the women could not articulate what the stigma was, they recognised that there was a barrier to disclosure of help. There was no overt discrimination that women had experienced either personally or through others. There was a recognition of endorsed stigma, for instance not wishing to attend the groups and there was also evidence of self-stigma.

4.7 Theoretical Code 4: "Saying It How It Is"

There was a common view that an honest portrayal of motherhood was often not communicated, either publicly through cultural vehicles, or through interpersonal communications. This appeared to contribute to the experience of self-stigma as women sometimes compared themselves to dominant public and idyllic portrayals of motherhood rather than more realistic representations. It also appeared that the absence of open dialogue about postpartum emotional difficulties perpetuated the difficulty of talking about it.

Dana: (L20) Has everyone lied to me? Has everybody? Do other people feel like this and just don't say?

4.7.1 Dominant media portrayal of postpartum depression perceived as binary.

Many of the participants perceived a binary portrayal of motherhood in cultural vehicles such as television programmes, newspapers, magazines and advertising, with only the extremes represented.

Chloe: (L651) It feels very binary. You're either a happy, well-functioning new mum, or you've got postnatal depression.

Dana talked about the seductive nature of celebrity mothers in the media and how it influenced her process of social comparison. There was also a sense that the extreme nature of reported stories about postpartum emotional difficulties might lead to confusion, for instance between postpartum depression and postpartum psychosis.

Dana: (L317) I'm sure everyone must do this, when you're pregnant, you've always got a celebrity pregnant doppelganger. (...) And they're stepping out looking fabulous all the time and as soon as, ummm, they've given birth, they're back in their jeans, and you see them walking around in pictures and (...) you're like. I mean obviously, they have an army of people to help them do that and that their career depends on them being like that, but still.

Chloe: (L655) I guess, most of it is media. (...) So you, somebody is doing something terrible with postnatal depression, which is more likely psychosis than depression. You hear about that, and that becomes what you think, where you think it comes from.

There was an appreciation that the 'normal' mothering experience, for instance the 'mundane/routine' aspects of life with a baby, were not deemed newsworthy enough to be portrayed in the media.

Fiona: (L264) Quite rightly, there isn't that much stuff about the mundane, day-to-day hum drum, it's just normal (...) you don't see that stuff on the news about other aspects of life.

As a result, this routine aspect of mothering came as a surprise to some women. Pleasure and mastery are two factors known to influence emotional well-being (Fennell, Bennett-Levy and Westbrook, 2004), but depending on how you cognitively appraise the routine of looking after a baby, it could be experienced in a way that constrains a woman's opportunity for emotional well-being, perhaps particularly where she had previously enjoyed a fulfilling, high-achieving career. So this absence of the reality of motherhood being represented in socially dominant vehicles is potentially problematic. There was a view that if a more realistic image of motherhood was presented, that women would feel better prepared and more accepting of the difficulty.

Ava: (L763) So if you expect that it's going to be boring and you're going to be holed up and you're going to be lonely and you know, you'll probably have days where you won't want to get out of bed (...) Then, when that happens, you're like, "Oh! You know, Ok! This is exactly what I thought!"

4.7.1.1 Stories hold power.

There was a clear sense that the public stories about postpartum emotional difficulties had a powerful effect on women's constructions of postnatal depression and feelings of fear.

Chloe: (L476) All it takes is one story like that.

There was also an awareness that although the public constructions of motherhood were not necessarily 'real', women still seemed compelled to attempt to emulate these perceived expectations themselves, which sometimes had a deleterious impact on emotional well-being. Eleanor was able to articulate the impact of advertising on women's self-concept, in particular the way that it could exacerbate pre-existing vulnerability.

Ava: (L523) You know, the ideal's obviously not everybody's reality (...) So then you start to compare yourself. [Refers to parenting books] They then compare themselves to that benchmark. And it's not really a benchmark, it's an ideal. And you know, maybe there's two babies in a hundred that conform to that (...) the other 98 don't and all of a sudden, the mother's like, "Oh no! I've done it all wrong!"

Eleanor: (L394) What's advertising there to do? It's there to make you feel inadequate. And if you already feel inadequate, then it's going to turn up the volume.

So while stories were perceived as not creating a realistic image of motherhood, they had the power to seed concern and create a desire to emulate a particular image.

4.7.2 Withholding disclosure of 'real' experience to others

The women expressed a reluctance to disclose their 'real' experience of motherhood, including difficulties, for a variety of reasons.

4.7.2.1 Desire to avoid judgement

Many women described a fear of being judged for describing their experiences truthfully. Fiona held in mind the public portrayal of extreme cases when considering her own difficulties and felt that her own challenges did not merit sharing as, in comparison, they were not that bad. For her, it seemed as if the extreme nature of public stories removed permission from her to talk about her own reality.

Fiona: (L283) If I've had a day where it's been, just a bit tiring and a bit, I would feel really guilty about complaining about that. (...) Because it's not the worst day ever. And (...) you're not allowed to complain about stuff, because there's always an extreme version.

This has a potentially deleterious impact on self-worth. Ava described how she did not disclose how she felt as she did not believe that people would understand.

Ava: (L798) I don't think they understand and I think they might think, "But you've got two beautiful girls".

Although the data did not explain the rationale behind this comment, one might query whether there is a common view that if one has healthy 'beautiful' children, one cannot be unhappy. My personal opinion is that the assumption seems to preclude the possibility of maternal ambivalence (Parker, 2010), that one can have both joy and sadness at the same time and that emotions are dynamic and transient.

Chloe: (L643) I would say since having [names baby], (...) I've had some of the happiest moments and some of my saddest moments. But even within the space of an hour. So it's not like, I guess it's not feeling depressed or feeling depressed all the time. (...) There needs to be some kind of definition that can allow for that, but there are wonderful things and there are the hardest times. (...) If you put a label on it, it almost sounds like you're not, not loving your baby or enjoying your baby".

Eleanor described her husband's response to her desire to have another baby. Of course, the researcher was not present during that exchange, but one wonders whether this is another example of the expression of difficulty from a mother being construed as 'not coping', the implicit message being, if you are coping, then you will not express any negativity.

Eleanor: (L51) "I wanna get cracking and have another one, and you know, I'm getting closer to 40!" And he says, "I don't know how you can say you want another one when even with just one, you say that you can't cope."

Chloe also sensed a lack of understanding and a willingness from her partner to explore her emotional experience.

Chloe: (L262) My husband tells me not to feel bad about it, "He's doing well, you're doing well, get over it!"

On the face of it, the intention behind these comments by partners might be supportive. However, it is possible that the way these comments are perceived is that the partners do not want to hear about the emotional difficulties, which may, in turn, dissuade women from further disclosures of difficulty and they stop "saying it how it is".

4.7.2.2 Desire to protect others.

Dana talked about finding it difficult to tell her husband about how hard early mothering experiences were for her and resorted to writing letters explaining her experience to him. Her husband told her that it made him sad to hear how she felt, so she stopped talking and writing to him about her feelings.

Dana_2: (L338) You don't want somebody else to feel powerless or frustrated or sad as a result of what you're telling them, because they don't know what to do about it.

It was not just negative experiences that the women chose not to share. Fiona was wary of sharing positive, joyful experiences about her baby with other members of her postpartum peer group, in case it upset them. This indicates a high regard for the experience of self in the eyes of others and a conscious process of impression management to uphold this.

Fiona: (L306) You kind of didn't want to upset someone else who maybe wasn't feeling so positive.

It was evident, within the data that women tended to want to protect new mothers-to-be by not sharing the difficult aspects of their experiences, because they did not want to "spoil" the idyll of motherhood. This was true even amongst the women who had stated they wished they had been forewarned themselves.

Dana: (L489) What we should be doing is passing down and along, um, to sister, mother, friends, saying, "Look, it could be really difficult. You could find that you feel like this. You could find that, um, that you, you really don't, don't love your baby on sight. And that's fine, that's ok. And, you know. It will be fine. And, err you can tell me about it, as well. You can come to me, you can ask me for help, there are places you can go for help." But we don't. And I don't know why.

As such, it appeared that the idylls of motherhood are perpetuated, by women colluding with it, even whilst recognising that it is a slightly mythical and unrepresentative picture of a normative mothering experience. In her second interview, which was approximately nine months after the initial interview, Dana demonstrated a change in her outlook about talking to mothers to be.

Dana_2: (L143) I tell them, what happ-, rather than gloss it over. (...) I want to tell them the truth. I just want them to have the facts, rather than not to do it to someone else.

This appears to be a positive example of someone using their own difficult experience to attempt to help others and be truthful about “saying it how it is”.

4.7.3 Endorsing a stigma of postpartum emotional difficulties.

There emerged from the data a number of examples of implicit stigma in the way that the women talked or behaved alongside either their own or others' apparent postpartum emotional difficulties. Most of the women initially stated that they did not believe that there was a public stigma associated with seeking help for postpartum emotional difficulties. However, as the conversations evolved, these views became less black and white.

4.7.3.1 Labelling self or others.

Certainly, the women interviewed showed signs of endorsing a stigma of postpartum depression. For instance, Dana described how she had a stereotyped view of one of her friends who had postpartum emotional difficulties (before she had had her own baby).

Dana: (L78) I had a friend who had postnatal depression and I'm guilty of thinking she kind of wallowed in that a bit. (...) it's that sort of idea that it's someone that kind of enjoys a drama. That's awful, but that's the truth. And almost, um, doesn't want to be helped, almost. So it's...it's err, with her, it, her identity became that, being the postnatal mum in the group.

Belinda stated clearly that she did not believe there was a stigma of postpartum difficulties or of seeking help. However, in the tone of her discourse, there appeared to be a shaming view about depressed women who did not seek help as being selfish.

Belinda: (L400) There's no stigma. And you know you should really, you need to do it because it's not just yourself, it's your baby. You know. You'll never get back this time with this, with the little person.

Ava admitted that were she to attend a postpartum support group, she would want to do so in secret in order to preserve a veneer of coping.

Ava: (L1114) I think I'd go in secret. (...) because you're, you want to appear that you're fine.

Although Eleanor did not admit to manipulating her EPDS questionnaire, she did state that the questionnaire was "rubbish" and that you could create whatever impression you liked with it. She stated that she saw her own difficulties as solely down to somatic difficulties of sleep deprivation. Stating that:

Eleanor: (L696) I only get miserable when I'm tired. And I'm tired all the time.

The implication was that Eleanor was miserable all the time. Yet she did not see this as depression, or perhaps, she might have wanted to avoid the label. Dana also recounted how her initial response had been to ascribe her low mood to hormonal difficulties, to avoid labelling herself as depressed, as to her, that was a sign that she was not coping. She only started thinking that depression was involved when things did not improve.

4.7.3.2 Avoiding asking others who appear to be experiencing difficulties.

Whilst using the snowball technique to recruit participants for this study, several individuals who had been invited to forward the recruitment poster to new mothers responded by saying, "I think I know someone who is struggling, but I don't want to forward this to her, because I don't want her to think that I think that she's not coping." This was in spite of the recruitment poster being carefully worded to avoid this scenario. Although the conduits of my recruitment poster were not interviewed about this, it hints that there is a source of embarrassment or awkwardness about engaging someone who may be experiencing difficulties in dialogue.

Fiona had distributed the recruitment poster to her postpartum peers. Despite all manner of practical baby-related things being discussed within the group, only one person mentioned the study to her in terms of expressing a general interest in psychology as a subject. However, one can be curious about whether research about practical matters, for instance, preferred methods of baby carrying, might have been met with a similar absence of discussion within the group.

Fiona suspected that someone in her postpartum circle was experiencing postpartum emotional difficulties. Whilst the suspicions were discussed within the group, no one actually engaged the woman they were concerned about in a conversation. Yet, Fiona declared that she did not believe there was a stigma about having difficulties.

Fiona: (L362) I don't think there's a stigma. And it's interesting, because in our little group, there's one person who we think is struggling a little bit. And we've all talked about it, but don't know what to do to help that person.

She went on to clarify that her concern was that enquiring might cause offense in case they got it wrong and the mother was, in fact OK. The mother in question had apparently disclosed that she had 'failed' her EPDS questionnaire and even then, Fiona and her peers did not discuss this further with the mother, instead rationalising the difficulties as being part of the woman's personality.

In summary, although the women seemed eager to declare they held no stigma, their comments and behaviour seemed to indicate otherwise. In addition, the analysis demonstrates that emotional difficulties are not talked about openly or honestly which reinforces a norm of not "saying it how it is".

4.8 Theoretical Code 5: Experiencing Pressure to Breastfeed as a Stigma which Inhibits Willingness to Seek Help

All the women interviewed observed or experienced intense pressure from healthcare professionals to breastfeed. Several of the women had experienced difficulties with breastfeeding and had felt judged if they supplemented with or converted to bottle feeding. For one mother in particular, perceived professional judgment about her difficulties with breastfeeding played a significant role in her emotional difficulties. The data suggest that this might influence women's desire to disclose difficulty to and seek help from Professionals for other difficulties, such as postpartum emotional difficulties.

4.8.1 Perceiving judgement about not breastfeeding.

Pressure to breastfeed was discerned from the start through the presence of breastfeeding posters on the hospital walls. Although Chloe had loved breastfeeding, she also commented on the emphasis on breastfeeding, in particular, the priority placed upon it compared to, for instance, other issues impacting women's well-being.

Chloe: (L686) We've got an agenda here, and we're going to push it. Even in the hospital, I found it quite funny. Every surface seemed to have a poster about breastfeeding. And in the ladies loo there was kind of a post-it sized note about, "If you are a victim of domestic violence, call this number". And it seems like breastfeeding is more important than if you're getting knocked around at home.

The absence of visible public information about bottle-feeding was echoed by a perception that healthcare professionals were unwilling to provide information about bottle feeding. Before birth, Eleanor had asked for information about bottle feeding. Her antenatal teacher had explained that she was not supposed to provide information about alternatives to breastfeeding. Fiona had also been shocked by the pressure to breastfeed in the hospital before she came home, commenting on a poster that stated that the hospital would not provide top-up milk. For her, this conveyed a message that:

Fiona: (L522) "Breastfeeding is the only way."

Arriving home, many of the participants continued to notice a preoccupation with breastfeeding by the Health Visitors.

Chloe: (L120) But you can tell they, they want you to breastfeed and they don't really want to talk about anything other than breastfeeding.

There was a view that the promotion of breastfeeding in itself was not bad. Instead, it was the prioritisation of breastfeeding benefits for the baby over and above the physical and emotional well-being of the mother that was problematic. Even when there were severe difficulties with breastfeeding, professional advice appeared to apply pressure on women to continue, irrespective of pain and mood. Dana was admitted to hospital with mastitis and at that point, decided to discontinue breastfeeding, but felt the healthcare professionals were not supportive of that decision.

Dana: (L260) So even in hospital when I've got this drain sucking green stuff out of my boob and I'm saying, "I'm not breastfeeding anymore" and they were going, "but it's the best thing for your baby!"

This professional behaviour might have contributed to Dana's low mood, by demonstrating a disrespectful and disempowering attitude to her autonomy and agency. Fiona also relayed a story about a friend who had struggled to breastfeed in hospital and who had not been allowed by hospital staff to top-up with a bottle, resulting in the baby losing weight and being kept in hospital for an additional five days. She commented on how this inhibited her friend's trust of professionals.

Looking at the NICE Guidelines on Postnatal Care up to Eight Weeks (NICE, CG37, 2006), it appears that the behaviour of the hospital staff was in line with guidelines to advise against supplementing breastfeeding. However, the impact of such an approach on a mother's sense of self, being allowed to determine how to feed her baby, and on how such stories influence other women's perceptions of professional help, should not be underestimated.

In addition to actual experiences of stigma about not breastfeeding by professionals, there was also an anticipated stigma about bottle-feeding one's baby in public.

Dana: (L596) The other thing about mothering is the level of 'judge-iness' is off the chart. I mean (...) a woman would never walk past a woman who was fat, say, eating an ice-cream and say, "you shouldn't eat that, you'll only get fatter!" But they feel absolutely *no* hesitation in telling you, "you shouldn't be giving him a bottle."

4.8.2 Experiencing emotional distress as a result of not breastfeeding.

Some women reported emotional difficulties resulting from breastfeeding, either from their own personal experience or from talking to their friends. Dana went on to identify breastfeeding as a significant influence on her emotional difficulties:

Dana_2: (L570) I do think, for me, that the breastfeeding, for me, was the catalyst for me feeling so down.

Ava experienced embarrassment in public when bottle-feeding her baby and felt the need to justify her behaviour. In contrast, Chloe commented how her positive experience of breastfeeding proved a source of comfort and implied that this boosted her resilience to cope with other difficulties.

Ava: (L711) I got a bottle out in the baby café and I was really embarrassed. I thought people were judging me because I was bottle feeding a child. (...) And I kind of felt it necessary to tell everyone that the reason I was bottle-feeding her was because she was too small to latch on.

Chloe: (L129) I mean breastfeeding has been one thing I've actually found easy and I've loved it. And I think it's actually, I've found it comforting in moments that I've found difficult, because as least then you feel like, if there's anything else I'm not doing right, I feel there's something I'm getting right". So I feel like I've taken comfort from it.

In her second interview, when exploring the link between breastfeeding and emotional well-being as part of data validation, Dana suggested how the absence of professional information about alternatives to breast feeding contributed to feelings of shame due to an inability to breastfeed.

Dana_2: (L507) You feel like you should just be able to do it. And why can't you? And that feeling of being a failure. (...) Um (...) And again, it's that thing of, the *only* option offered, the *only* classes, the *only* thing is breastfeeding. Nobody offers any other solution. And no one ever gives you permission to not do it. Ever.

Some of the women commented on how breastfeeding was a natural, basic, biological function. Eleanor empathised with women who were finding exclusive breastfeeding difficult and suggested that this could lead a woman to question her identity as a woman and a mother, resulting in further shame and self-stigma.

Eleanor: (L412) I know some of my friends have experienced a lack of understanding and kind of, a lack of support, and especially, because it's really hard and like, it must be really hard as a woman thinking, "I can't do this thing for my baby that's so basic so basic in terms of his needs."

4.8.3 Withholding disclosure of emotional difficulties as a result of (lack of support with) breastfeeding experience.

Follow-on interviews aimed to probe participants about how the perceived stigma about choosing not to exclusively breastfeed might influence a woman's decision to disclose other difficulties to a health professional. Dana had formed a view that health

professionals were so focused on the needs of the baby, through her difficulties with breastfeeding, that she made an assumption that Health Professionals might prioritise the baby's well-being, even if she expressed concerns about her own mental health.

Dana_2: (L523) So you might assume, because it's the natural way, ummm, and that you should do what we've all done for years and years and years with breastfeeding. So you might assume that that would be their attitude to mental health as well, not just, "Come on mum, just get on with it. And this is best for your baby. You're –" And that's the thing as well, I find with breastfeeding, is that I also think you might apply to mental health, is that, in the breastfeeding directives, it's all about what's best for baby. And actually, the mum has to be, it has to be good for the mum as well as the baby. So, um, you might think that if you went and said, "I don't feel-", they might say, "well is the baby ok?"

The interviews signal that women do perceive a pressure to breastfeed. For some women this appears to contribute to postpartum emotional difficulties, in particular around feeling shame of not being able to fulfil expectations of those around them that they will breastfeed. As such, there appears to be public stigma about not breastfeeding and this can turn into self-stigma about not fulfilling society's expectations, in particular the pressure from Health Professionals, to breastfeed. Some of the data support a hypothesis that the stigmatising way in which some women experienced professional support with breastfeeding difficulties, constructed their views about the degree of help they could expect from Health Professionals, were they to disclose emotional difficulties.

“Perhaps the rare and simple pleasure of being seen for what one is
compensates for the misery of being it.”

- **Margaret Drabble**

“It wasn't only that she reached out to comfort me, though I welcomed that.
Nor that she normalized my base impulses. No, it was something else: It was the word *we*.
It was the inference that she and I were alike, that she, too, had her shadow side.”

- **Irvin Yalom, The Gift of Therapy**

These quotes have been included as a prologue to the main findings that will be explored in
the discussion that follows.

CHAPTER FIVE

DISCUSSION

5.1 Overview

The current research proposed to build a theoretical understanding of the factors and processes related to stigma that may play a role in a woman's decision to seek help for emotional difficulties in the postpartum period. The specific research questions were:

- How do women understand stigma in the context of postpartum emotional difficulties?
- What role does stigma play in decisions to seek help for postpartum emotional difficulties?

This chapter will explore the main findings emerging from the analysis in the context of the study's aims and objectives and explore how the findings compare to past and more recent research about motherhood, stigma and the provision of help. Thereafter it will highlight the significance of the psychosocial processes of social comparison and impression management in creating and maintaining a perception of stigma for emotional difficulties before introducing some of the potential implications for both further research opportunities and service provision. Limitations of the current study will also be set out. Finally, the Chapter will conclude by considering a Counselling Psychologist's stance on the findings of this research.

5.2 Review of Main Findings

Based on the content of seven interviews with six first-time mothers, this research identified five theoretical concepts related to stigma and its relationship to seeking help for postpartum emotional difficulties:

1. Experiencing a difference between expectations and reality
2. Re-evaluating a sense of self
3. Seeking and trusting the help available
4. "Saying it how it is"
5. Experiencing pressure to breastfeed as a stigma which inhibits desire to seek help.

Each of these themes will now be reviewed in reference to the literature on postpartum emotional difficulties, stigma and help-seeking before progressing to a more detailed discussion about how these findings contribute to our understanding of the primary research question: the role of stigma in women's help-seeking behaviours for postpartum emotional difficulties.

5.2.1 Experiencing a difference between expectations and reality.

The findings highlight how participants experienced a gap between their expectations and the reality of motherhood, which is concordant with results from other research (Bilstza et al, 2010; Staneva and Wittkowski, 2013; Patel, Wittkowski, Fox and Wieck, 2013). This was the case regardless of whether or not the women described themselves as experiencing postpartum emotional difficulties. Bilstza and colleagues (2010) reported how the difference between expectations and the reality of motherhood can lead to difficulties with adjustment. This thesis observed how the participating women who described greater emotional difficulty appeared to experience the variance between expectations and reality as more problematic. Similarly, Staneva and Wittkowski (2013) found that unrealistic expectations of motherhood contributed to onerous maternal adjustment.

Women in this study cited the media as a key source of information that influenced the formation of their expectations of motherhood. As with other research, these expectations were often either idealised (McCarthy and McMahon, 2008; Bilstza et al, 2010) or expressed in terms of catastrophic fears based on media stories such as infanticide (McCarthy and McMahon, 2008) or suicide. Pressure to conform to media expectations or the 'myths of motherhood', also identified in research by McCarthy and McMahon (2009) and Staneva and Wittkowski (2013) respectively, was also reported by participants in the current research.

5.2.2 Re-evaluating a sense of self.

The finding that the women in this study tended to re-evaluate their sense of self after giving birth is consistent with other research tracking the emotional experiences of perinatal women (Bilstza, 2010; Staneva et al, 2015). Bilstza and colleagues' research (2010) mirrors the current study in the way that their participants described "significant guilt" about "failing at parenting" (p48) and how the women were then tempted to conceal their difficulties. Concealment and withdrawal have been identified as strategies of

coping with shame within the stigma literature (Corrigan, 2010). Although Staneva et al's research (2015) linking sense of coherence and maternal orientation with emotional difficulties focused on the antenatal period, there were indicators within the current research of orientations influencing postpartum emotional well-being. Ava, for instance, had described how she had envisaged a baby in a bouncy chair on the decking while she enjoyed her garden, suggestive of a regulator mothering orientation. There was also evidence that women who had enjoyed a strong sense of coherence in a professional setting prior to giving birth sometimes seemed to have difficulty in maternal adjustment postnatally. It was not the purpose of this research to explore that phenomenon, but the interaction of maternal orientation and sense of coherence operating against the background of a professional social context seemed to have a particular resonance to the observation that professional women seemed to find maternal adjustment problematic, perhaps because looking after a baby did not fit with the routines and control they associated with their previous careers.

In addition, this thesis found evidence of the relationship between maternal attitudes and levels of maternal adjustment. For instance, the concern about the judgement of others voiced by participants echoes the finding of Sockol et al (2014) that maternal attitudes, defined as concern about the judgement of others (or anticipated stigma), idealisation of the maternal role and levels of maternal responsibility, were predictive of depressive symptomology. In particular, the women interviewed within the current research expressed a view that mothering should be instinctive and that difficulties created problematic dissonance with the sense of self as mother. The idealisation of motherhood as instinctive has been highlighted elsewhere as a problematic and potentially shaming narrative for women's maternal adjustment (Cree, 2015). Indeed, Paula Nicholson (2010) argues that the "mental well-being of mothers now appears to be less a matter of depression through social isolation and more one of depression brought about through guilt, anxiety and the stress from not feeling good enough as a mother, partner or professional" (p193). It is important to note that the journey to motherhood will be unique for each woman. Furthermore, there may be cross-cultural differences in the perception of self as mother and these may influence the adjustment to motherhood for instance relating to gender roles within different cultures and how this influences the sense of self as mother (O'Mahoney and Donnelly, 2010). Issues of diversity related to the current research are discussed further within the limitations section in 5.6.

Some of the women in this study talked about the way that services might reinforce a loss of self-worth, for instance when Health Visitors focus on the baby rather than the mother. The desire for healthcare professionals to focus on the feelings of the mother was also reported within research by Boath, Henshaw and Bradley (2013), albeit with a younger sample of teenage mothers. This highlights the importance of healthcare professionals reinforcing a woman's sense of self through showing interest in her emotional well-being.

5.2.3 Seeking and trusting the help available.

The thesis has also highlighted some factors related to service provision. Whilst relational factors between health professionals and women in the perinatal period have been previously researched (Gawley, 2011; Chew-Graham et al 2008; Chew-Graham et al, 2009), this paper has identified how there appears to be an absence of emotional validation. Evident within other research (Bilstza et al, 2010; Holopainen, 2002) is the experience of women whose disclosure to healthcare professionals is met with reassurance which results in feelings of inadequacy and “exacerbated feelings of low self-esteem and guilt at being unable to cope” (Bilstza et al, 2010, p49). In the current research women described how concerns about their baby were met with statements like “baby's doing fine”. Such ‘reassuring’ comments were not appreciated by the women because they seemed to neglect the underlying emotion. Research by Coates et al (2014) highlighted how women reported that healthcare professionals did not probe deeply enough about their levels of emotional distress. This may support the suggestion within Theme 3, ‘seeking and trusting the help available’ that healthcare professionals may be inadvertently stigmatising through the absence of appropriate validation of a mother's concerns.

In addition, there were indications that women's expressed concerns, were not always taken seriously, for instance Dana reporting being told that she was “not sad enough”. Such experiences fit with the commentary offered by Coates et al (2014) about the problematic nature of diagnosis and treatment that takes a narrow medical view of symptomology that fails to fully accommodate symptoms that do “not fit with the dominant concept of postnatal depression” (p2). As described within the section on re-evaluating a sense of self, the journey to motherhood is unique to each woman based on her particular psychosocial position. As such, regardless of factors such as psychosocial or sociodemographic predictors, which can be a useful lens for consideration, the primary

focus for intervention needs to consider the unique idiosyncrasies of how these factors blend together for each individual woman.

In this research, with the exception of Dana, the women admitted to emotional difficulties with the adjustment to motherhood but did not identify with having postpartum depression. Nonetheless, they described symptoms and difficulties that caused them significant emotional distress. Women's mixed attitudes about the label 'postpartum depression' have been identified in other research (Patel, et al, 2013). Perhaps this signifies a need for healthcare professionals to reconsider what is understood by the term postpartum depression within lay and medical communities and move towards a framework of terminology, embracing the broader spectrum of postpartum mental health experiences, including maternal adjustment, postpartum depression and postpartum anxiety to ensure a common conception of the range of experiences. Although it did not come up within the sample of this study, a further consideration would be how mental illness is perceived within different cultural groups, as this may introduce a further layer of complexity of the factors influencing decisions to seek help (Collins et al, 2011). On this point, the NICE guidelines have the opportunity to provide more guidance to healthcare providers with regard to issues of diversity within service provision, for instance highlighting immigrant women as being at particular risk of postpartum emotional difficulties due to the juxtaposition of adjustments to motherhood and being in a new cultural setting (Collins et al, 2011).

In evaluating options for help, women observed that the timing and resourcing of care was not always appropriate for their needs, which has also been identified in other research (Holopainen, 2001). Women commented on the range of different professionals they saw during the perinatal period and that this range made it difficult for them to form a relationship with any particular person. As a consequence, they did not feel they would disclose difficult emotions to someone that they did not know. The lack of a single point of contact has been reported as problematic elsewhere within the literature (Coates et al, 2014). In psychotherapy, the quality of the therapeutic alliance has been identified as the strongest factor in influencing outcomes (Norcross and Wampold, 2011) and this might have some significance for other professional relationships. Their research focuses on a therapy setting, but research about the importance of the relationship in other healthcare settings, such as Health Visitors and Doctors also highlights the importance of relationship (Department of Health Policy Research Programme, 2013; Goold and Lipkin, 1999). The imperative for strong relationships with healthcare professionals has been identified within

literature focusing on perinatal women (Boath et al, 2013; Shakespeare et al, 2006), including research with women from ethnic minorities (Abrams et al, 2009). Yet despite the literature, perhaps the imperative of the relationship has not always been translated to guidance and practice. Certainly, the NICE Care Pathway of working with perinatal women focuses on what to do/what not to do, with minimal attention to the *process* involved in doing these things, such as the relationship.

While some mothers shared that they used on-line sites such as Netmums and Mumsnet (Netmums, 2017; Mumsnet, 2017), none of the mothers volunteered that they used sites specifically aimed at women experiencing postnatal depression, such as #PNDhour (PND & Me, 2017) or the PANDAS online community (Pre and Postnatal Depression and Support, PANDAS, 2017). Research has indicated that the use of online media such as social support groups can help women find “information, encouragement and hope” (Evans, Donelle and Hume, Loveland, 2012, p405). McDaniel, Coyne and Holmes (2012) estimate that new mothers spend up to three hours per day using a computer. Given this usage, there is an opportunity for healthcare professionals to proactively champion such online groups and guide women towards this potentially helpful source of social support in their routine conversations with perinatal women. In addition, there is an opportunity for further research to explore the impact of online media tools on postpartum emotional difficulties (McDaniel et al, 2012).

5.2.4 ‘Saying it how it is’.

The findings demonstrated how few women openly articulate an honest account of their actual experience of motherhood. This created a view that it was difficult to form realistic expectations of what motherhood would be like before birth and reinforced a stigma of “saying it how it is” as this fell outside the norms of public discourse about the joys of motherhood. Beck (2006) noted how the “the belief that all mothers should be happy can cause shame, fear or embarrassment” (p48). Because of the concern about being judged as ‘not coping’, women tended to conceal difficulties, a behaviour also identified by Coates et al (2014). The absence of a precedent for open conversations about difficulties reduced a willingness to disclose difficulties to family, friends and professionals.

All the participants within this study recognised a period of disequilibrium following the birth of their baby. The language used to describe this experience and the degree to which the women felt they could discuss it offered some interesting insights.

The current research highlighted that when stigma was discussed, it seemed to be focused on 'not coping' with motherhood, rather than on labels such as postpartum depression, a term that few of the participants used unprompted. Echoing findings by Bilstza et al (2010), being labelled as 'not coping' caused more concern than being labelled depressed. However, other research has highlighted the significance of a mental health label in different cultures (Holopainen, 2002) and the stigma such a label carries, so this finding is not generalisable. Indeed, several women initially stated that they did not believe there was a stigma, but when questioned about things like, attending a support group for postpartum depression, their views became less certain. Similar to the women in research by Currie and Develin (2002), women in this study vocalised a desire to distance themselves from any support groups which included the words 'postnatal depression', as they felt this would be a public declaration that they were 'not coping', indicating a sense of shame and embarrassment. In contrast, they could see the advantages of spending time with people who were experiencing similar things to themselves. This highlights the role of social desirability in the discourse of motherhood, which may reinforce the construction of a stigma of not coping.

Whitton et al (1996) identified how primiparous women and those of a higher socio-economic group may be less likely to identify themselves as depressed. Bilstza et al's study (2010) also highlighted how women find it difficult to distinguish between normal adjustment difficulties and depressive symptoms and how women may fear depression. Other research suggests that women have difficulty in distinguishing between normal difficulties of adjustment and symptoms that require seeking help (McCarthy and McMahan, 2008). These findings may support the suggestion of this thesis in terms of the way that the women did not use the term postpartum depression, yet described symptoms associated with it. Much of the research conducted to date on the subject of barriers to help-seeking in the postpartum period has focused on women who have been treated for postpartum depression rather than a broader range of postpartum emotional difficulties such as postpartum anxiety or postpartum obsessional compulsive disorder. However, the presence of emotional difficulties within the participants in this study, who generally did not present for treatment, highlights the importance of the broader issue of postpartum emotional distress. It appears that the meaning that women give to their symptoms, including the language they use to describe it, is an important factor in understanding and supporting women with their postpartum mental health. This presents an opportunity for

future research to focus on a more inclusive definition of mental health concerns that may be present in the postpartum period rather than just postpartum depression.

5.2.5 Experiencing pressure to breastfeed as a stigma which inhibits desire to seek help.

An unexpected finding from the research was the role of breastfeeding in women's experiences of emotional difficulties and how this potentially impacted on women's attitudes to healthcare providers and their willingness to disclose emotional difficulties. The general impression of the women interviewed in this study was that the way health professionals promoted breastfeeding implied that the benefits of breastfeeding for the baby outweighed the potential deleterious impact on a mother's emotional well-being. Coates et al (2014) also found that women felt unsupported by healthcare professionals in their attempts to feed. Tuteur (2016) criticizes breastfeeding advocates for being anti-feminist, for rendering a woman's needs "invisible" (p. 265). She describes how breastfeeding has become a "moral imperative" (Tuteur, 2016, p.243) where its benefits have been over-sold. Indeed, the women in this study talked about breastfeeding being seen as natural and instinctive which they should automatically be able to do, which was also evident in the research by Coates and colleagues (2014). Participants in the current research sensed a stigma of not breastfeeding, accompanied by shame and self-stigma which led to emotional distress. This is concerning for two reasons. Firstly, it is known that a mother with postpartum depression might have difficulties in bonding with her baby, resulting in long term difficulties for the child's development (Cooper and Murray, 1998; Gerhardt, 2004), so pressure from professionals which leads to emotional distress needs to be addressed. Secondly, undermining a woman's ability to choose how she feeds her baby may be contributing to the threat to self-concept which, in turn, appears to contribute to self-stigma. Furthermore, there was an indication that pressure to breastfeed by professionals inhibited trust and a mother's desire to seek emotional support from these professionals.

A recent cohort study of 14,000 women explored the associations between maternal mental health, intention to breastfeed and actual breastfeeding outcome (Borra, Iacovou and Sevilla, 2015). They identified that women who *intended* to breastfeed, but did not end up doing so were two and a half times more likely to develop postpartum depression by eight weeks postpartum compared to women who had not intended to breastfeed. The study also showed that women who intended to breastfeed and were able to

do so decreased their chances of developing postpartum depression. The analysis of the current research supports Borra et al's finding that breastfeeding impacts emotional well-being.

5.2.6 Support for the Grounded Theory model.

The Grounded Theory Model, presented in 4.3, aligns broadly with Clement et al's conceptual model (2014) which demonstrated an association between stigma and help-seeking for mental-health concerns. Their model identified processes such as being impacted by structural stigma, re-evaluating the self, experiencing stigma, deciding to disclose and help-seeking behaviour. Clement et al recommended that further research was undertaken to explore how their model related to particular groups likely to be vulnerable to stigma. It is useful to note that the processes identified within Clement et al's work may also be applicable to women in the UK, as shown by the current research, given that the postpartum research papers on which their model was based were undertaken outside the UK. The current study has demonstrated that women with postpartum emotional difficulties are influenced by similar processes to those identified by Clement et al. It is important to consider, though, that whilst some aspects of stigma or help-seeking related to postpartum emotional difficulties may share similarities with other mental health conditions, postpartum emotional difficulties have "unique physiological and psychological aspects such as fatigue, interrupted sleeping and the adoption of new routines such as breastfeeding" (Coates et al. 2014, p2).

In addition to similarities with previous research findings, this thesis has introduced a number of contributions, which at the time of writing appear to be new in terms of the understanding of stigma and help-seeking for this population. Firstly, where other studies identified stigma as an outcome of their research, this thesis identified it as a primary target for research and highlighted the significance of the psychosocial processes of social comparison and impression management in creating and maintaining a perception of stigma for emotional difficulties. Furthermore, the findings demonstrated how few women openly articulate an honest account of their actual experience of motherhood. This created a view that it was difficult to form realistic expectations of what motherhood would be like before birth and reinforced a stigma of "saying it how it is" as this fell outside the norms of public discourse. The absence of a precedent for open conversation about difficulties reduced a willingness to disclose difficulties to family, friends and professionals. Finally, this thesis included the experiences of women who had not been treated, which McCarthy

and McMahon (2008) suggested would be beneficial in understanding help-seeking behaviour. The sample interviewed, albeit small, suggested that women experienced similar processes of social comparison and impression management, irrespective of symptoms of emotional distress and whether or not they had sought or received treatment. Hall and Wittkowski (2006) also identified similarities between women with and without emotional difficulties in terms of similar experiences of negative cognitions.

A detailed account of the theoretical codes and Grounded Theory Model emerging from the research has been presented in the analysis. Here, the researcher will focus on what is perceived to be the main finding of this research: how the absence and avoidance of 'open and honest' conversations about the difficult elements of mothering at a public, professional, inter- and intra-personal level might perpetuate the stigmatisation of postpartum emotional difficulties.

5.3 How the Absence and Avoidance of Open and Honest Conversations about the Difficulties of Mothering Relates to Stigma

There were several aspects of the analysis which suggested a lack of openness and honesty about the emotional realities of motherhood. Participants perceived that public messages about motherhood, which influenced the construction of their expectations of motherhood, were binary in terms of focusing on extremes and that they neglected to sufficiently portray the full spectrum of experiences, including routine aspects of motherhood. This led to the construction of unrealistic expectations in the antenatal period, leading to adjustment difficulties in the postpartum period, potentially through the absence of 'real' examples of the realities of motherhood and public stigma of difficulties.

The women also described a tendency to manage the impression they gave others about their reality to escape judgement. This was true for both positive and negative experiences. The participants also admitted to deliberately withholding negative experiences from pregnant women in order to avoid 'spoiling' the ideal for others, despite, in some cases, wishing that someone had told them ahead of giving birth about the potential difficulties that lay ahead.

Women reported conversations between partners and peer groups where practical things were shared; however, emotion-based topics were either shut down (e.g., "he's fine, stop worrying") or just not discussed. Approach-avoidance (Lewin, 1935) was also evident amongst peers, where a new mother was perceived to be struggling. Group members wanted to help, but avoided doing so for fear of offending. Participants indicated a sense

that professionals did not engage them in an open discussion about the emotional experience of motherhood, such as validating the (non-disclosed) intense anxiety that might accompany physical concerns about their babies. Several women in this study constructed beliefs that they would not get the kind of help they needed from healthcare professionals. This was often based on the way that medical concerns were handled. In addition, the researcher's difficulties in obtaining ethics approval and recruiting participants due to reticence of both organisations and individuals to facilitate the connection with postpartum women perceived as vulnerable is suggestive of avoidant behaviour. The absence of routine and open conversations, which normalise the experience of uncomfortable emotions, might have inhibited disclosure of more moderate or severe emotional responses to adjustment. Drawing on the findings of Evans-Lacko et al (2012), that the more comfortable people in a country felt talking to someone with a mental illness, the less self-stigma individuals in that country tended to experience, this finding might make sense. In summary, people appear to be complicit in reinforcing a public stigma of postpartum emotional difficulties through the absence of open and honest normalising discussions about the difficulties. There are a number of psychosocial processes which might explain this phenomenon of avoidance.

5.3.1 Social comparison.

As with other research, the current study illustrated how women with emotional difficulties tended to be influenced by the media (Currie and Devlin 2002; Bilstza et al, 2010). The analysis suggested that the greater the experienced difference between expectations and reality, the more likely a woman was to construe herself as responsible for not being able to live up to the expectations. What this study emphasises is that all women can be influenced by culturally dominant messages communicated through public vehicles and the key difference is the meaning that is attributed to them. The women with no difficulties tended to take a conscious approach to evaluating the external reality of messages they were exposed to, noticing that they were sensationalised and binary. They were then able to cognitively reconstruct their experiences to assist with their adjustment to their new role, accepting that difficulties, including emotional ones, are part of motherhood. In contrast, women inclined to emotional difficulties tended to be less consciously discerning about the images and messages they were exposed to and seemed to internalise them as public cues and stereotypes about what they should be emulating. In doing so, it is possible they misconstrued the extremes of glamorised motherhood as a normal experience. This thesis

provides an alternative explanation of these experiences by using the language of stigma research, such as the concept of self-stigma. To compound matters, there appeared to be a view from participants that motherhood is an innate skill, which is a culturally dominant belief (Cree, 2015). Therefore being faced with difficulty was experienced as deeply shaming, upholding Goffman's definition of stigma as "blemishes [sic] of character" (p.14 in Goffman, 1990). Through a process of social comparison, a phrase coined by Festinger (1954), the women often found themselves failing to live up to stereotypes and their internal locus of control led to attributions of failure to be self-directed. This resulted in self-labelling and self-stigmatising behaviour. Given that there appears to be little precedent for talking about difficulties, it is understandable how this might reinforce a stigma through its absence.

5.3.2 Impression management.

Motherhood can be perceived as both a "personal and social identity" (Collett, 2005, p328), which reflects the findings from the current research that motherhood prompted a change in self-concept and influenced the way women wanted others to see them in their new role as a mother. Collett describes the lengths to which women will go to fulfil this, through a process of impression management which "helps women to convey competence to both self and audience" (p329). In the current research, it was clear that people employed "defensive practices" (Goffman, 1959, p144) to conceal 'bad thoughts' (in case they were negatively judged) and negative experiences (in case others thought they were not 'bad enough'). They also concealed good experiences as "protective practices" (Goffman, 1959, p144) in case these would make others feel sad. This highlights the contextual forces (Pearce, 2007) compelling women to behave in a particular way and the complexity of what is and is not conveyed to others. This emphasises how difficult it is for people to construct an accurate idea of what motherhood is like and the lengths that people will go to manage the impression they give.

Darvill et al (2010) undertook a grounded theory study of first-time mothers' experience of the transition to motherhood, which recognised the women's experience of a change to self-concept as part of this transition and suggested that the transition commenced in the early stages of pregnancy. This might prioritise the development and acceptance of a coherent self-concept rather than one overcome by the tensions of impression management.

5.4 Implications for Research and Clinical Practice

The finding that open and honest conversations about common difficulties associated with becoming a mother are often avoided at both a public, inter- and intra-personal level provides several opportunities for further research and clinical practice in order to reduce stigma. This is intended to complement other psychological research that looks to understand the experience of women in the postpartum period. Thornicroft et al. (2008) identified individual contact as possibly the most effective intervention for overcoming stigma, followed by social marketing aimed at the general population. Recommendations for research and clinical practice will therefore focus on these two approaches.

5.4.1 Changing stigma within the general population.

Feminist writers suggest that the current dominant narrative imposes unrealistic pressure on women (Tuteur, 2016). In the public domain, there are opportunities to give a more balanced picture of what early motherhood can be like, rather than just the perceived binary view that the participants of this research observed. Participants engaged in social comparison, but the benchmark was seen as unrepresentative of the realities of motherhood. Although recent public television programmes have looked to counter some of the myths of postpartum illness, for instance, about puerperal psychosis in *Eastenders* and *My Baby, Psychosis and Me* (Packham, 2015; BBC iPlayer, 2016), these represent the extremes of experience that women in this research described as problematic and it is a balanced portrayal of the full spectrum of experience that women are seeking, rather than just the extremes.

Hall and Wittkowski (2006) have already argued for the normalisation of negative thoughts. In this study, participants talked about simultaneously feeling both joy and deep despair or spoke about the deep shame of having negative thoughts about mothering. Maternal ambivalence has been written about in relation to modern motherhood in books (Parker, 2010; Almond, 2011; Hargreave, 2015) and journals (Murray and Finn, 2011). Yet given that as many as 40 per cent of women might experience delayed maternal affection (Kumar, 1980, as cited in Cree, 2015), one might reasonably expect to see the phenomenon featured more widely, for instance in parenting magazines or even the NHS Pregnancy and Birth Booklet which all mothers are given. In her book about taking a compassionate mind approach to postpartum depression, Michelle Cree (2015) outlines typical perinatal maternal emotions and their evolutionary basis as a way of normalising

some of the difficulties that women might encounter. In the researcher's opinion, this is the material that would be helpful to disseminate widely at a public level. Beck (2006) emphasises the importance of providing women with "anticipatory guidance" (p48) about the realities of motherhood to help "dismiss the myth that new motherhood is constantly blissful" (p49) and reduce the shame and guilt that can arise when women feel they do not conform.

Part of the Time to Talk campaign, designed to overcome stigma of mental health, printed conversations in the press between an individual with a mental health difficulty and one of their friends or co-workers. A review of their campaign shows a reduction in experienced discrimination (Thornicroft et al, 2008, Henderson and Thornicroft, 2013; Evans-Lacko et al, 2013). The current research indicated a fear of talking about emotional issues and a tendency to avoid them. A Time to Talk style campaign could be targeted at both mothers and those who come into contact with them in order to raise awareness about the normal experience of postpartum emotional and adjustment difficulties. The women in this study were not explicitly invited to comment about their use of online sites providing support for perinatal mental health issues, such as #PNDhour (PND & Me, 2017). Further research might explore how women experience stigma in relation to help-seeking from online resources.

A formal discourse analysis of how society communicates issues, such as not coping with motherhood, would provide a more nuanced understanding of how women and professionals think about these issues and the language they use to do so. "Language is constitutive of our sense of the real and the ways we understand and manage our experiences" (Brown-Bowers, McShane, Wilson-Mitchell and Gurevich, 2015, p321). Marshall and Woollett (2000) undertook a discourse analysis of eight popular pregnancy texts to identify common interpretive repertoires emerging, identifying competing tensions between the medical position, which limited women's agency and more woman-centred texts which focused on women as consumers with responsibility. Ultimately, they argued that both positions worked towards "the regulation of women" (p. 351). Focusing on public discourse of postpartum experience, it would be important to consider what is communicated and how, as well as what is *not* discussed and how this might relate to stigma. This could provide insights for professionals tasked with working with women in the perinatal period, as well as public campaigns tasked with constructing more balanced expectations of motherhood and normalise this period of adjustment rather than reinforce cognitions that not coping is shameful.

5.4.2 Changing stigma at an inter- and intra-personal level.

The other focus for overcoming stigma identified by Thornicroft et al (2008) was through individual contact. There is an opportunity to change the way that information about postpartum emotional difficulties is presented to women in the antenatal period in order to educate women about typical adjustment difficulties in the transition to motherhood. At present, the views expressed by mothers in this study, suggest that preparation for birth appears to be predominantly focused on getting through childbirth and providing the practical and nutritional needs of the baby, rather than on the emotional demands.

The provision of services might therefore benefit from a more systemic approach to the provision of support for postpartum emotional difficulties. Just as maternity appointments ask women to prepare a birth plan, perhaps there is an opportunity to prepare an early mothering/parental support plan. Patient choice is a priority of the NHS in the UK, which includes the provision of mental health services (Samele et al, 2007). In addition, Corrigan, Larson and Rüsch (2009) have suggested that through the empowerment of patient choice, the effects of self-stigma can be reduced. A support plan would help women think through the importance, for instance, of proactively establishing an emotional and social support network. Equally, such a plan could prompt consideration of typical cognitive behavioural patterns that each woman may be prone to when faced with stress, including reactivation of negative core beliefs, and to build an action plan for addressing them. This approach would embrace the myriad sources of emotional support that women in this study referred to and perhaps ensure that people identified in the support network were appropriately equipped for monitoring, validating and supporting emotional well-being.

The contents of such a plan would need to be grounded on sound research. There is a growing body of literature about how help-seeking behaviour for general mental health concerns might be influenced and predicted by self-stigma (Vogel et al, 2006; Vogel et al, 2013). Research into pregnancy distress is also evolving to consider personal factors which might contribute to pregnancy distress, such as coping styles (Faisal-Cury et al, 2012) and low self-esteem (Clavarino et al, 2010; both cited in Staneva, Morawska, Bogossian and Wittkowski, 2015), maternal orientation (Raphael-Leff, 1986; Sharp and Bramwell, 2004), sense of coherence (Staneva et al, 2015) and body image (Hodgkinson, Smith and Wittkowski, 2014). The analysis in this thesis includes processes such as social

comparison and impression management and how these relate to stigma. Hodgkinson et al (2014) recommended talking to women about their body image in pregnancy in order to identify “problematic attitudes” (p.10) and “at-risk women”. It is the researcher’s opinion, that there is an opportunity to expand on this recommendation in order to form the basis of more comprehensive conversations between professionals and women in the antenatal period. On this basis, there appear to be opportunities to work with women to raise their (and others’) awareness of typical cognitive-behavioural repertoires and how they impact emotion (such as the use of impression management and avoidance as a means of coping with shame) to make them more susceptible to self-stigma.

Helping women to understand the psychosocial processes as well as their idiosyncratic context may distance them from having a fixed view of their sense of self and increase the psychological flexibility, a term described within Acceptance and Commitment Therapy (Harris, 2009) and cognitive-behavioural choices available to them. This would provide a more idiographic and woman-centred approach to care (Baker et al, 2005). Awareness of self can in itself be therapeutic, for instance, a technique called video-interaction guidance of dyadic interactions between mother and infant has been shown to increase self-reflection and reduce depressive symptoms (Vik, 2011). The current NICE guidelines recommend Interpersonal Psychotherapy (IPT) and Cognitive Behavioural Therapy (CBT) to support women with postpartum mental health difficulties (NICE, 2014). The proactive development of coping strategies may be a particularly helpful strategy for primiparous women to counteract potential feelings of uncertainty about what the role of mother entails (Boath, Bradley and Henshaw, 2005). In addition, there is an expanding body of research building evidence for third wave therapeutic approaches for mood disorders in women experiencing perinatal emotional difficulties which include mindfulness-based interventions (Vieten and Astin, 2008; Dunne, Hanieh, Roberts and Powrie, 2012; Goodman et al, 2014), shown to reduce symptoms of anxiety and depression and Compassion Focused Therapy (CFT) which focuses on validating emotion and addressing issues of shame (Cree, 2010). This research has linked shame and stigma as a barrier to help-seeking. There is currently a 3-year longitudinal trial to evaluate the effectiveness of a cognitive behavioural therapy based psychoeducational programme for preventing postpartum depression. The trial which includes a focus on personal insight may illuminate the utility of such an approach (Ugarte et al, 2017). There is also a NICE endorsed, though not yet routinely used, “My pregnancy & post-birth wellbeing plan”

designed to increase awareness of individual coping strategies and support networks in the antenatal period (NICE, 2015).

5.4.3 Recommendations for service provision.

Clement et al (2014) and Vogel et al (2006) highlight the importance of services being shaped to minimise stigma. This thesis indicates that the way that services operate does not always support women in a way that nourishes their self-worth and how they can be inadvertently stigmatising. This includes the avoidance of emotion-based conversations, lack of relational continuity (which inhibits disclosure), an absence of proactive preventative action which could normalise difficulties and naming of services with names such as “Baby Clinic” which may compromise self-worth.

The NICE guidelines (2007, p.10) state that “professionals should be sensitive to the issues of stigma and shame in relation to mental illness”. To do this, they need to understand what these issues are. This thesis would also advocate health professionals’ consideration of how the psychosocial processes of social comparison and impression management might influence the emotional well-being and help-seeking behaviours of their postpartum clients. As an example, participants saw the use of the Edinburgh Postpartum Depression Scale as something to be ‘passed’ and that it could be manipulated in order to deliver a desired impression to a professional. Buist et al (2006) indicated how women with higher scores tended to find the EPDS less acceptable. It will be important for healthcare professionals to actively consider the process and content of their interventions in the context of women’s active process of impression management, for instance to help women to cognitively restructure what it means to *not* be discharged in a way that is less-stigmatising.

In some cases, the quality of the medical advice provided was perceived as inadequate, for instance, suggestions to Google remedies at home or to use trial and error as a way of finding solutions. The purpose of this paper is not to critique medical advice. However, it appears that the message that women might take away from such advice is two-fold. Firstly, a view might be formed that the professional does not have answers and is therefore not a credible source of help. Perhaps more importantly, given that the focus of this paper is on stigma’s role in help-seeking, such advice might send the message that ‘you have to sort this out yourself’ which may reinforce a mother’s feelings of helplessness and shame about the inability to sort things out herself, which brought her to the surgery in the first place.

Continuity of care due to the many professionals a woman sees in the perinatal period was cited as a barrier to the formation of the relationship. Furthermore, the process by which advice was provided, where the emotional content of queries seemed to be avoided and contributed to perceptions that (some) healthcare professionals would be unable to provide the help needed. The absence of a relationship that proactively engages with the psychological aspects of maternity care has been highlighted elsewhere (Baker, Choi, Henshaw and Tree, 2005). The lack of proactive role-modelling of talking about emotional content may reinforce a stigma of discussing those issues. Perhaps a further study can be undertaken to explore these factors in the specific context of postpartum women to better understand why the 'normal' emotional content is not discussed, possibly considering the role of relational reflexivity (Burnham, 2005) to explore what is and is not talked about. Health Visitors might also wish to clarify their role, to counter the fear surrounding the perceived power they have to remove a child, as whilst this preoccupation persists, disclosure of difficulty may continue to be a challenge. This research supports the view advanced by Coates and her colleagues (2014) that further exploration of the relationship between the extent to which a woman feels supported by healthcare professionals and her emotional well-being is merited.

There also seems to be an opportunity for the NICE guidelines on breastfeeding to be reconsidered. The NICE Guideline "From postpartum care up to eight weeks" recommends avoiding asking women about their "proposed method of feeding until after the first skin-to-skin contact" (NICE, CG37, Section 1.3.14, 2006), which appears to be at odds with the finding from Borra et al's paper (2015), which indicates an association between feeding intention, actual feeding method and postpartum depression. The NICE Postpartum Care Pathway Overview (2015) states that staff are to "avoid promoting or advertising infant or follow-on formula" (p6) and this includes using or displaying leaflets that promote formula feeding. This means that a woman's potential to weigh up the balance of evidence herself and make a choice about how to best cater for the nutritional needs of her baby are compromised. This study suggested that the way that breastfeeding is prioritised can influence a mother's well-being. The intention to breastfeed (Borra et al, 2015) might be a useful data-point for Midwives and Health Visitors to gather in the antenatal period in order to identify women who may be at greater risk of experiencing postpartum emotional difficulties. Health professionals can then proactively monitor these women and perhaps normalise the emotional impact of difficulties with breastfeeding.

Whilst the promotion of breastfeeding may make sense for the nutritional needs of the baby (although the magnitude of these benefits is contested; Tuteur, 2016), perhaps the balance of emphasis needs to be adjusted so that the other feeding options are communicated in a way that enables women to take a fully informed decision about how to feed their child without judgement. As detailed in 4.7.4, statistics suggest that by six to eight weeks, the majority of women are not exclusively breastfeeding (NHS England, 2015), and perhaps this reality could be shared more widely to normalise and destigmatise women who do not breastfeed. This might preserve a relationship between new mothers and professionals to keep alive the possibility of asking for emotional support.

As a final recommendation, there is an opportunity for research and clinicians to think more systemically about perinatal mental health. Although the women in this research were largely sub-clinical in their symptoms and none had been given a formal diagnosis, they referred to emotional difficulties which included symptoms consistent with depression and anxiety. Research has tended towards a disorder-focused approach to perinatal mental health (Coates et al, 2014), yet this thesis has highlighted that women who do not conform to a specific diagnosis still experience difficulties which merit attention and support. This highlights the imperative for future research to consider a more “transdiagnostic” approach which accounts for women’s lived experience. Equally, it is necessary for future research into postnatal mental health (Coates et al 2014, p2) to build understanding and raise awareness of the wide range of factors which may contribute to the broad spectrum of postpartum mental health experiences, including maternal adjustment and postpartum depression.

5.5 Limitations of Study

There were several limitations within the research design and these are outlined below.

5.5.1 Sampling and recruitment.

The study targeted first-time mothers with a range of postpartum experiences with regards to emotional well-being and help-seeking. The study specifically set out to address a gap in the literature, interviewing women with symptoms who do not present for treatment and to some extent, was able to begin to do this as five of the six participants had not actively sought help themselves. The design of targeting women with a spectrum of presentations of depressive symptoms and help-seeking behaviours has been identified as problematic. Whilst the intention of this approach was to respect the grounded theory

principle of heterogeneity and of seeking negative case-examples (in this case, ensuring the experiences of both women who had sought help and those who hadn't as well as those who classified their experiences as emotional difficulties as well as those who did not), the approach might be criticised by some who see this engineering of the target sample to be at odds with the grounded theory approach of allowing data to emerge. Furthermore, the actual participants were more homogenous than expected. In retrospect therefore, the study might have lent itself to an Interpretative Phenomenological Assessment method. However, such an approach would have missed the benefits of formulating a model which grounded theory provides.

A further critique of the approach to sampling is that by only interviewing women who conformed to the target categories, many of the women who responded to the recruitment poster whose depressive symptoms were not indicated on the EPDS were excluded. The sample was self-selecting and therefore women coming forward had experiences which they wished to share within the context of this research. Had they been interviewed, emotional difficulties and perspectives on stigma may have emerged, as they did with Eleanor. Although a formal clinical assessment was not undertaken, it seems that many of the women presented with adjustment difficulties rather than symptoms of postpartum depression. Nonetheless, they had all experienced some form of emotional distress and could contribute to issues raised within the research question. Including more of the initial respondents may have substantially boosted the sample size, which, as it stood, compromised the ability of this thesis to reach theoretical saturation.

Recruitment proved to be extremely problematic, with few women with postpartum emotional difficulties volunteering to participate. Perhaps this makes sense, given the finding that women feel shame about not coping. Had more participants been forthcoming, the researcher would have evolved the interview schedule to explore in more depth the psychosocial processes of social comparison, impression management and maternal ambivalence in the context of stigma and help-seeking for emotional difficulties. The interview schedule might also have explored in more depth the view on services and how they might inadvertently belittle self-worth through the tendency to overlook the emotional undercurrent of expressed medical concerns. Following the personal circumstances outlined in section 5.7.2, the final decision to cease further attempts to recruit women with symptoms of postpartum depression indicated by the EPDS was taken in consultation with the thesis supervisor when it was felt that the seven interviews with the six participants

provided theoretical sufficiency. Given the struggles to recruit and the resulting sample size, theoretical saturation cannot be claimed and the model is presented tentatively.

It might also be argued that a lengthy selection process including response to a poster and the on-line screening pack which participants needed to complete prior to interview might have been off-putting and discouraged some women from taking part. Furthermore, the focus on primiparous women within the sample meant that potential differences from the experience of multiparous women are not represented. For example, Coates and colleagues (2014) highlighted how primiparous and multiparous women shared in their endorsement of themes about their experience of emotional difficulties, such as feeling “uncared for” by professionals, although primiparous women tended to experience this more.

One organisation responded to my recruitment enquiries by stating that they did not allow researchers access to women using their services, due to the vulnerable status of these women. In addition, during the university ethics approval process, concerns about the vulnerability of this population of women were expressed by the anonymous reviewer and several amendments to the research design were required in order to satisfy the committee. As a consequence, the EPDS screening criteria were made more stringent in order to exclude participants that were too depressed or who expressed suicidal thoughts on their EPDS, so the depressive/anxiety symptoms of the women who participated would have been in the mild to moderate category. There are a number of aspects of the sampling and recruitment strategy which, had it been more inclusive, might have yielded a more representative sample of participants. Had the approach included women with a previous history of depressive symptoms, known to be most at risk of developing postnatal depression (Beck, 1996), then more participants with clinically significant symptoms may have come forward. Therefore, the study is unable to comment on the experience of women with moderate or severe symptoms of postpartum emotional difficulties. If this study were to be expanded upon, the researcher would seek to obtain NHS Ethics approval to allow access to a larger pool of women who potentially had experience of postpartum emotional difficulties through Health Visitors and GPs.

Perhaps, influenced by the implicit concerns about the vulnerability of the preferred recruitment sample, a decision was taken to avoid recruitment through online forums, instead opting for a snowballing technique. A frequent response from people who had been invited to forward the recruitment poster was, “I think I know someone, but I don't want to send them this, in case they think that I think they're not coping.” In the end, three

participants were recruited through mother and baby groups and three participants were recruited using the snowball technique. Grounded theory advocates a heterogeneous sample and in this research, the diversity of the sample was intended to focus on the different experiences of postpartum emotional well-being and help-seeking, rather than diversity of demographics. However, the women participating in the study had a similar demographic profile, which limits how representative the findings are of a more diverse population.

The actual sample was more homogenous than expected in terms of symptoms, help-seeking behaviour, age, ethnicity, educational and socio-economic status. Other research has highlighted how these dimensions can impact issues related to postnatal emotional difficulties and help-seeking (Boath, Henshaw and Bradley, 2013; Collins, Zimmerman and Howard, 2011; Ahmed et al, 2008; Lam and Wittkowski, 2012; Gardner, Bunton, Edge and Wittkowski, 2014; Abrams et al, 2009; Jesse et al, 2008). A lack of diversity of sociodemographic characteristics amongst samples is a common challenge in healthcare research (Woodall et al, 2010, as cited in Sockol et al, 2014). Nonetheless, for this thesis, the lack of diversity within the sample limits the generalisability of the findings to a wider population. Further research would need to consider the specific issue of stigma in relation to help-seeking for postpartum emotional difficulties within a more diverse sample which better represents the population who reside within the UK to include different ages, socio-economic backgrounds, sexuality, ethnicity, as well as a woman's relationship and professional status. There is a further opportunity to explore help-seeking for postpartum emotional difficulties within more diverse samples (Collins et al, 2011; Templeton et al, 2003) which could include developing an understanding of the interplay between cultural beliefs about mental health stigma and help-seeking in the specific context of postpartum emotional difficulties. However, this would need to be done sensitively, mindful of an individual woman's idiosyncratic context, to avoid relying "heavily (...) on broad cultural stereotypes" which may "reinforce or inhibit reaching out to ethnic minority mothers around PPD [sic; postpartum depression]" (Abrams et al, 2009, p547).

5.5.2 Interview environment.

Interviews were conducted in participant's own homes and hopefully, this helped them to feel relaxed and comfortable. In two cases, the interview was undertaken in the interviewer's own home where efforts had been made to make the room as neutral as

possible. In five of the seven interviews, the babies of the participants were present for part of the interview. Attempts were made to avoid this scenario, but practically, it was not feasible to do so without incurring additional costs for room hire or childcare. As a consequence, it is possible that participants were distracted by the needs of their baby or may have withheld subject matter associated with difficult feelings towards their baby. However, the interviewer did not detect any reticence to talk and the participants seemed to offer a full and frank account of their experiences.

5.5.3 Screening tools and interview schedule.

The use of the Edinburgh Postpartum Depression Scale (Cox et al, 1987) (to indicate symptoms of postpartum depression), Self-Stigma of Seeking Help scale (SSOSH, Vogel, Wade and Haake, 2006) and the Barriers and Access to Care Evaluation scale (BACE, Clement et al, 2012) (to indicate attitudes to stigma and help-seeking) as screening tools posed some difficulties for the study. All three questionnaires are self-report measures and therefore open to manipulation by participants, and one participant commented that “you can create whatever impression you like”. The limitations of self-report measures are documented in the literature (e.g. Cousineau and Shedler, 2006). In terms of a measure to assess emotional difficulties, the ideal scenario might have been to undertake a formal clinical assessment about symptoms, but this was not seen as practical or financially viable. Whilst unvalidated cut-off scores of the EPDS are common (Matthey, Henshaw, Elliott and Barnett, 2006), in hindsight, the cut-off scores identified within the current methodology would have been more appropriate had they been aligned with standard recommended practice, where a score of 13 or more indicating a depressive disorder needing further assessment by a mental health worker to see if a major depression is present and a threshold of 10 as appropriate for routine use in the community (Cox et al, 1987; 1993). The current research used 20 as an arbitrary cut-off for exclusion. Perhaps a cut-off score of 13 for exclusion within this research would have been a more appropriate threshold for exclusion, based on the recommendations within Cox et al's papers (1987; 1993).

The use of the Self-Stigma of Seeking Help (SSOSH) scale and Barriers to Access to Care Evaluation scale (BACE-3) within this research had been intended to provide contextual information about participants' self-stigma and help-seeking attitudes. However, as only one participant had formally sought professional help, they were perhaps an unnecessary embellishment to the research materials and potentially confusing to

participants. The interviews seemed able to explore the respondent's lived experience of stigma and help-seeking attitudes without the need for the questionnaire data. The results of this research also highlighted that whilst women might publicly state that they hold no stigmas, their behaviour and thoughts might not fully reflect this, suggesting that these questionnaires might also be subject to a degree of social desirability. This poses a challenge for healthcare professionals tasked with identifying and supporting women with symptoms of postpartum emotional distress, especially if women might seek to hide their true experience.

As a final limitation, had the recruitment volume been more abundant, it would have been appropriate to pilot the interview schedule with a woman meeting the selection criteria, rather than with just a peer and mother whose child was more than one year old. Piloting the interview schedule in addition to independent coding by the supervisor of the analysis, would have been appropriate additions to the research process.

5.6 The Opportunity for Psychologists

5.6.1 The role for Applied Psychologists

The perspectives which follow focus predominantly on the opportunities for Counselling Psychologists, given that this is the required stance from which this thesis has been written. Counselling Psychologists are often found working alongside Clinical Psychologists within NHS settings (Strawbridge and Woolfe, 2010), hence the reflections might be equally pertinent to the broader spectrum of psychologists who work with women in the perinatal period. The difference between Clinical and Counselling Psychologists has traditionally been one of training and perspective (James and Bellamy, 2010) but in recent years there is a general anecdotal view that the distinction between the two approaches has diminished (Jacobsen, 2012). The role of Perinatal Clinical Psychologists is extensively set out within the British Psychological Society's Briefing Paper on Perinatal Service Provision (BPS, 2016). Furthermore, there is an opportunity for Applied Psychologists, including Developmental, Health, Clinical and Counselling Psychologists to work collaboratively together as well as with other healthcare disciplines to consider how they can build a systemic approach to working with families in the perinatal period. As an example, the literature indicates concerns that addressing postpartum depression symptoms in a mother in isolation of attending to the relationship with her child may be insufficient to protect her infant from poor child outcomes (Forman et al, 2007). This emphasises the importance of a developmental psychology perspective. Health psychologists can also

contribute, for instance, by considering the impact of postpartum emotional distress on the health and well-being of the whole family system (Goodman, 2004b) as well as considering the issues related to how 'health' is perceived within particular communities and systems (Brown-Bowers et al, 2015). There is consensus that multi-disciplinary working is seen as essential to the appropriate care of women in the postpartum period (Brockington, 2004; Brown-Bowers et al, 2015).

5.6.2 Considerations for Counselling Psychologists

Pluralism is one of the foundations of a Counselling Psychology philosophy (McAteer, 2010). This research has illuminated how the realities of motherhood sit neither with the individual mother, nor the external sphere. Rather, they sit in the interpretative space between particular people where meaning is dynamic, depending on who the players are. This is important, for practitioners within the sphere of postpartum maternal mental health to consider, as women appear to be constantly reviewing the multiple realities they interpret and project and therefore, this poses a challenge for the professionals tasked with identifying and supporting women with postpartum emotional difficulties.

Counselling Psychology leans towards a non-pathologising stance (Douglas, 2010; Milton et al, 2010). The analysis suggested that women tended not to use labels, such as postpartum depression and favoured terms, for example 'not coping'. Admittedly, the sample population were mild or sub-clinical in terms of their reported symptoms, so this might not apply to women presenting with more moderate to severe emotional distress. The very principle of Counselling Psychology states the importance of supporting individuals where they have been challenged by life, irrespective of how severely (BPS, Division of Counselling Psychology website). Counselling Psychologists could usefully share this perspective on pathology with medical peers to breed a more systemic perspective of women's experience of motherhood. Sometimes, perhaps women don't want (or need) an action-oriented intervention; the power of validation of emotion might be sufficient.

Another finding, which illustrates the contribution that Counselling Psychology can lend to this subject area, is the way that women reported the importance of the relationship in the interactions they had with professionals and that when this was lacking, it influenced decisions to engage further with professionals. Non-listening can contribute to shame, just as listening can build self-coherence (DeYoung, 2015). Although the importance of the therapeutic relationship is not alien to other professional groups, such as GPs (Greenhalgh,

2010), the process aspect of interfacing with clients is at the heart of a Counselling Psychology philosophy and there is an opportunity to contribute this knowledge and expertise to multi-disciplinary teams in order to strengthen the relational skills which women seem to be calling for in their postpartum relationships with professionals.

Since the original literature review, there continues to be minimal material about stigma and help-seeking in relation to postpartum depression within Counselling Psychology journals, although a steady flow of research on stigma and help-seeking with regards to general mental health emerges from the United States (Hammer and Vogel, 2013; Lannin, Vogel, Brennar, Abraham and Heath, 2016). There is therefore an opportunity for UK-based Counselling Psychologists to further this work. This might be in the context of training professional colleagues in other disciplines about the importance of process, relational-reflexivity and self-schema for the therapeutic relationship (Bennett-Levy and Thwaites, 2007) as well as contributing to the design of services which educate women about the impact of social processes such as social comparison and impression management on stigma and help-seeking and working within the wider community, including the media, to encourage women to talk about difficulties openly and honestly in order to normalise difficulty and increase compassionate support. With their systemic stance and their knowledge of the power process as well as the conscious cognitive process of personal and relational reflexivity (Dallos and Stedmon, 2009) and microskills of the therapeutic relationship (Gilbert and Leahy, 2007), Counselling Psychologists are well placed to share their knowledge with medical peers to increase awareness of these subtle but powerful processes. This could be the difference that makes a difference (Bateson, 2000) for the care of women's postpartum emotional well-being.

5.7 Methodological and Personal Reflexivity

5.7.1 Methodological reflexivity.

The findings of this research, where social comparison and impression management have been highlighted, reflect a social constructionist stance, where people are inherently social, constantly considering how they relate and compare to others. As such, there are multiple realities at play in the world of postpartum emotional well-being, for instance, the reality one aspires to, the reality experienced privately and the various realities presented to others. This upholds the selection of grounded theory, due to its' ontological stance that there is no objective reality (Ponterotto, 2005). The challenge of this approach, as with any qualitative approach, is that the interpretation is inevitably influenced by the views of the

researcher, no matter how rigorously they attempt to bracket. This is the epistemological nature of the relationship between researcher and those being researched (Ponterotto, 2005). In addition, actually, this is a parallel process to that of professionals and peers of people who support women with postpartum emotional difficulties, and it is helpful to highlight this and build this into a more systemic way of supporting these women, rather than try to pretend that interventions can succeed as an objective, unilateral approach.

5.7.2 Personal reflexivity.

The nature of qualitative research is that the researcher will inevitably shape the research based on their own conscious and unconscious bias through the questions they ask participants, the attention they give to some answers and not others and the way they extract meaning from the data. As a white British, university-educated mother in her early 40's, my personal demographic is similar to that of the participants within this study and it is possible that my analysis was influenced by an unconscious identification with those potentially similar to myself. However, the sample was not designed to be deliberately homogenous and the researcher's clinical training which emphasises the importance of the idiosyncratic experience of the individual was at the forefront of her mind during analysis, attempting to highlight areas of difference, as well as similarity, within the experiences reported by the participants.

With no previous history of depression and a successful, full-time career prior to becoming a mother, the researcher's adjustment to motherhood, as described in the Prologue (see page xiii), bore many similarities to the experiences of the professional women described in this research. As a result, this may have triggered a strong compassionate urge within the researcher to champion the experience of the participants and give them the voice that they had perhaps been unable to use themselves, by "saying it how it is" on their behalf.

Towards the end of my Doctorate, I experienced a life-changing event, when my husband was knocked off his bicycle, sustaining a broken back, multiple maxillofacial fractures and a traumatic brain injury. He spent three weeks in an induced coma, a further 12 weeks in hospital and over a year later, is still unable to return to his job full-time. I see several similarities between this crisis and my experience of becoming a first-time mother.

When the outcome of the accident was so uncertain, I wondered whether my life was ruined. I noticed a desire to ruminate about all the retrospective 'if only' and future-

oriented 'what ifs' and I mourned for the life that I had once had. Similar to my postpartum experience, I experienced a rapidly changing emotional state, from joy to despair. In addition, I observed a tendency towards intense guilt about some of the unspeakable thoughts that I had.

Upon my husband's return from hospital, there was great jubilation from friends and family; the news was met with comments such as, "you must be delighted!". Whilst I felt relief that he was alive and would be able to have a future without constant medical care, the reality was that I was terrified about the implications for the future. I wondered whether I would be able to look after him, whether I would be able to juggle his needs with those of my children and what these tensions meant for progressing with my Doctorate. I noticed there were very few people I was willing to share these thoughts with, for fear of not being understood or being perceived as ungrateful. Again, this echoed experiences of early motherhood.

Yet, there was a stark difference between the way I handled this crisis and the way I handled the initial shock of motherhood. The difference was my understanding of the link between my thoughts, emotions and behaviours. This allowed me to comprehend my internal experience, offer myself warm self-compassion and accept myself and my response to the trauma without chastising myself. Ultimately, it was this self-knowledge which helped me to cope with the trauma and to navigate myself and my children through the unknown landscape. Equally, my self-concept remained intact and I saw no shame in needing to proactively seek help or accept help when it was offered to me.

This life event will probably have steered me towards recommendations which encouraged women to develop greater self-awareness of their inner cognitive-behavioural repertoires in order to lend them greater choice about behaviours in the postpartum period where difficult thoughts might surface. In addition to my self-awareness, I also observed how others responded to me in my situation. There were some wonderful family members and friends who descended to envelope me and my children in love, practical and emotional support. There were others, some of whom I had expected to be helpful, who stayed away. Occasionally, people came up to me once my husband was home and freely said, "I saw you and wanted to say something, but I didn't know what to say". Such comments reinforced my curiosity in the factors which lead to approach-avoidance (Lewin, 1935), and so again, it is perhaps not surprising that in choosing how to interpret my results, the role that avoidance of difficult conversations has in perpetuating stigma emerged.

So it is through this lens that I have considered the findings of this study, and highlighted issues related to self-awareness and avoidance in my discussion and recommendations. Had I not had this experience, I might have chosen to focus on different aspects of the analysis such as how peer relationships might influence the experience of stigma or factors governing how women choose whom to disclose to.

5.8 Conclusion

This thesis set out to explore how women understand the role of stigma in seeking help for postpartum emotional difficulties. Using a grounded theory approach, six first-time mothers offered their reflections over seven interviews about their experiences of motherhood, stigma and help-seeking. This emphasised how their understanding of stigma focused more on 'not coping' rather than on mental health labels such as postpartum depression. Highlighting how the process of social comparison lay behind the experience of 'not coping' due to the influence of dominant public narratives which set high expectations of what motherhood looked like, there was a perception that more normative experiences were not discussed at either a public or interpersonal level. This meant it was difficult to construct realistic expectations of what motherhood would be like. The meaning that women gave to the difference between expectations and the reality of their experience sometimes led to self-stigma.

Due to a desire to be seen as coping, women described a process of impression management which they used with peers, family and professionals to preserve the illusion of competence. The absence of "saying it how it is" was amplified by the way that peers, family and even professionals avoided discussing the emotional difficulties accompanying early motherhood. This prompted the researcher to consider the importance of what is and is not communicated.

Recommendations for further research and improvements to practice focused on increasing open and honest conversations to normalise postpartum emotional difficulties at the public, professional and peer levels. Ideally, a renewed focus on helping women to understand their multiple realities and how these are influenced by their personal context will build awareness of the cognitive and behavioural responses that are typical for them, including self-stigma and desire to avoid help. With greater awareness of these processes, hopefully they can move towards emotional well-being through greater compassionate self-acceptance. From my position as a trainee Counselling Psychologist, this thesis privileges the view that "being with" someone in an emotional capacity is invaluable and

that those who avoid this in favour of “doing to” (Boucher, 2010, p.156), through their focus on interventions, potentially contribute to stigmatising the women they seek to support.

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APPENDIX A: Recruitment, Consent and Debrief Materials

RECRUITMENT POSTER/EMAIL:

Are you a first time mother?

Have you, or someone you know, found being a mother harder than expected?

Do you, or someone you know, find it difficult to tell others about these experiences?

Perhaps you, or someone you know, fear being judged or labelled as a "bad mother"?

If this sounds like you or someone you know, please read on!

I am a Trainee Counselling Psychologist at London Metropolitan University. I am researching the role of stigma in women's decisions to seek help for emotional difficulties in the first year of motherhood.

I am looking for first time mothers who would be prepared to complete a 10-15 minute questionnaire and possibly a follow-up face-to-face interview which would last about 1 hour.

If you would like to find out more about participating in this study, please contact Suki Smallwood at: sk0157@my.londonmet.ac.uk

This research has been approved by the Ethics Committee of London Metropolitan University and is being supervised by Dr. Angela Loulopoulou (A.Loulopoulou@londonmet.ac.uk).

APPENDIX B: PARTICIPANT INFORMATION FOR RECRUITMENT LETTER

Thank you for expressing an interest in taking part in my study. This letter provides more information about my research so that you can make an informed choice about whether you would like to participate and find out if you meet the criteria to participate.

I am a trainee Counselling Psychologist at London Metropolitan University. As part of my training, I am undertaking research to understand the help-seeking behaviours of women with postnatal emotional difficulties. This research has been approved by London Metropolitan's Ethics Committee.

Summary of the research

Current research shows how women might experience a number of different emotional challenges and difficulties following the birth of their child. Whilst some women might understand this as postnatal depression, others may not and may not view it as a significant problem requiring professional help, even if the symptoms are severe.

Research also indicates that as many as 58% of women with symptoms of postnatal depression, such as feelings of sadness and lack of pleasure, do not seek professional help. There are many reasons why this might be, such as feeling that their symptoms are a normal reaction to childbirth, rather than something that requires professional help, not knowing enough about what postnatal depression is to recognise that they have it, not knowing where to find help, or feeling that there is a stigma attached to seeking help because they might be seen as a 'bad mother'.

As yet, little is known about how this stigma, where it exists, is formed. A greater understanding of this might help health professionals make the provision of help more accessible to women who would like help, but feel unable or ashamed to ask for it.

Participant involvement

I am looking for adult women (18+) who have had their first baby within the last year. I am interested in the experiences of both women who have postnatal emotional difficulties (regardless of whether they call it postnatal depression) and those who don't. As the focus of my research is postnatal emotional difficulties, if you have received professional help for a mental health difficulty other than postnatal depression, such as general depression or anxiety, unfortunately, you will be unable to participate.

There are 2 parts to my research: a questionnaire and a face-to-face interview. If you are prepared to be interviewed, then please complete the questionnaire. Some people will be invited to interview within the next month, others may be contacted in a few months time, whilst others may not need to be interviewed at all.

Part One

This questionnaire will enable me to identify women with different experiences so that I can invite a small number to be interviewed face-to-face. It will take you about 10-15 minutes to complete.

All answers to this questionnaire will be kept confidential and your personal contact details will be kept separately from your questionnaire and stored securely for the duration of the research, after which they will be responsibly destroyed. The questionnaire contains:

- Basic information about you, such as your age and the age of your baby
- How you feel you are coping at the moment using the Edinburgh Postnatal Depression Scale (EPDS)
- Your attitudes to seeking help for emotional difficulties, using the Self-Stigma of Seeking Help Scale and the Barriers and Access to Care Evaluation scale.

If your answers to the EPDS indicate possible symptoms of postnatal depression, I will inform you and provide you with details of organisations that can provide you with support, in addition to recommending you contact your GP.

Part Two

The second part of my research will involve a face-to-face interview with me to discuss your views in more detail. This will be a 60 minute interview held in a mutually convenient location. The interview will be digitally recorded and held securely until the research is complete, after which it will be responsibly destroyed. The interview will be transcribed and all information which could identify you personally will either be removed or anonymised. Quotes from interviews (that contain no personally identifying information) may be included in the Doctoral Thesis, which may go on to be published.

You may find that the subject matter of this research invites you to talk about aspects of your mothering experience that you have felt too embarrassed or ashamed to talk about before, and you may find this upsetting.

If you feel you may be experiencing postnatal emotional difficulties, including postnatal depression, and would like help, please talk to your GP. Details of organisations who support families with postnatal depression are provided at the end of this questionnaire.

This research project is being supervised by Dr. Angela Loulopoulou at London Metropolitan University. If you have any questions about this research, please contact me at: sks0157@my.londonmet.ac.uk . Alternatively, you may contact Dr. Loulopoulou at: A.Loulopoulou@londonmet.ac.uk .

CONSENT FORMS

Participant Information and Consent for Questionnaire

Thank you for agreeing to complete this questionnaire.

This questionnaire forms part of a study aiming to understand the role of stigma in women's help-seeking behaviours for postnatal emotional difficulties. This research forms the basis of a Doctoral Thesis in Counselling Psychology and the finished work may be published. The content of this questionnaire may lead you to think about how well you are coping as a mother, which you may find uncomfortable or upsetting. If you feel you have postnatal depression, you should discuss this with your GP. Details of organisations that provide support for families affected by postnatal depression are provided at the end of the questionnaire. Completing the questionnaire is voluntary and you may stop completing the questionnaire and choose not to submit it at any point.

The questionnaire will take 10-15 minutes to complete and will ask you:

- A little bit about you and your baby – e.g. how old you are
- How you are coping at the moment using the Edinburgh Postnatal Depression Scale (EPDS)
- Your attitudes to seeking help

Once you submit the questionnaire, your answers will be analysed and you may be invited to attend a follow-up interview with the researcher within a month or in a few months' time depending on your availability. It may even be that a follow-up interview is not required.

If completing the questionnaires brings up difficult emotions for you, you are free to opt out of the interview. Furthermore, if your answers to the EPDS indicate possible symptoms of postnatal depression, I will inform you and provide you with details of organisations that can provide you with support, in addition to recommending you contact your GP.

If you attend the interview, a summary of your questionnaire data will be included in the written research along with data collected from other participants. However, all personally identifying material will be removed so that it is not possible to identify you within the written report. Your contact details will be stored separately to your questionnaire data and held securely until after the research has been assessed, after which it will be destroyed.

Please read the following statements and sign to confirm that you wish to participate in the questionnaire.

I understand that:

- The content of the questionnaire may lead me to consider how I am coping as a mother which I may find upsetting
- I can contact my GP if I am experiencing postnatal emotional difficulties.
- I am free to choose not to submit my questionnaire.
- My answers to the questionnaire will be stored securely.
- I understand that if I go on to be interviewed, my questionnaire data will be included in the written research report, but that any information that might identify me will be anonymised or removed.

- I understand that the final Doctoral Thesis may be published, for instance in academic journals.
 - I can confirm that I am over 18 years old
 - I confirm that I have not previously received treatment for a mental health condition other than one directly related to postnatal emotional difficulties.
 - I understand that if I disclose a serious intention to harm myself, or someone else whilst participating in this research, that the researcher may feel it is necessary to contact my GP so that I can receive appropriate care.
- Please tick and sign to signify your consent to participate in this research.

Name (Please print): _____ Signed: _____ Date: _____

This research project is being supervised by Dr. Angela Loulopoulou at London Metropolitan University. If you have any questions about this research, please contact me at: sks0157@my.londonmet.ac.uk . Alternatively, you may contact Dr. Loulopoulou at: A.Loulopoulou@londonmet.ac.uk .

Participant Information and Consent for Interview

Thank you for agreeing to be interviewed for my research, following your completion of your recent questionnaire.

This interview forms part of a study aiming to understand the role of stigma in the help-seeking behaviours of women with postnatal emotional difficulties. The interview questions may invite you to talk about aspects of your mothering experience that you have felt too embarrassed or ashamed to talk about before and you may find this upsetting. You are free to pause or stop the interview at any point.

If you are experiencing postnatal emotional difficulties, you can discuss this with your GP. Details of organisations who provide support for families affected by postnatal depression will be provided at the end of the interview.

The interview will take about one hour and will ask you to describe your experiences and/or attitudes about postnatal emotional difficulties, stigma and seeking help.

The interview will be digitally recorded, transcribed and used as part of the research analysis. All personally identifying details, such as names, will be changed to ensure you remain anonymous. Quotes from interviews, with all identifying information removed, may be replicated within the research paper. The research paper may be published at a later date, for instance, in academic journals. The recordings will be stored securely until after the research paper has been assessed and will then be destroyed. You are free to withdraw your consent to participate until <<insert date two weeks after interview>>. After this the analysis will have taken place and merged with other interview data.

Please read the following statements and sign to confirm that you wish to participate in the interview.

I understand that:

- The content of the interview may lead me to consider how I am coping as a mother which I may find upsetting.
- I am free to pause or stop the interview at any point.
- The interview will be digitally recorded, transcribed and held securely until after the research is assessed after which the audio recording and transcript will be destroyed.
- Quotes from interviews may be included in the written Thesis. All personally identifying details will be changed in the transcripts and Thesis to preserve my anonymity.
- I understand that the final Doctoral Thesis may be published, for instance in academic journals.
- I can withdraw my consent up until << insert date two weeks after interview >> after which time the data will have been analysed and merged with other interviews.
- I can contact my GP if I feel concerned that I have postnatal depression or any other postnatal emotional difficulties.

- I understand that if I disclose a serious intention to harm myself, or someone else whilst participating in this research, that the researcher may feel it is necessary to contact my GP so that I can receive appropriate care.

- Please tick and sign to signify your consent to participate in this research.

Name (Please print): _____ Signed: _____ Date: _____

This research project is being supervised by Dr. Angela Loulopoulou at London Metropolitan University. If you have any questions about this research, please contact me at: sks0157@my.londonmet.ac.uk . Alternatively, you may contact Dr. Loulopoulou at: A.Loulopoulou@londonmet.ac.uk .

APPENDIX C – Screening Materials: measures for identification of research sample. Completed using Survey Monkey. First page to be completed replicated consent form (see Appendix B) and participants needed to click they consented before accessing the questions.

This research is looking for women with different experiences of postnatal emotional difficulties. In order to identify a suitable sample for the study, some screening questions are required. If you are prepared to talk in confidence about your postnatal experience with a researcher face-to-face for about an hour, please complete the questionnaire below. The questionnaire will take 10-15 minutes to complete.

QUESTIONNAIRE PART ONE: ABOUT YOU

- Name:
- Email:
- Telephone number¹⁷:
- Name of GP:
- Name of GP Surgery
- Address of GP Surgery:
- GP Phone number:
- How old are you? (years)
- How many children do you have?
- How many months old is your baby? (months)
- Since having your baby, have you ever felt you had symptoms of postnatal depression?
 - Yes
 - No
- Since having your baby, have you ever asked for help for postnatal emotional difficulties? If so, who did you speak to (tick all that apply)?
 - GP
 - Health Visitor
 - Midwife
 - Counsellor/psychotherapist
 - Family member
 - Friend
 - Support group
 - Postnatal depression charity
 - Other
 - I have chosen not to ask for help, although I do have postnatal emotional difficulties
 - I do not have postnatal emotional difficulties and therefore do not need help
- If you are currently receiving professional help for postnatal emotional difficulties, what sort of help are you receiving?
 - Medication (e.g. anti-depressants)
 - Counselling

¹⁷ This information will be stored separately to the remainder of the questionnaire to preserve anonymity

- Support group
 - Listening visits from my Health Visitor
 - Other (Please specify)
 - Although I have symptoms, I have not asked for professional help
 - I have no symptoms, so am not receiving professional help
- Have you ever received professional support for a mental health condition other than postnatal depression?
- Yes
 - No

QUESTIONNAIRE PART TWO: Edinburgh Postnatal Depression Scale (EPDS) – to provide an indication of depressed mood

This questionnaire is included in order to identify possible signs of postnatal depression and to gauge the psychological well-being of participants. Participants scoring 20 or more in total and/or answer 'sometimes' or 'yes, quite often' to question 10 will be excluded, as they may be too vulnerable to participate safely.

Edinburgh Postnatal Depression Scale¹ (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

Here is an example, already completed.

I have felt happy:

- Yes, all the time
- Yes, most of the time This would mean: "I have felt happy most of the time" during the past week.
- No, not very often Please complete the other questions in the same way.
- No, not at all

In the past 7 days:

- | | |
|---|--|
| <p>1. I have been able to laugh and see the funny side of things</p> <ul style="list-style-type: none"> <input type="checkbox"/> As much as I always could <input type="checkbox"/> Not quite so much now <input type="checkbox"/> Definitely not so much now <input type="checkbox"/> Not at all | <p>*6. Things have been getting on top of me</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes, most of the time I haven't been able to cope at all <input type="checkbox"/> Yes, sometimes I haven't been coping as well as usual <input type="checkbox"/> No, most of the time I have coped quite well <input type="checkbox"/> No, I have been coping as well as ever |
| <p>2. I have looked forward with enjoyment to things</p> <ul style="list-style-type: none"> <input type="checkbox"/> As much as I ever did <input type="checkbox"/> Rather less than I used to <input type="checkbox"/> Definitely less than I used to <input type="checkbox"/> Hardly at all | <p>*7. I have been so unhappy that I have had difficulty sleeping</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes, most of the time <input type="checkbox"/> Yes, sometimes <input type="checkbox"/> Not very often <input type="checkbox"/> No, not at all |
| <p>*3. I have blamed myself unnecessarily when things went wrong</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes, most of the time <input type="checkbox"/> Yes, some of the time <input type="checkbox"/> Not very often <input type="checkbox"/> No, never | <p>*8. I have felt sad or miserable</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes, most of the time <input type="checkbox"/> Yes, quite often <input type="checkbox"/> Not very often <input type="checkbox"/> No, not at all |
| <p>4. I have been anxious or worried for no good reason</p> <ul style="list-style-type: none"> <input type="checkbox"/> No, not at all <input type="checkbox"/> Hardly ever <input type="checkbox"/> Yes, sometimes <input type="checkbox"/> Yes, very often | <p>*9. I have been so unhappy that I have been crying</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes, most of the time <input type="checkbox"/> Yes, quite often <input type="checkbox"/> Only occasionally <input type="checkbox"/> No, never |
| <p>*5. I have felt scared or panicky for no very good reason</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes, quite a lot <input type="checkbox"/> Yes, sometimes <input type="checkbox"/> No, not much <input type="checkbox"/> No, not at all | <p>*10. The thought of harming myself has occurred to me</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes, quite often <input type="checkbox"/> Sometimes <input type="checkbox"/> Hardly ever <input type="checkbox"/> Never |

Administered/Reviewed by _____ Date _____

¹Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-Item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

²Source: K. L. Wisner, B. L. Parry, C. M. Plonitak, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

Users may reproduce the scale without further permission providing they respect copyright by quoting the names of the authors, the title and the source of the paper in all reproduced copies.

QUESTIONNAIRE PART THREE: Self-Stigma of Seeking Help (SSOSH) scale – to measure self-stigma

David Vogel has endorsed an amended version of the SSOSH which has changed the wording slightly to make it more appropriate for a UK audience. A copy of this correspondence appears after the questionnaire.

INSTRUCTIONS: People at times find that they face problems that they consider seeking help for.

This can bring up reactions about what seeking help would mean. Please use the 5-point scale to rate the degree to which each item describes how you might react in this situation.

1 = Strongly Disagree 2 = Disagree 3 = Agree and Disagree Equally 4 = Agree 5 = Strongly Agree

1. I would feel inadequate if I went to a health professional for help.
2. My self-confidence would NOT be threatened if I sought professional help.
3. Seeking professional help would make me feel less intelligent.
4. My self-esteem would increase if I talked to a health professional.
5. My view of myself would not change just because I made the choice to see a health professional.
6. It would make me feel inferior to ask a health professional for help.
7. I would feel okay about myself if I made the choice to seek professional help.
8. If I went to a health professional, I would be less satisfied with myself.
9. My self-confidence would remain the same if I sought professional help for a problem I could not solve.
10. I would feel worse about myself if I could not solve my own problems.

Items 2, 4, 5, 7, and 9 are reverse scored.

Vogel, D., Wade, N. and Haake, S. (2006). Measuring the self-stigma associated with seeking psychological help. *Journal of Counselling Psychology*, 53(3), 325-337. DOI: 10.1037/0022-0167.53.3.325.

Correspondence with David Vogel:

Vogel, David L [PSYCH] x

30/05/2013

To: xxxx

Feel free to alter the scale. Let me know how the study turns out and if you would like me include your version of the scale on the website.

David

30/05/2013

To: dvogel - preferred wording.docx

Dear David

I am a trainee Counselling Psychologist on the Professional Doctorate in Counselling Psychology program at London Metropolitan University in the UK.

I am currently preparing a research proposal for submission this July. My proposed research title is: Understanding the role of stigma in women's decisions to seek help for symptoms of postnatal depression.

I would like to use your Self-Stigma of Seeking Help scale as one of my measurement tools, administered using an online tool such as Survey Monkey. I note on the Iowa State University website (<https://selfstigma.psych.iastate.edu/?q=SSOSH>) that the scale is freely available for research purposes. However, I wanted to ask if I could alter the wording slightly to make the scale more meaningful for a UK audience. In the UK, the primary access point for psychological help for postnatal depression might be via a number of health professionals, including a GP(Doctor) and Health Visitor who would then refer them for psychological help if appropriate. Therefore, I would like to alter the wording of the scale slightly, replacing the word therapist with health professional. I have attached a document with the proposed amendments for your consideration.

I am, of course, happy to give more details of my proposed research.

I look forward to hearing from you.

Kind regards

Trainee Counselling Psychologist, London Metropolitan University

QUESTIONNAIRE PART FOUR: Barriers to Access to Care Evaluation (BACE-3) – to measure broader barriers to help seeking

Barriers to Access to Care Evaluation scale (BACE), Clement, Brohan, Henderson, Hatch and Thornicroft (2012). 30 items

Barriers to Access to Care Evaluation

BACE-3

Note to researchers distributing this scale: please only use after reading instructions in "Manual for Researchers".

Instructions: Below you can see a list of things which can stop, delay or discourage people from getting professional care for a mental health problem, or continuing to get help. By professional care we mean care from such staff as a GP (family doctor), community mental health team (e.g. care coordinator, mental health nurse or mental health social worker), psychiatrist, counsellor, psychologist or psychotherapist.

Have any of these issues ever stopped, delayed or discouraged you from getting, or continuing with, professional care for a mental health problem?

Please circle one number on each row to indicate the answer that best suits you.

For 'not applicable' e.g. if it is a question about children and you do not have children, please cross the Not applicable box.

	Issue	This has stopped, delayed or discouraged me NOT AT ALL	This has stopped, delayed or discouraged me A LITTLE	This has stopped, delayed or discouraged me QUITE A LOT	This has stopped, delayed or discouraged me A LOT
1.	Being unsure where to go to get professional care	0	1	2	3
2.	Wanting to solve the problem on my own	0	1	2	3
3.	Concern that I might be seen as weak for having a mental health problem	0	1	2	3
4.	Fear of being put in hospital against my will	0	1	2	3
5.	Concern that it might harm my chances when applying for jobs Not applicable <input type="checkbox"/>	0	1	2	3
6.	Problems with transport or travelling to appointments	0	1	2	3
7.	Thinking the problem would get better by itself	0	1	2	3
8.	Concern about what my family might think, say, do or feel	0	1	2	3
9.	Feeling embarrassed or ashamed	0	1	2	3
10.	Preferring to get alternative forms of care (e.g. traditional / religious healing or alternative / complementary therapies)	0	1	2	3
11.	Not being able to afford the financial costs involved	0	1	2	3
12.	Concern that I might be seen as 'crazy'	0	1	2	3

	Issue	This has stopped, delayed or discouraged me NOT AT ALL	This has stopped, delayed or discouraged me A LITTLE	This has stopped, delayed or discouraged me QUITE A LOT	This has stopped, delayed or discouraged me A LOT
13.	Thinking that professional care probably would not help	0	1	2	3
14.	Concern that I might be seen as a bad parent Not applicable <input type="checkbox"/>	0	1	2	3
15.	Professionals from my own ethnic or cultural group not being available	0	1	2	3
16.	Being too unwell to ask for help	0	1	2	3
17.	Concern that people I know might find out	0	1	2	3
18.	Dislike of talking about my feelings, emotions or thoughts	0	1	2	3
19.	Concern that people might not take me seriously if they found out I was having professional care	0	1	2	3
20.	Concerns about the treatments available (e.g. medication side effects)	0	1	2	3
21.	Not wanting a mental health problem to be on my medical records	0	1	2	3
22.	Having had previous bad experiences with professional care for mental health	0	1	2	3
23.	Preferring to get help from family or friends	0	1	2	3
24.	Concern that my children may be taken into care or that I may lose access or custody without my agreement Not applicable <input type="checkbox"/>	0	1	2	3
25.	Thinking I did not have a problem	0	1	2	3
26.	Concern about what my friends might think, say or do	0	1	2	3
27.	Difficulty taking time off work Not applicable <input type="checkbox"/>	0	1	2	3
28.	Concern about what people at work might think, say or do Not applicable <input type="checkbox"/>	0	1	2	3
29.	Having problems with childcare while I receive professional care Not applicable <input type="checkbox"/>	0	1	2	3

	Issue	This has stopped, delayed or discouraged me NOT AT ALL	This has stopped, delayed or discouraged me A LITTLE	This has stopped, delayed or discouraged me QUITE A LOT	This has stopped, delayed or discouraged me A LOT
30.	Having no one who could help me get professional care	0	1	2	3

Sarah Clement has endorsed the use of the BACE-3 for the purposes of this study.

Correspondence with Sarah Clement:

Clement, Sarah
31/05/2013

To: xxx

Dear Suki

It would be great if you use the bace in this context. It is fine to use it in an online survey

Best wishes
Sarah

Sarah Clement PhD
Lecturer
Programme Coordinator SAPPHIRE research programme www.sapphire.iop.kcl.ac.uk

DEMOGRAPHIC INFORMATION TO BE COMPLETED AT INTERVIEW:¹⁸

- What is your household income?
 - Less than £32,000
 - More than £32,000
 - I don't wish to answer this question
- What is the highest level of education you have completed?
 - GCSEs/NVQs
 - AS/A-Levels/IB
 - Undergraduate degree
 - Masters/Doctorate
 - Other
 - I don't wish to answer this question
- What is your employment status?
 - Employed full-time
 - Employed part-time
 - Maternity leave
 - Full-time home-maker
 - Other (please specify): _____
- What is your marital status?
 - Married
 - Separated
 - Divorced
 - Single
 - Widowed
 - I don't wish to answer this question
- What is your ethnic group?¹⁹
 - White
 - English/Welsh/Scottish/Northern Irish/British
 - Irish
 - Gypsy or Irish Traveller
 - Any other white background
 - Mixed/multiple ethnic groups
 - White and Black Caribbean
 - White and Black African
 - White and Asian
 - Any other mixed/multiple ethnic background
 - Asian/Asian British
 - Indian
 - Pakistani
 - Bangladeshi
 - Chinese
 - Any other Asian background
 - Black/African/Caribbean/Black British

¹⁸ This demographic information is being collected so that the sample can be compared to previous research, for instance, the significance of ethnicity on experience of postnatal emotional difficulties.

¹⁹ From: Office of National Statistics (2009)

- African
- Caribbean
- Any other Black/African/Caribbean background
- Other ethnic group
 - Arab
 - Any other (please write in)
- I don't wish to answer this question

APPENDIX D: Interview Schedules

Questions are based on the content of the literature discussed in the Critical Literature Review and focus on the distinction between public and self-stigma and their potential relationship with help-seeking. Consistent with the method of Grounded Theory, further interview questions will be constructed based on categories that emerge from the data. *Follow-up prompts are marked as bullet points and the researcher used judgement to assess whether it was appropriate to use these.*

INTERVIEW SCHEDULE FOR A 60 MINUTE INTERVIEW:

(As an ice-breaker) – How would you describe your experience of being a mother?

What has been good about it?

What has been difficult?

- How would you describe the characteristics of a 'good mother'?
- How would you describe the characteristics of a 'bad mother'?
 - How have you formed these views (e.g. personal experiences, public influences)?

What is your experience of stigma in relation to postnatal emotional difficulties?

- *(Where stigma is experienced personally)* – What personal factors would you say have contributed to this stigma? What public factors would you say have contributed to this stigma?
- *(Where stigma is not experienced personally)* - For women that do experience stigma in relation to postnatal emotional difficulties, What personal factors do you imagine might contribute to this stigma? What public factors do you imagine might contribute to this stigma?

What is your experience of seeking help to relieve symptoms of postnatal emotional difficulties?

How would you describe the relationship between stigma and help-seeking for postnatal emotional difficulties?

- If there is a stigma, what might help to change the meaning that people have of seeking help for emotional difficulties after childbirth?
- If there was one thing that would improve your experience of feeling supported as a mother, what would this be?

Is there anything else about stigma or help-seeking that may be important and which you would like to add?

Questions used for Theoretical Sampling

Based on the interviews, there appear to be 2-3 key areas that seem to influence help-seeking for difficulties with postnatal emotional well-being which need to be explored further.

1. Construction of motherhood and postnatal difficulties in society
2. Self-concept before and after birth
3. Perceptions of professionals providing support to mothers postnatally

Optional prompts to follow-up the interview questions appear in bullet-form following the opening questions. In hindsight, the additional prompts appear more like a Memo. They were designed to assist the researcher's memory.

Construction of motherhood and postnatal difficulties in society

How do you understand the suggestion that stigma of talking about emotional difficulties after birth is maintained by a deficit of accurate/truthful stories about motherhood?

- Self-stigma can arise when awareness of stereotypes evolves to agreeing with them and then turning them in on oneself. The women in this study seemed to perceive the collective representation of motherhood as binary, e.g. either it is heavenly or it is of women finding things so difficult that they harm their baby. How do you see public stereotypes of mothers? Do you think there are some experiences that are not represented? How realistic do you find portrayals of motherhood? What meaning do you give the public representations of motherhood you encounter?
- What emotional response do you think positive and negative stories about motherhood create and how might these lead to prejudice? *“The fact that most people have knowledge of a set of stereotypes does not imply that they agree with them (5). For example, many persons can recall stereotypes about different racial groups but do not agree that the stereotypes are valid. People who are prejudiced, on the other hand, endorse these negative stereotypes (“That’s right; all persons with mental illness are violent!”) and generate negative emotional reactions as a result” (from Corrigan)*

How do you understand the suggestion that women are complicit in maintaining the ‘stigma’ of finding things difficult after birth by not telling the truth about their experience?

- What stereotypes and prejudices exist about someone with emotional difficulties in the postnatal period?
- Any overt experience of discrimination? To what extent do you have views about mothers finding it difficult? Has this changed before and after you had children?
- What do you think of the suggestion that stigma is built in to our community structure in some way? E.g. media stories?

- How do you see the idea that finding the transition to motherhood difficult might lead some women to develop a belief that they are not functioning as a woman and feel shamed as a result? Do you think there is a particular stigma attached to postpartum depression as opposed to depression not associated with birth?

Self-concept before and after birth

How do you see the idea of normalising difficulties in adjustment and helping women to understand what is normal and when help is needed?

- What particular issues do you think might apply to professional women who have babies and how can these best be addressed? E.g. how to reach them if they do not engage with antenatal provision?
- At what point does the balance tip from thinking about seeking help to taking action and actually contacting someone, given the potential concerns about stigma?
- What other factors influenced the decision to seek help? Partner? Friends? Wider family?
- What do you think motivated you to take part in this research?
- To what extent do you think it is possible to distinguish between self-stigma of having emotional difficulties (e.g. not coping as a mother) from self-stigma of seeking help. i.e. how does being labelled as 'depressed' differ in terms of stigma from the stigma of seeking help?
- Many of the women interviewed said they held no prejudice against women with for instance, postnatal depression, and yet they would not want to be associated with a group that was aimed at supporting people with postnatal depression. What do you suppose this is about? What is it about a support group which seems to be problematic?

Perceptions of professionals providing support to mothers postnatally

What were your beliefs about seeking help for emotional difficulties before you had your baby? How have these changed since? What stories do/would you tell others about your experiences of seeking help?

- To what extent do you think information about what it means to seek help is accurate? Are there myths and how can these be addressed?
- How do you think professionals may (inadvertently) contribute to a stigma of seeking help for emotional difficulties following childbirth?

There were a lot of comments about breastfeeding and judgements (by professionals and others) about a woman's choice of feeding. How do you think this contributes to a woman's experience of emotional difficulties? In what way might the way breastfeeding is handled by professionals influence attitudes about seeking help for emotional difficulties?

APPENDIX E: DEBRIEFING LETTERS

DEBRIEF LETTER FOR QUESTIONNAIRE AND INTERVIEW

Thank you for participating in this research. Your contribution will help to build a greater understanding of how women experience stigma associated with seeking help for postnatal emotional difficulties. If you have follow-up questions about this research, please contact me on: sks0157@my.londonmet.ac.uk. Alternatively, you may contact my research supervisor, Dr. Angela Loulopoulou at London Metropolitan University: A.Loulopoulou@londonmet.ac.uk

Additional paragraph for participants in interview:

If you wish to withdraw your consent to participate, please contact me by <<insert date two weeks after interview>>. After this date, the data will have been analysed and it will not be possible to extract your particular contribution. However, please remember that all contributions will be anonymised meaning that no personally identifying details will be included within the final research paper.

Further Help and Resources:

If you feel that you are experiencing postnatal depression or any other postnatal emotional difficulties, please talk to your GP.

The following organisations also provide support to families affected by postnatal depression²⁰:

Association for Postnatal Illness

Helpline: 020 7386 0868. Provides telephone helpline, information leaflets and a network of volunteers who have themselves experienced postpartum depression.

Depression Alliance

Tel: 0845 123 23 20; email: information@depressionalliance.org

Information, support and understanding for people who suffer with depression, and for relatives who want to help. Self-help groups, information, and raising awareness for depression.

Cry-sis

Helpline: 08451 228669. Provides self-help and support for families with excessively crying and sleepless and demanding babies.

²⁰ Reproduced from the Royal College of Psychiatrists online resources about postnatal depression. More information can be found at: <http://www.rcpsych.ac.uk/expertadvice/problemsdisorders/postnataldepression.aspx>

Family Action

Tel: 020 7254 6251. Support and practical help for families affected by mental illness, including 'Newpin' services - offering support to parents of children under-5 whose mental health is affecting their ability to provide safe parenting.

Home Start

Tel: 0800 068 6368. Support and practical help for families with at least one child under-5. Help offered to parents finding it hard to cope for many reasons. These include postpartum depression or other mental illness, isolation, bereavement, illness of parent or child.

National Childbirth Trust

Helpline: 0300 330 0700; Pregnancy and Birth Line: 0300 330 0772; Breastfeeding: 0300 330 0771; Postnatal: 0300 330 00773. Support and information on all aspects of pregnancy, birth and early parenthood. Local groups and telephone helplines.

Netmums

A website offering support and information on pregnancy and parenting. There is a specific section on offering support. There is also information on local resources and support groups.

Pandas Foundation

An organisation that helps individuals and their families with pre- and postnatal depression advice and support. They also offer support to families in the antenatal period. Helpline (open 9am to 8pm): 0843 2898401.

The Samaritans

24-hour helpline 08457 90 90 90 (UK) or 1850 60 90 90 (Ireland); Email: jo@samaritans.org.

Confidential emotional support for those in distress who are experiencing feelings of distress or despair, including suicidal thoughts.

Relate

Tel: 0300 100 1234. Relationship support including couple and family counselling. Face-to-face, telephone or online counselling.

Thank you again for taking the time to participate in this study.

Suki Smallwood

sks0157@my.londonmet.ac.uk

EPDS DEBRIEF LETTERS

Letter/email to be sent in addition to debrief materials (see Debrief letter), to supplement a phone call, in the event of a participant stating they think of harming themselves 'sometimes' or 'yes, quite often' on the EPDS. (These participants will be excluded from the study.)

Dear xxxx

Thank you for taking the time to complete the questionnaires as part of my Doctoral Research. To follow-up our recent phone conversation, one of the questionnaires you completed was the Edinburgh Postnatal Depression Scale (EPDS). You indicated that you think of harming yourself <<*sometimes or quite often*>> [delete as appropriate]. To ensure you receive the appropriate support, I strongly recommend you discuss this with your GP. I also attach details of various organisations that provide additional support, in particular the Samaritans who are available 24/7 on 08457 90 90 90. You can also attend your local AandE department if you feel you are in crisis and need immediate support.

Please do not hesitate to contact me if you would like to discuss this further.

Kind regards

Suki Smallwood

Letter/email to be sent, in addition to Debrief materials, to supplement a phone call, in the event of a participant scoring 20 or more on the EPDS, indicating possible depression, even if they do not think about self-harm. (These participants will be excluded from the research).

Dear xxxx

Thank you for taking the time to complete the questionnaires as part of my Doctoral Research. Further to our recent phone conversation, one of the questionnaires you completed was the Edinburgh Postnatal Depression Scale (EPDS). A score of 10 or more on this scale is an indication of *possible* symptoms of postnatal depression. Your score on the EPDS at the time of filling this out was x. To ensure you receive the appropriate support, I strongly recommend you discuss this with your GP. I also attach details of various organisations that provide additional postnatal support.

Please do not hesitate to contact me if you would like to discuss this further.

Kind regards

Suki Smallwood

APPENDIX F: Distress Protocol

Distress protocol

At the start of the interview, in addition to asking the participant to read and sign the consent form, the researcher will verbally tell the participant that participation is voluntary and that they may pause or terminate the interview at any time. Throughout the interview, the researcher will be observing the facial expressions and body language of the participant for signs of distress. In the unlikely event that a participant becomes upset or distressed during the interview, the researcher will follow the procedures set out below:

Scenario One: Participant appears mildly to moderately upset, observed by crying.

The researcher will pause the interview and provide the participant with affirmation that it can be difficult to talk about these things and that it is ok to share the emotion. The participant will be given time to gather herself. The researcher will ask the participant if she wishes to continue. Unless the answer is yes, the interview will be terminated. The researcher will give and discuss a list of organisations that provide support for postnatal emotional distress.

A follow-up phone call will be made to the participant the next day and an offer of talking through the various supporting organisations on the list provided will be made.

Scenario Two: The participant appears moderately to severely distressed, observed by uncontrollable crying, shaking, panic attack, disassociating, shouting.

The researcher will terminate the interview. Grounding and relaxation techniques will be worked through with the participant, based on clinical judgement of what will be most helpful. When the participant is calm, the researcher will go through a list of different supporting organisations that might be helpful to contact and the participant will be given a copy of this list to take away. The participant will be encouraged to make an appointment with her GP to talk about her difficulties.

A follow-up phone call will be made to the participant the next day and an offer of talking through the various supporting organisations on the list provided will be made.

Scenario Three: The participant discloses suicidal thoughts or a serious intention to harm herself or another individual.

The researcher will terminate the interview immediately. She will then engage the participant in a conversation to assess and manage risk, using skills learned at the Risk Assessment and Management Course, run by APT (Association of Psychological Therapies). This will include focusing on the specificity and timing of the plan, in addition to identifying access to the means to carry out the plan. Protective factors will also be explored. These include assessment of the family, community and medical support easily accessible to the individual, as well as exploration of reasons for living, e.g. responsibility to family, moral objection to suicide and coping beliefs (Malone et al, 2000; Linehan et al, 1983). If there is no specific plan associated with the thoughts, then the protocol associated with Scenario Two will be followed. If the participant has a specific plan in place, the researcher will phone the participant's GP to make an emergency appointment for the same day to ensure the participant receives appropriate care. She will attempt to agree a contract with the participant to postpone the plan until the appointment is attended. The researcher will ensure the participant is accompanied to the surgery. If an emergency appointment is

unavailable, the researcher will escort the participant to the local A&E department. A follow-up phone call will be made to the participant the next day and an offer of talking through the various supporting organisations on the list provided will be made.

APPENDIX G: Participant Characteristics

The table below summarises participant responses to the screening pack that was used to identify the target sample. Further demographic information appears in Section 4.1.1.

Name ²¹	Age	Age of infant at time of interview (months)	Help-seeking from health care professionals?	EPDS score	SSOSH score	Notes on SSOSH This was used as contextual information.	Barriers to Access to Care indicated within BACE-3 – This was not scored, as most of the participants had not sought professional help. It was used as contextual information.
Ava	37	4	No – but depressive symptoms proactively identified by Health Visitor	5	17/50	No indications of self-stigmatising attitudes about help-seeking	Concerns about how others would see her and wanting to solve the problem herself discouraged her from seeking help ‘a little’
Belinda	37	7	No	5	22/50	As above	Indicated a preference to seek help from family or friends (‘quite a lot’)
Chloe	37	9	No	11	22/50	As above	Indicated wanting to solve the problem herself, thinking that professional care wouldn’t help, disliking talking about feelings and concerns about how others would see her discouraged help-seeking ‘a little’.

²¹ All names are pseudonyms

Name ²¹	Age	Age of infant at time of interview (months)	Help-seeking from health care professionals?	EPDS score	SSOSH score	Notes on SSOSH This was used as contextual information.	Barriers to Access to Care indicated within BACE-3 – This was not scored, as most of the participants had not sought professional help. It was used as contextual information.
Dana	40	10	Yes – via GP	10	36/50	Indications of self-stigmatising attitudes about feeling less satisfied for seeking help and not being able to solve own problems	Indicated wanting to solve problems on her own stopped her from seeking help ‘quite a lot’ and concerns about how others would see her for seeking help, concerns about her medical record and feelings of embarrassment and shame inhibited help-seeking ‘a little’.
Eleanor	36	4	No	5	14/50	No indications of self-stigmatising attitudes about help-seeking	Indicated that thinking that the problem would resolve on its own discouraged her from seeking help ‘quite a lot’.
Fiona	39	4	No	1	18/50	As above	Indicated that concerns about what her family would say inhibited help-seeking ‘a lot’ and concerns about having her difficulties on her medical records , concerns that professional care would not help and feeling embarrassed and ashamed discouraged help-seeking ‘quite a lot’.

Notes:

EPDS – Edinburgh Postnatal Depression Scale

SSOSH – Self-Stigma of Seeking Help Scale

BACE-3 – Barriers to Access to Care Evaluation

APPENDIX H: Sample extract from a Transcript/Interview

Extract from Transcript for Dana

R Perhaps to get us started, you'd like to just tell me a little bit about what your initial experiences of becoming a mother have been.

DANA Ummmm (. . . .) that, that its an instant robbing of everything you know about yourself. Umm, that's what surprised me. I, I instantly completely lost myself, in terms of there was now time, to do anything that I liked, and I didn't know how to do this. And I thought it would be something automatic or be something primeval that would kick in and I would know and I didn't so I...the first weeks were just a state of constant sort of panic and fear. Actually. And I sort of, if someone had come along with a magic wand and said you can change it back to how it was, I'd probably have been quite tempted to do that. Which was really, ummm, shocking to me, that I would feel like that. And I felt a bit guilty about feeling like that. And, ummm, it was not at all what I expected. Ummmm, I mean I did expect that it would be hard. And that I might find it a tricky new skill. But not that it would be such a huge, ummm [talks to baby: come here! no one can hear if they're trying to transcribe!]. Not that it would be such a sort of huge change of, of everything. Absolutely everything. So, yeah. There wasn't, there wasn't any of this joy, there wasn't any joy, this "it's amazing". None of that. And also, I was a bit sort of angry about that as well. Like...

R Yeah

DANA Has everyone lied to me? Has everybody? Do other people feel like this and just don't say, or am I, why, why haven't I go this [Shhhh] amazing, "oh my god, it's amazing, it's the best thing I ever did; it's the hardest.." you know, everyone's ...and that was quite a different thing to work out what was going on as well. Umm, so, yeah.

R Yeah. So all sort's of things were happening

DANA All sorts of things but not much actual positive which is horrifying really! Um.

R Well interesting. What is it that makes you say it is horrifying? It sounds like there's a judgement there that it wasn't a positive experience.

DANA Mmm, Yeah. Ummmm (. . . .), just because, I think, if I knew what that might feel like, I'm not sure I would have had kids. And that's sort of, quite a hard thing to think about. Umm, or, actually, probably, if I'd known about it, I would have loved to have been better prepared for feeling that way. Umm. So.

R Yeah

DANA So, it was, yeah, the most horrible time of my life.

R Yeah.

DANA Which is not what. And people go, "is it wonderful? Aahhh, isn't it wonderful!" And you're like, and you have to, you end up having to say, because that's what society expects going, "Oh yes, you know, he's amazing!" (...) But, umm, that wasn't how I felt at all.

Extract from Transcript for Fiona

FIONA You only hear about the total highs. Or the total lows. You know, people really struggling or having a really bad time of it. Or really depressed or psychosis or whatever. And whatever that Eastenders story was. It was on the news and the TV programmes. But there isn't, quite rightly, there isn't that much stuff about the mundane, day to day, hum-drum, it's just normal. But then, you don't see that stuff on the news about other aspects of life so,

R No.

FIONA You, you shouldn't really expect that people say, "Oh she's quite boring today!" But yeah I think that maybe the reality of how routine and, I think boring's the wrong word, I don't really ever feel bored.

R Yeah.

FIONA Erm. I don't think that's talked about as much.

R Yeah.

FIONA I mean there's not much really to talk about. [Talks to baby].

R I suppose one of the potential impacts of, of this sort of binary view of what's going is that when people are finding it difficult to disclose, to deal with, you know, the emotional consequences of having had a baby, is that they didn't actually feel comfortable disclosing they were finding it difficult because they didn't want to be associated with having a really terrible time and they didn't live up to the media view of what it should be like, and so women were a bit complicit in not saying when it was difficult.

FIONA Yeah, I think that, I can completely see how that would be the case. And even just, even if I've had a day where it's just been, just a bit tiring and a bit, I would feel really guilty about complaining about that.

R Uhuh.

FIONA Because it's not the worst day ever. And um, so you're kind, you don't, you're not, you're not allowed to complain about stuff, because there's always an extreme version.

R So say a bit more about that, not being able to complain about it being difficult.

FIONA So, if I, for example, she woke up at 3 last night. I can't really say too much about that to others that I know, because their baby might wake up 3 or 4 times a night *every* night.

R Yeah.

FIONA So it's only. And it's interesting actually, when she first rolled over,

R Yeah.

FIONA We've got a little What's App group going with our NCT group. I put a message saying, "She rolled over." And [names husband] had asked, me, "Oh, did you tell the girls?" And the reason he was asking was, because there were a couple of babies who are doing some things and a

couple of them aren't, and I was like, "Well, you know, I think we need to celebrate the positives as well as sharing the lows". Because that group became a bit, we only ever talked about stuff when someone was having a bad time. We were very supportive to each other

R Uhuh.

FIONA But not celebrating the positives.

R Yeah.

FIONA Because you kind of didn't want to upset someone else who maybe wasn't feeling so positive

R So being a bit delicate?

FIONA Yeah. So I think you can be a bit careful about only talking about the extremes.

R Yeah.

FIONA If that makes sense.

R Yeah. So you have this sense that there are things that are ok to say and things that are not ok to talk about, or?

FIONA Yeah, or, only to certain people. You know, maybe things that are ok on a one-on-one are better, but some mum friends that you've got, you kind of don't quite have that relationship. I suppose that's kind of the same as anything.

R Yeah, yeah.

FIONA Selective in what you talk about with people you know well and feel comfortable with. I think definitely, unless you're having the worst time ever, you feel a bit cheeky complaining about something that actually *does* matter to you. You know, she's been sleeping every night and suddenly, she isn't. That is a huge change for me.

R Yeah.

FIONA But, so I can see if someone was seeing, oh, you know, "I'm coping most days, but every now and again, I'm not". Then, actually, I can't say anything about it, because most of the time it's all ok, or most of the time, I don't feel like that.

APPENDIX I: EXTRACT FROM A CODED TRANSCRIPT (P10 is DANA)

75 P10 Like to not be able to get on top of that.

76 R Mmmm. And nothing had, you'd not heard of that being a possibility leading up
77 to...

78 P10 I mean people talk about postnatal depression, and I, I had a friend who had
79 postnatal depression and I'm guilty of thinking she kind of wallowed in that a bit.
80 And I'm, you know, errr, (...) she was quite, she is quite a pessimistic person, for
81 whom everything is someone else's fault. And when she, well it was a little bit like,
82 "hmmm" and you sort of think to yourself, "well that won't happen to me, because
83 I'm not that sort of person!" So it is, quite strange when you do feel like that.

84 R So there was an assumption there that only a certain kind of person gets ..

85 P10 Yeah! I think so!

86 R And what kind of person do you expect would be the stereotype of someone with
87 postnatal depression then?

88 P10 [Sighs]. Probably someone who's already sort of got a propensity to that.
89 Somebody who um, well I'm only going on what my friend was like, and is like... but,
90 but, it's that sort of idea that it's someone that kind of enjoys a drama, that's awful,
91 but that's the truth...and, almost, um, doesn't want to be helped almost. So it's.. It,
92 err, with her, it, her identity became that, that was her identity, being the postnatal
93 mum in the group. Umm. And so...and also I thought, "ooh, I'm going to notice if I
94 start to feel that way and I'll fix it soon, I'll fix it immediately. It'll never get to a point
95 where I need to talk to a "Oh I will know what to do!" It will be ...

96 R I can fix it.

97 P10 Yeah, if it was to happen, I'd fix it. [Baby laughs]

98 R OK, so, but it didn't turn out as expected. At what point did you realise that
99 things weren't quite right with you?

100 P10 Umm, well, I mean, the whole expectation that society sells you on
101 motherhood, the, the difference began the minute he was born.

102 R Yeah

103 P10 And I had a caesarean section so umm,

104 R And was that planned?

105 P10 Yes, because I had um [details medical condition] that could have made it
106 difficult for him, or could have caused problems so they decided to do that. And I
107 was absolutely fine about that. Umm, but, umm, they, obviously just hold your baby
108 up and I was just like, and I was expecting angels and then I got him and it just felt
109 like, oh, I had a baby. It just felt like really ordinary and not amazing and not like in
110 the movies. And that very first night when they send all the Dads home and you're

*Stigma of freed
"guilty of thinking,"
she wallowed in*

*Self identity
not that sort of
person.*

*Assumption that
PND happens to a
particular sort...*

*Perception - prod-
someone who
enjoys a drama
and doesn't want
to be helped.*

*Friend's identity
as "the one with PND"
"It'll never get to
a point where I
need to talk"*

*Society sells you
an expectation
of motherhood.*

*for her - started
minute he was born*

*It felt
ordinary...
and not
amazing
& not like in
the movies*

P10

111 left on your own and there's not enough staff to come and check on you so you're
 112 literally left on your own with a little creature and you've literally no idea what to do
 113 with it. So that was the first thing when I was like, "oh, gosh, this is going to be quite
 114 scary." And then I got baby blues from the milk coming in, which is just classic. But
 115 they just didn't go away. And that was when I sort of thought, after 2 weeks, I
 116 shouldn't still be feeling this down and bleak about it.

117 R Yeah

118 P10 So that's when I thought, "hmm, oh. I don't really know why I'm still not feeling
 119 that good about it." So.

120 R So, so, at what point did you decide to talk to someone about this, or what
 121 happened?

122 P10 I talked to my husband, but it upset him to hear it, umm

123 R So what was that like for you?

124 P10 Well awful, because I didn't want to upset him. And I didn't want, I didn't want,
 125 I just felt like, is it Linus in?

126 R Snoopy?

127 P10 Yeah, Charlie Brown, I just felt like I was just walking around with this massive
 128 cloud and I was trying to transfer it on to him and that's not very fair. And at the
 129 same time I was quite angry that he couldn't help me, at all. He, he just couldn't. I
 130 mean, maybe it's because he's used to me being that person that if something goes
 131 wrong, I fix it. If you have a, he's had disasters of losing work and I've found ways
 132 round to, you know

133 R Mmm

134 P10 I seem a sort of person that can fix things, so I don't think he really understood
 135 either. So then, it, it wasn't great. SO I just though, "oh", so I started writing a diary
 136 and letters to him that I never gave him.

137 R Letters to your husband?

138 P10 Yeah.

139 R About what you were feeling?

140 P10 Just to get it out at some point, because I couldn't really talk to him about it. So
 141 yeah.

142 R And how did that help or not help?

143 P10 It kind of did help, cos it's like that whole being able to say it.

144 R Mmm

Left on own
 with you're
 literally no idea
 what to do.

Baby blues
 -classic- but
 not going away,

Not understanding
 feelings.

Talked to husband,
 but he was upset.

Husband couldn't
 help - angry.

Others view of
 self as fixer.
 Feel bound to live
 up to that image?

Others not
 understanding.

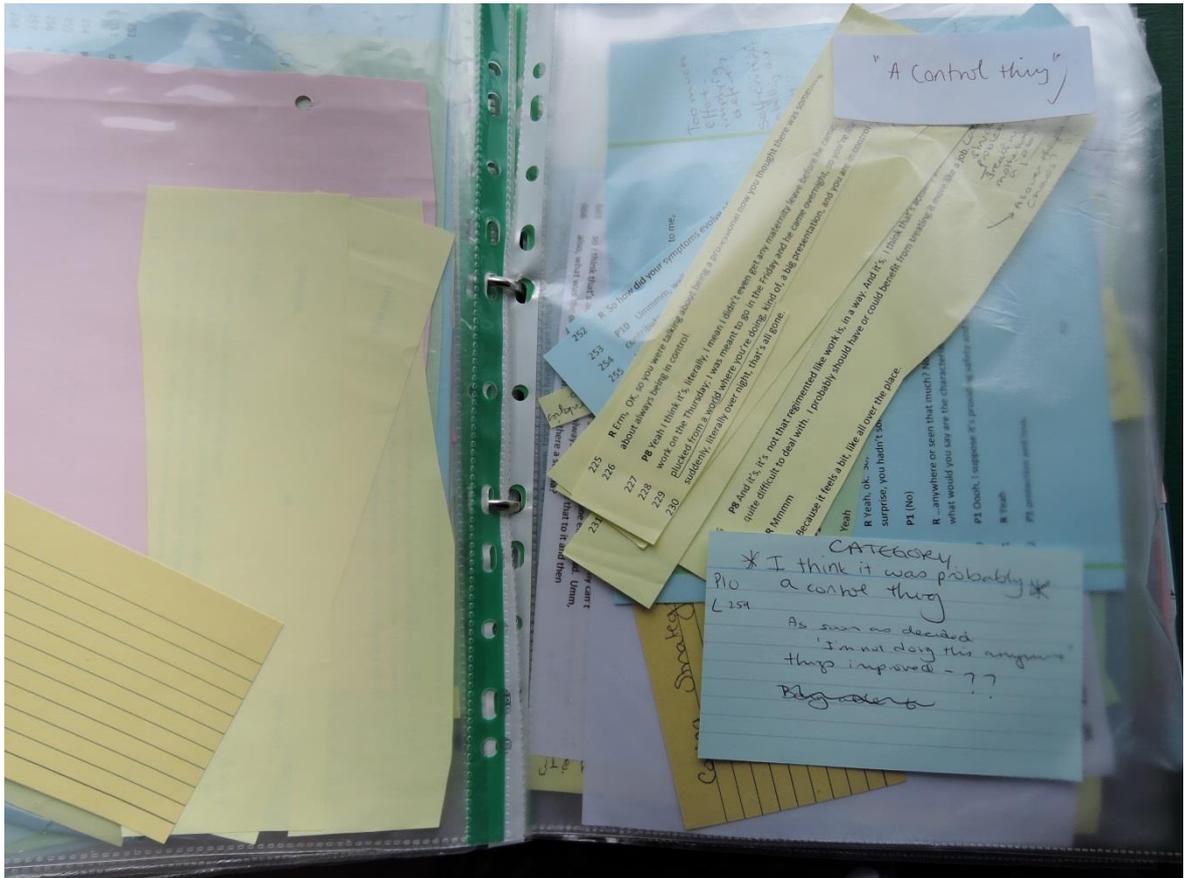
Finding way to
 tell others without
 actually doing so.
 (R: Sounds lonely?)

Needed outlet
 to say things.

P10

APPENDIX J: ILLUSTRATION OF CODING APPROACH:

Transcripts were coded and printed on different coloured paper to ensure the researcher could trace which participant 'owned' each comment'. Transcripts were then cut up in to codes, which were then sorted and re-sorted in to pockets, as the analysis evolved.



APPENDIX K: Coding tables

Table One: Coding table for Theoretical Concept 1.

Theoretical Concept: <i>Experiencing a difference between expectations and reality (and how this influences perception of self-concept)</i>		
Focused codes	Initial codes	Example from interviews
Anticipating the role of motherhood	What expected of motherhood	Chloe_201 Ava_36
	What expected of them self	Ava_35
Constructing meaning from the gap between expectations and reality	Recognising the magnitude of change	Belinda_141/394 Dana_12 Eleanor_150
	Making sense of the reality	Eleanor_54 Dana_14/100 Ava_1056

Table Two: Coding table for Theoretical Concept 2.

Theoretical Concept: <i>Reviewing a sense of self (which results in self-stigma)</i>		
Focused codes	Initial codes	Example from interviews
Pre-natal self as capable	Problem-solver	Dana_68; Dana_2_25; Ava_152; Chloe_67; Fiona_450
	In control	Chloe_219; Ava_244
	A social being	Ava_1050
Internalising postpartum self-stigmatising view of self	Guilt and shame	Chloe_307/665; Dana_417/421 Ava_189/319/356/593/998/1109/1114 Fiona_283/462
	Self-labelling	Ava_148/1056; Dana_355 Fiona_23/465; Dana_2_298
	Motherhood as an innate skill	Eleanor_669; Dana_2_182
Reinforcing loss of self through design of perinatal care	Focus on care of baby	Dana_509/241; Dana_2_489/583; Fiona_227; Belinda_425

Table Three: Coding table for Theoretical Concept 3.

Theoretical Concept: <i>Seeking and trusting the help available</i>		
Focused codes	Initial codes	Examples from interviews
Availability of information	Freely available information	Ava_1085; Belinda_459; Chloe_510; Fiona_50/575
	Disregarding information	Dana_82; Dana_2_605
Constructing views about healthcare professionals capacity to provide help	Using own personal experiences (+/-)	Ava_447; Dana_187; Belina_424; Eleanor_481; Fiona_138
	Influence of "others" experiences (+/-)	Chloe_114; Eleanor_553; Fiona_142
	Quality and consistency of advice	Chloe_443; Belinda_291; Fiona_145/158; Eleanor_519
Making decisions about <i>who</i> to seek healthcare information from	Using non-NHS professionals (e.g. friends, family, non-NHS professionals)	Belinda_219/333; Chloe_70/447/529; Eleanor_171/577/588; Fiona_409/469
	Timing of routine help not available when needed	Dana_157; Fiona_93; Belinda_230
Willingness to disclose difficulties	Anticipating stigma from Professionals	Eleanor_540; Chloe_520/539; Eleanor_622; Fiona_229
	Anticipating stigma from friends	Ava_305; Fiona_381/475; Dana_585

Table Four: Coding table for Theoretical Concept 4.

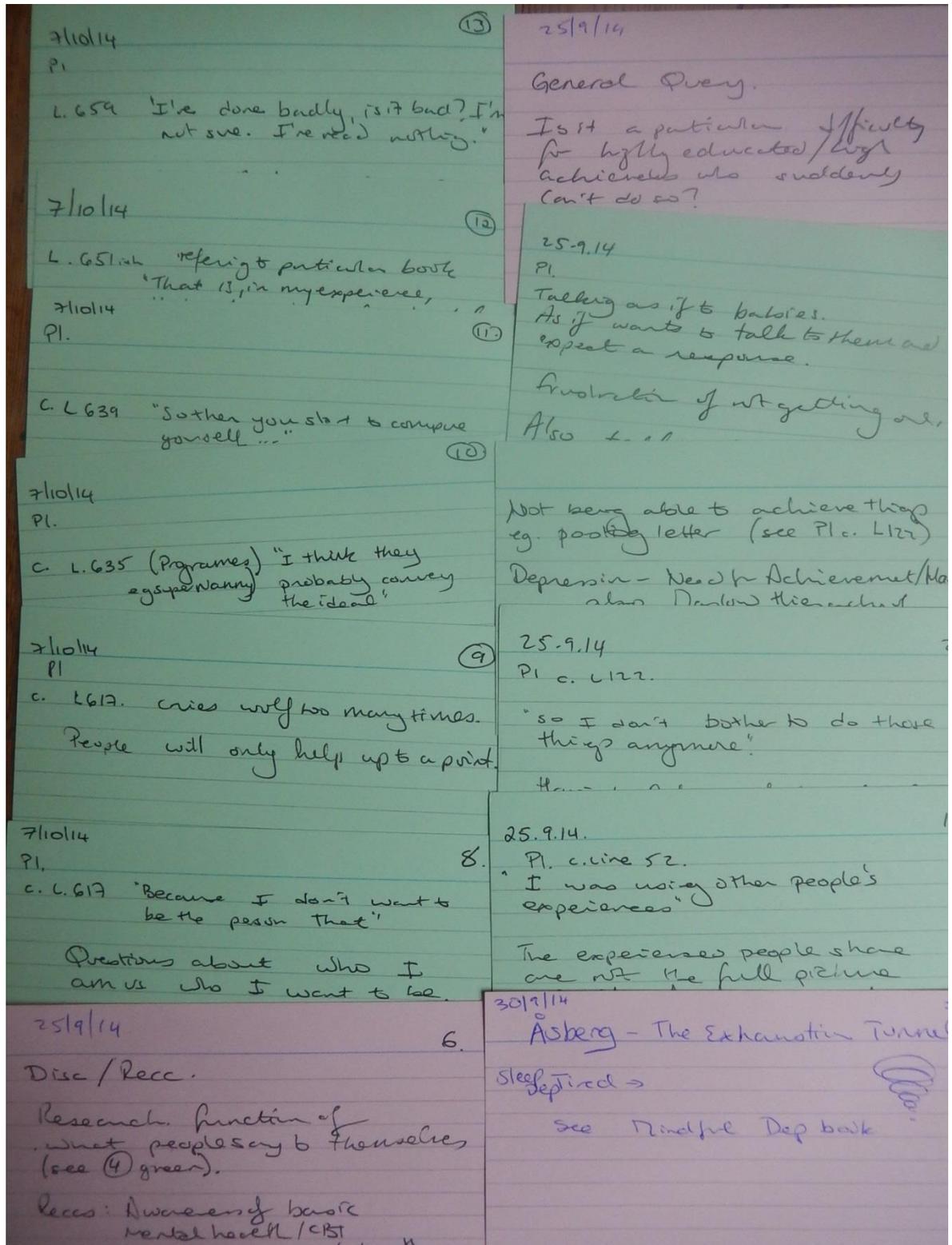
Theoretical Concept: <i>“Saying it how it is”</i>		
Focused codes	Initial codes	Example from interviews
Dominant media portrayal of postpartum depression perceived as binary	Binary portrayal of motherhood	Chloe_466/651/L655; Belinda_L92/L97/L104; Ava_192 Fiona_261/264 Dana_317 Dana_2_70 Eleanor_177
	Stories hold power	Chloe_476/655 Dana_29 Eleanor_394 Fiona_283
Withholding disclosure of ‘real’ experience to others	Desire to avoid a judgement	Belinda_191 Eleanor_51 Chloe_262/643 Ava_798 Fiona_238
	Desire to protect others	Ava_827/833/919 Dana_489/498 Dana_2_143/336
Endorsing a stigma of postpartum emotional difficulties	Labelling self or others	Dana_78/2_601; Belinda_400 Ava_497/1114 Eleanor_696; Dana_2_28
	Avoiding asking others who appear to be experiencing difficulty	Fiona_362/371 Dana_2_382

Table Five: Coding table for Theoretical Concept 5.

Theoretical Concept: <i>Experiencing pressure to breastfeed as a stigma which inhibits desire to seek help</i>		
Focused codes	Initial codes	Examples from interviews
Perceiving judgement about not breastfeeding	From antenatal and hospital staff	Chloe_L686; Ava_725 Eleanor_L440; Fiona_509
	Influence from Health Visitors and GPs.	Chloe_120/123; Dana_287; Eleanor_440; Dana_2_513
Experiencing emotional distress as a result of not breastfeeding.	Embarrassment in public about bottle feeding.	Ava_L711; Dana_278/300
	Causal relationship between difficulties with breastfeeding and emotional difficulties .	Dana_570; Chloe_676; Eleanor_412; Belinda_424; Fiona_528; Dana_2_507
Withholding disclosure of emotional difficulties as a result of (lack of support with) breastfeeding experience.	Assumptions made about how professionals would respond to emotional difficulties, based on experience of perceived stigma about not breastfeeding.	Dana_L596; Eleanor_465; Fiona_535; Dana_2_535

APPENDIX L: SAMPLE MEMOS

Memos were written on coloured index cards, so that the researcher could quickly remember which interview had triggered the Memo.



Memo, based on comments by Fiona. Written 4/4/16

Line 617 – She is laughing at the purpose of the EPDS, because it's 'just so obvious'.

Line 622 – She goes on to say that you can decide what impression you want to create.

There is a possibility that people are intentionally skewing the results of their EPDS questionnaires, which is one of the main tools that professionals use to identify symptoms of postnatal emotional distress. Is there a social desirability factor built in to the questionnaire? If not, how can professionals work with the reality that people are intentionally managing the impression they give (to conceal distress?). What can literature on impression management/in-group/out-group social psychology offer us to explain this?

Memo, based on comments by Dana in her second interview. Written 9/3/16

Line 535 – "It's all about the baby".

I have the sense that this approach might be particularly difficult if your self-concept has been rocked and actually professional focus on the baby might reinforce a belief (since birth?) that you have ceased to exist. It seems that the impact of breastfeeding on the mum is secondary to the baby's needs and perhaps a negative impact on mum's emotions is down-played. So whilst breast may be best, it might not be worth it given potential negative impact on mental health of Mum – and that might negatively impact the baby in the long-run.

APPENDIX M: ETHICS APPROVAL



London Metropolitan University,
School of Psychology,
Research Ethics Review Panel

I can confirm that the following project has received ethical approval to proceed:

Title: Understanding the role of stigma in women's help-seeking behaviours for postpartum emotional difficulties: A Grounded Theory study
Student: Susannah (Suki) Smallwood
Supervisor: Dr. Angela Loulopoulou

Ethical clearance to proceed has been granted providing that the study follows the ethical guidelines used by the School of Psychology and British Psychological Society, and incorporates any relevant changes required by the Research Ethics Review Panel. All participating organisations should provide formal consent allowing the student to collect data from their staff.

The researcher is also responsible for conducting the research in an ethically acceptable way, and should inform the ethics panel if there are any substantive changes to the project that could affect its ethical dimensions, and re-submit the proposal if it is deemed necessary.

Signed:

A handwritten signature in blue ink, appearing to read "C. Chandler".

Date: 28/07/2014

Dr Chris Chandler
(Chair - School of Psychology Research Ethics Review Panel)
chandler@staff.londonmet.ac.uk