Women who Present with Mental Health Problems during pregnancy: How Can Midwives be Helped to Manage their Care?

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Chapter 1 – Background to the Study

While a number of studies have focused on women’s experience of mental health problems postnatally relatively little in depth research has been carried out on women who experience mental health problems during pregnancy. Previous research on mental health problems in pregnancy centre on the symptoms (O’Keane 2007), pre-disposing factors (Kitamura 1996) and risk factors (Field 2006) surrounding the condition. There remains an absence of research on the subjective experience of pregnant women with mental health problems.

A recent survey of maternity units in England showed considerable variation in midwifery policy and practice as regards the identification, referral and support of women with mental health problems in pregnancy (Tully 2002). Lack of experience, lack of training, and lack of support from the mental health team were highlighted as some of the problems midwives experience in caring for women with mental health problems in pregnancy.

This report summarises the findings of a study that was conducted to explore women’s experience of mental health problems in pregnancy and midwifery practice in relation to care with the objective of improving the care women receive.

Aims and objectives of the study

The aims of the study were to examine women’s experience of mental health problems during pregnancy and to identify ways in which midwives could be helped to manage the care of such women.

The objectives of the study were:

- To explore the subjective experience of women with mental health problems in pregnancy and recognition of their symptoms.
- To explore women’s perception of the care they receive from midwives and GPs when experiencing mental health problems in pregnancy.
- To explore the attitudes, perceptions and experiences of midwives in caring for women with mental health problems in pregnancy.
The content of the chapters

This chapter provides a rationale for the study and an overview of the aims and objectives. Chapter 2 contains a discussion of the literature under two headings (a) women’s experience of mental health problems in pregnancy; (b) midwives training and knowledge of mental health issues in pregnancy. Chapter 3 describes the methodology used, discussion of study design and rationale for using qualitative methods.

The findings of the study are presented in chapters 4 to 6. Chapter 4 presents a preliminary analysis of data generated from internet discussion groups and discusses the potential use of such data to explore women’s perception of care from midwives and GPs when experiencing mental health problems in pregnancy. Chapter 4 also presents findings from “archived” internet postings of the subjective experience of women and the recognition of their symptoms.

Chapter 5 presents the findings from analysis of solicited or “invited” postings from women and discusses the care women received from midwives and GPs and the factors that influence disclosure of their symptoms. This chapter also contains further discussion of women’s symptoms and their subjective experience of mental health problems in pregnancy.

Chapter 6 presents finding from small group discussions with midwives used to explore their attitudes, perceptions and experiences in caring for women with mental health problems in pregnancy. Chapter 7 is presented in three sections and includes a discussion of the limitations of the study, a discussion of the findings and their implications for practice, research and education.

The following chapter presents a review of the literature.
Chapter 2 – Literature Review

Two research questions were generated from a preliminary examination of the literature.

1. What are women’s experience of depression and anxiety during pregnancy?

3. What factors affect health professionals providing care to women?

The results of the literature review are presented using these two questions as headings.

Objectives of the Literature Review

The main objectives of the literature review were to summarize and critique the results of primary research which explored women’s experience of mental health problems in pregnancy and the barriers midwives faced in providing care to these women. The literature was also reviewed to identify gaps where further research was needed.

Methods for the literature review

The literature review focused on literature from 1971 onwards [May 2007] and examined mental health problems in pregnancy from the perspective of both service users and service providers. There were no restrictions placed on language in any of the searches undertaken.

Search terms were generated by an initial search of the literature combining simple terms, for example depression, anxiety, antenatal, pregnancy. Librarians were consulted on several occasions for advice on the search strategy that was being used. The electronic databases Cochrane, Medline, PsycINFO, CINAHL, MIDIRS [Maternity and Infant Care], International bibliography of the Social Sciences and Social Citations Index were searched. This was supplemented by publications from mental health charities, e.g. MIND. References were also obtained from researchers in the field, PhD theses, and conferences. Additional papers were identified from reference lists in key papers. Appendix 1 contains the terms used to conduct the searches; Appendix 1 also contains the framework
for the literature review and Appendix 2 contains details of the selection of studies.

**Structure of the Literature Review**

The literature review is presented in three sections using the two research questions identified earlier. The first section discusses women’s experience of depression and anxiety during pregnancy by examining how they legitamise their experience, how they cope with the experience of having a mental health problem and the responses received from health professionals and others.

The second section comments on factors which might affect the care provided by midwives to women who are experiencing mental health problems in pregnancy.

The literature review ends with a summary of the literature presented.

**Findings**

**What are women’s experiences of mental health problems during pregnancy?**

Three studies were identified as exploring women’s subjective experience of mental health problems in pregnancy (Sleath et al 2005, Edge 2005, Stanley 2006).

The first study used questionnaires and open ended questions to examine the relationship between ethnicity and women’s experience of severe and moderate depression, (Sleath et al 2005). Twenty-five white, twenty-three Hispanic and twenty-five African American women were interviewed between twelve and thirty-two weeks of pregnancy. The study explored the barriers to women communicating their feelings to health providers and factors that would help improve communication.

A second study examined the experiences and meaning women from an ethnic minority group gave to depressive illness (Edge 2005). In depth interviews were carried out exploring twenty eight black Caribbean women’s beliefs about depression in pregnancy and how these beliefs influenced their ability to seek help.
The final study explored the experience of twenty-eight mothers up to two years after delivery, their experience and awareness of antenatal depression and the response of the maternity services. (Stanley 2006).

Four themes were identified from the literature, (1) how women legitimize their experience of mental health problems women’s experience of legitimizing their experience; (2) women’s coping mechanisms how women cope with mental health problems with antenatal depression; (3) women’s experience of communicating their feelings to providers (4) and factors that would improve service provision.

**Legitimizing the experience of antenatal depression [mental health problems in pregnancy**

Studies which focused on women’s experience of mental health problems in pregnancy identified the difficulties women face in legitimizing their experiences (Stanley 2006, Edge 2005). Some women talked about feeling ill-prepared for the roller-coaster of emotions experienced and many did not associate mental health problems or depression with the antenatal period (Stanley 2006). The expectations placed on women to be “happy and blooming” during pregnancy caused many women who were not, to feel ashamed, believe that their negative feelings were not “normal” and “not how you are supposed to feel.” As a result depressed women reported feeling that they were not living up the expectations of pregnancy and were reluctant to disclose their feelings. Women reported feeling very isolated and felt they had no frame of reference for their feelings, as they assumed other women were finding pregnancy easier than they were (Stanley 2006).

The transformation that occurred in pregnancy, in relation to both women’s physical appearance and social roles, also caused considerable anxiety for many women. Changes in physical appearance not only caused practical problems by placing restrictions on what some women could do physically, but women also reported that changes in physical appearance sometimes changed the attitudes of others (Stanley 2006). Other authors have also commented on the anxiety changes in body shape during pregnancy cause women (Fox, P. and Yamaguchi, C. 1997).

One of the studies reported that black Caribbean women also had difficulty in legitimizing mental health problems, but for different reasons. Although black Caribbean women were twice as vulnerable for depressive illness as white women, they were less likely to record above threshold depressive scores. Black Caribbean women believe that a diagnosis of depressive illness was a sign of weakness and posed a threat to their ability to cope (Edge 2006). Black Caribbean women rejected a diagnosis of depressive illness and by adopting a frame of reference of a “strong black women” they were able to cope with their
depressive illness. Their refusal to legitimize depressive illness gave them the resilience to cope with adversity and allowed them to be in control. They resisted being labelled depressed as they believed the associated sick role would cause others to regard them as less competent (Edge 2006).

**Coping with mental health problems in pregnancy**

When women sought help for their depression they received mixed responses. Families, especially mothers, were often the first person women turned to when coping with depression during pregnancy, however sometimes families could be judgmental (Sleath et. al. 2006, Stanley et. al. 2006). Women reported that friends who were also pregnant could be a source of support but sometimes were not. Women reported that friends might not able to understand things from the women’s perspective (Stanley 2006).

In comparison black African Caribbean women thought it inappropriate to discuss problems outside of the home “you don’t talk your business” (Edge 2006, page 22). Black African Caribbean women were more likely to draw on their inner resources in order to manage psychological distress rather than engage in discussion with others. They were able to cope with adversity through their spirituality, by being in control and by being financially independent (Edge 2006).

Black Caribbean women also found health professionals dismissive towards their experience of perinatal depression. However, unlike other women the dismissal of a women’s experience of depression by health professionals reinforced black Caribbean women’s belief that depression was a reasonable response to hardship and adversity. The study suggested that non-validation of their depression reinforced black Caribbean women’s belief that they could not rely on anyone for help. This belief was felt to contribute to the reduced numbers of black African Caribbean women seeking help for depressive illness in the future (Edge 2006).

Black Caribbean women reported a lack of trust in the help offered by general practitioners and believed that taking anti-depressants resulted in dependency and increased the likelihood of developing a more serious mental illness.

In contrast Sleath et. al. (2005) found that African American were more likely that white women to initiate discussion of emotional issues pregnancy with their health provider. These results suggest that the experiences and attitudes of pregnant women towards depressive illness and the responses they receive from health professionals may not be attributed to their ethnicity, but may be due to other causes (Chattoo and Ahmad 2003). Women from ethnic minority groups in this study were also likely to have wished more time was spent discussing their emotions and feelings in antenatal clinic.
Midwives preoccupation with checklists and procedures was perceived by women to prevent good communication (Stanley 2006). Women from non-English speaking groups felt that the inability of health professionals to speak their language was a barrier to effective communication.

**improving the service**

Women felt that their care would improve if they had a relationship with a professional that was continuous throughout their pregnancy (Stanley 2006). Women wanted to be given time and space and the opportunity to develop a trusting relationship with their health professional and for professionals to make them feel more comfortable.

**What factors affect health professionals providing care to women?**

Those factors that act both as barriers to the provision of care and those that facilitate provision of care of pregnant women experiencing depression and anxiety are considered.

Several studies identified comment on the training, skills and knowledge of midwives in the provision of care to women who are experiencing mental health problems in pregnancy (Stewart and Henshaw 2002, Buist et al. 2006, Gunn et al 2006, Craig 2004, Stanley 2006).

**Midwives knowledge of mental health issues**

In many of the studies midwives recognised deficiencies in their knowledge of mental health problems in pregnancy and after childbirth (Stewart and Henshaw 2002). In a questionnaire survey of hospital and community midwives the need to improve knowledge of mental health in pregnancy was indicated. The findings are similar to those by Craig (2004) who found that many community midwives were aware of gaps in their knowledge in caring for pregnant and postpartum women with mental health issues. Those midwives surveyed requested further training in mental health issues.

A questionnaire survey in Australia by Buist et al (2006) evaluating the knowledge, experience and awareness of perinatal mental health issues and the extent to which perinatal mood disturbances are recognised among health professionals caring for pregnant women found that midwives were the group
least likely to recognise the need for providing help to women with emotional distress.

A survey of UK based midwives knowledge, attitudes and confidence indicated that although the majority of midwives were confident in exploring mental health issues with women at booking clinic, many were concerned about their ability to respond adequately to the needs of those women identified (Ross-Davies et al 1999). The study concluded that midwives were less confident in dealing with mental health issues than in other aspects of their role, for example dealing with women with HIV or cholestasis and that nearly fifty percent of midwives had significant gaps in their knowledge of mental health issues. Midwives were lacking in confidence and unclear with regards the high incidence, signs and symptoms and risk factors of perinatal mental health problems.

Further evidence of midwives uncertainty in distinguishing between expressions of anxiety and trepidation which might be considered within the "normal" range and those that might warrant concern was provided in study of UK midwives, health visitors and health practitioners’ awareness of and screening for antenatal depression (Stanley 2006). This study indicates varying degrees of awareness from health professionals in relation to expressions of high levels of distress from pregnant women and again suggests that midwives were less likely than health professionals to detect antenatal depression. The authors felt this might be due to midwives lack of familiarity with screening women for depressive illness, for example screening for postnatal depression is more common than for antenatal depression and is usually carried out by health visitors.

**Education and training of health professionals**

Education and training in perinatal mental health issues could be seen as either a barrier or facilitator to providing good care.

Craig (2004) reported that training in perinatal mental health training was not felt by midwives to be a priority within the trust. Of a sample of fifty-five community midwives working in primary care trusts only thirteen percent of midwives received pre-registration training in antenatal mental health problems. Most of the training was didactic with little opportunity for midwives to receive clinical experience in perinatal mental health. Of those midwives surveyed only eleven percent felt that their training in perinatal mental health issues was adequate and nearly eighty percent considered their training inadequate.

Other studies also indicated deficiencies in midwives training both pre- and post registration. A substantial minority of midwives reported receiving inadequate training pre-registration [Ross-Davie et al 2006], while only a minority of midwives received training post registration [Stewart and Henshaw, 2002].
A number of training programmes have been developed to help midwives in the management of psychological issues in pregnancy. A programme developed in Australia [ANEW] aimed to introduce a new approach to psychosocial risk assessment (Gunn, J et al (2006). The emphasis of the programme was on the management of psychosocial problems such as domestic violence, child abuse and substance abuse as well as depression, and offered training in advanced communication skills and common psychological issues. The programme aimed to enhance the knowledge and skills of midwives and doctors to identify and support women presenting with psychosocial issues in pregnancy and to improve the degree to which pregnant women reported they felt comfortable disclosing these issues. Participants undertook advanced communication skills training and were encouraged to consider various parts of the antenatal interview including understanding the women’s experience of pregnancy for example focusing on the emotional and social health issues of women. An evaluation of the program indicated increased self reported comfort and competency of health professionals to identify and care for women with psychosocial issues.

Other programmes also sought to address some of the gaps in midwifery education with regards management of mental illness in pregnancy. PATA (Positive attitude towards antenatal and postnatal adjustment, training for all) is an intervention package designed to help midwives identify those women experiencing emotional stress in pregnancy earlier and more effectively, to encourage women to share their experiences and to help women adopt skills which would make them happier and more relaxed parents. Although the project focus was the identification of women experiencing antenatal depression in order to reduce postnatal depression, the project aims to focus on identification and treatment of depression during the antenatal period also (Buist, 2003).

Evaluation of a tool to assess the psychological health of pregnant women and their families (the Antenatal Psychosocial Health Assessment (ALPHA) form, indicates that women believed the process of enquiry offered by the assessment allowed them to reflect on their situation and validate their experiences. Some of the factors included in the screening tool included recent stressful life events, feelings towards the pregnancy, self-esteem, depression in pregnancy, history of psychiatric and emotional problems. Although providers anticipated that uncovering complex problems might lead to a loss of control of the interview, none were reported. Providers reported that women usually just wanted to talk about their problems and have the situation understood and appreciated by their providers (Reid et al 1998).

Access to services

In many of the primary studies explored midwives described their frustration at lack of access to services. Some of the community midwives reported that
although the general practitioner was the first port of call for support, many midwives were unable to access services directly and would liked to have been able to make direct referrals (Craig 2004).

Summary of chapter

Two questions were identified, which formed the basis for a review of the literature. These questions related to women’s experience of mental health problems during pregnancy, and the factors which might affect women’s care during pregnancy.

Pregnant women often found it difficult to legitimize their experience of having a mental health problem. Women commented that they felt ill-prepared for the negative feelings they were experiencing and felt reluctant and ashamed to disclose these feelings (Stanley 2006). Some women commented on feeling isolated. Ethnic differences in pregnant women’s experience of mental health problems with black Caribbean women being reluctant to admit to depressive illness. (Edge 2006).

Health professionals could be dismissive about women’s emotional problems in pregnancy and women sometimes felt ashamed to discuss their problems with health professionals. Black Caribbean women did not want their depression recognised by health professionals as this would invalidate their coping strategies and challenge their belief that depression was a normal response to social adversity. Other research has indicated however that some ethnic minority groups are proactive in seeking help for depressive illness (Sleath 2006). Women felt that communication could be improved with less preoccupation with procedures and the provision of continuous care during pregnancy by the same health professional (Stanley 2006).

Factors which influenced and affected the provision of care for women included midwives lack of awareness and knowledge of mental health issues both during pregnancy and postpartum. Midwives sometimes were not able to recognize the need to provide help nor were they confident in providing help for women who were experiencing emotional distress (Craig 2004). Educational programmes designed to improve the management of psychological and psychosocial aspects of antenatal care for midwives have been developed and evaluated with encouraging results in improving the outcomes for women.

When studies have reported on women’s experience they often exclude the social, political and structural inequities in women’s lives. Rather than presenting mental health problems in pregnancy as a condition embedded in relationships
and social meaning, the presentation is of a pathological condition requiring individual treatment.

Following a structured review of the literature the need for a better understanding of women’s subjective experience of mental health problems in pregnancy was identified. The current literature focuses on the experiences of specific ethnic groups and other groups of women. There needs to be more research on women’s subjective experience and their reasons for their non-disclosure of symptoms to health professionals.

Previous research focuses on the deficiencies in midwives knowledge, training and the problems they have in identifying women with mental health problems in pregnancy, however there have been no studies which focus on the experiences of midwives in responding to women.

The next chapter describes the methods used in the study and the study design.
Chapter 3 – Methodology

The previous two chapters introduced the study, discussed the aims and objectives of the study and presented a review of the literature. This chapter describes the research design, the research questions and the methods used to address the research question.

The study comprises of two phases of data collection and each phase specific methods of data collection, sampling and methods of analysis were used. For these reasons ethical considerations relevant to each stage of data collection will be discussed along with study findings.

As discussed in the last chapter the overall aim of the project was to conduct a study of midwifery practice in relation to the care of pregnant women experiencing mental health problems, with the objective of improving the care women receive.

Project Design

The project was conceptualised as a process of midwives helping women.

Phase One acknowledged that the process of helping women starts with the recognition and interpretation of a woman’s symptoms. If a woman does not recognise the symptoms she is experiencing then she is unlikely to disclose them. Exploring women’s experience of mental health problems and recognising her symptoms was therefore an important factor in midwives helping women.

Phase one of the project explored women’s subjective experience of mental health problems during pregnancy, the recognition of her symptoms and how this might influence her disclosure to health professionals. Phase One also focused on pregnant women’s experience of the care she received from GPs and midwives when experiencing mental health problems.

Phase two focused on the attitudes, perspectives and experiences of midwives in caring for women with mental health problems in pregnancy. Findings from Phase one of the study informed data collection for Phase two.

Objectives for Phase One

Phase one of the study focused on women’s experience of mental health problems in pregnancy and the care they received from midwives and GPs.
Phase one was conducted in two stages.

**Phase 1a** focused on pregnant women’s recognition of her symptoms and used “archived” internet postings.

The objectives for Phase 1a of the study were:

- explore women’s recognition of her symptoms of mental health problems in pregnancy.
- explore the perceptions, attitudes and experiences of pregnant women with mental health problems that are likely to influence disclosure of their symptoms to midwives.

**Phase 1b** focused on women’s experience of care from GPs and midwives when experiencing mental health problems in pregnancy and used solicited or “invited” internet postings. Women were asked to answer the following questions about the care they received:

1. In what ways were midwives and GPs helpful or not helpful to you?
2. If you did not want to talk to your midwife or GP about the mental health problems you were experiencing, why not?
3. If you were able to talk to your midwife or GP, was that easy to do?
4. Was there anything that your midwife or GP did that made it easier or more difficult for you to talk to them?
5. Were your GP or midwife able to help you?

**Objectives for Phase Two**

Phase Two of the study focused on the attitudes, perceptions and experiences of midwives in caring for women with mental health problems in pregnancy using focus group discussions.

The objectives for Phase two:

- explore midwives’ recognition of mental health problems in pregnancy and their attitudes towards supporting women.
- explore midwives’ understanding of guidelines and policies pertaining to the care of pregnant women with mental health problems and their perception of the role and responsibility of the midwife.
- explore the factors that might facilitate or act as barriers to midwives caring for pregnant women with mental health problems.
explore the educational needs of midwives in supporting women with mental health problems.

Rationale for using qualitative research methods

The methodology chosen to meet the aims of the study was qualitative. The specific characteristics of qualitative research made it a more appropriate approach over more traditional methods of enquiry. Methods of qualitative enquiry are fundamentally different from quantitative methods in how they view social reality and how it ought to be studied. Qualitative research proposes that there are many forms of knowledge and many ways in how events can be interpreted, understood, experienced and produced. This is in comparison to quantitative research which believes that there is one objective reality. Qualitative research takes the subjects perspective as seen through the eyes of the individual being studied and explores the frames of meaning within which they operate [Bryman]. Since the aims of the project were concerned with exploring the subjective experiences, attitudes and perceptions of both pregnant women with mental health problems and health professionals in the context of care, qualitative methods were felt to be most appropriate method of enquiry.

Ensuring quality in qualitative research

The methods used to assess the quality of the project included using criteria that intrinsic to the research project and that have emerged directly from the qualitative endeavour.

Issues such as reflexivity, [researcher self-awareness and agency within that self-awareness] and representation [representing participant’s viewpoints equitably and fairly] were employed to ensure standards of credibility and trustworthiness were maintained [Morrow 2005]

Analysis of Data

Data were analysed using thematic analysis in both phases of the study. Thematic analysis is a method for identifying, analysing and reporting patterns or themes within data and which minimally organises and describes data in rich detail (Braun and Clarke 2006) Data in both phases of the study were analysed using both an inductive and theoretical thematic approach. In an inductive approach the themes identified were closely linked to data themselves, without trying to fit them into a pre-existing framework. The data were also analysed using a thematic approach where the data were coded with a specific research question or research question in mind (Braun and Clarke 2006).
The process of analysis of the data began with searching the data set to find repeated patterns of meaning and issues of potential interest in the data. The process involves repeated reading of the data in an active way to gain familiarity. Transcription of data is another method of achieving familiarity of data or immersion and for this reason all recorded discussions were transcribed by the study researcher.

After familiarisation of the data an initial list of codes were generated. Codes can be defined as a feature of the data that appear interesting to the analyst and refer to the most basic segment or element of the raw data or information that can be assessed in a meaningful way regarding the phenomenon [Braun and Clarke 2006]. Coding was carried out by initially identifying the codes and then matching them with data extracts that demonstrated the code. All data extracts were coded and then collated together within each code.

When all the data had been coded and collated the analysis was re-focused at the broader level of themes, using mind maps to aid organisation. After coding and thematic analysis the final stage is the interpretation of the data, where broader analytic statements about the overall story were made.

**Summary**

The project was conducted in two phases. Phase one explored women's experiences of mental health problems in pregnancy and the care they received using internet mediated data, while phase two aimed to explore the attitudes, perceptions and experiences of midwives in caring for women using small group discussions.

Chapter four discusses the use of data generated from internet discussion groups to explore, women's recognition of her symptoms when experiencing mental health problems in pregnancy.
Chapter Four – Preliminary analysis of internet generated data

Chapter three described the study design, objectives for the study and methods of data collection. This chapter will present findings from an analysis of internet postings of pregnant women’s experience of mental health problems during pregnancy.

The study design for phase one originally proposed interviewing women who were experiencing or had recently experienced mental health problems in pregnancy. However, it was felt that involving women during pregnancy might introduce an intervention whose effects may not be benign while identifying women after they have recovered might bias women’s retrospective accounts. As a result, alternate routes of exploring women’s experiences were discussed.

Internet Discussion Groups

The discovery of a series of internet discussion groups or “chat rooms” dedicated to the discussion of women’s experience of mental health problems in pregnancy appeared to be an alternate source of information. The internet contains a large number of electronic discussion groups many of which offer information and support for health related conditions. The main purpose of many electronic discussion groups is to enable discussion of problems and provide social support. Individuals who participate in discussion groups post messages which are disseminated to all internet sites which carry the discussion group.

No previous studies were found which explored pregnant women’s experience of mental health problems in pregnancy using data from internet discussion groups.

Advantages of Using Internet Discussion Groups

Advantages in using internet discussion groups over traditional methods of data collection have been documented. Internet discussion groups are felt to provide a wider access to research participants and offer a rich insight into the way people cope with problems that are seldom publicly expressed (Chen, Hall and Johns 2004). Using data from internet discussion groups also reduces the time taken for data collection and for transcription of interviews. Using data from electronic discussion groups also has the advantage of enabling relatively cheap and easy access to the views of a range of people that would not be possible through other methods of data collection [Eysenbech and Till 2001].
Disadvantages of Using Internet Discussion Groups

The main concern in using data from discussion boards was that members of internet communities do not expect to be research participants and that researchers posting or ‘lurking’ on internet communities may be perceived as intruders and may damage the communities (Eysenbach and Till 2001). The British Psychological Society [The British Psychological Society 2006] suggest that although publication on the internet may have parallels to publishing a letter in a newspaper, there are important psychological differences and people participating in an online discussion group cannot always be assumed to be seeking public visibility.

“Archived” internet postings were explored for evidence of pregnant women’s discussion of care when experiencing mental health problems over. Five episodes of data collection and analysis were undertaken.

Ethics approval for the project

Approval to conduct the project was obtained from the Department of Health Sciences research governance committee, University of York.

Episode 1 – [January 2007] Preliminary analysis of internet postings from pni-uk discussion board

Perinatal Illness UK [www.pni-uk.com] was explored as a potential data source for phase one of the study, was

PNI-UK is a registered charity set up to help support women and their families affected by perinatal illness. The charity defines perinatal illness as any distressing psychological and emotional condition which has developed during pregnancy, birth or the postnatal period. These include antenatal depression, postnatal depression, puerperal psychosis and birth trauma.

A preliminary analysis of the content of the PNI-UK discussion group was conducted in January 2006 and revealed several themes discussed by women regarding their experience of mental health problems in pregnancy.

Episode 2 – [August 2007 – March 2008] Presentation of the characteristics of nine internet discussion boards and further preliminary in-depth analysis of two discussion boards which discuss women’s experience of mental health problems in pregnancy
The characteristics of other internet discussion boards were investigated to establish websites which contained discussion of women’s experience of mental health problems in pregnancy and their suitability in providing data for the study.

The names and URL’s of nine discussion boards containing women’s discussion of antenatal depression were returned by the search. The discussion boards contained different characteristics in terms of their background, structure and purpose and these characteristics are presented in tables 1 – 4 [see appendix 3]

**Quantitative Analysis of Postings from Two Discussion Boards**

A quantitative analysis of postings from two of the internet discussion groups identified was carried out. The postings were examined for evidence of women’s discussion of the care they received from health professionals when depressed during pregnancy.

Analysis of the two discussion boards indicate

- Much of the discussion made by women centred on the symptoms they were experiencing or the causes of their mental health problems, not on their experience of care from health professionals.

- When women did discuss the care they received when experiencing mental health problems in pregnancy, they reported a lack of support from midwives.

- Women appeared very confused about the safety of taking anti-depressant medication during pregnancy and discussed the ambivalence of health professionals in advising them.

In conclusion, internet discussion groups provide an opportunity for women to offload worries and gain advice about the experiences they were having. Further exploration of two discussion groups indicated that pregnant women experiencing mental health problems in pregnancy do not use internet discussion groups to discuss their experience of care and are therefore not a good source to inform this part of the study.

**Episode 3 – [February 2008 – May 2008] Preliminary analysis of women’s recognition of her symptoms and disclosure to health professionals.**

Although not providing information about a women’s experience of care, archived internet postings were felt to provide information which might affect a women’s disclosure of her symptoms. Discussion boards which focused on perinatal mental health and offered access to non-registered members were searched for women’s recognition of her symptoms and disclosure to health professionals.
Women were confused about whether the symptoms they were experiencing were related to normal hormonal changes in pregnancy or to something else which often hindered them in seeking help.

Those women who did recognise they needed help for their symptoms found it hard to speak to their health professional.

Women recognised that they could potentially develop mental health problems after delivery, but did not expect to experience mental health problems during pregnancy.

Episode 4 – [May 2008 – July 2008] Perceptions, attitudes and experiences of women with mental health problems in pregnancy and their effect on the disclosure of symptoms to health professionals

Further analysis was conducted to examine the perceptions, attitudes and experiences of women with mental health problems and examination of issues that might affect the disclosure of women’s symptoms to health professionals. These included the following:

1. Evidence of how women might raise issues of their symptoms with health professionals.
2. What action women take in resolving their mental health problems
3. What affected their decision to discuss their symptoms with health professionals?

Findings from analysis of this data indicated:

- Women could not understand the symptoms they were experiencing.
- Women reported negative experiences when discussing symptoms with their GP.
- Women reported a lack of confidence in the response they would receive from health professionals and the treatment they would be offered when experiencing mental health problems in pregnancy.
- Services that were offered to women experiencing mental health problems were reported as being ineffective.
- Coping mechanisms women used when experiencing mental health problems in pregnancy included non-medical interventions such as aromatherapy, Pilates, Yoga, accessing support from others or recording their feelings.


Phase 1a – archived internet postings

Two discussion boards were selected to explore the symptoms women with mental health problems experienced and how these might differ from symptoms experienced by women at other times.
Data Analysis

Data analysis was conducted using thematic analysis, a method which involves the data being organised through a process of coding and categorisation as described by Braun and Clarke (2006). The theoretical principles behind cognitive behavioural therapy were also used to inform data analysis. Cognitive behavioural therapy is a form of psychotherapy which is used in the treatment of mental health problems and is based on the belief that our thoughts influence our actions and in turn our actions can influence how we think and feel.

Patients undergoing cognitive behavioural therapy are asked to identify the thoughts, moods, behaviours and the physical reactions that occur when they are depressed. The theory informing cognitive behavioural therapy suggests that it is the meaning attributed to a situation, rather than the situation itself that affects a depressed individual’s response either through dysfunctional moods, behaviours or relationship interactions.

In order to understand how mental health problems in pregnancy might differ from depressive illness at other times the thoughts, moods, behaviours and physical reactions of women were examined. Triggers for mental health problems, coping mechanisms and language women used were also examined.

Environmental Factors or Triggers for depression in pregnancy

The cognitive behavioural model suggests that certain situations or events occurring later in life, for example a loss or major life event may trigger beliefs learned in childhood and activate negative thoughts which lead to dysfunctional behaviour and negative thoughts which affect mood and behaviour leading to mental health problems.

Factors which contribute to women’s mental health problems in pregnancy included fears about developing postnatal depression after delivery and unplanned pregnancy.

Other women attributed the experiences they were having to hormonal changes in pregnancy.

Thoughts

Depressed people usually have negative thoughts about themselves, their worlds and their future [Hammen 1998]. The thoughts, beliefs, images and memories
women experienced when they were depressed during pregnancy were explored.

Women experiencing mental health problems in pregnancy often had negative and desperate thoughts about themselves and used negative language to describe themselves and their unborn baby.

**Moods**

Discussion boards were searched for evidence of those moods most commonly experienced by women with mental health problems. Women often experienced moods that were described as “low” or “down” and of feeling anxious or experiencing anxiety. Other moods experienced by women included guilt and shame and feeling scared, frightened and worried. Women described feeling guilty not only because of their mental health problems but also because of the effect their mental health problems were having on their children and families. A number of women described feeling scared and especially frightened of becoming ill again after experiencing postnatal depression in a previous pregnancy.

**Behaviour**

Cognitive behavioural theory suggests that the behaviour that arises as a result of mental health problems can be described as an activity that an individual would like to change or improve or as a situation that they would like to avoid (Greenberger and Padesky 1995).

The behaviour that women identified as being difficult included lacking motivation which affected the care that women were able to provide for their other children. Other dysfunctional behaviours that women reported included uncontrollable outbursts which were sometimes violent and directed against their partners.

The majority of women who contributed to the discussion groups reported being tearful or crying during their pregnancy. Sometimes this was due to the moods they were experiencing or their feelings towards the pregnancy or from feeling overwhelmed or exhausted.

**Physical reactions or physical symptoms**

Troublesome physical symptoms such as changes in energy levels, changes in appetite and sleep as well as specific symptoms such as heart fluctuation rates,
stomachaches, sweating, dizziness, breathing difficulties and pain are common in individuals experiencing mental health problems.

From the postings it was evident that there was sometimes a relationship between symptoms experienced by women as a result of mental health problems and other physical symptoms they were experiencing. For example women reported experiencing pain as a result of symphsis pubis dysfunction, which led to exhaustion and tiredness and this was making them feel depressed.

Women also talked about changes in their weight and eating habits as a result of experiencing mental health problems. Some women reported that their sleep and their ability to relax had also been affected.

**What helped?**

Women with mental health problems believed discussion of their problems with another person was helpful. Women also found alternative therapies such as aromatherapy, hypnotherapy, Bach's rescue remedy and yoga helpful. Women reported stopping taking anti-depressant therapy because it had made them feel worse.

**Language women used to describe their experiences**

Depression is often linked to low self esteem and negativity about the self. The words and language women used in the postings to describe themselves supported this.

Women sometimes felt they did not have the right to express the feelings they were experiencing and described themselves in derogatory terms. Women often apologised for their moods and for expressing their needs. In this way women often undermined the distress they were experiencing.

**Prescribing anti-depressants**

Women were confused about the safety of taking anti-depressants during their pregnancy. Women perceived lack of clarity about the safety of taking anti-depressants during pregnancy from some doctors. Women reported being taken off anti-depressants after becoming pregnant but then not being offered any alternative therapy.

**Barriers to disclosure**
Women were sometimes reluctant to discuss their depression with their health provider because of the response they might receive. Women perceived the response they would receive as sometimes good and sometimes poor.

Summary

Issues associated with interviewing women experiencing mental health problems in pregnancy suggested a need for an alternative method of data collection. The discovery of a series of internet discussion groups dedicated to women’s discussion of perinatal mental health issues was explored as a potential alternative. The advantages and ethical considerations of using internet generated data were identified and discussed.

A preliminary exploration of two discussion boards indicated that women’s discussion tended to focus on the symptoms and causes of their illness, the safety of taking anti-depressants medication and rarely focused on in-depth discussion of their experience of care. Internet discussion group postings [archived] therefore were considered to be not a good source of information on women’s experience of the care.

Further analysis of archived postings indicated women’s ambivalence about the normality of the symptoms they were experiencing prevented them from seeking help. Women reported being unsure of the response they would receive from their health professional, were dissatisfied with some of the services they were referred to and wanted less medical intervention.

An analysis of postings from two discussion boards using the theoretical principles behind cognitive behavioural therapy identified environmental factors that triggered women’s mental health problems, the thoughts, moods, behaviour and physical symptoms that women experienced as a result of mental health problems. Women experienced much the same symptoms of poor mental health during pregnancy as at other times. However, the contexts for their symptoms were specific to women with young children and families, who were experiencing pregnancy.

Women often used language which described themselves in derogatory terms, undermining the experiences they were having and apologising for their needs. Women reported being confused about the safety of taking anti-depressants during pregnancy and that being able to express themselves to another person and using alternative therapies was helpful in managing the symptoms they were experiencing.

Chapter 5 presents the findings from solicited postings to discuss the care women received from midwives and GPs and the factors that influence disclosure of their symptoms.
Chapter 5 - Phase 1b – solicited internet postings

Chapter Four presented findings from a preliminary analysis of data generated from internet discussion groups and discussed the potential use of such data to inform phase one of the study.

The decision was made that archived postings from internet discussion groups were not a potential source of data to provide information on pregnant women’s perspective of care when experiencing mental health problems in pregnancy and an alternative method was sought.

Permission from PNI-UK to access discussion board postings

This decision not to use archived internet postings to explore women’s experience of care was strengthened after a number of issues were raised by the CEO of one of the proposed discussion boards. The Chief Executive Officer [CEO] of Perinatal Illness-UK [PNI-UK] was contacted in October 2007 and terms of access to the internet discussion board were discussed in December 2007. Some concerns were raised by her about the method of data collection that was proposed.

The CEO explained that the purpose of the PNI-UK discussion board and website was to build a trusting relationship with women. Although in the public domain, women considered their postings to be private and expected that they would not be used outside the discussion group. An alternative way of accessing women’s discussions was suggested by PNI-UK. It was proposed that women be explicitly invited to share their experiences of the care they received when pregnant and depressed by posting them on the PNI-UK website. It was felt that this would allow women to decide whether or not they wished to have their postings used in a research project.

PNI-UK was selected as a potential internet discussion board because of their previous collaboration with MIND to conduct an on-line survey of the views of women experiencing mental health problems. This indicated that they might have a positive attitude towards the conduct of research and be more open to further research involvement than other discussion groups.

Advantages and ethical considerations of using internet generated data

Some specific ethical issues in using internet generated data needed consideration.
Maintaining the confidentiality of the women whose postings were used was a consideration. It was proposed that no contact with individual women would be made by the research team and individuals would not be identifiable. To prevent identification of women it was decided that only paraphrasing or short quotes that are not easily traceable would be used in the write up and analysis.

**Amendment to the research protocol**

Application for an amendment to the protocol was made to the Research Governance Committee in order to obtain solicited postings from women. Permission from the CEO, PNI-UK was granted to access potential research participants. A contract stating terms of access was agreed between PNI-UK and the University of York.

**Advertisement of banner on www.PNI-UK.com**

A banner inviting women who have experienced depression in pregnancy was posted on the PNI-UK website. Women were asked to post their experiences of the ways in which midwives and GPs had or had not been helpful to them when they were experiencing depression during pregnancy. Women could post their responses or send a private e-mail to the site administrator at PNI-UK which was then automatically forwarded onto the research team at the University of York. The banner was advertised on the PNI-UK website from the February 14th until October 16th 2007.

**Advertisement of banner on www.mothersvoice.org.uk**

The initial response from women to the PNI-UK website was slow, therefore after permission from the research governance committee a second website was approached, www.mothersvoice.org.uk.

Mothersvoice describe themselves as a ‘not for profit’ organisation providing support and information to women and families affected by perinatal mental illness. Perinatal mental illness is described as including postnatal depression, puerperal psychosis, birth trauma and pregnancy related anxiety. The founders

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1 Banners are interactive online advertisements in the form of a graphic image that typically runs across the top or bottom of a web page. When a user clicks on the banner they are sent through to the advertiser’s website or a advertisers landing page.
of the web site have all experience of perinatal depression and include a qualified nurse and counsellor, birth trauma therapist and postnatal support worker amongst them. Their aims are to offer support and information to women affected their partners and families. Their website includes a message board dedicated to the discussion of antenatal anxiety or depression.

The banner and posting were advertised on the mothersvoice website from March 2\textsuperscript{nd} 2007 until October 20\textsuperscript{th} 2007. The option for women to send private e-mails of their experience was not offered to women on this discussion board however one woman did send a private e-mail to the research team.

**Data Analysis of emails and internet postings**

Preliminary analysis of the postings indicated that women did not always address the questions that were asked of them. This was disappointing but not entirely surprising given that internet mediated data often allows little researcher control over the data that is collected, for example the researcher is unable to probe the respondent for further details or clarification... Furthermore, although ethical constraints prevented the research team from clarifying issues raised by women who posted and e-mailed some direct communication was unavoidable. For example, women sometimes requested information through e-mail and in order for them to make a contribution to the research project, a response from the research team was needed. There were also occasions when, due to the sensitivity of the e-mail discussion, it was necessary for a member of the research team to respond to a woman directly. Women sometimes requested clarification of their eligibility to participate in the study, asked for advice, feedback or collaboration on other projects or made offers to provide more information on the experience of their illness. In these instances it was felt necessary to respond to women and e-mail responses were made.

**Inclusion and exclusion criteria**

A total of twenty six women forwarded e-mails or made postings to the two discussion boards in response to questions about the care they received from midwives and GPs when experiencing mental health problems in pregnancy.

*[See Appendix 9: Tables showing Chronological listing of “invited postings” and e-mails received from discussion board members]*

The purpose of the study was to investigate care delivered to pregnant women living in the United Kingdom and although participants did not always reveal the origin of their care, when they did disclose that their care was non-UK based, their postings or emails were excluded from the analysis. Postings and e-mails were also excluded from the analysis if they did not contain discussion relevant
to the study. For example postings and e-mails sometimes contained advice, support or encouragement from moderators, requests from members to sign petitions or requests from members for clarification of their eligibility to participate in the study. If postings or emails exclusively had this content they were excluded from the analysis.

One woman, whose discussion was included in the study, made contributions to the study by both postings and sending an e-mail. The content of the participant’s e-mail and posting contained different aspects of her experience of mental health problems and care and therefore was counted as two separate contributions in the analysis.

A second woman also made two contributions by posting and then by e-mail, however she was ineligible for inclusion in the analysis as her care was not UK based.

From the total of thirty-five postings and e-mails sent in response to a banner posted on two discussion boards, twenty-four postings and e-mails were included in the analysis [12 postings from pni-uk.com, 6 postings from mothersvoice.org.uk and 6 private emails from users of mothersvoice.org.uk and pni-uk.com]. From a total of twenty six participants who made postings or sent e-mails, discussions from twenty-two participants were included in the analysis. Four participants who responded to the banner were excluded from the analysis [see flow chart]

**Characteristics of participants**

Due to the nature of the data collection it was not always possible to obtain information about age, occupation, socio-economic background and marital status of the women who posted or e-mailed, therefore the characteristics of the sample were largely unknown.

**Findings**

A preliminary appraisal of the postings was made by reading through each of the thirty five postings and e-mails. Each posting and e-mail was read thoroughly and a list made of the issues that were raised. Women often discussed other aspects of their experience of mental health problems in pregnancy, other than care they received. When women did discuss their satisfaction with the care they received from health professionals the issues discussed included
• reasons why women did not want to disclose their experiences of mental health problems to midwives and GPs.
• Response of women to the care they received from midwives and GPs
• Care from health professionals that women found effective
• The knowledge and experience of health professionals in the care of women perinatal mental health problems and health professionals access to resources

Topics raised by women in their emails and postings were grouped under the headings of the questions that we asked of them.

Q1 Maybe you did not want to talk to your midwife or GP?

• reasons why pregnant women did not want to disclose their experiences of mental health problems to midwives and general practitioners

Reasons for non disclosure of symptoms to GPs and midwives centered on the environment where the consultation took place and the response they received from health professionals.

Women reported that antenatal appointments were often rushed and that there was not enough time for women to talk about their feelings or about care options that were available to them.

“....appointments all so rushed, didn't have time to complain about my feelings”

When women did make an attempt to disclose their symptoms they reported the difficulties they experienced in doing this. Women felt their symptoms were dismissed as normal symptoms of pregnancy or they were offered treatment options which were unacceptable to them. Some women did not want to discuss the feelings they were experiencing because they “felt ungrateful not to be ecstatic I was finally pregnant”, while other women reported not speaking to anyone about their symptoms until after they had given birth.

One of the reasons for women’s’ failure to disclose was a lack of confidence in the ability of health professionals to help deal effectively with the problems women were experiencing or fear of the consequences of being labeled mentally ill and having their children taken into care. Women did not believe that any effective care could be provided for them.

One woman wrote:
“put on a brave face when I see midwife…don’t want people judging me…”

And another woman wrote:

“….never said anything….thought someone would take the children away…”

Q2 Were they able to help?

- health professionals knowledge, experience and access to resources

Women believed that midwives and doctors did not received sufficient training in perinatal mental health issues. There was a perceived emphasis in caring for women’s physical symptoms with less on the emotional aspects of pregnancy and childbirth. Women perceived education and training of issues in perinatal mental health to be a neglected area of care. Midwives and doctors were described as being “out of their depth” in their management of care. Women reported they would have liked their doctor or midwife “to have been more informed” or to have had more experience in caring for women with mental health problems. Doctors and midwives were reported as being sympathetic but lacking in specialist skills.

“ ..Drs and midwives were sympathetic, but that’s about it…”

There was an expectation from women that midwives and doctors should pick up the clues from their mood and behaviour that they were having mental health problems regardless of whether a woman recognized this herself or not.

Q3 Was there anything that they did which made it easier or more difficult? Were they able to help?

- women’s perspective on the care they received

Some women reported being happy with their care, “when I hit rock bottom, doctor very caring and understanding”. There were mixed reports from women regarding receiving care from the same midwife throughout their pregnancy, with some women satisfied with the care they received.

Other women however reported being less than satisfied with the management of their care. Women reported suffering considerably when symptoms they disclosed to the midwife or doctor were not taken seriously. Other women reported that they were not asked about their feelings by their midwife or doctor,
the antenatal appointments were rushed and health professionals did not always appear to have enough time.

Women reported that when they did seek help from health professionals, it was not forthcoming.

“I went in needing some help and support but came out being told some people have real problems”.

Some women felt undermined in the responses they received from doctors and midwives and one woman reported being laughed at by her consultant when she disclosed her symptoms.

- treatment and services offered to women

Women felt let down by the treatments and services offered to them. Women felt they were either inappropriate for the symptoms they were experiencing or were not available until after the birth of their baby.

One woman wrote:

“..Suggested by midwife that I see a doctor, all he did was give me a leaflet on depression…”

And another woman reported:

“….I was offered counseling through my doctor’s surgery but was told the waiting list was very long, i.e. I would have had the baby before I saw anyone…”

Women complained of feeling let down or not understood by the services that were supposed to help them. One woman complained that her “emotional needs were not being met”.

- response from mental health services

Other ways that women felt their symptoms were not been taken seriously was the lack of urgency with which referrals to mental health services were made. Women were not referred to mental health services despite having reported suicidal ideation.

When they did receive a referral to mental health services, this was not always a positive experience for women. One woman described her experience of care
from the community psychiatric nurse as “horrible”. Other women talked about the frequent cancellations of appointments. Other women complained about how slow the service was in responding to a referral.

“mental health services taking their time, so gave up.”

Mental health services appeared to provide the “cheapest, easiest option” in the treatment options they offered and women reported feeling like “second class citizens” when receiving treatment.

“..so pressed for time…..never got any counseling or CBT as requested, so had to opt for medication as no other alternative…”

When women were referred to mental health services this was often reported to be a beneficial experience.

For example one woman wrote:

“My midwife suggested counseling, and although I have rejected the idea in the past……..have found it extremely beneficial.”

- women’s perceptions of the attitudes of health professionals

There were mixed responses from women’s perceptions of the attitude of health professionals caring for them. As well as being described as being sympathetic and understanding, women also described the midwives and doctors who cared for them as “horrible” and “uncaring”.

One woman wrote

“my midwife didn’t care”

And another wrote

“midwives at hospital were horrible when I rang them”

A third woman wrote

“seen same midwife as before and she is bad”

Women also reported that they were not understood or taken seriously by midwives and doctors who were caring for them.
• What care women would have liked to have received?

Some women did comment on the care they would have liked to have received. One woman reported

“I think more understanding and genuine concern would have helped”

Other women also reported insufficient help when experiencing mental health problems during pregnancy and generally felt that women experiencing these problems needed more support from health professionals. One woman regretted that discussion of mental health was such a taboo subject and believed it was her own lack of understanding and awareness of the problems she was experiencing that made it difficult to for her cope.

• What helped?

Women reported that being listened to, especially by someone who understood, was paramount in helping them cope with mental health problems.

“….understanding that you are not the only person to feel like this……that there are people who understand….can give you a sense of relief/comfort”

Women found the internet discussion group supportive in helping them cope with their mental health problems.

One woman found antidepressant medication helpful in overcoming her depression, but alternative therapies such as meditation, relaxation and counselling were reported by other women as being helpful also.

Although women reported that their mental health problems lifted after the birth of their baby, other women reported that they were still struggling with poor mental health several months after giving birth.

Symptoms women experienced [solicited postings]

Although asked specific questions about the care they received from midwives and doctors, women often discussed other aspects of their experience of mental health problems in pregnancy. Most of the discussions centered on symptoms women were experiencing.

Moods
• **fear, worry, anxiety**

Anxiety is usually accompanied by a perception of danger, threat or vulnerability in some way. The threat can be physical, mental or social and the physical symptoms experienced can help prepare a response to the danger or threat expected [Greenberger and Padesky].

Nine women who made solicited postings to two discussion boards reported symptoms of anxiety fear and worry when experiencing mental health problems. Women reported feeling petrified or scared about the possibility of repeating their experience of a traumatic birth or of developing postnatal depression. The previous traumatic experience of pregnancy and giving birth had affected the moods they were experiencing in their current pregnancy making them feel anxious and scared.

Women’s fears also centered on the safety and welfare of their unborn baby and women reported being worried about the effects of taking prescribed medication during their pregnancy. Women also reported being frightened that they would not love their baby after the birth, or that the baby would be taken away from them if the disclosed their feelings. Some women believed that the baby would die.

Women often worried excessively and were scared that they were going to develop a serious illness, that they would have no control over the symptoms they were experiencing or that they would never go away. Other women worried that they would have no control over their actions.

• **anger**

Anger has been recognized as a symptom for individuals with mental health problems. The emotion of anger can range from irritation to rage. Anger is linked to a perception of damage or hurt and to a belief that important rules have been violated. Anger results from unfair treatment, from being hurt unnecessarily or from being prevented from obtaining something we expected to achieve. It is not the hurt or damage that makes us angry, but the violation of rules and expectations [Greenberger and Padesky, p 192].

Four women who made postings to the discussion boards reported experiencing angry moods or being irrational, although they did not always explain why they felt this way.

• **depression**
Nine of the women reported feelings of depression and feeling worthless. This depression ranged from an occasional depression to moods that lasted throughout their pregnancy or that coincided with a particular milestone, i.e. leaving work. When women reported on the intensity of their depression it was sometimes described as severe or horrific.

- guilt

We tend to feel guilty when we have violated those things that are important to us or have not lived up to the standards we have set for ourselves [Greenberger and Padesky]. Women reported feeling guilty about something they had done or not feeling ungrateful about not being ecstatic about being pregnant.

- Other moods

When women described there moods as relating to situation or a place, for example “feeling low”, “stuck in a rut”, “feeling on edge” or “feeling down”.

Other moods women experienced included feeling resentful, despairing, isolated and upset.

Thoughts

The cognitive behavioural model proposes any problem is composed of five components – these are environment, physical, mood, behaviour and thoughts and each of the five components interacts and affects the other. Our perception of an event or experience powerfully affects our emotional, behavioural and physiological response [Greenberger and Padesky].

Many of the thoughts reported by women were related to the moods they were experiencing. For example, women reported feeling petrified and the thought associated with this was that they would experience another traumatic birth.

- violence

Women often had thoughts about violence either to themselves or others.

Six women reported thoughts of suicidal ideation or self harm. Two women reported that they had thought about killing themselves without harming the baby or that they would have committed suicide if they had not been pregnant. Other women had images or thoughts of harming other people

- coping
Women reported not being able to cope or struggling to cope, particularly with the moods they were experiencing.

- **intrusive, negative thoughts**

Women also reported having intrusive thoughts or obsessive thoughts that they couldn't understand. This made it difficult for them to discuss with health professionals'. Some women had negative thoughts or predictions about what was going to happen to them in the future. They could not imagine the situation would improve or predicted there would be an occurrence of some negative event or behaviour in the future.

**Behaviour and Physical Reactions**

Thoughts and behaviours are usually closely connected. Deep core beliefs about the self tend to influence both automatic thoughts and behaviour. The behaviour and physical reactions reported by women were often similar to those usually associated with depressive illness.

Women’s reported behaviour when experiencing mental health problems in pregnancy included withdrawing from people and social situations, or “finding it hard to leave the house”, “pushing partner away” or shutting themselves in their room. Women behaviour sometimes included violent outbursts against their partner.

The physical reactions women experienced included crying and sobbing but women also experienced physical reactions such as overeating, binge eating and insomnia. Women also experienced physical symptoms such as lack of energy, sickness and pain from symphysis pubis dysfunction.

**Triggers**

The environmental factors that triggered women’s mental health problems during pregnancy included previous long term psychiatric illness and some women reported experiencing problems after stopping their anti-depressant medication during pregnancy. Other women identified the source of their mental health problems with some previous traumatic event.

**Conclusion**

A previous analysis of archived postings indicated they were not a good source of information on pregnant women’s perception of care when experiencing mental health problems in pregnancy. An alternative method of data collection was proposed through obtaining solicited internet postings from women. Women were asked to post or email their experiences of care from midwives and GPs via
a banner advertising the study and asking questions about their care, which was posted on two internet discussion boards for a period of six months.

Analysis of the discussions indicated that women did not always answer the questions that were asked of them and preferred to discuss other experiences as a result of the mental health problems they were experiencing. When women did discuss their care they received they commented on the lack of knowledge of health professionals regarding mental health problems. Some of the reasons why women had difficulty disclosing the symptoms they were experiencing were due to the attitudes of health professionals, either as being dismissive of their symptoms or because of the fear of the response from health professionals.

Women believed there was less emphasis on women’s emotional wellbeing in pregnancy in contrast to the physical care. The response of mental health services was felt to be slow and poorly timed. Women reported that they would like those providing care to them to be more understanding and be genuinely concerned. Having contact with another person who understood what they were experiencing was most helpful to women when faced with mental health problems.

Although not asked, women talked mostly about the symptoms they were experiencing. Analysis of women’s symptoms using theory from cognitive behavioural model indicated that women demonstrated symptoms that were typically associated with depressive illness. The triggers for mental health problems were often women discontinuing their anti-depressant medication. Many women reported fear, worry and anxiety, usually about the repeat of a traumatic birth experience or concern over their pregnancy outcome. Women appeared to feel most vulnerable about situations over which they had no control. Women also expressed anger and guilt about the negative feelings they were having about the pregnancy. Women’s thoughts were sometimes violent towards themselves or others or they had negative thoughts about their futures. The physical reactions women experienced eating and sleeping problems but women also experienced irrational and violent behaviour or became socially withdrawn.

The next chapter will present the findings from focus group discussions conducted with midwives and health visitors exploring their experiences of caring for women with mental health problems.

A summary of the responses from women who made solicited postings to two internet discussion boards are presented in tables [appendix 12]
www.pni-uk.com

...... registered charity for women and their families who think they have any type of perinatal illness.....incorporates any distressing psychological and emotional condition which has developed during pregnancy...

www.mothersvoice.org.uk

..........to support mothers and family members affected by any form of perinatal illness including antenatal depression and pregnancy related anxiety.....

September 2007 - Approval obtained from Research Governance, University of York

March 2008 - Amendment to Research Governance application to include mothersvoice website as a second source of data

December 2008 - Discussion with CEO, PNI-UK led to:

- re-thinking of data collection methods
- Request for amendment to Research Governance application, to obtain solicited postings from women.

14th February 2008

- “banner” placed on home page of website
- Women invited to post or email their experiences of ways in which midwives and GPs have or have not been helpful while experiencing depression in pregnancy

22 participants made contributions [16 participants eligible for inclusion in analysis]

- 14 postings received were [[12 suitable for inclusion in analysis]
- 10 emails received [5 suitable for inclusion in analysis]

Data collection on website closed - 16th October 2008

2nd March 2008

- “banner” placed on Antenatal anxiety or depression forum of website
- Women invited to post only their experiences of ways in which midwives and GPs have or have not been helpful while experiencing depression in pregnancy

7 participants made contributions [6 eligible for inclusion in analysis]

- 10 postings received [6 eligible for inclusion in analysis]
- 1 email received and was suitable for inclusion in analysis

Data collection on website closed - 20th October 2008

22 participants made a total of 24 postings/e-mails [18 postings and 6 e-mails] from two discussion boards. These postings and e-mails contained discussion of women’s experiences of mental health problems in pregnancy and the way in which midwives and GPs have or have not been helpful.
Chapter 6 – focus group discussions

Introduction

Chapters four and five discussed women’s perceptions of the care they received from midwives and GPs when experiencing mental health problems in pregnancy, their recognition and their disclosure of the symptoms they were experiencing. Since the overall aim of the study was to improve midwives care of such women, it was important to establish the factors which affect midwives provision of care. This chapter presents the findings from phase 2 of the study which explored midwives perceptions and experiences of caring for women with mental health problems in pregnancy.

Objectives for phase 2 of the study

The study objectives were to explore [1] the knowledge [midwives understanding] and [2] the attitudes of midwives in supporting women who are experiencing mental health problem in pregnancy [3] and explore midwives educational needs.

Collection of Data

Data were collected from midwives and health visitors attending a study day in perinatal mental health at the University of York in November 2008. Members of the research team for the project were involved in organization and presentations on the day. The objectives of the study day were to provide participants with up-to-date knowledge and opportunities for discussion, which would enable them to provide a high quality service to women in their care who have mental health problems.

Organisation of the study day

The day was organized to include presentations in the morning followed by small group discussions after lunch, where participants were able reflect on what they had learned and how it related to their practice. After obtaining written consent from the participants I recorded the small group discussions as research data. This allowed me to obtain midwives perspectives and in a way which caused them no additional inconvenience.
Twenty five free places were available to participants to attend the study day and were offered to health professionals working in two strategic health authorities.

**Sampling strategy**

Considering the restrictions inherent in asking midwives to participate in research, convenience sampling was the strategy employed for this phase of the study. With a chronic national shortage of midwifery posts and a rising birth rate it is increasingly difficult to engage midwives in research during the course of their working day. The organisation of a perinatal mental health study day provided an opportunity to invite midwives who were attending the study day to participate in the research project and without inconveniencing them.

**Characteristics of the participants**

Twenty two participants attended the study day and nineteen agreed to participate in the research project and have their discussions recorded. The group included fourteen midwives, nine of whom introduced themselves as community midwives. The remaining five midwives introduced themselves as being either hospital based [n=3] or student midwives [n=2]. Health visitors who participated in the group discussion comprised four trained health visitors and one student health visitor. The participants described themselves as either National Health Service employees, working in Primary Care Trusts or National Health Service Trusts or as university students completing a degree in Midwifery.

Information such as age, experience and training, length of time in post or educational background was not collected from focus group participants as permission from the Research Ethics Committee to conduct the study did not include storage of personal information on participants.

**Composition of small group discussions**

Those participants attending the study day and who had agreed to participate in the research project were divided into four small groups with the aim of ensuring that each group had an equal number of midwives and health visitors,

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2 Two additional midwives, who were attending the study day, initially agreed to take part, but decided to leave the study day early and therefore withdrew their participating from the focus group discussions.
Recruitment of participants

To ensure that participants had at least twenty-four hours to consider their participation in the study, health professionals who had applied to attend the study day were sent information about the research project along with study day information. Written consent for permission to record and use their data was obtained from participants on the study day. It was made clear to participants that those who did not wish to have their discussions recorded or used for research purposes could be easily accommodated in a group excluded from the study.

Inclusion of health visitors

Attendance on the perinatal mental health study day was open to both health visitors and midwives. Although the focus group discussions were intended solely to explore the experiences and perceptions of midwives care of women who are experiencing mental health problems in pregnancy, it was felt that there could be a positive spin-off by including the views and perspectives of health visitors and student health visitors in the discussion groups. Including health visitors in the discussions might reflect or mimic clinical practice where midwives and health visitors often collaborate on potentially challenging or worrying situations and in situations where health visitors sometimes have contact with pregnant women.

Rationale for using focus group discussions

Focus groups are “in-depth, open-ended group discussions….which explore a specific set of issues on a predefined and limited topic.” with the objective of obtaining data [Robinson 1999].

“The group is “focused” in the sense that it involves some kind of collective activity such as, for example debating a particular set of questions or examining a health education message. The crucial distinguishing factor of focus group discussions from group interviews is the use of group interaction as research data [Kitzinger 1995].

Participants are encouraged to talk to one another, ask questions, exchange anecdotes and comments on others experiences and views. Using methods of communication used by people in everyday interactions can reveal complex dimensions in the discussions that would not be accessed by other traditional methods [Kitzinger 1995].
Another important aspect of focus group discussions is that they enable examination of participant’s views within a social and cultural context. I was aware that health professionals do not work in isolation, but work within a team and a social context in which they influence and are influenced by. The focus group discussions presents a more “natural environment than an individual interview, as focus group participants “are influencing and influenced by others – just as they are in real life” [Litoselliti 2003].

**Discussion group moderators**

The focus group discussions were moderated by four members of the academic and research staff at the Mother and Infant Research Unit, University of York. The group sessions lasted between fifty five minutes to an hour and twenty minutes and each discussion group was digitally recorded.

**Vignette scenarios as a stimulus for discussion**

There are methodological problems with measuring actual behaviour of health professionals in their care and interaction with women, for example problems of compromising the privacy of women. In order to overcome this, hypothetical or intended behaviour of participants was measured through the use of vignettes scenarios presented to midwives and health visitors during the focus group discussions.

Some of the advantages of using vignette scenarios to gauge individual’s response include the ability to distance the issues from the participant or respondent. Using hypothetical situations has the effect of breaking away from the limitations imposed by personal experience and circumstances making them less personally threatening, especially in discussions around sensitive issues. Using vignette scenarios offers a way of asking questions concretely and of distancing participants from personal experience.

In order to develop vignettes scenarios which reflected situations that were credible and realistic and which midwives could relate to as genuine situations that they might encounter, internet postings used to explore pregnant women’s symptoms of mental health problems and their experience of care [Phase One] were used in the development of the vignette scenarios.

Three vignette scenarios were developed [see appendix 11]. Each vignette scenario was developed as a hypothetical situation affecting one pregnant woman and which occurred over a period of time. The vignettes were presented in three stages and each stage introduced an additional complexity to the
experience of the women. Each vignette was developed in order to give a chronological and unfolding account of one woman’s experience of mental health problems during pregnancy and was presented to focus group participants in three stages. Each stage in the vignette introduced an additional complexity to the experience of the woman.

Use of vignette scenarios in discussion groups

The vignette scenarios were presented to health care professionals participating in the focus group discussions. Midwives and health visitors were then prompted to respond to the situation via a set of questions for example “what would your responsibilities be to these women?”, “what support would you offer?”, “what action would you take?” [See appendix 11].

Transcription and analysis of focus group discussions

Although funding was available for professional transcription of the tapes I made the decision to transcribe all four focus group discussions myself. Although this was time consuming it provided an excellent way of familiarizing myself with the data. Braun and Clarke [2006] consider transcription of data as a key phase in the analysis of the data. They believe that transcription should not be seen as a mechanical act of putting spoken sounds on paper, but as an interpretative act where meanings are created and issues of potential interest are noticed and looked for [Braun and Clarke 2006].

The focus group discussions were transcribed to produce a verbatim account of participants discussions and were presented in a way that remained true to the original nature of the discussions. [Braun and Clarke 2006] After transcribing the discussion groups I checked the transcripts against the original audio recordings for accuracy. Identifiers were used in place of midwives’ and health visitor’s names in order to maintain their anonymity [se appendix 6].

Braun and Clarke emphasis the importance of complete familiarization with the data set before coding and of being immersed in the data to the extent of becoming familiar with the depth and breadth of the content [Braun and Clarke 2006]. I became immersed in the data by active and repeated reading of the data, searching for meanings and patterns and taking notes as I read. Note taking is an important part of the process of analysis [Strauss and Corbin 1998]. and therefore throughout the process of analysis I made notes, drew mind maps and made tables containing the thoughts and ideas I had about the data, and the reasons for grouping them in a particular way.
A process of coding and thematic analysis as described in chapter 3 was used to
analysis the data. Using Atlas-ti version 5 I identified several “units” or “data
extracts” were identified which were then collated together into an initial set of
codes.

Further development of codes occurred and the codes were then considered in
light of how they relate to the aims and objectives of the research question and
were grouped into themes and sub-themes, as presented below [see table, appendix 5]]

Analysis of the data was facilitated by using Atlas-ti version 5.
In the final analysis two main themes were identified from the data (1) Care of
Women who are experiencing mental health problems in pregnancy and (2)
Barriers to the provision of care, which are presented in the following section.

(1) Care of Women experiencing mental health problems in pregnancy
Several factors were identified by focus group participants in the care of pregnant
women with mental health problems

Midwives as the lead professional

Focus group participants believed that the midwife was the lead professional in
the care of pregnant women. A women’s relationship with her midwife was seen
to be special, in comparison to her relationship with other health professionals
and pregnant women had high expectations from the maternity services. Despite
this however recognition of leadership in the care of pregnant women was not
clear.

SHVI: ………. there is no clear path and the care pathways, there is no actual clear
leadership who takes the control of what is going on and can lead, be the lead for that
person…..

Awareness of mental health problems in pregnancy

Focus group participants were aware of the triggers that might precipitate mental
health problems during pregnancy. Those women who had difficulty coping with
change, or were worried about coping after the birth were felt to be more at risk
of developing problems than those who coped well. Focus group participants
recognised pregnancy as a major life event that required considerable adaptation
to the changes that were occurring. Some women were less able to adapt to
these changes than others and as a result pregnancy could act as a trigger for mental health problems. Pregnancy and childbirth were events that could not be fully prepared for, there was always an element of uncertainty and sometimes this was very hard for women to deal with. Women became anxious in situations where they had high expectations and little control over events.

HV1: pregnancy or childbirth isn’t one of those things you can join the AA for and have a route map for and you know do everything that you can to prepare you will end up in, into the uncertainty…and for some people that in itself is really hard…

Isolation from friends and family was also indentified as a trigger for mental health problems. Those most at risk were women from ethnic minority groups and those women who did not speak English. Service men’s wives were also reported to have high levels of mental health problems due to their continual relocation.

CM2: ………cause I work in the garrison and there are big problems with isolation and all the rest of it… because they are moving in and out lot of things going on there

Care offered to women

Although midwives discussed the barriers they experienced in providing care to pregnant women they did discuss and the modifications to their practice they would make in the care of pregnant women.

Most of the care delivered by midwives was directed at providing support to women experiencing mental health problems in pregnancy.

Acknowledging a woman’s experience of mental health problems

Acknowledging and validating the experiences and symptoms that a women was having was seen to be an important aspect of her care. Pregnant women were reported to have felt better after knowing that a referral had been made for them to see a mental health specialist or specialist service. Referring a pregnant woman with mental health problems to a specialist service made her feel she was being listened to and that something was being done to help her.

For example, one hospital midwife said

HM2:…… and when she got to about 24 or 28 weeks she said that she was starting to feel more low and she was referred to……. I think she is a cognitive behavioural therapist….., and while she was waiting for the appointment she said actually I feel better now just knowing that I have got this appointment….
While a health visitor reported

_HV1:_ … the number of people that I have referred to Home Start, who when the referral has actually got through do no longer needed it but that sense of having felt that someone had listened to them and trying to activate something on their behalf — makes a huge difference.

**Enabling women to talk about mental health problems**

Allowing women the opportunity to express themselves in their own time and in their own way was helpful in enabling women to disclose the symptoms they were experiencing. Another midwife believed that supporting a woman by listening to what she had to say, rather than automatically offering a solution to her problem could help in the disclosure of her depression.

_CM6:_ .. Because once you give her a solution, like referring to physio, then she might feel that, she is like, that is it is, it like, it is dealt with, really want to say something else, but you know, I really wanted to say something else, but you know, my window is gone....

Rather than anticipate a woman’s feelings about her pregnancy, it was important to allow a woman the opportunity to express any ambivalent or negative feelings that she might have.

_HV2:...... when I see a mother now and I know she is pregnant I don’t automatically say congratulations… I say “are congratulations in order?” , because it is only a slight thing but it’s not an assumption that this baby is wanted or planned and that they are happy about it and I think if you start off from that premise you know, things might not be hunky dory, um, it sort of opens up before you have said anything else.......

One participant believed that conducting antenatal visits in a women’s own home would enable her to open up more about her symptoms of depression. The combination of a less formal environment with fewer restraints on time would produce an environment that was more likely to enable a woman to talk about sensitive issues

**Referring Women to other Services**

**Health visiting service**

Midwives talked about the benefits of involving health visitors in the care of women experiencing symptoms of depression in pregnancy. Midwives reported having a good relationship with their health visitor and were able to refer women that they had concerns about to the health visiting service. Health visitors were felt to be an important source of support to women introducing them to other
Health visitors also reported benefits in visiting women experiencing mental health problems during pregnancy. Visiting a woman during her pregnancy was more beneficial than after delivery as the absence of a baby made it easier to give a woman undivided attention. Health visitors relied on midwives assessment and the referral of women who were at risk of pregnancy and were grateful for the opportunity to visit women identified by midwives as high risk during pregnancy.

The health visitor’s role was seen as vital to the needs of mothers and families and there was some concern among midwives and health visitors about the reduction in the health visiting service.

CM7: …..to not have the health visitor to support them it is going to have a profound effect on women’s mental health and just the detection of, the impression is that. I’m really worried about it…..[Community Midwife]

Support services

Other support services were recommended to pregnant women when they were identified as experiencing mental health problems. These services were able to provide advice and support to women, help with child care and offer women continuity of care throughout their pregnancy and the postpartum.

Focus group participants believed that involving services such as Home Start and Sure Start could prevent further deterioration of a women’s mood.

CM: …..so hopefully the young girls especially and the young mums may have ended up with depression but because the Sure Start support is there initially then maybe we avoid that…….[Community Midwife]

Sure Start could also help women with childcare issues with existing children if they had physical problems associated with mental health problems in pregnancy.

Mental health services

Variation in the referral powers of midwives to mental health services was reported. Focus group participants reported that having access to a psychotherapeutic service would be beneficial to women experiencing mental health problems during pregnancy. However, these services were sometimes difficult to arrange until after the baby was born.
Women receiving counselling during pregnancy might benefit by not having to take anti-depressants for mental health problems, although therapists were reluctant to counsel pregnant women because they were more liable to be emotionally vulnerable during the antenatal period than at any other time.

Modification to antenatal visits

Midwives reported supporting women with mental health problems by increasing the frequency with which they saw women, increasing the length of time of the visit and arranging to see a woman sooner in her pregnancy. Midwives also arranged to visit a pregnant woman in her home as this was felt to provide a better indication of what the needs of the family were as well as providing a more informal setting enabling the woman to discuss issues that were going on in her life.

Sometimes a midwife reported that her colleagues were not always sympathetic to offering women additional appointments especially if someone else had to cover her workload. Other difficulties identified by midwives in supporting women were a lack of time to arrange longer and more frequent appointments.

(2) Barriers to the provision of care of women experiencing mental health problems in pregnancy

Focus group participants identified barriers to providing pregnant women with mental health problems with effective care.

Lack of emphasis on emotional problems in pregnancy

There was a lack of awareness of antenatal depression in the care of pregnant women, with the emphasis on problems postpartum. This lack of emphasis was demonstrated by the lack of screening tools that were available for the detection of mental health problems during pregnancy. Midwives and health visitors recognised the difficulties women might experience in asking and receiving support from health professionals when experiencing mental health problems in pregnancy. Focus group participants also felt that although student midwives did receive training in managing mental health problems in pregnancy, it was unclear whether this transferred into practice.
There was a disproportionate amount of time devoted to a pregnant women’s physical care in comparison to her emotional care, which was exemplified in lack of a care pathway for women who presented with mental health problems in pregnancy.

**Pregnant women failed to recognise symptoms of mental health problems**

Women themselves, through their actions and behaviours, were seen as instrumental in preventing the delivery of appropriate care. Women sometimes chose not to disclose either because they did not recognise the symptoms they were experiencing as a mental health problem or because they chose not to disclose the full extent of their symptoms.

*SHV1: It also depends on the person who actually believes that they have a mental illness and I’m not being peculiar but some people have been on antidepressants ‘cause they have had reactive depression, but do not see themselves as being mentally ill, it was just a significant life event that has left them a bit sad…*

Sometimes women, especially those from higher social groups, failed to disclose the symptoms they were experiencing because of the stigma associated with mental illness. Women felt that they had to be seen to be a perfect mother and did not want to admit they were finding it difficult to cope. Other women believed they did not have any reason to experience mental health problems and therefore should not be. This prevented them from disclosing their illness to health providers.

*HV1…….. professional women can find it extremely hard to disclose mental health issues the GP’s, teachers, nurses, your fellow midwives, can find it really hard to say that they are struggling because somehow there is an expectation that, you know that they have got a nice house and a certain…. [Health Visitor]*

**Women failed to comply with services or treatment offered**

Women failed to prevent the provision of good care because of their failure to access services or comply with treatment that was offered them. There reluctance was sometimes due to the association the services offered had with mental illness.

*CM3: the other side then is that it is straight to the community psychiatric team… which a lot of ladies are whay! You know this is just you know, I’m not mentally ill you know and sometimes you put the terms psychiatric, you know they sheer back from it, they want help but you know there is sort of something maybe in between…….[Community Midwife]*
Women with mental health problems sometimes would not accept offers of help from voluntary sector services. These women, who were particularly vulnerable, sometimes found it difficult to acknowledge they needed help and needed encouragement and help from midwives and health visitors to do so.

Sometimes women did not want to take medication during pregnancy because they believed it would be harmful to their unborn child and it was not uncommon for women to stop taking antidepressants when they became pregnant.

*CM2: You get a girl coming to you to say, I’ve stopped taking my anti-depressants, well why, “because I’m pregnant”*

Focus group participants reported finding it difficult to get women to agree to taking any pharmaceutical preparations during pregnancy and in order for them to comply with antidepressant therapy reassurance about its safety during pregnancy was needed.

**Midwifery Practice as a factor in preventing delivery of Care**

**Midwives ill-equipped and lacking in training**

Midwives talked about feeling ill-equipped in caring for women who did not qualify for referral to mental health services or referral to their General Practitioner, but did require some type of intervention. Midwives wanted to offer women more help but needed more information, training and resources to be able to do this.

*SPM1: You know they might not need mental health services....they might not need the GP for antidepressants but need something there is a big gap isn’t there in the middle that as midwives we are expected to fill that really we haven’t got the competencies to fill it you know....*

Other midwives described feeling inadequate to deal with the potential problems that women presented with. Midwives reported not having the skills or time to work with women who disclosed problems, but, but refused referral to mental health services. Midwives did not feel it was within their role or that they had necessary skills to effectively care for women who presented with these types of problems.

Often midwives were frustrated because they were not able to offer women the support that they needed. Sometimes the source of women’s mental health problems had social origins and women needed appropriate help to deal with
their underlying problems. Midwives were restricted in what they could offer women and this left them feeling ill equipped to deal with a woman’s problems.

CM5…..in fact I’ve recently had three women who have come to me with symptoms of depression, but I feel but with the help of the housing issue I have directed them there and they have been able to initiate their things and that has helped……so it is actually looking at what causes this depression, this feeling…. there is actually two different types…[Community Midwife]

The source of women’s mental health problems were sometimes complex and midwives were not always able to offer an alternative intervention other than referral to the GP or to mental health services. Midwives and health visitors felt that training in listening skills would be helpful to them in supporting women. Although available, training in perinatal mental health was not always accessible because of staffing levels. Health visitors and midwives reported that efforts to communicate their need for further training to managers were unsuccessful. Study days and training in perinatal mental health although available, were not always accessible to midwives because of poor staffing levels were low.

Lack of time as a barrier to providing care

Midwives commented on the amount of time that they were able to offer pregnant women when they saw them in clinic for antenatal care. Midwives believed they saw pregnant women less frequently than before, and that the amount of time they had available to spend with a pregnant woman was inadequate to deal with both the physical and emotional issues that they presented with.

Sometimes it was difficult to fit both the emotional and physical care of a woman into one ten minute appointment. Midwives reported finding it difficult extending the length of a woman’s antenatal appointment, in order to spend more time with her in the consultation. Midwives schedule of work and the other responsibilities that they had, made it difficult for them to see women at additional times.

CM2: Um and how long are your booking appointments [laughs][Community Midwife]  
CM1: Um, well it is an hour now but sometimes you could do with two hours, that’s the problem aint it…..it’s the time….that is one of the biggest problems, the time factor [Community Midwife]

Midwives reported that a busy clinic could be intimidating for a woman, if there were a large number of women waiting to be seen and she felt she was taking up time that her midwife was unable to provide. Sometimes it was the midwife who was affected by a busy clinic. A heavy work schedule could affect midwives ability to identify women who were experiencing mental health problems.
HM3: You would hope that you could pick up on it but that can be masked by being really busy in a really busy clinic, knowing that you have got seven visits to do postnatally after the end of this clinic, that these women that you don’t know, that you might never see again, so things can reduce your ability to or desire to pick up on these things [Hospital Midwife]

Lack of continuity of carer

Focus group participants were aware that women did not always see the same midwife at antenatal clinic and this made it difficult for women to build up a relationship based trust and confidence, which might enable them to disclose the symptoms they were experiencing. A lack of continuity in the care of pregnant women affected a women’s disclosure of her depression. A relationship of confidence and trust was needed for women to disclose the symptoms they were experiencing.

……….there is quite a difference, where I work, between the part of the practice that has got a constant midwife, you know what the women see, compared to the one that is covered by lots of different people because…..she is on maternity leave…..

……..and you say to them, you know who is your midwife, actually don’t know her name cause I’ve seen three different ones, you know…….[Health Visitor]

Limitations in midwives role, lack of ability to influence wider policy, nothing to offer women.

Midwives reported that they would have liked to offer women some other form of treatments when they refused to be referred to specialist services, however midwives reported that there was nothing they could do except wait and see if the problem developed into something more serious. Other issues that midwives felt acted as barriers were the difficulties they had in making referrals to mental health services. It was difficult for midwives to assume the responsibility of lead professional if they were unable to refer the woman to the services that she needed. In addition midwives felt unable to communicate their concerns effectively or to effectively influence priorities in the care and management of pregnant women.

Midwives reported that the expectations women had of the midwifery service were sometimes unrealistic. One midwife reported that she was expected to meet the needs of every woman, to be “everything to everybody”. She reported that within the restraints that were imposed on her professional role, this was not possible.

CM5: you’ve got your parent craft, you’ve got your middle class that want to come to the hospital and this that and the other, you’ve got your teenage pregnancy, you’ve got your vulnerable people and then you’ve got the rest of the work going on at the same
time so you can’t be everything to everybody… with the time restraints that you’ve got [Community Midwife]

Midwives also discussed the limitations in their role. One midwife reported that her role was limited to normal pregnancy, psychiatric care was out of her remit and midwives did not have the expertise to deal with psychiatric illness. There were limits in the level of care you could deliver to women and midwives had to work within these limits.

Variations in the provision of services by midwives

A final barrier to the provision of good care was the variations in services that were available for pregnant women. Quality of services and women’s access to services were not the same throughout the region and focus group participants reported variation. One health visitor described the provision and quality of services for women like “a lottery”. She believed that financial restraints were responsible for the variation in provision and quality of services. There was also variation between professionals’ attitude and skills in caring for women with mental health problems in pregnancy and this affected the quality of women’s care.

Conclusion

Focus group discussions which included midwives and health visitors explored the experiences of midwives in caring for women with mental health problems in pregnancy. The focus group discussions were held as part of a study in perinatal mental health in November 2008. The focus group discussions were recorded, transcribed and analysed using thematic analysis.

The analysis indentified two main themes (1) the care that women received when experiencing mental health problems in pregnancy and (2) the barriers to providing appropriate care for women.

Midwives and health visitors were aware of the triggers that might precipitate mental health problems in pregnancy. Pregnancy was seen as a life event which required considerable mental and physical adjustment and not all women were able to adjust to these changes successfully. Anxiety about the birth, social isolation and feelings of loss of control were factors which contributed to women experiencing mental health problems.

Actions that midwives and health visitors took in the care of women with mental health problems were mostly supportive and caring. Midwives reported the importance of acknowledging a woman’s symptoms, of allowing discussing of a woman’s feelings and of offering modified antenatal appointments as additional
support. Midwives reported supporting women through referral to specialist services such as health visiting service, mental health service and other supportive services such as Home Start and Sure Start.

Midwives and health visitors identified several barriers to the provision of good care. Sometimes the barriers were due to a lack of awareness and emphasis of mental health problems in pregnancy. At other times it was felt that women’s lack of disclosure of their symptoms and lack of compliance with services and treatment offered that prevented the delivery of care.

Midwives reported a lack of training and skills in caring for women with mental health problems in pregnancy and being unable to access training when available. Midwives also reported feeling powerless in making any changes or affecting policies which informed the care of women with mental health problems in pregnancy. A lack of time due to busy clinics was also felt to affect a women’s disclosure of symptoms and the care she received from midwives. Busy clinics inhibited women taking up additional time with the midwife but it also discouraged midwives from spending additional time with a woman.
Chapter 7 - Discussion Chapter

This study has explored the experiences of women with mental health problems in pregnancy and the way in which midwives can be helped to care for such women.

The study began by exploring pregnant women’s experiences of care from midwives and general practitioners. Women’s recognition and disclosure of their symptoms is an important factor in the process of caring for pregnant women with mental health problems; therefore factors which might affect these were explored. The study then focused on the perceptions, attitudes and experiences of health professionals who care for women with mental health problems in pregnancy. Midwives and health visitors gave details of the care they were able to provide for women as well as identifying barriers which prevented them from providing adequate care to women with mental health problems. This study then is an exploration of women’s perceptions and experience of receiving care when experiencing mental health problems in pregnancy and health professionals experience and perceptions of providing care to such women.

The discussion is presented in three sections: a critique of the methods used; discussion of the main findings; and the implications of these for service delivery, professional education, maternity policy and further research.

A critique of the methods used

Strengths and limitations of the study

The focus of the study was to understand the experiences of pregnant women who present with mental health problems and to explore the ways in which midwives might be able to improve the care of such women. This was done by exploring the attitudes, perceptions and experiences of both women and health professionals. This combined use of data methods and data sources enabled more in the validity of findings than either method or data source alone would have done.

Internet generated data of the experiences of women from “archived” postings provided naturally occurring data and included issues which women raised themselves about their experience of mental health problems in pregnancy. Data generated from “invited” postings were able to provide more specific data on the experience, feelings and thoughts women had on their experience of care from
health professionals. Focus group discussions from health professionals provided the opportunity to obtain data from an in-depth, open-ended discussion which explored a specific set of issues on a pre-defined and limited topic [Kitzinger 1995]. The focus group discussions also allowed an examination of the perspectives of midwives and health visitors as they operate within a social network

**Use of internet generated data**

The advantages and ethical problems with using data generated from internet discussion groups have already been discussed. Using data from internet discussion groups is a fairly new and innovative method of generating data. One of the biggest advantages of using internet generated data is the relatively inexpensive and easy access to data that it allows. Data can also be collected without the researcher being present therefore eliminating the possible intrusiveness of researcher presence and any bias as a result of the researcher being present during data collection. Another advantage of using internet generated data is the possibility of access to a much wider geographical network of research participants than may be possible using traditional methods. It is also thought that participants may be more candid when involved in internet mediated research because the social desirability effects may be diminished [Hewson 2003].

This study relied on two sets of data generated from internet discussion groups. Both data sets were concerned with the experiences of woman who had mental health problems in pregnancy. The first data set focused on women’s experience of their care, using solicited or “invited” postings and emails which were specific to the study, while the second focused on women’s recognition of their symptoms, using “archived” or retrospective postings from women which were independent of the study.

Both data collection methods had their own strengths and limitations some of which will now be discussed.

**“Invited” internet postings**

**Lack of researcher control**

One of the difficulties of using internet generated research over more traditional methods of enquiry is the lack of control researchers have over the research environment.
Researchers using internet generated data are unable to exert any control over the reactions of the participants to the research questions posed, the environmental conditions in which they were responding under or who the participants were [British Psychological Society Guidelines]

Despite asking specific questions about the care they received when experiencing mental health problems in pregnancy, women did not always answer the questions that were asked of them. Research ethics approval prevented me from making contact with women in order to clarify their responses, resulting in data which was extraneous to the subject under investigation. Although many women provided information that was relevant; some women gave information on the symptoms they were experiencing, the causes of their mental health problems or relationship problems they were experiencing.

Sometimes respondents used the study discussion thread or email address inappropriately, for example to asking for support to sign a petition or requesting other information or help outside of the study.

**Reluctance from women to use postings for research purposes**

There was a low level of response from women to an invitation to post their experiences of care on the discussion boards and there was a variety of factors identified which may have contributed to this. Women who post to an internet discussion group expect their postings to be private and not accessed by those outside of the group. Researchers posting or “lurking” internet discussion groups were felt to be intrusive and damaging to the level of trust that existed within the discussion group community.

Further exploration of this topic with those who moderated the PNI-UK discussion board indicated that previous involvement of the site with researchers had led to complaints from women. It was felt some women would refuse to participate in a research project posted on the discussion board.

**Representativeness of the sample**

Restrictions were placed on access to biographical information of women who posted on the PNI-UK website, therefore little is known about the characteristics of the women who posted to this discussion board. Although some biographical information was available on women who posted on the Mothersvoice website, it was not enough to establish the representativeness of the sample to a wider population.
Other research has commented on the bias of male internet users who tend to be highly educated and high earners [Bordia 1996]. Unfortunately, it is not known how this tendency translates to women internet users. However, there does need to be acknowledgement that there is a self-selection bias inherent in a group of people who communicate via computers and despite the growing number of people who use computer communication a certain segment of the community do not have access to the internet and therefore would have been excluded from the study.

Richness of women’s accounts

In order to protect the confidentiality and anonymity of the respondents, it was agreed that paraphrasing or short quotes only of the discussions made by women, would be used in the analysis. The use of verbatim quotes from postings on internet discussion boards could be easily traced and thereby compromise the anonymity of the participants. This lead to a less than rich and illustrative account of the analysis presented. Use of verbatim passages have a crucial role in presenting qualitative research because of what has been referred to as the “generative and enhancing power of peoples accounts” [Ritchie and Lewis 2003, p 312]

Verbatim quotes and passages give richness to individual’s accounts. They give an account of the meanings that people attach to social phenomena and the expressions of their views or thoughts about a particular subject [Richie and Lewis 2003]. The absence of the presentation of verbatim quotes meant that this type of rich description and illustration of the data was lost in the analysis.

“Archived” internet postings

Use of “archived” postings presented their own set of limitations.

Analysis of “archived” data

“Archived” postings from on-line discussion forums consist of naturally occurring talk and participants discuss and respond to issues that are of interest to them. The purpose of the discussion groups are to act as a forum for women to share their concerns and experiences, ask for help and advice and offer support.
Searches conducted on internet discussion groups revealed that women’s postings rarely contained sufficient discussion of their experiences of care from health professionals, to satisfy the needs of the research project. For similar reasons comparative analysis of the experiences between groups of women was not possible as women did not discuss the same issues or give details about their backgrounds that would lend them to being categorised into groups for comparison.

Women were also inconsistent in the discussions they made, for example women sometimes made statements in their postings which they then contradicted later in the posting. These issues made valid analysis of the postings very difficult.

**Identification of relevant postings**

Identification of postings relevant to women’s experience of mental health problems in pregnancy could be time consuming and did not always yield the desired results. Although some discussion boards did have forums dedicated to the discussion of mental health problems in pregnancy, others did not. Even when dedicated discussion forums were available, postings were found to contain discussion which was not relevant to the study. This often resulted in a manual search through several postings in order to identify those postings which might be suitable to use in the study.

**Limitations to focus group discussion**

**Representativeness of the sample**

Participants of the focus group discussions were selected from midwives and health visitors participating in a study day on perinatal mental health. The biographies of the participants were not obtained and therefore it was difficult to establish how representative the participants were to a wider population of midwives and health visitors. Although some information was obtained on the professional backgrounds of all participants, there was not enough to establish the diversity of the group.

It was difficult to establish the motivation behind midwives and health visitor’s attendance on the perinatal study day. It was unclear whether participants were a self select group and were attending because they had an established interest in perinatal mental health. However, participants also had the opportunity to

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attend the study day free of charge and this might have provided an incentive for them to attend.

Benefits and limitations of using focus group discussions

_sampling strategy_

There was a difficulty in having a representative sample because of the limited number of participants but also because of the restrictions in selecting a diverse and varied group. There was no permission to access participant demographic and biographical information, therefore it was not possible to determine how the findings transferred to a wider population of midwives and health visitors.

_artificically set up situations_

Focus group discussions are artificially set up situations and it would be incorrect to imply that the group is “natural” and reflects everyday interaction. Focus groups can assess what participants say they do or believe, but not necessarily what they actually do [Litoselliti 2003] so therefore it is unsure how they accurately represent health professional actions and beliefs.

Focus groups do not always distinguish between an individual and group view. Groups may appear more consistent than they are because individuals who disagree may not say so; individual behaviour may also be subject to group influence. As in any other interview situation there is the danger of leading participants and encouraging them to respond to the moderators prejudices [Litoselliti 2003].

Benefits and limitations of using vignette scenarios

Similar problems of authenticity arise with the use of vignette scenarios. In responding to a vignette scenario participants are more detached from the situation and this can produce unrealistic results as they are not directly comparable to real life [Hughes 1997]. It has been described as the distance between the vignette world and the real world. People are right in the thick of things in real life, whereas they are always detached or detachable from stories they read [Parkinson and Manstead 1993 cited in Hughes 1997]. Therefore, as with focus group discussions, vignettes do have clear limitations if they are being employed to provide an interpretation of the real world.
Main findings, implications for service delivery, education, maternity policy and further research.

Summary of main findings in terms of the study aims

The following section will contain a discussion of the main findings of the study as they relate to the study aims and objectives.

Phase One - women’s experience of symptoms (1)

The objective of phase 1a of the study was to explore the subjective experience of women with mental health problems in pregnancy and recognition of their symptoms from archived postings.

Most of the discussion made by women centered on symptoms they were experiencing or the causes of their depression and were not focused on their experience of care.

- There was confusion and ambivalence among women about the safety of taking anti-depressants in pregnancy and women were concerned about the effect on their unborn child.

- Women complained about the lack of alternative therapies that were available to them. Rarely did women report seeking help from counsellors or having had access to non-medical therapies.

- Women reported a lack of support from midwives and rarely were midwives recommended as a potential source of help.

Women’s understanding of the normality of their symptoms

- Women indicated a lack of understanding of the symptoms they were experiencing and could not decide whether to seek advice from a health professional. This was often compounded if they were experiencing isolation as they had no one with whom they could validate their experience.

- As a result of not understanding the symptoms they were experiencing women found it hard to discuss symptoms with their doctor..

- The language women used was usually hostile, derogatory and self damaging towards themselves and their unborn baby.
Women lacked confidence in the responses and treatment they were offered by health professionals,

Women also talked about their mental health problems as being related to a previous trauma or mental health problem.

**Triggers for mental health problems and the symptoms women experienced**

- Mental health problems were triggered by fear of repeat of trauma such as postnatal depression or from hormonal changes.
- Women often experienced anxiety, also guilt, shame, fear and worry about a repeat of postnatal depression.
- Women had negative and intrusive thoughts about themselves and their pregnancy and used language which undermined themselves and the distress they were experiencing.
- Women experienced behaviours that included lack of motivation and reduced coping strategies. Women’s physical reactions included pain, feeling tired and changes in their sleep and eating patterns.
- Women were reluctant to discuss their depression with their health professional because they believed their baby would be taken from them.

**Phase One – women’s experience of care**

Women were asked about the ways in which midwives and general practitioners were helpful or not helpful to them when they were experiencing mental health problems in pregnancy. The responses received were grouped under five categories which were felt to reflect the topics discussed by women.

**GPs and Midwives level of knowledge of mental health in pregnancy**

- Rarely did women express having had a positive experience of care from midwives or general practitioners.
- Women believed health professionals had a poor understanding of perinatal mental health problems and appeared “out of their depth”.
- There was more emphasis on the physical care of a women’s pregnancy than emotional or psychological aspects.
Talking to your GP

♦ Women found it difficult to disclose their symptoms of mental health problems to health professionals because of the lack of time available at antenatal appointments.

♦ Other women did not disclose feelings because they did not want to be judged or were frightened the symptoms they were experiencing would be dismissed as normal. Other women did not disclose as they did not believe anything could be done.

Women’s experience of help

♦ Women reported receiving inadequate help or poor advice from health professionals who were uncaring and not understanding.

♦ Those women experiencing a second and subsequent pregnancy felt they received less attention than primiparous women.

Response from mental health team [MHT]

♦ Response from mental health services was reported as slow with poor attitudes from staff and poor availability of treatment options.

Response from GPs/Drs

♦ Women reported GPs not taking their symptoms seriously, being told that they were being irrational or being told that their symptoms were normal.

♦ Women described staff as being uncaring and unsympathetic.

What helped?

♦ Having someone to talk to and availability of alternative therapies.

♦ More genuine understanding and concern from midwives and doctors.

Women’s experience of symptoms (2)

♦ Commonest trigger for the development of mental health problems in pregnancy was stopping anti-depressant medication
Women experienced anxiety about repeating their experience of postnatal depression or experiencing some other trauma. Women were anxious about the safety of taking anti-depressants during pregnancy or having their children removed from them. Women also experienced anger and depression.

Women complained of obtrusive, compulsive thoughts involving aggression and violence towards themselves and their unborn child.

Women reported being socially withdrawn or displaying irrational or violent outbursts. Women often reported crying and being tearful when experiencing mental health problems in pregnancy.

Attitudes, perceptions and experience of Health Professionals in Caring for Women with Mental Health Problems in Pregnancy

Midwives and health professionals were aware of those women who might be more susceptible to experiencing mental health problems in pregnancy.

Midwives offered support and care to women experiencing mental health problems in pregnancy through modification of antenatal consultations, validation of a women’s experience and allowing her the opportunity to express her feelings.

Midwives advocate the use alternative therapies, such as aromatherapy and reflexology for women experiencing mental health problems, but found they were sometimes difficult to provide as part of National Health Service care.

Midwives involved health visitors in the care of a woman who was experiencing mental health problems to provide additional insight and continuity of care.

There was considerable variation in the referral powers of midwives in the care of women experiencing mental health problems in pregnancy.

Midwives referred women to mental health services, community psychiatrists, counselling services and mother and infant units. Midwives also referred pregnant women with mental health problems to services such as Home Start and Sure Start.

Perceived Barriers to Providing Care to Women with Mental Health Problems
Focus group participants identified barriers to the provision of appropriate care for women experiencing mental health problems.

- There was a lack of awareness of mental health problems in pregnancy among health professionals, with more emphasis on physical care and care of emotional problems post delivery.

- No clear pathway of referral for women experiencing mental health problems was identified and midwives reported having difficulties in providing adequate mental health services for women.

- Reasons for non-disclosure of symptoms by women was due to misunderstanding of mental health problems, stigma associated with mental illness and women’s inability to validate the experiences they were having.

- A relationship offering continuity and built on trust was important for a woman to disclose the symptoms she was experiencing.

- Midwives felt ill-equipped and inadequate in identifying and caring for women with mental health problems. They lacked skills and the time to effectively care for women with mental health problems. Midwives were not always able to access the training that was available due to staffing issues.

- Alternative therapies were not always available for midwives to offer women.

- Midwives were unable to influence wider policy in the care of women with mental health problems.

- Effective provision of care was sometimes due to the reluctance or the refusal of women to access treatment and services offered.

**Conclusions**

The discussion chapter brought together the findings from women’s experience of mental health problems in pregnancy, the care they received from health professionals and the experiences of those who delivered care to such women.

Similarities and parallels were indentified between the experiences of care of women with mental health problems in pregnancy and the experience of those health professionals who provided care to such women. Analysis of these
similarities and parallels were felt to be potentially useful in informing the provision of appropriate care to women and providing a framework in helping to inform further research, clinical practice and policy in the care of women with mental health problems in pregnancy.

Implications for future research

Implications for clinical practice

The findings of the research project suggest strategies which could be implemented into maternity services and improve the care of women experiencing mental health problems in pregnancy. These include:

- **Interprofessional education or training** for those involved in the care of pregnant women, to resolve some of the tensions clarify roles and responsibilities and provide a more seamless service. The focus group discussions indicated tension in the relationship between midwives and obstetricians in the care of women experiencing mental health problems in pregnancy. Midwives reported dissatisfaction with the responses of GP’s in women’s care and considerable variation in provision of GP services. Midwives felt that as the lead professional in the care of pregnant women they should have direct powers of referral to mental health services.

- **Improved access to non-pharmaceutical interventions** for women in the management and treatment of mental health problems in pregnancy. Where this was not possible, accurate and concise information to women on the safety of taking anti-depressant medication during pregnancy and breast feeding is needed. Women who responded to the internet discussion groups often reported their dissatisfaction with taking anti-depressant medication during pregnancy and many women reported having stopped taking medication when they became pregnant. Health professionals also reported women’s reluctance to take any medication during pregnancy because of the risks to the unborn child. Other services such as counselling were believed by midwives to be a more acceptable intervention to pregnant women. Midwives also believed that other interventions and resources such as self help manuals should be made available for them to offer women experiencing mild to moderate mental health problems.

- **Midwives need to have more flexibility and autonomy** in decisions they make about care provided to pregnant women, including the number of
times they see a woman during her pregnancy. Midwives reported feeling that they were being monitored in the number of visits they provided to pregnant women and this prohibited them from offering women additional support. There needs to be better communication among midwives in their care of pregnant women. Midwives covering other caseloads sometimes did not understand why a woman was being seen outside of her routine scheduled antenatal appointments, when there was no medical indication. Better communication between health professionals through improved note taking and the recognition that women may need more frequent input for emotional and psychological problems as well as medical problems is needed.

- Midwives need to be able to audit the effectiveness of care they offer to women identified as experiencing mental health problems in pregnancy. Midwives strategy of care often involved offering a woman the opportunity to be seen more quickly or offering longer or more frequent appointments. The effectiveness of modifying a woman’s appointments in this way to improve her mental health must be established. Midwives also reported that women’s mood or mental health improved once the referral to the specialist or specialist service was made and before receiving the intervention. Assessment and identification of the elements of care which contribute to the improvement of a women’s mental health need to be established.

- Midwives and other health professionals caring for pregnant women with mental health problems need training in listening and counselling skills, either as part of their undergraduate training or as continuing professional development. Midwives reported that they wanted to offer pregnant women who were experiencing mental health problems more help, but needed more information and training in order to do this. Midwives reported feeling ill-equipped and inadequate in dealing with women who were experiencing mental health problems in pregnancy. In order to identify the source of the problems women were experiencing midwives needed appropriate training in skills to allow the woman to open up and express herself. Midwives needed time in order to attend such programmes
Bibliography


(Stewart 1995,


Published Conference Abstracts

2010 Pregnant women who present with mental health problems: How can midwives be helped to manage their care? Oral presentation, MARCE Conference, Pittsburgh, Pennsylvania.


2009 Pregnant women who present with mental health problems: How can midwives be helped to manage their care? Poster presentation, Society for Reproductive and Infant Psychology, Newcastle-Upon-Tyne, UK.

2009 Pregnant women who present with mental health problems: How can midwives be helped to manage their care? Poster presentation, Thinking Qualitatively, International Institute for Qualitative Methodology, University of Alberta, Canada.

Presentations


2007 Pregnant women who present with mental health problems: How can midwives be helped to manage their care? Research Presentations Day, Mother and Infant, Research Unit [MIRU], University of York.

Appendix 1: literature search strategy
Search terms for women’s experience of depression in pregnancy

depression
anxiety
stress
pregnancy
pregnancy
perinatal
prenatal
qualitative
Interview
dysphoria
mood
anxious
upset
questionnaires
antenatal depression
survey
experience
sad
unhappy
unhappiness
mental health
behaviour mechanisms
psychological processes
psychological principles
mental health
mental health processes
<table>
<thead>
<tr>
<th>Search terms for communication and interaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>communicat$</td>
</tr>
<tr>
<td>talk</td>
</tr>
<tr>
<td>interact$</td>
</tr>
<tr>
<td>discuss$</td>
</tr>
<tr>
<td>consult$</td>
</tr>
<tr>
<td>perinatal</td>
</tr>
<tr>
<td>prenatal</td>
</tr>
<tr>
<td>working together</td>
</tr>
<tr>
<td>midwives</td>
</tr>
<tr>
<td>midwife</td>
</tr>
<tr>
<td>obstetric nurse$</td>
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<tr>
<td>maternity nurse$</td>
</tr>
<tr>
<td>expectant mother</td>
</tr>
<tr>
<td>pregnant wom$</td>
</tr>
<tr>
<td>antenatal</td>
</tr>
<tr>
<td>trimester</td>
</tr>
<tr>
<td>general practice</td>
</tr>
<tr>
<td>GP's</td>
</tr>
</tbody>
</table>
### Search terms for impact or barriers to care

- care
- manage$
- treat$
- therapy
- pregnan$
- diagnosis
- prenatal
- perinatal
- antenatal
- depression
- midwife
- midwife$
- general practitioner$
- GPs
- barriers
- awareness
- clinical practice
- policy
- mental health
- nurse practitioners
- nurse midwives
- training
- education

### Framework for Literature Review

<table>
<thead>
<tr>
<th>Theme</th>
<th>Scope</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background to depression and anxiety in pregnancy</td>
<td>Models of causation [biomedical, social, psychosocial, genetic, ethic] of depression and anxiety in women. Risk factors and predisposing factors, e.g. domestic violence, drug abuse symptoms of depression and anxiety in pregnancy, Prevalence of depression in pregnancy. Maternal mental illness</td>
</tr>
<tr>
<td>Effects of depression and anxiety on</td>
<td>Adverse effects on the woman, fetus</td>
</tr>
<tr>
<td>Section</td>
<td>Content</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Pregnancy and infant,</td>
<td>Effects on obstetrical outcomes</td>
</tr>
<tr>
<td></td>
<td>Effects in psychological development of the child and mother infant attachment</td>
</tr>
<tr>
<td></td>
<td>Effects on relationships, partners</td>
</tr>
<tr>
<td>Pregnant women [experience]</td>
<td>Women’s experiences of disclosure to health professionals, families and friends</td>
</tr>
<tr>
<td></td>
<td>Women’s experience of depression [what is it like for them]</td>
</tr>
<tr>
<td></td>
<td>Symptoms and predisposing factors</td>
</tr>
<tr>
<td></td>
<td>Coping mechanisms</td>
</tr>
<tr>
<td>Communication between women and midwives</td>
<td>Patient-centred communication.</td>
</tr>
<tr>
<td></td>
<td>Effects of behaviour, attitude, language on patient outcomes.</td>
</tr>
<tr>
<td></td>
<td>Verbal and non-verbal communication/patterns of communication during antenatal consultation</td>
</tr>
<tr>
<td></td>
<td>Effectiveness of interventions in improving communication</td>
</tr>
<tr>
<td>Factors affecting provision of care to pregnant women</td>
<td>Midwives awareness of perinatal mental health</td>
</tr>
<tr>
<td></td>
<td>Educational programmes to support midwives management of perinatal mental health issues</td>
</tr>
</tbody>
</table>
Women’s experience

Selection of studies

Design: Studies which used interview or questionnaire surveys to record women’s subjective experience of depression and anxiety in pregnancy were included in the literature review.

Studies were not included if they discussed risk factors for women developing depression or anxiety in pregnancy; if they recorded serious mental illness in pregnancy; if they discussed psychosocial factors associated with women developing depression or anxiety during pregnancy; if they discussed anxiety and depression during pregnancy as a predictor for postnatal depression. Studies were included where they made reference to perinatal depression and where women’s experience of depression and anxiety during pregnancy was included.

Subjects: studies were selected if women experiencing depression and anxiety were recruited during pregnancy or the postpartum.

Outcomes: any subjective experience that women felt was important and that she felt was relevant to her experience of anxiety or depression.


Language: no language restrictions

Type: Published papers
Communication

Selection of studies

Design: Research study using any methodology.

Subjects: midwives and pregnant women during antenatal clinic; health providers and pregnant women during antenatal clinic.

Outcomes: any study which reported on women’s experience of communicating their feelings to health providers and the barriers women face in communicating their feelings; studies were also included which commented on patterns of communication, the use of language and the different characteristics of communication styles used by midwives and other health providers in their communication with women.


Language: no language restrictions

Type: Published papers
Impact on the provision of care

Selection of studies

Design: Research study using any methodology.

Outcomes: Any impacts on the provision of care to women who are experiencing depression and anxiety during pregnancy, including training, education, policy.


Language: no language restrictions

Type: Published papers
Appendix 2: Summary of key literature
<table>
<thead>
<tr>
<th>Study, country</th>
<th>Focus of study</th>
<th>Study design</th>
<th>sample</th>
<th>outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sleath et al 2005, USA</td>
<td>(1) Relationship between ethnicity, presence of severe and moderate depression and (2) communication and feelings during antenatal visits</td>
<td>Self reported identification of ethnicity. Questionnaires measuring self-esteem, social interactions, depression. Open ended questions regarding (1) communication with health provider, (2) barriers to communication, (3) what would make it easier</td>
<td>73 women 12-32 weeks prenatal [25 white, 23 hispanic, 25 African American]</td>
<td>Identified barriers to communication including fear of health professionals perception, language barriers [non-english speaking participants]. Over 80% of discussion of depression during pregnancy was initiated by the health providers. Those women with highest scores on the beck depression inventory were most likely to say there were barriers discussing emotional problems with health providers.</td>
</tr>
<tr>
<td>Study, country</td>
<td>Focus of study</td>
<td>Study design</td>
<td>sample</td>
<td>outcomes</td>
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<tr>
<td>Sleath et al 2005, USA</td>
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<td>Self reported identification of ethnicity. Questionnaires measuring self-esteem, social interactions, depression. Open ended questions regarding (1) communication with health provider, (2) barriers to communication, (3) what would make it easier</td>
<td>73 women 12-32 weeks prenatal [25 white, 23 hispanic, 25 African American]</td>
<td>Identified barriers to communication including fear of health professionals perception, language barriers [non-english speaking participants]. Over 80% of discussion of depression during pregnancy was initiated by the health providers. Those women with highest scores on the Beck depression inventory were most likely to say there were barriers discussing emotional problems with health providers.</td>
</tr>
<tr>
<td>Stanley et al 2006, UK</td>
<td>(1) Explored mothers and practitioners, experience and awareness of antenatal depression and (2) considered the service response offered by midwives and health visitors</td>
<td>Focus group interviews with mothers Postal survey with midwives and health visitors</td>
<td>28 mothers with babies under two years of age [experience of antenatal depression not necessary]</td>
<td>no concept of antenatal depression, no frame of reference, shame, isolation, social and physical transformation, access to support family judgemental, difficult to engage friends, gp's dismissive, barriers included health professionals preoccupation with checklists</td>
</tr>
<tr>
<td>Study, country</td>
<td>Focus of study</td>
<td>Study design</td>
<td>sample</td>
<td>outcomes</td>
</tr>
<tr>
<td>Edge 2005, UK</td>
<td>Illumination of the models, experiences and</td>
<td>In depth interviews Women's narratives</td>
<td>20 black Caribbean women</td>
<td>Black Caribbean women more vulnerable to depression, but</td>
</tr>
</tbody>
</table>
meaning of perinatal depression held by Black Caribbean women and how they coped with personal adversity

Black Caribbean women’s beliefs about depression in pregnancy and how these beliefs influence their actualization to seek help

depression measured using the EPDS sample reflected the diversity of marital status, socio-economic status, adverse life events

less likely to have above threshold depression scores. Did not like the term postnatal depression, but OK with the label of depression in pregnancy. Unfamiliar with depressive illness, reluctance to discuss or acknowledge Depression was a sign of weakness, threatened their concept of strong black women. Having this concept helped them maintain their psychological well-being. Distrustful of doctors [dependence on antidepressants] talking therapies [don’t talk your business] Welcomed dismissal of depressive illness by general practitioners.
Appendix 3: Summary of internet discussion groups
<table>
<thead>
<tr>
<th>Name and website</th>
<th>Objectives</th>
<th>Sponsorship and funding</th>
<th>Philosophy of site</th>
<th>Policy for researchers and journalists</th>
<th>Expertise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babyworld [UK]</td>
<td>provides information and shopping.</td>
<td>commercial online journal – source of funding not specified</td>
<td>none given</td>
<td>must seek permission before posting</td>
<td>fertility experts, midwives, doctors, breast feeding specialists, health visitors and antenatal educator’s</td>
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<td><a href="http://www.babyworld.co.uk">www.babyworld.co.uk</a></td>
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<tr>
<td>Pregnancyweekly [USA and Canada]</td>
<td>provides information, support and advice</td>
<td>not clear</td>
<td>none given</td>
<td>no policy</td>
<td>midwives, obstetricians and child educators</td>
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<td>Netmums [UK]</td>
<td>provides information</td>
<td>BT, Early Learning Centre and <a href="http://www.nickjr.com">www.nickjr.com</a></td>
<td>none given</td>
<td>must seek permission before posting – dedicated forum for media and research requests</td>
<td>none given</td>
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<tr>
<td><a href="http://www.netmums.com/coffeeshouse">www.netmums.com/coffeeshouse</a></td>
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<td></td>
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<tr>
<td>Mumsnet</td>
<td>provides support</td>
<td>not clear</td>
<td>parents make each others lives easier by pooling their knowledge</td>
<td>must seek permission before posting – fee charged</td>
<td>childbirth, postnatal care, childcare and parenting, education, relationships and travel with children.</td>
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<td><a href="http://www.mumsnet.co.uk">www.mumsnet.co.uk</a></td>
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<td>Perinatal Illness UK</td>
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<td>charity – funded through donations</td>
<td>none given.</td>
<td>no policy</td>
<td>not clear</td>
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<td><a href="http://www.pni-uk.com/">http://www.pni-uk.com/</a></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TABLE 1 - INTERNET DISCUSSION BOARDS CONTAINING DISCUSSION OF DEPRESSION IN PREGNANCY**
### TABLE 2 - INTERNET DISCUSSION BOARDS CONTAINING DISCUSSION OF DEPRESSION IN PREGNANCY

<table>
<thead>
<tr>
<th>Name</th>
<th>Moderators</th>
<th>Support</th>
<th>Topics discussed</th>
<th>Framework</th>
<th>How the postings arrive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babyworld</td>
<td>20 moderators with relevant background experience.</td>
<td>from moderators, expertise and other users</td>
<td>infertility, pregnancy, baby care, pregnancy, support and parenting</td>
<td>part of larger website which offers shopping and advice.</td>
<td>from users</td>
</tr>
<tr>
<td>Pregnancyweekly</td>
<td>moderators present – no background information</td>
<td>encourages women to support each other</td>
<td>Pre-conception, pregnancy, parenthood also fashion and beauty</td>
<td>part of a larger website which covers pre-conception, pregnancy and parenting.</td>
<td>from users</td>
</tr>
<tr>
<td>Netmums</td>
<td>moderators present – no background information</td>
<td>from coffeehouse forums, chat rooms and articles</td>
<td>Pregnancy and parenting – also domestic violence, relationships, single parents, special needs and home start</td>
<td>part of larger website which offers local and national support to parents</td>
<td>from users and responses to commissioned articles</td>
</tr>
<tr>
<td>Mumsnet</td>
<td>not clear</td>
<td>from information through commissioned articles</td>
<td>mainly pregnancy and child development – also education, childcare, travel and finances</td>
<td>part of larger website which offers advertisement, shopping and information to parents</td>
<td>from users and responses to commissioned articles</td>
</tr>
<tr>
<td>Perinatal Illness UK</td>
<td>moderators present – limited background information available</td>
<td>from moderators</td>
<td>antenatal and postnatal illness.</td>
<td>website dedicated to information and discussion</td>
<td>from users</td>
</tr>
<tr>
<td>Name and website</td>
<td>Objectives</td>
<td>Sponsorship and funding</td>
<td>Philosophy and principles of site</td>
<td>Policy for researchers and journalists</td>
<td>Expertise</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>------------------------------------------------</td>
<td>-------------------------</td>
<td>-----------------------------------</td>
<td>----------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Cow &amp; Gate [UK]</td>
<td>not clear</td>
<td>from Nutricia Ltd.</td>
<td>none given</td>
<td>no policy</td>
<td>midwives, dieticians and nutritionists</td>
</tr>
<tr>
<td><a href="http://www.cowandgate.co.uk">www.cowandgate.co.uk</a></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baby Centre [UK]</td>
<td>provide information, support and advice</td>
<td>from Johnson &amp; Johnson.</td>
<td>none given</td>
<td>no policy</td>
<td>gynaecologists, counselors, dentists and physiotherapists</td>
</tr>
<tr>
<td><a href="http://boards.babycentre.co.uk/n/pfx/">http://boards.babycentre.co.uk/n/pfx/</a></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression-in-pregnancy [UK]</td>
<td>provide information and support</td>
<td>not clear</td>
<td>none given</td>
<td>no policy.</td>
<td>midwife, counsellor and homeopath.</td>
</tr>
<tr>
<td><a href="http://www.depression-in-pregnancy.org.uk/">www.depression-in-pregnancy.org.uk/</a></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mybounty [UK]</td>
<td>provide support</td>
<td>not clear</td>
<td>none given</td>
<td>no policy</td>
<td>none</td>
</tr>
<tr>
<td><a href="http://mybounty.com/">http://mybounty.com/</a></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### TABLE 4 - INTERNET DISCUSSION BOARDS CONTAINING DISCUSSION OF DEPRESSION IN PREGNANCY

<table>
<thead>
<tr>
<th>Name</th>
<th>Moderators</th>
<th>Support</th>
<th>Topics discussed</th>
<th>Framework</th>
<th>How the postings arrive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cow &amp; Gate</td>
<td>none</td>
<td>telephone and e-mail support from advisors</td>
<td>pregnancy, birth, childcare and post natal – also family life, fashion and beauty</td>
<td>part of larger commercial website</td>
<td>from users</td>
</tr>
<tr>
<td>Baby Centre</td>
<td>moderated by community managers</td>
<td>from “ask the experts”</td>
<td>pre-conception, pregnancy and parenting.</td>
<td>part of larger website which promotes Johnson &amp; Johnson baby products</td>
<td>from users</td>
</tr>
<tr>
<td>Depression-in-pregnancy</td>
<td>moderated by site administrators</td>
<td>from “depression in pregnancy” team</td>
<td>depressive illness in pregnancy</td>
<td>dedicated website to discussion and information</td>
<td>from users</td>
</tr>
<tr>
<td>Mybounty</td>
<td>not clear</td>
<td>from other users.</td>
<td>pre-conception, pregnancy, childcare – also diet, fitness, adoption, hobbies</td>
<td>part of larger website which gives information on pregnancy and child development – also competitions, news reports, surveys and articles</td>
<td>from users</td>
</tr>
</tbody>
</table>
Appendix 4: Approval letter from Health Sciences Research Governance Committee
Appendix 5: Correspondence from Chief Executive Officer, PNI-UK
18th October 2007

Dear Ms Charteris

Re: Pregnant women who present with mental health problems at antenatal clinic: How can midwives be helped to manage their care?

I am a research fellow at the Mother and Infant Research Unit, University of York working on the above research, funded by the Burdett Trust for Nursing, an independent charitable trust whose grants support the contribution of midwifery and nursing to healthcare. My professional education includes nursing and midwifery and for the past twelve years I have worked on several projects researching aspects of women’s health in pregnancy. Supervision for the research is provided by Professor Josephine Green, Professor of Psychosocial Reproductive Health and Ms Helen Spiby Senior Lecturer (Evidence based practice in midwifery).

We consider that it is important to understand women’s experiences of depression in pregnancy because of the adverse effects this illness has on the mother, her family and her infant. However, approaching women when they are actually experiencing depression or after they have recovered from depression poses ethical and methodological problems. I am therefore writing to you as moderator to explore the possibility of accessing the archives of PNI-UK.

I am seeking permission to access and analyse archived postings to obtain insights into women’s experience of depression and their experience of disclosure to midwives. I realise that members of internet communities do not expect their postings to be accessed by researchers and some may consider this to be an intrusion of their privacy. I have given the privacy of contributors much consideration and I am following the guidelines published by the British Psychological Society on conducting research on the internet. I would, therefore, wish to notify users of the website about the planned research through a posting on the bulletin board, if that is acceptable.
This would provide contributors with the opportunity to indicate a preference not to have their postings included in analysis. With the privacy of contributors in mind and to reduce the possibility of tracing the identity of participants, direct quotes would not be used in any reports of the research, only paraphrasing and short direct quotes that are not easily traceable.

This phase of the proposed research has been peer reviewed and approved by the University of York’s department of Health Sciences’ Research Governance Committee.

I would welcome the opportunity to discuss the research with you either by telephone or in person. An email to pmj502@york.ac.uk is the best way to contact me. I look forward to hearing from you.

Yours sincerely

**Patricia Jarrett**

Research Fellow

Cc Professor Josephine Green
Ms Helen Spiby, Senior Lecturer (Evidence based practice in midwifery)
Tuesday 30th October 2007

Dear Patricia,

Thank you for your e-mail and letter regarding your research and using the archives from PNI-UK.

We don't allow anyone access to the archives partly for the reasons you have stated, but above all, because our services are offered to mothers and families on the following basis.

Firstly, we are here to protect them and to offer them a place of safety where they can confide in our staff, often when the statutory services have failed them.

Secondly, those mothers who are afraid of approaching the statutory services in the first instance are encouraged to contact us in the hope they will build up a trusting relationship with our staff and eventually they will seek the treatment they need, in order to stabilise their clinical symptoms.

Protecting the parents and offering them a 'safe place to go' is our first and main priority.

What I would suggest however, is for you to devise a research tool which we can place on the website for mothers to answer? We have done this before and announced to the parents our intentions and reasons for doing this, because we are constantly asked to provide research for many projects. We are selective about taking on such projects, but when we do it is on the following basis.

1. PNI-UK has a contract with the research body in question to outline certain details;
2. PNI-UK is mentioned in the research paper for its input.
3. Any expenses arising for uploading the website, maintaining that area of the website which holds the research material etc, is paid for by the researcher or the professional body they represent.

This list is not exhaustive, but it demonstrates some of the conditions outlines in the contract we use.

By seeking the permission of families, we are aware of many who would be willing to participate.

However, we are aware of some mothers, who may question our motives because of the very symptoms their illness induces.

As we are asked so many times for help with research, it is a fine line to have a website which is designed primarily for supporting ill mothers and families, but along with this to balance the demand for requests with vital research, which we as a registered charity acknowledge is necessary.

I hope this clarifies our policy.

Please contact me again if I can help you further.
Yours sincerely,
Deborah Morgan-Graham BSc (Hons) RN C ITEachingCert, ENB 100, ACLS, Fd Mgt Cert, 
CEO Perinatal Illness-UK
Contract between Perinatal Illness-UK and the Mother & Infant Research Unit, University of York

1) PNI-UK will advertise your questions/research on our website for women to answer if they wish to and will set up a separate area on the website for women to post their accounts.

2) Any costs incurred by us in order to do this will be met by the University of York, (Mother & Infant Research Unit) up to a maximum of seventy pounds sterling. Based upon the figure given by Jill Studholme of one hour’s work at £35 per hour and allowing for a margin of error.

3) Any research we place on the site is subject to the Terms and Conditions of the PNI-UK website with the exception of the data, which belongs to PNI-UK until payment is made whereupon receipt of payment, it is then the property of University of York: Mother & Infant Research Unit.

4) PNI-UK will not be held liable for the failure of mothers deciding not to answer the research questions. Placing the research on PNI-UK website constitutes an 'as is' usage of the said website, as per Terms and Conditions of the PNI-UK website.

5) Confirmation of the above conditions and adherence to the Terms & Conditions of PNI-UK website are to be agreed and sent in writing.

6) Any other information from the PNI-UK website used for this research will be based only on information that is publicly accessible.

7) Perinatal Illness-UK will be referred to in publications and reports to funders using our full name, charity registration number and reference to our website.

8) It is not expected that the Mother & Infant Research Unit will offer advice or support to mothers who respond. Perinatal Illness-UK will respond to such mothers just as if they had made their postings elsewhere on the PNi-UK discussion board.

D.Morgan-Graham CEO
Perinatal Illness-UK
Appendix 6: “Banner” and Questions for “invited” postings
Do you have experience of feeling depressed during pregnancy?

An ongoing study at the Mother & Infant Research Unit, University of York is aiming to improve the care of pregnant women who feel depressed during pregnancy.

We particularly want to hear women’s experiences of the ways in which midwives and GPs have or have not been helpful.

We would be most grateful for your postings on this site telling us about your experiences. Maybe you did not want to talk to your midwife or GP. If so, we’d be interested to know why not. If you did talk to them, was it easy to do? Was there anything that they did which made it easier or more difficult? Were they able to help?

We look forward to your postings. Anything around this topic will be potentially useful to us in helping to improve women’s care.

The study is funded an independent charity, the Burdett Trust and has been approved by the Health Sciences Research Governance Committee at the University of York. If you would like to know more about the Mother & Infant Research Unit, please see www.york.ac.uk/healthsciences/research/miru.htm.

Thank you, in advance for your help which is much appreciated.

Please note that we will not be responding to postings here other than to say thank you. Please continue to use the antenatal message board if you are seeking advice and support.
Appendix 7: Tables showing quantitative analysis of “archived” internet postings
<table>
<thead>
<tr>
<th>Gravida</th>
<th>Gestation</th>
<th>Reason for posting</th>
<th>Currently pregnant</th>
<th>Previous history of depression</th>
<th>Anti-depressants</th>
<th>Family support</th>
<th>Profess support</th>
</tr>
</thead>
</table>
| A A(24) | ✗ 30/40   | -sorry you are feeling low  
- share similar experiences | ✓ | ✗ | ✗ | ✗ | ✗ |
| Amanda d(29)* | ✗ ✗ | -share similar experience  
- send hugs | ✓ | ✗ | ✗ | ✗ | ✗ |
| Amanda L(11)* | 3 ✗ | -starts thread  
- explains feelings  
- feels selfish to have another baby | ✓ | Felt like this with other pregnancy  
but not this bad | ✗ | husband says it is her hormones | ✗ | |
| Amber E* | ✗ ✗ | ✗ | ✗ | Found it hard when baby was little and  
and got very down  
now feel like crying | ✗ | ✗ | ✗ |
| Amy S* | 3 26/40 | feeling the same way  
[share similar] | ✓ | PND with first baby  
PND after | stopped anti-depressant medication | -husband is my rock  
husband - | Have a CPN  
who comes to see me all | |
<table>
<thead>
<tr>
<th>Experience</th>
<th>Advised</th>
<th>Referral to see CPN or get some other help</th>
<th>Miscarriage</th>
<th>when pregnant with third child – very bad morning sickness Need the medication to feel normal again but don’t want to take it while I’m pregnant</th>
<th>works shifts but want him with me all the time - dependancy straining our relationship - none of my family knows except husband. - Mother told me to pull myself together when I had PND</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amy T (35)</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>depression during pregnancy, felt better after baby born</td>
<td>no strength to go shopping with friends</td>
</tr>
</tbody>
</table>
| **Angela F*** | 2 | 31/40 | has anyone had depression in pregnancy?  
Cannot cope some days | ✓ | PND with first baby  
Depression with this pregnancy. | put on anti-depressants one year after delivery  
[feel failure] reluctant to take anti-d’s in this pregnancy | ✓ | ✓ |
| **Angie W(7)** * | multip | 8/40 | Can I offload to you?  
Is there anyone who can relate [to my experience] and offer supportive and positive words?  
Thank you for advice from another member  
dissapointed that no one responded – compounds her | ✓ | have anxiety attacks and low level anxiety with this pregnancy  
- had the same with first pregnancy and upset that it has returned with this pregnancy  
anxiety and depression at different time [last 10 yrs] but | ✗ | feel isolated | feel isolated  
will ring my midwife |
<table>
<thead>
<tr>
<th>Name</th>
<th>Age/Week</th>
<th>Share Experience</th>
<th>Vulnerability</th>
<th>Doing Great for Years</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anne C(12) *</td>
<td>×</td>
<td>×</td>
<td>please see your midwife</td>
<td>depression with pregnancy</td>
<td>didn’t tell anyone sat in silence and wish I hadn’t</td>
</tr>
<tr>
<td>Anne m(217) *</td>
<td>×</td>
<td>×</td>
<td>share similar experience</td>
<td>PND and feeling suicidal</td>
<td>×</td>
</tr>
<tr>
<td>Anon (1) *</td>
<td>2</td>
<td>14 – 26 weeks</td>
<td>share experience</td>
<td>PND prior to getting</td>
<td>×</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>been on antidepressants</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Multiparity</td>
<td>Age</td>
<td>Symptoms and Experiences</td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------</td>
<td>-------------</td>
<td>-----</td>
<td>--------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anon (8)*</td>
<td>multip</td>
<td>20+/40</td>
<td>Do I need tablets? Thank you for advice Good to know not alone last birth horrific pregnant again – feel in turmoil about this pregnancy from start Depression not same as before [has had it twice before] for a few months towards husband – hasn’t left me yet antenatal depression wasted my time with the general practitioner – nothing he could do cause I am pregnant - said to talk to people,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>APRIL T(3)*</td>
<td>multip</td>
<td>✓</td>
<td>Is it me? Is it hormones? ✓ had depression and PND and OCD ✓ Feel alone, lonely, misunderstood, want some affection from my</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Multiparity</td>
<td>Respond/Want to Respond</td>
<td>Advice</td>
<td>Feel Low and Stressed This Pregnancy</td>
<td>Boyfriend/Want to Talk to Boyfriend</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------</td>
<td>-------------------------</td>
<td>--------</td>
<td>--------------------------------------</td>
<td>------------------------------------</td>
</tr>
<tr>
<td>Ari R*</td>
<td>multip</td>
<td>×</td>
<td></td>
<td></td>
<td>×</td>
</tr>
<tr>
<td>Barbara M(7)*</td>
<td>multip</td>
<td>×</td>
<td></td>
<td></td>
<td>×</td>
</tr>
<tr>
<td>Beccy H(3)*</td>
<td>multip</td>
<td>×</td>
<td></td>
<td></td>
<td>×</td>
</tr>
<tr>
<td>Name</td>
<td>Age</td>
<td>Read</td>
<td>Talked about her experience of PND only</td>
<td>PND only</td>
<td>Advice</td>
</tr>
<tr>
<td>------------------</td>
<td>-----</td>
<td>------</td>
<td>-----------------------------------------</td>
<td>----------</td>
<td>--------</td>
</tr>
<tr>
<td>Beth B(21) *</td>
<td></td>
<td>×</td>
<td>Talked about her experience of PND only</td>
<td>×</td>
<td>PND only</td>
</tr>
<tr>
<td>Candy C(7) *</td>
<td>2</td>
<td>×</td>
<td>Never knew you could suffer depression like this in pregnancy and wonder if anyone else feels this way? Anyone any advice?</td>
<td>✓</td>
<td>PND after first baby and never returned to the person I was now resentful [of pregnancy] and guilty</td>
</tr>
<tr>
<td><strong>Cara S(8)</strong></td>
<td>3</td>
<td>39/40</td>
<td>Share her experience</td>
<td>came off anti-ds when pregnant - started to feel bad again, cpn advised to go back on anti-d’s [sertraline] told to come off them before delivery but now really bad and advised to go back on them again. Disappointed to be on the anti-ds again but feel better on them</td>
<td>spoke to my step mum and she was supportive but kept thinking that she would be talking about me and say that I was a bad mum – feel paranoid</td>
</tr>
<tr>
<td>Name</td>
<td>Age</td>
<td>Occupation</td>
<td>Comments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------</td>
<td>-----</td>
<td>------------</td>
<td>--------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Carla R(10)*  | 2   | 16/40      | - respond to posting
- reassure
“you will be a brilliant mum”
- share experience
- go and see your GP
✓                                                                 |
|               |     |            | (1) suffered from depression for a long time
(2) time esp when pregnant with little boy
on citalopram with first pregnancy and fluoxetine with second
met people at baby massage and at Rhythm time |
| Caroline M(31)* | 2   | ×          | - reassurance
- share experience
- you are not alone feeling this
✓                                                                 |
|               |     |            | worried what a new baby will do to our relationship
×                                                                 |
| Christine D*  |     | ×          | advice, reassurance and caring attitude
×                                                                 |
|               |     |            | ×                                                                 |
| Claire E(112)* |     | ×          | sharing her experience[s] with another member
✓                                                                 |
|               |     |            | - have nothing to compare it to, so never know if what I am feeling
✓                                                                 |
|               |     |            | Husband really good and lovely.
×
another member well is normal mood swings, one minute I say that I love my husband the next minute I hate him phase feel highly emotional and stressed, unhappy wanted a baby for years

| Claire J(13) |  |  | sympathise share experience advised to see mw or gp | sick until 16/40 felt so exhausted all the way through pregnancy really tough |  |  |  |
| claudia k(4)* |  |  | -empathise with member depressed in pregnancy sending |  |  |  |  |  |

110
<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Gender</th>
<th>Hugs</th>
<th>Reassurance</th>
<th>Depression</th>
<th>Common with assisted deliveries</th>
<th>Midwife and GP should give support</th>
<th>Depression – not clear when</th>
<th>Members of my family look down on me because I have depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dawn m(17)*</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Deborah G(4)*</td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Debra a(2)*</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
<td>support, advice, caring [xxxx]</td>
<td>support and encouragement for</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Delyth J*</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
<td></td>
<td>seeking help</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Donna C(9) *</td>
<td></td>
<td></td>
<td>her unborn child</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
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<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Donna H*</td>
<td>Netmums Coffee House Team: Parent Supporter</td>
<td></td>
<td>sympathise did not want to read and run advice</td>
<td></td>
<td>know how hard it is with bump and LO</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ellizabeth s(133) *</td>
<td>Primip</td>
<td></td>
<td>we will do whatever we can to help you – keep posting Do you think you could give your midwife a ring?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ellie B*</td>
<td>2</td>
<td>36/40</td>
<td>I honestly don’t think I can do this for another 24 days glad</td>
<td></td>
<td>PND with first child mw dx AND with this pregnancy not coping</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Dr put on anti-ds as soon asap

Dr said you will be fine, I am not going to Rx anything
Consultant is
Emma (23) multip nearly term reponse to women debate about safety of taking anti-d’s in pregnancy ✓ PND and AND depression with this pregnancy on anti-ds and told to come off [due shortly] On half a dose to minimise the risk of baby having a withdrawal. ×

Emma H (669) 3 20/40 Being ✓ pains, no OH is getting my midwife
<table>
<thead>
<tr>
<th>Name</th>
<th>Multip</th>
<th></th>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>emma k(185)*</td>
<td></td>
<td>supportive by sharing experiences</td>
<td>energy and starting to get me down</td>
<td>is starting to get short with me cuase he cant understand what is going on</td>
<td>said she was glad that I told her I was feeling low and put me in touch with health visitor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>fiona r(116)</td>
<td></td>
<td>Being supportive by sharing experiences</td>
<td>felt dreadful with my 3rd pregnancy. spots [which got me down] had no energy and was as sick as a dog improved towards 20/40 weeks</td>
<td></td>
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</tr>
<tr>
<td>Gail B(14)*</td>
<td></td>
<td>sharing her experiences reassuring</td>
<td>1st pregnancy was fine but the 2nd tired</td>
<td></td>
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</tr>
</tbody>
</table>

DH said all I did was moan
<p>| Geraldine D(3)* | 2 | ✗ | • HUGS shared her experience • advised her to speak with her mw we are here to support you pm if you want to talk • AND and PND in both pregnancies • mood swings one day I did not want to see anyone then upset because no one wanted to see me |  |
| Getule@ | 4 | 13/40 | ✓ | • sharing experience • Could this be hormonal or something more serious? • AND depressed, stressed and upset and feel I just want to die felt so down feel something terrible is going to happen • partner works till late then goes out with his friends until early morning, he really is useless when it comes to home life and I think I am beginning |  |</p>
<table>
<thead>
<tr>
<th>Username</th>
<th>Multiparous</th>
<th>Age Group</th>
<th>Text Note 1</th>
<th>Text Note 2</th>
<th>Text Note 3</th>
<th>Text Note 4</th>
<th>Text Note 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>hannah (203)*</td>
<td>multip</td>
<td>34/40</td>
<td>congrats sharing experiences and recommendations for treating depression in pregnancy</td>
<td>✓</td>
<td>Suffered with PND after the birth of my second child. This pregnancy wakes between 2 – 4.30 am [symptoms of pregnancy]</td>
<td>anti-depressants? for PND really eased it</td>
<td>offered counselling during her second pregnancy</td>
</tr>
<tr>
<td>Hayley M(102)</td>
<td>×</td>
<td>×</td>
<td>share experience see your doctor or midwife</td>
<td>×</td>
<td>anemia caused me to be miserable</td>
<td></td>
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<tr>
<td>HAYWARD@</td>
<td>×</td>
<td>×</td>
<td></td>
<td>×</td>
<td>feeling really bad to-night</td>
<td>taken too many</td>
<td></td>
</tr>
<tr>
<td>User</td>
<td>Multiparity</td>
<td>Other Comments</td>
<td>Supporting Comments</td>
<td>Diazepam and drank far too much red wine</td>
<td>Other Comments</td>
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<tr>
<td>Heidi R(38)*</td>
<td>multip</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
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<td></td>
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<td></td>
<td>my mother is making me depressed</td>
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<tr>
<td>Helen (512)*</td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>✓</td>
<td>✓</td>
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<td></td>
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<td></td>
<td></td>
<td>snappy with her husband when depressed and pregnant</td>
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<tr>
<td>HEPPERS103@</td>
<td>Primip</td>
<td>×</td>
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<td>my partner tells me I’m silly</td>
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<td></td>
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<td></td>
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<td>speaking to people about how I was feeling</td>
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<td></td>
<td>when</td>
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<tr>
<td>jenni s (4)*</td>
<td>✗</td>
<td>✗</td>
<td>sharing experience [relate to similar experience] support reassurance</td>
<td>✗</td>
<td>acting irrationally and being powerless to stop it</td>
<td>✗</td>
<td>✗</td>
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<tr>
<td>Jennifer C(12)*</td>
<td>✗</td>
<td>✗</td>
<td>offering advice to another</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Member</td>
<td>Multiparity</td>
<td>Age (wks)</td>
<td>Advice</td>
<td>Description</td>
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<tr>
<td>Member re: relaxation and being on her own postnatal</td>
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<tr>
<td>Offering sympathy and advice please tell your midwife suggests counselling encourage to try meds offer to contact her if suicidal</td>
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<tr>
<td>Have had depression but does not say when</td>
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<tr>
<td>Member</td>
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<tr>
<td>Jodi H(10)</td>
<td>multip</td>
<td>38/40</td>
<td>advice to other member try and relax shares her experience it is worth telling your</td>
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<tr>
<td>Have suffered depression in the past [due to bad events] suffered PND diagnosed with</td>
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<tr>
<td>Agreed to take citalopram and am beginning to feel more focused and getting there. I am pleased I made that</td>
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<td>A couple of my friends have admitted to feeling low and tearful</td>
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<tr>
<td>My consultant and midwife are taking my problems very seriously and are keeping a close eye on</td>
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</tr>
<tr>
<td>Jonathon S(2)*</td>
<td>male contributor</td>
<td>advice to assemble a team including friends and professional help</td>
<td>midwife how you feel</td>
<td>antenatal depression at 36/40 [this pregnancy] this time I feel I am managing a lot better</td>
<td>have dad depression for the last four years and with the last 3 pregnancies. I had terrible depression with with my second daughter I am a born worrier</td>
<td>decision for me it was the best one</td>
<td>me my midwife has been great have included my hv in conversation so everyone aware of what is going on</td>
</tr>
</tbody>
</table>

* Jonathan S(2) is the name used by the contributor in the study.
<table>
<thead>
<tr>
<th>Name</th>
<th>Advice</th>
<th>Exercise</th>
<th>Feel Better Soon</th>
<th>Member Response</th>
<th>Depression</th>
<th>PND Birth of First Child</th>
<th>Outbursts with This Pregnancy</th>
<th>Anti-Depressants</th>
</tr>
</thead>
<tbody>
<tr>
<td>julie h(397)*</td>
<td></td>
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<tr>
<td>kale, M(3)*</td>
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<tr>
<td>Karen H(49)*</td>
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<tr>
<td>Kate A(108)</td>
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</tr>
</tbody>
</table>

- Keeping a diary
- Diet and exercise
- Good wishes
- Don't stress yourself
- See your GP
- Respond to member
- Hope you feel better soon
- Go and see your GP and tell them you are depressed
- PND after birth of first child
- Get the same uncontrollable outbursts with this pregnancy
- Took Prozac the whole way through pregnancy

- Shares experience
- Took meds during preg
<table>
<thead>
<tr>
<th>Name</th>
<th>Status</th>
<th>Age</th>
<th>Experience</th>
<th>Advice</th>
<th>Postnatal Depression</th>
<th>Other Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kate H(25)*</td>
<td>multip</td>
<td></td>
<td></td>
<td>advice you can take antipsychotics during pregnancy maybe counselling would help please ask for help now, the sooner you get it the better</td>
<td>PND only PND with first and second baby</td>
<td></td>
</tr>
<tr>
<td>Katherine E(18)*</td>
<td></td>
<td>25/40</td>
<td>share experience advice to other member – talk to your doctor, midwife or local self-referral</td>
<td>not eating or sleeping</td>
<td></td>
<td>doctor has been helpful my doctor has been lovely and wants me to talk to someone</td>
</tr>
<tr>
<td>kathy f(6)*</td>
<td></td>
<td></td>
<td></td>
<td>reassurance its natural to worry Have you tried to speak to your</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midwife</td>
<td>Multiparity</td>
<td>Experience</td>
<td>Description</td>
<td></td>
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<tr>
<td>Katie G (36)*</td>
<td>×</td>
<td>×</td>
<td>don’t suffer from anxiety and no advice but happy to listen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Katie H (6)</td>
<td>multip</td>
<td>×</td>
<td>share experience you can get antenatal depression</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Katie H (6)</td>
<td>multip</td>
<td>×</td>
<td>Excited in pregnancy but sometimes feel a bit trapped – wake up in the middle of the night and couldn’t bear anything on top of me.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Katies 2</td>
<td>2</td>
<td>×</td>
<td>hope this helps sharing experience about taking anti-depressants in pregnancy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Katies 2</td>
<td>2</td>
<td>×</td>
<td>AND anxiety and found pregnancy hard mentally worried about getting PND again really struggled</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Katies 2</td>
<td>2</td>
<td>×</td>
<td>went on meds during my pregnancy – helped lift my mood and settle my anxiety on seratoline when</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Midwife**

- Katie G (36)*

  - don’t suffer from anxiety and no advice but happy to listen

- Katie H (6)
  - multip
  - share experience you can get antenatal depression
  - Excited in pregnancy but sometimes feel a bit trapped – wake up in the middle of the night and couldn’t bear anything on top of me.

- Katies 2
  - 2
  - hope this helps sharing experience about taking anti-depressants in pregnancy
  - AND anxiety and found pregnancy hard mentally worried about getting PND again really struggled
  - went on meds during my pregnancy – helped lift my mood and settle my anxiety on seratoline when
with the pregnancy – didn’t realise how much til I had the baby and started to feel much better

rough pregnancy with my dd suffered badly after my dear son was born

really rough pregnancy with my dd – on top of this I worried about everything and was convinced I would go mad as soon as she was born
| **KELLY C(126)** | 2 | 30/40 | need to get this out  
Shares experience  
need to get it out – know that I am horrible and don’t deserve to be happy | ✓ | AND with first baby and ?then pnd [Rx anti-depressants after delivery] now pregnant and feeling really bac | ✓ | on anti-d after delivery of first baby but stopped them [reduced due to preg and then stopped felt sick] and feeling bad now [gone back down to my lowest in short space of time] | ✓ | husband threatens to take children off her cause of her depressive history  
he is the only one that knows I have managed to keep it from my family and I don’t have friends who would care  
20 years old |
<p>| <strong>Kelly H(18)</strong> | × | × | no advice, just hugs have you friends talk to your mw | ✓ | depressed [don’t know why] but perhaps because of all the problems I have had with this pregnancy. | × | × | × |</p>
<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Week</th>
<th>Score</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>KELLY K(6)</td>
<td>2</td>
<td>20/40</td>
<td>✓</td>
<td>Any advice? Anyone else felt like this? it is doing my head in share experience PND from first baby and feel depressed and low with second pregnancy for no reason [AND] feel unusual at times</td>
</tr>
<tr>
<td>Kerry L(5)</td>
<td>3</td>
<td>24/40</td>
<td>✓</td>
<td>know exactly how you feel pm me we are suffering similar things advice alternative therapy, walk, getting out and about share experience PND x 2 after first two babies now feeling crappy and the baby isn't here yet [AND] Dreading have PND this time around</td>
</tr>
<tr>
<td>Kimberley D(3)</td>
<td>×</td>
<td>28/40</td>
<td>×</td>
<td>Did anyone worried × feel better if mw my doctor said I had PND from the first pregnancy but I don’t think it is</td>
</tr>
<tr>
<td><strong>Laura B (22)</strong></td>
<td><strong>Multip</strong></td>
<td><strong>X</strong></td>
<td>can you go to see your GP or MW about speaking with someone?</td>
<td>some meds safe to take in pregnancy?</td>
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<td></td>
<td>yes</td>
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</tbody>
</table>
| **Laura H (36)** | ✓ | 39/40 | If I can get through the next few days will be OK
Do you think if I explained all this to the midwife they will induce me soon?
the waiting for the birth is adding to the anxiety | ✓ | AND can't cope with the preg had depression disorders in the past [does not state whether specific to pregnancy
anxiety, tears and can’t cope | dr did not want mum to got on meds when preg – risks to baby | young single mum
I feel alone | Gp was not much good – referred to counselling and still have no appointment [3 months later] he does not want me to take meds – risks to baby
I will see my midwife – hopefully I can be brave and tell her everything |

<p>| <strong>Lisa D (292)</strong> | ✗ | ✓ | share experience it might be worth talkig over with your midwife | ✓ | I have been very teary eyed during both pregnancies | ✗ | my husband is a little scared of me and one minute I am going on |</p>
<table>
<thead>
<tr>
<th>Lisa E(20)*</th>
<th>×</th>
<th>18/40</th>
<th>reponse to other member share experience hope you find some help and feel better</th>
<th>✓</th>
<th>experiencing panic attacks and stress and feeling low in pregnancy</th>
<th>×</th>
<th>×</th>
<th>×</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lisa H(505)*</td>
<td>Primip</td>
<td>18/40</td>
<td>P1 twins [IVF] share experience why do I feel so down?</td>
<td>✓</td>
<td>cryin,cant cope with this pregnancy feels trapped want my life back</td>
<td>husband supportive [wonderfull and comes to every mw appt] but busy m-i-l is not supportive [tells you things you have done wrong]</td>
<td>seeing mw</td>
<td></td>
</tr>
</tbody>
</table>
hobby and I are not in the same bed at the moment and haven't had sex since the treatment started [scared miscarry] I worry if the relationship will cope want our life and relationship back and need a big cuddle tired so don’t see my mates much

| Lisa R(23) | 2 | 32/40 | sharing experience wondering if anyone else has been through the same and | PND with first baby went undiagnosed for 9 months, then went on antidepressants for six | Doctor said he would not normally give antidepressants when pregnant because of | my partner has been great my little boy is picking up on it and mostly wants his dad |
| If the doctor is not helpful I have an appointment with the CPN to fall back on | Saw a cpn |
| what will happen next | months came off the anti-ds when pregnant with second child now feel low and depressed [AND] and all over the place] feels like it did when I had AND was not offered any alternative or counselling I think I am feeling depressed at the minute – just not looking forward to having the baby at all I came off the implications for the baby and unless you were going off your rocker. I don’t want to have to take something unless I have to. Dr did not know last time what meds were safe to take in pregnancy I am confused what is safe and what is not safe to take in pregnancy the doc I saw the last time Spoke to my partner and my mum about going back on meds and they said it would make the baby deformed. I feel embarrassed when I talk to other people about being depressed, Only really talk to people that I am close to. I find it hard talking to my mum about it as I feel she constantly | and she was so unsympathetic and not understanding at all seeing cpn |
the tablets because the doctor said I had to
Feel like I am on the road back to pnd depression again
pnd with first child
said I should come off tablets double quick and I was really ill
had counselling but really did not like it
after telling the doc that I had suicidal thoughts she said that she could see no reason why not Rx meds – but would check with cpn – don’t think doc wants to take the resps – could have done with starting them to-day came
judges me. affecting relationship with son and husband
<table>
<thead>
<tr>
<th>Lisa W(105)*</th>
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</thead>
<tbody>
<tr>
<td>share experience</td>
<td>send big hug</td>
<td>know how desperate you can feel</td>
<td>pm me if you need to talk</td>
<td>I had pnd and suffered from depression and ocd for a number of years</td>
<td>my OH is supportive but sees it all in black and white men are such idiots sometimes</td>
<td>OH did not really get his head round that we were having a baby</td>
</tr>
<tr>
<td>Lisa@</td>
<td>Administrator moderator but also</td>
<td>advice support and caring</td>
<td>infers that she had depression with other</td>
<td>know how hard it was to stay on meds but out of</td>
<td>seeing perinatal psychologist and who</td>
<td></td>
</tr>
<tr>
<td>Liz B(10)*</td>
<td>had antenatal depression</td>
<td>get GP to refer you to perinatal psychiatrist</td>
<td>pregnancies AND four children</td>
<td>feels they are good at explaining things</td>
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<td></td>
<td>G4</td>
<td>shares personal experience</td>
<td>this is the first time I have been so well – no pni at all</td>
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<td></td>
<td></td>
<td>have support network in place</td>
<td>on meds during 4^{th} pregnancy</td>
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<td>has your midwife been helpful?</td>
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<td></td>
<td>Advice, reassurance</td>
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<td>advice on antidepressants</td>
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<td>I know how you feel</td>
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<td>Talk to your doctor</td>
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<td></td>
<td>sympathise</td>
<td></td>
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<td></td>
<td></td>
<td>have you spoken to</td>
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<td></td>
<td></td>
<td>sickness in pregnancy – exhausting – home from</td>
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<tr>
<td><strong>lois m</strong>*</td>
<td>2</td>
<td>✗</td>
<td>your mw or gp to check you over</td>
<td>work, eat and go to bed</td>
<td>✓</td>
<td>✓</td>
</tr>
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</tbody>
</table>
| **Thought I would be the only one to feel like this glad that people reply to how I feel**
| | | | wonder if anyone had experienced anything similar | upbeat with first pregnancy but with this pregnancy can hardly drag myself out,[AND] I look terrible and feel so tired - felt like this for the last week wondering if it is a sign that I am going to suffer from PND this time | ✗ | ✓ | ✓ | ✓ |

<p>| <strong>LORRAINE S(9)</strong>* | 5 | ✗ | share experience advice to other member – | PND when pregnant with third baby when pregnant go on anti-ds [?after delivery]had to come off because of preg no 4 | | | |
| | | | | husband supportive fantastic | | | |</p>
<table>
<thead>
<tr>
<th><strong>Louise w(62)</strong>*</th>
<th>2</th>
<th>*</th>
<th>share experience</th>
<th>×</th>
<th>PND with first and scared of getting it again when pregnant with my second - got very down in pregnancy</th>
<th>×</th>
<th>×</th>
<th>HV was good – friendly ear – visited throughout pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>manda@</td>
<td></td>
<td>*</td>
<td>advice about breast fed babies and protection against eczema</td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>×</td>
</tr>
<tr>
<td><strong>Mary D(58)</strong>*</td>
<td></td>
<td></td>
<td>advice re: taking anti-ds please talk to your doctor and get the support that you need</td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>×</td>
</tr>
<tr>
<td>mary h(6)*</td>
<td></td>
<td>×</td>
<td>sorry to hear</td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>×</td>
</tr>
</tbody>
</table>
you are having a bad time
ring your mw and make an appointment to see your GP and tell them how you are feeling

<p>| maxine w(3)* | mutlip | × | share experience | × | lost control and lashed out in the first 4 months of my first pregnancy | had ant-ds during pregnancy | loss of control and lashed out at my partner | saw my gp enrolled with anger management classes had counselling which dealt with problems in my childhood |
| Michelle S(49)* | × | × | response to member advice | × | I had a difficult first pregnancy? depression and it took | × | × | × |</p>
<table>
<thead>
<tr>
<th>Mummy070</th>
<th>6</th>
<th>×</th>
<th>response to member</th>
<th>reassurance</th>
<th>ring the</th>
<th>hospital and</th>
<th>speak to the</th>
<th>consultant to</th>
<th>express your</th>
<th>concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>nanny s*</td>
<td>×</td>
<td>×</td>
<td>advice</td>
<td></td>
<td>exercise</td>
<td>st johns wort</td>
<td>help</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>naomi r(35)*</td>
<td>primip</td>
<td>27/40</td>
<td>×</td>
<td>×</td>
<td>I have suffered with depression off and on for most of my life [depression has been mild for the past 5 years so I have not taken any</td>
<td>if it gets worse will take antidepressants</td>
<td>my best friend has a one year old but she has moved to the USA and it would have been great for her to be over here.</td>
<td>×</td>
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</tr>
</tbody>
</table>
NASREEN H*  2  37/40  | sending hugs  | ×  | feeling pretty rubbish – do not know if it is prenatal depression or beginning of postnatal

| sharing experience | | know what it is like to have no family support Moved to new part of the country |

Natalie S(22)*  G3 [1 miss]  | ×  | share experience | ✓  | miscarriage, then finding pregnancy stressful |

| advice | | my partner is not the most sympathetic persons and were not as intimate as we used to be which I knew was causing |
| NEL S* | 2 | 8/40 & 30/40 & 33/40 | Desperate not sure I can do the PND road again sharing experience | ✓ | PND with first baby No AND with first preg but second pregnancy feels black cant look forward to anything or see anything good about the world, desperate a huge fear of getting a repeat of pnd on anti-ds – reduced when to ttc second baby did not have AND with her first preg now desperate in second pregnancy was on venlafaxine 225 mg [350mgs before] I am a born worrier and have not had the easiest of Feel desperate and don’t know where to turn desperately lonely in the day but feel too sad and down to talk to hub in evenings Having relationship problems with S-I-L and B-I-L seeing psychiatrist but lacking motivation to phone and get an earlier appt | problems. I sat him down and although I don’t think he truly understands where I am coming from it did help |


<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Gender</th>
<th>Experience</th>
<th>Advice</th>
<th>Antidepressants</th>
<th>Outcome</th>
<th>Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nic R</td>
<td></td>
<td></td>
<td>you can get AND might be worth talking to your GP or midwife</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Nicki C(37)*</td>
<td>37</td>
<td>Female</td>
<td>share experience advice worth going to your midwife</td>
<td></td>
<td>suffered AND both pregnancies and with PND too</td>
<td>offered antidepressants as told that the benefit to the mother is greater than the risk to the child – I refused to take them as I was not happy taking them in pregnancy – made me</td>
<td>midwife was a ton of support</td>
</tr>
<tr>
<td>nicki k(5)</td>
<td>2</td>
<td>×</td>
<td>spaced out</td>
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<tr>
<td></td>
<td>×</td>
<td>hope this reassures you support and share experience</td>
<td>×</td>
<td>AND both pregnancies took anti-depressants [20 mgs of citalopram] in both pregnancies doc would prefer his patients on meds than have ill mums</td>
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<td></td>
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<td>my husband also works way a lot and he is the only person that I feel safe with</td>
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<td></td>
<td></td>
<td></td>
<td>As for the people who say pull yourself together – that makes me feel bloody furious</td>
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<tr>
<td>Nicola N(96)</td>
<td>×</td>
<td>second trimester</td>
<td>feeling so ill starting to get me down and don’t know how to snap out of it currently on cyclizine and fortisip drinks for the sickness</td>
<td></td>
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<td></td>
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<td>other half is becoming short tempered fed up running after me all the time</td>
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<td></td>
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<td>going to see the doctor next week so see what they say</td>
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<tr>
<td>User</td>
<td>Multiparity</td>
<td>Sent</td>
<td>Message</td>
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<tr>
<td>Nicola P (264)</td>
<td>×</td>
<td>×</td>
<td>reassuring and knowing things will be better if just sick</td>
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<tr>
<td>Nini G</td>
<td>multip</td>
<td>×</td>
<td>sending hugs and support</td>
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</tbody>
</table>
I know how you feel.

Is there a chance taking medication could harm the baby?

Experience

Too [AND]

Pregnancy

Sometimes I am relieved as I need some me time.

Haven’t really spoken to anyone about my PND.

The only friend I have I hardly see.

Doctor who put me on anti-depressants then when pregnant dr thought it best to try without.

The only friend I have I hardly see.

Sometimes I am relieved as I need some me time.

Haven’t really spoken to anyone about my PND.

The only friend I have I hardly see.

Doctor who put me on anti-depressants then when pregnant dr thought it best to try without.
and I can't talk to her like that so when DH is away there is no one to turn to

<p>| <strong>Pat J(4)</strong>* | <strong>Parent support one plus one</strong> | × | advice reassurance talk to your other half about how you feel | × | × | × | × | × |
| <strong>Paula H(17)</strong>* | <strong>Multip</strong> | × | I know how you feel helps to know you are not alone share experiences | × | AND with first baby not too bad with this preg suffer from depression anyway [(\text{does not say when}) so dread it creeping back] | × | horrid to hubby I wanted him to feel a fraction of the grief I feel I don’t know how he puts up with me OH cant comprehend it cause he has never felt like this Our living been to counselling but don’t really feel I am getting what I need |</p>
<table>
<thead>
<tr>
<th><strong>Penny (tiredmummy)@</strong></th>
<th>multip</th>
<th>8/40 &amp; 30/40</th>
<th>share experience support and advice</th>
<th>suffered with anxiety after my 2nd baby so PND and found the first trimester of this pregnancy the most hormonal never wanted to feel like I did after the last baby really scared I will be ill and not able to cope again</th>
<th>am on sertraline now which seems to have picked up my mood but also lessened the anxiety</th>
<th>situation sucks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>pippa h(17)</strong>*</td>
<td>3</td>
<td>×</td>
<td>share experience</td>
<td>PND with all my boys reduced my meds with 3rd pregnancy and went downhill on meds reduced them when preg with 3rd baby and then went downhill</td>
<td>no support from husband family did not want her on anti-ds when pregnancy</td>
<td>×</td>
</tr>
<tr>
<td>User</td>
<td>Status</td>
<td>Group Type</td>
<td>Group Details</td>
<td>Comment</td>
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<tr>
<td>POPPYCAT@</td>
<td>multip</td>
<td>12/40 &amp; 15/40</td>
<td>Sharing experiences as they occur</td>
<td>I was on pre-pregnancy meds and they pose a risk to baby in the first</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>and the third trimester.</td>
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<td></td>
<td>I was on anti-psychotic drugs and lithium before I got pregnant I</td>
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<td></td>
<td></td>
<td>already stopped the lithium because of</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>I was on anti-depressants medication</td>
<td>worried about separation from little girl</td>
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<td>I have got good support and if things go wrong I know that I</td>
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<td></td>
<td>will get fixed</td>
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<td></td>
<td></td>
<td>has OH who discussed anti-depressants medication</td>
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</tbody>
</table>
the risks and stopped the other shortly afterwards. My consultant wanted me to stay on the meds – the benefits of staying on the meds outweighed the risks to the baby.

I decided that meds were not right for me after lots of discussion with my oh and for personal reasons.

I don’t want to start back on the meds but everyone with my husband has been away such a lot – all this week and away all next week.
else thinks I should
I honestly don’t know
how I am going to
stand there and swallow
pills that every part of
me thinks is going to end
up killing my baby

I know that my
consultant is going to say
that I need to go back on
meds when I see her but I
feel that the baby is not
ready for me to be on
meds and I feel that I
would be damaging her
| RACHAEL1977@ | G3 [1 miscarriage] | 20/40 | says that she is in the first trimester but posting Jan 2 and due 4th May | wanted to chat somewhere where women know how it feels share experience it is good to know I am not alone in it | ✓ | pnd after 2nd baby. mcc sent me spiralling for a long time Dx with AND and severe anxiety disorder | on citalopram with pnd doc Rx diazepam but afraid to take them in case something happens to the baby | Great husband and support network | told gp and that was exhausting, havent broached with midwife – way too proud. It has always been hard for me to admit I have problems |
| Racheal D(23)* | × | × | gp will not call social services speak to your midwife support and reassurance | × | × | × | × | |
| RACHEL B(472) * | Primip | × | empathise share experience advice | × | AND throughout preg | 6 months after del started again and on and off anti-d’s | single mum dad does not want to know single mum | did a course called beating the blues which was good |
| Rachel J(114)* | × | × | keep your chin up | × | I have been stressing out | × | × | × |
these last few weeks because I have been unwell but does not mean my baby will be doomed

| Rose C(16) | multip | × | It is possible to have depression during pregnancy as well as after I just want to know peoples opinions | ✓ | AND in this pregnancy not sure whether it is depression or upset about recent breakup worried about how I will cope with toddler and a new baby | × | × | recent breakup [?with partner – does not say] don’t want this to affect my relationship with my daughter |
| ruth a(56)* | Primip 1 mmc | 28/40 | ✓ | feel so sad all the time paranoid that something will go wrong | × | hate the idea of having sex – my boyfriend is OK with it but I feel really guilty | × |
I used to suffer badly with depression and feel a bit like it is returning with this pregnancy. I put on lots of weight – over two stone.

I just want to argue with everybody and push them away. I know that I won't tell anyone about it – I will just be the life and soul of the party when I am outside and then totally miserable the rest of the time.

SALLYX@

Global Moderator

reassurance

talk to your doctor about your concerns

feelings are normal

Samantha (417) *

2

share

pregnant and bump and
<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Weeks</th>
<th>Comment</th>
<th>Advice</th>
<th>Baby Sessions</th>
<th>Pizza Express</th>
</tr>
</thead>
<tbody>
<tr>
<td>Samantha W (35) *</td>
<td>2</td>
<td>37/40</td>
<td>I think you should start talking to your midwife and doctor, share your experience if you are not the only one to have these experiences. PM me.</td>
<td>PND and panic attack and scared now pregnant with about the whole thing.</td>
<td>Anti-depressants and counselling for PND.</td>
<td>Snapped at husband and child and feel really awful.</td>
</tr>
<tr>
<td>Sarah C (153) *</td>
<td>4</td>
<td>38/40</td>
<td>Need some advice and this seemed the most appropriate place.</td>
<td>31 years old PND with 2nd and third babies now is depressed with this pregnancy.</td>
<td>Divorced from father of other children unplanned pregnancy and.</td>
<td>Know I should see the doctor but scared they will call social services.</td>
</tr>
<tr>
<td>Sarah D(544)*</td>
<td>Parent Supporter, Relationships</td>
<td>really just reassurance advice and support can friends or family help</td>
<td>[AND]</td>
<td>partner is unsupportive and asking for DNA for paternity</td>
<td>went to see the midwife but could not tell her I know that I need professional help before depression gets worse</td>
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<tr>
<td>Sarah E(40)</td>
<td>multip</td>
<td>sympathise how hard it was go and see your #</td>
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<tr>
<td>Sarah M(58)*</td>
<td>multip</td>
<td></td>
<td></td>
<td>uncontrollably outbursts with her second pregnancy [prenatal depression]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sarah p(339)*</td>
<td>5 [2 x mmc]</td>
<td>30/40</td>
<td>Understand where you are coming from</td>
<td>✓</td>
<td>became very depressed after mmc this pregnancy over the moon but feel a bit sorry for myself and some days want to stay in bed [AND]</td>
<td>x</td>
</tr>
<tr>
<td>Sarah W(804)*</td>
<td>x</td>
<td>18/40</td>
<td>hugs feeling exactly the same go to the doctor</td>
<td>✓</td>
<td>sickness is getting me down</td>
<td>x</td>
</tr>
<tr>
<td>SARAH@ Global Moderator Mothers voice</td>
<td>x</td>
<td>advice writing diary challenging self destructive</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>SARAH78@</td>
<td>3</td>
<td>12/40 &amp; 15/40 &amp; 38/40</td>
<td>✓</td>
<td>nearly back on track after having Thomas [?PND] now I am going backwards and it is only going to get worse. I am so scared I am going to get bad again – I had to fight so much in the last 2 ½ years after having Thomas just getting over my pni [does she mean post natal depression] on low does of anti-depressants</td>
<td>Bryan is being really good cooked dinner and isn’t working this week-end MIL has offered to have the boys for the week-end do not trust midwives just feel they don’t care and you are not really their problem part of me feels that the doctors will think I am being silly worried that the midwife will be cross with me and then will not want to see me. don’t trust midwives and scared of not getting baby checked</td>
<td></td>
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<tr>
<td>to stupidly fall pregnant again was nearly 90% better from my pni and now I know I am going backwards all the feelings I had are flooding back and scared of getting really ill again feel like I climbed a big hill with my pni and I was ready to go down the other side and live my life, but now feel like I am falling back down that big hill</td>
<td>still hate the midwife but luckily got a good cpn and health visitor midwife promised to come and didn’t – feel like I am an inconvenience and they don’t care shouting at the kids and bryan not had the support I was promised by the midwife lucky I have got my cpn and hv – don’t know what I would have done if I hadn’t bryan will be off for the</td>
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Sharon B(42)  

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</table>
| 2 | × | Don’t know why I am feeling this way  
share experience  
don’t know whether I am coming or | × | PND after having my son now slipping back into horrid black hole again [AND] on and off anti-d’s for ages and finally came off in September, thought back on track, got preg again and slipping into black | × | lost my beloved dad loving hubby, loving son, friend moved away and lonely snappy with my husband |  |
<p>|  |  |  |  | first two weeks and then my mother-in-law is off as well for two weeks |  |  |  |</p>
<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Pregnancy</th>
<th>inson</th>
<th>Advice</th>
<th>mood</th>
<th>Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sharon W(30)</td>
<td>33</td>
<td>Unplanned</td>
<td>Hole</td>
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<td>Hole</td>
<td>Hole</td>
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<td></td>
<td></td>
<td>pregnancy</td>
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<td>I am where</td>
<td>hole</td>
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<td>hole</td>
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<td>you are at</td>
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<td>experience</td>
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<td>One day at a time</td>
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<td></td>
<td>Rx for PND [?from 2nd pregnancy] when became pregnant</td>
<td>hole</td>
<td>Hole</td>
<td>Hole</td>
<td>Hole</td>
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<tr>
<td></td>
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<td>my meds don’t work when I am being sick</td>
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<td>Hole</td>
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<td>Hole</td>
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<td></td>
<td></td>
<td>she has morning sickness</td>
<td>hole</td>
<td>Hole</td>
<td>Hole</td>
<td>Hole</td>
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<tr>
<td></td>
<td></td>
<td>having panic attacks in pregnancy</td>
<td>Hole</td>
<td>Hole</td>
<td>Hole</td>
<td>Hole</td>
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<tr>
<td></td>
<td></td>
<td>I am still not blooming in pregnancy</td>
<td>Hole</td>
<td>Hole</td>
<td>Hole</td>
<td>Hole</td>
</tr>
<tr>
<td></td>
<td></td>
<td>You are not alone</td>
<td>Hole</td>
<td>Hole</td>
<td>Hole</td>
<td>Hole</td>
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<tr>
<td></td>
<td></td>
<td>Please pm me</td>
<td>Hole</td>
<td>Hole</td>
<td>Hole</td>
<td>Hole</td>
</tr>
<tr>
<td>Steph A</td>
<td></td>
<td>Chronic depression for many years</td>
<td>Hole</td>
<td>Hole</td>
<td>Hole</td>
<td>Hole</td>
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<tr>
<td></td>
<td></td>
<td>PND with eldest – went down right down in this pregnancy</td>
<td>Hole</td>
<td>Hole</td>
<td>Hole</td>
<td>Hole</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I am taking anti-depressants for panic attacks [do not think I could cope without meds] but also take anti-sickness as I could not keep anything down</td>
<td>Hole</td>
<td>Hole</td>
<td>Hole</td>
<td>Hole</td>
</tr>
<tr>
<td></td>
<td></td>
<td>midwife and cpn supportive</td>
<td>Hole</td>
<td>Hole</td>
<td>Hole</td>
<td>Hole</td>
</tr>
<tr>
<td>steph j(4)</td>
<td>multip</td>
<td>×</td>
<td>Advice through sharing experience</td>
<td>×</td>
<td>PND with last pregnancy and suffering ongoing and with this pregnancy AND</td>
<td>Rx prozac but have found they have made me feel much worse and have taken myself off them</td>
</tr>
<tr>
<td>-------------</td>
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<td>---------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Stephanie T(4)*</td>
<td>2</td>
<td>×</td>
<td>What do you think I should do? Would you see the doctor or the midwife/ Anyone who had depression in pregnancy your help would be</td>
<td>✓</td>
<td>suffered with PND with my first now pregnant with my second and starting to feel sad again [AND] worrying in pregnancy that I would suffer from</td>
<td>started taking citalopram when my daughter was 10 weeks old and took them for about 4 months went off antids before preg but if was not</td>
</tr>
</tbody>
</table>

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160
<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>G</th>
<th>Feelings</th>
<th>Postnatal Depression (PND)</th>
<th>Side Effects</th>
<th>Support System</th>
</tr>
</thead>
<tbody>
<tr>
<td>tea@</td>
<td></td>
<td></td>
<td>Great</td>
<td></td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>teresa g(31)*</td>
<td>38/40</td>
<td></td>
<td>Just needed to write down how I felt</td>
<td>PND after birth of first child eight years ago</td>
<td>Started back on fluoxetine 4 weeks ago</td>
<td>Husband is fantastic but works shifts and is not home until late</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>really good to get other opinions on this</td>
<td>Now AND feel like pooh tired and no motivation</td>
<td>On and off meds for the past 8 years since birth of my son</td>
<td>No parents or family</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Share experience</td>
<td></td>
<td>2nd posting PND after birth of first child – on and off them ever since</td>
<td>Have friends but they have kids of their own</td>
</tr>
<tr>
<td>tracey C(188)*</td>
<td>G2</td>
<td></td>
<td>Wondering if it is possible to go through antenatal depression rather than postnatal</td>
<td>Feel awful during pregnancy not very excited – taken me ages to bond</td>
<td>Unplanned and upset at the effect will have on daughter</td>
<td></td>
</tr>
</tbody>
</table>
| **Tracy T(41)** | ❌ | ✗ | see your midwife  
it is something they take seriously share experience | ✗ | AND during pregnancy but miscarried the pregnancy | ✗ | ✗ | GP told me to see mw  
my midwife was brillant – taken AND very seriously  
appt made to see consultant but mmc |
|-----------------|----|----|---------------------------------------------|----|---------------------------------------------|----|----|---------------------------------------------|
| **Yana G**      | 2  | ✗  | advice – seek help before it gets any worse  
no one will | ✔  | Dx with PND after I had my first child but I think I started | ✗  |    | I wish I would have asked for help sooner |
| **Depression**  |    |    | I’m going through something similar  
Relief to know I am not the only one |    | with the bump going through the motions |    |    |                                            |
| Yvonne@ | Global Moderator | advice | make an appointment with your doctors please keep persisting advice on Rx | getting it when I was pregnant [AND]
I think I start getting it when I am pregnant
Stopped taking the pills now that I am pregnant with my second [coping better] but not kidding myself might come back | history of depression |  |  |  |

| Yvonne@ | Global Moderator | advice | make an appointment with your doctors please keep persisting advice on Rx | getting it when I was pregnant [AND]
I think I start getting it when I am pregnant
Stopped taking the pills now that I am pregnant with my second [coping better] but not kidding myself might come back | history of depression |  |  |  |
| ecezma and other general advice |   |   |   |   |   |
Key

* = Netmums Coffeehouse
@ = Mothersvoice
✓ = Yes
◆ = No information

133 women have contributed to 46 threads
Appendix 8: Tables showing quantitative analysis of “invited” internet postings
<table>
<thead>
<tr>
<th>nId</th>
<th>GPs and Midwives level of knowledge of mental health in pregnancy</th>
<th>Maybe you did not want to talk to your GP?</th>
<th>Where they able to help?</th>
<th>Response from mental health team [MHT]</th>
<th>Response from GPs/Drs</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>n/a</td>
<td>Did not want to talk to my GP, nothing they could do for me</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>02</td>
<td>n/a</td>
<td>n/a</td>
<td>not understood, emotional needs are not being met</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>03</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>MHT are taking their time</td>
<td>GP and consultant are very, very worried – wanted it sorted out</td>
</tr>
<tr>
<td>04</td>
<td>GP well informed on perinatal mental health</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>GP treated me as an intelligent human being Other pregnancy [violent, suicidal] – no one suggested I could see anyone</td>
</tr>
<tr>
<td>06</td>
<td>n/a</td>
<td>Never said anything, thought someone would take children away</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>07</td>
<td>Put down to hormones in pregnancy</td>
<td>Told my midwife I didn’t feel too good</td>
<td>Wish I had got the help I needed mw’s should have asked me why I did not want to breast feed</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>08</td>
<td>Doctor told me I had anxiety which I had worked out for myself</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>Doctor told me I had anxiety which I had worked out for myself</td>
</tr>
<tr>
<td>09</td>
<td>n/a</td>
<td>scared Dr would think I did not love baby and they would take him away</td>
<td>n/a</td>
<td>n/a</td>
<td>scared Dr would think I did not love baby and they would take him away</td>
</tr>
<tr>
<td>10</td>
<td>Dr’s put it down to pregnancy hormones</td>
<td>Dr</td>
<td>n/a</td>
<td>n/a</td>
<td>Dr’s put it down to pregnancy hormones</td>
</tr>
</tbody>
</table>
| 11  | -All doctor did was give me a leaflet on depression  
- no information on the side effects of anti-d’s  
Dr said it was pregnancy hormones | Spoke to Dr  | All doctor did was give me a leaflet on depression  
Seen six midwives during pregnancy  
Never see the same midwife | MH services cancelled my Appt x 3 times, so gave up  
All Dr did was give me a leaflet on depression  
Changed doctors half way through pregnancy  
Dr said it was pregnancy hormones  |
|-----|---------------------------------------------------------------|-------------|---------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|
| 13  | n/a  | Did not want to discuss it with anyone really  
Rushed appts, mw rarely asked how I was  
Spoke to Dr at practice who was lovely  
CPN good at listening | n/a  | n/a  | Tried hard to speak to GPs but they would not help unless I gave up breast feeding  |
| 14  | n/a  | Saw GP at 20/40  
-my midwife didn’t care | Refer to mental health team | -midwife didn’t care/midwife horrible/bad |
17 -my midwife is bad
-midwife and hosp horrible when I rang [false starts] Dr refer to MHT and put me on meds
-cpn was horrible
-see cpn every 2/52
counselling groups
-Dr referred me to MHT

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>n/a</th>
<th>n/a</th>
<th>- don’t know who I can talk to [?Professional or Friend]</th>
<th>Counselling didn’t help when I had depression a few years ago</th>
<th>n/a</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td></td>
<td>n/a</td>
<td>n/a</td>
<td>- Have not spoken to anyone about the way I feel Put on a brave face when I see the mw Don’t want people judging me and not believing me</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>16</td>
<td></td>
<td>n/a</td>
<td>n/a</td>
<td>Not seen doctor or midwife to talk about my feelings Not seen them to talk about my feelings - don’t think there is much they can do</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>17</td>
<td></td>
<td>n/a</td>
<td>n/a</td>
<td>MHT so pressed for time - felt like a 2nd class citizen; no CBT, counseling; only option was medication;</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td></td>
<td>Felt antenatal care was a low priority as it was my 4th baby</td>
<td>Provided the cheapest, easiest option. Don’t want to resort to them again</td>
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</tr>
<tr>
<td>18</td>
<td>-midwife and doctor were understanding but that was about it</td>
<td>-discussed with doctor and midwife -resources, time to chat with m/w were scarce</td>
<td>midwife and doctor were understanding but that was about it</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-visited private counselor and have found it extremely beneficial</td>
<td>-offered counseling through doctors surgery but would have had baby by the time seen</td>
<td>- midwife and doctor were sympathetic but that was about it</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- 2nd or 3rd pregnancy you are left to get on with it</td>
<td>-midwife suggested counseling</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Mw told me it was normal not to feel anything for unborn child</td>
<td>- did try and talk to my midwife - didn’t say anything to anyone else until after baby born - spoke to my health visitor a little about this</td>
<td>Mw told me it was normal not to feel anything for your unborn child</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>n/a</td>
<td>- did try and talk to my midwife who told me it was normal not to feel anything for your unborn child - spoke to my health visitor a little about this</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>-mostly they were out of their depth and decided they would ignore it</td>
<td>-did talk to my midwives who said it would be fine and left go over 11/7</td>
<td>-no one would listen or help me -planned to kill myself and no one took me seriously</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-no one would listen or help me -felt let down by people who should have helped me</td>
<td>n/a</td>
<td>-midwives said it would be fine and left to go over 11/7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Page</td>
<td>n/a</td>
<td>-trying to get help from midwifery and pregnancy assessment unit</td>
<td>-trying to get help from midwifery and pregnancy assessment unit and this is the response told me to stop being irrational</td>
<td>n/a</td>
<td>-hospital told me to stop being irrational -told some people have real problems</td>
<td></td>
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<td>--------------------------------------------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>23</td>
<td>n/a</td>
<td>-liked my GP, psychiatrist, midwife to have been more informed -“normalized” symptoms -not taken seriously -3/12 before diagnosis made Dr</td>
<td>n/a</td>
<td>n/a</td>
<td>-medics do not think sickness might be due to something sickness ;upsetting ;confusing me - professionals “normalized” my symptoms -only one person took my coming off 5-HPT seriously -only after 3/12 did obstetrician suggest that I might be suffering withdrawal</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>-Gynaecologists and psychiatrists had little knowledge of the severity of my condition -difference in care and input from specialist psychiatrists and n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>-blanket term of depression was used, but was not an adequate explanation of the symptoms I was displaying</td>
<td></td>
</tr>
<tr>
<td></td>
<td>psychotherapists was striking</td>
<td></td>
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<tr>
<td>26</td>
<td>- Midwife little experience or access to resources - Medics and midwives understand body mechanisms but not mind - Annoyed that midwifery books not devoted to depression in pregnancy - Don't think medical profession trained enough</td>
<td>- Went to see my midwife, getting help long time and many visits back and forth</td>
<td>- Went to see my midwife, getting help long time and many visits back and forth - Treatment with sleeping pills, helped a little, but not symptoms</td>
<td>n/a</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- PND mentioned but not ANXD - Felt never taken seriously enough - Doctor said normal hormonal fluctuations
<table>
<thead>
<tr>
<th>Id</th>
<th>MOODS</th>
<th>THOUGHTS</th>
<th>BEHAVIOUR</th>
<th>PHYSICAL REACTIONS</th>
<th>TRIGGERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Mild depression</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>02</td>
<td>Depression [occasional]</td>
<td>Don’t feel loved/liked/desired</td>
<td>Stay in pj’s for days on end</td>
<td>Cant stop crying</td>
<td>PTSD from previous emergency C Section</td>
</tr>
<tr>
<td></td>
<td>Anger</td>
<td>Dissatisfied with life</td>
<td></td>
<td>No energy – go no get</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Resentful</td>
<td>Yearn for happiness</td>
<td></td>
<td>up and go</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Despair</td>
<td>Prospect of loneliness and</td>
<td></td>
<td>anymore/don’t bother doing anything</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Isolated</td>
<td>domesticity daunting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>03</td>
<td>Terrible Depression</td>
<td>n/a</td>
<td>Stay in pj’s for days on end</td>
<td>Cant stop crying</td>
<td>History of Depression since I was young</td>
</tr>
<tr>
<td></td>
<td>Stressed</td>
<td></td>
<td></td>
<td>No energy – go no get</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Upset</td>
<td></td>
<td></td>
<td>up and go</td>
<td></td>
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<tr>
<td></td>
<td>Scared</td>
<td></td>
<td></td>
<td>anymore/don’t bother</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>doing anything</td>
<td></td>
</tr>
<tr>
<td>04</td>
<td>Petrified [Repeat performance of</td>
<td>Suicidal</td>
<td>Violent outbursts</td>
<td>n/a</td>
<td>• threatened travelers</td>
</tr>
<tr>
<td></td>
<td>terrible birth]</td>
<td>Urge to self harm</td>
<td></td>
<td></td>
<td>• parents separated</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• house move</td>
</tr>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td>• traumatic first birth</td>
</tr>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td>• held to ransom by patient</td>
</tr>
<tr>
<td>06</td>
<td>Scared [get pni after birth]</td>
<td>What if…thoughts</td>
<td>n/a</td>
<td>n/a</td>
<td>Baby not planned</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Will someone take</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lot of anxiety in the 3&lt;sup&gt;rd&lt;/sup&gt; trimester Mixed emotions</td>
<td>children away if I admit feelings</td>
<td></td>
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<td></td>
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<td>---------------------------------------------------------------</td>
<td>----------------------------------</td>
<td>---</td>
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<td></td>
</tr>
<tr>
<td>07</td>
<td>Angry all the time Anxious Constantly upset Scared; Worried taking betablockers “felt on edge”</td>
<td>Not coping</td>
<td>Bleeding Sickness Did not feel too good</td>
<td>Things went wrong with the 2&lt;sup&gt;nd&lt;/sup&gt; pregnancy</td>
<td></td>
</tr>
<tr>
<td>08</td>
<td>Fear Severe anxiety throughout pregnancy</td>
<td>Mind working overtime Didn’t understand the way I was feeling Thought I was going to end up a bad person, like a murder or something</td>
<td>Panic going to meetings or the shops</td>
<td>Felt sick Diarrhoea [due to fear inside]</td>
<td>Anxiety when came off pill</td>
</tr>
<tr>
<td>09</td>
<td>Scared [dr think would not love baby and take him away]</td>
<td>Wanted to die Thought take baby away [because I did not love him]</td>
<td>n/a</td>
<td>No energy/motivation - did not want to dress/work/tidy</td>
<td>Went down hill after threatened with traveller</td>
</tr>
</tbody>
</table>
| 10 | Depression [horrific]  
    Worthless  
    Guilt  
    Afraid [feelings wont go away] | Suicidal  
    Can't cope feeling like this much longer | Trying hard to fight feelings, wont go away until my relationship destroyed | n/a | Had depression all my life  
    Suffer from guilt after cheating on my husband a few years ago |
|---|---|---|---|---|
| 11 | Depression [since leaving work]  
    Severe depression throughout my pregnancy  
    “Feeling low” | | Crying, insomnia [want to sleep all the time] | Depression worse since leaving work |
| 13 | Felt ungrateful [not to be ecstatic]  
    Hit “rock bottom” | Suicidal/Felt could not go on/ If not pregnant would have attempted to take my own  
    Thinking and feeling in ways I could not understand myself | n/a | |
| 14 | Feeling more and more down  
    Worried [going to get really ill /baby going to die] | Baby going to die  
    Going to get ill again | SPD, bleeding | Baby not planned [wanted abortion, could not go through with it]  
    SPD and on crutches and support belt |
<table>
<thead>
<tr>
<th></th>
<th>Emotions</th>
<th>Experience</th>
<th>Coping Strategies</th>
<th>Supporting Circumstances</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>Depressed&lt;br&gt;Guilty&lt;br&gt;Angry&lt;br&gt;Upset&lt;br&gt;“Stuck in a rut” insecure</td>
<td>n/a</td>
<td>Take it out on my partner&lt;br&gt;Pushing my partner away</td>
<td>Crying</td>
</tr>
<tr>
<td></td>
<td>Scared [depression will get the better]&lt;br&gt;Feel things will get harder before better&lt;br&gt;Think I will get PND&lt;br&gt;Scared of losing the baby</td>
<td>Feel things will get harder before better&lt;br&gt;Lost all my friends&lt;br&gt;Shut myself in my room&lt;br&gt;Find it hard to leave house&lt;br&gt;Lay in bed</td>
<td>Don't like daylight</td>
<td>Partner in prison&lt;br&gt;Practically homeless&lt;br&gt;Had abortion when 14 years old, depressed me a lot&lt;br&gt;In debt</td>
</tr>
<tr>
<td>17</td>
<td>n/a</td>
<td>Struggling to cope&lt;br&gt;Know that I can do this, prefer to persevere</td>
<td>Husband immature&lt;br&gt;Came off anti-d’s to get pregnant</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Depression</td>
<td>Difficult to cope with feelings</td>
<td>Have not been able to tell my friends how I feel</td>
<td>Came off SSRI’s when found pregnant&lt;br&gt;Had bouts of depression in previous years</td>
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<td>Depressed</td>
<td>SPD from 14/52</td>
<td>Miscarriage six month before SPD from 14/52 gestation</td>
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<td>21</td>
<td>Depression</td>
<td>thought child parasite thought better to kill myself</td>
<td>Pre-term labour</td>
<td>Went into prem labour and in hospital for 2/52</td>
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<td>planned to kill myself without harming baby</td>
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<td>Don't know what to do</td>
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<td>Confused</td>
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<td>24</td>
<td>Mood swings</td>
<td>Suicidal</td>
<td>Irrational</td>
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<td>Irritated</td>
<td>Obsessive thoughts</td>
<td>Over eating/binge eating/ no control over eating/overweight Vomiting</td>
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<td>Thought would get PND</td>
<td>Long term user of MHS Anxiety, depression and eating disorders See psychiatrist regularly</td>
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<td>Hyperemesis Gravidarum Massive weight loss from nausea</td>
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<td>Worried excessively Panic Depression</td>
<td>Intrusive thoughts Thought I would hurt someone or do something to someone I love Thought must be a bad person</td>
<td>Couldn’t sleep Panic</td>
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<td>Thought I was going to die</td>
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<td>Depression lifted when my baby was born</td>
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<tr>
<td>02</td>
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<td>Don't feel liked or loved by anybody</td>
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<tr>
<td></td>
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<td>Not heard; Husband not demonstrative</td>
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<tr>
<td>03</td>
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<td>Baby's father left me when he found out</td>
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<td></td>
<td></td>
<td>I was pregnant – had one night stand with</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>my friend</td>
<td></td>
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<td>04</td>
<td>On Prozac then taken off after making attempt on my life prescribed sertraline</td>
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<tr>
<td>06</td>
<td>On meds for ?this pregnancy</td>
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<td></td>
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<tr>
<td>07</td>
<td>Beta blockers but stopped taking them as worried they would affect the baby</td>
<td>Relationship with my partner suffered as I was angry all the time</td>
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<td>08</td>
<td>Had meds</td>
<td>Tried talking to my husband and mum but no one understood much</td>
<td>With help of meds and the discussion board slowly becoming the person I used to be</td>
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<td>09</td>
<td>Can't take anti-depressants when fell pregnant and doctor took me off citaloprom</td>
<td>Partners mum made me have an abortion [previously] and still not over it</td>
<td>Discussion board website and medication [sertraline]– now fine postnatally</td>
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<td>10</td>
<td></td>
<td>I had affair, but we are happy together now</td>
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<td>11</td>
<td>Stopped ant-depressants before pregnancy – no information on the side effects of them</td>
<td>Have moved house/Left work Changed doctors</td>
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<td>13</td>
<td>Dr refused medication if I intended to breastfeed</td>
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<td>Still struggling despite the baby being 15 months old</td>
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<td></td>
</tr>
<tr>
<td>14</td>
<td>Put on meds at 20 weeks pregnancy</td>
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| 15 | Taking things out on my partner  
Feeling very insecure and pushing my  
partner away  
Don’t know who I can talk to |
| 16 | Lost all my friends  
Ptnt in jail [preg 3/12 into relationship  
and ptnt not too sure]  
Grandmother died  
Father alcoholic  
No support from parents  
Partners parents don’t know |
| 17 | Came off anti-depressants to become pregnant  
Husband not grown up, if he was would  
feel a whole lot better.  
I am the only adult in the family  
2 children in the family who are  
registered disabled |
| 18 | Periodically taken SSRI’s - came off them when found I was pregnant  
I have not been able to tell my friends  
how I’ve been feeling |
|   | Did not say anything until after my baby  
was born |
| 21 | On fluoxetine at 32/40 but did nothing  
No one would listen or help me |
| 23 | -----  
----- |

Counseling did not help when I had depression a few years ago  
Know I can do this and will come through, so prefer to persevere  
My midwife said she had other mums to be with similar or worse  
feelings – found comforting to know that I was not the only person  
in the world feeling like this  
Not only person who feels like this, feelings don’t mean you are a  
failure, there are people who understand – can give you sense of  
relief
| 24 | Came off all prescribed meds when pregnant  
    Started to take 5-HTP [self prescribed]  
    but stopped after fear of possible implications | Did not want conventional meds  
    Meditation, relaxation and reading  
    Understanding and explanation from obstetrician made me feel more hopeful and positive about the future |
| 25 | | |
| 26 | On meds during pregnancy | Access to discussion group  
    Moderators and website were a Godsend | Wonderful husband and family |
Appendix 9: Tables showing Chronological listing of “invited postings” and e-mails received from discussion board members
Chronological listing of “invited postings” and e-mails received from discussion board members regarding care they received from midwives and GP’s, when experiencing mental health problems in pregnancy [February – October 2008]

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Appendix 10: Information sheet and consent form for health professionals
Information about the research

Midwives' views on the care of women who are depressed in pregnancy

We would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish.

What is the purpose of the study?
Antenatal depression is a serious condition affecting 1 in 10 pregnant women. Depression in pregnancy can have several adverse effects on the mother and infant and is associated with serious obstetrical, fetal and neonatal complications. The care and management of depressed women in pregnancy are therefore important health issues.

The purpose of our study is to investigate the views of midwives in caring for women who are experiencing depression in pregnancy. Our objective in carrying out this research is to improve the care that women receive when they are depressed in pregnancy.

Why have I been invited?
You have been asked to take part in the study because you have booked to attend a midwives’ study day in perinatal mental health at the University of York.

What is involved in the study?
As part of the study day programme, all participants will take part in small group discussions based on the presentations that you have heard earlier in the day. We would like to be able to tape record these discussions so that we have a record of midwives’ perspectives on the care of women who are depressed in pregnancy. It is for the tape recording, transcription and subsequent use of these as research material that we are seeking your consent. No personally identifying information will be included in the transcripts.
Do I have to take part?
Taking part in the study is completely voluntary. If you decide that you do not want to take part in the research study then you will be placed in a group where the discussions will not be audio-taped nor will any data be used for research purposes.

If you do decide to take part in the study we would ask you to sign the consent form giving us permission to audio-tape and use your data. If after signing the consent form you wanted to withdraw specific comments or statements that you have made during your participation in the discussion group you would be free to do so. You would not be asked to give us a reason for wanting to withdraw comments or statements but we would ask that you make this request within seven days of the focus group discussion having taken place.

Would my taking part in this study be kept confidential?
We will follow ethical and legal practice and all information collected as part of the study will be handled in confidence. Your name and any information contained in the transcripts that might identify you will be removed.

What would happen to the results of the research?
The study findings will be reported to the funders and written up for publication. Direct quotations may be used but no research publication would identify you individually. The data will be stored, in anonymised form, for 5 years. If you would like to see the study findings, please indicate this on the consent form and we will email you when a summary is available.

Will participating in the study have any direct benefit for me or carry any risks?

There is no direct benefit for you participating in the study, beyond the opportunity to have your views represented in our research and subsequent recommendations.

Who is running the study?
We are based at the Mother and Infant Research Unit, Department of Health Sciences, University of York. The study is supervised by Josephine Green, Professor of Psychosocial Reproductive Health and Helen Spiby, Senior Lecturer in Evidence- based Midwifery Practice. It is funded by the Burdett Trust for Nursing and has been approved by York Research Ethics Committee (REC Ref.)

Patricia Jarrett
Research Fellow
Mother and Infant Research Unit
Department of Health Sciences
University of York
Heslington
York, YO10 5DD.
CONSENT FORM

Title of Project: Midwives' views on the care of women who are depressed in pregnancy

Name of Researcher: 

1. I confirm that I have read and understand the information sheet dated Autumn 2008 [version2] for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand my participation is voluntary and that I am free to withdraw use of my data any time without giving any reason.

3. I consent to the use of audio-taping to record group discussions and I understand that there is a possibility of anonymised direct quotations being used in reports and journal articles.

4. I agree to take part in the above study

Name of Participant ___________________________ Date ______________ Signature ___________________________

Name of person taking consent ___________________________ Date ______________ Signature ___________________________
Appendix 11: Vignettes scenarios used during focus group discussion
Method used to develop vignettes

Referred to paper by Hall Moran, V., Dykes, F., Burt, S and Shuck, C [2006] *Breastfeeding support for adolescent mothers: similarities and differences in the approach of midwives and qualified breastfeeding supporters.* International Breastfeeding Journal who have used vignettes in a qualitative research project.

A number of themes were identified from the “archived” and “invited” postings. Themes which were felt to represent some aspect of interaction between women and health professionals or those themes which were felt to represent the most commonly expressed experiences of women were selected to inform the development of the vignettes. These were identified as:

- experiencing physical pain
- not being taken seriously
- lack of continuity of care/carer
- use of anti-depressants during pregnancy
- fear of getting postnatal depression
- anxiety
- isolation
- self harm
- postnatal depression before pregnancy
- frightened of disclosure to health professionals

The study objectives were to explore [1] the knowledge [midwives understanding] and [2] the attitudes of midwives in supporting women who are depressed in pregnancy [3] and their educational needs. Although we did use prompts to explore the actions of midwives, we did acknowledge the difficulty associated with using vignettes in reflecting the action of practitioners in real situations.

### Vignette One

(a) Sharon is a 28 year old married woman who is pregnant with her second child. She has a five year old child living with her. She tells you that she has had a bad back for years and has symphysis pubis dysfunction with this pregnancy. She says that she has had to stop picking her son up from school because walking for ten minutes has her in tears. She says that she is snappy with her son and husband, feels like a bad mother and ends up in tears.

What would your response be to this woman?

Prompts after initial response:

1. What do you feel are your responsibilities to this woman?
2. What else would you want to know?
3. What support would you offer?
4. What action would you take?
(b) She has gone to see her GP who has told her that it is just one of those things and that there is nothing he can do. She says that she has seen a total of six midwives in the course of her pregnancy and her appointments are always rushed.

What would your response be to this woman?

Prompts after initial response:
(1) What do you feel are your responsibilities to this woman?
(2) What else would you want to know?
(3) What support would you offer?
(4) What action would you take?

(c) She now tells you that she had postnatal depression with her first child and has taken herself off anti-depressants when she discovered she was pregnant with her second child. She now feels very low.

What would your response be to this woman?

Prompts after initial response:
(1) What do you feel are your responsibilities to this woman?
(2) What else would you want to know?
(3) What support would you offer?
(4) What action would you take?

(d) She tells you that she is frightened of getting postnatal depression again and this is causing her to feel anxious in her current pregnancy.

What would your response be to this woman?

Prompts after initial response:
(1) What do you feel are your responsibilities to this woman?
(2) What else would you want to know?
(3) What support would you offer?
(4) What action would you take?

Vignette Two

Claire is a 32 year married woman who has become pregnant for the first time. Her pregnancy was planned and she has wanted a baby for years. She has been very anxious throughout her pregnancy. Clare tells you she is having regrets about the pregnancy. She doesn't understand why she feels as she does.

What would your response be to this woman?
Prompts after initial response:

(1) What do you feel are your responsibilities to this woman?
(2) What else would you want to know?
(3) What support would you offer?
(4) What action would you take?

She tells you that her husband has his own business and works long shifts. A close friend of hers has moved away recently. She tells you that she finds it difficult to open up to and express her feelings to her doctor.

What would your response be to this woman?

Prompts after initial response:

(1) What do you feel are your responsibilities to this woman?
(2) What else would you want to know?
(3) What support would you offer?
(4) What action would you take?

Later in the pregnancy Clare tells you that she has thoughts of harming herself. She does not feel that she is going to be able to cope when she has the baby.

What would your response be to this woman?

Prompts after initial response:

(1) What do you feel are your responsibilities to this woman?
(2) What else would you want to know?
(3) What support would you offer?
(4) What action would you take?

Vignette Three

Anne is a 36 year old single woman who is pregnant with her third child and says that she has been feeling very bad during her pregnancy, keeps crying, is really irritable, can't sleep, and has gained loads of weight through eating junk, and just generally feeling rubbish. She has not being able to shake the impending doom feeling she constantly has.

What would your response be to this woman?

Prompts after initial response:

(1) What do you feel are your responsibilities to this woman?
She said that she had a horrific birth with the last baby and still has the nightmares. She had PND with her last pregnancy and has felt in a lot of turmoil about the pregnancy from the start. She was told by her GP that she might be suffering from antenatal depression but that there was nothing he could do as she was pregnant.

What would your response be to this woman?

Prompts after initial response:

(1) What do you feel are your responsibilities to this woman?
(2) What else would you want to know?
(3) What support would you offer?
(4) What action would you take?

She has told you that she does not feel that she can cope anymore. She feels guilty all the time about the effect her depression is having on her other children. She feels like a bad mother and is frightened that Social Services will take away her children away from her.

What would your response be to this woman?

Prompts after initial response:

(1) What do you feel are your responsibilities to this woman?
(2) What else would you want to know?
(3) What support would you offer?
(4) What action would you take?
Appendix 12: Major Themes and Sub-themes from focus group discussions
Table 3 – Major themes and sub-themes identified from focus group discussions

<table>
<thead>
<tr>
<th>MAJOR THEMES</th>
<th>SUB-THEMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midwives Practice</td>
<td>• <strong>Midwives awareness</strong> of women’s experience of depression and the vulnerability of women to developing mental health problems in pregnancy,</td>
</tr>
<tr>
<td></td>
<td>• <strong>Midwives interaction with women</strong> e.g. acknowledging and validating women’s experience, making yourself open, making sure she does not feel rushed</td>
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<tr>
<td></td>
<td>- Exploring</td>
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<tr>
<td></td>
<td>- Direct Questions</td>
</tr>
<tr>
<td></td>
<td>- Observing body language</td>
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<tr>
<td></td>
<td>• <strong>Midwives management of antenatal appointments</strong></td>
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<tr>
<td></td>
<td>- Flexibility in appointments</td>
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<tr>
<td></td>
<td>- more frequent or longer appointments</td>
</tr>
<tr>
<td></td>
<td>- Home Visits [convenient for woman and assess home situation]</td>
</tr>
<tr>
<td></td>
<td>- Communication [importance of, mobile phone, EPDS as communication]</td>
</tr>
<tr>
<td></td>
<td>- Continuity</td>
</tr>
<tr>
<td></td>
<td>- Support from other midwives</td>
</tr>
<tr>
<td></td>
<td>• <strong>Midwives attitudes to providing care</strong></td>
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<tr>
<td></td>
<td>- Don't know what to do, left floundering, stood on a cliff</td>
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<tr>
<td></td>
<td>- Only deal with the normal</td>
</tr>
<tr>
<td></td>
<td>- Midwife lead professional</td>
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<tr>
<td>Involvement of Services</td>
<td>• <strong>Services accessed</strong>, e.g.</td>
</tr>
<tr>
<td></td>
<td>- Health visitors</td>
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<tr>
<td></td>
<td>- Mental health services</td>
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<tr>
<td></td>
<td>- Voluntary services</td>
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<tr>
<td></td>
<td>- Alternative therapies</td>
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<tr>
<td></td>
<td>- Non-professional services</td>
</tr>
<tr>
<td></td>
<td>• <strong>Re-organisation of services</strong>, effect on communication and relationship**</td>
</tr>
</tbody>
</table>

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| Women’s Experience of depression | Variation in provision of services, [Home Start, perinatal mental health midwives] variation in quality of professionals [GP’s], variation in midwives power of referral  
Response of mental health services  
Lack of clear pathway for provision of care  
Women will not disclose, e.g. don’t realise depressed, don’t disclose to strangers  
Women will not access services, e.g. vulnerable women won’t or, cannot access  
Women do not understand what they are being asked  
Stigma, women do not want to be thought of as mentally ill  
Women’s perception of health professionals, midwives vs. health visitors and social workers  
Support for women  
origins and experience of women’s depression  
women’s expectations and cultural expectations as catalyst in depressive illness  
women’s use of medication in pregnancy |
|---|---|
| Barriers to providing good care | Time restraints  
Resources [not enough people]  
Finances |
| Training | Lack of training in counselling and listening skills  
Perinatal mental health midwives  
Midwives confidence and understanding of dealing with mental health problems |
| detection and management of antenatal depression | Management of Physical versus emotional care of women  
Management of Antenatal versus postnatal depression |
<p>| Policy and legislation | Confidential Enquiry into Maternal and Child Health influences |</p>
<table>
<thead>
<tr>
<th></th>
<th>awareness]</th>
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<tbody>
<tr>
<td></td>
<td>• NICE report [impact on practice]</td>
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<tr>
<td></td>
<td>• Whoolley questions</td>
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<tr>
<td></td>
<td>• Midwives’ inability to influence wider policy</td>
</tr>
<tr>
<td>Health Visitors</td>
<td>• Referral to health visitor</td>
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<td>• Health visitors’ practice</td>
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Table 2 – identifiers for midwives and health visitors

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<thead>
<tr>
<th>Focus Group</th>
<th>ID</th>
<th>Professional Status</th>
<th>Focus Group</th>
<th>ID</th>
<th>Professional Status</th>
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<tbody>
<tr>
<td>FG1</td>
<td>SM1</td>
<td>Pre-registration midwife</td>
<td>FG3</td>
<td>HV2</td>
<td>Health Visitor</td>
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<tr>
<td></td>
<td>HM1</td>
<td>Hospital midwife</td>
<td></td>
<td>SPM1</td>
<td>Community Midwife [Perinatal Mental health specialist]</td>
</tr>
<tr>
<td></td>
<td>HV1</td>
<td>Health Visitor</td>
<td></td>
<td>CM6</td>
<td>Community Midwife</td>
</tr>
<tr>
<td></td>
<td>CM1</td>
<td>Community Midwife</td>
<td></td>
<td>CM7</td>
<td>Community Midwife</td>
</tr>
<tr>
<td></td>
<td>CM2</td>
<td>Community Midwife</td>
<td></td>
<td>HM2</td>
<td>Hospital midwife</td>
</tr>
<tr>
<td>FG2</td>
<td>SM2</td>
<td>Pre-registration midwife</td>
<td>FG4</td>
<td>HV3</td>
<td>Health Visitor</td>
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<tr>
<td></td>
<td>SHV1</td>
<td>Student Health Visitor</td>
<td></td>
<td>CM8</td>
<td>Community Midwife [non-specialist]</td>
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<tr>
<td></td>
<td>CM3</td>
<td>Community Midwife</td>
<td></td>
<td>HM3</td>
<td>Hospital midwife</td>
</tr>
<tr>
<td></td>
<td>CM4</td>
<td>Community Midwife</td>
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<td>HV4</td>
<td>Health Visitor</td>
</tr>
<tr>
<td></td>
<td>CM5</td>
<td>Community Midwife</td>
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