Women's experience of postnatal depression – beliefs and attitudes as barriers to care

AUTHORS

Justin Bilszta
BSc(Hons), PhD,
Research Fellow, Department of Psychiatry, University of Melbourne and Austin Health, Austin Hospital, Heidelberg, Victoria, Australia.
jbilszta@unimelb.edu.au

Jennifer Ericksen
MPsych,
Parent Infant Research Institute, Austin Health, Victoria, Australia.
jennifer.ericksen@austin.org.au

Anne Buist
MBBS, MMed, MD, FRANZCP,
Professor of Women's Mental Health, Austin Health and Northpark, Austin Hospital, Heidelberg, Victoria, Australia.
a.buist@unimelb.edu.au

Jeannette Milgrom
PhD, Professor of Psychology, University of Melbourne and Parent-Infant Research Institute, Austin Health, VIC, Australia.
jeannette.milgrom@austin.org.au

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KEY WORDS

Postnatal depression, barriers to care, patient beliefs and attitudes, qualitative.

ABSTRACT

Objective
Despite the increasing use of screening instruments to identify women with postnatal depression (PND), many do not access services and supports. It is unclear how women's experiences of PND influence their beliefs and attitudes and their choice to seek help. We will also explore ways family, friends and health professionals can facilitate help seeking behaviours.

Design
A qualitative study which explored: 'experiences after having a baby', 'recognition of symptoms', 'seeking help', 'treatment experiences and options' and 'ideal treatment'.

Setting
Participants were recruited from either hospital based outpatient PND treatment programs or community based mutual support programs.

Subjects
Forty women experiencing PND and either receiving treatment or attending support groups.

Main Outcome Measure
To gain an insight into the ways women experience PND and perceive their distress, and how this influences their beliefs and attitudes towards acknowledging their distress and seeking treatment.

Results
Findings suggest the lived experience of PND and associated attitudes and beliefs result in significant barriers to accessing help. Eight theme clusters were identified: expectations of motherhood; not coping and fear of failure; stigma and denial; poor mental health awareness and access; interpersonal support; baby management; help-seeking and treatment experiences and relationship with health professionals.

Conclusion
Implications for improved identification and management include helping health professionals to be aware of the personal and societal barriers preventing mothers from acknowledging their distress. Media campaigns may also be helpful in challenging community views of PND, as well as highlighting the range of treatment options available to mitigate concerns over medical/pharmacological approaches.

INTRODUCTION

Postnatal mood disorders have a high prevalence, affecting around 15% of women (Leahy-Warren and McCarthy 2007), and potentially serious consequences for maternal, partner and infant well-being (Milgrom et al 2006; Milgrom et al 2004; Hay et al 2001; Murray and Cooper 1997; Milgrom and McCloud 1996). The use of screening tools such as the Edinburgh Postnatal Depression Scale (EPDS) has gained increased popularity (Buist et al 2006; Austin 2003) as a means of identifying women who are distressed postnatally. However, even when identified, women are often reluctant to accept a clinical diagnosis that labels them as 'depressed' (Buist et al 2005; Whitton et al 1996; McIntosh 1993).

The reasons behind this attitude are varied. In a survey conducted as part of the Australian beyondblue National PND Program, 36% of women recognised depressive symptoms in a hypothetical case compared to 80% of general practitioners (Buist et al 2005), suggesting poor recognition of symptoms as a major factor. Other beliefs and attitudes that might contribute have emerged in a number of studies: heightened feelings of failure or of never recovering, uncaring and unknowledgeable health professionals, unsupportive partners and families, perceived ramifications of being identified as mentally ill, minimising of symptoms, stigma/fear of being labelled as mentally ill and attributing feelings of distress to psychosocial issues such as loss of freedom, financial pressures and housing issues (Carter et al 2005; Ugarriza 2002; Tam et al 2002; Whitton et al 1996).

Whilst there has been a number of studies that have explored the lived experience of depression and provided a rich description of the despair experienced (Beck 1992), current research directly asking women about barriers and facilitators to accessing help appropriate to their mental health needs is sparse. To our knowledge only one other study exists addressing these issues, in a Canadian population (Sword et al 2008). A number of questions remain unanswered including how women's experience of PND and the related beliefs and attitudes influences their choice to seek help, and how family, friends and health professionals can facilitate help seeking behaviours.

The aim of the current study was to explore in an Australian population barriers to care by asking women who are experiencing PND and who have accessed treatment and support services how they recognised and acknowledged their depression; how being depressed affected their ability to actively seek help; what sort of help they wanted and why and how the attitudes of health professionals, friends and family, and the general community influenced the type of treatment sought.

METHOD

Focus groups were used to collect qualitative insights into women's perceptions of their PND experience. This methodology has been used in a number of previous studies to explore the lived experience of PND (Carter et al 2005; Ugarriza 2002; Tam et al 2002; Whitton et al 1996). Focus group methodology is an effective way for women to explore personal experiences in a non-threatening environment and allows a naturalistic collection of qualitative data (Holstein and Gubrium 2003). This approach is also valuable where the goal is to elicit conversation from participants and to explore sensitive issues or where information of this nature may be revealed (Leask et al 2001; Krueger and Caseey 2000).

Participants (n = 40) were recruited from either:

- outpatient depression treatment programs offered by the Infant Clinic, Parent-Infant Research Institute, Austin Health, or the Northpark Private Hospital Mother-Baby Unit and Day Program. These units are located in metropolitan Melbourne, Australia.
- community-based mutual support programs located in cities around the greater Melbourne metropolitan area and a large rural centre of Victoria.

This recruitment approach was undertaken to ensure inter-group diversity via involvement of women

seeking assistance through both public and private, as well as urban and rural health providers, as it has been demonstrated there are differences in the experiences of women accessing these services (Lane et al 2001; Griepsma et al 1994).

The focus groups lasted a maximum of 90 minutes and took place between November 2005 and March 2006. They were conducted by two facilitators. A discussion guide (see table 1) was developed based on a comprehensive literature review and clinical experience of the investigators and modified as the study progressed (e.g. to clarify the intent of a question). This guide was used to ensure consistent coverage of the topics and questions were phrased in a language and style that participants would easily understand.

Table 1: Discussion Guide

Topic	Aim	Example Questions
Experiences after having last baby	To obtain the context for each participant and raise the topic of depression	What was it like/how did it feel to be expecting a baby? What expectations about parenthood did you have during your pregnancy? How did your partner/family feel about your pregnancy? What expectations did they have?
Self recognition of symptoms	To explore how depression was recognised	Did you ever think about depression following the birth of your baby? Did your midwife, obstetrician or antenatal class ever discuss depression during pregnancy and early parenthood? How did you feel telling your partner, family and friends about how you were feeling? Why/how long did it take to tell them? Did you feel that some of the things you were experiencing were normal? How do you think the media views women with postnatal depression and how does this affect you?
Seeking help	To explore barriers to seeking help when depressed	How much do you think your mood and the way you were feeling affected your motivation to seek help? How much do you think the depression itself contributed to your way of dealing with your problem Do you think your symptoms made it harder for you? Would you have done things differently if your partner or relative had taken responsibility for your help seeking? If others recognised your problems would this have made a difference?
Treatment experiences	To explore experiences with treatments	Describe some of the treatment options you sought to help you with your mood. What was appealing about these options? What did you think they would involve? What barriers were there to getting treatment/support you want? Did you try to access help for yourself through a service for your baby eg GP visit for baby or MCHN visit for baby?
Ideal treatment	To identify the ideal treatment experience	Why do you prefer one type of treatment/support over another? For the treatment/support you do like, what is it about them that make them appealing? For the treatment/support you dislike, what is it about them that they dislike? Do you think it would be easier to seek treatment if someone came to see you in your home? Would you rather access information about depression from someone in person, from the internet or from a written brochure? Should partners be more involved in assisting you to find help? What support do they need to be able to do this?

Participants were encouraged to respond with whatever level of detail they felt comfortable and issues that arose or were important to participants, but not included in the guide, were followed up and discussed (Krueger 1998). Questions were formulated to reduce socially desirable responses and allow participants to express their opinions in a way that would make them feel safe (Fisher 1993). Clarifying questions were asked whenever meaning of a response was not clear.

Interpretative phenomenological analysis was used to analyse the data (Smith et al 1999). This process was selected as it allows the researcher to construct an understanding of participants' experiences through their (the participants') personal account, rather than an attempt to find causal explanations or produce an objective description (Smith and Osborn 2008). Thus, it is dynamic research process involving both the participant's experience and the researcher's values and beliefs to assist in understanding and making sense of the lived experience (Reid et al 2005; Shaw 2001).

Interviews were tape recorded with the participants' permission and supplemented with hand written notes. Audio recording of the group discussion was transcribed verbatim. Each transcript and written notes taken during each group (for example, what was said and what was meant in terms of the context, who said it, what came before, unspoken body language and silences), was read and reread to facilitate familiarisation with the content and to begin to understand the women's accounts of their experiences (Smith and Eatough 2006).

Passages and paragraphs were reviewed within the context of the interview to identify any major themes, the intent of the participant's response or any phrases, words, terms or descriptions that illustrated recurring patterns of experience. Statements were organised into logical sub themes which were then aggregated into theme clusters. These theme clusters were used to provide a description of the lived-experience. Themes that overlapped or had similar content were merged. Transcripts and themes were discussed and agreement was reached as the analysis proceeded. Potential variations between different focus groups (eg severity of symptoms, age, treatment phase, location etc.) were assessed to determine the relative importance to each theme cluster.

The resultant theme clusters were checked against the original description in each transcript to maximise objectivity and allow refinement of themes or to highlight relationships between clusters. This process was designed to ensure the developing analysis was systematic and data supported the results. Results are presented to illustrate key components of the women's experiences.

RESULTS

A summary of the participant's age, demographic profile and mental health status at the time the interviews were conducted is provided in table 2. Eight main themes were identified: expectations of motherhood; not coping and fear of failure; stigma and denial; poor mental health awareness and access; interpersonal support; baby management; help-seeking and treatment experiences and relationship with health professionals.

Expectations of Motherhood

Many of the women identified a major difference between their expectations and the reality of becoming a parent. They struggled with the transition to becoming a parent and fulltime carer of an infant. Often the joy experienced in the first few days after birth, rapidly vanished once the baby was taken home. Comments from the women indicated many struggle with the 'loss of life as it used to be' (ie before the baby was born) and feel they have lost control over their lives. Difficulties reconciling the anticipated 'perfect' life with their fragile emotional state, especially when women were not expecting to experience problems with adjusting to motherhood was also a major source of distress: *'when you've got a beautiful baby, you've got a beautiful home, why would you be sad?'* (Private hospital focus group).

Many women, before delivery, perceived motherhood to be effortless, they should automatically know how to care for their baby and immediately and continually enjoy being a mother: *'that's how we're told everybody does it. It's so natural to everybody isn't it? I mean as a woman, it's natural to be a mother...it's a fundamental thing that women should do'* (Private hospital focus group)

Not Coping and Fear of Failure

One of the most often repeated comments from women was a need to be seen to be, 'keeping up appearances' - the facade or image of being seen to be able to cope with the demands of parenthood. This stemmed from a desire to not, 'be seen as a failure' or 'as being different from others'. An idealised comparison with other mothers, either real or media images, reinforced the notions of not fitting-in or a sense of failure should the ability to cope be compromised. Many women had very high expectations of themselves, were very proud and felt significant guilt at not being 'able to cope', 'failing at parenting' or blamed themselves when not able to live up to their own expectations or that of others.

When parenting difficulties were encountered, women felt they entered a downward spiral and completely centred on one aspect of the mothering experience. Problems quickly generalised to all aspects of infant care: *'once you failed at one thing, for example you thought you'd failed at your breastfeeding, you then decided you were going to fail at everything. So it kind of just circles off'* (Community focus group).

Stigma and Denial

Women's fear about acknowledging emotional problems and the stigma associated with this, real or imagined, was a constant theme. Women repeatedly spoke of being scared of being depressed and this fear was often caused by a perception they should be, or needed to be seen to be, 'strong and organised'. Women believed that PND, and depression in general, 'can't happen to me' and, 'other people get it'. It was also acknowledged the stigma of being a bad mother was worse than being labelled depressed. This often resulted in women denying how bad they felt.

Poor Mental Health Awareness and Access

Not being able to identify or distinguish between the normal emotional and psychological adjustment associated with parenthood and when they were 'depressed' was identified by women as a major barrier to seeking assistance: *'to me depression is when you can't get out of bed, like you physically cannot function. And I'm like...I can get myself out of bed, I can get myself up and get dressed, but then there's days that I can't... And then I have to drag myself through the day and then spend the rest of the time thinking about how little I've done or how bad I've spoken to the kids'* (Public hospital focus group)

On reflection, women believed antenatal education classes should include specific sessions on emotional changes in the first few months postnatal and information about how to seek help. However, when emotional health issues were discussed in antenatal class, women acknowledged they often did not listen or were disinterested: *'during the antenatal class when postnatal depression was talked about, you kind of switched off for that little 15 minutes. Because at the time you think, well that's not going to be me'* (Private hospital focus group).

Women often did not know what services were available to assist them or how these could meet their particular needs. This uncertainty was exacerbated by the symptoms of depression with women reporting they felt completely overwhelmed by their emotions 'everything just got too much for me, and I couldn't go anywhere to get any help' – and lacking motivation and positive decision making capabilities. Those women who did seek help remarked it was not easy to find. Some of the barriers identified included: difficulty in accessing information on line, the lack of a 24hour telephone support line specific for postnatal mood disorders, long waiting times before being able to access existing telephone support services, perceived inappropriateness of support services and lack of cohesion between the public and private sector services. A lack of continuity of care between antenatal and postnatal services was also highlighted.

Interpersonal Support

Many women admitted the power balance within their partner relationship changed once they had their baby and began experiencing emotional distress. Once difficulties were experienced, the ability to focus on both the needs of her partner and of the baby diminished, and she relied on him taking up 'some of the slack'. For many women this put significant strain on their relationship and this was, at times, difficult to emotionally and physically sustain: *'I rang my husband to say you have to come in now, I don't care you haven't slept, I'm not coping. So it was huge for him to see me not being strong, when I'm the strong one, and I'm strong for him'* (Private hospital focus group).

Family background was also identified as having an impact on both acknowledgment of emotional health needs and help seeking behaviour. In families described as having negative attitudes to help seeking, the understanding was that it was the role of families to manage difficulties. Women were expected to only talk to their family and were limited from seeking wider assistance: '*my dad said why do you have to keep (saying you're not OK) – he didn't want me painting this impression to everyone that things weren't right with me. And so when I came in here...I even lied to my family about why I came in here'* (Private hospital focus group).

Baby Management

Difficulties in baby management were identified as a major precipitating factor for feelings of parenting inadequacy. There was also the belief if mothers were unable to find a solution to a baby management problem, this reflected negatively on their parenting ability and they were a 'failure as a parent'.

Perceived patronising attitudes of health professionals also undermined the confidence of mothers and their parenting abilities and a number of women felt immense frustration with the support and advice given. When professionals themselves had problems managing the baby women felt relief and vindication: *'even the nurse that I felt had the greatest rapport with ... said I don't know what to do, I can't do it, what do you do at home?...you get to the point where these people who've been doing it for 25years can't deal (with the child) and I've been doing this for six months, what am I supposed to do now?...so it was a relief as they can't do it either, so it's not just me'* (Private hospital focus group).

When asked about the type of baby management advice supplied, a common response was women struggled to utilise this advice, as they often received conflicting information, even from the same health service provider.

Help Seeking and Treatment Experiences

Women acknowledged a number of other factors, aside from those already highlighted, as significant inhibitors to help seeking: poor sleep, physical discomfort from delivery complications, the inability to think clearly and logically, lack of motivation, changes in perception of body image and distinguishing between the symptoms and consequences of depression.

Views regarding the help provided by general practitioners (GPs) were mixed. Many women were ambivalent whilst others remarked that in many instances, GPs attempted to normalise feelings and provide reassurance, rather than actively treat or manage a women's mood. When this occurred, this exacerbated feelings of low self esteem and guilt at being unable to cope.

When medication was offered as a treatment option, many women found it extremely difficult to weigh up the risks and/or benefits of medication in relation to the severity of their symptoms and the potential side effects to their infant. Women felt shame at not being able to cope on their own and stigmatised for taking medication: *'that was another issue for me really to get over, was the fact that I did need help in the form of that medication. It was very hard for me to accept that, and I still feel very bad sometimes that I have to take it. There's been a couple of times over the last three years that I've just stopped taking it because it's made me feel so bad that I'm taking medication'* (Community focus group).

Table 2: Details of the focus group participants (n= 37[Ψ])

Age: Mean in years (range)	34 (27-47)
Marital status	
Married	28 (75.6%)
De facto	2 (5.4%)
Separated	6 (16.2%)
Single	1 (2.7%)
Income	
Up to $20,000	5 (13.5%)
$20,001 - $40,000	2 (2.7%)
$40,001 - $60,000	4 (10.8%)
$60,001 - $80,000	10 (27%)
Greater than $80,000	15 (40.5%)
Not divulged	1 (2.7%)
Number of children (mean ± SD)	1.6 ± 0.9
Number of pregnancies (mean ± SD)	2.3 ± 1.4
Perceived level of personal support	
Rarely/Not at all	6 (16.2%)
Occasionally	8 (21.6%)
Sometimes	7 (18.9%)
Yes, most of the time	11 (29.7%)
Yes, all of the time	5 (13.5%)
Reason for seeking assistance[†]	
Feelings of depression/not coping	33 (89.1%)
Your sleeping difficulties	16 (43.2%)
Baby sleeping difficulties	19 (51.4%)
Feeling isolated	16 (43.2%)
Financial difficulties	6 (16.2%)
Baby crying	16 (43.2%)
Relationship difficulties	14 (37.8%)
Baby feeding	19 (51.4%)
Moving House	5 (13.5%)
Other	11 (29.7%)
EPDS Score	
Mean ± SD	13.9 ± 6.9
Median	14

[Ψ] Three participants did not return questionnaires; total participants n = 40

[†] Percentages may be greater than 100, as women may have selected more than one reason

Relationship with Health Professionals

A strong theme to emerge was maternal child health nurses (MCHNs) should play a vital role in identifying and managing postnatal distress. An especially strong belief amongst mothers was MCHNs should 'see it (depression) coming, recognise it and take control'. Many women stated the MCHN was the most helpful of all health professionals.

Many women said they would not talk to their health professionals until 'the time is right'. Many stated they needed to be at the 'right stage' before initiating discussion. Certain behaviours of health professionals negatively impacted on the ability of women to actively seek assistance for their distress: *'there's just nothing that's done to help you with the emotional side of becoming a mum and childbirth. One maternal nurse just told me to suck it up. Babies scream. That was helpful!!'* (Private hospital focus group). If health professionals did not validate the extent of distress but tried to normalise or dismiss it, women felt they were being told to 'shut-up'. Validation was seen by women as vital as it gives them 'permission to speak' about their feelings. If this did not occur, women remained silent and attempted to cope as best they could.

Women listed the key attributes of the ideal health professional as: empathy, kindness, knowledge of what is available, good listening skills, availability, able to actively assist the mother (eg making telephone calls on behalf of the mother, making home visits) and nurturing through, 'mothering the mother'. Women also wanted their health professional to have an on going relationship, even when they have been referred or sought treatment elsewhere. There is a need to provide continuity of care for the woman so she can feel held by her community. Ultimately women are seeking support and understanding from *'the right person, at the right time, with the right options'*. (Community focus group)

DISCUSSION

This qualitative study of women's experiences of depression suggests that there are significant beliefs and attitudes that form barriers to accessing

help. All of the mothers involved in this study were participating in treatment programs and this suggests because they had accepted their distress and had sought assistance, they were perhaps more willing to discuss elements of shame, disappointment and denial they had to overcome as well as negative personal attitudes toward acknowledging and discussing mental health concerns. Eight theme clusters were identified, and some of these interrelated as described below.

'Myths of Motherhood" and 'Not Coping or Fear of Failure'

Findings from this study support the negative impact on women of 'myths of motherhood' which are prevalent within society (Knudson-Knight and Silverstein 2009; Tammentie et al 2004) and the belief that becoming a mother is a natural event, with the mother automatically and unconditionally loving her infant and inherently being able to meet her child's needs. Women, who perceive themselves to fail at these tasks, completely lose confidence and feel stigmatised as a poor mother or not loving or caring for their infant. As in this study, others have reported that the lived experience of depression includes obsessive thoughts, overwhelming loneliness of feeling alone in this experience and feelings of failure (Beck 1992). Although it may be considered an insurmountable task, it appears vital that these community myths are deconstructed to reduce both the pressure to conform and the stigma of mental illness during the postnatal period. Others have also suggested that expanding the social constructs of motherhood is required to overcome idealised notions of motherhood and standards of perfection beyond the reach of most mothers (Dougals and Michaels 2004; Mauthner 1999). Both these approaches could begin to be addressed through the development of media campaigns which target these myths, educate the wider community on the challenges women and families face when making the adjustment early parenthood and emphasise women who seek help are not a '...failure...' or '...poor parent...'.

'Mental Health Awareness and Access'; 'Help seeking and Treatment Experiences'; 'Stigma and Denial'

The findings of this study reinforce the notion of maternal ignorance of PND (Sword 2008), coupled with feelings of stigma and denial. As in other studies, many women found it difficult to distinguish their distressed mood from normal psychological adjustment in the postpartum period (Hanley and Long 2006; Hall and Wittkowski 2006) and were likely to dismiss or deny depressive symptoms as '...other people get it...'. It is interesting to attempt to reconcile this observation with the finding non-depressed mothers also experience negative thoughts and emotions during the postpartum period (Hall 2006; Nicolson 1999). This has important implications for the way health professionals discuss these issues with women. Clinicians need to strike a balance which acknowledges the extent of the distress and also explains how common thoughts such as fear, failure, inadequacy or disappointment are. For some women acknowledging the emotional changes associated with childbirth and becoming a mother and providing simple reassurance can be helpful (Chew-Garden et al 2008; Sit and Wisner 2005).

This does not mean that feelings of postnatal distress should be minimised, but seen to lie in a continuum. A key message women conveyed is not to minimise the distress they report. When feelings are not validated or are normalised to the extent that distress is down played, they exacerbate feelings of inadequacy and frustration. Clinicians themselves may need to be better trained in risk assessment/identification so as to distinguish when reassurance and support are adequate, to when specialised intervention is needed.

'Health Professionals'

Whilst women wanted their mood managed and believed a sensitive health professional who took control and managed their depression '...at the right time...' was needed, there was an ambivalence about assuming the role of a '...patient...' in order to obtain the necessary medical and social support. The negative consequences of this was women felt they needed to accept being labelled - but this caused problems, as reinforced by this study and others, in relation to the stigma associated with depression and mental illness and the fear of being labelled an unfit mother (Sword 2008; Hall 2006; Edwards and

Timmons 2005; Ugarriza 2002; Wood and Meigan 1997; Stern and Kruckman 1983).

This questions, to some degree, the best terms to use to describe emotional distress in the postnatal period (Chew-Garden et al 2008; McConnell et al 2005). A 'postnatal depression' diagnosis, whilst allowing women to receive treatment and support, also has the potential to heighten anxiety and perceived stigma and thereby may contribute to reluctance to seek help. Given the multiple risk factors for PND (Milgrom et al 2008), once a woman is identified as depressed, the focus needs to rapidly move the spotlight from the diagnostic label to understanding the individual mother's reactions to the transition to parenthoodand the diverse range of causes for her emotional distress, as well as an experience impacting on the entire family dynamic. Mothers need to recognise and reconcile their feelings with their new identity as a 'mother' and reflect on the factors contributing to the depressive disorder.

Ultimately, improving understanding of the triggers of distress may help women to overcome negative attitudes associated with poor postnatal mental health and reduce their reluctance to seek, and accept, help.

We are aware that mother's health beliefs and their sense of self efficacy (about treatment) (Bandura 2004) will determine which treatments they will comply with. Beliefs about treatment options will impact the types of interventions sought and accepted (Dennis and Lee 2006; Sword 2008). The findings of this study also confirm the ambivalence of women to the use of medication as a treatment option (Dennis and Lee 2006; Boath et al 2004; McIntosh 1993). These issues need to be considered by health professionals, in particular GPs and psychiatrists – although it may be easy to simply develop resource material with this information, it is more important professionals consider how to effectively work with ambivalence in their patients and to understand the attitudes that cause this response.

Through increased understanding and appreciation of the maternal beliefs associated with these emotional changes and how they intersect with the lived experience, health professionals may be better placed to help mothers restructure their perceptions about the disorder and reduce stigma.

'Interpersonal Support'

Another key message was that the role of partners and families in providing support and facilitating help seeking behaviour. In general, partners and families were felt to be supportive but consistent with other studies (Di Mascio et al 2008; Hanley and Long 2006; Holopainen 2002; Berggren-Clive 1998) women were hesitant revealing they were unable to cope or were experiencing a mental illness fearing shame and embarrassment. Strategies, which emphasise and reinforce utilising support and accessing services, as a normal part of the perinatal journey, are needed. These could assist fathers to better understand their partner's experience, and attitude toward their disorder, and help them to grasp the magnitude of the transformation taking place to their partner, themselves and their relationship. These programs would aim to improve a father's understanding and contribution to pregnancy, birth and early parenting; their role should difficulties arise in maternal recognition of distress and facilitation of help seeking.

HUMAN SUBJECT APPROVAL

This research was approved by the Melbourne Clinic/ HealthScope Research Ethics Committee (Approval Number: 145) and the Human Research Ethics Committee of Austin Health (Approval Number: 02600). It was conducted according to the National Statement on Ethical Conduct in Research Involving Humans (June 1999) developed by the National Health and Medical Research Council of Australia.

All participants were provided with, and given the opportunity to read, a plain language statement before enrolling in the study. All women who agreed to participate signed a consent form before commencement of the focus group sessions. No financial incentives were provided to women to encourage participation.

STUDY LIMITATIONS

The majority of women involved in this study were participating in a structured treatment program for PND. Only a small number (<10) were receiving assistance from a mutual support/community based group. It may be the experiences of women involved in specialist programs are different from those utilising community support or other primary sources of care (eg general practitioner only management or telephone support). We propose further work to address this important distinction.

CONCLUSIONS

The authors are cognisant there is no simple answer in relation to improving the uptake of treatment for PND. Distressed women, isolated at home with their young infants, frequently end up managing their mental health problems on their own and without appropriate support or are offered treatment they are ambivalent about. It is vital for us to develop a range of options and approaches to assist womenat risk of depression, and their families (Sword et al 2008), to ease their suffering and to avoid long term consequences. Strategies need to effectively support women so they can access treatment options they feel comfortable with in a timely manner (Bandura 2004).

Importantly, it is vital there is better understanding of how a mother's lived experience of postnatal mental illness and her associated attitudes and beliefs that may form barriers to her help seeking. This understanding allows those involved in the care and treatment of these mothers to be better placed to help them restructure their perceptions about the disorder.

Findings of this study highlight the need for women themselves and their families to be better able to understand, and recognise PND (which may help them be prepared to accept support or seek assistance) and the need for health professionals to be more aware of the personal and societal attitudes which prevent women from acknowledging their distress (Chew-Garden et al 2008; McConnell et al 2005; Marks et al 2005). In particular, health professionals need better appreciation of how their response to women's distress may heighten maternal feelings of guilt and failure and how this impacts on help-seeking behaviour (Appleby et al 2003; Simons et al 2001). Women in this study suggest a key facilitator to help seeking is a professional who is empathic, does not attempt to normalise or minimise feelings, helps women recognise depression is not a sign of failure and recognises that the factors contributing to their distress are likely to stem from a broad range of personal and psychosocial influences.

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