The Experiences of Mothers who Received Therapy for Postnatal Depression – A Qualitative Study

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Professional Doctorate in Counselling Psychology

2013

ACKNOWLEDGEMENTS

Many thanks to the participants who generously shared their experiences so that many others receive the help they deserve. Many thanks to my supervisor Anna Butcher for her constructive feedback. Many thanks to Philippa Blythe, Helen Cleeve and Zakia Mahmood for sharing their work and for their encouragement. Many thanks to my professional supervision group (Mijal Bar-Yosef, Cynthia Duque, Lian Florshein, Susan Kite and Paula Samper) for their feedback on the analysis and organisation of themes as well as their monthly encouragement. Many thanks to Kim Wittenstrom and Ravinder Bhatia for proofreading the final draft. Many thanks to Ravinder Bhatia for his unshakable support and belief in my capacity to bear this project to completion.

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ABSTRACT

A sizeable percentage of women develop psychiatric symptoms after the birth of a baby. Postnatal depression (PND) is the most widespread of such conditions, with an average incidence rate of 13%. Postnatal depression represents a serious public health concern because it may have adverse effects on the physical, emotional and cognitive development of children, as well as affecting the mother herself, the mental health of fathers and the marital relationship. It is imperative to treat postnatal depression early and effectively. Mothers consistently indicate that they prefer therapy to anti-depressants, because of concerns over their safety when breastfeeding. However, there is still a scarcity of research on psychological treatments for this population, and what research is available indicates lower response to psychological treatments compared to other populations. This qualitative study investigated mothers' experiences of therapy, to understand how therapists can best respond to the needs of mothers suffering from postnatal depression. Eight semi-structured interviews were carried out with mothers who were recruited via the Association of Postnatal Illness. Data collected was subjected to an Interpretative Phenomenological Analysis. Three themes emerged that encapsulate how therapists can facilitate recovery from postnatal depression: creating a safe space, assuaging guilt, and empowering. The themes articulate how therapists can adapt their therapeutic stance and the therapeutic focus to address some of the needs of this population. Tailoring of assessment, formulation and therapy to each individual client emerged to be imperative given the heterogeneity of needs, symptoms and vulnerabilities characterising mothers suffering from PND. Findings are discussed in the context of previous research on psychological treatments for postnatal depression.

INTRODUCTION

This study aims to inform the practice of counselling psychologists working with mothers who suffer from postnatal depression (PND), by listening to the mothers' experiences of therapy.

Counselling psychologists are likely to work with this population in multiple settings. For example, the UK Government has committed to expanding access to psychological therapies for people of all ages via the Increasing Access to Psychological Treatments initiative (Department of Health, 2011). Additionally, the NICE guidelines on Antenatal and Postnatal Mental Health (2007) advocate the establishment of multi-disciplinary Perinatal Mental Health Teams dedicated to addressing the needs of mothers, and counselling psychologists may find work in these teams. Counselling psychologists working in the private sector and charities are also likely to work with mothers with PND, especially given the patchy availability of NHS services for this population (4 Children, 2011; The Patients Association, 2011). As counselling psychologists seek to adapt the delivery of therapy to the individual needs of the clients, listening to the mothers' experiences of therapy could help enhance psychologists' understanding of the needs of this particular population and to approach the assessment, formulation and delivery of therapy with more confidence.

In a special issue of the Counselling Psychology Review dedicated to families, Davy and Hutchinson (2010) noted that " it is fair to say that work with children, adolescents and families has a lower profile within our Division than work with adults" (p.1). However, counselling psychologists are well equipped to help mothers with PND (Nicholson, 1989) and this could become one of the possible areas of specialisation for them. Given the impact of maternal mental health on children, working with mothers also affords to counselling psychologists the opportunity to prevent mental health problems rather than focusing on psychopathology. This preventative approach is one of the anchoring philosophical stances of the identity of Counselling Psychology (Strawbridge & Woolfe, 2010).

The literature review will first introduce the diagnostic criteria, prevalence, and

aetiology of PND, how women experience it, and its impact on the family. Then, we will give an overview of the literature on existing psychological treatments for PND. Limitations of this literature will be noted, warranting further research in this area. The search for abstracts for this literature search was performed in PsychInfo by different combinations of the keywords "postnatal/postpartum depression", "therapy/counselling", "treatment", "perinatal", "motherhood", "mothers".

This study refers to "therapy" as a broad term to refer to a range of talking therapies, such as counselling and psychotherapy, delivered by trained practitioners to bring about effective change or enhance wellbeing (www.bacp.co.uk).

Postnatal Depression (PND)

Diagnostic issues

There is a debate in the literature over whether PND is a unique diagnosis, or simply a depression occurring after childbirth. The American Psychiatric Association's (2000) Diagnostic and Statistical Manual of Mental Disorders [DSM-IV] does not include a diagnosis of postnatal depression, but does include a "postpartum onset" specifier for depression developing within four to six weeks postpartum. The criteria for major depression include (a) depressed mood or loss of interest and (b) at least four of the following symptoms: sleeping and eating disturbances, physical agitation, fatigue, cognitive impairment, guilt, and suicidal ideation. Some studies found no substantial differences in clinical presentation between episodes of major depression occurring after childbirth and at other times (Cooper et al., 2007). However, some researchers (and some women themselves – for example a large association offering support to women with postnatal depression is named the Association of Postnatal *Illness*) argue that there should be a distinct diagnosis, perhaps even with a different label, as the diagnosis of depression does not account for the full range of symptoms experienced by women in the postnatal period. Specifically, studies indicate that many women in the postpartum period experience anxiety as well as depressed mood, and indeed for some women anxiety is prominent (Austin et al., 2010; Di

Pietro, Costigan & Sipsma, 2008). Bernstein and colleagues (2008) compared a group of postnatally depressed women with women with depression and found that the postnatal group experienced less depressed mood and more psychomotor symptoms (restlessness/agitation) and impaired concentration/decision-making. Marrs, Durette, Ferraro and Cross (2008) carried out a retrospective internet survey of postpartum women and also found that a small but noticeable percentage of women surveyed (about 6%) experienced morbid or psychotic thoughts as part of their depression, a symptom that is not included in the diagnostic criteria for depression. Although research on the full spectrum of symptoms remains limited, there is an indication that PND can co-occur with Post-Traumatic Stress Disorder (PTSD) following childbirth and Obsessive Compulsive Disorder (OCD) (Brandes, Soares & Cohen, 2004; Zaers, Waschke & Ehlert, 2008).

Epidemiological studies also indicate that the indicated 4-6 week time frame is too short, as depression can occur at a later stage in the postnatal year, with most studies using a 12-month time frame (Leahy-Warren & McCarthy, 2007). Depression can last for up to one year after delivery in about 4% of all mothers, i.e. a quarter of mothers who become depressed (Morrell et al, 2009).

There are various measures used to diagnose and estimate prevalence of PND. These include the Edinburgh Postnatal Depression Scale (EPDS; Cox, Holden & Sagovsky, 1987) with varying cut-off scores (11– 13) and varying timescales (6–12 weeks post-delivery), the Beck Depression Inventories (BDI, Beck, Ward, Mendelson, Mock & Erbaugh, 1961; BDI- II, Beck, Steer & Brown, 1996), the CES-D (Radloff, 1977), the Postpartum Depression Screening Scale (PDSS; Beck & Gable, 2000), the Structured Clinical Interview for DSM Disorders (SCID) (First, Spitzer, Gibbon & Williams, 1997). Limitations of these scales include a high percentage of false positives (e.g. Mauri et al., 2010), lack of inclusion of symptoms such as anxiety and obsessional thoughts, and lack of cross-cultural validations.

Despite the lack of agreement on the diagnostic criteria and the limitations in the diagnostic measures, the term "postnatal (or postpartum) depression" has been widely used by clinicians and researchers world-wide, and literature suggests that

women themselves find it helpful to receive a diagnosis of PND as it helps in accessing services and validates what they feel to themselves and others (Di Mascio, Kent, Fiander & Lawrence, 2008).

Prevalence

Research indicates that PND often remains undetected. Goodman and Tyer-Viola (2010) found that only 25% of the women that they screened positive for anxiety and depression were identified and referred for treatment by their obstetric providers. Screening barriers include time constraints, lack of training and lack of diagnostic criteria (Leddy, Haaga, Gray & Schulkin, 2011). Women themselves are often reluctant to disclose problems because of various reasons such as difficulties distinguishing the symptoms of depression from normal fatigue and challenges of motherhood; perceived stigma of suffering from mental health problems; unresponsive health care providers; shame in not coping by themselves; and fear of losing access to their babies (Dennis & Chung-Lee, 2006).

Gavin and colleagues (2005) estimated a prevalence of major depression between 6.5% and 12.9% at different trimesters in the first postpartum year. Their review only included studies carried out in Western countries and confirmed the rates (13%) previously found in the meta-analysis by O'Hara and Swain (1996). More recent studies in Western countries confirmed prevalence rates of about 10-13% (Glavin, Smith, Sørum & Ellefsen, 2009; Horowitz, Murphy, Gregory & Wojcik, 2011; Howell, Mora, DiBonaventura & Leventhal, 2009). Higher rates are usually found in developing countries, indicating a link between socio-economic disadvantage and mental health problems in the postpartum (e.g. Chibanda et al, 2010; Kadir, Daud, Yaacob & Hussain, 2009; Quelopana, Champion, Reyes-Rubilar, 2011).

In the UK, the most recent NICE guidelines (2007) on antenatal and postnatal mental health cite the rates given by Gavin and colleagues (2005), indicating an absence of recent estimates. Recently, the charity 4Children (McVeigh, 2011) noted that only 9% of health trusts were keeping track of PND in their area, and moreover that the Department of Health holds no statistics at all on PND.

Vulnerability

An interaction of several biological, psychological, and socio-economic factors appears to be responsible for making a woman vulnerable to PND.

Stewart, O'Hara and Gorman (2003) reviewed the literature on risk factors for PND. They found that strong predictors were depression or anxiety during pregnancy, stressful recent life events, poor social support and a previous history of depression. Moderate predictors are childcare stress, low self-esteem, maternal neuroticism and difficult infant temperament. Minor predictors include obstetric and pregnancy complications, negative cognitive attributions, single marital status, poor relationship with partner, and lower socioeconomic status including income.

What Women Say

Whilst most of the research in the area is quantitative, some qualitative studies have investigated how mothers experience PND. These are in-depth studies conducted with small samples of women, which –whilst yielding rich material about what it is like to suffer from PND - resist generalisation of their findings. However, two meta-syntheses of this literature conducted by Beck (2002) and Knudson-Martin and Silverstein (2009) found that there are a number of themes that recur in these studies, suggesting that many women suffering from PND face some of the same challenges. Most of the studies reviewed by Beck were conducted in North America and Europe, whilst Knudson-Martin and Silverstein included studies from a wider range of countries, including Japan, India and Uganda. Beck reviewed 18 studies with a total of 309 participants, and Knudson Martin included nine studies with a total of 179 participants.

These meta-syntheses indicate that one significant factor in the development of PND is the discrepancy between cultural discourses and the reality of motherhood. Many women feel ashamed and inadequate for not living up to cultural images of motherhood, which in many cultures set potentially unrealistic standards for mothers. In the West, many women struggle to be "perfect mothers", coping and fulfilled in their role (Beck, 2002; Knudson-Martin & Silverstein, 2009). A study amongst African American women found that some

of the participants felt they had to be able to care for "babies, work, homes, families, husbands, and themselves without complaining of the pain or discomfort during their postpartum period" (Amankwaa, 2003, p. 310). Gao, Chan, You and Li (2010) also found that many Chinese women suffering from PND perceived themselves to be failures as mothers and found that cultural practices such as the forced closed daughter-in-law/mother-in-law relationship and "doing the month", a traditional Chinese custom whereby women are confined to the house and assisted with tasks for a month after giving birth, aggravated their depression.

Another common theme highlighted by the meta-syntheses is that women feel silenced and isolated. Many women describe an inability to share their negative feelings, partly because they feel ashamed, and fear to be judged as "bad mothers". Family, friends, and health care professionals may seem often insensitive to their suffering, and reluctant to listen and understand a mother's unhappiness (Beck, 2002).

The meta-syntheses found that loss (of control, old self, time, voice and relationships) is another relevant theme in the context of PND. Many women describe struggling to come to terms with the radical change that having children cause to their lives and identity. They report feeling "unreal", as they lose previous ways of being (Beck, 2002).

Many women also report feeling overwhelmed by the responsibility of caring for their children. Abram and Curran (2009) found that this was the main theme emerging from her interviews with women with low income suffering from PND, who struggled to mother in materially and socially stressful conditions. Many women often report lack of sleep and tiredness contributing to their inability to cope, exacerbated by lack of emotional and practical support, for example where there is conflict in the couple or in the absence of a family network. Some women also report feeling uncertain and unprepared to care for their children (Homewood, Tweed, Cree & Crossley, 2009).

Finally, most women describe the condition as a progressive spiralling into the depth of despair. They describe a wide array of symptoms including intense

anxiety, obsessive thinking, anger, cognitive impairment, feeling of isolation, guilt, contemplating harming oneself, feeling unreal, and difficulties relating with their children (Beck, 2002).

These qualitative studies confirm the quantitative findings that an interplay of factors is responsible for PND, including physiology, unrealistic cultural discourses, financial hardship and lack of support for mothers in society, as well as psychological processes such as feelings of loss and difficulties in relationships.

The Case for Treatment

In addition to helping women recover from a debilitating condition, there is a strong case for treatment of PND because of PND's effect on children's development. Indeed, the relationship with the main caregiver is increasingly recognised as a key influence in children's development (National Scientific Council on the Developing Child, 2004). Although a 2003 review by Grace and colleagues suggested the mother's concurrent depression and social and economic adversity are more powerful predictors of poor developmental outcomes, literature indicates that some depressed mothers find it more difficult to respond sensitively to their baby's relational and regulatory needs and that their children may consequently be at risk of impaired mental and motor development, poor self-regulation, low self-esteem and long-term behavioural problems (Milgrom, Ericksen, McCarthy & Gemmill, 2006). Recent literature continues to implicate PND in poor developmental outcomes. For example, Murray and colleagues (2011) found that children of postnatally depressed mothers were more likely (41.5% vs. 12.5%) than children of control mothers to develop depression. However, literature suggests that mother-infant interactions are only affected when women suffer from protracted depression (that is, lasting at least 6 months), rather than with women who experience more short-lived depression. This makes a strong case for treating PND early (Misri & Kendrick, 2007).

PND is also associated with increased paternal depression and higher paternal parenting stress (Goodman, 2008), and with an increased risk of marital stress

and divorce (Burke, 2003). Because of its effects on the wider family system, PND represents a significant public health concern, warranting prompt and effective treatment.

Treatments

Biological Treatments

A few small-scale, controlled trials provide some evidence for the efficacy of antidepressant medication in the treatment of PND (Appelby, Warner, Whitton & Faragher, 1997; Misri, Reebye, Corral & Mills, 2004; Wisner et al., 2006). However, women with PND are reluctant to take anti-depressants. Appelby and colleagues (1997) for example found that of the 188 women with depression invited to take part in the study, less than half agreed, and the main reason for refusal was 'reluctance to take medication'. Dennis and Chung-Lee (2006) reviewed qualitative literature on help-seeking barriers and treatment preferences of women with PND and found that their reluctance to take medications was due to a host of reasons, including worries about dependency and side-effects, stigma associated with taking pills, and effects on their breastfed babies. There is no evidence to counteract this last worry, as there have been no controlled trials of the effects of antidepressant medication on the development of exposed infants (O'Hara, 2009). The NICE guidelines (2007) do in fact recommend psychotherapy as a first-line treatment and only recommend anti-depressants for severe cases of PND. However, recently McVeigh (2011) in *The Guardian* reported that of more than 2,000 mothers questioned, 70% were given antidepressants when they approached their doctor.

Psychological Treatments

The NICE guidelines (2007) recommend the use of self-help approaches, brief (4-6 sessions) CBT or Interpersonal Therapy (IPT), or non-directive listening home visits for mild depression and again CBT or IPT, or anti-depressant, or combination of the two for moderate/severe depression in the postpartum period. The authors point out that their recommendations are partly based on the (untested) assumption that psychological treatments specifically designed for

depression and found to be effective in depressed populations, for example CBT and IPT, are likely to be as effective in women with PND, given that the presentation of PND is similar to depression in non-pregnant women (p. 121). Nonetheless, the postpartum period carries specific challenges to women. Two reviews (Dennis & Hodnett, 2009; Cuijpers, Brännmark, & van Straten, 2008) have looked at the efficacy of psychological treatments specifically for PND. Psychological treatments that were investigated in clinical trials included Cognitive Behavioral Therapy (CBT), counselling, mother-and-infant psychotherapy, Interpersonal Therapy (IPT), and psychodynamic therapy. These now will be described to give an overview as to how various therapies have been adapted for this population.

Cognitive Behavioural Therapy (CBT)

CBT focuses on educating the client to identify and modify negative thoughts and behaviour (Morrel et al., 2009). CBT has a solid evidence base in the treatment of depression (NCCMH, 2010) but only six trials have tested the efficacy of CBT to treat PND.

Appelby and colleagues (1997) compared six sessions of CBT with Fluoxetine alone and combined therapy of CBT and Fluoxetine. Such CBT focused on feelings of not coping, lack of enjoyable activities, lack of practical support, and caring for any older children. Prendergast and Austin (2001) designed an intervention with an emphasis on anxiety management, assertiveness training, and self-esteem as well as on pleasant-event scheduling. In contrast, CBT in the Cooper, Murray, Wilson and Romaniuk's (2003) study focused on the problems of caring for the infant and the mother-and-infant relationship. The mothers were provided with advice on managing common practical problems of caring for infants. The mothers were encouraged to examine their thinking patterns in relation to their baby and themselves as mothers, and helped to modify dysfunctional interactional pattern via modelling. Milgrom, Negri, Gemmill, McNeil and Martin (2005) adapted the CBT treatment by adding partner sessions and modules on "family of origin issues" (p. 532).

In these trials, CBT was found to reduce the symptoms of PND at least in the

short term and in women with mild to moderate depression. Only one trial (Cooper et al., 2003) compared CBT with other therapeutic approaches and in this trial, all treatments equally reduced scores on the Edinburgh Postnatal Depression Scale, although the benefits of the treatments were no longer apparent at nine months follow-up.

Further research appears to be warranted in understanding whether CBT is superior to other approaches for this population, and which modifications of the CBT treatment might be more effective for this population. In most CBT trials, CBT was delivered by nurses or health visitors trained to deliver the intervention, rather than by psychologists. To investigate whether this made any difference, Milgrom and colleagues (2011) compared ideal GP management (GPs trained in PND), with six sessions of CBT delivered by nurses, and six sessions of CBT delivered by specialists. As found by Cooper and colleagues (2003), therapy provided by non-specialists was more efficacious than that provided by specialists. The authors attribute this finding to the health visitors being experienced in home visiting, unlike the professional therapists. Milgrom and colleagues (2011) attributed the same finding to the environment where the therapy took place, with nurses practicing from health centres and psychologists from a public hospital. Another hypothesis is that the relationship is more salient than the technical skills for this population, a hypothesis also supported by the equivalence of efficacy of all orientations found in the study by Cooper and colleagues (2003).

Interpersonal Therapy (IPT)

IPT (Klerman, Weissman, Rounsaville & Chevron, 1984) is a structured, time-limited psychological treatment that focuses on working through interpersonal problems to alleviate depression. IPT focuses on interpersonal disputes, role transitions, and bereavement, which are relevant for women with PND (Carter, Grigoriadis, Ravitz & Ross, 2010). One large trial tested the efficacy of IPT for PND (O'Hara, Stuart, Gorman & Wenzel, 2000). Treatment consisted of 12 weeks of individual therapy delivered by experienced therapists compared with a waiting list condition. In this trial, IPT was adapted to focus on conflict with partner or extended family, loss of social/work relationships, and losses

associated with the birth. The authors found a significant improvement of depressive symptoms. However, there was no follow up. Additionally, more than half of eligible women declined participation and 20% withdrew from treatment, indicating a difficulty of this population to attend regular therapy sessions. It is unclear whether IPT is superior to any of the other psychological approaches as no comparative studies are available. However, given the promising results of this study, more research appears to be warranted.

Non-directive Counselling and Listening Visits

Counselling was developed by Carl Rogers, who believed that people had the means for self-healing, problem resolution and growth if the right conditions could be provided (Rogers, 1957). These include the provision of positive regard, genuineness and empathy. Counsellors are trained to carefully listen, empathise with, and reflect patient feelings without structuring the therapy (Morrel et al., 2009). In the case of PND, this approach is usually offered by briefly trained healthcare professionals and often takes place in the client's home. Holden, Sagovsky and Cox's (1999) found that eight listening visits by health visitors effectively reduced symptoms of depression compared to routine care. Wickberg and Hwang (1996) also found this approach to be effective. The samples in these trials however were small (26 / 20), and there was no follow-up. Morrell and colleagues (2009) also found that up to eight listening visits by trained health visitors, with either a cognitive behavioural or a non-directive stance, were equally effective in reducing PND compared to usual care. This trial was larger and the women were followed up after 18 months. On the basis of these promising studies, the NICE guidelines (2007) found listening visits to be the best cost-effective treatment for women with mild to moderate depression in the postnatal period. Morrell and colleagues (2009) also conducted qualitative interviews with the participants after the study, which reinforced the conclusion of the usefulness of this approach.

Psychodynamic Psychotherapy

There are many forms of psychodynamic psychotherapy, all derived from Freud's psychoanalysis. Psychodynamic therapy is an unstructured psychological

therapy which uses the therapeutic relationship to gain insight into conscious and unconscious conflicts originating in the past, with a focus on interpreting and working through them (Morrel et al., 2009).

There is a wealth of literature on psychodynamic conceptualizations of PND, summarized by Besser, Vliegen, Luyten and Blatt (2008). Only one trial (Cooper et al., 2003) evaluated ten sessions of psychodynamic psychotherapy for the treatment of PND. This trial used "treatment techniques in which an understanding of the mother's representation of her infant and her relationship with her infant was promoted by exploring aspects of the mother's own early attachment history" (p. 412). The trial found that psychodynamic therapy effectively reduced the levels of depression, but only in the short term. Psychodynamic theory indeed highlights the importance of early attachments and internal working models of relationships as a key to understanding the difficult transition some women experience after the birth of their babies. According to Raphael-Leff (2009), becoming a mother reactivates early unprocessed preverbal raw emotions, which risk 'haunting' and distorting the relationship of the mother with the baby if they are not brought to consciousness (p. U-3). Research does indicate that parental representations and attachment styles impact postnatal fluctuations of mood (Mayes & Leckman, 2007; McMahon, Trapolini & Barnett, 2008).

Some psychodynamic theorists have proposed that mothers develop a specific "psychic configuration" (Stern, 1995) – different preoccupations, wishes, interests, and feelings - that the therapist needs to adapt to. Winnicott (1958) described intensive affective changes in the mother's psychic functioning after the birth of her baby, which he termed "primary maternal preoccupation" whereby the mother becomes focused on providing for the baby. According to Stern (1995), following the birth of their babies mothers evolve a different mental organization that he calls the "motherhood constellation". This mental organization is characterized by four main concerns: the life growth theme, that is a concern to keep the baby alive; the primary relatedness theme, that is a concern with engaging emotionally with the baby in a way that assures the baby's psychological development; the supporting matrix theme, that is a

concern to create a support network around herself and the baby; and the identity reorganization theme, a concern to transform the mother's self-identity. These theories are based on clinical observations and they remain to be researched systematically. Indeed, despite the relevance of this approach and the wealth of relevant theory for this population, surprisingly little research is available to support psychodynamic therapy for PND.

Mother-and-Baby Therapies

One significant difference in treating mothers compared to other clients is that the babies are likely to be physically or psychologically present in the therapeutic room. Therapists have a responsibility to think of the welfare of these vulnerable dependents (BPS, 2007). Research indicates that approaches designed to target individual maternal depressive symptoms may not be sufficient to protect against negative child outcomes (Forman et al., 2007). For example, in the IPT trial (O'Hara et al., 2000), mothers' depression was alleviated but at 18 months' post-treatment, children of depressed mothers continued to show lower attachment security, higher negative affect, and more internalizing and externalizing problems than did children of nondepressed mothers. Milgrom and colleagues (2006) found that high parenting stress persisted even after CBT intervention improved depression, and Cooper et al found no impact of the four therapy interventions on children's outcomes.

Existing approaches to mother-and-infant therapy focus on the infants' needs and aim at increasing maternal sensitivity and responsiveness. They have demonstrated an ability to ameliorate the negative consequences of maternal depression on the developing child but have focused less on maternal depression (Nylen, Moran, Franklin & O'Hara, 2006). Recently however, mother-and-infant therapeutic programs have been developed to also target maternal depression. Mellow Babies (2010) focused both on the mother-and-infant interaction and on maternal well-being. Mothers participate in a psychotherapeutic group in the morning, and in a video-feedback session in the afternoon aimed at promoting sensitive and attuned care with their babies. Similar programs have been developed by Clark, Tluczek and Brown (2008) and Paris, Bolton and Spielman (2011). These integrative approaches have demonstrated in small-scale trials that

they can reduce symptoms of PND as well as increase maternal sensitivity. However, the evidence in support of these approaches remains limited.

In summary, some clinicians propose that mothers' psychological needs change after giving birth. Psychological treatments have been adapted to the needs of this population by addressing specific psychological challenges such as role transitions and lack of self-esteem, by using health instead of mental health professionals, by delivering the therapy at home instead of in the clinic, and by including the partners or the baby in therapy.

Other Orientations

Other non-biological treatments investigated in the trials include support groups, psychoeducational groups, and peer support. These are interventions for mothers with mild depression and are not designed to be delivered by mental health professionals.

Although not investigated in any clinical trials, feminist psychology also developed principles for the psychological treatment of PND and is considered a major approach in the field (Beck, 2002). Feminist researchers have given a significant contribution to the literature on PND, as they first stimulated qualitative investigations focused on the women's experiences (Nicholson, 1990; Oakley, 1980). Feminist theorists oppose the medical model of PND and instead highlight the social nature of women's problems (Abram & Curran, 2007). They contest social discourses pressurising women to be perfect mothers and the stressful reality of mothering without much societal support are implied in the development of the condition. Oakley (1980) proposed that the medical control of childbirth also reinforces feminine helplessness. Creedy and Shochet (1996) proposed a treatment based on feminist principles, which focuses on validating women's experiences, reinforcing the mother's personal power, and encouraging self-nurturance and the expression of anger. Thoits (1985) proposes that women suffering from PND should engage in "voluntary treatment", that is self-help postnatal depression groups which can challenge the ingrained myths of blissful motherhood and validate the feelings of loss and anger associated with it. These approaches, unlike the psychological treatments reviewed above, have the merit

of highlighting the responsibilities of society towards mothers. On the other hand, they do not adequately take into account the psychological and physiological factors that make women vulnerable to depression.

Limitations of Literature on the Treatment of PND

The two most recent reviews looking at the efficacy of psychological interventions for the treatment of PND (Cuijpers et al., 2008; Dennis & Hodnett, 2009) concluded that psychological interventions appear to be moderately effective in ameliorating PND. However, no conclusions could be drawn on their efficacy in the long term, nor on whether any intervention was more effective. They concluded that, despite the public health significance of PND, research into psychological treatments for the condition remains very limited.

According to the authors of the NICE guidelines (2007), one explanation of this limited research is the "widely held but poorly substantiated beliefs that neither pregnancy nor the early postnatal period are times to make life changes and that psychological treatment may be harmful and should be avoided" (p. 125). Nicholson (1989) noted that research into PND has placed psychologists in a marginal role, because it is presented as either a medical or social problem. Indeed, as noted, in many of the trials non-specialists are selected for delivering treatment to this population. Further, the interventions tested are mostly short term (6 – 8 sessions) and some of the trials included in the reviews looked at the efficacy of only very mild interventions, such as telephone peer support. However, at least in Western countries, therapy is the treatment of choice of mothers with PND, warranting further research on how to deliver it effectively for this population (Dennis & Chung-Lee, 2006).

Most research on psychological treatments for PND is quantitative. Although controlled trials provide valuable information as to the efficacy of treatments to reduce the gravity of the symptoms, there are problems in using exclusively controlled trials to inform therapeutic practice. It is difficult for trials to capture the full complexity of the process of therapy, which is affected by multiple factors (and their interrelations) such as the client and the therapist's personality, expectations, and worldview, as well as their moment-to-moment feelings and

reactions (Cooper, 2008; Duncan & Miller, 2000). A further problem with trials of psychological intervention is the narrow focus on symptom reduction (Levitt, Butler & Hill, 2006). Few of the trials for PND have included measures other than depression and investigated for example children's outcomes or the women's quality of life. A number of researchers, and counselling psychologists, argue that qualitative methods are better equipped to investigate the process of therapy because they account for the subjective experience of the client and the nuances of the therapeutic process (e.g. Gordon, 2000; Higginson & Mansell, 2006; Levitt, Butler & Hill, 2006; Strawbridge & Woolfe, 2010). Indeed, another limitation of trials is the absence of the clients' voice (Duncan & Miller, 2000). Qualitative literature on clients' views of therapy has afforded researchers the possibility to draw helpful recommendations to guide clinical practice (see e.g. McLeod, 2001; Levitt et al., 2006).

Existing Literature on Sufferers' Views of Treatments

There is a scarcity of qualitative research on the views of therapy of women who suffered from PND. As seen above, the interventions examined in trials were often adapted to the needs of mothers in a variety of ways, based on theoretical and research considerations. However, none of the authors describes any process of consultation with the women on, for example, how they prefer to access therapy, who they would prefer to deliver therapy, where (home/clinic), in which format (group or individual), the length of therapy, the model (structured or unstructured), or which areas they might feel that psychological therapy could most be helpful with.

Only a few studies explored the experiences of therapy of mothers with PND. Morrell and colleagues (2009) conducted 30 semi-structured interviews with the women who participated in their trial, to gain insight into how the interventions were perceived. These interviews suggest that women were mostly positive about the intervention, especially if they had a good relationship with the health visitor. However, some women required additional input. Shakespeare, Blake and Garcia (2008) also conducted qualitative interviews with 16 women who received four listening visits by their health visitors. In contrast to women in the Morrell's study, these women estimated that listening visits made only a small contribution

to their recovery. Also in this study, the relationship with the health visitor emerged as a key determinant of the acceptability and helpfulness of the intervention, confirming that this variable is highly significant. These women also wanted to be given treatment options rather than offered a standard treatment, and preferred to speak to a trained mental health professional. They also wanted more structure and purpose in their treatment, as they found venting feelings was not enough. These results counterpoint existing recommendations based on quantitative literature.

Dennis and Chung-Lee (2006) reviewed qualitative literature on help-seeking barriers and treatment preferences of women with PND, and found that women consistently indicated that their treatment of choice was talking to a non-judgemental and empathic listener who could validate their feelings, accept them and understand them for whom they were. They wanted to be reassured that there were other women experiencing the same feelings and that they would get better. They wanted this person to be knowledgeable about postnatal depression. Their conclusions were based on studies of how women experience PND, as they found very few studies focused on views of treatments.

Nicholson (1989) found that motherhood involved radical changes in role and relationships, and proposed that therapy included grief work, that is working through and processing the pain associated with loss, similarly to the therapeutic work recommended for bereaved clients. She also recommended couple and family counselling to increase emotional and practical support. Beck (2002) also recommended grief work. She also found that recovery involved a process of self-acceptance and therefore recommended interventions focused on challenging unrealistic expectations of motherhood. Based on their review, Knudson-Martin and Silverstein (2009) suggested a relational focus to help the woman "reconnect" with her baby, her partner and others.

In summary, there is some limited qualitative literature on which counselling psychologists can draw some recommendations for their practice with women suffering from PND. However, there is no qualitative study of women's views of therapy delivered by a mental health professional for the treatment of PND. Such

a study may point to areas that mothers feel important to address in therapy, so that counselling psychologists are better equipped to understand how to tailor their therapy to mothers' needs.

Research Questions

This study's primary research question is: How do mothers who suffered from PND describe their experiences of psychotherapy? This question reflects the focus of the study on mothers' lived experience as valuable and able in itself to inform practitioners. Secondary research questions include the mothers' expectations of therapy, what they found helpful and unhelpful in therapy, and how they think the provision of care could be enhanced.

METHODOLOGY

Design

As the aim of the current study was to listen to mothers' experiences of therapy, it was important to use a methodology that could capture and validate the uniqueness of each participant's experience. Quantitative methods are not concerned with individuals' uniqueness but rather look for common laws of behaviour (Willig, 2001). A qualitative methodology was selected as it allowed to focus on the meaning (Willig, 2001). It has become increasingly apparent that each client's identity, world view and meaning making affect the process of therapy (Cooper, 2008). Meaning-making is affected by a the social, cultural, historical and environmental context, which can also be accounted for by a qualitative methodology focusing on how individuals make sense of their experiences (Gordon, 2000). By allowing the collection of in-depth contextualised accounts of the therapeutic experience rather than pre-elaborating hypotheses on specific determinants that might impact on therapy, qualitative methods can retain the complexity of the therapeutic process and thus allow to extract findings that are particularly relevant for therapists who are faced with the same complexity in their work (Midgley, Target & Smith, 2006). Further, qualitative methods value and empower participants, who are seen as active co-equals in the research process (McLeod, 2003). This was a particular important aspect, as this study was carried out from the philosophical standpoint of Counselling Psychology, for which client empowerment is paramount (Strawbridge & Woolfe, 2010). Indeed, qualitative methods are particularly consonant with the philosophy of Counselling Psychology, which is rooted in the existential-phenomenological tradition. Counselling Psychology seeks to move away from an exclusively technical and rational research base towards a research practice grounded in humanistic values and characterized by uncertainty and value conflict (Strawbridge & Woolfe, 2010).

There are different methods of qualitative inquiry, grouped in the four main categories of grounded theory, discourse analysis, narrative analysis and

phenomenology. Each focuses on a different aspect of the data and has different goals (Smith, Flowers & Larkin, 2009), and each can be located on an epistemological continuum between realism and radical relativism (Willig, 2001). Grounded theory leans more towards realism as it attempts to render the process of qualitative research as objective as possible. Although grounded theory has been used to investigate both the experience of motherhood and the experiences of counselling (e.g. Homewood, Tweed, Cree & Crossley, 2009; Levitt, Butler & Hill, 2006), it aims at building a theory of the phenomenon investigated, which was not an aim of this study. Discourse analysis emphasise how societal ideas define individual psychology and therefore leans towards radical relativism. Social and cultural discourses heavily influence maternal mental health (Bina, 2008), but this study views them as only one of several components affecting individual psychology. Narrative approaches are interested in the content or structure of stories that people use to describe their experiences. As such, the approach overlaps both with phenomenology and with social constructionism. This approach has also been used to study experiences of counselling from the client's point of view (Kuhnlein, 1999), but this study viewed narratives as one of the components of the psychological world of participants rather than the defining one, and therefore preferred a methodology more open to the emergence of the different aspects of the participants' identity.
The current study seeks to explore the individual lived experience of the participants, therefore presupposes the existence of a relatively stable identity (in contrast with relativism) but also concedes that this identity is relative to some extent (in contrast with realism). Therefore, the study sits in the middle of the epistemological continuum, like Interpretative Phenomenological Analysis (IPA). IPA has been already used to explore the experiences of motherhood (Smith, 1999) and the experiences of counselling (Midgley et al., 2006). IPA was selected as the most suitable method as it allowed a focus on the participants' psychological world.

Interpretative Phenomenological Analysis

IPA is a qualitative research method committed to the examination of how people make sense of their life experiences. The first studies to use this approach

were in the area of health psychology, but since then it has been widely used in the clinical and counselling psychology fields. IPA is psychological at its core as it aims to investigate people's lived experience (Smith et al., 2009).

IPA has roots in the three theoretical perspectives of phenomenology, hermeneutics and idiography (Smith et al., 2009). Phenomenologists are interested in understanding what it is like to be human, and how to investigate this lived experience. Hermeneutics is the theory of interpretation of texts, which had its origins in attempts to interpret biblical texts. Idiography is concerned with the individual's experience. IPA, like idiography, is committed to detail and depth of analysis of a small, purposely-selected and carefully-situated sample rather than focusing on general laws of behaviour or investigating group behaviour by focusing on specific aspects of psychology like nomothetic psychology. This commitment to the particular is more cautious about making generalisations, although it does not shy away from it completely (Smith et al., 2009). IPA recognises the *intersubjective* and therefore inevitably complex nature of our identity (Larkin, Watts & Clifton, 2006).We are interconnected to objects, relationships and language. IPA views human beings as meaning-making creatures. Therefore, the participants' accounts are seen to reflect their attempts to make sense of their lived experience. The IPA researcher then tries to make sense of the participant trying to make sense of what is happening to them, a process termed a double hermeneutic (Smith et al., 2009). The researcher actively and cyclically seeks to reflect and to bracket his/her assumptions to remain open to the text (Smith et al., 2009). IPA combines an empathic hermeneutics (seeking to look at the world through the participants' eyes) with a questioning hermeneutics (through which the analysis also looks at deeper layers of meaning the participant might not be aware of, such as the intention hidden in what they say). However, the interpretations must always be grounded in the text (Smith et al., 2009).

Data Collection

Data collection for this, as for most IPA studies (Smith et al., 2009), was through semi-structured interviews. Semi-structured interviews are open enough to allow for the participants to express themselves and tell their individual histories and interpretations, thus facilitating rapport, whilst simultaneously providing boundaries so that the interviews do address the research questions (Smith et al., 2009). Because questions are open, semi-structured interviews are sensitive to the participants' perspectives by encouraging them to talk freely about what is important to them rather than what is important for the researcher (Yardley, 2003). For this study, semi-structured interviews were carried out with eight participants. Eight interviews were considered to be a good sample size to make possible the in-depth analysis of each individual case, whilst allowing some comparing and contrasting within the sample, and some degree of generalisation, all in the context of the word limit allowed for a thesis submitted towards a Professional Doctorate (Smith et al., 2009). A pilot interview took place before recruitment to test the interview schedule. As this pilot interview yielded rich enough data addressing the research question, no changes were deemed necessary to the interview schedule, and the pilot was included in the final sample for the analysis.

Participants

In IPA, participants are selected purposely rather than randomly as they need to have the experience investigated in the study. The original recruitment criteria for this study were that participants had to have received therapy following postnatal psychological difficulties, that their therapy was concluded (so that the interview would not interfere with the process of therapy), and that they were not currently depressed. Originally, the study was advertised with the additional criteria that the baby would not be older than one year old, so that the therapy experience would be fresh in the minds of participants. However, only one participant responded to the first extensive advertisement campaign. The participant involved warned that many women do not realise straight away that they are suffering from postnatal depression, and when they do, there are waiting

lists in the NHS that may delay the start of the treatment. The study was therefore re-advertised, this time for mothers who had sought therapy for help with postnatal illness without specifying the child's age.

Table 1 details the age range of the participants, the type of therapy they received and the length, the number and age of children, whether PND was the participant's first episode of depression and how long the episode lasted.

Table 1 – Participants

	Age Range	Treatment Received	Length of counselling	First episode of depression/length	No of children	Marital Status
Stella	40-45	Individual therapy (psychology), mother and baby therapy, psychiatric input	10 month approx.	Yes (10 months)	2	Married
Jennifer	35-40	Individual therapy (psychodynamic), psychiatric input	4 months approx.	No (5 years)	3	Separated
Sonia	35-40	Individual therapy (CBT and solution-focused) and support group	6 sessions of each	No (15 months)	2	Married
Monica	35-40	Individual therapy (counselling) and group therapy	12 sessions	Yes (1 year)	2	Married
Danielle	30-35	Individual therapy (counselling)	4 months	No (4 months)	1	Separated

	Age Range	Treatment Received	Length of counselling	First episode of depression/length	No of children	Marital Status
Rachel	30-35	Individual therapy (CBT)	1 year +	No (1 year)	1	Married
Kate	35-40	Individual therapy (counselling and CBT), support group, hospitalisation	6 months	Yes (6 months)	2	Married
Joanne	40-45	Individual therapy (counselling), psychiatric input	1 session	Yes (3 months)	2	Married

Five participants received counselling privately, two in voluntary organisations, and one in the NHS. The children ranged in age from 15 months to 8 years old. Six of the mothers lived in the South East of England, one in Scotland and one in the Midlands. As can be seen, there is considerable variability in the final sample as regards to the type and length of therapy received, the type and length of the depression and the geographical location. Only very few potential participants (13) responded to an extensive advertisement effort and only nine of them had concluded therapy (1 potential participant withdrew her participation because of difficulties arranging a mutually convenient time and location for the interview). As Smith and colleagues (2009) point out, homogeneity needs to be evaluated in each single study on the basis of practical constraints and an interpretation of how much variability can be tolerated and contained in a single phenomenon. Despite the variability in the type and length of counselling, all participants had the experience of suffering from postnatal depression and seeking and receiving therapy for it. This was deemed to be a strong homogeneity factor that could contain the variability. Indeed, it was felt that the variability added interest to the study. For example, it was felt important to include the experience of the participant who only received one counselling session to understand both positive and negative experiences of therapy. Similarly, variation in the type of therapy allowed to extracting the therapeutic needs of participants suffering from PND beyond those addressed by any single therapeutic orientation.

Procedure and Materials

Once ethical clearance had been received (see Appendix 7), the study was advertised through the Association of Postnatal Illness website, the NCT and in the 'Families' magazine (see Appendix 6 for an example advertisement). As only one participant responded, the advertisements were continued for three months and the Association of Postnatal Illness mailed out the advertisement for the study to all its members. Potential participants contacted the researcher via the email address provided in the advertisement. The researcher then contacted the potential participants via phone to understand if they met the recruitment criteria. If they did, they were sent an information sheet (Appendix 1), a consent form

(Appendix 2), and the Edinburgh Postnatal Depression Scale (EPDS) (Cox et al., 1987) which is the recommended self-report tool to confirm depressive symptoms in postpartum mothers (McQueen, Montgomery, Lappan-Gracon, Evans & Hunter, 2008). Participants sent the EPDS via post to the researcher. None of the potential participants scored above the threshold of +13, which is the cut off point to diagnose depression, so they were contacted to arrange an interview.

An interview schedule was developed on the basis of the research questions, starting with a general question about how participants came to seek counselling, and then moving on to ask about their experiences of counselling. The first interview was a pilot, to test the schedule. As mentioned, this interview did not highlight any need to modify the schedule (in Appendix 3).

The participants lived in diverse geographical locations, so the interviews could not take place at London Metropolitan University as originally planned. Five of the interviews were carried out at the participants' home, and three at a café. For the interviews held at home, safety of the researcher was ensured by leaving the address with a colleague and calling the colleague before and after the interviews. Before the interview, the mothers were briefed on the aim of the study and were given a chance to ask any questions they had. The mothers were invited to sign the consent form, and did so in each case. Rapport was established before the interviews, which allowed for the discussion of the questions to happen in the 30 to 45 minutes time frame. The interviews were recorded using a digital voice recorder. After the interview, participants were debriefed about their experiences of participating in the research and were given the debrief form with a list of support resources (Appendix 4). The recruitment and interview phase lasted from September 2010 until January 2011. The interviews were then transcribed and analysed.

Analysis

IPA seeks to understand how participants make sense of their experiences. However, these meanings are not always transparent, and IPA requires a

laborious engagement with the transcripts and a gradual process of interpretation (Smith & Osborn, 2003).

The first step of the analysis was to note significant passages and preliminary interpretations. These initial annotations included descriptive comments (focused on content), linguistic comments (focused on specific use of language), and conceptual comments (which were more interpretative and questioning). Emergent themes were identified and annotated on the transcript (an example of annotated transcript can be found in Appendix 8). All the emergent themes were then listed, connections were sought between them, and clusters of themes formed. A table of themes was then produced with corresponding links to the texts. This table was then used to identify commonalities and differences across all transcripts. As the analysis progressed, the table of themes for previous transcripts was continuously revised in the light of new interpretations or clustering. The table emphasized both convergences and divergences in the transcripts. An example of the initial table of themes obtained can be found in Appendix 9. On the basis of this table, a narrative was developed describing the themes. In this process, themes that were not relevant to answer the research question were not included in the narrative and themes were re-organised in fewer clusters. As Smith and colleagues (2009) point out, the process of the analysis is iterative, the process involved continually going back and forth from the thematic organization to the transcripts and back, to check that the themes and the narrative respected the participants' voices. The final table of themes with their respective frequencies in each transcript can be found in Appendix 10.

Validity

Objectivity, reliability and generalizability are criteria often used to judge quantitative research, but these cannot be applied to qualitative research. Alternative criteria have therefore been proposed to evaluate validity of qualitative data. For assessing the quality of IPA studies, Smith and colleagues (2009) suggest that Yardley's (2003) criteria are sufficiently comprehensive and broad. These criteria are sensitivity to context, commitment and rigour, coherence and transparency, and impact and importance. With respect to

sensitivity to context, the research introduction and discussion contain abundant references to the existing literature and socio-economic context within which the study is located. A quantity of verbatim extracts with a view of representing all the participants' voices is presented, which provide sensitivity to the data. *Commitment* is demonstrated through attentiveness to the participant during data collection and the care with which the analysis is carried out. *Rigour* refers to the thoroughness of the study, in terms of the appropriateness of the sample to the question, the quality of the interview and the completeness of the analysis to highlight themes and recommendations addressing the research question. This is communicated by the completed study, which could highlight themes and recommendations addressing the research question. For *transparency*, the stages of the research process needs to be described clearly, including the selection of the participants, how the interview schedule was constructed, and how interview and the analysis were conducted. This is detailed in this present section. *Coherence* refers to the coherence of the arguments in the final write-up, as well as to the degree of fit between the underlying theoretical assumptions and the approach. Finally, the research should have *impact and importance*. In the present study, the research insights and recommendations are addressed to counselling psychologists and other professionals offering therapy to mothers.

Ethical Considerations

Ethics can be defined as the science of morals or rules of behaviour (BPS, 2009). This study was approved by the ethical committee of London Metropolitan University and followed the Code of Ethics and Conduct set out by the British Psychological Society (2009). This code requires that psychologists carrying out research adhere to four main principles: respect, competence, responsibility and integrity.

In the present study, participant recruitment was not carried out through any specific agency through which participants might have felt obliged to participate, ensuring that only mothers who were interested in the study and were keen to talk about their experiences replied to the advertisement. Gaining informed consent ensured that only participants who understood what the study entailed

participated in the study. Confidentiality of the participants was safeguarded by keeping names and any demographic and contact details separate from the recordings. Recordings and transcripts were identified using pseudonyms. Recordings will be stored safely in the researcher's computer for a period of five years, as detailed in the informed consent.

Mothers were screened for depression, to make sure that those who were still depressed, and who could therefore be more vulnerable, did not participate in the study. A distress protocol was required by the ethics committee and can be found in Appendix 5. Participants were informed beforehand that they were free not to answer any question they found intrusive or uncomfortable. They were informed they could stop and withdrew from the interview at any point without explanation. Only on one occasion did a participant become tearful during the interview. However, she recovered quickly and felt that she wanted to conclude the interview.

After the interviews, participants were asked about the feelings elicited by the interview and about any concerns they may have about the study. Some mothers told me that it was painful to go back to a very difficult time of their lives. However, all of the participants described a process of recovery from depression and appreciated the importance of research in the area. Participants were all aware of how to seek professional help in case of distress. Nonetheless, they were given a debrief form which listed various sources of psychological support.

All of the participants expressed an interest in learning about the results of this research and the researcher will send them a copy of the recommendations for practice and of any research articles and conference proceedings generated by the study.

Reflexivity

Qualitative research acknowledges a subjective element in the research process. As Smith and colleagues (2009) note, it is never possible to put aside all the assumptions that might be held in relation to a phenomenon. Reflexivity requires

an awareness of the researcher's contribution to the construction of meanings throughout the research process (Willig, 2001). Personal reflexivity involves reflecting upon the ways in which our own values, experiences, interests, beliefs, political commitments, wider aims in life and social identities have shaped the research. Steier (1991, cited in McLeoad, 2003) also invites reflections on the relationship (e.g. transference/countertransference, power) between the researcher and the participants. These will be presented, when relevant, in the results section. This section is written in the first person pronoun, as it will focus on the reasons why I decided to carry out the study, and on some of the personal assumptions and issues that might have influenced the research.

Motivation

My interest in postnatal depression sprung from my own difficult transition to motherhood five years ago. I went through all the negative reactions described in the literature: panic at the sudden and overwhelming feeling of responsibility, sadness for the freedom I had irrevocably lost, difficulties coping with sleep deprivation, and feelings of failure when I could not successfully breastfeed my baby. Although I did not develop depression, my experiences helped me to empathise with the challenges facing the participants in this research. Furthermore, at that time I was surprised by how little support was offered to mothers and when I started my professional doctorate, I decided this was an area I would be interested in working in.

My other motivation for the study springs from my clinical experience as a Trainee Counselling Psychologist at the Perinatal Psychiatry Team in Tower Hamlets. In this position, I experienced the complexity of the challenges faced by the professionals treating mothers. Although I mainly provided short-term CBT, I was well aware that mothers needed more: solving the underlying problems causing the depression, coping with worries of caring for a baby, working on the bonding with the baby, working on the often fragile relationship with the partners. I did a literature search and realised there was not much research on the experiences of therapy of mothers. I decided to carry out such a study as it would allow me to deepen my understanding of postnatal depression

and the psychological processes of motherhood on one side, and my understanding of the process of therapy on the other, two areas I was particularly interested in.

Assumptions and Personal Issues

This study allowed me to realise that I held some assumptions about the results that I would obtain. These were largely assumptions I constructed whilst reading the literature on PND and also whilst working therapeutically with mothers. Assumptions I held included an expectation that mothers would mention their babies frequently, that they would focus on the relationship with their partner, and that they would prefer an insightful form of therapy. However, whilst writing the interview schedule and interviewing the participants, I maintained an open stance allowed these results to emerge. A reflection on how these assumptions were managed in the analysis and writing up can be found at the end of the Discussion in the "Final Reflexivity" (p. 79).

Carrying out this study also highlighted some of my personal anxieties, which probably affected the interviewing process. Whilst reading the transcript I realised that I was particularly reluctant to probe and lead the participants into difficult territory because of my personal concern with protecting the other, as well as the ethical concern of no harm. As soon as participants talked about something potentially upsetting, I often fell back into practical, leading questions such as "how long did you have therapy for?". I realised I could have probed more in a few points during the interview to gain depth into what the participants were saying. I also realised that at times I was too keen to put across my empathy towards the participants, because of my anxiety to please others. This sometimes resulted in intrusive interruptions. On the other hand, I did manage to establish rapport quickly with the participants. I believe participants felt I was genuinely interested in and respected what they were saying, which created rapport. I also made clear at the beginning of the interview that there were no right or wrong answers, and always ended with an open question where mothers could add anything that was not covered in the interview that they wanted to voice.

Individuals who volunteer to participate are not only willing and interested participants, but they may benefit therapeutically from doing so (Etherington, 2010). All participants expressed interest in the study and appreciated the importance of investigating the treatment of postnatal depressions. Indeed, the participants strengthened my motivation to finish the research and disseminate the results.

RESULTS

The results section presents the researcher's interpretation of the interviews. These interpretations will be linked to the existing research literature in the Discussion. Large space will be given to the words of the participants as these are at the heart of the study. An effort was made to give equal voice to all the participants by including an equal number of quotes from all the interviews, although for practical constraints, this could not be done for all the sub-themes.

During the analysis of the data, themes emerged which were continuously organized and reorganized within a developing thematic hierarchy. This process continued well into the writing up of the results section. Themes were in the end grouped into three interrelated families.

The organization of themes is depicted graphically in Table 2, and presented in detail in Appendix 10, which provides a comprehensive list of all the themes with their frequencies.

Throughout this section, extracts are annotated with the participant's pseudonym. When text is omitted because it is irrelevant –i.e. the words of the interviewer – a square parenthesis [] will be used. (...) denotes a significant pause.

TABLE 2 Table of Themes

1 - Creating a safe space for the relationship to emerge	- professionalism - empathy and positive regard
2 - Assuaging guilt	- external attribution of cause - normalising
3 - Empowering	- guidance and grounding - containment and management of emotions - fostering maternal self-efficacy - fostering self acceptance

Theme 1 – Creating a Safe Space for the Relationship to Emerge

Participants in this study experienced PND as isolating and stigmatising. Stella, Jennifer, Kate, and Rachel revealed that they did not feel any love for their babies initially; something that they felt was against cultural ideas of motherhood. This increased their feelings of isolation and made them reluctant to disclose what they felt was a failure to be a good mother. Jennifer and Stella feared that their babies would be taken away. In this context, participants talked about the importance of finding a safe space where they could talk openly about how they were feeling. This theme looks at ways in which the participants' therapists managed to (or failed to) establish the trust that facilitated the therapeutic relationship to emerge. This relationship was for these participants the only space where they felt they could be truthful, but also where they could find the support they desperately needed when they were at the depth of their depression.

Professionalism

Professionalism cemented trust for these participants, who expressed their appreciation of their therapists' experience, qualification, and professional conduct. This theme will look at some of the relevant quotes articulating this and explore some of the reasons why this aspect emerged as significant.

One of the things was to feel safe that I could tell the truth because I had the fear that my baby would be taken away from me, especially my first one, which is why I didn't get help you know,...and it wasn't until I went and asked for help at all and I said it to the psychiatrist and he said your child is not going to be taken away from you, it was only at that point that I felt really safe to say how I was feeling, and I think you know... **Jennifer**

Jennifer expressed the importance of feeling "safe" (repeated twice) as a premise for seeking help. Jennifer confidently and clearly stated that for some time she did not feel safe to tell the "truth". This word is in the same sentence as "the baby being taken away from me", which suggests that the "truth" was probably to do with her inability to mother adequately her baby perhaps because of severe depression. Jennifer did not state openly the feelings or the behaviour that made her scared that her baby would be taken away. Later on in the quote she referred to this "truth" with the general pronoun "it". This may be seen to convey a difficulty in talking about the challenges she experienced in mothering her baby. The word "fear" suggests an intense feeling, linked in the sentence to the "baby being taken away". This suggests that the fear emerged in the context of a perceived lack of power and control to keep her baby, and a perceived threatening external powerful entity being able to take her baby away. "It wasn't until" suggests that it took Jennifer a long time to reach out for help due to this fear. Nothing was said as to why she finally took this step, this does not appear to be important for Jennifer, or perhaps she did not want to mention it. Later on, Jennifer would hint at being hospitalised, but would not elaborate. Finally, she talked to a psychiatrist. The psychiatrist's power and confidence comes across in the simple and tight sentence structure. Jennifer perhaps needed to be reassured by someone with the power and status of people who previously she believed

would take her baby away. In the following part of the sentence, Jennifer repeated the word "said" in the context of expressing relief from her fear ("I felt safe"). This suggests that speaking about the fear enabled her to finally regain trust in herself and the external world represented by the psychiatrist. Indeed, most participants expressed that just being able to speak about how they were truly feeling helped them.

Joanne saw a counsellor for one session and quickly realised the counsellor could not help. The counsellor tried to help her relax with a visualisation that did not feel relevant to her own specific issues. Joanne articulated in the following quote how the counsellor failed to reassure her of her competence:

But the counsellor, yes, she didn't seem to understand postnatal depression, I wanted her to come back with answers, I wanted her to tell me how many women she cured, I wanted her to tell me how it worked and how I would be feeling and how I would improve. **Joanne**

Joanne, like most of the other participants, could not see a way out of her postnatal depression and in this quote she expressed how she needed to know that she was in the hands of someone capable, who understood postnatal depression and could guide her towards recovery. Joanne's brief plunge into postnatal depression was indeed successfully treated with anti-depressants by a psychiatrist who specialised in postnatal depression.

The shortness and simplicity of the sentences, the use of repetition, the repeated use of the first person pronoun communicate Joanne's directness and self-assurance. Joanne repeated three times "I wanted". This suggests an image of someone pressing the therapist to give the answers she wants to hear, without leaving scope for the other to express herself, which incidentally is how I felt at various times when I interviewed her. The repetition also communicates Joanne's desperate need to be "cured" and "improve" from an illness that was particularly difficult to bear because of its acute symptoms (which included for Joanne panic and inability to sleep) in the first place, but also because, I felt, it represented a threat to her strong and positive identity. There are different

elements in this quote that communicate Joanne's attempt to gain distance from postnatal depression. "Coming back with answers" conveys sending someone off to do their research and then come back with answers to her questions, implying that postnatal depression is something that can be objectively studied. This is reinforced in the following sentence, where the verb "cured" conveys that postnatal depression is like a physical illness. The verb in the next sentence - "how it worked" - suggests an image of a fault in a machine, which could be quickly fixed by a skilled technician, which also conveys a distancing from the emotional aspects of the illness and a focus on the physical aspects. Joanne then wanted to hear how she "would be feeling". There are two perhaps co-existing interpretations of this sentence. One interpretation is that Joanne was at loss as to how to understand her own feelings and she wanted someone else to explain what was going on inside of her. Another interpretation could be that she did not want to name the feelings herself and take the responsibility for them as she perceived them to be a threat to her positive ego. This quote communicates the need for an experienced and knowledgeable professional who could help explain the physiology of postnatal depression rather than just focus on the psychological aspects. This aspect will be explored further when talking about external attribution.

Monica also articulated the appreciation of professionalism surrounding her therapeutic experience when discussing the information she was given on the experience of the charity that delivered her counselling.

Well, first of all, the whole professional set up you know, from the first correspondence I got from them, the letters again explaining absolutely everything about the project and about how long they have been there and about what their hopes were, about their experience and this kind of - a lot of women have the same and you are not alone, so the first contact and them establishing the relationship with their clients. **Monica**

This is how Monica opened her comments on the usefulness her counselling experience (in response to the question: "in which ways was counselling helpful?"), indicating that this very first contact was for her important. The

charity communicated their professionalism by explaining "everything" – who they were, how long they had been operating, their experience and their hopes. It was reassuring for Monica to receive this information. The other useful information in the contact letter was that they communicated that "a lot of women have the same", which is a normalising message. This communication meant that a relationship was established and Monica felt less "alone".

Notable in this quote is the absence of the first person pronoun. For example, Monica talks about "their" hopes and at the end she uses "with their clients" instead of "with me". This suggests that Monica felt more comfortable with the association taking all the steps towards establishing a relationship. This may be because when she was depressed she needed someone to reach out to her. It could also be that Monica felt safer in talking about the other as this material is less emotionally charged. Indeed, at no point during the interview Monica did touch on any emotionally charged issues. For example, in this quote the depression is referred to impersonally by "a lot of women have the same". Writing, normalising, explaining helped Monica to feel safe in counselling, where –perhaps unlike in the interview - she could afford to talk about distressing feelings.

Empathy and Positive Regard

All participants talked about the capacity for listening and understanding as a key useful ingredient of therapy. Empathy emerged to be as tightly interlinked with positive regard, as participants perceived their therapist's capacity for careful listening and understanding as a sign that their therapists cared and appreciated them. The following quotes articulate some of the reasons why this was crucial for the establishment of the relationship.

I think one of the things was just having someone who was listening to me. 'Cause he just had a baby himself, so he kind of knew the lack of sleep, and all of that, he knew how bad that was. 'Cause often you think a man wouldn't understand because they don't go through it but I think, his baby is two months younger than my baby so he kind of understood, and I think that he saw what his

wife was going through, I had lots of problems with breastfeeding so I could explain that to him, so it was just having someone to listen 'cause at home I didn't feel like anyone was listening to me, no-one was taking what I said seriously and he took it and he actually listened to me and that was the only time in the week that I felt that someone was looking at me and listening to me, so that helped. **Rachel**

This quote contains many repetitions of the verb "listening", which convey the central importance for Rachel of being listened to. Listening is immediately linked in the second sentence to being understood ('cause he just had a baby himself'). The verb "understanding" is also repeated twice in the third sentence, suggesting that that is something important and interlinked with listening. Specifically, for Rachel it was important that her therapist understood what it means to have a baby, "how bad that was", which conveys that it was important for her that her therapist validated the negative feelings of motherhood. Rachel was one of the three participants whose therapist was male. In this quote she appears to justify to herself that it was not an issue to have a male therapist – "you think" and "they don't go through" appear to be efforts to distance herself from doubting her therapist's ability to understand her. Although Rachel often uses a tentative tone, in this context the repetition of "think"..."kind of" and "I think", may be seen to communicate a reluctance to acknowledge this doubt directly. In the next part of the sentence, Rachel explained another aspect of motherhood that she felt was important for her therapist to understand, that is her difficulties with breastfeeding. The use of "explain" also suggests that Rachel had to make an effort to convey these difficulties, which in turn point to a difficulty for her therapist to immediately acknowledge it. This is also reinforced by "he saw what his wife was going through", which implies the therapist had an indirect, although relevant, experience.

Rachel then explained that she did not feel anyone was listening to her at home. This is an indirect attack to her husband, which again suggests Rachel's difficulty to acknowledge that she is angry or disappointed. Rachel was angry for not being "valued" by her husband, who did not even look at her, as the quote conveys. Conversely, Rachel's therapist effectively put across his willingness to

understand and help her, thus showing he cared, which made Rachel feel valued. Listening and valuing are strictly interlinked in this quote.

Sonia received solution-focused therapy, which emphasises behavioural changes rather than emotional processing and talking. However, the first thing she mentioned when talking about her experience is her therapist's listening skills.

The gentleman who has been dealing with me has been brilliant, really - no problem talking, it feels like he has all the time in the world so that was really, it was much better than I expected. **Sonia**

Previous to the solution-focused therapy Sonia had a course of six CBT sessions and she complained in the interview that these felt rather rushed. What made her more recent therapist "brilliant" is that it "feels he has all the time in the world". This expression conveys that the therapist put her at her ease and showed interest in what she was saying. It also conveys that there is no limit to her therapist's listening time and interest for her, which also could be seen to express, as in Rachel's quote, the need to be valued.

At the same time, the use of "gentleman" may be seen to convey a certain distance between Sonia and her therapist. Sonia will specifically say later on that she preferred talking to a man rather than a woman. One reason may be that she felt more comfortable in maintaining a distance between herself and her therapist. Sonia's interview was brief and I felt she also kept me at a distance. Perhaps in the context of a closer relationship Sonia would have had to express feelings that were too threatening. This quote could be seen to communicate the need to be valued but also to feel safe by being allowed time and space to face difficult feelings.

The next quote articulates more directly the need for a caring therapist, willing to go beyond the therapeutic hour. This emerged as another very strong common theme across the interviews.

Uhm, just the fact that I knew that she genuinely...it wasn't just that I was going for one hour a week and after I was on my own, she said to me if I was feeling particularly desperate or troubled then before I did anything else or made rushed decisions I needed to phone her and then she also said, I mean it wasn't an issue fortunately for me, she said if I couldn't afford to pay then she would, because it was private counselling, then she said I just needed to tell her and she would sort out the fees or arrange something with the fees so...it was really I knew she was in it for the right reasons if you know what I mean, it wasn't just that this was your hour and after that you go so I think I was very fortunate.
Kate

The combination of "fact" and "knew" conveys the confidence that Kate had that her therapist was "genuine". It is interesting that Kate did not finish the sentence with "care" although she conveyed this indirectly in the next sentence, where she communicated that her therapist made herself available beyond the one hour a week they were meeting. This happens again in the second part of the quote where the therapist's availability at reduced fees reassured Kate she was in the profession for the "right" reasons, which given the context appear to be caring for their clients and not just for money. Kate seems reluctant to speak openly and directly about the need to be cared for, perhaps because it could be taken as an indication that she is needy and not strong. The expression "rushed decisions" in the context of a sentence that contains "desperate" may hint at suicidal ideations and the lack of explicitness may also be seen as a way to minimise the admittance of feeling desperate and in need of help.

The therapist's care made Kate feel that she was not "on her own", hinting at the loneliness Kate experienced when she was feeling "desperate". Kate found useful that her therapist conveyed that Kate "needed" to call her. The therapist here comes across as directive and active in showing her care. The repetition that it was not "just abut the hour" (*it wasn't just that I was going for one hour a week....* And later... *it wasn't just that this was your hour and after that you go*) could be seen to suggest that at the depth of despair what was said in the therapeutic hour was less important than feeling that her therapist cared, which in turn suggests the centrality of the relationship.

The importance of the relationship is conveyed in the interviews by the fact that all the participants commented on the positive relationship they had with their therapists. For example, Joanne described as following her relationship with her psychiatrist:

I was just in tune with her, she said what I wanted to hear. **Joanne**

The use of "in tune" suggests that an image either of a two radios communicating at the same wavelength , or two instruments playing together, which are metaphors of something not tangible. This quote describes an ingredient of therapy that is difficult to measure, that is the "attunement" between therapist and client. The use of "just" indeed suggests that Joanne was at a loss of how to describe the relationship in a more tangible way. However, one important component of this attunement was that her psychiatrist intuitively understood what she needed, implying that this understanding is an important aspect of establishing the relationship.

In summary, this theme has illustrated that participants found it helpful to relate to a professional who established confidentiality, provided information about their experience and qualifications, and conveyed confidence in their abilities. At the same time, participants particularly appreciated their therapists' empathy, warmth, and care. The therapeutic relationship made these participants feel valued and accompanied at a time where they felt disempowered and lonely. This theme also articulated how difficult these participants found talking about how they were feeling, which reinforces the importance of establishing a safe therapeutic space.

Theme 2 – Assuaging Guilt

Similarly to talking openly about difficult feelings, letting go of the guilt of suffering from postnatal depression emerged as another important step of recovery and one that therapy facilitated. Participants in this study interpreted postnatal depression as a sign of their own weakness and inadequacy. They

believed that they were deviating from the norm by feeling unhappy and unable to cope with motherhood. The analysis highlighted that taking on themselves the exclusive responsibility for their illness accentuated the feeling of being at fault in some way, whilst the converse release of guilt helped them realise that this was not the case. This theme articulates how therapists helped participants with this aspect by externalising the causes of the depression and normalising their negative feelings.

External Attribution of Cause

Participants appreciated their therapist helping them see that they were not completely responsible for falling ill, as Rachel articulated in the following quote.

I think the most helpful thing was how he explained that it wasn't my fault, that I didn't cause it to happen, and I wasn't,...that I shouldn't blame myself and that I shouldn't feel guilty about it. So one of the things he did was he got a whiteboard, he drew a diagram, and he put how much percentage the fault could be laid elsewhere so then I could see all the other causes and why I got it. **Rachel**

Rachel's therapist helped her see that it "wasn't her fault". The word "fault" is repeated later on, suggesting that Rachel believed the illness was at least in part due to a fault in herself. Rachel used "it" many times to refer to her depression. This could suggest a difficulty in talking explicitly about the depression and the feelings accompanying it. Another interpretation is that Rachel was at loss to describe what made her feel at fault. This contrasts with the therapist's clarity in drawing diagrams and assigning percentages. Rachel was relieved by her therapist projecting on a board the depression and depicting it as objective and unemotional external entity.

The repetition of different synonyms: "it wasn't my fault", "didn't cause it to happen", "blame" and "guilt", could suggest that the therapist had to reinforce this concept in different ways as Rachel struggled with this, or that Rachel was

still struggling to release the guilt, and needed to repeat it to herself. This could denote a difficulty in releasing the guilt at a deeper level than the rational one.

Rachel's therapist comes across as very active. Firstly he explained, then he used directive verbs ("shouldn't", repeated twice), then he "did", "got" and "drew a diagram". This directivity becomes apparent also in other parts of the interview. It may be that when lost for how to get better, Rachel needed to be guided towards recovery. This indeed emerged as a theme across the interviews and will be explored further in the next section.

Kate also found it useful when her therapist helped to see that her illness was extrinsic to her self.

She said I understand and what you are feeling is not you, is not you as a bad person, it's the illness and she tried to separate out me and the illness and the effects of the illness and she said it wasn't my daughter really that I had a problem with, it was just a hook if you like for the illness to hang itself on and if it wasn't her it might be for some women is that they didn't want to go out or they were terrified that their babies would be sick, she said it kind of latches itself onto a thing that you become a bit obsessive about. And she tried to explain it to me from her own experience, to make me realise that I wasn't a bad person for feeling those things. **Kate**

Kate found it helpful to see the illness as an entity "separate" from her, as seeing herself as responsible made her feel "bad". Kate felt like "a bad person" for having a "problem with her daughter". Kate told me in another part of the interview that one of the reasons she became depressed was that her daughter suffered from colic and kept crying. The hint at suffering from obsessions ("you become a bit obsessive about"), and the sinister quality of the illness ("a hook" – followed by the word "hang") could communicate indirectly that Kate was suffering from obsessions of harming herself or her baby. This only being hinted at may be seen to communicate a difficulty in openly talking about obsessions. The difficulty in being explicit about the manifestations of the illness also comes across in the use of the vague "those things" at the end of the quote, and in the

convoluted and confused structure of the passage where Kate spoke first about her therapist, then with the impersonal pronoun, then in the first person pronoun, then about the illness using "it", then about "some women".

The repeated use of "illness" and the use of "effects" convey a conceptualisation of postnatal depression as a physical illness. It appears that this conceptualisation helps Kate to let go of the burden of responsibility for suffering from it. The illness comes across as a distinct and active entity that "latches itself onto a thing". The sufferer is conversely passive, like a door (conveyed by "latch"). Letting go of the guilt appears in this quote to be more important than feeling in control of the depression.

Normalising

All participants consistently mentioned the need to feel normal, which highlights that the experience of postnatal depression made them feel abnormal. In the following quotes, Joanne explained how her psychiatrist effectively normalised her feelings, and communicated how important this was for her.

I went to the private hospital and saw the most amazing psychiatrist, who made me feel very normal, and put me at ease, and for the first time I felt that I was normal, and it was just something I could get better from, so straight away she made me feel, it was a combination of her talking to me and prescribing the right medication for me. And she was superb, absolutely superb. **Joanne**

She said you know I have seen so many women like you so straight away she made me feel that actually this was normal, that more people suffer from it than I would have ever imagined, and that was an enormous relief. **Joanne**

"For the first time I felt that I was normal" conveys that Joanne felt abnormal before seeing the psychiatrist. In the second quote, we learn that Joanne's psychiatrist convincingly made her feel normal by telling her that she had seen "many women" like her. This suggests that Joanne could not imagine that there

were other women experiencing postnatal depression like her, indicating perhaps that an unbearable aspect of feeling abnormal is feeling isolated and alone.

Joanne appreciated that the psychiatrist put her "at ease", conveying that Joanne's anxiety was relieved by feeling normal again and by feeling that she could get better. The presence of "just" suggests that her psychiatrist convincingly conveyed that Joanne's depression was less severe than she believed. The instillation of hope was another crucially ("enormous") helpful aspect of Joanne's treatment.

The quotes contain various superlatives: "amazing", "superb", "absolutely", "right". These suggest a certain degree of idealisation of the psychiatrist, who indeed in Joanne's narrative comes across as all good. Joanne related a narrative of being rescued by the psychiatrist, which conveys her perceived lack of power over the depression and the need for an external powerful entity to defeat it. This narrative also supports the conceptualisation of postnatal depression as a tangible entity ("something I could get better from"), external to self. Additionally, the psychiatrist helped Joanne feel better "straight away", which suggests an almost magical, instantaneous healing. One interpretation of this is that stressing the quick recovery from depression helped Joanne minimise the severity of her depression. Perhaps for Joanne suffering from depression felt like a weakness, and therefore a threat to an otherwise positive and strong identity that she clearly put forward in the way she looked and talked. This will be elaborated on further below when discussing disempowerment.

In the following quote, Jennifer articulated how she wished someone had normalised her depression in the context of her dramatic birth experience.

Yes. To normalise it. I mean I had some cranial sacral therapy and he said during labour your adrenalin levels are ten times higher than if you did a bungee jump you have a huge surge of hormones which then you have to recover from. And because I am a scientist I needed to be explained to at that level, you know your hormones are doing X this is why you feel like Y, and I had all this kind funny kind of, I didn't love my baby. [] Making it something not so heavy, so

hazy (scary sound). **Jennifer**

The simplicity and nimbleness of the hormonal explanation conveyed by the simple sentence structure contrasts with the weight of the words "heavy" and "hazy". We understand that a logical scientific explanation (your hormones are doing "X" that is why you feel "Y") helped Jennifer lift her feelings up and that the lack of understanding of her depression weighed her down, possibly because she assumed herself the responsibility for her depression. Jennifer communicated that what was particularly "heavy" was the feeling of not loving her baby. The use of "all this kind funny kind of", where funny has the double meaning of "strange" and "causing laughter", also may be seen to convey a need to make this experience lighter and less dramatic than she experienced it to be. Jennifer appears to communicate here the need for therapy to contextualise the feelings of not loving her baby in the framework of a traumatic birth experience. The use of the bungee jump as a simile conveys the feelings of fear, and at the same time euphoria that accompanies the experience of birth. Birth is a jump in the void, which also can be seen to communicate the emptiness and sense of unreality that can accompany the process of birth. Jennifer's therapist failed to recognise the significance ("huge") of her birth experience, which could have unburdened Jennifer from guilt.

In summary, this theme illustrated that participants felt abnormal when they compared themselves to others, and that bearing the responsibility for becoming depressed accentuated this feeling and made them feel inadequate and weak. Therapists helped assuaging guilt by articulating that depression has physical as well as other external causes and that there are many women experiencing it. These simple steps emerged to be very important for the recovery of these participants.

Theme 3 – Empowering

As illustrated in many of the quotes above, participants experienced postnatal depression as disempowering as it made them feel weak and at fault. The process of recovery told in the interviews emerged to be a journey towards more

confident and relaxed selves. This theme articulates the various ways in which therapy fostered (or failed to do so) the empowerment of these participants.

Guidance and Grounding

Most participants found it particularly difficult not to be able to cope with their everyday responsibilities whilst suffering from the disabling symptoms of anxiety and depression. Regaining control of their lives emerged to be a premise of re-empowerment. In this context, participants relied on their therapist to take the lead, and to give them advice and strategies on how to manage their symptoms. Guidance and containment will be looked separately but emerged as interlinked, as symptom resolution largely meant for these participants the ability to manage disabling emotions such as fear, panic and overwhelming sadness. The findings indicate that providing guidance on problem solving helped participants be grounded again in their reality, relieving them from the unsettling feeling of being lost and overwhelmed. In the following quote, Stella articulated eloquently the need for both guidance and containment in the context of the disorientation she experienced.

And the two different types, the psychologist is a relief because you can talk about the stuff and then the parent-infant person has solutions to problems. I was completely barking all over the place and she taught me how to bond with my baby. She really helped me with the problems. **Stella**

I think when I went and talked to her I was so desperate for someone to give me some solutions to all my problems, it was the fact that she said now do these things that helped. **Stella**

Stella received help both by a psychologist and a mother-and-baby therapist, and she found the two to be equally helpful and complementary. In the first quote, Stella summarised how the two therapists helped her, and conveyed that it was helpful both to talk and to focus on practical problems. However, the use of "talking about the stuff" can be seen to downplay the usefulness of talking and conversely stresses the importance of solving practical problems.

The use of "psychologist" and parent-infant "person" suggests a de-personalisation of her relationships with the therapists, emphasising their professional functions, which may be seen to indicate a need for professional help rather than equal relationships. Indeed, Stella here and often in her interview described confident and directive therapists who helped her take decisions and looked after her. The next sentence may be seen to explain why this was the case. Stella communicated that she was "barking all over the place". The expression "barking mad" means "crazy", however Stella did not use that expression. The image she conveys with "barking all over the place" is of a dog barking madly and running around. Emotionally, a dog barking conveys intense anger, or fear, or hunger, which may suggest that Stella experienced strong emotions. "All over the place" additionally suggests a lack of boundary, or disorientation. These feelings perhaps can explain why Stella needed a confident therapist, with "solutions to problems". The metaphor of a dog barking reminds me of psychodynamic conceptualisation of the transition to motherhood as a reconnection to primitive, raw and powerful emotions. Interestingly, establishing a bond with the baby appears to have helped Stella to become calmer and grounded.

In the next quote, referring to her psychologist rather than the mother-and-infant therapist, Stella repeated that she desperately needed "solutions to the problems". The word "solutions" suggests a need to quickly resolve the problem, either because of the intolerable nature of being depressed, or because of the pressing need to get better when she needed to take care of a baby, or both. Stella was "desperate", again hinting at the depth and uncontrollable nature of her emotions. Her therapist again helped by being confident and directive: "now do these things", which conveys the image of a teacher or a parent telling a child what to do. This strikes a similarity with Joanne's earlier quote, where she communicated that she wanted her therapist to tell her "how I would be feeling and how I would improve". Interestingly, both Stella and Joanne do not perceive their therapists' directivity to be paternalistic, but helpful. Both participants appear to have found comfort in being allowed at the depth of her depression to be in the child's shoes.

Jennifer also communicates the need for guidance and containment by explaining how her therapist failed to help her.

It was my first experience and I had no idea what therapy was like, what type it was so I literally went down into this room and the woman didn't speak (laughs), I just couldn't cope with it, I was in tears, I wasn't in a good place really, and I found it, and she was, you know, like you do, the whole my life sort of thing and I just feel now looking back to it, it was not the right time to do that. I needed to be able to cope with the present and going back to my past at that time was really (emphasis) difficult. And I know it's a process you go through in therapy, you go back to the past, you blame your mother so during this time I had a huge falling out with my mother when I really... [I: needed her?] needed her. So the whole...it was quite negative. **Jennifer**

This quote came at the beginning of the interview: this is what Jennifer really wanted to communicate about her experience of therapy. Jennifer had various therapy experiences but in the interview she mainly talked about her first therapy experience, which she sought after her second baby was born and she suffered from postnatal depression. "During this time" suggests a return to the present, which reinforces how this experience was still quite relevant to her despite taking place six years before. First of all, Jennifer opened by saying that she did not know what to expect from therapy, conveying some anxiety about embarking in it. Her therapist did not reassure her, as she did not give her any explanations about what therapy would imply. In the sentence not speaking ("did not speak") is immediately followed by not coping, which suggests that by not talking, the therapist did not help Jennifer to cope. This verb is repeated later on, reinforcing that Jennifer could not cope. We do not know whether she could not cope with her children or with her emotions, or both. "I was in tears" immediately after however suggests that she needed help to cope with her sadness or despair. The problem with therapy was that it focused on "looking back" instead of focusing on the present crisis. "Whole (my life sort of thing)" conveys a feeling of heaviness and suggests that Jennifer felt overloaded with more emotions that she could deal with. Jennifer also felt that looking at her past made her "fall out"

with her mother, which meant that she did not receive her mother's help and support at that difficult time. The use of the verb "fall out", which contains the verb "fall" instead of an alternative like "had an argument" for example, could also be seen to suggest that Jennifer felt that during that first therapy experience she was sinking deeper in her despair.

The articulation of the clichés about therapy - "the woman did not speak", "the whole my life sort of thing", "you go back to the past, you blame your mother" – could be seen as downplaying the complexity of therapy, which may be seen to convey the disappointment that Jennifer still experienced about that therapeutic experience.

Containment and Management of Emotions

Originally used by Bion (1962) in the context of the mother and infant relationship, "containment" in the therapeutic encounter can be defined as the therapist's capacity for being in touch with the sometimes unmanageable feeling or intense emotions of the client without collapsing or being overwhelmed. Thus, allowing the expression of emotions is an essential part of containment. Indeed, whilst needing help to manage intense emotions, participants also expressed appreciation for their therapists acknowledging and accepting difficult emotions that would otherwise have remained unexpressed. Monica and Danielle articulated how this was helpful.

[] How do people feel about crying, even things like that, the way she dealt with that, just very very experienced and not everyone that I know is comfortable about crying in public but it's definitely an important part of that [] and the box of tissues was there and she said you could leave at any point if you get sobbing or sad and you can't continue or if you want to go and see your child at the crèche. It was really important to be able to do that. So I sobbed (laughs) several times but it was good, it was very good to be able to do that because most people's natural instinct is to go "there, there it will be alright" but most of the times is not helpful because it's not ok, it's bloody awful at times. **Monica**

Monica received group therapy as well as individual therapy and this was a particularly helpful experience for her. The therapist clearly addressing the difficulty of crying in public made her feel that the therapist was "very, very experienced". Thus, talking and feeling comfortable with difficult emotions communicated competence. Monica appreciated being given guidance on what was or was not allowed in regards to emotional expression. The therapist providing a box of tissues communicated that it was acceptable to cry, which for Monica was "very good". However the therapist's instructions appear contradictory as she seemed to almost suggest that they should leave if they cry, or take a break by going to see their child at the crèche. Perhaps Monica found useful both to be able to cry and to be able to leave, indicating perhaps ambivalence, or a difficulty expressing intense emotions. It is interesting that Monica used the third person and the impersonal subject throughout this quote (which is the answer to the question "what do you think the therapist did to make you feel that way?"), which could also indicate a difficulty to talk about her own feelings.

The last sentence articulates a common complaint of mothers who suffered from postnatal depression, which is that people around them do not want to acknowledge the awfulness of motherhood. "There, there it will be alright" suggests that people trying to console and silence the crying instead of accepting it made Monica feel like a child whose feelings are dismissed. This dismissal indeed provokes anger, expressed by "bloody awful". This passage communicates how diminishing and damaging it can be not to acknowledge and respect negative emotions.

Danielle expressed how her therapist's acceptance of difficult emotions helped her process the trauma of birth. Most participants describe experiencing traumatic births as contributing to the precipitation of their depression.

The birth itself was not very good, and I was able to talk to her about the physical aspects of what had happened to my body, which were quite, the treatment I received was pretty brutal, but that's so normal in a British hospital, but I hadn't expected it. [] And I...I suppose I felt very weak that...I wasn't

coping and that I had experienced something not very nice but I wasn't coping with it, so I felt very weak but I was able to talk to her about all the gruesome details and she wasn't disgusted or horrified, she was so accepting. [] She wasn't horrified, she wasn't disgusted, and that was really...it was so cathartic. And sometimes she listened to me repeat the story week after week and that was fine, I was allowed to do that, and by the end of it...I now look back and think that wasn't very nice but I got my baby, but to begin with you know I was having nightmares, I couldn't sleep properly, I was so... **Danielle**

"Gruesome" and "brutal" are terms suggestive of torture, which could suggest that Danielle felt she was a victim in the birth experience. That Danielle felt like a victim is supported also by her admittance that she felt "weak" and that she had to receive permission ("I was allowed to do that") to repeat the story of the birth. This image of torture and victim is carried forward when Danielle uses "cathartic", an adjective which was originally used to describe the effects of dramatic tragedy in the spectator. These elements communicate that the birth experience was disempowering for Danielle. The expression "that's so normal in a British hospital", with the emphasis on "so" suggests that this experience made Danielle feel angry. Indeed, Danielle came across as angry whenever she recalled the birth experience. This experience caused her nightmares and difficulties sleeping and some kind of intense emotion she cannot articulate or chooses not to articulate *("I was so...")*.

The therapist helped Danielle by being emotionally contained, i.e. not showing disgust or horror, which appear to have showed Danielle that the horrific nature of her birth could be tolerated and accepted. This acceptance ("I now look back and think that wasn't very nice but I got my baby") meant that Danielle could release ("catharsis") some of the anger and disappointment and symptoms associated with it. The other aspect of therapy that helped in this context was repeating the story week after week. The therapist showed respect and patience for Danielle's needs, which appear to have countered her disempowerment, as she felt she was "allowed" to express herself.

Four out of eight participants were counselled by CBT therapists and all

appreciated its usefulness. Participants mentioned the CBT technique of thought challenging, which consists in writing down automatic thoughts in one column and thinking of possible alternative thoughts in another column (Beck, 2011), as a particularly helpful and empowering strategy as it helped them manage their emotions. Kate articulated this in the following quote.

Loads [she found helpful in the CBT] and I still use them now, in every day, I think everyone regardless of life should kind go through some of those strategies because they are really helpful and I think for example if some day you feel a bit overwhelmed you know with life and work and the kids and you start to kind of feel a bit anxious or whatever, and particularly after I've been ill if I started to feel like that I would kind of panic and think I am getting unwell again but what they say is that it is quite normal with a lot of pressure to feel like that, and everyone feels overwhelmed from time to time, just sit with it and it will pass, and don't panic, just ride it out. And it will pass. And it took the fear out of feeling like that. **Kate**

Kate talks in this quote about some of the feelings associated with her depression: "feeling overwhelmed with life, work and the kids", "anxious", "panic" "pressure" "fear". "Fear" is repeated twice, suggesting that Kate particularly appreciated that the CBT strategies helped her master and override the fear of getting unwell again. This can be seen to communicate the awfulness and unbearable nature of the illness. Throughout the quote, Kate hesitated to use the first person pronoun and kept switching between the impersonal and the first person pronoun. Although these switches are common in everyday language, they may also suggest Kate's need to distance herself from the illness.

Kate articulated how the CBT helped with the difficult feelings she experienced when she felt she was relapsing and becoming ill again. Firstly, CBT educated her that it is "normal" to feel anxious at times, again reinforcing the usefulness of normalisation in the context of therapy. "Just sit" suggests that CBT helped Kate accept and experience her feelings of anxiety, Kate could sit and face the wave instead of being swept away. Thirdly, CBT helped her realise that anxiety is transient – "it will pass". Finally, thinking rationally about her emotions

(strongly conveyed by "reason", "believe","rationalise") and writing them down helped Kate to gain distance and hence master them. Whilst "overwhelmed" in the first part of the quote conveys the image of a big wave swiping everything away and lack of control, -"ride it out" suggests a surfer mastering the forces of nature. This suggests that the CBT psycho education empowered Kate and helped her regain control of her life and her emotions.

Fostering Maternal Self-efficacy

Most of the participants communicate some uncertainty as to how to mother their children, which contributed to their feelings of insecurity and loss of self-esteem. Stella and Sonia expressed the need for receiving guidance on how to mother their children in the following quotes.

[] she [the mother-and-baby therapist] just taught us basic things like ask how he is feeling and to explore it with him and I think he is a very different, I think he is growing up to be a very different child because of what we've been taught. [] Yes, and to acknowledge emotions and what is the right way to dealing with it, like I'm upset, it's normal you know, all that sort of stuff it gave me the confidence to talk about his feelings. [] And actually it has given me the confidence, 'cause I know physically how to look after children, I know intellectually how to look after children, their development, sitting down you know, jigsaw etcetera, very easy – no concept of how to look after them emotionally. It's been a huge gap in my childhood. **Stella**

In this quote Stella articulated what she felt was the most helpful aspect of the mother-and-baby therapy. Stella conveys that therapy filled a "gap" of something "basic" she was missing. The presence of the word "jigsaw" may also be seen to convey the image of a picture with missing pieces. These images suggest an absence, something missing in the foundations of her life. The last sentence indeed clarifies that therapy gave her a knowledge that she should have acquired in her childhood. Because of this missing knowledge or experience she felt unconfident as to how deal with her son's emotions. The repetition of "confidence" conveys the importance Stella attributes to this aspect. The

empowerment comes across in words such as "right", "acknowledge", "dealing with it". The knowledge Stella was missing was to do with naming, appraising and dealing with emotions. Stella acknowledged that the lack of emotional literacy in herself affected the mothering of her baby, who thanks to therapy will be growing up to be "different". Stella talked later on about not only her mother but also her grandmother suffering from postnatal depression. In this context, this quote suggests that Stella doing things differently through the help she received stopped the intergenerational transmission of depression.

The confidence Stella developed thanks to the guidance she received strikes a contrast with Sonia's lack of confidence and call for more guidance.

What would have been nice would be to be told that they would be ok. You are going through this but you won't have any lasting effect on them, you won't be damaging them, you are doing a good job, look they are fine, they are healthy, that would have been nice. 'Cause you are worried that they pick up your good habits as well as your bad habits. And you think...am I? You know...my depression stemmed from upbringing and self-confidence and that is something that I worry about and I want to make sure she doesn't have those issues. But I don't know how to do that...really. All I do is watch my husband's parents, whom I think are wonderful, and think what would they do? How would they behave? What would they say? **Sonia**

This quote communicates Sonia's need for reassurance (which is also a form of containment) because she was worrying (repeated twice) that she was "damaging" her children. Sonia articulates in this quote a need for a reassuring presence telling her that she is doing a good job, which could point to an absence of positive voices in her relational world. This interpretation is validated by her communication that she had low self-confidence due to her upbringing. "They are fine, they are healthy" focuses on physical health, perhaps indicating that Sonia is sure they are fine physically but not psychologically.

There are many of questions and hesitations, expressing the uncertainty and lack of confidence Sonia experienced when thinking about how to make sure her

children did not suffer from her "bad" habits, which is left undefined but appear to be her low self-confidence. Her bad habits and upbringing are contrasted later on with the "wonderful" in-laws, thus suggesting that she feels apart and far from how she would like to be as a parent. Sonia's need to look for external guidance in her in-laws suggests a perceived lack of internal resources and strengths. Sonia's lack of confidence is also conveyed by "all I do", which suggests that Sonia believed she was not doing enough.

In summary, participants expressed the need and appreciation for guidance both in managing their symptoms and their lives and times of crisis, and some of them in mothering their children. Effective therapists came across as confident and able to provide guidance as well as holding and containment of the intense anger, anxiety and despair characterising postnatal depression as experienced by these participants.

Fostering Self-acceptance

Participants described a process of regaining confidence not only through symptom resolution, but also through increased self-acceptance. This emerged as a common positive outcome of therapy for these participants, who all conveyed that one trait triggering their depression was their perfectionism. Participants appreciated feeling more relaxed and accepting at the end of therapy, as Danielle articulated in the following quote.

I think I am a lot more accepting with the fact that I am only human (laughs) and I think I did really well actually, I was alone, I was in a new area...[I: so it gave you more confidence in yourself] *Yes. That I could get through it, that I wasn't weak, it wasn't a weakness to need help, that's because it's a very British thing isn't it you must be weak if you need help, and I think maybe realising that everybody does, it's perfectly natural.* [] *And then to have someone, a professional person, telling me that I wasn't mad, and I needed to be listened to, that I was worthy of being listened to and that actually for the situation I was in I was coping pretty well. That really, that meant everything, it really did.* **Danielle**

With the humorous phrase "I am only human" Danielle recognises that one of her problems was that she tried to be perfect, a term which she used later on ("perfectly natural"). Her high standards and expectations made her feel inadequate and "weak", whilst lowering her standards and accepting her limitations allowed her to see her strengths – Danielle realised she actually did well considering the circumstances she was in.

We learn that whilst depressed, Danielle felt that she was "weak" for needing help. This feeling of inadequacy is still difficult to own, as Danielle immediately after switch to the impersonal pronoun "you must be weak". This suggests that Danielle experienced suffering from PND as a disempowering experience. "Everybody does, it's perfectly natural" can be seen to convey the importance of adhering to the cultural standards and to what is "natural" and to be like "everybody" (which contrasts with "alone" earlier). Further, "it is a very British thing", echoes with the earlier quote (which occurred earlier in the interview) where Danielle mentioned that traumatic births are "so normal in a British hospital". This recurrence highlights Danielle's concern about what is normal in the culture she lives in. Together with the earlier reference to what is "natural" and "everybody", this quote communicates the central role of normalisation as a way to reverse loss of power and lack of belonging.

The next part of the quote needs to be contextualised. When Danielle became pregnant, the pregnancy tests were all negative. Danielle felt pregnant but the GP practice refused to carry out further tests, in Danielle's view because they labelled her as "neurotic" and "mad" because she suffered from chronic depression. As a result, Danielle did not have her pregnancy confirmed until she was six months pregnant. This passage conveys anger, as Danielle appears to be forcefully addressing the "professionals" themselves: "I wasn't mad, I needed to be listened to, I was worthy of being listened to". Danielle communicated how disabling feeling unworthy and demeaned was in her experience, and that being given back her worth in the context of therapy "meant everything".

Danielle referred to her therapist as "someone" and "a professional person",

which suggest a certain distance and emptying of the therapist's identity. This could either be due to Danielle's anger, as after all her therapist was a professional as the other professionals who did not believe in her. Another interpretation is that Danielle put forward the need for someone with a professional status to reinstate her worth.

In the following quote, Sonia also mentioned the ability to accept imperfection as a positive outcome of therapy.

Not scared to talk to other people about it. Not scared to ask for help. And not ashamed of it, really. And...not trying to cover it up. 'Cause it's ok to say I feel crap, I've had a rubbish day.... Just a bit more confident and a bit more relaxed. 'Cause previously I was saying about the mess I would think oh I am a bad mum if I don't tidy...really? That'd be ok. **Sonia**

"Crap", "rubbish", "mess", and "bad" convey that Sonia felt "not ok", almost rotten inside. Instead of covering up and being afraid to reveal it, she could now "talk" and "say" and "ask for help". The healing force of simply sharing negative feelings is reinforced by this quote, which appears to convey that keeping negative feelings inside made them rotten. Therapy helped Sonia assuage shame, like in Danielle's quote, which meant that she felt "okay", that is she accepted who she was despite her disturbing feelings. Feeling "okay" meant that she felt more "confident", which is in the same sentence as "relaxed", indicating that confidence and relax are linked. This confidence allowed her to question a judgemental and pressurising voice, which told her that she was a bad mother if she did not tidy up. Sonia, like Danielle, appears to have internalised an accepting voice ("really? It's ok").

In summary, participants expressed the need for guidance in managing the debilitating symptoms of depression. Grounding emerged to be a necessary premise to the process of empowerment. Containment of emotions and strategies to manage emotions were particularly helpful in this context. The process of recovery emerged to be a process of self-acceptance, which therapy facilitated and enhanced.

DISCUSSION

This chapter will look at the main insights for therapy that have emerged from this study, and will contextualise those insights in view of the available literature on psychological treatments for PND. Practical recommendations for counselling psychologists, the strengths and weakness of the study, and implications for further research will be discussed.

The Therapist and the Therapeutic Relationship

The therapeutic relationship was not specifically addressed in the interview schedule in an effort to maintain the interview schedule open to what participants would find useful rather than guiding participants to specific aspects of therapy. However, participants often referred to the relationship with their therapists and to aspects that were helpful or unhelpful. This study found that participants wanted their therapists to be professional and experienced. For some of the participants, the onset of PND was both rapid and dramatic, whereas for others it took a more progressive and slow course. In both cases, the participants reached out for help at an advanced stage of the condition, when they felt particularly desperate and unable to cope with their daily lives. This study suggests that, when at the depth of depression, participants needed to feel particularly reassured that their therapists could help them. This finding is not in line with the results of two quantitative trials, which have found that non-specialists with minimal training are more effective than mental health professionals in treating women with PND (Cooper et al., 2003; Milgrom et al., 2011). But our findings do concur with Shakespeare and colleagues (2008), who reported that some mothers do not think their health visitors are best able to look after their mental health. As such, this study suggests that any professionals treating mothers should proactively reassure women about their ability to help by sharing about their experience and qualification.

Moreover, effective therapists were described as warm and caring. Participants in this study repeatedly mentioned their appreciation of their therapists going the extra mile for them, for example by being available in between sessions, staying late because the mother had to wait for her husband to come back and babysit, or

communicating on behalf of the participants to other professionals. This care and commitment cemented the participants' trust in their therapists. Further, all participants explicitly mentioned liking their therapists, indicating that a positive therapeutic alliance was a component of successful therapies. Participants reported that at the depth of their depression the therapeutic relationship was the only source of support they had. Although some of the participants had families who gave instrumental support, it appears that the families cannot always offer the emotional support mothers need. Effective therapists did not shy away from this dependency and actively offered their support. Therefore, traditional psychoanalytic therapies proposing a passive, impersonal stance (Jacobs, 2004) risk not meeting the mothers' need for support. Jennifer's experience of feeling worse after talking with a therapist offering a passive, impersonal stance highlighted this risk clearly. This finding lends support to Stern's (1995) call for psychodynamic therapists to adapt the therapeutic alliance when working with mothers. According to Stern, therapists can be more active in showing that they care and appreciate the mother so that the mother feels "supported, valued and appreciated" (p.177). Perhaps this finding might explain why non-professionals have been found to be more effective than professionals with this population in trials comparing delivery of therapy by mental health professionals and non professionals with minimal training (Cooper et al., 2003; Milgrom et al., 2011). Both sets of authors attributed this finding to the experience of nurses and health visitors in home visiting. One hypothesis that this study offers is that it may be easier for non-professionals to offer active support to mothers, as they are less constrained by professional boundaries.

The therapist's ability to empathise with the participants, by understanding the difficulties with mothering, was universally expressed as another essential quality of successful therapy. Empathy in the context of PND emerged to be particularly relevant in the context of converse lack of understanding of what these participants - and many other mothers with PND (e.g. see Beck, 2002) - experienced in their social and professional encounters. These participants expressed that they felt a great relief by simply breaking the silence and secrecy that surrounded their difficulties with motherhood. Thus, listening to mothers' distress and validating their negative emotions in the context of a non-

judgemental space, emerged to be important aspects of the therapeutic work with mothers, as also concluded by Dennis and Chung-Lee (2006) in their review. One implication of this finding is that therapies emphasising structure and limited number of sessions may risk hindering this therapeutic process, as noted by Sonia in this study. It might be useful to precede these therapies by one or two sessions where mothers can articulate their feelings freely. This finding also explains the usefulness of listening visits for this population (Morrell et al., 2009). However, this study, like the study by Shakespeare and colleagues (2008) and Morrell and colleagues (2009), suggests that some mothers might need a more complex and structured therapeutic process than venting feelings.

Effective therapists were described by these participants as confident, self-contained, and active - not afraid to take the lead and provide advice and support. The need for guidance emerged in the context of the confusion, anxiety and lack of self-esteem that characterise the acute phase of PND for these participants. This could carry challenges to non-directive therapists for example from the person-centred or the psychodynamic perspectives (Cooper, 2008).

The findings around the importance of the therapeutic relationship and the core conditions of empathy and positive regard (Rogers, 1957) do not distinguish this from other counselling populations (Norcross, 2002). The appreciation of care for example was also found by Bedi, Davis and William (2005) with general adult counselling clients. This study however highlighted why these aspects are salient for mothers with PND and may explain the equivalence of efficacy of the various therapeutic approaches (Cuijpers et al., 2008; Dennis & Hodnett, 2009). It appears imperative to include measures of therapeutic alliance in any quantitative investigations of the effectiveness of therapy for this population.

Therapeutic Foci

Assuaging Guilt

This study confirmed the debilitating role of stigma and guilt in PND as highlighted by previous qualitative studies (see Beck, 2002). Participants felt that

by suffering PND, they violated the cultural standards of motherhood. They – initially at least – bore the entire responsibility for becoming depressed, and felt that the condition was due to a fault in themselves. The interviews suggest that because of these evaluations, these participants experienced PND as an ego-debilitating condition, whereby they were reluctant to talk about it. Guilt maintained their isolation and hindered frank disclosure. Participants indicated that therapists could cement the safety of the therapeutic space by articulating the various external causes responsible for the condition, such that mothers do not bear the entire responsibility for becoming depressed.

In this context, normalising the condition was highlighted as an effective therapeutic focus. Participants felt abnormal for suffering from PND and this emerged to be a particularly unbearable feeling perhaps because, as the analysis suggests, feeling abnormal included both feeling of being inadequate and feelings of isolation and lack of belonging. In the context of individual therapy, effective normalisation strategies mentioned in this study include self-disclosure of having suffered from the condition and having first hand specialist knowledge of treating many women suffering from the condition via specialisation. Cognitive strategies such as the thought challenging technique were also mentioned as helpful in challenging internalised unhealthy standards of behaviour. Furthermore, women who belonged to a support group (four out of eight participants) found the normalisation afforded by the group to be powerful, strongly supporting this intervention as an adjunct of individual therapy.

The relevance of guilt and normality can be linked to qualitative findings highlighting that one prominent aspect of PND is the felt discrepancy between cultural discourses and the reality of motherhood, whereby women feel that normality is happy and fulfilled motherhood (Beck, 2002; Knudson-Martin & Silverstein, 2009). Whilst some of the participants recognised the pressures to be happy and to do things right, these participants rarely mentioned society as responsible for their depression. Rather, participants strongly endorsed the medicalisation of PND, whereby PND is perceived to be a largely physical illness due to hormonal imbalances and physical stresses. This conceptualisation allowed them to see PND as something external for which they did not feel

completely responsible for, in the guise of a physical illness.

This finding may create a dilemma for counselling psychologists, some of whom are critical of the medicalisation of mental health (Douglas, 2010). There are clearly risks in the exclusive medicalisation of PND, whereby the illness is seen to be located in the individual rather than in the society, thus exonerating societal and economic factors impacting on the mental health of mothers. Indeed, there is a substantial body of literature supporting the impact of societal discourses and poverty in the development and maintenance of PND (Bina, 2008; Goyal, Gay & Lee, 2010). Some mothers who strongly endorse the medical explanation may also be reluctant to engage in therapy, although this was not the case for most of these participants, who strongly believed in the usefulness of therapy. This study suggests that therapists need to listen to mothers' conceptualisations of their depression and support their need for releasing the guilt that the narratives in this study suggest might oppress them. Whilst they may choose to articulate the complexity of factors that may lead to PND, therapists are advised to recognise the role played by hormonal imbalances, lack of sleep, and difficult birth experiences in the development of the condition.

Empowering

All participants described various disempowering experiences linked to their pregnancies, delivery and parenting which they believed contributed to their difficulties. Some of them had particularly difficult and traumatic birth experiences, which betrayed their expectations and made them feel that they had lost all control of their bodies. Some of them had particularly difficult or crying babies who made them feel uncertain of their abilities as a mother. Although this was only touched on in the results of this study, which was focused more on the therapy experience, it is relevant here to point out - in the context of elaborating on the multiple causes leading to the disempowerment of mothers - that most participants experienced disempowering relationships with the professionals looking after their pregnancy, birth and baby. In particular, they recounted encounters with GPs, midwives or health visitors that were either judgemental, disinterested, or patronising. Participants were told to "pull themselves together" during traumatic birth experiences, were left to cope alone with the labour all

night, were labelled neurotic and refused tests to confirm their pregnancy, were looked down upon for choosing not to breastfeed their babies. Participants recounted these episodes with anger, as they felt let down at a moment when they needed support most of all. As well as recounting these experiences, some of the participants recognised that they had previous issues of low self-esteem and perfectionistic tendencies. Both self-esteem and perfectionism have been identified as vulnerability factors of PND (Beck, 2001; Gelabert et al, 2011). As participants tried to do everything well, they found themselves continually failing against their self-imposed standards.

Once depression set in, these mothers perceived their difficulties as an indication that they were weak, and that they had failed as mothers. Their mental health problems then made it difficult for the mothers to fulfil their daily responsibilities, which exacerbated their feelings of guilt and perceived inadequacy. Participants appear to have experienced this progressive cyclical process of loss of self-esteem and confidence in their mothering abilities, as also noted by Homewood and colleagues (2009) in their qualitative study.

The process of recovery for these participants emerged to be a process of empowerment. One implication of this finding is that therapists should focus more on the strengths of mothers rather than on their difficulties, as proposed by Stern (1995). Participants felt that their therapists had trust in their capacities and prized them as persons. Once again, the relationship itself, as well as the therapeutic foci described below, emerged to be helpful in the process of recovery.

Grounding

Coping again with daily responsibilities emerged as an important premise of regaining control and power, especially given the presence of a dependent baby. The findings suggest that going back to their normal routines also relieved participants from the unsettling sense of upheaval and unreality they experienced. Røseth, Binder and Malt (2011) too found this sense of alienation from the self and the social and material world to be a feature of PND.

According to Beck (2002), this is due to the loss of their normal selves experienced by mothers as a result of the birth of their babies.

This study suggests that therapists treating mothers who are at crisis point should help those mothers become grounded again *before* exploring the psychological issues that may have lead to their depression. Jennifer's experience warns therapists that focusing on the past and highlighting pre-existing conflicts at the onset of therapy may accentuate some mothers' feelings of feeling lost and ungrounded. Highlighting relational conflicts with family members, especially with the mothers of the clients, may mean that clients lose the support of their own mothers at a time when they need it most. Therapists are therefore likely to be more effective by focusing on the present rather than on the past. In this context, participants appreciated their therapists helping them with practical problem solving such as how to carve out time for themselves, how to arrange childcare, and how to source practical help. Stella's experience suggests that helping mothers reconnect with their babies might also help them become more grounded. Indeed, isolation is likely to maintain despair and feelings of disorientation, and helping mothers reconnect with their baby and with others, as also suggested by Knudson-Martin and Silverstein (2009), is likely to help mothers become more grounded.

Symptom Management and Resolution

Symptom management and resolution emerged as empowering aspects of therapy, largely meaning being able to manage intense and overwhelming emotions. Participants described overwhelming emotions as interfering with their cognitive abilities, making it difficult for them to think clearly, to cope with their responsibilities, and to see a way out of their depression. As found by Beck's (2002) metasynthesis, women suffering from the condition often experience increasingly distressing emotions. Despair, anger and guilt and feelings of anxiety, often escalating into fear and panic, hindered participants from coping. The difficulties in the regulation of emotions that has emerged through this and other studies of experiences of PND can be seen to resonate with psychodynamic conceptualisations proposing that the transition to motherhood reactivates raw

and often unprocessed early emotions (e.g. Raphael-Leff, 2009). Another theory that may be relevant to these findings is modern attachment theory. According to this theory, now substantiated by neurobiological research (Schore & Schore, 2008), early attachments play an important role in the development of the right part of the brain responsible for the processing of emotions, self-regulation and the response to stress (Schore & Schore, 2008). This part of the brain operates at an implicit non-verbal level and has been found to be particularly active in mothers and infants (Schore, 2001). According to this theory, mental health distress is largely caused by difficulties in affect regulation and the role of the therapist is to regulate the clients' arousal state through empathic understanding (Schore & Schore, 2008). Indeed, these participants found helpful to interact with a calm and self-contained therapist who accepted and validated the expression of negative emotions but was not overwhelmed by them.

Validation of emotions also emerged to be particularly important; participants did not feel they could freely express their negative emotions outside the therapeutic space due to perceived or real inability of family, friends or society at large to accept their unhappiness. Participants also appreciated being given techniques for managing emotions. Particularly useful in this context were CBT strategies such as thought diaries, whereby clients are asked to keep track of their thoughts by writing them down, naming, whereby clients label the different types of negative thought processes (e.g. catastrophising), as well as psycho-education, that is a formal instruction about how emotions are triggered, how emotions, thoughts and behaviour are interlinked and about the transient nature of emotions (Beck, 2011). CBT emerged as an empowering therapy for Kate and CBT strategies also helped Sonia and Rachel. Some women from the Shakespeare et al. (2008) study who received listening visits expressed the need for more structured forms of therapy; this was echoed by some of the participants in the current study. It may be that structured forms of therapy feel more containing to mothers struggling with overwhelming emotions. It is worth noting however that participants, such as Sonia and Jennifer, warned against the risks of rigid application of CBT, which they experienced as disempowering through not meeting their individualised needs.

In addition to emotional disregulation, some participants (like Danielle and Stella) experienced flashbacks and nightmares as a result of a traumatic childbirth. Four out of eight participants experienced traumatic births that in their view contributed to their depression, confirming the high prevalence of PTSD following childbirth (Beck, Gable, Sakala, Declercq, 2011; Zaers et al., 2008). Experience or training in trauma work might therefore be a desirable skill of therapists working with this population.

Literature suggests that a sizeable percentage of women suffering from PND will experience obsessions (Brockington, Macdonald & Wainscott, 2006). Only one participant openly talked about this symptom in this study, hindering any conclusions as to how to best manage it in therapy. Other participants hinted at suffering from obsessions, which supports Brandes and colleagues' (2004) finding that this is a particularly difficult symptom to explore for mothers as well as their recommendation to actively normalise this symptom in the context of the postpartum so that mothers can talk about obsessions and receive help.

Self-acceptance

Most participants described feeling more confident and at ease with themselves as a valuable outcome of therapy, which supports the framework of empowerment as a central therapeutic theme for this population. Interventions that supported this outcome included the therapeutic focus on strengths and ability to cope, the challenging of perfectionism, and the provision of reassurance and guidance around mothering (which will be covered in the next section).

Participants consistently described a process of recovery whereby they started by wanting to be perfect mothers, then gradually accepted their limitations and realised that being "good enough" (Winnicott, 1953) was enough. Winnicott's concept of the "good enough mother" emerged to be a particularly helpful in the context of the participants' awareness that one contributing factor to their depression was their high expectations of themselves as mothers meeting all their babies' needs. Winnicott (1953) proposed that the best "facilitating environment"

for a baby maturing a healthy sense of self is provided by "an ordinary mother" who meets her baby's need for security by providing physical care and a containing environment for his extreme emotions, but at the same time also gives the baby the opportunity to experience disappointments and frustration by failing at times to meet his needs. This study indicates that the process of recovery for participants involved allowing themselves occasionally to be 'failures' by thinking of their own needs as well as their babies' needs.

The strong consistency of the "perfectionism" theme across the interviews suggests either that perfectionism is a vulnerability of PND, or that participants have assimilated unrealistic cultural standards. As Choi, Henshaw, Baker and Tree (2005) argue, cultural representations of femininity today are of a 'superwoman' able to cope with many competing demands, and the participants initially tried to conform to this representation. Moreover, Gelabert and colleagues (2012) found an association between perfectionism and depression in the postpartum period in a sample of 115 women in Spain. Thus, both psychological and cultural factors may be implicated.

The usefulness of acceptance for these participants supports the relevance of the theme of loss in the context of PND (Nicholson, 1989; Beck, 2002). One psychological task of motherhood and corresponding relevant focus of therapy may be the release of the need for control and the acceptance of a different, unexpected identity.

Self-acceptance has been highlighted as a key outcome of psychological therapy in studies by Carey and colleagues (2007) and Higginson & Mansell (2008) of clients undergoing general counselling. This study also found that clients appreciate both symptom resolution and changes in the self-concept, indicating a need to include both assessments in quantitative studies investigating psychological therapies. Similarly, this study also found that a range of therapeutic approaches facilitated the process of self-acceptance. It is likely that a common ingredient of therapy – perhaps the client's internalisation of the therapist's non-judgmental and accepting stance - is largely responsible for this outcome. Participants also reported the thought challenging technique to be effective in challenging their perfectionist standards. Again, a combination of

therapeutic stance and techniques may be effective in helping mothers in the process of self-acceptance.

The Presence of the Baby

Some theorists believe that PND can be seen as a disruption of the mother-and-baby relationship (Cramer, 1993) and mother-and-baby therapies have been proposed as effective therapeutic modalities for mothers with PND. This study found heterogeneity of issues and needs as regards to the baby, which advises against a universal focus on the baby or on the mother-and-baby relationship. Some participants (Rachel, Kate, Joanne, and Monica) clearly expressed that they preferred focusing on themselves during therapy and were indeed relieved to be away from the baby during their therapy time. For mothers like these, exclusively focusing on the mother-and-baby relationship or providing mother-and-baby therapy, or even home visits, could have been experienced as disempowering.

However, other participants, like Danielle, Sonia, Stella and Jennifer expressed the need for reassurance and teaching around how to mother their babies. Research indicates that depressed mothers may be more intrusive or withdrawn in their interactional style with their babies (Field, Diego, Hernandez-Reif, Schanberg & Kuhn, 2003), they report higher parenting stress (Milgrom et al., 2006), and they are observed and self-report more problems in the mother-and-infant relationship (Righetti-Veltema, Conne-Perreard, Bousquet & Manzano, 2002). Not all mothers with PND experience such problems, but therapists nonetheless have a duty to protect vulnerable children and cannot afford to ignore possible disruptions in the mother-and-baby relationship. The provision of assessment, reassurance and teaching regarding the mother-and-baby relationship may represent a challenge for therapists used to work with individuals, who may not have received training around these issues. As Puckering points out (2005), there seems to be a void in the service provision around which professional is more apt to think of the baby and therefore assess problems in the mother-and-baby relationship. Working as part of a team as recommended by the NICE guidelines (2007) can facilitate responding to the needs of the baby as well as the

mother. One option illustrated by Stella is to have two separate professionals collaborating, one focusing on the mother and the other on the needs of the baby. However, not all mothers will engage with two professionals and the experiences of these participants, as well as women and organisations at large, indicate that there is still a vacuum of adequate service provision for PND (The Patients Association, 2011; Royal College of Psychiatrists, 2005). Thus, therapists working with postnatally depressed mothers need to decide how they will address the psychological presence of the baby in therapy.

Therapists working with postnatally depressed mothers will also need to decide how to manage the physical presence of the baby. Some mothers simply needed to leave their baby behind but this may not be possible for all mothers. Solutions encountered in this study were managing the baby in the room (like Sonia's therapist), or being more flexible in terms of the times made available to mothers (for example Rachel's therapist offered longer sessions more spaced out rather than weekly sessions).

Finally, this study highlighted that, with severe cases of PND, where women may suffer from obsessions of child harm, or may particularly struggle to look after their baby, or may not have bonded with their babies, it is important to explicitly address the fear of the baby being taken away. Openly discussing confidentiality appears to be particularly important with this population, as well as normalising the lack of love or any conflicting feelings for the baby. Also important is sounding out the mothers' beliefs about social services practices, as they might feel particularly vulnerable and threatened by external agencies. Therapists will need to provide reassurance on this issue, whilst keeping in mind the code of ethics (BPS, 2009) and a duty to breech confidentiality in case of threat to "the health, welfare or safety of children or vulnerable adults".

The Presence of the Partner

Participants expressed different needs as regards to their partner so this theme was not included in the results. Whilst the baby is likely to be present, the partner might not. Indeed, two out of eight participants separated from their partners

before or soon after their baby were born. Where the partner was present, most participants appreciated their partners' provision of practical support. For only one of the participants - Rachel - the pursuit of couple therapy and the inclusion of the partner in one therapy session were particularly helpful. Stella's husband suffered himself from depression, which required separate treatment. Given the heterogeneity of needs likely to be encountered in this population, this study suggests that the inclusion of partner in therapy or the focus on the couple relationship should not be automatically part of the treatment of women with PND. However, therapists might want to be ready to respond to the needs of the couple or of the partner himself if these needs play a significant role in the maintenance of maternal depression.

Implications for the Practice of Counselling Psychologists

In light of the findings from this qualitative investigation, a number of cornerstones of the counselling psychologists' practice are likely to be particularly helpful in working with mothers with PND: these are the importance of the therapeutic relationship, the respect for the individual clients' subjectivity and needs, the focus on empowerment rather than psychopathology, and the provision of individualised assessments and formulations taking into consideration the wide spectrum of causes and presentations of mental discomfort.

Counselling psychologists working with this population should stay mindful of the secrecy and shame surrounding the condition and might want to invest additional focus on ensuring the safety of the therapeutic space. With respect to this, recommendations emerged from the findings include giving information about qualifications and experience, normalising negative feelings in the context of motherhood, and not shying away from demonstrating care. These findings highlighted that mothers suffering from PND might need a particularly supportive therapeutic relationship. Indeed, counselling this population might require exercising flexibility and going beyond traditional boundaries of therapy. Counselling psychologists are afforded the opportunity to think creatively, for

example about how to adapt the delivery of therapy to mothers with dependent babies through re-thinking the length of sessions or the location of therapy.

It is likely that counselling psychologists will be able to respond adequately to the therapeutic foci emerged in this study, given that self-esteem, management of symptoms of anxiety and depression, and grounding strategies are likely to feature in their training. However, given the emphasis on individual therapy, and the few opportunities to work with families, not all counselling psychologists might be equipped to assess and manage the presence of the baby in the therapeutic relationship. Counselling psychologists working with mothers with PND might better respond to their needs by gaining knowledge, experience or training not only in the diagnosis and understanding of PND with its wide range of symptoms, but also in the assessment and treatment of the mother-and-baby relationship, child protection policies and practices, and parenting courses offered in their areas. To enhance Counselling Psychology's profile in the perinatal field, providers of training for counselling psychologists could encourage trainees to gain experience in family or perinatal settings so that they are equipped to work effectively with this population.

Working as part of a team or a network of professionals is likely to help counselling psychologists meet more adequately the complex needs of mothers suffering from PND and their babies. Thus, counselling postnatally depressed mothers affords the possibility of collaborating closely with other professionals involved in the care of mothers and babies, such as midwives, GPs and health visitors. In this context, counselling psychologists are afforded the opportunity to assert their professional identity within a network of different professionals.

Broader Implications

This study has highlighted that the approach adopted by health professionals such as midwives, obstetricians, GPs and health visitors can affect the mental health of mothers. However, organisational inadequacies or limitations in their training may influence the attitude of these professionals towards mothers. For example, lack of resources or personnel in maternity care (Lepper, 2012) can

lead to the provision of damaging rather than nurturing maternal care. Promotion of a broader mother-centred birthing and perinatal care approach throughout the medical profession is paramount.

The establishment of specialised perinatal services as advocated in the NICE guidelines (2007) should be pursued, as these participants lamented a lack of services available for mothers suffering from PND and difficulties in accessing therapy via the NHS. Lack of services, together with the stigma surrounding the condition, hinder postnatally depressed mothers to access the help they need to feel better and to provide sensitive care for their babies. These participants clearly felt that without professional help they would not have been able to overcome PND.

Given this prominent role of stigma and guilt in the development and maintenance of PND, combating unhealthy discourses of the "perfect and fulfilled mother" is likely to help this population. Counselling psychologists might consider getting involved in media debates, or might support the establishment of support groups where women can challenge unrealistic standards of motherhood by sharing their struggles. Better preparation for the challenging reality of motherhood might also reduce the high expectations of providing perfect care for the baby, whilst more provision of parenting courses and mother-and-baby therapies might support maternal self-efficacy.

Strengths and Weaknesses

The key strength of this study lies in its respect of the participants' voices afforded by the methodology used, which allowed the identification of some needs that mothers would like therapy to respond to, as well as to suggest avenues of further research based on the women's voices themselves.

The work reported here represents an initial exploratory study. Qualitative methods such that used here aim to yield rich material rather than generalisations (Smith et al., 2009). Generalisations of qualitative findings are possible only after a number of studies have been produced and, because this is not the case for this specific study, its generalizability remains limited. The researcher aimed to

remain as faithful as possible to the words of the participants and most of the findings are in line with previous literature in the area of PND. However, in line with IPA's methodological requirements (Smith et al., 2009), the interpretations are personal conclusions based on the researcher's own worldview and knowledge. One limitation of the study is that participants appear to have found it particularly difficult to talk openly about their experiences of PND. This might have limited the scope of the findings. Further, there was some heterogeneity in the sample (for example as far as the need to include and think of the baby in therapy is concerned) - not all findings were endorsed by all participants. This reflects the wide variation therapists are likely to encounter in treating women with PND and highlights the need for assessing individual clients beyond research findings. The fact that all participants who responded to the call for recruitment were members of the Association of Postnatal Illness might have affected the results as the association endorses with its name a medical model of PND. The emphasis on externalising the cause of the condition might have been partly due to this factor.

This study did not recruit from a specific therapeutic orientation, and this allowed for the identification of useful therapeutic foci beyond the ones emphasised by single therapeutic orientations. However, perhaps reflecting the availability of therapy in the UK, participants only received counselling from the CBT, the person-centred and the psychodynamic traditions, which may have eclipsed needs that other traditions would have focused more on. For example, Stella expressed the need for guidance on how to parent her babies based on the usefulness of the instruction she received as part of the mother-and-baby therapy. The other mothers who did not receive such guidance did not highlight this need as clearly, perhaps because nobody had brought it to their attention. This suggests that the findings might be limited by the lack of experiences from other major therapeutic traditions such as IPT or system theory, or more experiences from the psychodynamic tradition. The need to conduct further research with mothers who received therapy from different therapeutic approaches is reinforced by this point.

Further Research

Given the limitations of current literature, further quantitative and qualitative literature on psychological treatments for PND would be welcome to inform the practice of therapists working with this population. Specifically, given the dearth of research available on the experiences of therapy of mothers, further studies such as this one could yield a more complete and solid picture of what mothers really need from therapy. However, given the secrecy and the reluctance of the participants to talk about PND, qualitative researchers might want to consider other data collection strategies, such as telephone interviews or written narratives. Understanding the therapists' own challenges along with how they adapt the therapy to this population could also enhance the understanding and hence delivery of therapy to postnatally depressed mothers.

This study found that postnatally depressed mothers have diverse needs in terms of for example the help needed with relating to their baby and with resolving difficulties in the couple. As regards to the baby, few studies exist on how to increase maternal self-efficacy in the context of individual therapy. As seen, individual psychotherapy to date has not been found to improve maternal self-efficacy and children outcomes (Forman et al., 2007). This study found that some postnatally depressed women would welcome assistance in how to relate or best parent their babies, making this a worthwhile avenue of further research. As regards to the couple, it would be interesting to select a more homogenous sample of mothers, or couples who sought couple counselling following postnatal depression to understand better how to address the needs of the couple in the postnatal period.

This study only hinted at the presence of obsessions of child harm as a manifestation of PND. As therapists clearly need to be equipped to address this symptom in the context of PND, it would be interesting to focus research more on this symptom through qualitative or quantitative studies as not much research exists on this (Brandes et al, 2004).

CONCLUSIONS

It is hoped that this study has enhanced counselling psychologists' understanding of what mothers suffering from PND want and need from therapy. Needs that participants highlighted in the context of therapy include: to feel reassured that therapists can help, to relate to an understanding person, to feel safe to disclose negative and disturbing feelings around motherhood and to have those feelings validated, to be appreciated, to feel normal, to be supported, to be helped to manage and resolve symptoms, to receive guidance in how to mother their children or reassurance in their capacities, and to be helped to accept their limitations and believe in themselves.

As seen above, various philosophical cornerstones of Counselling Psychology mean that counselling psychologists are well placed in meeting the needs of mothers with PND. Gaining further training to address the needs of the baby and the mother-and-baby relationship may enhance this capacity. Given the dearth of counselling psychologist literature in this area, this study has provided a first step towards stimulating further research in the area of perinatal care from the Counselling Psychology's perspective. In this context, dissemination in the Counselling Psychology and in the Perinatal Psychology circles via peer-reviewed articles and participation in conferences and workshops will be particularly important.

FINAL REFLEXIVITY NOTE

IPA presupposes that the researcher actively and cyclically seeks to reflect and endeavour to bracket his/her assumptions to remain open to the text (Smith et al., 2009). This section will make transparent my personal and professional assumptions, which were highlighted in the process of uncovering surprising results, and describe how I endeavoured to manage them in the analysis and writing up stages.

Firstly, I realised I expected participants would value the insight gained in therapy into past underlying issues leading to their depression. Although most of the participants mentioned past issues such as poor parenting, traumas or low self-esteem, most of them did not elaborate on how therapy helped, except for Stella. It was difficult to let go of this theme, but in the end I recognised my attachment to it and I did not include it, as it did not have enough support across the interviews.

Another assumption was that participants would talk about their difficulties mothering or relating to their babies. This theme did not emerge strongly, and surprisingly, some participants did not express concerns at all about their babies, and instead maintained that what they needed when depressed was more time away from them. I was attentive in the analysis and write up to point out the lack of consensus around "the presence of the baby".

Similarly, I expected mothers to welcome help with their couple relationship, and I probed this in sometimes leading ways during the interviews. However, this emerged as a strong theme for only two participants – Rachel and Stella. Another finding that surprised me is that participants found useful structured and directive forms of therapies, such as CBT. Although I did use CBT techniques in my practice, I did not practise it in a structured and directive form, as I believed it is more important to follow the client's lead. The fact that the theme of directivity (under "grounding and guiding") emerged clearly in the results indicates that I managed to put aside and indeed turn around this assumption.

Other findings that I found surprising although they did not clash with my assumptions were the level of emphasis on the provision of a caring environment, and the importance of normalisation. The strength of this last theme allowed me to highlight the impact of societal expectations and norms on the development of PND, a point that I felt was particularly important to put across.

In demanding that the researcher always goes back to the participants' words (Smith et al., 2009), IPA ensured that I remained faithful to the participants'

voices. Although unfortunately I could not include all the rich material that emerged, I believe the results do put across the main messages participants wanted to share.

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APPENDICES

APPENDIX 1 – INFORMATION SHEET

The experience of mothers who have received counselling for postnatal psychological difficulties.

This is an invitation to take part in the above study that is carried out as part of a Professional Doctorate in Counselling Psychology. This information sheet will explain the aim of the study and what participation involves. Please read through the information before you decide to take part in the study.

Purpose of the study
This study aims to explore what women find helpful and unhelpful in one-to-one counselling that they sought due to psychological difficulties after the birth of their babies, what their expectations were of the counselling and how they think their experience could have been improved. The study will help professionals delivering counselling to mothers to tailor their interventions so that they appropriately address the needs of mothers.

What the study will involve
Participation in the study involves a face-to-face interview. The interview will last about 45 minutes and will be audio-recorded for the purpose of the analysis. Questions will look at your experience of what you found helpful and unhelpful in your counselling experience. If for any reasons you find any of the questions upsetting you will not have to answer them. You are free to stop the interview at any time without having to justify yourself. The participation in this study is entirely voluntary.

Where will the study take place?
The interview will take place at a venue convenient for you.

Is the study confidential?
Your name and contact details will not be revealed in any circumstances. The transcripts of the interviews will be anonymous and it will not be possible to trace your identity from any of the material used. Pseudonyms will be used throughout. Your name will be kept separate from the transcripts and audio files. The texts and the audio files will be stored safely for a period of 5 years and will then be destroyed.

What will happen to the results of the study?
The results will be used to write up a thesis and may be published in a specialist journal. They will be presented to professionals involved in counselling and maternity services. They may be presented at conferences. If you wish to know more about the results of the study and how they will be disseminated you can leave your email with the researcher and she will let you know.

About the researcher
I am a trainee Counselling Psychologist at London Metropolitan University and a mother myself. I am carrying out this study as my doctoral research project. I am bound by the Code of Conduct of the British Psychological Society. If you

have any questions or complaints about my conduct during the study you will be able to contact my supervisor.

Many thanks for your time.

Regards,

Researcher Laura Ruaro Bhatia Tel. no: 0208 875 0320	Supervisor Anna Butcher Tel. no: 020 7320 1077

APPENDIX 2 – CONSENT FORM

To be completed by the participant: **Please circle Yes or No**

Have you read and understood the information sheet?	**Yes/No**
Were you given the opportunity to ask questions and discuss the study?	**Yes/No**
Do you understand that all information given will be kept confidential and anonymous by the researcher?	**Yes/No**
Do you understand that you are free to decline entry into the study and at any time leave the study without having to give reason for leaving up to two weeks after the interview?	**Yes/No**
I agree for the researcher to audiotape the interview and allow her to use verbatim quotations from my speech, withholding any information which may reveal my identity.	**Yes/No**

I agree to take part in the study.

APPENDIX 3 – INTERVIEW SCHEDULE

Could you tell me why you sought therapy in the first place?
-was this your first experience of therapy?

Was it easy to access therapy?

What did you expect from therapy?

How was your experience of therapy?
-what did you find most helpful/unhelpful?
-was there anything that you would have liked help with that therapy did not address?

What changed for you – if anything- as a result of therapy?

APPENDIX 4 – DEBRIEF FORM

The experience of mothers who have received counselling for postnatal psychological difficulties

Many thanks for participating in this study. If further questions occur to you or if you wish to withdraw your participation in the next two weeks you can contact me via telephone or email. If you have any complaints about how the interview was conducted you may contact my supervisor.

If participation has raised any concerns or issues that you wish to discuss further, a number of agencies can provide advice and support in confidence.

- Association for Postnatal Illness (http://apni.org/)

Helpline: 020 7386 0868 (10am-2pm).
Provides support to mothers suffering from post-natal illness. It exists to increase public awareness of the illness and to encourage research into its cause and nature.

- CRY-SIS

Helpline: 020 7404 5011 (line open 9.00 am to 10.00 pm, 365 days a year)
Provides self-help and support for families with excessively crying and sleepless babies.

- Meet-A-Mum-Association (MAMA)

Helpline: 0845 120 3746 (7.00 pm to 10.00 pm weekdays)
Self-help groups for mothers with small children and specific help and support to women suffering from postnatal depression.

- National Childbirth Trust

Enquiry line: 0300 330 0770; Breastfeeding line: 0300 330 0771; Postnatal line: 0300 330 0773.
Advice, support and counselling on all aspects of childbirth and early parenthood.

- The Samaritans

Tel: 08457 909090 (UK) or 1850 609090 (Eire); Email: jo@samaritans.org.
Provides confidential emotional support to any person who is suicidal or despairing.

You can access counselling services via your GP or you can find a counsellor or a psychotherapist in the following websites:
http://www.bps.org.uk/ The British Psychological Society
http://www.bacp.co.uk/ The British Association for Counselling and Psychotherapy.

Researcher	**Supervisor**
Laura Ruaro Bhatia	Dr. Mark Donati
Tel. no: 0208 875 0320	Tel: 020 7320 1110
Email: lauraruaro@yahoo.com	Email: m.donati@londonmet.ac.uk

APPENDIX 5 – DISTRESS PROTOCOL

Participants will be screened for depression and will have received some psychological treatment so it is not expected that participants will develop severe distress. However, due to the emotional content of the interview, a distress protocol is outlined below. The researcher is a Counselling Psychologist in Training so has experience in monitoring and managing situations where distress occurs.

If participants become tearful, the interviewer will ask them if they are happy to continue, will offer them time to pause and compose themselves, and will remind them they can stop at any time if they become too distressed.

If participants become distressed to a greater extent, e.g. cry uncontrollably or develop symptoms of panic, the researcher will terminate the interview and start the debrief immediately. Relaxation techniques will be suggested to regulate breathing and calm the participants. The researcher will recognize and normalise participants' distress. However, if any unresolved issues arise during the interview, the researcher will suggest that they discuss them with mental health professionals and remind participants that this is not a therapeutic interaction. Details of associations which can provide further support are listed in the debrief form.

If participants admit to suicidal ideation during the interview, they will be informed that confidentiality will need to be breached and that the researcher will need to inform their GP. If the researcher believes that either the participant is in immediate danger, then she will accompany the participant to the local A&E Department.

APPENDIX 6 – ADVERTISEMENT

Can you help with a study aimed at improving mothers' experiences of therapy?

I am looking for mothers who received therapy in the first three years following birth. If you are one of these, please help me understand your needs so that others can receive better professional support.

Participation in the study involves a 45 minute discussion. All information is kept confidential. I am a Trainee Counselling Psychologist (BPS member 166572) doing a doctorate at London Metropolitan University, where this study has been ethically approved.

If you are interested please email and I will send you more information. Thank you, Laura Ruaro Bhatia. lauraruaro@yahoo.com Mobile 07866959830

APPENDIX 7 – ETHICS FORM

APPENDIX 8 - EXAMPLE OF ANNOTATED TRANSCRIPT

Themes	Nr.	Transcript (my underlying)	Initial annotations
Depth of feelings. Relapse.	1 2	I: So, could you tell me to start with why to start with you sought therapy in the first place? P: Uhm, I sought it after my second child was born. I had my son in 2000 and my daughter in 2002, and I got very seriously depressed with my son	"Very seriously", she emphasises she got very depressed. Two children close together? A bit confused: she got depressed after son or daughter was born?
Professionals not helpful.	3 4	I: Your first one? P: My first, which...never got treated, but...when I was pregnant I was much better and I changed doctor surgery so they were much more aware of the possibility that it was going to happen and then when I had her it did happen again and at that point I tried...counselling.	"it" to refer to depression, no use of first person. Passivity: they were much more aware. Difficulties accessing treatment for the first depression.
Depth of feelings. Impact of birth experience. Access and provision of services.	5 6	I: So it was after your second one, and...was it easy to access counselling then? P: Well...I was given, I was recommended somebody by my I had an active birth teacher with me with my second child and I had a really traumatic birth, and my first one had been too, and she recommended her, and she was the sort of therapist, I don't remember the exact branch but I found it really difficult and...and...	Hazy, confused. Don't want to remember/difficult to remember? Passivity: was given/recommended. Traumatic birth is important.

Themes	Nr.	Transcript (my underlying)	Initial annotations
Congruence Depth of feelings Explanations about the process of therapy Modulating therapy Coping and focusing Impact of past Environment	7 8	I: Was it your first experience of therapy? P: It was my first experience and I had no idea what therapy was like, what type it was so I literally went down into this room and the woman didn't speak (laughs), I just couldn't cope with it, I was in tears, I wasn't in a good place really, and I found it, and she was, you know, like you do, the whole my life sort of thing and I just feel now looking back to it, it was not the right time to do that. I needed to be able to cope with the present and going back to my past at that time was really (emphasis) difficult. And I know it's a process you go through in therapy, you go back to the past, you blame your mother so during this time I had a huge falling out with my mother when I really	Descending, spiralling down metaphor of how she was feeling? The woman: derogative Despair Changing subjects, interrupted sentences. Heaviness Sort of thing: derogatory Repetition of cope: important? Now – present: clear Past: difficult – heavy Derogatory of therapy This time: present. Past and present merged. Whole: heaviness Huge: everything amplified.
	9 10	I: needed her P: needed her. So the whole…it was quite negative.	Whole: sense of heaviness again.
	11 12	I: Oh right. It's interesting. So far I have had mothers with positive experiences but it's important to understand also the negative experiences. So you said that someone recommended this psychotherapist to you, you had no idea of what the process was going to be like, and she didn't explain what it was going to be like, and how old was your baby then? P: She was quite little. I think she was three months or four months, I can't really remember any of that…	Disoriented by her negativity, going back to basic questions not encouraging depth Annoyed by my question

Themes	Nr.	Transcript (my underlying)	Initial annotations
Modulating therapy Needing to address depth and complexity Impact of past Upheaval	13 14	I: So your baby was still little and the therapist took you back to your past P: Which obviously I needed to process at some point, but at that time was at crisis point and I needed help with the crisis if you know what I mean, go back and wake up stuff with my mother...	Crisis repeated Her need for help not responded, unheeded. Wake up: Stirring a monster, stirring ghosts. Stuff: derogatory.
Diagnosis Explanations about the process of therapy	15 16	I: It was not the right time. P: It wasn't the time. I think I was very seriously depressed but nobody told me that you see, because it was very hard to judge, because	Repetition of seriously depressed. Nobody: loneliness. Confusion, lack of thought clarity.
Spiralling down Explanations about the process of therapy Difficulties thinking clearly	17 18	I: You're in the middle of it... P: You're in the middle of it and you sort of got there slowly, so it's been building up so it's very hard to judge yourself where you are at, you know you are struggling but you can't...and she said to me I think you should come at least twice a week and looking back what she was trying to say was you need some help here but she never said to me actually I think you have quite a bad depression and you need to deal with it, she just said you need to come twice a week, which I thought...which I did...but you know.	Building: wall Middle: conveying vortex and loneliness Difficulty judging repeated, confused mind. Slowly: struggling: idea of nightmare in slow motion, again suggesting blurred, slow mind Needing help repeated. Just: not enough Interrupted sentences. Why didn't she ask? Difficult communication therapist-patient

Themes	Nr.	Transcript (my underlying)	Initial annotations
Not coping Spiralling down Difficulties thinking clearly Diagnosis Acceptance Forgiveness Guilt Process of recovery	19	I: So you feel it could have helped if someone diagnosed it. Because you didn't feel right but you didn't know what it was.	
	20	P: I couldn't see daylight at all, I could not care for my children, I was really in a bad place, that dark place,...awful. It's the hardest thing when you are in that sort of depression, you haven't broken your leg, you still feel like you although you are not functioning properly, it's very hard to feel that you are ill. It's taken me a long time, actually years, actually until I had James, which I haven't had postnatal depression with him, to be able to say...to kind of forgive myself and to say I was ill, because I don't know with mental illness you don't feel like you're ill, you just feel like...you're not keeping, you can't tell why you are not keeping	Darkness. Lack of coping. Darkness repeated. Hard repeated many times. Lack of insight. Lack of coping. Ill. Long time to re-emerge. Guilt for not coping. Confusion. Lack of mental clarity/insight. Use of impersonal pronoun to distance. Repetition of ill. Use of impersonal pronoun, distancing.
External attribution of cause Understanding PND	21	I: So you think it would have helped if someone actually told you, explained that's the reason why you are going through it, it's quite common...	Needing clarity, explanations (given the darkness, confusion described above) Impersonal pronoun again
	22	P: Yes, and you know explain the reasons why you might have had, external reasons, not just what you feel, you know...	

Themes	Nr.	Transcript (my underlying)	Initial annotations
Environment Safe space	23	I: Uhm. And...this is how you felt before you went into the therapy. Do you remember what you expected from therapy?	Denigration of therapy again.
	24	P: I mean I had this American sitcom image (laughs) of therapy, and...the whole sitting in a chair with a box of tissues, when I first sat down and there was this box of tissues there I went (laughs), god this is strange. And I am very reserved as a person, and very...English you know, I do not naturally talk about my feelings, which has been one of my problems but you know, but to have someone who didn't speak to me I found it incredibly difficult. And I had therapy, much more successful therapy, since where the therapist does say you know how was your day (laughs), or what about this, or ...	Not at ease, strangeness. Continuation of the nightmarish narrative Incongruence, lack of relationship. Repetition of difficult. Box of tissues challenging as representing crying with a stranger Successful: normal not strange. You know repeated What about this: advice, active.
Congruence Warmth and care Therapist active.			
	25 26	I: Yes, like a human P: This was terrible.	Terrible: from comedy to tragedy
Process of therapy Loss Lack of coping	27 28	I: So how long did you have therapy for? P: And again, I don't really know, I feel all very sort of hazy but I think I probably went for six months, or four, five months I can't remember and then my grandmother died, whom I loved very much and for some reason I just couldn't deal with that anymore so	Why this question? Again not interested in replying Loss of grandmother. Death gives her an excuse to stop, she could not take the initiative otherwise. Passivity.

Themes	Nr.	Transcript (my underlying)	Initial annotations
	29	I: So you stopped. So you said about what was unhelpful about it, the attitude of the therapist...(interruption, baby comes in)	
	30	I: So we were talking about what you found unhelpful in therapy, that she didn't explain the process, she wasn't talking to you, and she didn't help you recognise in which way you were sick, and also she brought up stuff that you really didn't need to deal with at that stage so you found the therapy mostly	Increasingly negative adjectives.
	31	P: Very disturbing.	Psychologically distressing.
Depth of feelings Complexity of illness. Modulating therapy Upheaval Spiralling down	32	I: So did you feel worse?	Strong emotions.
	33	P: Yes, I kept crying and I felt quite completely sort of traumatised when I came out, and...I mean it's very hard to unravel it because it's all twisted up together but I felt like I was being unravelled and I had such small grip on my life, I was hanging on and then to have this whole unravelling where all this stuff came up from my past was just...awful.	Crying: a call for help not responded. Complexity. Sense of unreality. Nightmarish again. Stuff again. Came up suggesting that therapy made her go down, deeper.
	34	I: It made it more difficult for you.	Therapy made things more difficult. Anger.
	35	P: Really hard and..	
Explanations about the process of therapy.	36	I: So you said you had therapy for six months twice a week, and your therapist didn't really tell you which kind, 'cause you know there are different kinds of therapy	Difficulties remembering again. Not really into the different kinds of therapy. Not sure why I asked?
	37	P: Yes, I can't remember which type she was, I think she's a kind of therapist.	

Themes	Nr.	Transcript (my underlying)	Initial annotations
	38 39	I: Psychodynamic. P: I think virtually the one with the couch thing.	Slightly denigratory
	40 41	I: And...was there anything helpful about it you think? P: No. I mean, I've had help since then but not that time.	Not even one helpful thing. Angry.
	42 43	I: You can't think of anything helpful. P: Not really. (laughs)	
Safe space. Impact of baby. Isolation and secrecy. Accepting help.	44 45	I: And what do you think you would have liked therapy to address? You said for example you would have liked therapy to help you understand what you were suffering from, but was there anything else for example help with the relationship with the baby, or with your husband... P: Uhm...one of the things was to feel safe that I could tell the truth because I had the fear that my baby would be taken away from me, especially my first one, which is why I didn't get help you know,...and it wasn't until I went and asked for help at all and I said it to the psychiatrist and he said your child is not going to be taken away from you, it was only at that point that I felt really safe to say how I was feeling, and I think you know....	Fear, lack of safety. Threat Continues nightmare scenario It wasn't until:Long time Active at last. Clarity, reassurance. Repetition of safe.

Themes	Nr.	Transcript (my underlying)	Initial annotations
Non-judgement Safe space Isolation and secrecy Negative self image – low self confidence	46 47	I: So first of all you would have needed a place where you could feel safe to talk about how you were feeling. P: Yes, without feeling judgement. I think you are terribly judgemental of yourself, well I was thinking what a terrible person I was to think that and you have so much evidence (laughs), you can prove it, so I think if I had gone to someone who said this is a safe space where you won't be judged, and nothing won't be said, and I am not going to report you to the police (laughs).	Non-judgement. Negative self image. Trial – like vocabulary Confidentiality. She felt threatened, persecuted, judged. Object relations?
Isolation and secrecy. Depth of feelings Upheaval Client/therapist fit/liking/attunement	48 49	I: Oh ok, so reassured about that. P: Because it took me a long time to tell the extent of my feelings, depression, fears and that I feel it would have been helpful if someone, I don't know how you'd do it but...I was saying I'm fine, I'm fine even though the whole world it's sort of...and I didn't feel that, except well probably the last counselling I had was the more successful...he was a really nice guy.	Depth of emotions. Façade. Hiding. Difficult to break through someone who does not want to disclose Positive alliance. Whole world: alliteration, again sense of heaviness. Whole: nothing was fine.

Themes	Nr.	Transcript (my underlying)	Initial annotations
	50	I: You felt safe to express. And you said at that time when you first sought therapy it was difficult to deal with the day-to-day stuff, do you think that a therapist helping you with that, perhaps breaking down the tasks...	
Secrecy Isolation Depth of feelings Complexity of illness	51	P: Yes, I had after, because I had also break down in my marriage you see, which was quite complicated you see but when I came out of hospital I had another probably six months of counselling then and the psychiatrist deliberately said this is not going to be in-depth, it's just going to help you with the day-to-day, I talked and we didn't go into anything, we just talked about day-to-day stuff, and...I mean...one of the things I feel is that you have a terrible rage and anger and I've never felt anything like it and it was really frightening, and...but I never would have admitted it you know because then you sort of think what kind of mother (laughs), and I had completely thought, to wake up suddenly feeling like a raving monster, you feel kind of, that you don't want to look at anyone, and I think if someone is going to tell me, I mean I was given a leaflet recently but ten years things have changed a lot hasn't it, but...don't know, they didn't penetrate me, because I think my health visitor picked up from my first child she said to me I can only get you help if I put your child in the at-risk register and of course I didn't..(laughs)	Breaking down: everything falling apart Complexity Lack of depth in CBT. Complexity again. It's difficult for her to figure it all out. Terrible rage. Intensity of emotions. Fear, fright. Secrecy. Difficulties disclosing feelings. She felt like a monster: not herself. Fear coming back. Use of impersonal pronoun again Lack of understanding. Superficial. Darkness, complexity Hence the fear. Not reassuring. Darkness, out of reach
Anger Depth of feelings Secrecy Isolation Shame – Impact of societal discourses			
Professionals not interested/helpful Needing to address depth and complexity			

Themes	Nr.	Transcript (my underlying)	Initial annotations
	52	I: Yes, I hope things have changed, there is much more awareness I think...	
	53	P: Next time she came I said I'm fine thank you (laughs)	
	54	I: (laughs)	
Need for guidance Understanding PND Strategies to cope Impact of baby Normalising feelings Anger Depth of feelings Difficulties thinking clearly Lack of coping	55	P: I think if someone said to me you might get extremely angry and this is how you should deal with it you know put your baby in the cot, get out of the room...having had my last child now I feel separated from him you know, he is a separate entity but with my first two that was so blurred you know, everything that my son did I felt deeply, if he cried I felt he hated me, you know I couldn't separate out, I couldn't be rational about it, I couldn't say - he is hungry (laughs). And I was so hyper-aware, so conscious about everything.	Explanations. Guidance. Normalising. Enmeshment. Blurring confusion, lack of boundaries. Depth, image of sinking Hate, intense emotions. Persecution again. Lack of thought clarity (blurred). Anxiety. Thinking too much.
	56	I: Do you think someone helping you understand that would	
	57	P: It would have been really helpful.	
	58	I: You know talking about the relationship with your baby you know.	
	59	P: Yes,	

Themes	Nr.	Transcript (my underlying)	Initial annotations
Isolation and secrecy Reducing stigma	60 61	I: And helping you realise that just because he is crying he does not hate you, he is hungry or sleepy. P: Yes, but I don't know if I could have admitted that that's the thing. I don't know how...and I think now because it's much more talked about maybe people might be more open.	Difficulties disclosing difficulties around mothering. Shame.
Stigma	62 63	I: But you do not think you could have admitted that. (....) So you felt you would be judged. P: Yes, well I felt ashamed.	
Impact of physical factors Understanding PND Perfectionism Difficulties thinking clearly	64 65	I: And what about practicalities you know like helping you with the crying.. P: Yes, one of the things with me...was the lack of sleep, and I think if someone said to me it's really important that you sleep, its really healing, it can really affect your mental state if you don't sleep. I mean I was a real perfectionist, I wanted to breastfeed forever, and to do this and that when I gave my baby a bottle I though I was poisoning him you know (laughs), something horrendous, if someone told me for goodness sake (laughs)	Sleep, physiology. Perfectionism. Lack of perspective. Murder Needed help to put things into perspective

Themes	Nr.	Transcript (my underlying)	Initial annotations
Acceptance Perfectionism	66 67	I: that would have helped P: Which, when I had James I heard through the internet you have to fit in with the family, you've got two other children you know, just do as much as you can, it was great and actually I breastfed him much more than the others because I didn't have that pressure...but yes. I suppose there is that expectation we have which is up here...	Pressure in the way of accomplishing tasks. High expectations. Lack of perspective. We: impersonal again. Through the internet: need for guidance
Perfectionism	68 69	I: So lowering your expectations could have helped. P: I set myself up you know, I had to ...do this and I had to	Harsh voice. Have to-s.
	70 71	I: You made it really hard for yourself. P: Yes, and when my mother came she said my god	
Loss Emptiness Process of recovery	72 73	I: So how do you think you got to this stage now where you are much more relaxed. This therapy you talked about didn't helped, and actually made it worse for you but what do you think helped then? P: Well, when I sort of talked to the postnatal society they were sort of horrified that I could have lost five years because most people take six months but I really felt I had it for that long...	Horror. Loss.

Themes	Nr.	Transcript (my underlying)	Initial annotations
	74	I: So it lasted five years, it lasted for a long time.	
Upheaval	75	P: I mean I had it really worse after my son I think and then after my daughter I've got it again but it wasn't so bad because I knew what I was doing and I had less, I suppose life change, it meant a huge life change being at work and being in a rational world to being in an irrational world.	Life change, adjustment. Rational to irrational. Struggled to adapt to motherhood. Difficult identity adjustment. Loss of identity. Repetition of change, too much change. Psychodynamic conceptualization, right brain prominence. Identity transition theme.
Upheaval Social comparison Balanced thinking Connecting with others Perfectionism Spiralling down	76	I: So you went back to work. *(misunderstood what she was saying)*	Balanced thinking.
	77	P: Well , I went back to work part-time eventually but that shock I think of being at home, I found it a very huge adjustment and I was really struggling with that. And I think now I've got more of a network of people and I can see that different women do different things and there are some who are at home, some who work full-time, some who are sort in the middle, which is where sort of I got to, but at that point I thought you'll have a baby, you'll love to be with him twenty-four hours a day and the fact that I didn't was just so awful....But anyway sorry, what was the question, I did do...I ended up in hospital then I had counselling...	Difficult to adjust to being at home. Did not love the baby as she expected. Awfulness of the depression again. Confusion. Connecting to others important, social comparison Expectations.

Themes	Nr.	Transcript (my underlying)	Initial annotations
	78 79	I: Soon after you terminated the therapy? P: No, a couple of years later, and then I had another six months of therapy	
Needing to address depth and complexity	80 81	I: After the hospital... P: It was much more helping with the day-to-day, which it did, but at some point I felt slightly frustrated by it because I felt that I wanted to get...	Slightly frustrated
	82 83	I: At that stage P: Really to kind of address...and then I moved to London and had another therapy and this one wasn't very successful either...uhm...(laughs)	Timing. After a while she wanted to address core issues. She does not finish sentences.
Therapist self-contained Concealing in therapy	84 85	I: (laughs) It's very interesting to know different experiences, then hopefully people can learn what not to do... P: She was very very thin, she did look quite sort of anorexic, and she was one of those sort of people and I found myself absorbing her issues, not that she ever talked about them but...I...it was...when I felt sort of beholden to her slightly and when I realised it wasn't working I said I have to stop it ... I didn't know how to go about doing it because I feel it ...	Lack of boundaries. Lack of containment in the therapist. Difficulties communicating in therapy. She cared if she did not go, dependent on clients Difficulties asserting herself.

Themes	Nr.	Transcript (my underlying)	Initial annotations
Therapist self-contained	86	I: No. So it didn't help you in the sense that you felt that you needed to help her rather than being helped	
	87	P: Slightly...(...). And if I compare her with my the one I then went on to, which was sort of much better,...he is very self-contained, I know nothing about him, I don't need to know anything about him, and...I didn't see him for a year and it was minor. Whereas with her..	Sort of much better – not convincing
Anti-depressants Impact of societal discourses Needing to address depth and complexity Professionals not interested/helpful Assertion of positive/strong identity Low self-confidence	88	I: Ok. So in the end you had a successful therapy experience, do you think that this experience address some of the postnatal depression?	Medication helped.
	89	P: Yes, and at that point, years later, I tried medication, 'cause I refused it for all those years....But yeah, he is a psychotherapist, and he does existential therapy and cognitive behavioural therapy and I found that most helpful. I did a bit of cognitive-behavioural therapy in hospital but I thought it was stupid (laughs) they really dumbed it down and I think one of the problems with the whole thing of being a mother is that people treat you like stupid you know, and that is the most detrimental thing I think because I'm not as unconfident as I was, I was very shy and when I first had children I was very unconfident but I was still very well educated and had, you know, a settled career but	Stupid/dumb. Lack of confidence. Did not feel respected. Largely implied in depression.

Themes	Nr.	Transcript (my underlying)	Initial annotations
Professionals not interested/helpful.	90 91	I: They made you feel...that's interesting. P: I felt my voice was not respected, or heard.	Lack of respect significant.

Themes	Nr.	Transcript (my underlying)	Initial annotations
	92	I: So what would you recommend to therapists, you know, based on your experience? You already said, non-judgemental, creating a safe space, respecting the voice, and helping you with the practical stuff, kind of following where you are at, because it seems like at that stage when you had the first experience you were not ready to bring up stuff but maybe later on you were ready and then the therapist didn't (both laughs) so it would have been helpful perhaps to have someone who could see where you are at...	
Gender Impact of birth experience Impact of societal discourses Professionals not interested/helpful External attribution of cause	93	P: Yeah. And I think my most successful experience was with men and I don't know if that had anything to do with it but my sister is a doctor and its known that women are much harder on other women in the medical profession, especially obstetricians, that's why I choose a male one well I hate making generalisations like that but I didn't know there is anything to that but I was very badly treated in hospital by women so I suppose that probably put me off, this whole sort of stuff like you get on with it attitude. You know I was told to pull myself together when I had a tear, I had been up for fourteen hours, my baby nearly died you know the whole thing. So to be treated like that and to feel that you can trust people again...I suppose what would have helped is if someone would have helped me recognise that the birth was actually very traumatic and the treatment I received in hospital was also really bad	Women hard on other women. Betrayed. Angry. Recognise significance of birth. Trauma of birth. Disrespected. The attitude of midwives contributing to the traumatisation.

Themes	Nr.	Transcript (my underlying)	Initial annotations
Impact of birth experience Impact of societal discourses Preparation Overwhelmed	94 95	I: It sounds like it P: because you have this sort of put up, shut up kind of you know... and... you know it has taken me a long time to realise that people giving birth are able to walk out of hospital in two hours time and that is a very different experience to have an emergency caesarean, and horrible tears, and not being able to walk, and still expected to look after your baby when you've never even held a child before...	Society expect that of women especially in the context of childbirth. Not knowing how to mother. Overwhelmed. Too much Lack of support, of understanding
	96 97	I: So very traumatic. P: It's hard	
	98 99	I: So talking about the birth. P: Yes, because I found myself dependent on some random people, just needing to talk.	Needing to talk about the birth.
Anger Impact of birth experience Depth of feelings	100 101	I: Yeah, to recount what happened. P: And I can still remember it so vividly, it was awful and so getting rid of that and for someone to say that..	Awful. Vivid. She would like to get rid of it but anger perpetuates the trauma? Struggles to accept it still.
Normalising	102 103	I: Helping you understand how awful it was. P: No wonder you are feeling so bad.	

Themes	Nr.	Transcript (my underlying)	Initial annotations
External attribution of cause Normalising Understanding PND Assertion of positive/strong identity Impact of baby	104 105	I: To normalise it? P: Yes. To normalise it. I mean I had some cranial sacral therapy and he said during labour your adrenalin levels are ten times higher than if you did a bungee jump you have a huge surge of hormones which then you have to recover from. And because I am a scientist I needed to be explained to at that level, you know your hormones are doing X this is why you feel like Y., and I had all this kind funny kind of, I didn't love my baby.	Scientist: positive assertion of identity. Physical explanations, recognition of physical factors helped. Birth like a bungee jump, feeling of void. Not loving the baby hinted at again but never explicitly talked about. Emphasis on psychological factors weighing her down
Acceptance of help External attribution of cause	106 107	I: So someone explaining things to you. P: Making it something not so heavy, so hazy (scary sound). So there's that. And then there's also...once you go to therapy, once you are at that point where you are asking for help, so you kind of got to that but it has taken me a long time to accept that it is ok to have an au pair (laughs) I mean it sounds ridiculous but you know	Accepting help.
Humour Acceptance of help	108 109	I: ok, so helping you to accept P: that you can't do everything...and you know it's a friend of mine who said, they won't be thanking you for it anyway (laughs) just get out, get some help.	Perspective

Themes	Nr.	Transcript (my underlying)	Initial annotations
Self-awareness, self discovery Questioning instinct reactions Time and space for self	110	I: (...) It's great, it's been very interesting to hear your experience so yeah (...) so do you think that therapy changed you in any way? I know you had different experiences but if you could pick one thing...I mean this kind of be easy on yourself do you think that's something?	Self-reflection, insight Giving different perspectives. Awareness. Own space.
	111	P: Uhm (...) I think when I compare myself to my partner (laughs) who has never done anything like that and if you had a journey of understanding of what he is going to bear, (...) I think I found that sort of mirror, that sort of feeling that you are holding yourself up to the mirror and at different angles and you suddenly see what you are doing, you kind of question that behaviour, why did I do that, really helpful. And having a neutral space out of the family out of work which is my own I found it really helpful. And it's a bit easier now especially since the children have been five, that kind of really intense where you can't have a conversation with anybody so it's nice to have that space to breath for a bit.	Mirror: insight, looking at self helpful. Questioning self. Space for self. Release of anxiety. Difficulties breathing: children or responsibilities weighing her down.
	112	I: To be about you.	
	113	P: Really helped.	

Themes	Nr.	Transcript (my underlying)	Initial annotations
Access and provision of services Explanations about the process therapy Concealing in therapy	114 115	I: Do you have anything else to add to that that we have not covered? P: (laughs) I suppose...uhm...because recently I started having problems with my relationship again and I thought I would like to talk with someone but the person I saw before lives quite far away and where do I start? Where do I find somebody that is good, it's really difficult. I went to the doctor and he said these are the options but basically you just have to find your own, meet the person, but once you've met the person and you've had that first session then it's quite difficult to get yourself out of it I find (laughs).	Difficulties accessing therapy. Not everyone is good. GPs as a point of access.
	116 117	I: I see what you mean. P: they say what about next week and you put it in your diary and you think actually I don't want to go.	
Explanations about the process of therapy	118 119	I: Yes, I think it's difficult to orientate yourself. P: Yes. It would be really helpful if in the doctors surgery they had a leaflet with these are the different kinds of therapies, this type is good if you want to know this, these are the people in your area...if you just want help with the day-to-day do this, if you need existential help do that, it would be really helpful ... today I'd find it helpful. (laughs)	Guidance on what is therapy. More information about therapy. Explanations about the different forms of therapy. Making therapy more accessible.

Themes	Nr.	Transcript (my underlying)	Initial annotations
	120	I: No, I think there is an awareness of that in the community but somehow nobody does.	
	121	P: I've realised the counselling has been slightly up in the NHS isn't it.	
Access and provision of therapy	122	I: There is more counselling in the NHS but I think it would be helpful if there was not only CBT but at the moment it's outside the NHS so it's difficult to access. There's the British Association of Counselling and the British Psychological Society where you can find the name of a therapists but it is not as accessible as having a local leaflet.	
	123	P: Yes, that would be helpful. And also one doctor said to me you can do CBT online I mean when am I going to do that? (laughs)	Difficulties accessing therapy.
	124	I: You ask for counselling and they say go on the computer (laughs) Ok, thank you very much for your help.	

APPENDIX 9 – FIRST TABLE OF THEMES

Stella	Monica	Jennifer	Sonia	Kate	Joanne	Danielle	Rachel
Needing guidance. Difficulty gauging severity of illness. Difficulty seeing things clearly. Anxiety. Complexity, interconnectedness of illness. Isolation, lack of trust in others, others not trusting. Good professionals taking an interest, asking relevant questions, guiding.	Awareness of not feeling right. Low mood, irritability, passivity. Urgency, need for help. Professionals sitting down and taking the time. Giving options and hope. Supportive. Approach and demeanour inspiring trust.	Awareness of depression after first son. Lack of treatment > relapse. Traumatic births Not clear of which branch therapist belonged to. No explanations of how therapy worked. Therapist not speaking not helpful. Exploration of past made her feel worse. Bad timing.	Depression before children, not treated. Scared of postnatal depression. Difficulties coping. Proactive seek for help. Therapy can make a difference. Did not expect to receive as much help after the birth of babies. Help is not forthcoming, is scarse.	Quick realisation and diagnosis. Proactively seeking help. Contacting voluntary associations. Preferred someone specialising in PND. Difficulties accessing counselling via the NHS. Upheaval. Group as a space for sitting and talking. Hospitalised.	Desperation. Difficulties sleeping. After second baby. Stagnation, not going forward. Difficulties coping with two. Overwhelmed. Sought help straightaway. Doctor not interested. Doctor offered anti-depressants. Proactively seeking help. Took initiative to see a psychiatrist privately.	Labelled as hysterical and crazy because of mental health history. Anger at labels, at not being listened to. Not listened to. Felt put down by doctors. Doctors trusted tests more than people. Doctors judgemental.	Another cycle of therapy after birth of baby. It took a long time to work on it. PND not diagnosed. Needed long-term help. Therapist there in case of crisis. CBT apart from general psychology. Difficult to see way out. Overwhelmed Knew therapy helpful.

Stella	Monica	Jennifer	Sonia	Kate	Joanne	Danielle	Rachel
Evidence for counselling helps the engagement. Need for the complexity/depth of problem to be addressed. Professionals recognising and respecting complexity helpful. Difficulties accessing therapy. Needing a skilled professional. Needing identity/status to be validated. Professionals listening, supporting views and decisions.	Feeling valued. Goals of enjoying being with the children. Goal: Recovery. Goals: confidence. Understanding the causes. Normalising. Isolation. Letting go of control. Relaxing. Self-confidence. Counselling giving relief.	Desperation. Lack of coping. Falling out with mother. Needed help with present crisis. Woke up stuff at the wrong time. Lack of diagnosis. Upheaval. Therapist did not diagnose. Therapist was not clear. Slow development of depression made it difficult to self-diagnose. Lack of insight. Muddled thinking.	PND acceptable, less shame/stigma than depression. Ability to be open about a problem makes help more accessible. CBT equated with skills. Six sessions not enough. Therapy and help beyond expectations. CBT simplistic, not addressing the problem.	Very unwell. Feels lucky to have received good care. Psychiatrist seeing many women with pnd. Different professionals involved communicating for best care. Mother-and-baby unit not available nearby. Relieved to be away from baby. Baby crying all the time. Difficulties coping with baby.	Waiting list for counselling. Needing prompt help. Lucky to have private care. Normalising. Giving hope. Prescribing right medication. Lack of professionalism. Home visit not helpful. Did not ask where she would prefer to be seen. Lack of understanding of counsellor way of working. Not understanding pnd.	Started doubting self because other people doubted. Challenging the obvious. Nightmarish. Doctors and specialists against her judgement. Losing mind. Anxiety. Marriage break-up. Depression. Intergenerational transmission Psychosis terrifying. Begging for tests.	Hoped that it helped. Long process. Difficult to see the way out Relieving guilt. Took all the responsibility for illness. Externalising responsibility. Visual technique: pie chart of responsibility. Self blaming. Understanding causes helps prevention. Anxiety about relapse with second baby. Therapist understanding.

Stella	Monica	Jennifer	Sonia	Kate	Joanne	Danielle	Rachel
Needing to be looked after, guided. Private healthcare helps you find the right care. Money gets prompt care. Normalising. Life stressors. Difficulties self-diagnosing. Fear rather than sadness. Feeling abnormal. Sudden upheaval. Not recognising world, self. Nightmarish. Felt like hell. Shock. Disintegration of self.	Professionalism, experience valued, inspiring confidence. Clear explanations. First contact establishing trust via professionalism. Normalising. Putting client at ease, welcoming. Not patronising. Empathy. Creche. Thinking of details. Trust.	Difficulty seeing things clearly/realistically. Lack of coping. Guilt for not coping. Difficulty self-diagnosing. Diagnosis helps reduce self-blame. Explanations of symptoms helpful. External attribution of blame/responsibility. Internal attribution leading to guilt. Odd, not comfortable environment.	Therapist not rushing. Therapist listening. Regrets not receiving help earlier. Not knowing exactly what therapy it is. Had to go privately. Desperate for help and support. Making friends, talking to others positive. Widening social network. Acceptable to talk about being depressed.	Exhaustion. Difficulty coping with baby and toddler. Needed help finding a way out. Difficulties seeing clearly/seeing a way out. Desperately trying to get better. Hoped for help with coping. Understanding the condition. Only having suffered from it makes it possible to understand.	Not specialised. Needed understanding and explanations of symptoms. Doctor not interested. Prompt care with private insurance. Felt better straight away. Feeling better: feeling normal. Quick recovery. Calm demeanour. Seeing other women with same problem. Normalising relief. Precision, professionalism, expertise.	Terror and joy. Marriage collapsing. Stress. Collapsed. Not understanding. No explanations. No explanations on qualifications. Low expectancy on NHS care. Reassurance of normality of reaction. Reassurance on mental health.	Therapist knowing what worked. Therapist understanding the causes. Therapist knowing how to help. Past issues leading to pnd. Listening. Understanding what it means to be a parent. Therapist was a parent himself. Self-disclosure helpful when supporting understanding. Not listened and valued at home.

Stella	Monica	Jennifer	Sonia	Kate	Joanne	Danielle	Rachel
Relief to talk. Relief to break secrecy. Shame. Safe space. Solutions to problems. Scattered, lack of focus. Bonding as grounding. Problem solving useful. Help with older child helpful. Therapy hard. Therapy helping. Reassurance. Help with managing symptoms. Nasty thoughts. Needing a distance from symptoms.	Rules, environment leading to trust. Space where you could be truthful. Feeling heard. Trust. Confidentiality. Honesty, saying things as they are. Non-judgemental space. Recognising that you have a problem. Tuning into each other.	Blank therapist unhelpful. Terrible. Threshold of how much pain you can take. Therapy as emotionally demanding. Disturbing. Uncontrollable crying. Complexity of situation. Small grip on life. Needing grounding. Safe space where she could be truthful. Fear of baby being taken away. Non-judgemental space to relieve self-blame and self-accusations.	Secrecy of mental health problems. Stigma around depression. Emotional expression positive. Allowed to cry. Lasting friendships and support network. Normalising. Isolation of depression. Resentment at not receiving help earlier. Ending difficult. Creche.	Therapist going the extra mile. Genuine interest, care. Understanding exactly how bad it makes you feel. Relieving guilt, self-blame. Locating causes/illness externally to the person. Relieving guilt about not loving the baby. Obsessions. Explanations about illness. Not a bad person.	Asking pertinent questions. Non judgemental. Reassuring. Instilling hope. Back to self. Not recognising self. Hope instilling. Capable. Relief to be in good hands. Panic. Self-absorption. Difficulties trusting people. Gravitas. Authority. Specialist. Trusting that she would get better. Trusting professional.	Professional manner, communication. Expected miracle. Difficulties seeing clearly. Needed directions to gain clarity. Telling all the details of birth. Normalising treatment. Assertion of identity. Assertion of positive identity. Feeling weak, like a failure.	Understanding difficulties. Listening, valuing. Emotional expression. Could cry and explain why. Being real. Writing things down helped. Sharing with husband. Homework as a reinforcement. Prescribed time off from baby. Therapist leading. Working out time for self. Enjoying life. Time for self. Getting out.

Stella	Monica	Jennifer	Sonia	Kate	Joanne	Danielle	Rachel
Normalising. Worrying about thoughts. Explaining symptoms makes them more manageable. Everybody made her anxious, worried about symptoms. Therapist calm, in control, trusting. Sharing fears. Life events impacting on illness. Husband unwell. Overwhelmed by problems. Breaking down problems makes them manageable.	Calm, self-containment and experience inspires trust. Prompting, not forcing. Dealt and explained potentially difficult aspects of therapy. Genuineness. Counsellor comfortable with crying. Good expressing negative emotions. Able to be real.	Safe space. Secrecy about feelings. Combination of fear and sadness. Safety to express how bad it was. Marriage breaking down. Rage and anger. Fear. Secrecy. Shame. Monster. Against cultural expectations. Lack of interest and understanding. Health visitor unhelpful. Normalising feelings. Strategies to deal with anger.	Being able to talk without the children. Making time for friends important Ignoring children, focusing on self. Control, perfectionism. Housework in the way. Questioning instinct reactions. Thinking realistically. Awareness of catastrophising and jumping to conclusions. Gaining perspective.	Therapist having experienced it reassuring. Instillation of hope. Reassurance. Cannot see the light. Instillation of hope helpful. Despair, depth of emotion. Falling down. Isolation. Feelings of failure. Challenging one-size-fits all. Normalising. Genuinely caring: available after sessions. Transitional object.	Quick improvement. Only needed three sessions. Professional confirming that you are ok. Keen to leave illness behind. Recovery as a journey. Sleeping helped. Afraid of dependency on drugs. Chemical balance. Hope and trust decisive. Relieved anxiety. Desperation. Suicidal ideation. Felt useless.	Difficulties coping. Containment. Accepting. Containment. Catharsis by repetition of story. Lead to acceptance and relief from symptoms. Trauma of birth. Making it less awful. Acceptance. Grounded. Able to control feelings. Calm. Logical.	Working together. Anxiety. Difficult baby. Difficulty coping with crying. Time for self. Anxiety, suffocation in the house. Getting out. Husband came to a counselling session. Explained to him what pnd was and how he could help. Therapist communicating on behalf of the client. Taking the client side. Resentment.

Stella	Monica	Jennifer	Sonia	Kate	Joanne	Danielle	Rachel
Thinking of practical solutions. Letting go of responsibility. Working out solutions together. Difficulties focusing, thinking. Overwhelmed. Flashbacks. Memories intruding on present. Looking at past useful, later on. Therapy reconnecting the disconnected. Therapist leading.	Honesty, genuine. Self-disclosure as supporting genuineness. Displaying emotions but without overdoing it. Structure giving containment. Structure. Structure giving control. Recognising the need to talk. Environment helping. Feeling at home.	Blurred boundaries and hazy reality. Hyper-awareness. Hyper-sensitivity. Inability to separate own/baby feelings. Difficulties admitting problem. Shame. Society perceived as judgemental. Sleeping important. Perfectionism. High expectations/demands on self. Bottle feeding perceived as 'bad mothering'. Pressures.	Mothers pressurised to be perfect. One-size-fits-all advice pressurising. Self-confidence. Lack of focus in CBT. Clarifying goals and what it means to feel better. Challenging self. Meeting people, keeping busy. Lack of clear goals not helpful.	Genuinely caring: Available to reduce fee. Qualification important. Different times requires different therapies. CBT empowering. Positive strategies to cope. Managing illness. Gaining control. Overwhelmed. Panic. Normalising stress. Challenging catastrophising.	Affirmation of positive identity. Guilt. Felt useless. Lack of sleep. Tiredness impaired coping. Guilt. Feeling like a failure because could not provide. Vicious circle. Difficulty seeing the way out. Reassurance key. Looking for a miracle. Counselling did not meet expectations.	Problem solving. Working through. Overwhelmed Breaking it down. Containment. Logic and warmth. Lack of privacy because of building structure. Accepted depression. OCD. Awareness of how to manage the illness.	Late diagnosis unhelpful. Problems in the relationship. Not wanting the baby. Fear. Husband angry at her for not wanting the baby. Not accepting changes, loss. Lack of support. Problems with breastfeeding. Regretted having a baby. Exhaustion. Co-morbidity: fibromyalgia. Difficulties sleeping. Vicious circle.

Stella	Monica	Jennifer	Sonia	Kate	Joanne	Danielle	Rachel
Therapy as a painful process Processing painful feelings Leading to acceptance. Therapist leading her into painful territory. Confident therapist leading the way. Depression can be quickly set off. Depression linked to painful past. Confident therapist, pushing, knowing what she is doing. Sudden insight, Understanding.	Counsellor listening better than other participants. Telling things as they really are. Asking questions, guiding. Following up on issues. Revisiting issues proves careful listening. Genuiness. Respect. Techniques as useful.	High expectations. Lowering pressures help mothering. Hard on self. Long time to recover. Losing years being depressed. Motherhood as a huge adjustment. Shock. Rational world to irrational world. Lack of balance. Social networks important. Frustrated with just focusing on practicalities. Wanted to address underlying issues.	Clarification of personal goals important. CBT not adequate/complex enough. CBT prescripting, pressurising. Scarsity of help. Organisation unhelpful, disorganised. Needing to push to receive help. Listening. Focusing on client's choices and decisions. Writing things down.	Gaining control over panic. Active coping. Facing fears. Thought challenge helpful. Challenging instinctual reactions. Rationalising. Controlling anxiety and fear. Gaining distance from negative thougths Naming thought processes. Self-awareness. Gaining distance from negative thoughts.	Did not feel reassured that she knew how to help. Needing to see a light. Needing hope to get better. Depression as a dark tunnel. Losing oneself. Desperately needing hope to get better. Agitation. Panic. Difficulty concentrating. Mechanical application of technique. Bad timing. Needed answers, solutions.	Acceptance that she will be ill forever. Awareness of importance of attachment. Doing everything perfectly. Pressures on self. Normalising feeding problems. Reassuring on breastfeeding problems. Lack of perspective, sense of reality. Good enough. Reassurance on bonding.	Marriage difficulties. Things falling apart. Difficulties self-diagnosing. Difficulties sleeping. Therapist did not diagnose. Therapist not diagnosing. Diagnosis would have got her the support. Lack of practical support. Needing practical support. Long process of understanding.

Stella	Monica	Jennifer	Sonia	Kate	Joanne	Danielle	Rachel
Processing. Understanding of the depression. External attribution of cause helps. Others understanding important. Labour triggers past traumas. Importance of others understanding and not blaming. Trust cemented by sticking to the client's side, supporting her views. Therapist as an ally.	Assisting and encouraging agency with positive imagery. Positive imagery encouraging strength and courage. Patience, respect, understanding, reliability. Ending as abandonment. Left to your own means. Left it open. Group vs individual. Focus on self vs friendship. Closeness.	Importance of self-care and self-containment. Difficult to stop therapy once you start. Therapist dependent on client. Self-contained. Easy to have breaks. Medication helps. CBT dumbed down. Mothers not heard or respected. Lack of confidence. Identity assertion. Voice not heard/respected. Women judgemental, hard on other women.	Client in charge. Focus on behavioural changes. Self-help. Writing things down consolidates change. Setting realistic goals. Effortless process of change. Doing gives confidence. Awareness of needing something different than CBT. Lack of crèche difficult.	Self-awareness. Distance from thoughts and emotions. Understanding emotions. Going back to past. Making connections. Sharing life experiences in a group. Understanding how the past connects/influences the present. Going back to past helps self-awareness. Self awareness. Understanding of self.	Not expressing disappointment. Panic. Desperate for sleep. Talking helpful. Guilt. Panic. Agitation. Experience and specialisation. Medicalisation of illness helps acceptance. Professionalism. Knowledge. Confidence. Caring environment. Beauty putting people at ease. Not wanting to be at home. Restlessness. Knowledge.	Insecurities about how to mother. Pressures from past. Pressurised to bond. Pressure to be a perfect mother. Talked about the baby in therapy. Holding baby all the time. Lack of sleep. Recognising her need to hold the baby. Needed reassurance. Referring to right agencies. Explanations.	Not clicking with therapist. Communication helped. Understanding that you are both on the same page. Anger. Forgiveness helped. Sudden realisation/change. Difficulties explaining change. Counselling helped understanding. Ability to think and talk about emotions. Meeting needs in the couple.

Stella	Monica	Jennifer	Sonia	Kate	Joanne	Danielle	Rachel
Therapist communicating on behalf of client to other professionals. Therapist understanding and meeting expectations. Therapist taking charge. Therapy as a process. Enhancing coping strategies initially. Therapist perceived as involved, interested, caring. Sense of humour. Therapist as anchor. Therapy as grounding.	Impatient to talk in a group. Able to be more honest in individual sessions. Focus on self good. Not having to worry about others. Group as normalising. Normalised difficulties with own mothers. Strengthening self-confidence, ability to cope. Difficulties coping.	Badly treated in hospital. Lack of respect. Put up-shut up detrimental for mental health. Recognising impact of traumatic birth experience important. Every birth experience is different. Talking about the birth experience. Getting rid of trauma. Normalising extreme emotions after birth. Physiological explanations useful.	Would prefer to concentrate on self. Therapist not interested in child. Guidance on parenting welcome. Reassurance on impact on children. Worries about impact on children. Worries about transmitting problems onto children. Depression caused by upbringing.	Connecting, understanding. Self-awareness prized. Understanding self. Positive reframing of illness. Illness as an opportunity to gain self-awareness. Challenging automatic thinking. Challenging perfectionism. OK to be good enough. Relaxing, easier on self. Looking after oneself.	Confidence. Straightforward. Instant connection. Harmony of expectations/service offered. Confidence that she is going to be ok. Group awful. NHS not professional. Large group threatening. Not helpful to see others suffering. Suicidal ideation. Took away hope. Assertion of strong, positive identity.	Relieving guilt of not breastfeeding. Feeling like a failure. Relieving guilt and responsibility by external attribution. Trusting the client. Empowering the client. Receiving explanations for care received. Normalising No explanations Mistreatment. Anger. Not respected.	Referrals via the therapist. Discounted possibility to get help in the NHS. Waiting lists in the NHS. Bad experience of NHS. Late diagnosis unhelpful. Therapist could not understand everything. Difficulties explaining problems with breastfeeding. Unhelpful self-disclosure about wife breastfeeding forever.

Stella	Monica	Jennifer	Sonia	Kate	Joanne	Danielle	Rachel
Therapy as a safe space. Helping to manage a difficult/complex situation. Transitional object. Husband support made a difference. Locating problem outside self. Relationship consolidating gains. Therapy as life transforming. Lack of congruence perceived as unhelpful. Blank face difficult.	Therapy as a process that can be exhausted. Confidence. Ability to relax, let go of control. Ignoring housework. Kind to self. Focus on present. Accessing support. Sharing with friends. Not a failure. Positively reframed experience of illness and recovery.	Blamed it on self instead. Explanations of symptoms to demystify condition. Accepting help. Wanting to do everything. Going out. Getting help. Therapy as a journey of understanding. Looking at yourself from different angles. Questioning your instinctive behaviour. Understanding yourself better. Neutral space.	Depression caused by lack of self-confidence. Needing guidance on how to be a good parent as not parented well. Using role-models. Reassurance and guidance on parenting. Admitting and talking about the problem. Reduced shame and secrecy. Confidence. Relaxed.	Living in the presence. Mindfulness. Finding time for oneself. Focus on self, not on others. Guilty about taking time for self. Able to self-help. Able to make herself feel better. Work/family balance difficult. Depression is sinking. Strategies help with coping.	Framing as medical, physiological problem. Needing hope to get better. Difficulty listening to somebody else problems. Panic. Difficulty listening to somebody else problems. Needing to recover quickly. Quick recovery. Awareness of problem. Assertion of positive identity. Discrepancy in how she was feeling.	Damaged. Brutal treatment. Anger. Disrespected Moving. No explanation. Treated cheaply. Lack of respect. Therapist could have informed of option to talk to doctor and midwife. Separating. Too fragile to cope with couple issues. Only a limited extent of energy. Accepting.	Difficult for a man to understand all the emotions. Self-disclosure unhelpful. Tolerant client. Giving options. Trusting, liking the therapist. Practical help in the house. Good to be away from baby. Relief to be away from baby. Health visitors intrusive. Health visitors not helpful.

Stella	Monica	Jennifer	Sonia	Kate	Joanne	Danielle	Rachel
Unsettling not to be able to understand the other. Withholding emotions perceived as unnatural. Witholding emotions = experienced = helpful. Importance of experience/status of therapist. Lack of congruence. Feeling of "fitting" between therapist and client. Sharing with others, normalising helpful.	Encouragement to face fears useful. Trusting intuition. Listening to body messages. Encouraging outsider perspective on self. Encouraging change by looking at what it means not changing. Building support. Accepting you cannot do it alone. Ok to ask for help.	Space to talk and breath. Difficulty finding the right therapist. More information on therapy needed. Difficulties ending once you start. Leaflet describing different therapies. How to access help locally.	Acceptance of own situation. Social comparison with other mothers. Insecurity about staying at home with children. Able to balance good and bad. Stressing difference between help for depression and help for pnd. More acceptance in society. Stigma still remains.	Understanding of pnd by other patients and professionals. Professional experienced in pnd. Caring environment. Standard tools can be applied to pnd. Restored ability to care for children. Restored coping. Went back to normality. Allowed bonding with daughter. Cannot bear to imagine not getting better.	Distancing from depression. Sticky condition. Fit client/counsellor. Huge relief when recovering. Trusting the client recovery. Giving options. Leaving it open. Assertion strong identity. Worries about taking anti-depressants. Calm, confident, firm. Guiding. Reassuring. Therapist in charge.	Self-confidence. Moving. Positive reframing. Accepted that she needed help. Normalising the need for help. Reassurance of mental health. Listened to, valued. Worthy. Positive reframing. Normalising reactions. Needing structure. Homework.	Difficult to image what help you could receive with baby. Doula adding pressures. Prescribing advice unhelpful. Not supporting decisions. Pressurised by people around. Self blame for not breastfeeding. Finding solutions. Not supported in her decisions.

Stella	Monica	Jennifer	Sonia	Kate	Joanne	Danielle	Rachel
Recovery as a journey. Normalising, sharing feelings. Excluded from regular groups. Services missing. Support groups helpful. Sharing feelings, difficulties. Reducing isolation. Qualification and experience inspiring trust. Working with other mothers helpful. Therapist teaching skills for approaching/bonding helpful. Fear of baby.	Internalisation of the experience of therapy. Idealisation of therapist. Experience makes a difference. Sense of humour. Energy. Inspiring. Role model. Sleep. Felt stronger. Finding feet. Exercise helped. Combination of things helped. Time away from children.		Depression: weakness. Failure. Positive reframing of experience of illness. More understanding. Acceptance. Feeling better. Impact on care of self and the children. Easing the struggle. Tailoring therapy to the individual. Long-term help rather than short-term. Spreading out sessions.	Gradual building of the relationship with baby. Family support helped. Considerable impact on family. Did not need mother-and-baby therapy. Health visitor helped. Regular visits. Health visitor unhelpful. Attitude of the mental health team unhelpful Difficulties seeing the way out.	Clear program. Explanations. Involving the patient. Therapist in charge. Did not need a lot of professional input. Quick recovery. Not understanding postnatal depression. Not talking about previous experience. Not giving explanations. Not giving reassurance that she could and knew how to help.	Not enough just to talk.	Society judgemental towards mothers who do not breastfeed. Society putting responsibility on mothers for well-being of children. Husband adding to pressures. Struggling. Husband unhelpful, cruel. Putting baby before mother. Reassurance helpful. Mother did not want to interfere.

Stella	Monica	Jennifer	Sonia	Kate	Joanne	Danielle	Rachel
Missing something. Reconnecting with baby with mindfulness. Therapist teaching her how to talk about emotions helped. Lack of skills to relate to baby. Symptom: not loving the baby. Managing anxieties about other children. Worries about how depression is going to affect them. Understanding how to help older child.	Combination of things helped. Relationship with children not an issue. Needed to focus on self rather than on children.		Rushed, mechanical perception of NHS. Not understanding, knowing exactly. Rigid standards and procedures in the NHS. Therapy needs to be tailored. Men easier to talk to. Positive data log. Incentivating pride, confidence and positive outlook. Pride on being mothers.	Needing guidance, right input. Multi-modal help useful. Comprehensive help. Without professional help you remain unwell. Money buy best care. Needing professional help. Made friends with others in the group. Normalising negative reactions to motherhood.	Not giving explanations. Not being clear on objectives and how techniques can be helpful. Not specific, tailored. Not a specialist. Specialisation inspiring trust. Understanding. Ability to guide recovery. Depression as being stuck. Desperate to move away from depression. Bond with baby reinforces positive identity. Overwhelmed.		Not finding the support, the reassurance. Isolation. Not knowing what to do. Reassurance needed. Lost. Health visitors not supportive. Health visitor pressurising. Panic. Pressure. No end to pressure. Mothers expected to do it all. Relieving guilt. Helping to find time for self. Husband helping.

Stella	Monica	Jennifer	Sonia	Kate	Joanne	Danielle	Rachel
Reinstating relationship, connection with baby. Worries about children's normality. Therapist connected to local health service good. Therapist going the extra mile, communicating to other professionals on behalf of client. Lack of communication between professionals unhelpful. Professionals leaving unhelpful.			Putting things into perspective. Homework not good. Effortless change/realisation in successful therapy. Homework as imposing. Worrying about getting the homework right. Homework waste of time. Writing what you need to write not what you really mean. Being allowed, given time.	Non-judgemental space. Understanding. Transitional object. No need for positive façade. Saying things as they really are. Relief to be able to be honest. Normalising. Reducing isolation. Isolation of illness. Expectations of society impacting on illness. Mothers can't express negativity.	Closeness with children reinforcing positive identity. Guilt. Husband not comfortable with feelings. Husband supportive in practical things. Guilt towards husband. Felt empty. Husband could not understand. Classes only preparing for practicalities. Talking about depression could lead women into it. Practical help enough.		Time for self. Therapist confident, leading. Technique: Positive data log. Challenging negative thinking. Listening. Giving advice. Structuring session helpful. Focusing helpful. Longer sessions. Therapist flexible, going the extra mile, caring.

Stella	Monica	Jennifer	Sonia	Kate	Joanne	Danielle	Rachel
Lack of co-ordination. PND as scary. Not dealing with the past limitation. Worries about other children. Importance of addressing both the underlying problem and the relationship with children. Importance of continuity, presence. Pregnancy physically demanding. Therapy as emotionally demanding/draining.			Hurried, tick-box therapy unhelpful. Talk, think and learn. Strong relationship. Communication. Came to a counselling session. Husband aware. Not valuing self.	Understanding provides relief. Husband provided practical support. Husband involved in care. Sharing with husband. Husband found it difficult to understand. Husband supportive although he could not understand. Divide private and NHS care. In private care you are looked after.	Assertion of positive, coping identity. Proactively seeking help. Distancing from depression. Stress leading to break-down. Complicated pregnancy. Afraid to go to hospital. Staff ignoring her during labour. Alone during labour. Enduring, coping identity. Isolation, lack of support in hospital. Coping.		Leaving it open for booster sessions gives reassurance. Knowing he is there. Reliable. Can count on therapist. Caring therapist. Feeling valued. Availability to see her as perpetuating dependency? Unhelpful disclosure. Using techniques in everyday life. Resting. Time away from baby. Time for self.

Stella	Monica	Jennifer	Sonia	Kate	Joanne	Danielle	Rachel
Therapy painful. Addressing painful stuff before holidays not helpful. Therapy as draining of energies. Breaks perceived as abandonment/lack of care. Could not cope with therapy. Needing to focus on the present. Prioritising. Envisaging solutions, seeing the way. Going back to work. Organising, prioritising, getting help.				Illness impacts on children, family and friends. Adequate help speeds up recovery. Ripple effect. Help needs to be prompt. Lack of understanding and services. Dreads to think of not to be able to pay for help. Counselling essential. Not just hormonal.	Isolation, lack of support. Coming home straight away not helpful. Overwhelmed. Lack of sleep. Panic. Not coping. Clarification of causes. Could not see a way out. Helping mothers setting realistic expectations. Warning them of difficulties. Not recognising self, life. Lost groundness. Overwhelmed.		Calming down. Not enjoying the baby. Did not feel love at the beginning. Expected to feel rush of love. Panic. Could not cope with crying. Difficult baby. Panic. Regretting having a baby. Trapped. Overwhelmed by responsibility. Difficulty admitting that you do not love your baby. Isolation.

Stella	Monica	Jennifer	Sonia	Kate	Joanne	Danielle	Rachel
Life under control. Symptom: fear. Inability to cope with day-to-day. Bonding and coping with everyday demands perceived as recovery. Need to feel normal. Needing confidence in mental abilities. Needing status/identity again. Asserting identity. Risks of therapy: draining.				PND needs treatment otherwise continues on as generalised depression. Right kind of treatment. Ripple effect. Long term effect if left untreated.	Different women need different things. Tailoring help. Help with other children. Worries about first child. Struggling, overwhelmed. Lack of sleep. Too much to carry. Tried to keep normality. Going out helped. Shock. Needing help. Society not understanding how difficult it is to be a mother.		Isolation. Isolation. Feels like the only one who is not coping. Secrecy. Feeling empty. Guilt. Difficulty admitting. Felt wrong, unnatural. Feeling empty. Demanding baby. Difficult relationship. Struggled all the way through. Trouble eating. Crying. Feeling like a failure.

Stella	Monica	Jennifer	Sonia	Kate	Joanne	Danielle	Rachel
					Stressful being a mother. Society not recognising how hard it is to be a mother. Conflicting advice. Expectations to do things right. Giving self a break. Good enough mothering. Mothering as a learning process. Tough to be a mother. Support and understanding of other mothers important. Responsibility. Anxieties.		Relieving secrecy would have helped. Isolation. Group therapy would have helped. Needing to share problems, to find support. Mothers putting up a façade. Feeling like a failure. Felt judged. Early diagnosis. Getting help. Reducing stigma. Sharing, talking about it. Relieving isolation.

Stella	Monica	Jennifer	Sonia	Kate	Joanne	Danielle	Rachel
					Company of other mothers. Normalising difficulties. Providing advice. More understanding of postnatal depression. Stress big element in postnatal depression. Pressures. Stress. Using one label unhelpful. Different conditions. Different types of postnatal depression.		Felt judged. Lack of understanding. Feeling like a failure. Normalising difficulties with relationship. Health visitor rushed, not taking the time. One-size-fits-all unhelpful. Mechanical, cold delivery of advice. Putting pressure. Judging. Adding problems instead of helping.

Stella	Monica	Jennifer	Sonia	Kate	Joanne	Danielle	Rachel
					Doctors do not take time to understand. One-size-fits-all unhelpful. Postnatal depression label stigmatising. Tailoring treatment. Normalising illness. More understanding so that treatments can be tailored. Going through it awful. Giving hope that it improves. Putting too much pressure on self.		Relieving pressures. Finding your own way. Self confidence. Naturally gain confidence with baby. Everyone is different. Finding own way. Not letting others pressurise you.

Stella	Monica	Jennifer	Sonia	Kate	Joanne	Danielle	Rachel
					Putting too much pressure on self. Pressure to go back to do everything. Specialists. Understanding means that it can be fixed.		

APPENDIX 10 – ALL THEMES AND FREQUENCIES

	Stella	Jennifer	Sonia	Monica	Danielle	Rachel	Kate	Joanne	Total
1. SAFE SPACE									
Isolation and secrecy	3	6	2	2	1	7	3	2	26
Relief to talk	1	0	2	1	1	0	2	1	8
Safe space	2	3	0	6	0	1	0	2	14
Professionalism									
Explanations about the process of therapy	2	5	3	4	2	0	0	4	20
Need for guidance	6	0	2	0	5	1	3	2	19
Non-judgement	0	1	0	1	0	0	1	2	5
Professionalism	6	0	0	2	3	3	4	11	29
Reliability	4	0	0	1	0	3	3	1	12
Relief to talk	1	1	2	1	1	1	2	1	10
Safe space	2	3	0	6	0	1	0	2	14
Understanding PND	6	4	0	1	1	1	3	3	19
Empathy and positive regard									
Client-therapist fit/attunement/liking	3	1	1	2	1	2	1	2	13
Prizing	2	0	1	4	1	1	0	0	9
Therapist empathic	0	0	2	4	2	7	5	3	23
Warmth and care	5	1	0	4	2	3	4	0	19
2. RELIEVING GUILT									
Guilt	0	0	0	0	1	5	2	5	13
External Attribution of Cause									
External attribution of cause	9	5	1	0	2	1	3	8	29
Impact of birth experience	2	4	0	0	6	0	0	1	13
Impact of physical factors	0	1	1	1	1	3	2	6	15
Normalising									
Normalising difficulties	7	2	2	6	5	1	6	3	32
3. EMPOWERING									
Assertion of positive/strong identity	7	2	0	0	1	0	0	8	18
Collaboration/empowerment	5	0	8	3	2	8	1	4	31
Impact of societal discourses	4	4	4	2	6	10	4	7	41
Low self-esteeem	0	2	3	4	3	4	1	1	18
Professionals not interested/helpful	0	5	4	3	8	5	2	4	31
Grounding and guiding									
Coping	5	1	0	2	0	1	3	0	12
Dependence on therapist	2	0	0	0	1	1	1	0	5
Difficulties thinking clearly/rationally	3	3	1	1	3	0	3	3	17
Feeling overwhelmed	2	1	1	1	2	7	7	10	31
Modulating therapy	4	3	1	1	1	0	1	3	14
Need for guidance	6	0	2	0	5	1	3	2	19
Strategies to cope	6	1	4	0	1	6	3	0	21
Techniques	0	0	3	2	0	4	2	1	12
Therapist active, guiding	6	0	2	8	1	3	1	4	25
Containment									
Anger	0	5	1	1	5	1	0	0	13
Containment	7	1	1	4	3	2	0	1	19
Depth of feelings	8	7	0	0	4	4	9	13	45
Reassurance	1	1	1	1	6	3	1	12	26
Therapist self-contained	1	2	0	2	1	0	0	2	8
Upheaval	6	5	0	0	2	1	3	5	22
Fostering maternal self-efficacy									
Confidence in parenting	6	2	1	0	3	1	0	0	13
Impact of baby	6	3	3	1	2	10	2	3	30
Fostering self-acceptance									
Acceptance	5	3	6	5	7	2	3	2	33
Forgiveness	0	1	0	0	0	1	0	0	2
Perfectionism	1	3	3	2	4	3	2	6	24
Self-confidence	0	0	1	2	2	3	0	0	8

	Stella	Jennifer	Sonia	Monica	Danielle	Rachel	Kate	Joanne	Total
THEMES NOT INCLUDED									
Access and provision of services	4	2	5	2	1	2	0	2	18
Anti-depressants	1	1	1	2	2	0	1	4	12
Balanced thinking	0	1	5	1	0	0	1	0	8
Complexity of illness	3	2	0	1	1	2	0	1	10
Concealing in therapy	0	2	1	0	0	2	0	2	7
Congruence	3	2	0	3	0	0	1	0	9
Connecting with other mothers	1	1	5	2	0	1	2	3	15
Diagnosis	2	2	0	1	0	7	0	4	16
Emptiness	1	1	0	0	0	1	0	1	4
Environment	0	2	2	2	1	0	1	2	10
Gender	0	1	1	0	0	1	0	0	3
Humour	5	1	0	0	0	0	0	0	6
Impact of couple	6	1	0	1	3	9	1	1	22
Impact of life events	2	0	0	0	2	0	0	0	4
Impact of past	6	2	1	3	2	2	1	0	17
Internalisation of therapist	0	0	0	2	0	0	0	0	2
Joy of motherhood	0	0	0	0	1	0	0	0	1
Learning from others	0	0	1	1	0	0	0	0	2
Matching clients' needs	3	0	0	0	1	1	0	3	8
Needing to address depth and complexity	7	5	5	4	0	1	3	2	27
Partner supportive	2	0	2	0	0	2	2	2	10
Preparation	1	0	0	0	0	1	0	1	3
Private help abundant, timely and professional	2	0	0	0	0	0	3	2	7
Proactively seeking help	2	2	5	0	0	0	2	2	13
Process of recovery	1	2	0	0	0	3	0	4	10
Process of therapy	10	3	6	4	2	0	3	0	28
Questioning instinct reactions	0	1	1	0	0	0	1	0	3
Reducing stigma	0	1	2	0	0	1	0	0	4
Relapse	2	1	1	1	1	1	0	0	7
Reliability	4	0	0	1	0	3	3	1	12
Ripple effect	0	0	0	0	0	0	2	1	3
Risks of groups	0	0	0	3	0	0	0	4	7
Scarcity of help	5	0	8	3	2	3	9	2	32
Self-awareness/self-discovery	2	1	0	1	0	0	6	0	10
Self-disclosure	0	0	0	1	0	4	3	0	8
Social comparison	0	1	1	0	0	5	2	0	9
Spiralling down	3	4	0	0	2	2	1	4	16
Stress	0	0	0	0	1	0	0	1	2
Tailoring diagnosis and therapy to the individual	0	0	7	0	2	4	0	4	17
Therapist well connected to services	1	0	0	0	1	0	0	0	2
Time and space for self	0	1	4	5	1	6	4	1	22
Tough to be a mother	0	0	0	0	0	0	1	4	5
Value of therapy	7	1	4	2	0	0	8	0	22